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, 1 August 2019 commencing at 9:00am

	Apologies		9.00am
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 30 May 2019		
3.	Carried Forward / Action List Items		
4.	Specialist Mental Health Services (Presentation)	Toni Gutschlag	9.05-9.35am
5.	Hospital Service Monitoring Report: Mental Health Older Persons, Orthopaedics & Rehabilitation Hospital Laboratories Rural Health Services Medical/Surgical & Women's & Children's Health ESPIs	 Toni Gutschlag Dan Coward Kirsten Beynon Berni Marra Win McDonald Pauline Clark	9.35-10.20am
6.	H&SS 2018/19 Year Results (Presentation)	Justine White	10.20-10.35am
7.	Clinical Advisor Update (Oral) • Allied Health	 Jacqui Lunday-Johnstone	10.35-10.45am
8.	Resolution to Exclude the Public		10.45am
ESTIMATED FINISH TIME – PUBLIC MEETING			**10.45am**
	Information Items: 2019 Workplan		

NEXT MEETING: Thursday, 3 October 2019 at 9.00am

ATTENDANCE – PUBLIC

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE MEMBERS

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

Executive Support

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

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

COMMITTEE MEMBER ATTENDANCE SCHEDULE 2019 – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NAME	31/01/19	04/04/19	30/05/19	01/08/19	03/10/19	05/12/19
Andrew Dickerson (Chair)	√	√	√			
Jo Kane (Deputy Chair)	√	√	^			
Barry Bragg	#	√	#			
Sally Buck	√	√	√			
Dr Anna Crighton	√	√	~			
David Morrell	√	√	√			
Jan Edwards	√	√	√			
Dr Rochelle Phipps	√	√	√			
Trevor Read	√	#	√			
Dr John Wood (ex-officio)	√	√	√			
Ta Mark Solomon (ex-officio)	#	√	#			

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

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

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

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

Andrew Dickerson **Chair – HAC** Board Member	**Canterbury Health Care of the Elderly Education Trust** - Chair Promotes and supports teaching and research in the care of older people. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Canterbury Medical Research Foundation** - Member Provides financial assistance for medical research in Canterbury. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Heritage NZ -** Member Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance and Heritage NZ has already been involved with CDHB buildings. **Maia Health Foundation -** Trustee Is a charitable trust established to support health care in the CDHB area. Current projects include fundraising for a rooftop helipad and enhancements to the children's wards at Christchurch Hospital. **NZ Association of Gerontology** - Member Professional association that promotes the interests of older people and an understanding of ageing.
Jo Kane **Deputy Chair – HAC** Board Member	**Christchurch Resettlement Services** - Member Christchurch Resettlement Services provides a range of services to people from refugee and migrant backgrounds. It works alongside refugee communities in delivering services that aim to achieve positive resettlement outcomes. **HurriKane Consulting** – Project Management Partner/Consultant A private consultancy in management, communication and project management. Any conflicts of interest that arise will be disclosed/advised. **Latimer Community Housing Trust** – Project Manager Delivers social housing in Christchurch for the vulnerable and elderly in the community. **NZ Royal Humane Society** – Director Provides an awards system for acts of bravery in New Zealand. It is not anticipated any conflicts of interest will arise.
Barry Bragg Board Member	**Air Rescue Services Limited** - Director Subsidiary of the Canterbury West Coast Air Rescue Trust. Has gaming licenses with specified purpose of fundraising for air rescue services. **Canterbury West Coast Air Rescue Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air rescue and air ambulance services. Garden City Helicopters has a long-term

	air ambulance contract with the CDHB. **CRL Energy Limited** – Director CRL Energy Limited provides air quality testing and asbestos sampling and analysis services; methamphetamine contamination testing; dust; gas and noise workplace monitoring services in New Zealand. There is the potential for future work with the CDHB. **Farrell Construction Limited** - Chairman Farrell's Construction Limited is a commercial and light commercial construction company based in Christchurch. **New Zealand Flying Doctor Service Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB. **Ngai Tahu Farming** – Chairman Farming interests in North Canterbury and Queenstown Lakes District and Forestry interests in Canterbury, West Coast and Otago regions. **Ngai Tahu Property Limited** – Chairman Potential for future property development work with the CDHB. Also, Ngai Tahu Property Limited manage first right of refusal applications from the CDHB on behalf of Te Runanga o Ngai Tahu. **Ngai Tahu Property (CCC-JV) Limited** – Director Wholly owned subsidiary of Ngai Tahu Property. **Stevenson Group Limited** – Deputy Chairman Property interests in Auckland and mining interests on the West Coast. **Taurus Management Limited** – Director Property syndication company based in Christchurch
Sally Buck Board Member	**Christchurch City Council (*CCC*)** – Community Board Member Chair of the Central/Linwood/Heathcote Community Board which has delegated responsibilities from the CCC. **Registered Resource Management Act Commissioner** From time to time, sit on Resource Management Act panels for the CCC. Specific interests will be declared at the time. **Rose Historic Chapel Trust** – Member Charitable voluntary body managing the operation of the Rose Historic Chapel, a CCC owned facility.
Dr Anna Crighton Board Member	**Christchurch Heritage Limited** - Chair - Governance of Christchurch Heritage **Christchurch Heritage Trust** – Chair - Governance of Christchurch Heritage **Heritage New Zealand –** Honorary Life Member CDHB owns buildings that may be considered to have historical significance. **The Art Registry Company Limited** - Shareholder **Theatre Royal Charitable Foundation** – Director
Jan Edwards	No conflicts at this time.

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

Canon Emeritus - Christchurch Cathedral
The Cathedral congregation runs a food programme in association with CDHB staff.
Friends of the Chapel - Member

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

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

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

Nurses Memorial Chapel Trust – Member
(CDHB Appointee) Trust responsible for Memorial Chapel on the Christchurch Hospital site. Note the chapel is now owned by the Christchurch City Council.</td></tr>
<tr><td>Dr Rochelle Phipps</td><td>Accident Compensation Corporation – Medical Advisor
ACC is a Crown entity responsible for administering NZ's universal no-fault accidental injury scheme. As a Medical Advisor, I analyse and interpret medical information and make recommendations to improve rehabilitation outcomes for ACC customers.

OraTaiao: New Zealand Climate & Health Council – Founding Executive Board Member (no longer on executive)
The Council is a not-for-profit, politically non-partisan incorporated society and comprises health professionals in Aotearoa/New Zealand concerned with:
• the negative impacts of climate change on health;
• the health gains possible through strong, health-centred climate action;
• highlighting the impacts of climate change on those who already experience disadvantage or ill health (equity impacts); and
• reducing the health sector's contribution to climate change.

Royal New Zealand College of General Practitioners – Christchurch Fellow and Former Board Member
The RNZCGP is the professional body and postgraduate educational institute for general practitioners.</td></tr>
<tr><td>Trevor Read</td><td>Lightfoot Solutions Ltd – Global Director of Clinical Services
Lightfoot Solutions has contracts with CDHB, and other health providers who have contracts with CDHB, to provide business intelligence tools and related consulting services. Should a conflict arise, this will be discussed at the time.</td></tr>
</table>

Ta Mark Solomon **Ex Officio – HAC** Deputy Chair CDHB	**Claims Resolution Consultation – Senior Maori Leaders Group** – Member This is an Advisory Board to MSD looking at the claims process of those held under State care. **Deep South NSC (National Science Challenge) Governance Board** – Member The objective of Deep South NSC is set by Cabinet, and is to understand the role of the Antarctic and Southern Ocean in determining our climate and our future environment. Building on this objective, the mission was developed to guide our vision, research priorities and activities. **Governance Board (General Partnership Limited) Te Putahitanga o Te Waipounamu** – Board Member Te Putahitanga o Te Waipounamu is a commissioning entity that works on behalf of the iwi in the South Island to support and enable whanau to create sustained social impact by developing and investing in ideas and initiatives to improve outcomes for Māori, underpinned by whānau-centred principles and strategies, these include emergency preparedness and disaster recovery. Te Pūtahitanga o Te Waipounamu also invests in Navigator roles to support and build whānau capability. **Greater Christchurch Partnership Group** – Member This is a central partnership set up to coordinate our city's approach to key issues. It provides a strong, joined up way of working and ensures agencies are travelling in the same direction (so they do not duplicate or negate each other's work). **He Toki ki te Rika / ki te Mahi** – Patron He Toki ki te Rika is the next evolution of Māori Trade Training re-established after the earthquakes to ensure Maori people can play a distinguished role in the Canterbury rebuild. The scheme aims to grow the next generation of Māori leadership in trades by building Māori capability in the building and infrastructure industries in Canterbury. **Interim Te Ropu** – Member An Interim Ropu has been established to work in partnership with the Crown, Ministers, and the joint venture to help develop and shape initial work on a national strategy to prevent and reduce family violence, sexual violence and violence within whānau. The interim Te Rōpū has been appointed by the Minister of Māori Development and the Lead Minister in consultation with the Minister of Māori/Crown Relations. It comprises up to ten members who bring appropriate skills and expertise and who can reflect communities, rangatahi and whānau, urban and regional Māori and wāhine Māori. The group will help inform the terms of reference of the permanent Te Rōpū, with advice due by April 2019. **Liquid Media Operations Limited** – Shareholder Liquid Media is a start-up company which has a water/sewage treatment technology. **Maori Carbon Foundation Limited** – Chairman The Maori Carbon Foundation has been established to deliver environmental, social and economic benefits through the planting of permanent carbon forestry, to Maori and New Zealand landowners throughout the country. **Ngāti Ruanui Holdings Corporation Limited** – Director Ngati Ruanui Holdings is the Investment and Economic Development Arm of Ngati Ruanui established to maximise profits in accordance with Te Runanga

	directions in Taranaki. **NZCF Carbon Planting Advisory Limited** – Director NZCF Carbon Planting Advisory Limited is a company that carries out the obligations in respect of planting and upskilling relating to the Maori Carbon Foundation Limited. **Oaro M Incorporation** – Member 'Oaro M' Incorporation was established in 1968. Over the past 46 years successive Boards have managed and maintained the whenua, located at 'Oaro M', Kaikōura, on behalf of its shareholders. Over time shareholders have requested the Board consider establishing an education grant in order to assist whānau with their educational aspirations. **Police Commissioners Māori Focus Forum** – Member The Commissioner of Police has a group of senior kaumatua and kuia who meet with him regularly to discuss issues of mutual interest and concern. Known as the Commissioner's Māori Focus Forum, the group helps guide policing strategy in regard to Māori and provides advice on issues of the moment. The Māori Focus Forum developed The Turning of the Tide with help from Police. The forum plays a governance role and helps oversee the strategy's implementation. **Pure Advantage** – Trustee Pure Advantage is comprised of business leaders who believe the private sector has an important role to play in creating a greener, wealthier New Zealand. It is a not-for-profit organisation that investigates and promotes opportunities for green growth. **QuakeCoRE** – Board Member QuakeCoRE is transforming the earthquake resilience of communities and societies through innovative world-class research, human capability development, and deep national and international collaborations. They are a Centre of Research Excellence (CoRE) funded by the New Zealand Tertiary Education Commission. **Rangitane Holdings Limited & Rangitane Investments Limited** - Chair The Rangitāne Group has these two commercial entities which serve to develop the commercial potential of Rangitāne's settlement assets. A Board of Directors oversee the governance of the commercial entities, and are responsible for managing Crown lease properties and exploring commercial development opportunities to support the delivery of benefits to Rangitāne members. **SEED NZ Charitable Trust** – Chair and Trustee SEED is a company that works with community groups developing strategic plans. **Sustainable Seas NSC (National Science Challenge) Governance Board** – Member This is an independent Board that reports to the NIWA Board and operates under the Terms and Conditions specified in the Challenge Collaborative Agreement. The Board is responsible for appointing the Director, Science Leadership Team, Kāhui Māori, and Stakeholder Panel for projects within the Sustainable Seas NSC. The Board is also responsible for approving projects within the Research and Business Plan and for allocating funding. **Taranaki Capital Partners Limited** – Director Not for profit company looking after share portfolios for Nga Rauru & Ngati Ruanui.

	Te Ohu Kai Moana – Director Te Ohu Kai Moana is an organisation that works to advance Maori interests in the marine environment, including customary commercial fisheries, aquaculture and providing policy and fisheries management advice and recommendations to iwi and the wider Maori community. **Te Ohu Kai Moana Portfolio Management Services Limited** – Director Sub-committee of Te Ohu Kai Moana **Te Ohu Kai Moana Trustee Limited** – Director & Trustee Charitable Trust of Te Ohu Kai Moana. **Te Putea Whakatupu Trustee Limited** – Shareholder Standalone Trust affiliated to Te Ohu Kai Moana. **Te Wai Maori Trustee Limited** – Shareholder Standalone Trust affiliated to Te Ohu Kai Moana. **Te Waka o Maui** – Independent Representative Te Waka o Maui is a Post Settlement Governance Entity.
Dr John Wood **Ex Officio – HAC** Chair CDHB	**Advisory Board NZ/US Council** – Member The New Zealand United States Council was established in 2001. It is a non-partisan organisation, funded by business and the Government, and committed to fostering and developing a strong and mutually beneficial relationship between New Zealand and the United States. The Advisory Board supports the day to day work of the Council by providing strategic and operational advice to both the Executive Board and the Executive Director. **Chief Crown Treaty Negotiator for Ngai Tuhoe** Settlement negotiated. Deed signed and ratified. Legislation enacted. **Chief Crown Treaty Negotiator for Ngati Rangi** Settlement negotiated. Deed signed and ratified. Legislation awaiting enactment. **Chief Crown Treaty Negotiator, Tongariro National Park** Engagement with Iwi collective begins July 2018. **Chief Crown Treaty Negotiator for the Whanganui River** Settlement negotiated. Deed signed and ratified. Legislation enacted. **Chief Crown Negotiator & Advisor, Mt Egmont National Park Negotiations** High level agreement in principle reached. Aiming for deed of settlement end of 2018. **School of Social and Political Sciences, University of Canterbury** – Adjunct Professor Teach into graduate and post graduate programmes in political science, trade policy and diplomacy – pro bono appointment. **Te Arawhiti, Office for Maori Crown Relations Governing Board, Ministry of Justice** – Ex-Officio Member Te Arawhiti, Ministry of Justice, are responsible for negotiating the settlement of historical Treaty of Waitangi claims, and the administration of the Marine and Coastal Area (Takutai Moana) Act 2011. They also advise and help claimant groups so they are ready to enter negotiations.

	Te Urewera Governance Board –Member The Te Urewera Act replaces the Te Urewera National Parks Act for the governance and management of Te Urewera. The purpose of the Act is to establish and preserve in perpetuity a legal identity and protected status for Te Urewera for its intrinsic worth, its distinctive natural and cultural values, the integrity of those values, and for its national importance. Inaugural term as a Crown appointment, re-appointed as a Ngai Tuhoe nominee. **University of Canterbury (*UC*) Council** – Council Member The University Council is responsible for the governance of UC and the appointment of the Vice-Chancellor. It sets UC's policies and approves degree, financial and capital matters, and monitors their implementation.

MINUTES – PUBLIC

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE HOSPITAL ADVISORY COMMITTEE MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch,
on Thursday, 30 May 2019, commencing at 9.00am

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

APOLOGIES
Apologies for absence were received and accepted from Barry Bragg; Dr Anna Crighton; and Ta Mark Solomon.
An apology for lateness was received and accepted from Jo Kane (9.25am).

EXECUTIVE SUPPORT
David Meates (Chief Executive); Mary Gordon (Executive Director of Nursing); Carolyn Gullery (Executive Director, Planning Funding & Decision Support); Sue Nightingale (Chief Medical Officer); Kay Jenkins (Executive Assistant, Governance Support); and Anna Craw (Board Secretariat).

IN ATTENDANCE

Item 4
Dr Amanda Lyver, Paediatric Oncologist and Chair, National Child Cancer Network
Kirsten Ballantine, Analyst, Coordinator New Zealand Children's Cancer Registry

Item 6
Pauline Clark, General Manager, Medical/Surgical & Women's & Children's Health
Toni Gutschlag, General Manager, Specialist Mental Health Services
Dan Coward, General Manager, Older Persons, Orthopaedics and Rehabilitation
Kirsten Beynon, General Manager, Laboratories
Berni Marra, Manager, Ashburton Health Services
Win McDonald, Transition Programme Manager, Rural Health Services

Draft

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
David Morrell – addition – Niece working as Policy Advisor on the public inquiry into the Earthquake Commission.

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 (07/19)
(Moved: Sally Buck/Seconded: Dr Rochelle Phipps – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 4 April 2019 be approved and adopted as a true and correct record."

3. CARRIED FORWARD/ACTION ITEMS

There were no carried forward items.

4. CHILDREN'S HAEMATOLOGY & ONCOLOGY CENTRE (PRESENTATION)

Dr Amanda Lyver, Paediatric Oncologist and Chair, National Child Cancer Network; and Kirsten Ballantine, Analyst, Coordinator New Zealand Children's Cancer Registry, presented to the Committee on the New Zealand Children's Cancer Registry (*NZCCR*).

An overview was provided of what NZCCR is; its eligibility criteria; what information it holds; what "Shared Care" is; and how this is achieved.

The presentation highlighted that:

- child cancer survival in New Zealand is comparable with our usual benchmark health systems; and
- there is no difference in survival for the usually accepted differentiators of ethnicity, urban/rural, socioeconomic status.

Jo Kane joined the meeting at 9.25am.
The meeting moved to Item 6.

6. H&SS MONITORING REPORT

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

General Managers spoke to their areas as follows:

Specialist Mental Health Services (*SMHS*) – Toni Gutschlag, General Manager

- Challenges continue in the AT&R environment. A workshop is scheduled with Ministry of Health colleagues mid June 2019 to focus on sustainability of AT&R services, with an emphasis on patient care and staff wellbeing.
- Joan Taylor has been appointed to the role of Director of Nursing.
- SMHS continues to work closely with Planning & Funding with regards to mosque attack recovery processes and ensuring that appropriate wrap around services are available.

The Government's response to the Inquiry into Mental Health and Addiction, as provided to CDHB Board members on Wednesday, 29 May 2019, is to be circulated to external HAC members for their information.

The meeting moved to Item 5.

5. 2019 WINTER PLANNING UPDATE

Pauline Clark, General Manager, Medical/Surgical & Women's & Children's Health, presented the report. Discussion took place around the following:

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- The high rates of influenza already being experienced, with it noted that this has hit harder and earlier than in previous years. 40 influenza cases have been admitted to Christchurch Hospital over the last week. The impact of this and flow on effects are significant.
- The need for flexibility and a system wide response. The importance of remaining cool, calm and collected when the system is under pressure.
- The effectiveness of the vaccine against the current flu strain.
- The ongoing health and wellbeing of staff.

The Committee received the report.

The meeting returned to Item 6.

6. H&SS MONITORING REPORT

General Managers continued to speak to their areas as follows:

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

- The Muslim community of Christchurch invited representatives from DHB services to a special dinner last week to express thanks for the treatment and care received. The ongoing support the DHB continues to receive locally, nationally and internationally by both Muslim and non-Muslim communities is extremely humbling.
- The "Save Teddies" operation has been a success and is now complete.
- All services have returned to the Outpatients building, which is now fully functional. The impact of this incident has been significant.

ESPIs
Agreement has been reached with the Ministry of Health for CDHB to provide monthly manual reporting on ESPI5, with the first report provided last month. ESPI5 is the current priority focus area to ensure surety around year end figures. Focus will then shift to ESPI2.

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

- Focus continues on falls. Strategies as part of the Safe Recovery Programme have been focusing on what activity can be improved during night shifts, such as the use of night lights in patient bedrooms and ensuites. There has also been a focus on working as a team on admission and focusing closer attention for the first few days of admission.
- A new programme is being rolled out to address medication errors.
- The Spinal Unit is on track for opening in August 2019.
- There has been a greater use of telemedicine in spinal care outreach. Work continues to advance in this area

There was discussion around the shortage of spinal surgeons and recruitment plans.

Laboratories – Kirsten Beynon, General Manager

- Influenza and respiratory virus activity is increasing.
- CDHB has a reputation for being a leader in the Point of Care Testing (*POCT*) setting. As such, it has had close interaction with the POCT team at Waitemata DHB when it was awarded funding for the Rural POCT implementation in the Auckland region, sharing its understanding of services implemented in Canterbury and other learnings.
- Two forensic pathologists have recently been appointed and will join Dr Martin Sage in the Forensic Pathology and Mortuary Service, ensuring stabilisation of the Service.

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- Updates were provided around Facilities, E-Ordering, Molecular Microbiology, and Laboratory Information System issues.

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

- In partnership with Otago University, Ashburton Health Services recently delivered the first Trauma and Emergency in Rural Settings programme. Seventeen participants from all over New Zealand, and including five from the Cook Islands, arrived in Ashburton for an immersion week of teaching and training. Several of the participants indicated a desire to work in the Ashburton Hospital and will be applying for RMO rotations as they arise later in the year. This is the first time that this course/programme has been delivered in a rural setting.
- As the result of a recent spike in Mycoplasma Bovis cases, primary mental health providers are coming together to address sustainable ongoing support in this area. There will be a focus on providing clear and succinct messaging, as well as easily accessible information to enable connection to appropriate services.
- Allied health staff have shifted their focus from a hospital based service to more of a community delivery based service.

Rural Health Services – Win McDonald, Transition Programme Manager

- The Akaroa IFHC is progressing as scheduled. The building handover will take place July 2019, with the official opening on 7 September 2019.
- Measles vaccination messaging has been successful in the Chatham Islands, with a further 47 families now vaccinated.
- There has been a recent focus across all rural sites on Advance Care Plans and Acute Care Plans.

The Committee received the report.

7. CLINICAL ADVISOR UPDATE – MEDICAL (ORAL)

Dr Sue Nightingale, Chief Medical Officer, provided updates on:

- Clinical Board. Has been in abeyance while being re-established to take a whole of system overview. This should occur in the next few months.
- Review of Research Office and Committees. Review has been completed. Primary recommendations are for an immediate review of the governance system, and the immediate appointment of a CDHB Director of Research in a leadership role across the DHB. Following this, a wider strategy for integration of activities with Te Papa Hauora/Health Precinct is recommended.
- New Technologies. A New Treatments and Technologies Programme (*NT&T*) has been developed in response to a recurring demand from the organisation for a clear rational process for adopting new treatments and technologies, including the purchase of new consumables.
- Health Emergency Planning. A designated business continuity planner is assisting services in developing plans, lining up policies and approaches. A review of the DHB's response to the events of 15 March 2019 has been undertaken, and whilst feedback has been very positive, learnings have also been identified.
- Resident Medical Officers. Industrial negotiations - facilitation process continues. Due to be completed 31 May 2019.

The Committee requested a presentation on the NT&T Programme to a future meeting. This will be scheduled.

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8. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (8/19)
(Moved: David Morrell/Seconded: Trevor Read – carried)

"That the Committee:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of the minutes of the public excluded meeting of 4 April 2019.	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(If required)*	Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)

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

INFORMATION ITEMS

- Quality & Patient Safety Indicators Level of Complaints
- 2019 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 11.25am.

Approved and adopted as a true and correct record:

________________________ ____________________
Andrew Dickerson Date of approval
Chairperson

Draft

CARRIED FORWARD/ACTION ITEMS

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE
CARRIED FORWARD ITEMS AS AT 1 AUGUST 2019

	DATE RAISED	ACTION	REFERRED TO	STATUS
1.	30 May 2019	New Treatments and Technologies Programme - Presentation	Dr Sue Nightingale	Scheduled for 5 December 2019 meeting.

Specialist Mental Health Services

Presentation to HAC 01.08.19

Demand

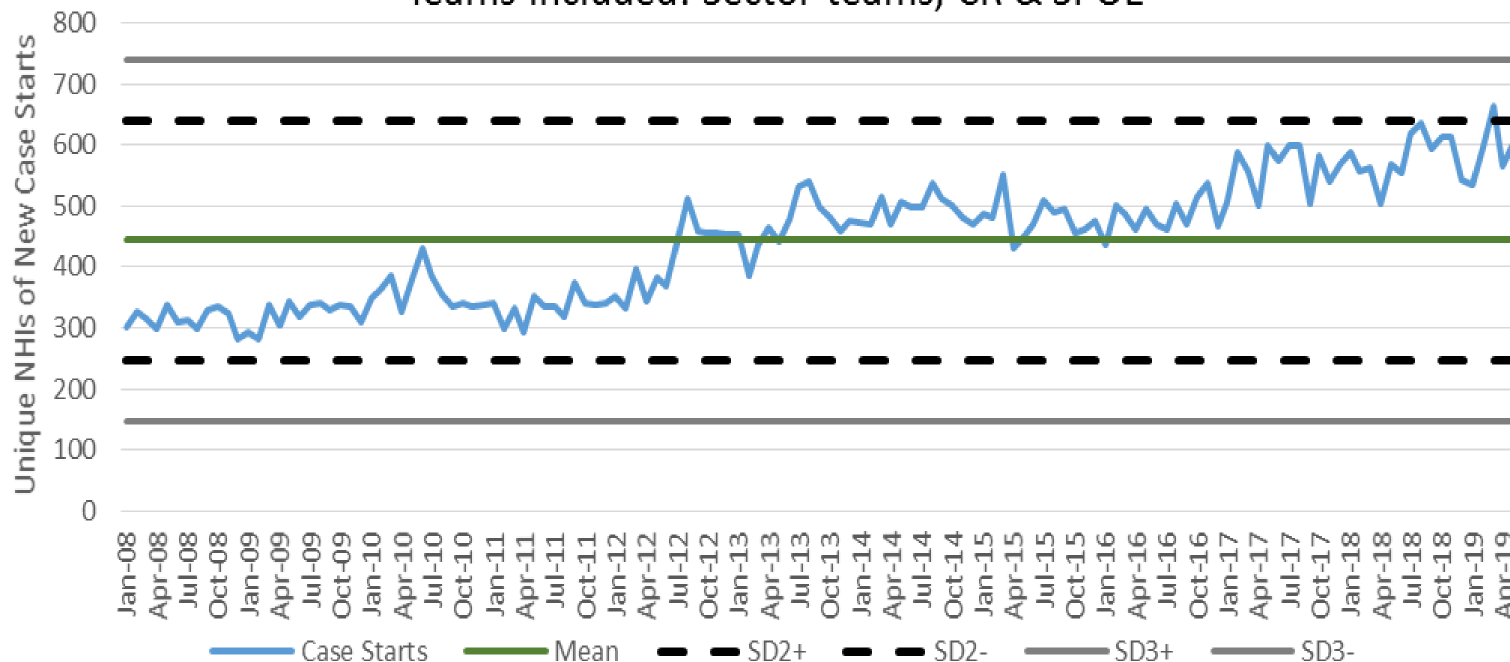
There have been measurable changes to service demand and utilisation in the period from January 2008 to June 2019. This includes the period following the Canterbury earthquakes.

Access Data

Age	Ethnicity	MOH	DHB	Population	MoH %	DHB%	Target
0-19	Māori	1166	803	21593	5.4%	3.7%	3%
	Non-Māori	3706	3426	119548	3.1%	2.9%	3%
	Pacific	117	108	3900	3.0%	2.8%	3%
	Total	4872	4229	139200	3.5%	3.0%	3%
20-64	Māori	2571	1572	26781	9.6%	5.9%	3%
	Non-Māori	10371	8630	314273	3.3%	2.7%	3%
	Pacific	336	237	8400	4.0%	2.8%	3%
	Total	12942	10202	340579	3.8%	3.0%	3%
65+	Māori	45	21	3462	1.3%	0.6%	3%
	Non-Māori	596	418	85143	0.7%	0.5%	3%
	Pacific	7	2	538	1.3%	0.4%	3%
	Total	641	439	91571	0.7%	0.5%	3%

Note: Population figures calculated using MoH client access numbers & access rates

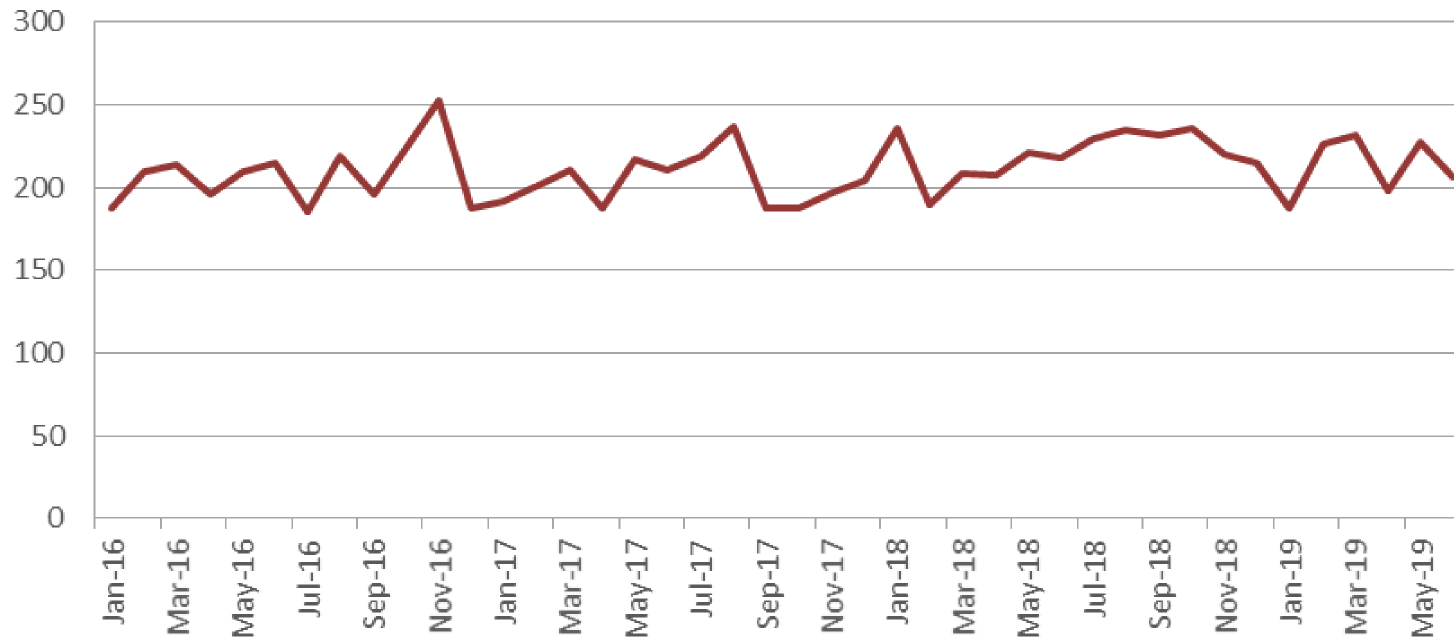
Adult Community New Case Starts



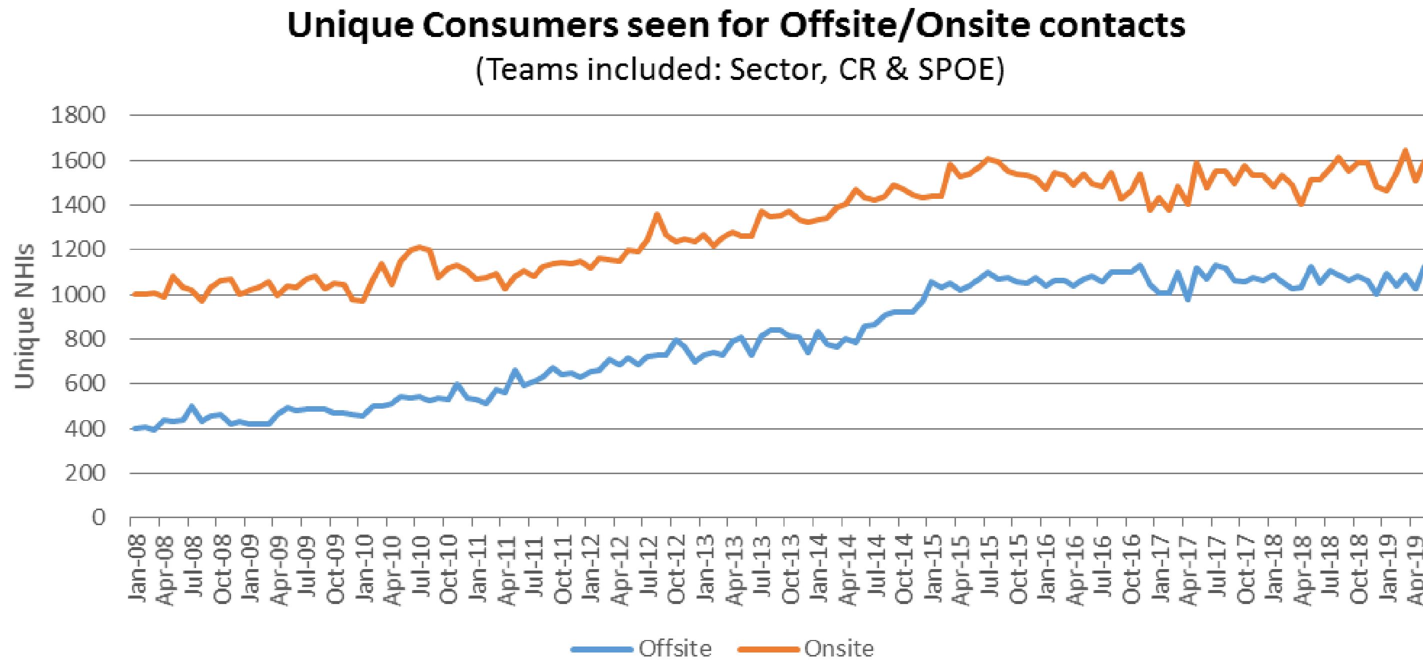
Unique NHI Adult Community Case Starts

Unique NHI-ACS Case Starts (Sector, PES, SPOE)		1 Yr change	2 Yr change	3 Yr Change	4 Yr Change	5 Yr Change	6 Yr Change	7 Yr Change	8 Yr Change	9 Yr Change
Yr 08/09	3760									
Yr 09/10	4230	13%								
Yr 10/11	4036	-5%								
Yr 11/12	4223	5%	0%							
Yr 12/13	5434	29%	35%	28%						
Yr 13/14	5921	9%	40%	47%	40%					
Yr 14/15	5869	-1%	8%	39%	45%	39%				
Yr 15/16	5743	-2%	-3%	6%	36%	42%	36%			
Yr 16/17	6162	7%	5%	4%	13%	46%	53%	46%		
Yr 17/18	6734	9%	17%	15%	14%	24%	59%	67%	59%	
Yr 18/19	7133	6%	16%	24%	22%	20%	31%	69%	77%	69%

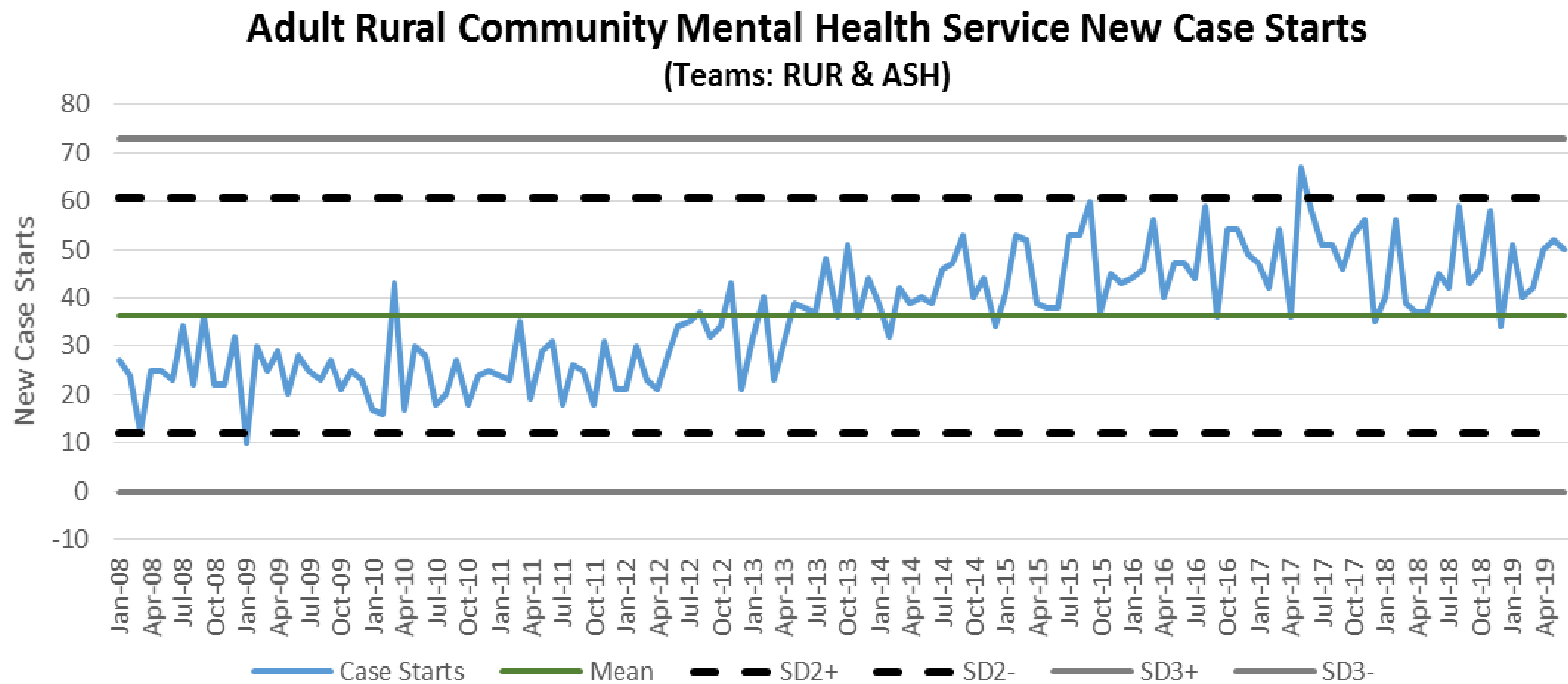
New Cases: Adult Crisis Resolution



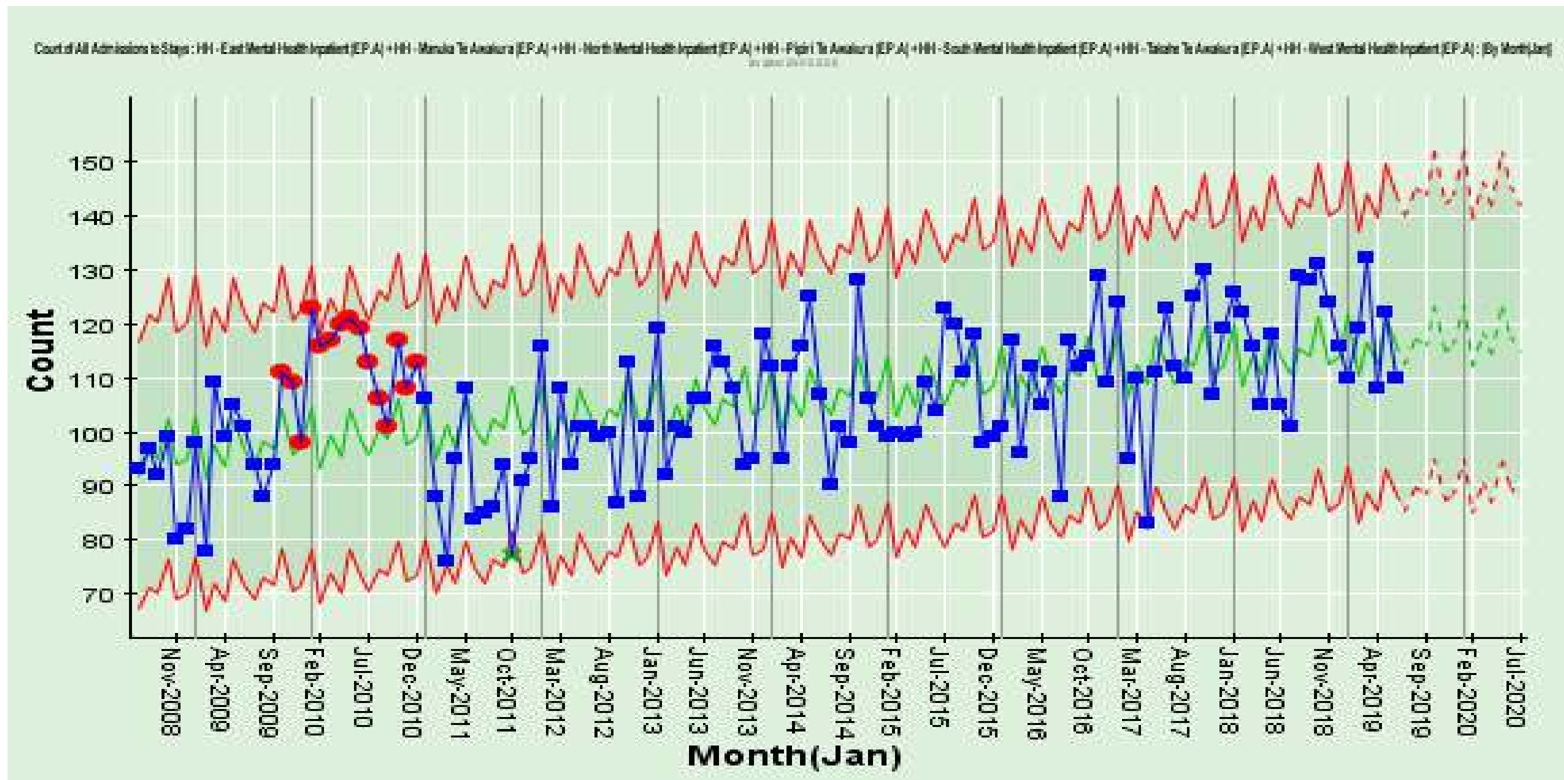
Offsite / Onsite Adult Community contacts



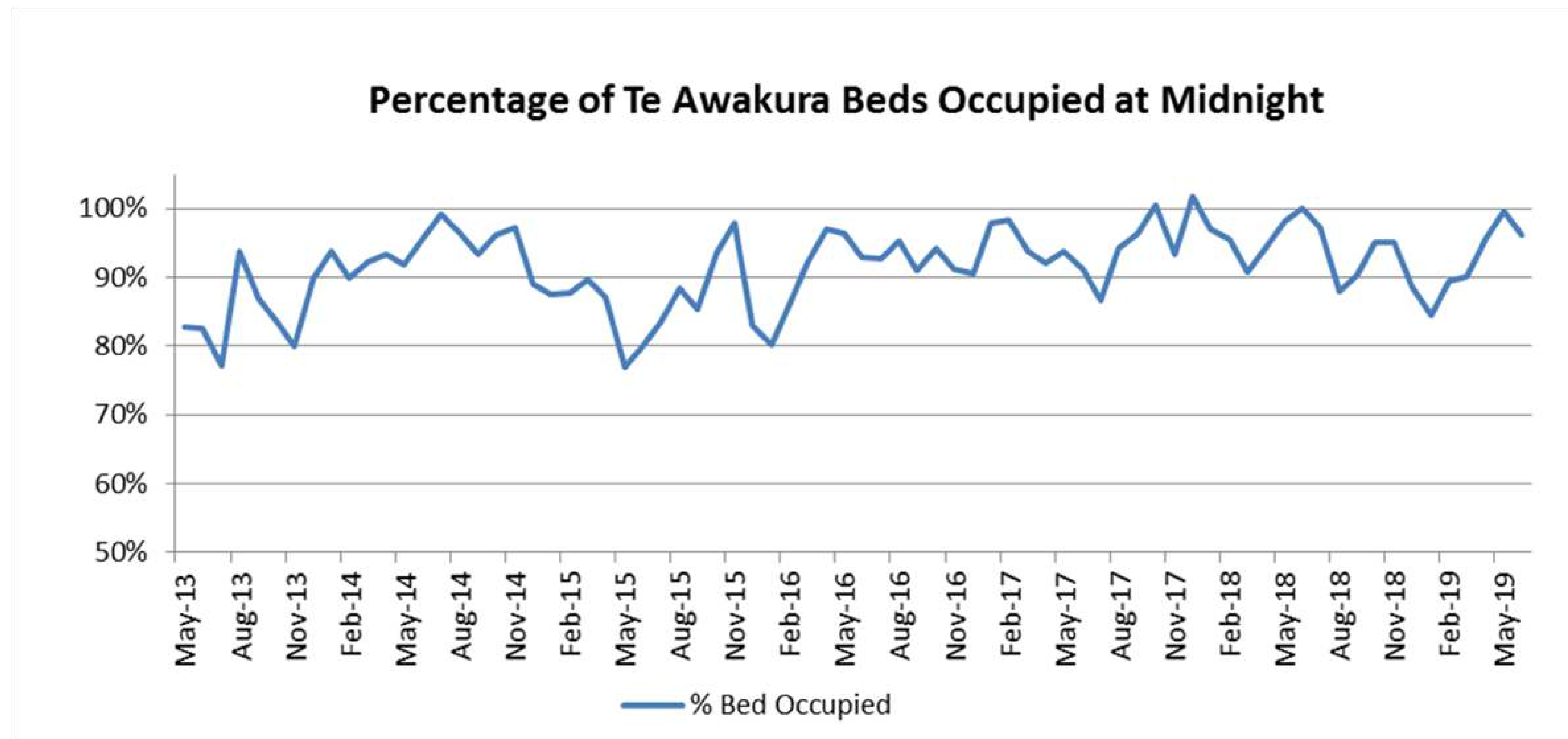
Adult Rural New Case Starts



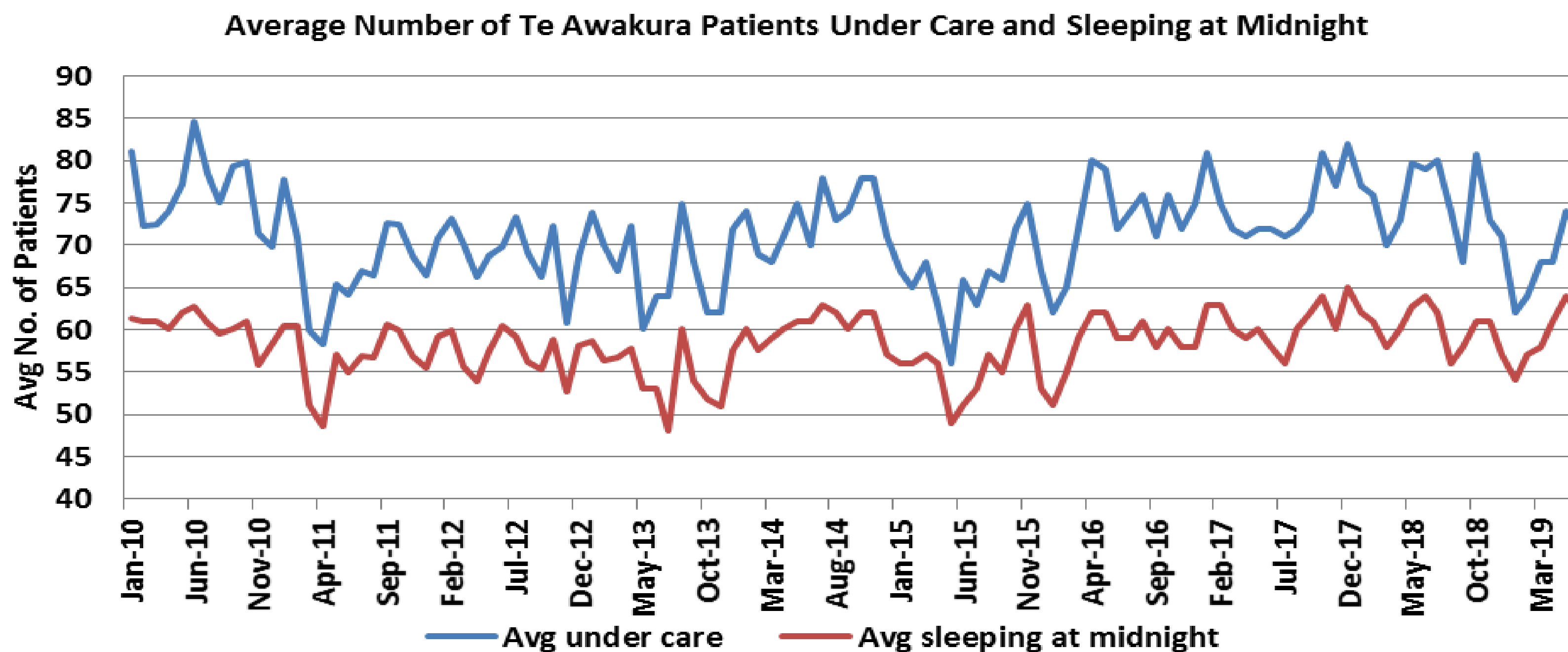
Te Awakura Admissions



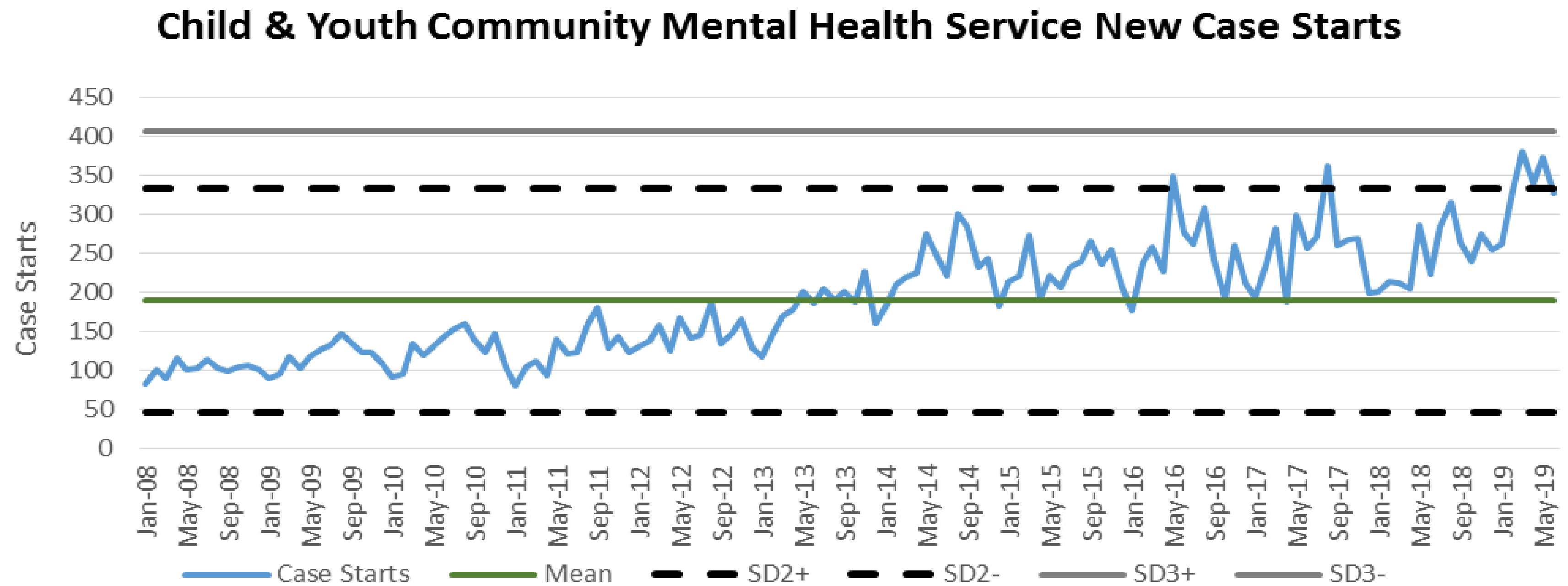
Te Awakura Occupancy



Te Awakura: Average number of patients under care



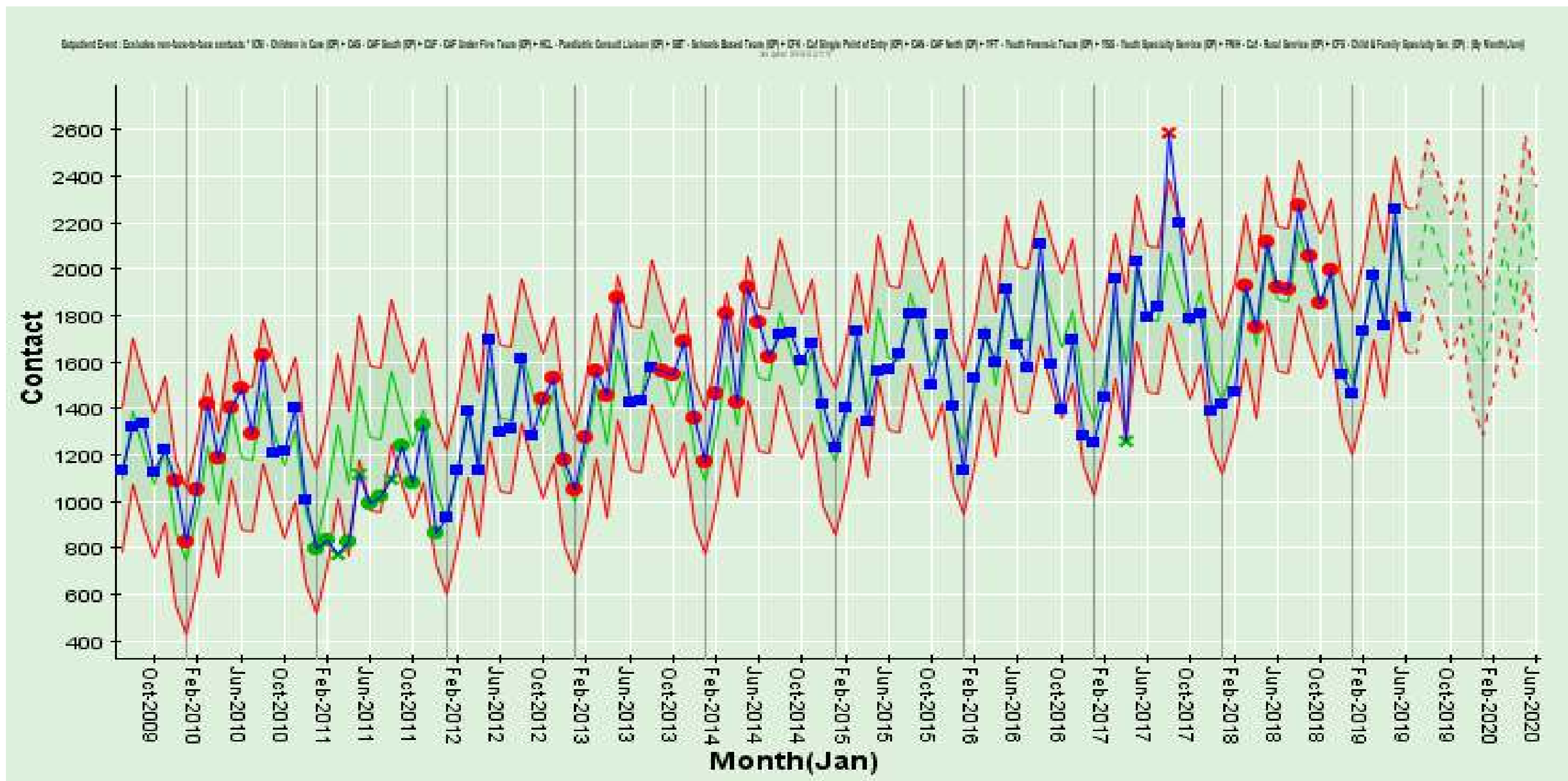
Child, Adolescent and Family New Case Starts



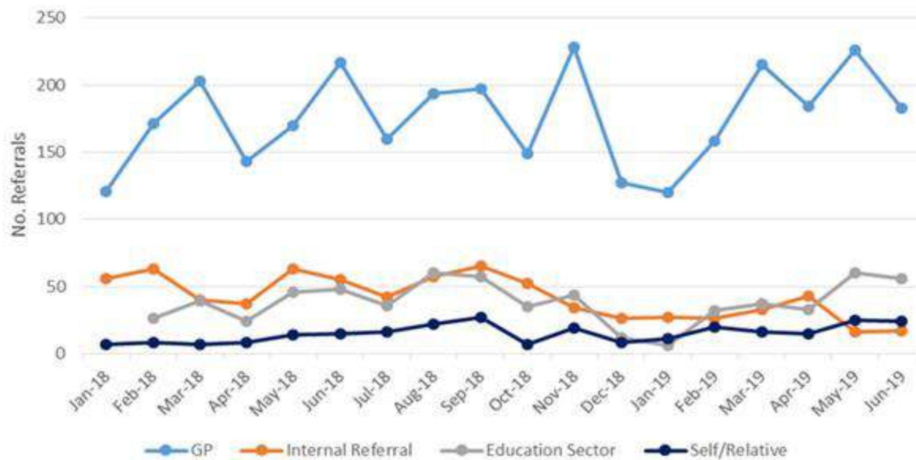
Child, Adolescent and Family Case Starts

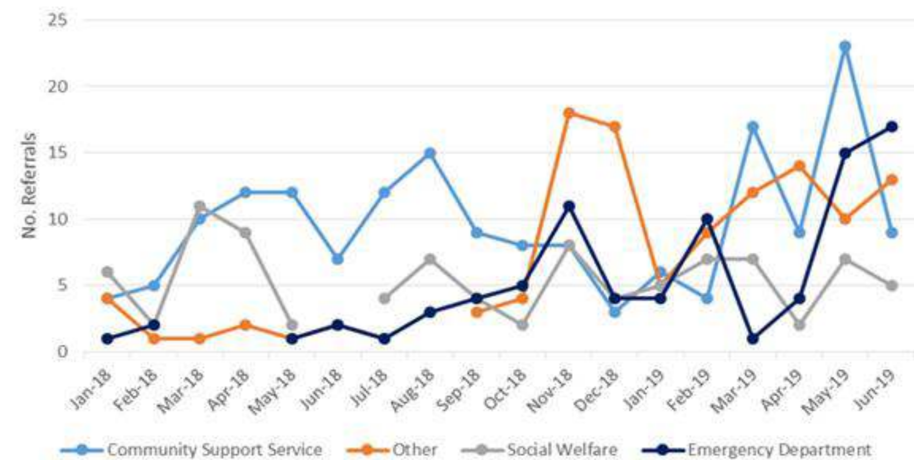
CAF Case Starts including CFK (modified)		1 Yr change	2 Yr change	3 Yr Change	4 Yr Change	5 Yr Change	6 Yr Change	7 Yr Change	8 Yr Change	9 Yr Change
Yr 09/10	1485									
Yr 10/11	1480	-0.3%								
Yr 11/12	1719	16%	16%							
Yr 12/13	1909	11%	29%	29%						
Yr 13/14	2306	21%	34%	56%	55%					
Yr 14/15	2756	20%	44%	60%	86%	86%				
Yr 15/16	2968	8%	29%	55%	73%	101%	100%			
Yr 16/17	2935	-1%	6%	27%	54%	71%	98%	98%		
Yr 17/18	2975	1%	0%	8%	29%	56%	73%	101%	100%	
Yr 18/19	3651	23%	24%	23%	32%	58%	91%	112%	147%	146%

Child, Adolescent and Family Outpatient Face to face contacts

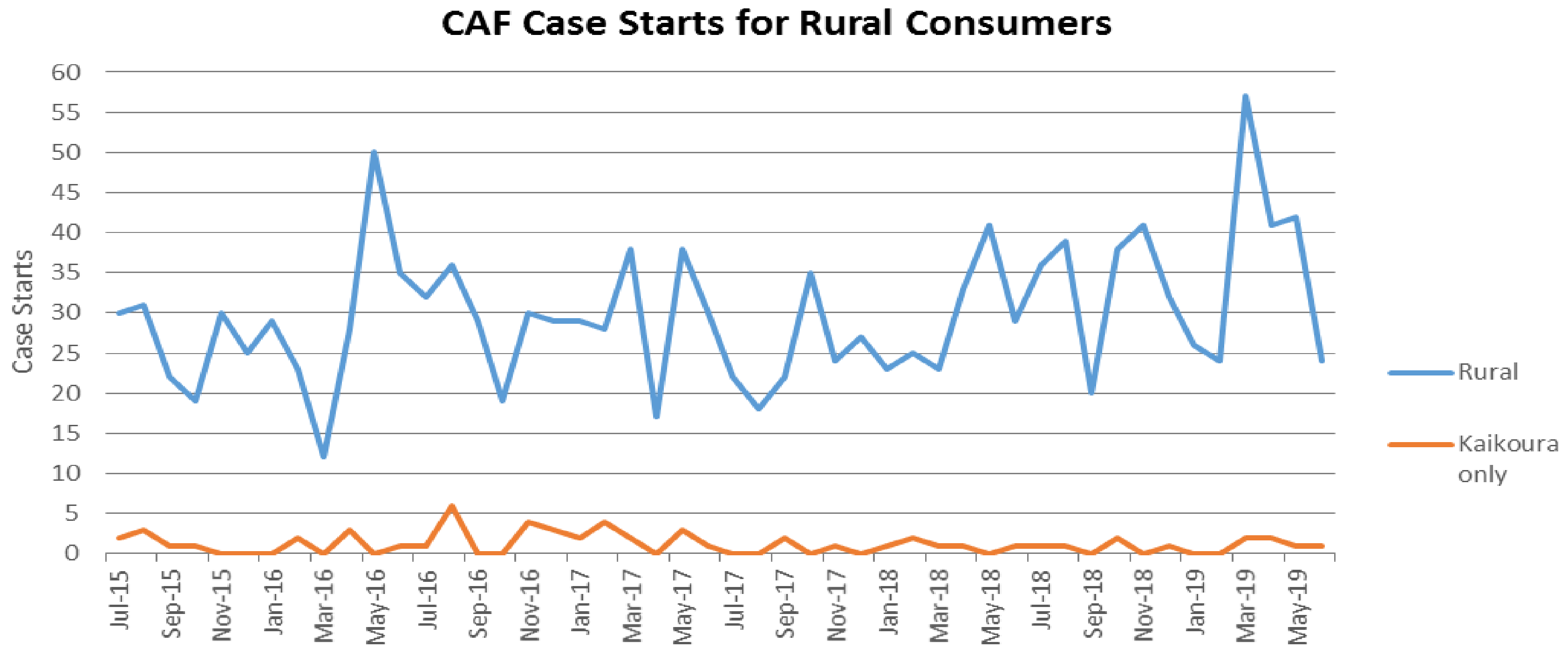


Child, Adolescent and Family referral analysis

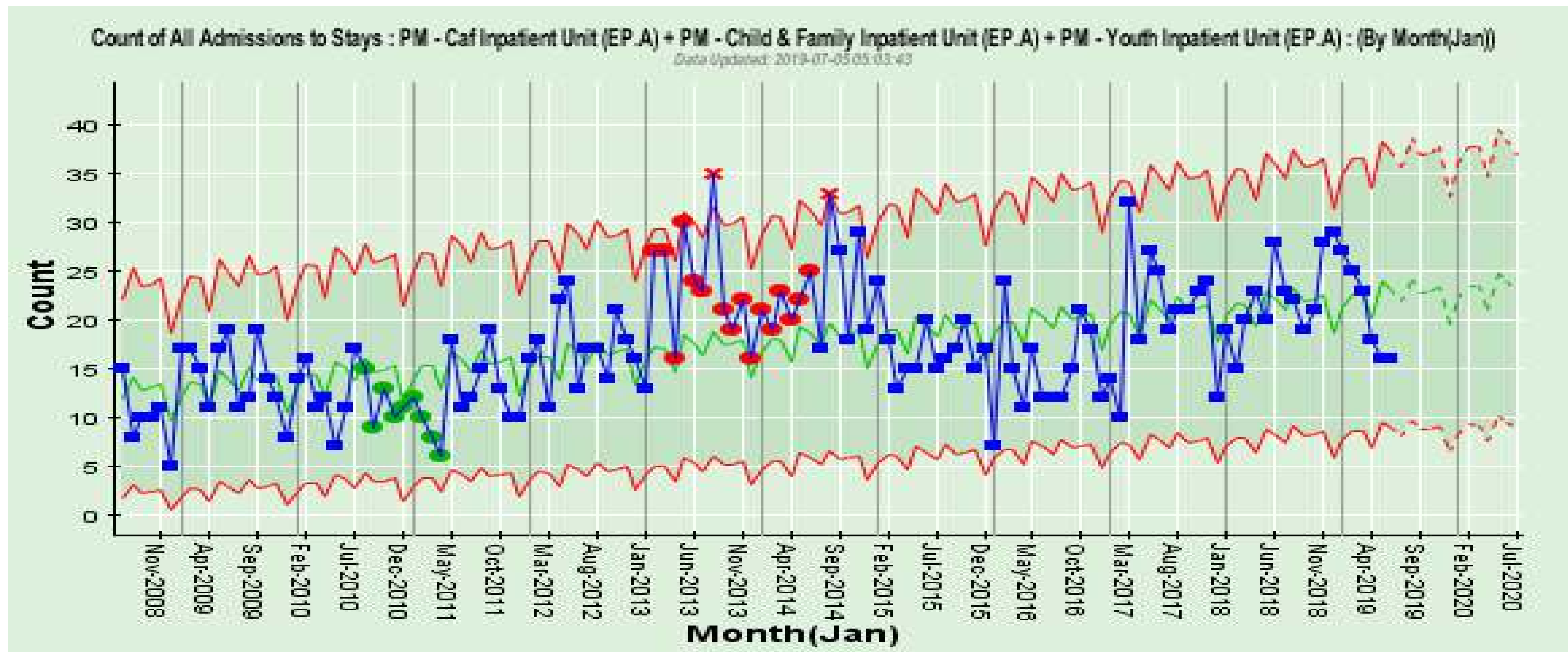




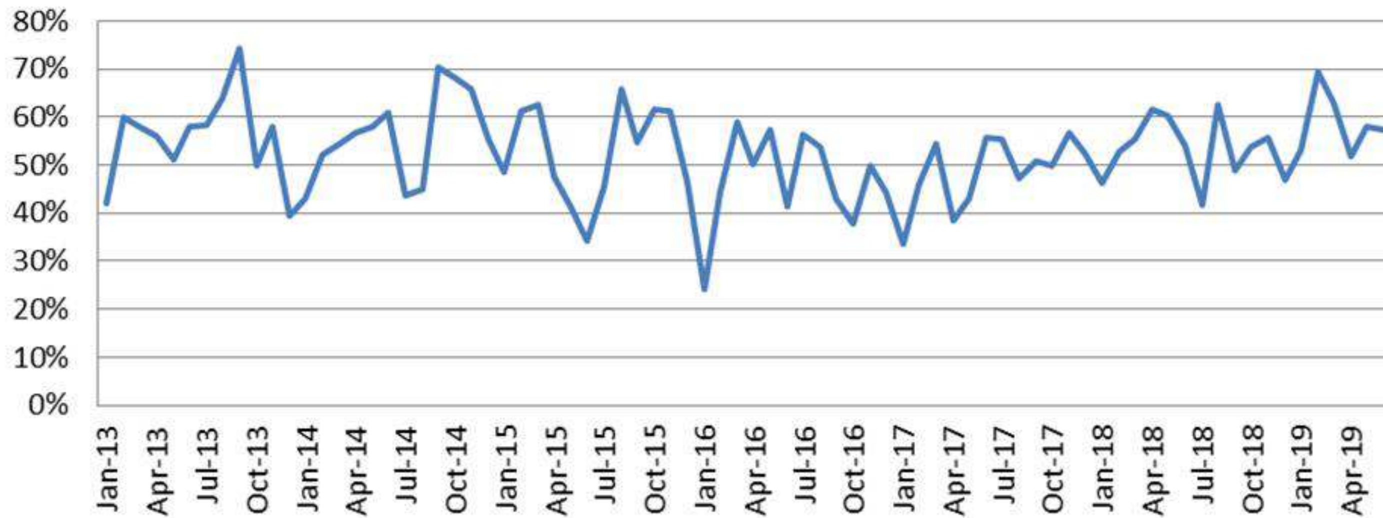
Child, Adolescent and Family: Rural Case Starts



Child, Adolescent and Family Inpatient Admissions



Child, Adolescent and Family Inpatient Occupancy



School Based Mental Health Team Survey

145 schools invited to provide feedback: 34.5% response rate

All respondents experienced value in working with SBMHT.

Most valuable service was consults with staff to discuss students

Key benefits:

- Professional, specialist advice
- Knowledge of health system and resources for schools and families-whanau

"I really appreciate having a professional perspective about the underlying causes of behaviour and expertise on next steps or direction. It is nice to have someone we value and trust being able to support and grow our knowledge and understanding and to suggest where to next."

Workforce Development

Staff are our greatest asset and investment

Workforce Development builds capability and confidence in practice.

Formal teaching and education achieved more then 2800 staff attendances at SMHS courses in 2018

Key Activities:

- Promote adult education principles to support trainers
- Coaching, monitoring and practice development.
- Nurse Coach roles
- New graduate specialist practice programmes
- New to practice ENs and hospital aides development programme

Talking Therapies Programme

SMHS provides a tiered framework for talking therapies that:

- Supports better access to the appropriate talking therapies/approaches
- Supports individualised approach
- Allows services to rapidly alter the level of talking therapies/approaches for consumers
- Provides a consistent, evidenced-based approach

SMHS Staff trained internally in talking therapies:

- Motivational techniques for behavioural changes (adult) over 680
- Motivational techniques for behavioural changes (CAF) approx. 100
- Cognitive-behavioural techniques (adult) 196
- Cognitive-behavioural techniques (CAF) 30

Quality Improvement

The HQSC Mental Health and Addiction Quality Improvement Programme

2x programmes underway in SMHS

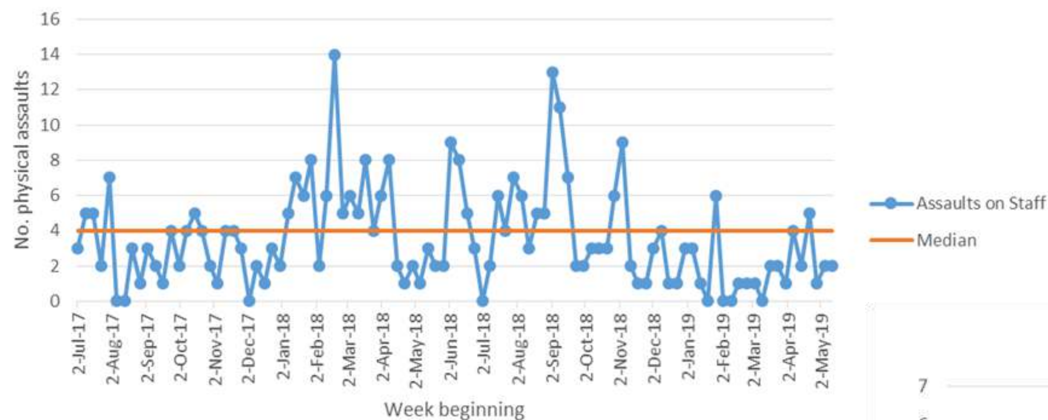
Zero Seclusion = Safer for All

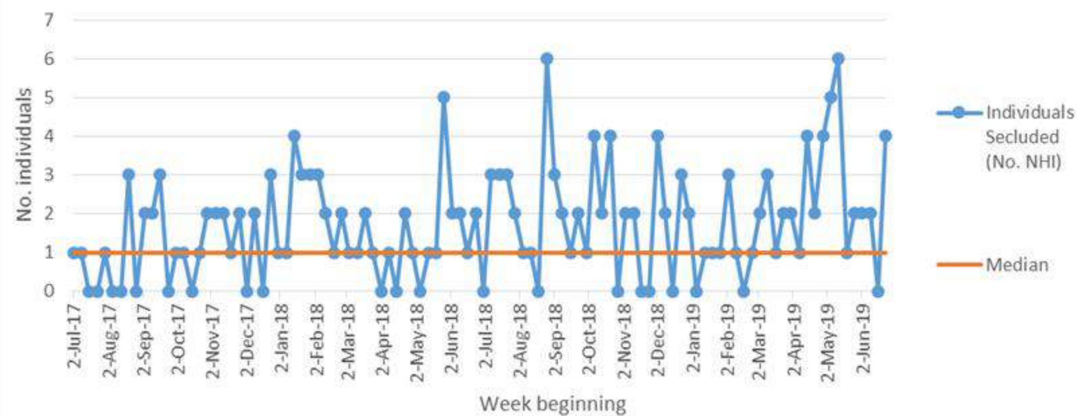
A programme that works towards least restrictive practice whilst continuing to ensure safety for all – Consumers, Family-Whanau and Staff.

Improvement outcomes include:

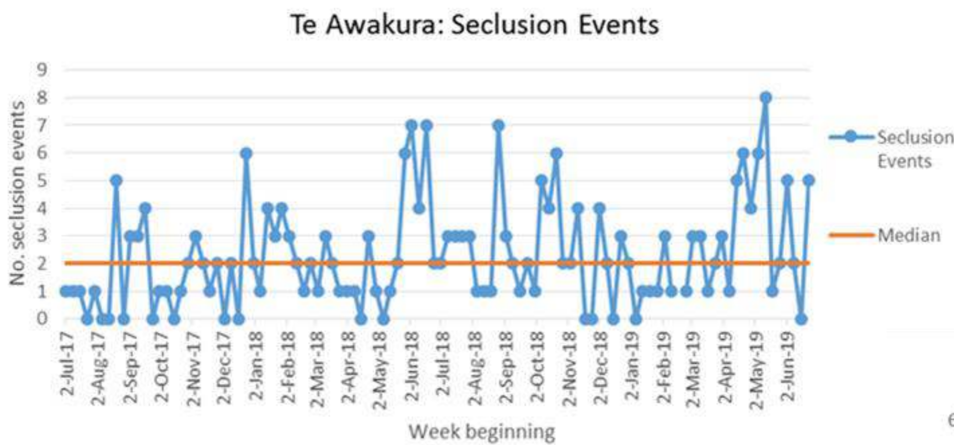
- After Hours leadership
- Increased Security presence
- Inpatient Safety Plans
- Low Stimulus Area and High Care Area guidelines re-developed
- Crisis admission policy, protocols including training programme
- Alcohol and other Drugs advisory group
- Rapid Tranquiliser policy

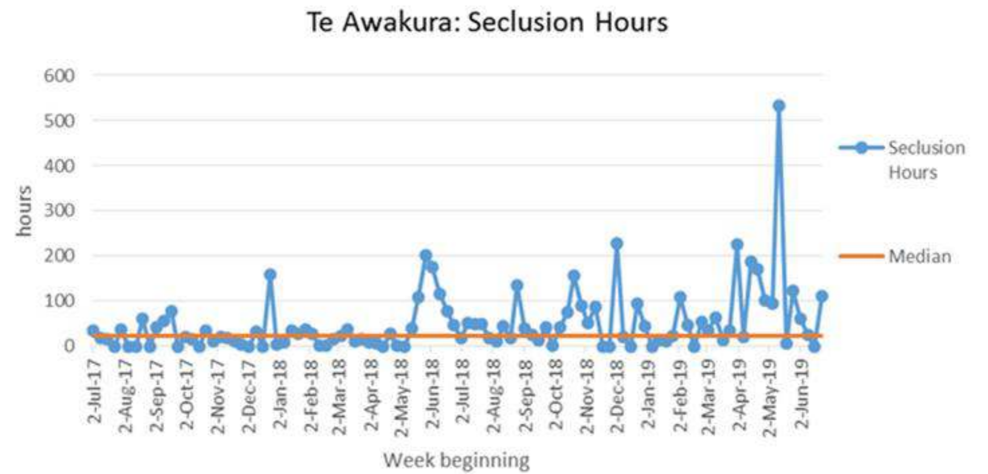
Zero Seclusion = Safer for All





Zero Seclusion = Safer for All





Connecting Care: Improving Service Transitions

The HQSC evidence review identified connectivity and integration between services as one of 4 key factors pivotal to the quality of service transitions:

SMHS focus is on the transition from youth to adult services, looking at effective integration between these services.

Connecting Care: Youth to Adult transitions

The SMHS Connecting Care project will ensure that mental health teams work closely with young people and their families before, during and after transfer of care to ensure that the young person's recovery is not adversely affected, delayed or interrupted by this process.

Facilities summary

User Groups actively involved in the design of the High and Complex Building and Integrated Family Services Building (Mothers and Babies Inpatient and South Island Eating Disorders Services Inpatient – and OP services for these teams)

AT&R – Internal alterations beginning this week to allow improved management of consumer group
Extension work underway to develop an improved high care (pod) area to support the delivery of the model of care and improve staff and patient safety

Greatest challenges

Workforce

Supply, recruitment, retention, wellbeing

Facilities

Constraining therapeutic benefit, compromising safety

Demand

Ability to meet need and expectations

SMHS Purpose & Strategy

Core Purpose

To provide safe, compassionate & effective services that enable people with serious or acute mental disorders in their recovery.

Five Strategic Pillars

1. A clearly defined focus on people with serious or acute mental disorders and who are unable to be treated elsewhere.

2. In-depth clinical/ specialist expertise in the assessment & treatment of people with serious or acute mental disorders.

3. A multi-disciplinary & integrated approach that places consumers & their families at the centre of all we do.

4. A positive culture and environment that values our staff & embodies compassion, hope & wellbeing.

5. Continuously building & sustaining our partnerships with the wider health system, other agencies & the community to support other professionals & help in the creation of a sustainable mental health system.

Connected leadership feedback

Great to have the time to stop, think, reflect and consider 'what next' in terms of my development as a leader. Wonderful array of speakers and contributors to the course.

That there is a lot of passion still amongst leaders to achieve the best outcomes they can for their consumers. I have enjoyed seeing a real focus on positive leading and caring for those you lead

A real sense that key people in the service are working in concert to provide the best possible care in a very challenging environment.

The importance of the art and performance aspect of leadership The importance of structured reflection for leadership practice The power of positive and compassionate leadership and art of reframing The whole connected leadership programme has been a very uplifting experience, I have witnessed people develop significantly both personally and professionally. It has had a powerful regenerative quality, where people feeling under incredible pressure have been able to create space to reflect, learn, regenerate and grow as leaders in spite of all the challenges. Amazing!

Consumer and Family-Whanau Experience

"We as a family, would like to show our appreciation for the exceptional, tireless efforts and energy from the wonderful team...... We were impressed by their individual care, consideration and expertise" CAFIU

"Our son has improved so much since been under your wings and it is amazing to see how far he has come. I can remember the sheer panic in my heart, however you all reassured me that he was going to be OK and made him safe" CAF OP

"Nurses have been above amazing." Adult IP

"Staff do their best to keep everyone safe" Adult IP

"I want to thank the staff here especially my case manager. I have never been treated with such kindness and respect in 10 years. My experiences in the past have not been so good." CADS

"Thank you so much for your support and care. There are special people in this world who have purpose in life and we believe you are one of them." Adult OP

H&SS MONITORING REPORT

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

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

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

DATE: **1 August 2019**

Report Status – For:	Decision	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Committee:

i. notes the Hospital Advisory Committee Activity Report.

3. APPENDICES

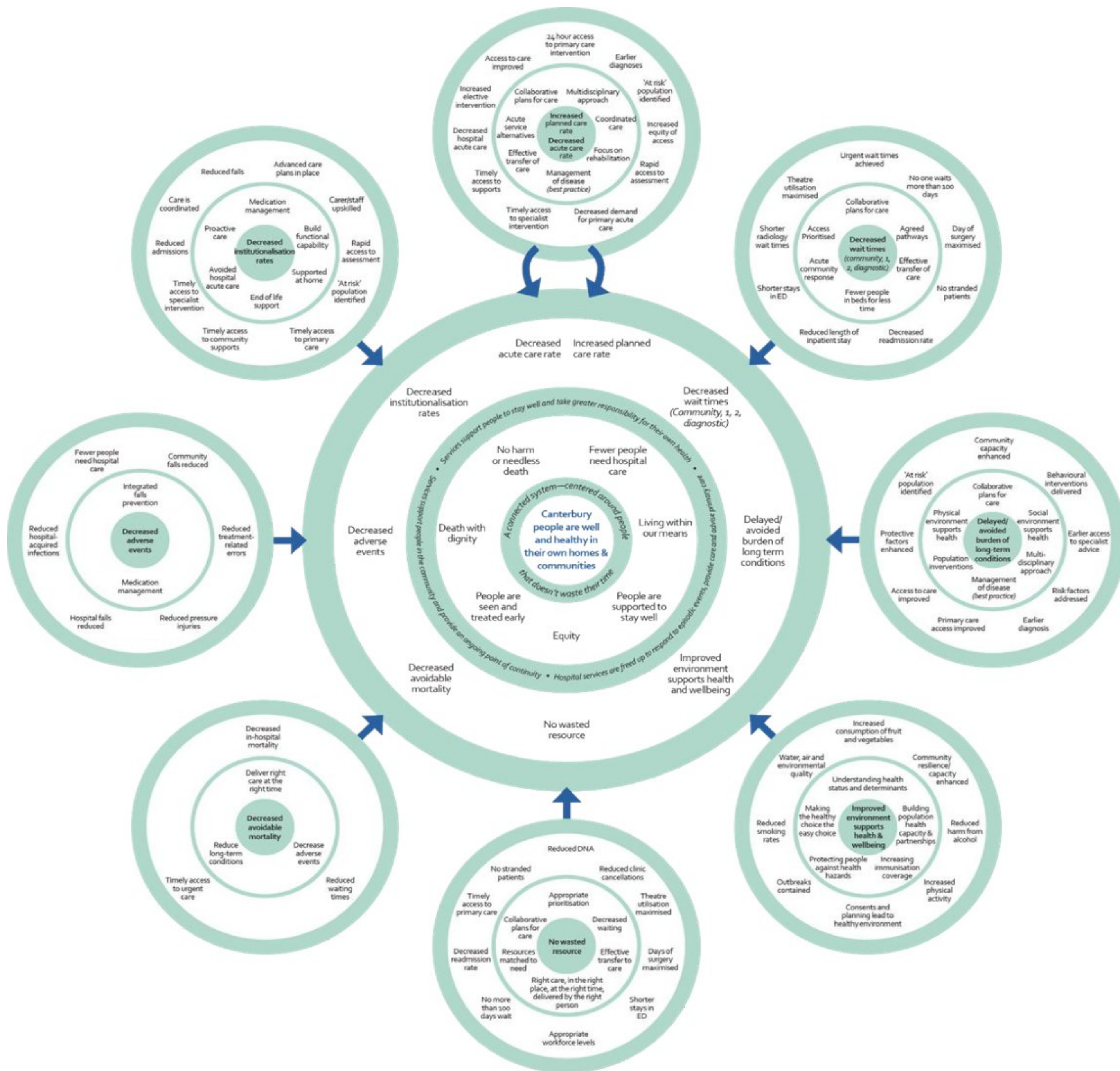
Appendix 1: Hospital Advisory Committee Activity Report – July 2019

Report prepared by: General Managers, Hospital and Specialist Services

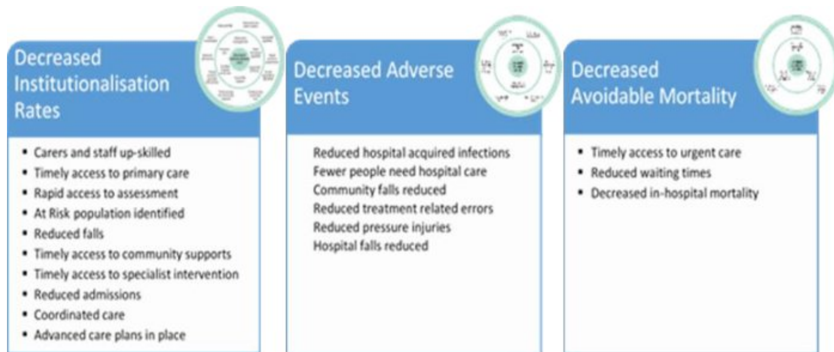
Report approved for release by: Justine White, Executive Director, Finance & Corporate Services

Hospital Advisory Committee

Activity Report



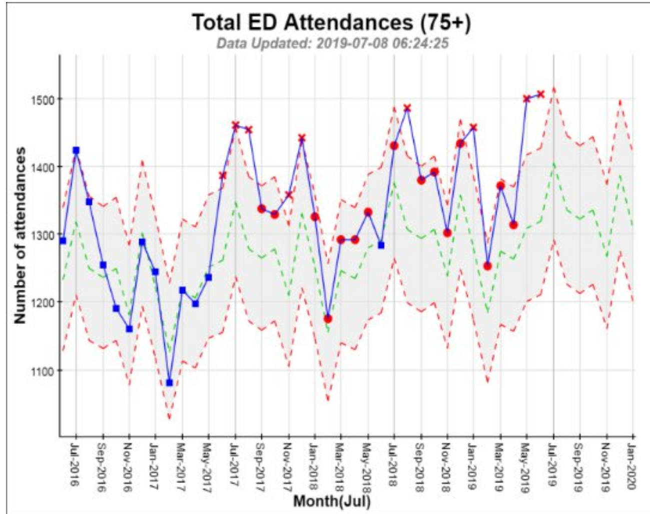
July 2019



Frail Older Persons' Pathway

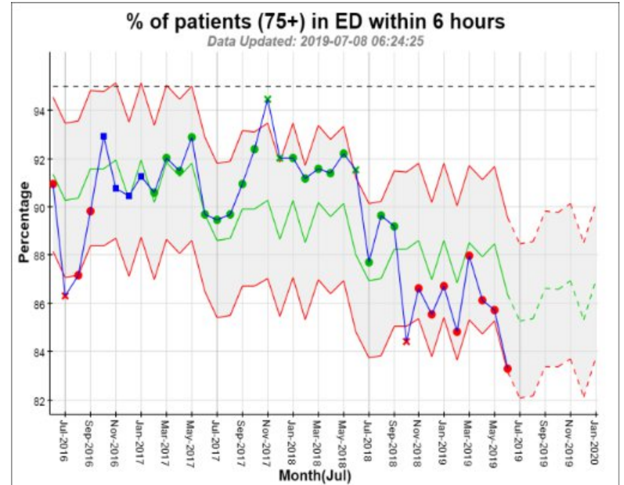
Outcome and Strategy Indicators

Figure 1.1



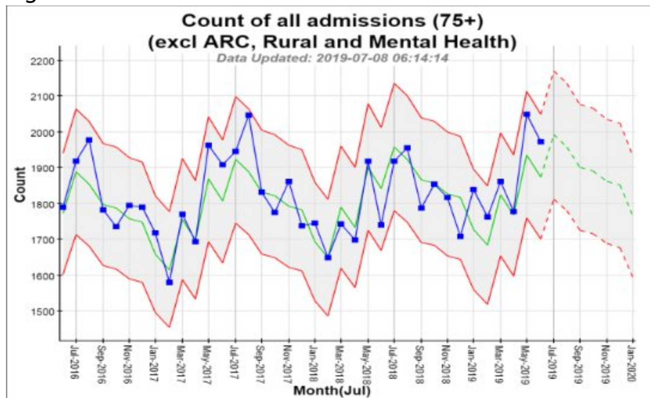
Total ED attendances of people over 75 has increased at a higher rate than the established trend.

Figure1.2



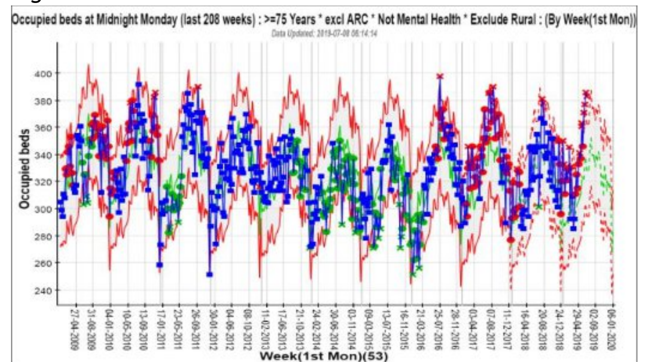
Analysis indicates there is a correlation between patients spending longer in the Emergency Department and hospital occupancy. Alongside this trend, however, a significant shift does appear to have occurred around the time that transition between old and new information systems occurred. Evaluation of the way that information about ED Obs unit data are managed between the two patient administration systems involved (EDaaG and SIPICS) is underway to determine if this is having an effect.

Figure 1.3



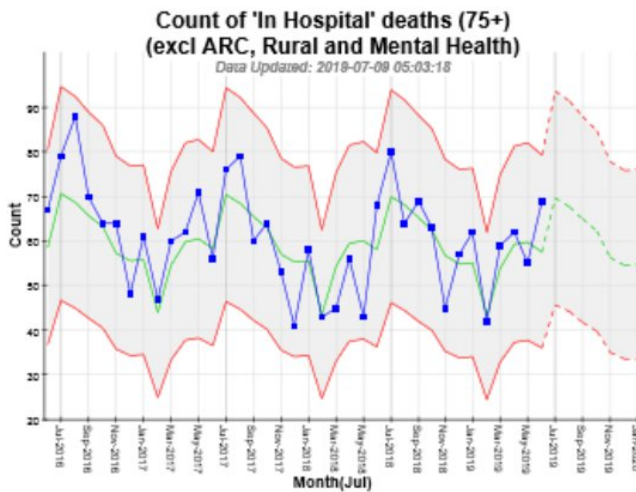
The count of all admissions for people 75 years and over continues to increase consistent with the established trend

Figure 1.4



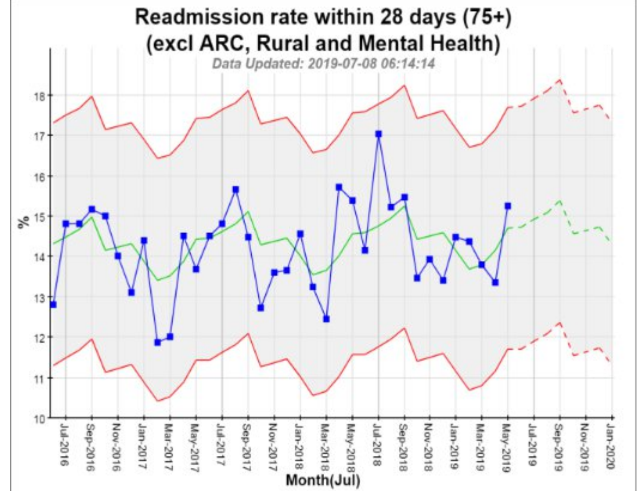
Apart from a period during March 2019, significantly more beds have been occupied by people >75 than projected. The winter peak appears to have hit far earlier in 2019 than it did in 2018 with occupancy by this group of patients higher than it was during similar months in the previous year.

Figure 1.5



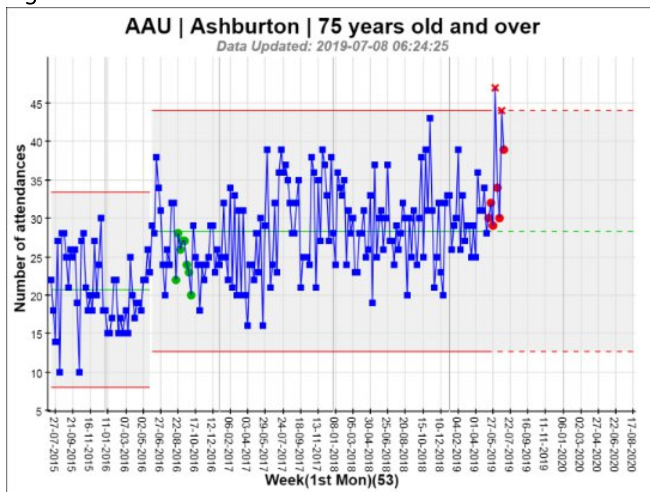
The number of in hospital deaths is within the expected range. Other analysis shows that the established trend of reducing rates of in hospital mortality continues.

Figure 1.6



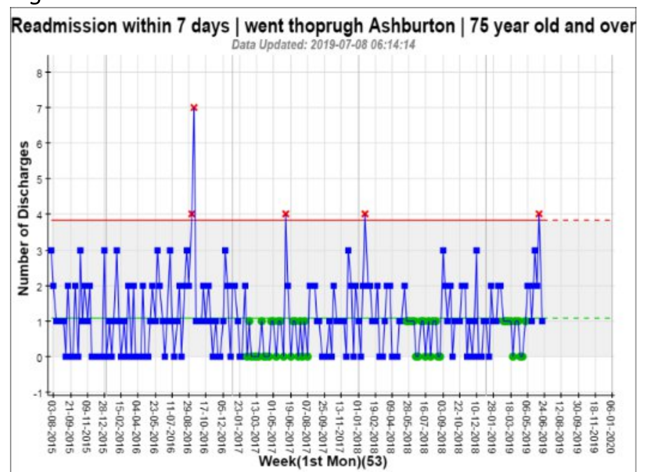
The readmission measure (balancing metric) for people aged 75 years and over continues to be within the expected range.

Figure 1.7



Ashburton is experiencing the same increase rate of presentations and admissions with the seasonal peak. This is discussed further in the report, the presentation rate for all demographics groups has increased.

Figure 1.8



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

Achievements/Issues of Note

Improved pathway for acting on suspected elder abuse

Elder abuse and neglect is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.

The West Coast and Canterbury DHBs have released their new Transalpine Elder Abuse and Neglect policy with guidance to staff on red flags for elder abuse, and how to support people if they disclose elder abuse and neglect. Documents align with the Violence Intervention Programme, including improvements to the pathway and include policy, procedure, screening tool, flowchart, safety planning booklet and an information sheet. An Allied Health Pathway and specific training for elder abuse and neglect are under development.

Tertiary Survey Form Developed for Trauma Patients

Major trauma victims are evaluated by a team of clinicians to rapidly identify life and limb threatening injuries. Primary survey, carried out by a registrar to identify life threatening injuries, and secondary survey, an initial head to toe examination are both completed prior to admission, are carried out in the emergency department. Even when this practice is reliably performed distracting injuries contribute to between 7% and 13% of significant injuries being missed during the initial evaluations. These can cause significant ongoing morbidity. Trauma tertiary survey is advocated to reduce the rate of missed injuries in hospitalised trauma patients. It has been shown to reduce the rate of injury missed during hospitalisation to as low as 1 in 40.

The Intensive Care Society and Trauma Quality Improvement Programs have therefore included the provision of tertiary survey as a quality standard. The tertiary survey is to be completed within 24 hours of admission by the primary admitting team. A comprehensive general physical re-examination and review of all investigations, including imaging and blood results. It provides guidance to the multidisciplinary team about tasks required to enable the patient's recovery.

The development of a Tertiary Survey Form for trauma patients was developed for Christchurch by the Trauma Service and a successful trial was conducted in the intensive care unit. Using this form has identified a number of missed injuries, enabling us to provide earlier interventions and improve the care provided to these patients.

Reallocating nursing tasks to timely achievement and patient flow

The Duty Nurse Manager role is very challenging in the after-hours period as they work to ensure that best use is made of the nursing staff capacity available to care for the patients in Christchurch hospital. A new role, the After Hours Nurse Coordinator, now contributes by addressing complaints, assessing the need for Hospital Aide Special duties, delivery of medicines and provision of support in an emergency. This releases Duty Nurse Managers to focus solely on patient flow processes and allocating available staff to the right places in the hospital.

The new role has also released another very busy role from tasks that do not require their expertise. Until recently Clinical Team Coordinators roles included retrieving supplies from the emergency drug cupboard outside of normal working hours. This added multiple interruptions to an already busy role and diverted Clinical Team Coordinator away from the sickest patients requiring their input. This task has been shifted to the Afterhours Nurse Coordinators and timeframes associated with the task have been defined. This has released Clinical Team Coordinators to focus on patients that most require their care, ensuring timely intervention and improving their recovery.

New e-text system developed for after-hours casual and permanent nursing pool

Issues with casual and permanent pool staff not arriving for rostered shifts have led to staffing shortages in the hospital after hours.

In order to improve confirmation of staff availability after hours a new e-text system has been developed. A text is sent out to those staff members that have not confirmed their availability to work within the next 24 hours requesting that they contact the Duty Clerk staff.

This new system has improved staff attendance after hours, ensures that the right staff are available as rostered and also that areas are not left short of staff. Another benefit is that it has also reduced the need for Nursing Directors to reshuffle staff around the campus at short notice when staffing is already tight.

Effect of the outpatient building flood on our ability to provide care.

Early morning on 29 March 2019 the Christchurch Hospital Outpatient building flooded as a result of overheated water in the steam heating system setting off the sprinklers on level two. The building was uninhabitable while it dried out and repairs were undertaken. Key areas of damage were the ground floor and levels one and two. Minor damage occur on level four as a result of flooding in the plant room on level five.

A phased return to the building occurred beginning with the return of administration teams to levels three and four on 10th April, clinical activity on levels three and four on 15th April. 60% of Diabetes and Endocrine space and 50% of Eyes clinical space was available on this date as well. By 10th May all clinical, administration and support areas were operational. Heating was reinstated on 18th April and fully operational by 23rd April. In the period before this

fluctuating temperatures were a challenge for both patients and staff and resulted in specific discussion between Unions and the Canterbury District Health Board.

A range of alternative locations were used for clinical and administrative work. This included outplacing of some clinical work to private healthcare facilities and provision of telephone assessment for some cohorts of patients. Finding temporary work places and clinic rooms took significant effort by organisation and private service providers. Staff demonstrated great patience as many worked in facilities not designed for the work being carried out and staff did not have access to their usual resources. Their patience and effort during this period was greatly appreciated.

Administrators were faced with a complex task which included in communicating changes in location and in appointment day/time to patients by telephone. Due to the number of facilities involved and patients that required rescheduling or postponement of their appointments, services were working one day in advance.

This also reflected the short lead in time of certainty of repairs and reoccupation of the building.

With the focus on contacting patients, other work was delayed, and this included the registration of new referrals coming into services.

The splitting of teams and range of locations that teams were working across made it challenging to check the impact of changes on individuals and how each person was managing. Senior managers routinely visited all locations over the two week period to check in with staff.

Despite the alternative arrangements put in place a total of 4,400 outpatient events were deferred. 4,000 fewer outpatient events were provided than the same period the previous year.

Services intend to run sessions, over and above the normal, in order to catch up on lost production. Additional costs will be charged to the Outpatient Flood Cost Centre

Some specific areas worth noting are:

- Services continue to work through the backlog of new referrals and postponed patients and therefore the actual number of patients that fall into this category is unknown.
- However, the Eye Service anticipate that approximately 1,800 patients who were referred will be triaged for FSA at 28 and 100 days. This group of patients will be added to the backlog developed as a result of being unable to see all patients during the period.

Canterbury Eye Service: The Eye Service's clinical activity was affected for a total of 25 days (note the data extract covers 15 days). Eyes did manage to assess and treat all acute patients and continued to provide Avastin treatments through this period. Overall 1,462 patients were postponed and 3,662 patients seen. Two operating theatre lists with 11 patients were cancelled as the pre-work required could not be achieved. The eye service provided care out of four different clinical locations with its administrative teams spread across five different locations. Because of the volume of work being carried out and timeframes involved communicating with patients via the post was not feasible so staff made telephone contact with every patient who had their appointments cancelled, deferred, rebooked and shifted. This period was testing for all clinical and non-clinical staff and the massive increase in effort, along with dislocation and the need to work out of unfamiliar settings that were not designed for the purpose, using borrowed mobile phones provided especially challenging for the administration team.

Dermatology: There was no phototherapy service provided during the three week period that services were provided from alternative settings. Dermatology outpatient assessments were 65% of previous year activity. Of that 65% activity, 34% were virtual/telephone contacts with patients. The tables below provide an estimate of the work provided compared with an equivalent period the previous year, indicating a number of people with skin conditions missed opportunity for timely treatment at follow up clinics, likely suffering ongoing discomfort as a result.

	17/18	18/19
M15 - Dermatology FSA	104	38
M15 - Dermatology FU	362	160
M15 - Dermatology Non Patient contact		104
Total	466	302

Hospital Dental: only acute patients were seen and mainly for pain relief. Care was provided from three different clinical locations.

	17/18	18/19
S20 - Dental Surgery	148	129
S20 - Dental Surgery	879	498
Total	1,027	627

Urology: worked at approximately 85% of planned capacity for both assessments and procedures during this period. Clinical care was provided to patients by hospital teams based from Urology Associates rooms.

	17/18	18/19
S70 - Urology FSA	207	194
S70 - Urology FU	366	312
S70 - Urology Non Patient contact		7
S70 - Urology Preadmission	66	55
Total	639	568

Cardiology: Increased non-patient contact events by 531 on the previous year. Cardiology managed to assess and test 51% of patients at multiple settings throughout the Christchurch Campus. It is important to note that access to electrocardiogram was not affected during this period as this service is located in Christchurch Hospital.

	17/18	18/19
M10 - Cardiology FSA	886	361
M10 - Cardiology FU	1,231	747
M10 - Cardiology Non Patient contact	28	559
M10 - Cardiology Preadmission	29	5
Total	2,174	1,672

A number of services (Senior Medical Officers and nurses) did telephone consults with patients. These increased from 124 (2017/18) to 1434 (2018/19).

This activity does not represent is the number of new referrals that were received during this period that were not registered, triaged and ready for First Specialist Assessment. This was due to the administrator's focus on contacting patients to postpone and reschedule appointments.

It will take weeks to months for services to recover a very disruptive start to the year – flood, strikes, and mass casualties.

Integrated Respiratory Nursing Service providing benefits to our community

The Integrated Respiratory Nursing Service has developed as a collaborative model of care between Advanced Lung Disease Clinical Nurse Specialists working in the Cardio Respiratory Integrated Specialist Services Team, the Canterbury Clinical Network, and Respiratory Nurses from CanBreathe and the Respiratory Clinical Nurse Specialist from Ashburton. The new way of working that they have put in place involves a single point of entry for referral of people with advanced and complex respiratory disease. Referrals are assessed against an agreed algorithm which is based on complexity of the condition and the number of recent hospital visits and sent onto the most appropriate provider. Nurses usually provide one or two visits with the patient, an assessment, ensure that any outstanding diagnostic requirements are completed, refer to other services as required and provide education and plans so that the patient, whānau and other health professionals are well informed about the agreed approach to management of the disease. Notes and plans are loaded onto Health Connect South and are available to any clinician working in the system at the point of care.

Plans developed in partnership with the patient include acute care plans and breathlessness management plans which provide simple, clear advice that is appropriate to the patient's level of literacy about how to manage

breathlessness. The service initiates conversations around advance care plans, however most patients requiring these are encouraged to work with their general practice to agree these plans.

The Nursing team meets regularly to ensure that shared approaches to problems are developed and used and that the service continues to improve. The development of IRNS has helped prevent fragmented services for patients with complex respiratory diseases and reduced duplication.

Data from the twelve months to February 2018 covering 139 patients shows that in the year prior to being seen by the service patients experienced 581 hospital admissions, in the year following engagement with the nursing team this reduced to 468 admissions. This is a reduction of 113 visits or 19%. For the same patient cohort the number of emergency department visits that did not result in admission decreased from 175 to 101, this may indicate that patients were less likely to present to the emergency department following specialist nursing intervention.

This new way of providing services to patients with significant respiratory disease has improved the ability of patients to stay as healthy as possible in their own homes, while releasing hospital capacity for those who most need it.

Nurse practitioner roles developing within the Cardio Respiratory Integrated Specialist Services Team

In 2018 two nurse Practitioners were appointed within the Cardio Respiratory Integrated Specialist Services team, one within the area of sleep services and the other with a focus on heart failure.

Nurse Practitioners provide a wide range of assessment and treatment interventions, making diagnoses, ordering and interpreting diagnostic tests and prescribing medicines within their area of competence with the same authority as medical practitioners.

The addition of these two roles within the service will ensure that lightly served populations are provided with benefits.

Since the sleep role was put in place in 2018:

- First Specialist Assessment clinics have been put in place where patients with sleep disorders are reviewed by the nurse practitioner. This includes assessment of nocturnal movement disorders, sleep phase issues and complex sleep disordered breathing.
- A sleep clinic has been established at Rehua Marae and is well attended. This clinic is well supported by the Māori community, with a focus to extend to Pacific Island peoples in 2019.
- Alongside clinics in Christchurch the Nurse Practitioner provides clinics in Ashburton and on the West Coast, providing regional sleep expertise.
- Around 60% of patients seen by the Nurse Practitioner are discharged to community management, this is a high rate compared with other clinicians working with this cohort.
- Her role also includes training and mentorship to other sleep health practitioners, both at a local and national level. The role also involves audit and quality improvement within the sleep service.

People with heart failure require frequent clinical assessment in order to ensure appropriate adjustment of medication. Since the heart failure nurse practitioner role was also put in place in 2018 it has supported provision of a much more seamless service for patients:

- Heart failure clinics are provided daily on weekdays from our facilities at Burwood, Rangiora and Christchurch Outpatients.
- The nurse practitioner and clinical nurse specialist colleagues can now provide a very efficient service to patients, eliminating time previously spent waiting while nurses located cardiologists in other parts of the hospital to sign prescriptions.

Some general practice referrals seeking cardiology input, that do not require cardiologist input, are triaged for the nurse practitioner to provide outpatient care to. These patients can be seen in their homes or at clinics as a first assessment. Care provided to these patients may include:

- Attendance at heart failure group sessions run by Cardio Respiratory Integrated Specialist Services clinical nurse specialists.

- Provision of continuous frusemide intravenous infusions provided by the Cardio Respiratory Integrated Specialist Services supported by District Nurses in the patient's home, avoiding hospitalisation.
- Sometimes transition to a palliative approach is required for those with advanced heart failure. Patients from this cohort often experience complex social and functional issues and management of end stage heart failure in the community is challenging. In such cases real benefit is provided through the partnership approach taken by the Nurse Practitioner, Older Persons Health Specialist Services, Specialist Palliative Care services and General Practice. The whanau of patients transitioning to palliative care have commented favourably on the quality of this transition.

Immunology input into Canterbury's beekeeper's day out

The Immunology Service at Christchurch Hospital provides an outpatient based service that regularly receives referrals of people who have had anaphylaxis for assessment, we provide this service for the South Island.

Staff members from the Immunology Department recently gave a lecture about honey bee venom allergy and treatment to the local beekeeping community. The talk touched on anaphylaxis diagnosis and treatment, bee sting reactions, the role of laboratory testing and our experience with bee venom desensitisation.

Providing this education is just one part of improving public knowledge about such issues, with the aim that this will support people to take actions that will enable them to remain healthy and avoid the need for hospital care.

Older Persons Health and Rehabilitation

Pressure Injury
Background:
Purpose T is a skin risk assessment tool introduced to OPH&R Clinical Governance Group in February 2018. It is a visual traffic light system that was developed by Professor Jane Nixon (University of Leeds). As part of an initial trial, OPH&R working group has permission from University of Leeds to use this tool. It is a comprehensive tool that addresses many known factors that can contribute to acquiring a pressure injury.

Following a successful trial and with approval from Executive Director of Nursing, Purpose T has a confirmed roll out date of 15 July 2019 across the wards at Burwood Hospital. This tool will replace the Braden Scale assessment tool currently used at Burwood Hospital. Currently, nursing and allied health staff are attending education sessions on how to use the tool including prevention strategies, e.g. positioning, continence

Education has been completed for Charge Nurse Managers, Clinical Nurse Specialists & Nurse Educators across the division. Nominated staff have been put forward and were in attendance with Charge Nurse Managers, or receive education from Clinical Nurse Specialists & Nurse Educators this week.
Key activities are:

All nursing staff receiving education in their wards this week, including pool staff & night staff. Education for Occupational Therapy, Physio Therapy and Dieticians will occur next week with Allied Health Clinical managers to embed across the inpatient environment.

We aim to make the documentation available electronically as some wards are already planning to incorporate in their weekly Inter Disciplinary Team meetings. Plan identified if any pressure injuries occur on the week of roll out (extra support, ensure documentation completed). Background work continues around terminology on the Purpose T (i.e. pressure ulcer vs. pressure injury), in view of likely implementation across CDHB.

Rethinking rehab
Another initiative being undertaken has seen all of the Older Person Health Wards developing action plans as a result of undertaking a "Rethinking Rehab" approach. There are x3 work streams that were identified out of the last workshop.

- The use of volunteer to support rehab activity within the ward environment building on our programme to date. This includes assisting over lunchtime and with early afternoon activities, also developing the current music groups to provide wider coverage and participation.

- Orientation and Resource Work stream Leader which is led by our Clinical Director for OPH. This will see a review of current resources and information provided to inpatients and their whanau. Development of this information to better support the inpatient journey and patient's transition back to the community – including falls information, community support groups and medication management.
- Goal Setting Workstream which further focuses on developing the concept of patient centred goals supported by the IDT but driven by the patient.

These workstreams are starting and focused on our outcomes that support both flow and visibility of activity. The OPH wards have moved to 24 patients for the winter flex.

Our Action Plan WARD B1

Aim	What is needed?	Outline your process	Barriers?	How will you communicate to the rest of you Team?	How will you measure improvement?
	Do we have what we need? Can we get what we need?		How might you overcome these?		
ALL PATIENTS TO SIT IN CHAIRS FOR ALL MEALS.	• PATIENT EDUCATION • UP TO DATE MOBILITY STATUS • HCA TO BE AVAILABLE PRIOR TO MEALS. • CATERING ASSISTANT INVOLVEMENT - SET MEAL TIME. - LOCATION OF MEALS. - DINING ROOM WHITEBOARD • TEAM EDUCATION	• SIGNS FOR THE PATIENTS. (DOCTORS ORDERS) • ENSURE REGULAR REASSESSMENT OF MOBILITY STATUS & UPDATE BOARDS. • NURSES & HCA TO COMMUNICATE WHO CAN GET UP THEMSELVES & WHO NEEDS Ⓐ. • COMMUNICATE NEW PLANS TO THE CATERING ASSISTANT & PUT A SIGN UP IN THE KITCHEN. • ARRANGE A MEETING ⅟c TEAM	★ RELUCTANT PATIENTS. - CONTINUE EDUCATION ★ TIME - COMMUNICATE AMONGST THE TEAM	• TEAM MEETING • REMINDERS FOR KITCHEN STAFF – WRITTEN. • SIGNS IN BEDROOMS. • GROUP E MAIL	• AUDIT IN TWO WEEKS.
PATIENTS TO BE GIVEN OPPORTUNITY TO WALK 3×/DAY - OUTSIDE OF TRIPS TO BATHROOM.	• PATIENT EDUCATION • WALKING CHART • STAFF EDUCATION.	• CREATE CHARTS • COMMUNICATE NEW INITIATIVE TO THE TEAM. • INFORMATION PROVIDED ON CHART FOR FAMILY INVOLVEMENT.	★ PATIENT UNWELL - TRY AGAIN NEXT DAY. ★ TIME - COMMUNICATE AMONGST THE TEAM.	• TEAM MEETING • GROUP EMAIL	AUDIT IN TWO WEEKS.
PATIENTS TO BE GIVEN OPPORTUNITY TO SPEND TIME DURING DAY IN A SOCIAL SPACE.	• STAFF EDUCATION • ACTIVITIES TO ATTEND • PATIENT EDUCATION	• INCORPORATE DAILY PLANNER. • ORIENTATE PATIENTS & FAMILY TO THE SOCIAL SPACE. • MAKE AREAS INVITING. • VOLUNTEERS TO ENGAGE	★ PATIENT UNWELL - TRY AGAIN NEXT DAY ★ ISOLATION PATIENTS - PERSONALISE TO PATIENT. ★ TIME - TEAM-WORK ★ SOCIAL PHOBIAS - ENCOURAGE QUIETER SPACES	• TEAM MEETING • CHART (SEE ABOVE)	• AUDIT IN TWO WEEKS.

Shared Care Planning

Within Canterbury we have three digital shared care plans available. Included are Acute, Advance Plan and Personalised Care Plan (PCP), within which we have been involved in the development of the PCP. The Shared Care Planning includes: What matters most to the patient, Goals and Actions. It also includes a workflow culture shift and this information stays with the patient and is updated by multiple services, it is not service or staff dependant, it is completed with the patient. We have also piloted this with one of OPH&R community teams for two years and the GP's, Allied Health and Community team use is increasing with streamlined approach and Canterbury wide Quality group to support work. We have a collaborative project team with Clinical Network, CDHB and Vendor to support with the development. We are also working with nursing and medical staff to use this, and have some private services as visibility now South Island wide.

The feedback from staff is that they like the visibility of information surfaced and goals that can be handed out to the patients as well as the ability to see who is involved in the patient care.

This approach will continue to support the patient pathway and support frail older persons to achieve their goals.

No Wasted Resource

- Reduce clinic cancellations
- Theatre utilisation maximised
- Timely access to primary care
- Shorter stays in ED
- No more than 100 days wait
- Appropriate workforce levels
- Days of surgery maximised
- Decreased readmission rate
- No stranded patients
- Reduced DNAs

Decreased Avoidable Mortality

- Timely access to urgent care
- Reduced waiting times
- Decreased in-hospital mortality

Decreased Wait Times

- No one waits more than 100 days
- Day of surgery maximised
- No stranded patients
- Decreased readmission rate
- Reduced length of stay
- Shorter stays in ED
- Shorter diagnostics wait times
- Theatre utilisation maximised
- Urgent wait times achieved

Faster Cancer Treatment

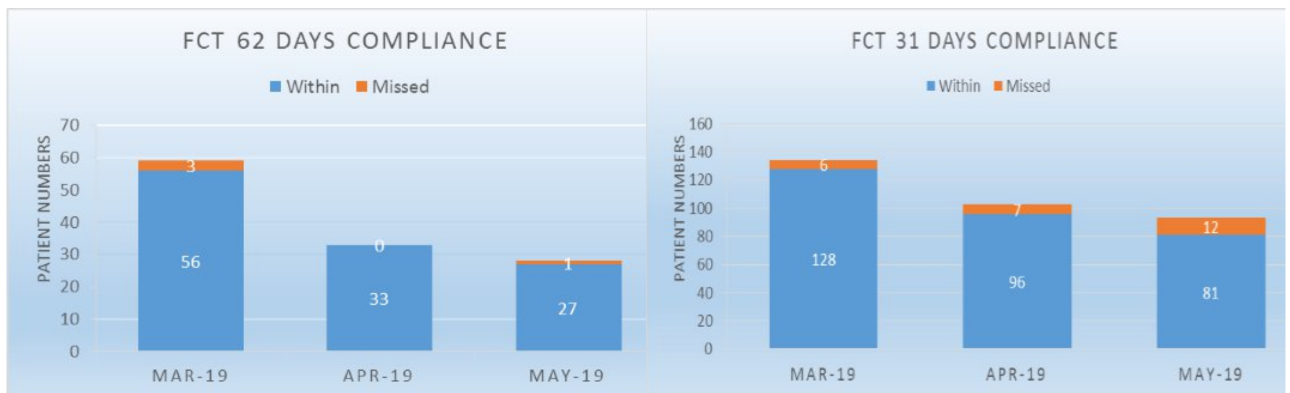
Outcome and Strategy Indicators

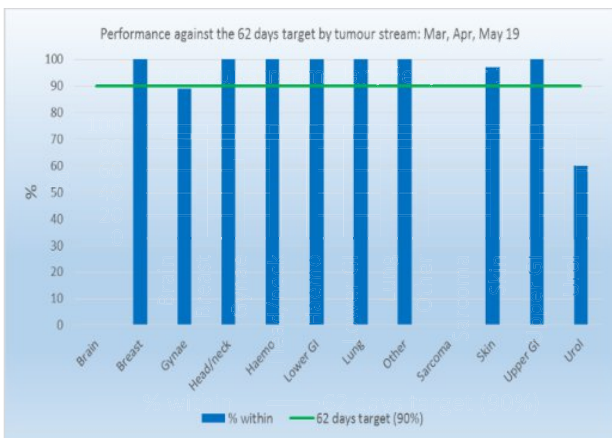
Key Outcomes - Faster Cancer Treatment Targets (FCT)

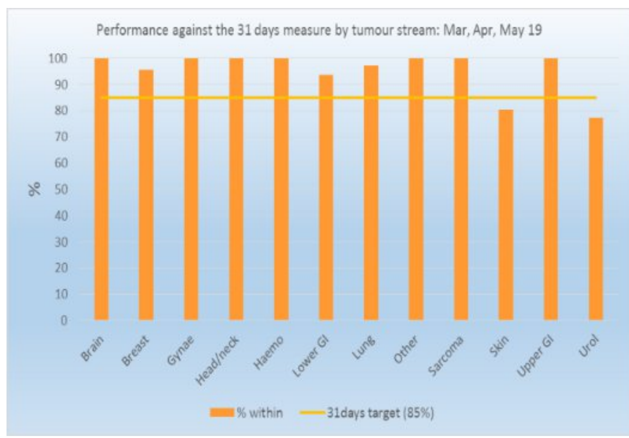
62 Day Target. For the three months of March, April and May 2019, Canterbury District Health Board submitted submitted 136 records to the Ministry. Of the 20 who missed the 62 days target 16 did so through patient choice or clinical reasons and are therefore excluded by the Ministry of Health from compliance calculations. This leaves 120 patients eligible for inclusion in the target calculations.

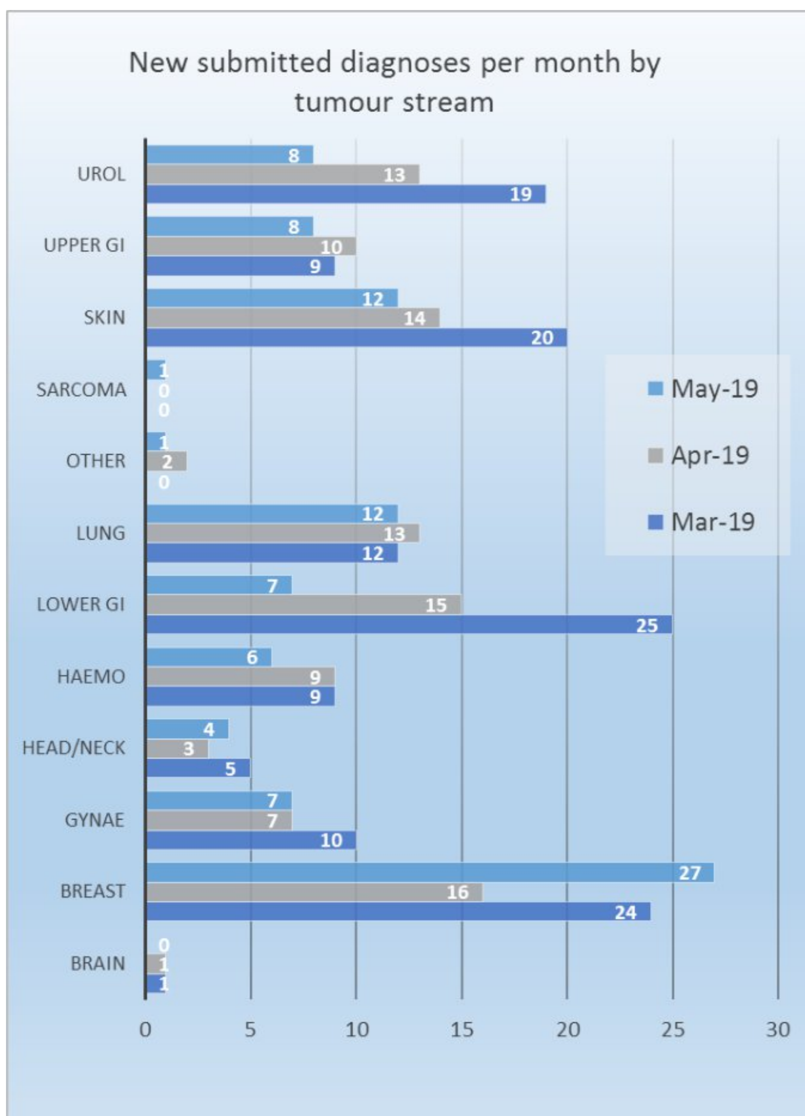
With 4 of the 120 patients missing the 62 days target through capacity issues our compliance rate was 96.7% so once again the Canterbury District Health Board met the 90% target.

31 Day Performance Measure. Canterbury District Health Board submitted 330 records towards the 31 day measure in the same three month period. Unlike the 62 days target all patients who miss the 31 days target are included: there are no exceptions made for patient choice or clinical considerations but the threshold remains at 85% rather than 90%. With 305 of the 330 (92.4%) eligible patients receiving their first treatment within 31 days from a decision to treat the Canterbury District Health Board continues to meet the 85% target.




Performance against the 62 days target by tumour stream: Mar, Apr, May 19
%
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, May 19
%
Brain
Breast
Gynae
Head/neck
Haemo
Lower GI
Lung
Other
Sarcoma
Skin
Upper GI
Urol
% within
31days target (85%)

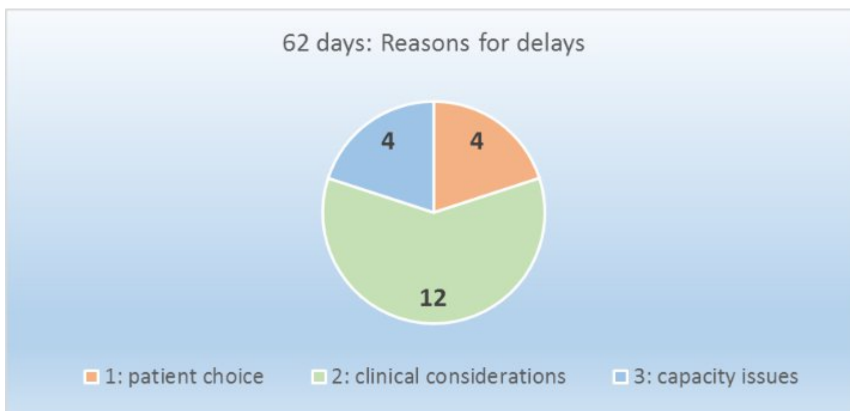

New submitted diagnoses per month by tumour stream
UROL
UPPER GI
SKIN
SARCOMA
OTHER
LUNG
LOWER GI
HAEMO
HEAD/NECK
GYNAE
BREAST
BRAIN
May-19
Apr-19
Mar-19

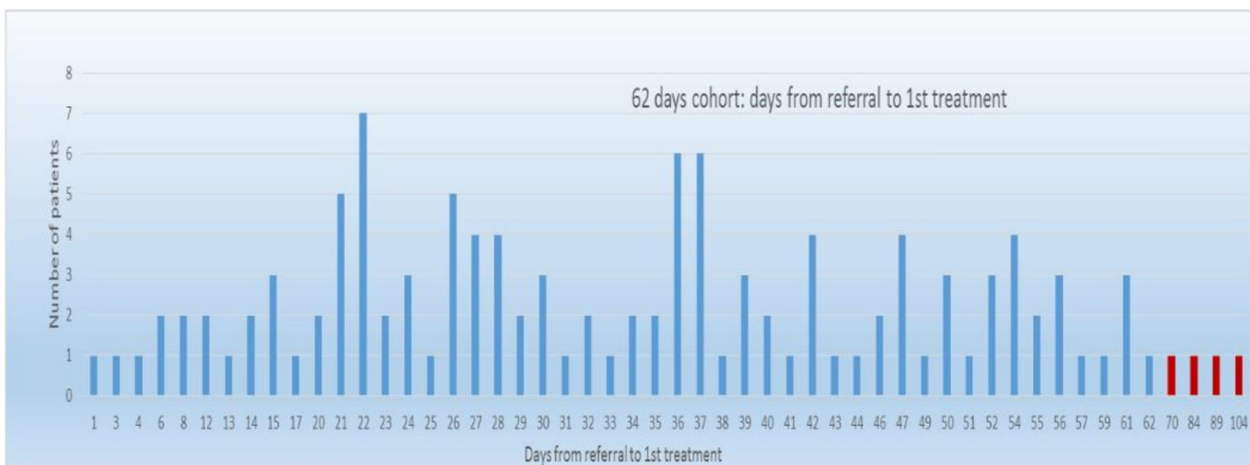
Patients whose treatment time misses the targets

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

The codes are:

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





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

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

Radiation Oncology Service: Changes in clinical practice that are right for the patient and the system

Low risk and intermediate risk prostate cancer: In 2018, the number of days that each patient needs to attend for radiation treatment decreased from 39 to 20. This was based on a number of randomised controlled trials that showed the regimens were equivalent in terms of disease outcomes at five years. This reduced the time spent by each patient in the treatment room by 4 hours and 45minutes and meant they saved 19 additional trips into the hospital. The 19 day difference is especially significant to patients required to live away from home and family to receive their treatment. This also released 304 hours of radiation treatment capacity to be used for other patients.

High risk prostate cancer: With current access to theatre, 18-24 patients per year benefit from brachytherapy (internal radiation treatment), followed by 15 treatments of external beam radiation. The advantage for patients is that each patient is able to avoid the requirement for a further 23 radiation visits. From a system perspective, 138 hours of additional treatment capacity are released, and use of a radioactive source with a three month life is maximised.

Advanced Breast Cancer: Utilising new technology, the service, developed a technique for advanced breast cancer that halved the time a patient was on the bed for radiation treatment. The patient received the same dose of radiation but it was delivered in 12.5hours less time over the 25 treatment sessions. This benefited over 25 patients and released 275 hours capacity per year. Furthermore, the amount of manual handling and exposure of staff to toxic materials was reduced.

These gains in capacity have enabled us to invest time in new techniques such as stereotactic radiotherapy which enables the provision of high radiation doses across fewer treatment appointments. Stereotactic treatments take longer to deliver due to the complexity but instead of the patient coming in for 25 treatments they only come in for three or four. We have been utilising this in radical lung cases for several years now and have made several improvements in our delivery to reduce the time from a 60 minute procedure to 30 minutes which has meant more patients are able to tolerate having the treatment. Initially a cohort of 10 patients was treated using this method in the first year and we are now treating 25 per year with this technique with the intention to enable cure.

Over the coming twelve months we aim to establish clinical guidelines for palliative sites that previously we were unable to offer treatment to, due to severe side effects which are now avoidable due to improved targeting of the tumour.

Cervical Brachytherapy treatment pathway streamlined

Cervical brachytherapy is a radiation therapy technique used to treat some cervical cancers in addition to external beam radiation therapy and chemotherapy. It involves insertion of radiation sources via the vagina to treat the cancer. The geometry and timing of the treatment is critical for effective treatment and minimising side effects. Cervical brachytherapy is delivered over two-two day admissions separated by about a week.

The brachytherapy treatment day is extremely complex requiring a theatre visit typically with ultrasound scanning, a magnetic resonance imaging scan, a computed tomography scan, followed by extensive computerised planning and safety checks, and then finally the treatment delivery. The medical physics team has recently completed a detailed study of the magnetic resonance imaging and computed tomography studies and the contribution each makes to the treatment accuracy. They found that with good protocols and imaging technique the computed tomography scan could be eliminated without affecting accuracy, removing the considerable time required to exactly match the images before the treatment could be planned. Removing this step from the pathway speeds up the planning process and reduces the length of the treatment day for patients and staff. Two-two day admissions are still required but considerable waiting has been removed and difficulty of the treatment day reduced with associated safety benefits.

The effects approximately 10 patients per annum. The study results have already been shared nationally and the resulting treatment changes should be shared more widely later in the year.

Increased Planned Care / Decreased Acute Care

- Earlier diagnosis
- At Risk population identified
- Increased equity of access
- Rapid access to assessment
- Timely access to specialist intervention
- 24hr access to primary care intervention
- Decreasedhospital acute care
- Increased elective intervention
- Decreased acute primary care demand
- Access to care improved

Decreased Avoidable Mortality

- Timely access to urgent care
- Reduced waiting times
- Decreased in-hospital mortality

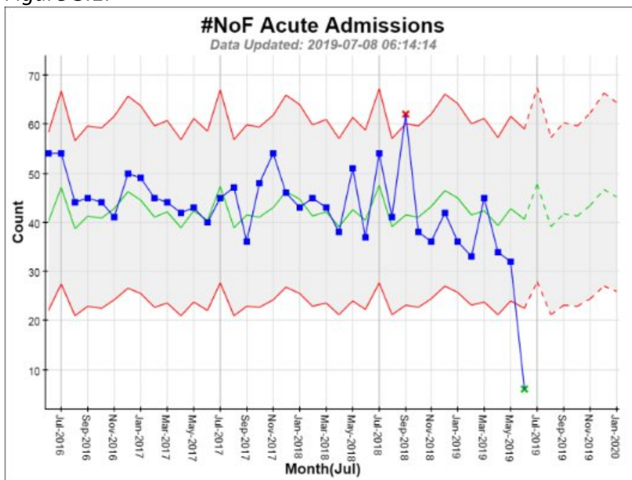
Decreased Wait Times

- No one waits more than 100 days
- Day of surgery maximised
- No stranded patients
- Decreased readmission rate
- Reduced length of stay
- Shorter stays in ED
- Shorter diagnostics wait times
- Theatre utilisation maximised
- Urgent wait times achieved

Enhanced Recovery After Surgery (ERAS)

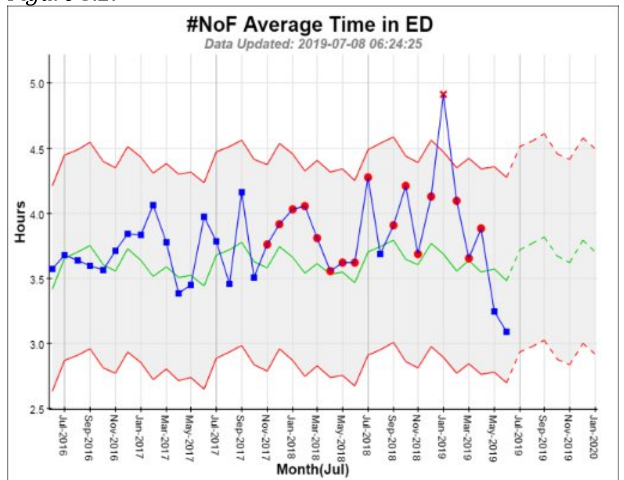
Outcome and Strategy Indicators – Fractured Neck of Femur (#NoF)

Figure 3.1:



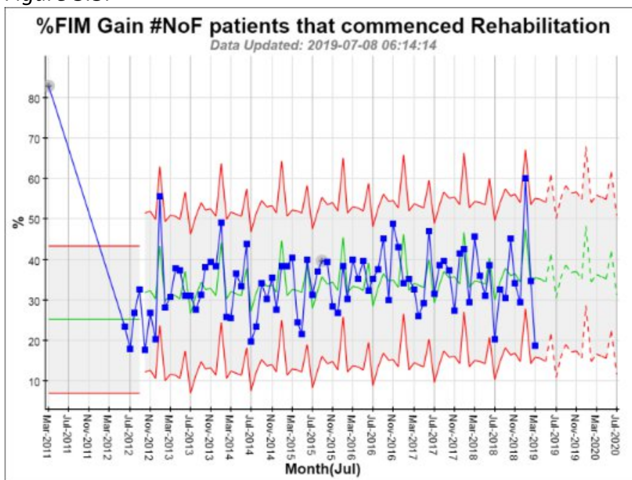
Coding delays impact on the latest data records for admissions.

Figure 3.2:



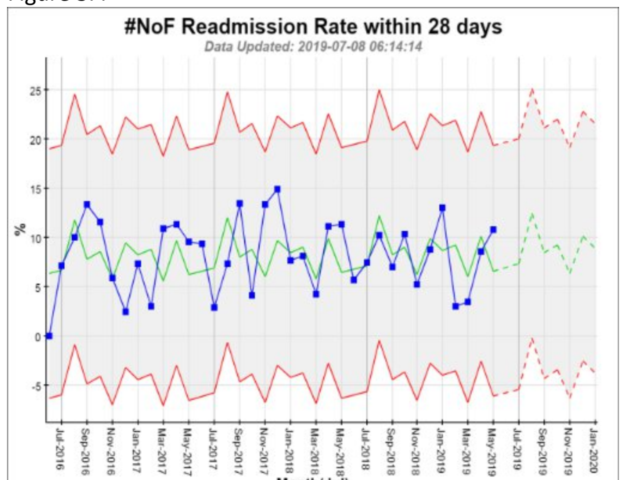
Patients with #NOF show a variable length of stay in ED.

Figure 3.3:



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

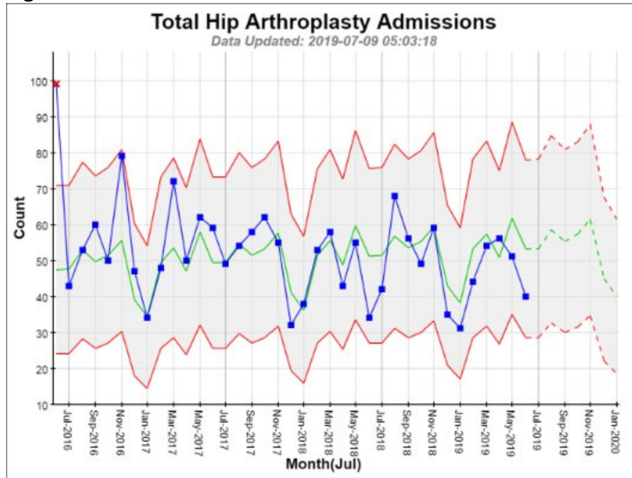
Figure 3.4



Readmissions continue to remain within expected mean values.

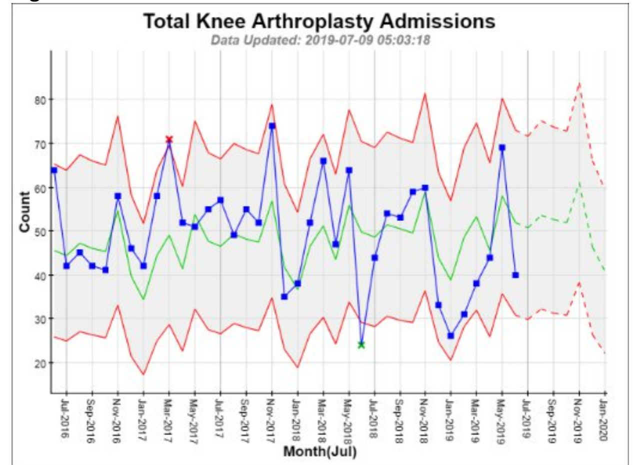
Outcome and Strategy Indicators – Elective Total Hip Replacement(THR) and Knee Replacement(TKR)

Figure 3.5



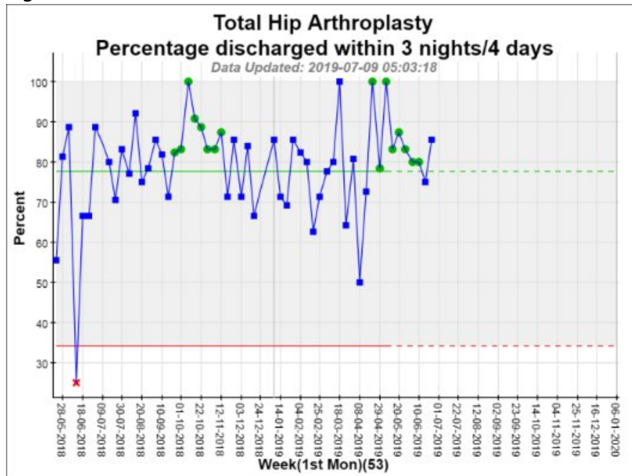
In recent months hip replacements have been tracking within or below projected levels.

Figure 3.6



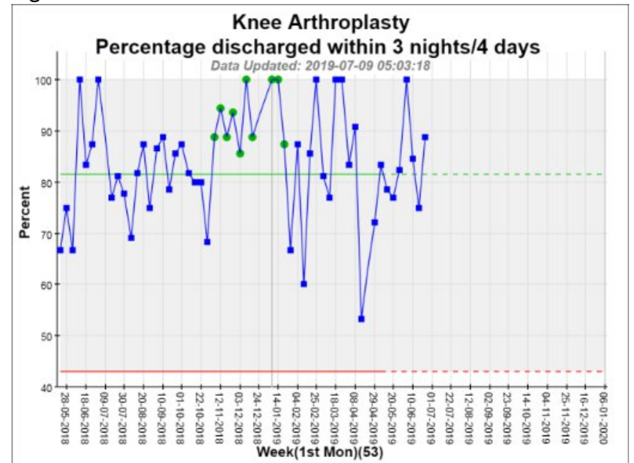
Knee replacement admissions over the previous twelve months have been tracking around the projected levels.

Figure 3.7



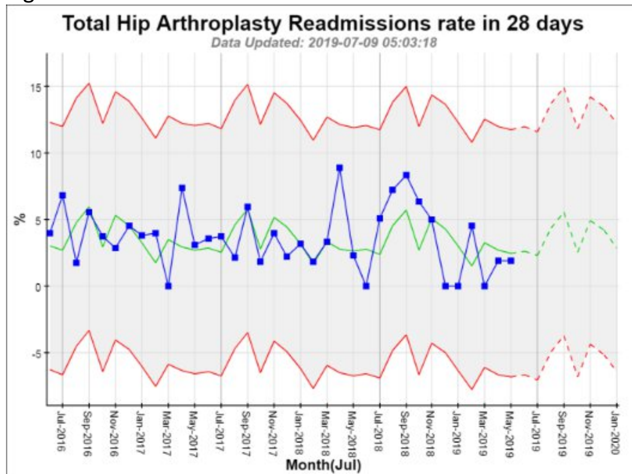
The percentage of patients clinically safe to be discharged within 3 nights/4 days is following established, increasing trend.

Figure 3.8



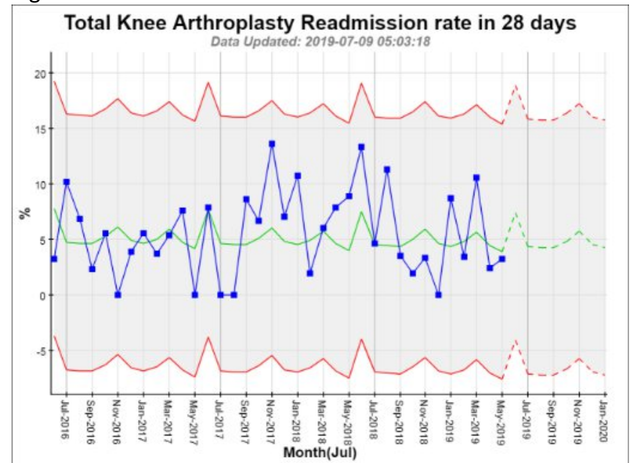
The percentage of patients clinically safe to be discharged within 3 nights/4 days continues to trend up.

Figure 3.13



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

Figure 3.14



Readmission rates are maintaining within tolerances.

Achievements/Issues of Note

Length of Stay in Emergency Department for fractured neck of femur patients in part reflects the increased complexity of # NOF patients, and the overall numbers of acute patients that are presenting to the Orthopaedic service

Overall numbers of # NOFs are down on projected volumes

Work continues on identifying the cohort of patients that can have a planned & predicted shorter LOS for elective hip and knee surgery, from 3 nights to a planned 1 night stay.

Decreased Wait Times

- No one waits more than 100 days
- Day of surgery maximised
- No stranded patients
- Decreased readmission rate
- Reduced length of stay
- Shorter stays in ED
- Shorter diagnostics wait times
- Theatre utilisation maximised
- Urgent wait times achieved

Increased Planned Care / Decreased Acute Care

- Earlier diagnosis
- At Risk population identified
- Increased equity of access
- Rapid access to assessment
- Timely access to specialist intervention
- 24hr access to primary care intervention
- Decreasedhospital acute care
- Increased elective intervention
- Decreased acute primary care demand
- Access to care improved

Elective Surgery Performance Indicators 100 Days

Achievements/Issues of Note

Christchurch Outpatient Florence Self Check-in Touchscreen Kiosks

In late February 2019, Christchurch Outpatients introduced Florence Self Check-in Touchscreen Kiosks that are integrated with the SI PICS patient administration system.

Florence is easy to use allowing patients to scan the bar code on their appointment letter in order to check-in for their appointment. Once this is done, Florence checks SI PICS and if there is an appointment for the services assigned to Christchurch Outpatients that matches the date and time, then Florence responds positively with the patient's demographics. Once the patient has validated their demographics Florence messages SI PICS to arrive the patient and directs the patient to the assigned waiting area.

Some of the features and benefits include:

- Questions for patients can be added. For example, it is proposed to add in a smoking cessation question which would send a referral request through to Te Hā - Waitaha.
- Clinic updates can be managed internally, including extra clinics and changes in the wait area mapping.
- The ability to add "Emergency Contact" to the patient demographic checks once this is integrated into the message from SI PICS.
- Ability to communicate with patients in their preferred language.
- Time spent waiting in line on the day is reduced - it is taking patients less than a minute on average to check in via the kiosks.
- Staff are spending less time arriving patients – freeing time up for other tasks.
- Errors in entry of patient data are reduced.
- Patient records are kept up-to-date.

Orthoptist Botox Clinics

Some patients with blepharospasm, a form of twitching of the muscles around the eye, can be so seriously affected that they are unable to open their eyes and therefore are effectively unable to see. This condition is managed with injections of botulinum toxin every two to four months to treat the spasm. Around 30 patients receive this treatment at the Christchurch Hospital Eye department, with a half day clinic scheduled once every four weeks specifically for this purpose. Conventionally this treatment has been provided by a specialist ophthalmologist.

Orthoptists are trained to have specialty knowledge about the testing, diagnosis and treatment of eye movements and, following specific training, are able to provide botulinum toxin treatment in the United Kingdom. A senior orthoptist at Christchurch Hospital has worked with the department's clinical director to customise the training package utilised in the United Kingdom and adopt this new way of working within the Eye Service at Christchurch Hospital. Since January 2019 this Orthoptist has carried out the training and has been working under the direct supervision of the clinical director to provide injections to many patients. This training will be completed by the end

of August after which the orthoptist will be able to provide the injections independently, with the specialist ophthalmologist working in an adjacent room. Patients will be assessed by an ophthalmologist on initial presentation and at annual review, with most patients' injections being provided by the orthoptist.

From a patient perspective this will mean that waiting time on the day of clinic is reduced as the orthoptist will not be called on for other duties during clinics in the way that the ophthalmologist is. This new model will release ophthalmologist time to see other groups of patients. The training package has been well documented and is available for use to upskill other orthoptists or registered nurses and this way of working has opened the door to other extensions of technical and nursing roles within the Eye Service.

Lessons learned from others leading to improvement in our endoscopy unit.

Two senior nurses from the endoscopy unit recently attended a gastroenterological nursing conference in Melbourne. This provided an opportunity to learn from other units' and build our own improvements on the experience of others.

Work is underway towards updating the reprocessing equipment that is used in the endoscopy unit to clean and store endoscopes. Information available at the trade displays at the conference, and during visits to endoscopy units in Melbourne, has been useful as the team has been considering the equipment specifications and the required facility changes to enable the process changes required to meet clinical standards and fit the new equipment. This information has led to changes in the planning and procurement process, potentially saving months of delay later down the track. This is important as delay in meeting clinical standards risks deferral of implementation of the national bowel screening programme in Canterbury.

Visiting endoscopy units in Melbourne provided other benefits as well. One highlight was attending the Inflammatory Bowel Disease weekly multi-disciplinary team meeting at the Alfred Hospital. This highlighted the importance of a collaborative meeting in this area to discuss complex cases, and troubleshoot patient issues. It was also clear that using intestinal ultrasound to monitor inflammatory bowel disease in an outpatient setting is a key tool, reported to be a 'game changer' for the management of these patients by reducing the need for invasive procedures and demand for colonoscopy. Seeing how another unit uses this was valuable as use of this modality has just commenced at Christchurch Hospital and there is a new intestinal ultrasound machine scheduled for purchase in the coming year.

The visit to St Vincent hospital provided inspiration about how to run the recovery area more efficiently. This information will be useful as we consider changes to our own processes.

Decreased Wait Times

- No one waits more than 100 days
- Day of surgery maximised
- No stranded patients
- Decreased readmission rate
- Reduced length of stay
- Shorter stays in ED
- Shorter diagnostics wait times
- Theatre utilisation maximised
- Urgent wait times achieved

No Wasted Resource

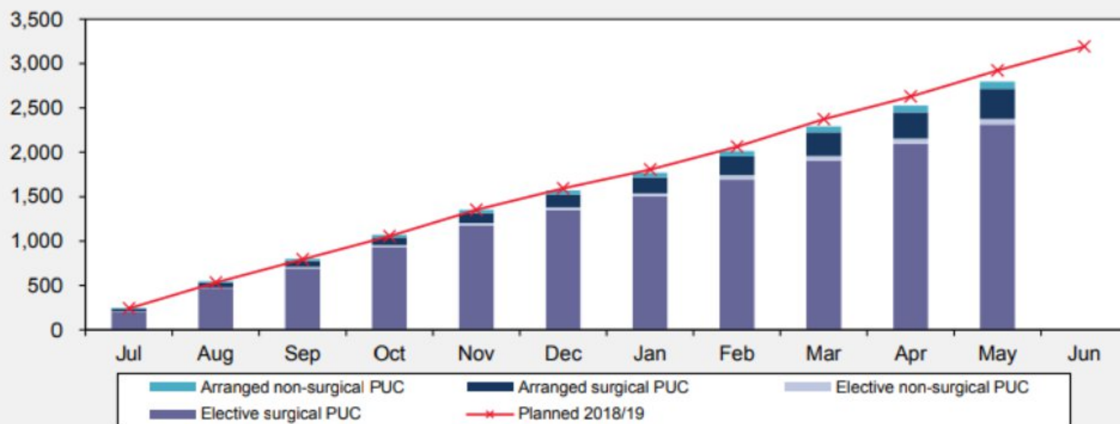
- Reduce clinic cancellations
- Theatre utilisation maximised
- Timely access to primary care
- Shorter stays in ED
- No more than 100 days wait
- Appropriate workforce levels
- Days of surgery maximised
- Decreased readmission rate
- No stranded patients
- Reduced DNAs

Theatre Capacity and Theatre Utilisation

Achievements/Issues of Note

Elective Surgical Discharges ▼ 91.8%

	2018						2019					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Planned	1,520	3,182	5,065	6,985	9,132	10,470	11,532	13,474	15,676	17,548	19,773	21,782
Actual	1,617	3,477	5,260	6,938	8,826	10,249	11,717	13,465	15,224	16,565	18,143	
Variance	97	295	195	-47	-306	-221	185	-9	-452	-983	-1,630	
%Achievement	106%	109%	104%	99%	97%	98%	102%	100%	97%	94%	92%	



Reporting from the Ministry shows that Canterbury DHB met its elective discharges objectives at the end of the first quarter (until the end of September 2018), and performance continued to be close to target until the end of February 2019. It indicates a significant under delivery developed during March and has continued since then. Internal reporting shows that at the end of June 21,139 elective and arranged discharges have been completed. While data corrections may increase the count industrial action by members of the Resident Doctor Association and the mass shooting incident of 15 March mean that we will not reach our target for elective services discharges this year.

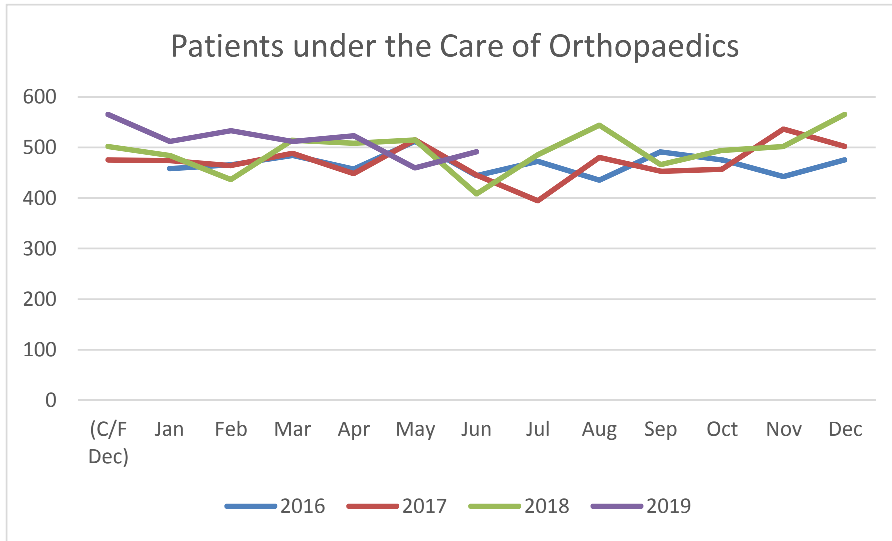
General Surgery team structure being optimised to make the most of new capacity when Christchurch Hospital Hagley opens.

The opening of Christchurch Hospital Hagley provides significantly more theatre capacity than is currently available on the Christchurch Campus. As well as enabling the repatriation of all outplaced and the majority of planned surgery a significant increase in theatre capacity is provided for people needing acute surgery. This will support the provision of more timely surgery to patients after admission. It is expected that length of stay in hospital for these patients will be reduced due to less time being spent in hospital prior to provision of surgery and associated reduced deconditioning will minimise the time required in hospital following surgery.

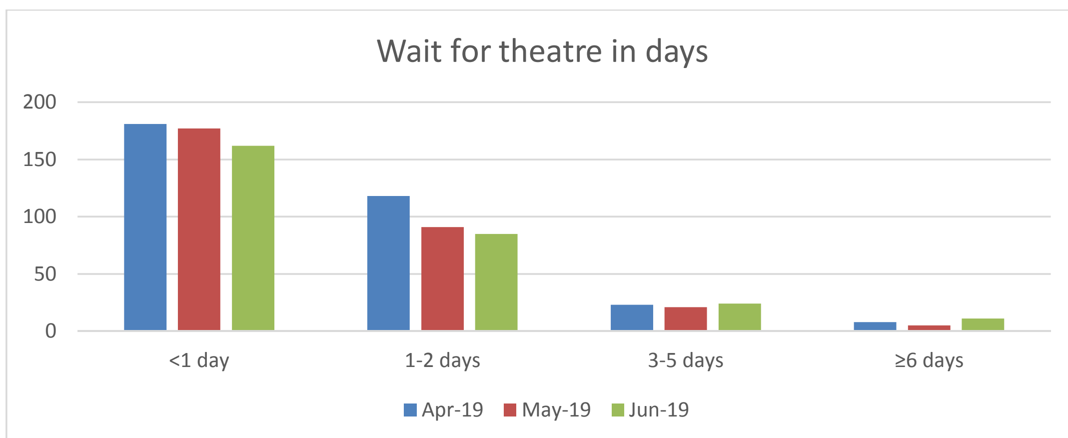
In order to ensure that General Surgery is able to effectively utilise this increased acute theatre capacity and support patient flow the team structure is being reorganised. Senior Medical Officer schedules and job sizes have been reviewed to enable this. Productive discussions are ongoing with resident medical officers about how best to support the new two team structure to ensure access to training opportunities for both junior and senior Registrars.

Orthopaedics

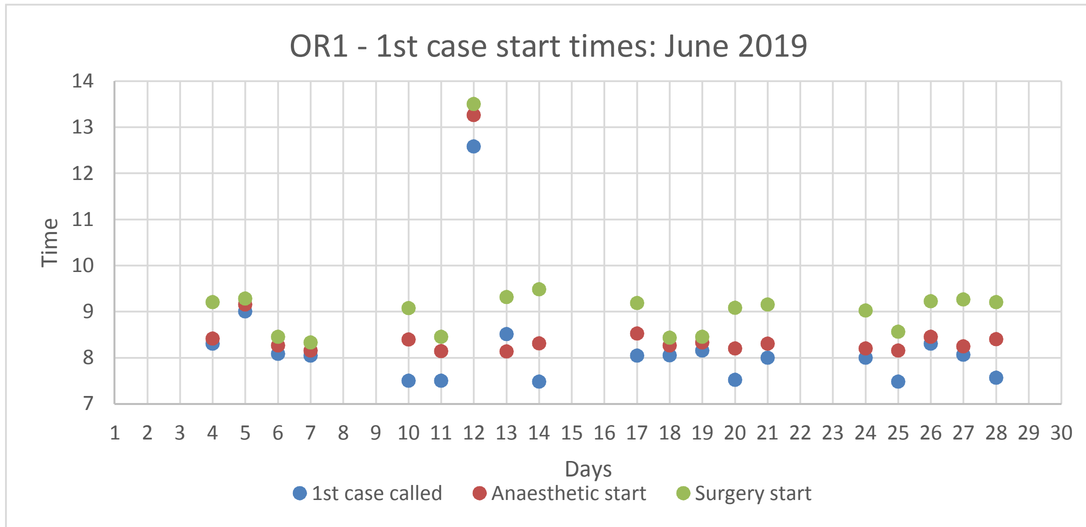
There has been a greater number of patients admitted under the care of orthopaedics in June 2019 compared with previous 3 years admissions. The average length of stay remains fairly constant at 3.56 days. The average wait for theatre based on patients "readiness for theatre" increased to 1.04 days compared with previous month of 0.79 days. This has also reflected on theatre time for several complex cases. However we are making progress with 57% of patients who were ready for theatre received their surgery with less than one full days wait, while 30% made it to theatre with between 1-2 days wait. A greater number of patients waited 6 or more days for their surgery (11) compared to the previous 2 months (April-8 and May-5). This is both access to subspecialty and access to theatre. There were 49 of our 282 patients transferred to Burwood for surgery. A major focus of utilising theatre sessions that are vacant due to annual leave has seen a significant leap forward with only 20% not being able to be used. This equates to only 5 half day sessions over the month of 26 sessions.

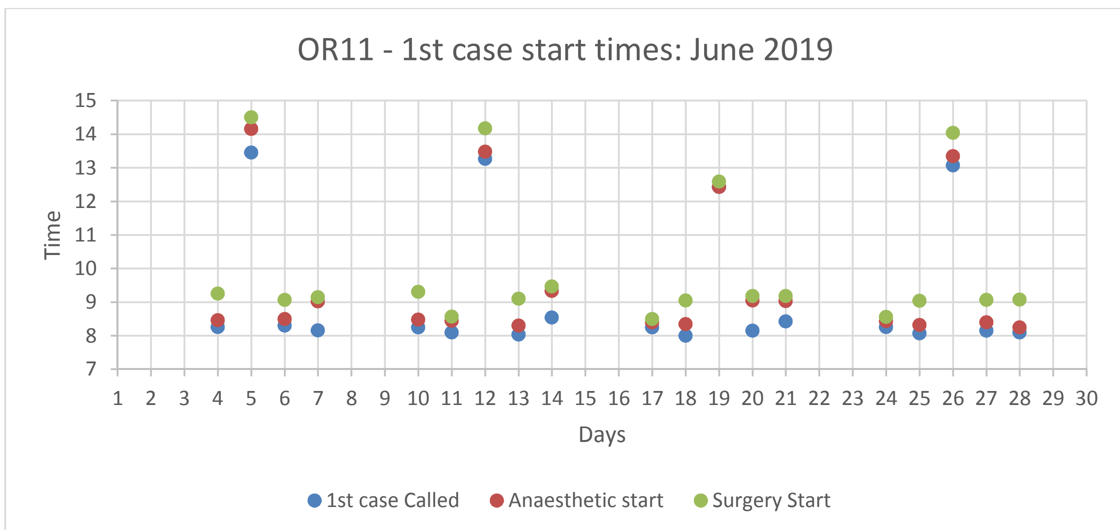


Currently Our Average Wait for Theatre is 1.04 days which is calculated using "ready for surgery" date rather than admission date.



We are undertaking a focus on 1st surgical start times at Christchurch Campus for Orthopaedics. Those that are not called prior to 0800 impact greatly on our start times. This can be seen in the attached graph:





Orthopaedic Service increasing capacity to meet increasing demands

The Orthopaedic Service is experiencing an ever increasing demand for its services. The ongoing increase in demand for acute services creates a real risk that we are unable to provide planned care for our population.

A National and international recruitment drive to grow our Orthopaedic Senior Medical Officer team has been very successful and enables us to both replace outgoing surgeons and grow to meet increasing acute and elective demands. The department has successfully recruited a senior orthopaedic surgeon from Sheffield into a 12 month fixed term position and an orthopaedic trauma surgeon, who trained in the United Kingdom and is currently in Canada completing fellowship, into a permanent position. These two appointments along with other positions we are recruiting towards will see an additional four new orthopaedic surgeons commence with the Canterbury District Health Board over the next six months.

The orthopaedics team meets weekly to ensure that coordination of resources (our people, patients, theatres and clinic activity) across Christchurch, Burwood and West Coast campuses are aligned. As well as ensuring we make appropriate use of resources these meetings allow us to highlight any opportunities that exist within the service to improve patient experiences.

Orthopaedics have been working on coordinating the spine patient activity. This to improve the constrained spine service, in both the short and long term.

Provision of spinal surgery is an area that holds particular challenges in ensuring that there are sufficient resources to provide care to acute patients as well as to those that are deteriorating while awaiting planned surgery. The pressure of demand in this area was such that we could not continue waiting for the availability of the new theatre capacity that will be provided when Christchurch Hospital Hagley opens. In the short term we have created dedicated access to four hours' of theatre capacity each weekday to allow timely access to theatre for this group. Putting a nurse coordinator in place has supported the service's aim to improve patient access in this area by ensuring that the various resource schedules are aligned and patients receive clear communication and are prepared for surgery.

Two new spinal surgeons start work in the District Health Board in September and February respectively. This will dramatically improve the capacity to deliver planned spinal both in clinic and theatre. The spine team has been strengthened by reallocating orthopaedic resident medical officer resources so that we now have a defined spinal team including a Senior Medical Officer, training registrar, junior registrar, House officer, and spine nurse coordinator. This team that supports service delivery and provides some depth to the spine service.

Increased Planned Care / Decreased Acute Care

- Earlier diagnosis
- At Risk population identified
- Increased equity of access
- Rapid access to assessment
- Timely access to specialist intervention
- 24hr access to primary care intervention
- Decreasedhospital acute care
- Increased elective intervention
- Decreased acute primary care demand
- Access to care improved

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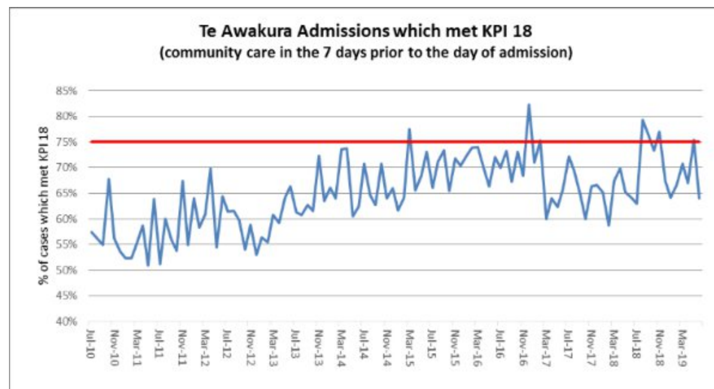
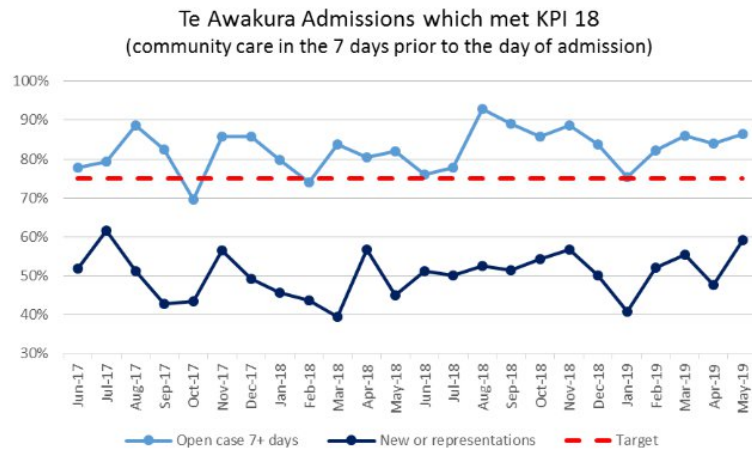
Mental Health Services

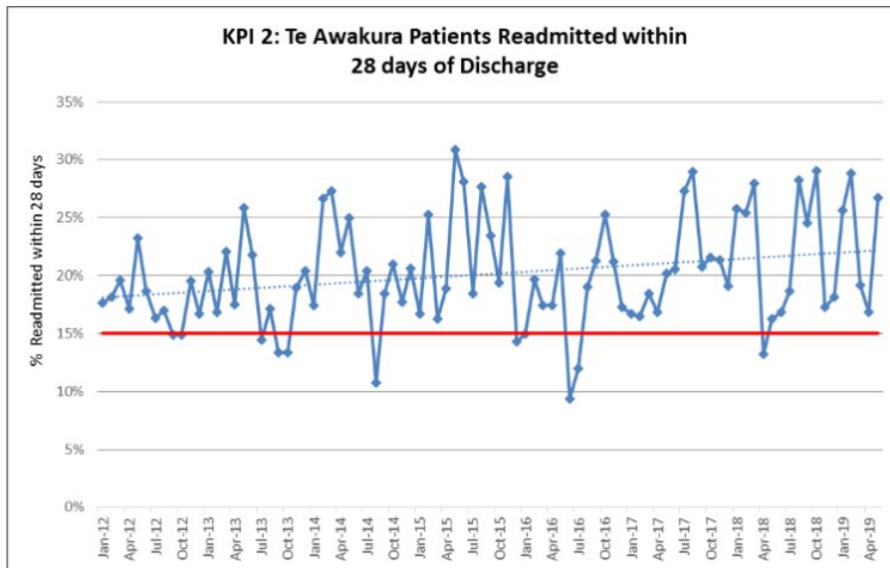
Adult Services



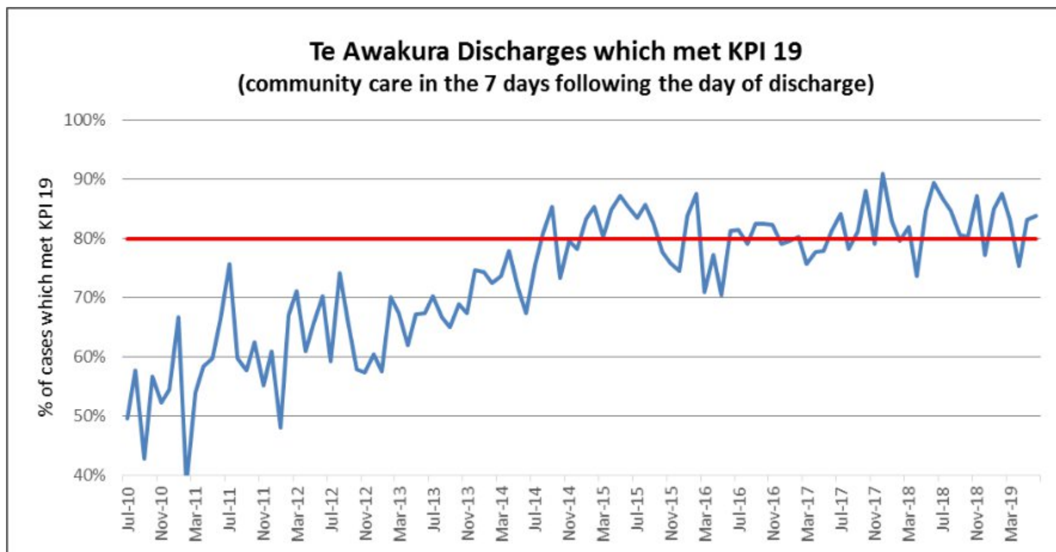
KPI 18 is an indicator of how well engaged we are with the consumers in our services. In May 2019, 75.5% of acute admissions to Te Awakura had a community contact in the seven days prior to the date of their admission. In June 2019, the figure was 64.1%.

A recent investigation into KPI 18 rates showed that in most instances where KPI 18 was not met, the person was not currently under the care of Specialist Mental Health Services. For people already under the care of Specialist Mental Health Services the target was achieved.

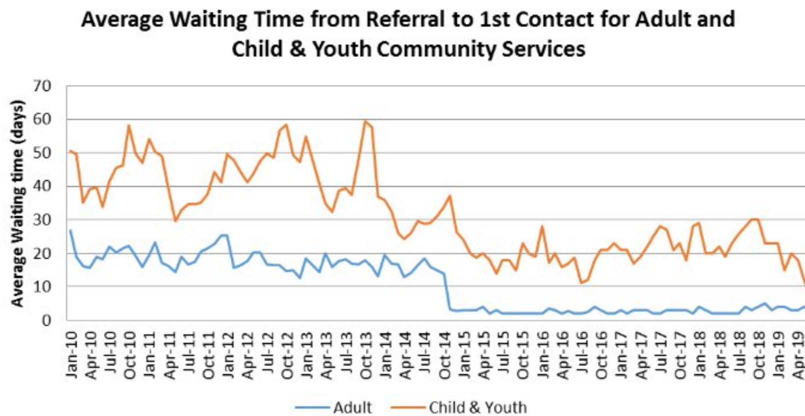




The graph above shows the readmission rate within 28 days of discharge. Of the 125 Te Awakura consumers discharged in May 2019, 26.7% were readmitted within 28 days. Readmission rates are closely monitored. We believe the increasing trend is related to the inability of people to move through the mental health system due to flow issues. On the day of writing this report 48 of acute inpatient beds were occupied by people who have been in the service for 17 days or longer, 24 of those people had been in for longer than 30 days, 12 for longer than 60 days, 7 have been in for longer than 90 days and 2 people have been in the unit for more than a year.



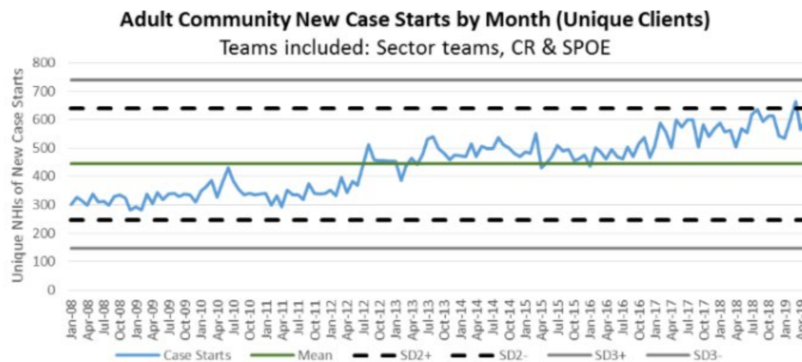
KPI 19 is a key suicide prevention activity and patient safety measure. In May 2019, 83.2% of consumers discharged from Te Awakura received a community care follow-up within seven days of discharge, and so met KPI 19. In June 2019, the figure was 83.9%. A review of cases where follow up did not occur indicates that a number of individuals were discharged out of region and a small number of individuals were elusive to follow up.



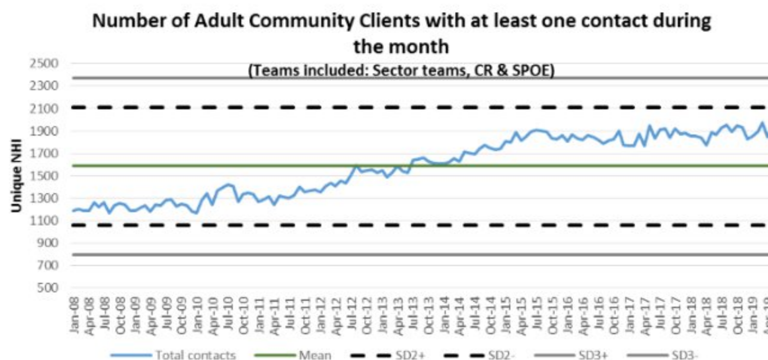
The graph above shows there has been an overall reduction in the time people spend waiting. Ministry of Health targets for these services require 80% of people to be seen within 21 days and 95% of people to be seen within 56 days. The average waiting time for adults was 4 days for May 2019 and 3 days for June 2019. Our results for the Adult General Mental Health Service show 92.4% of people were seen within 21 days of referral in May 2019 and 99.0% were seen within 56 days of referral. In June 2019, these figures were 94.9% and 99.5% respectively.

For child and family services, the average waiting time to first contact was 12 days in May 2019 and 7 days in June 2019. Our results show 61.8% of people were seen within 21 days of referral in May 2019 and 78.3% were seen within 56 days of referral. In June 2019, these figures were 62.9% and 86.2% respectively.

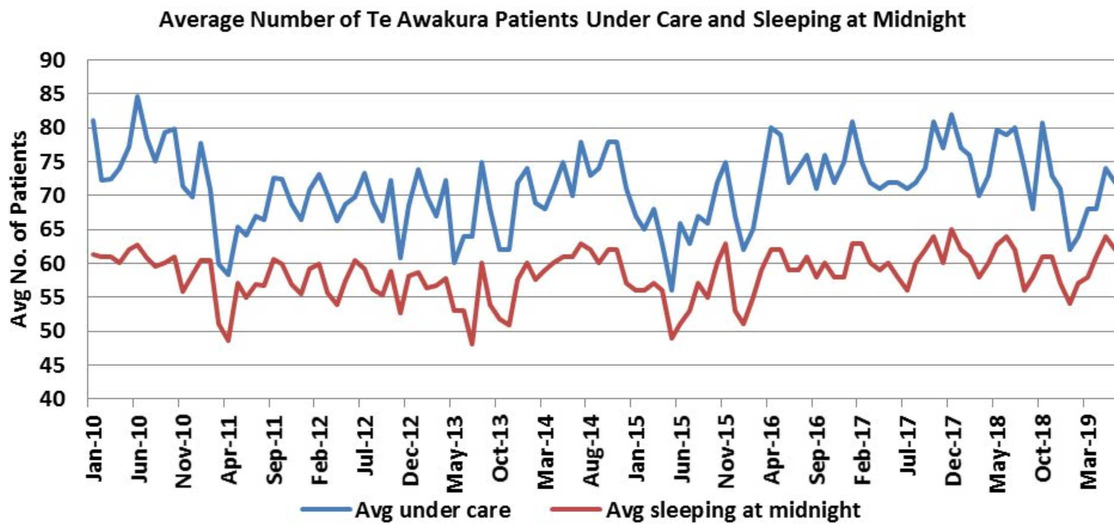
These results are occurring in the context of significant increase in demand.



New cases were created for 603 individual adults (unique NHIs) in May 2019 and 550 in June 2019.



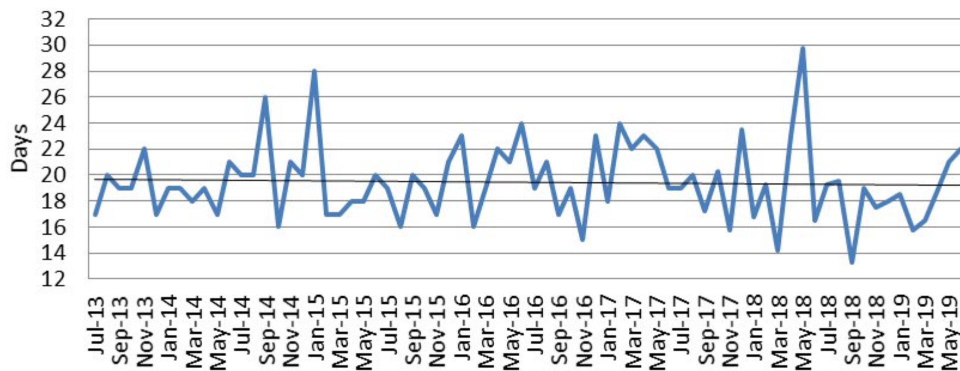
In May 2019 there was at least one contact recorded for 1934 unique adult community mental health consumers and 1807 in June 2019.



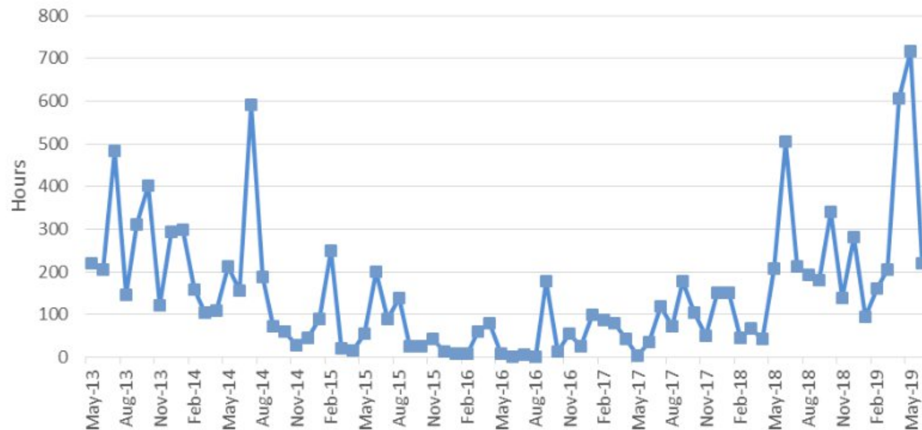
85% occupancy is optimal for mental health acute inpatient services.

Occupancy in Te Awakura (the acute inpatient service) has regularly been above this figure. Occupancy was 100% in May 2019 and 96% in June 2019.

The average number of consumers under care in this 64 bed facility was 74 in May and 72 in June 2019. There were 33 sleepovers during May 2019 and five sleepovers during June 2019.



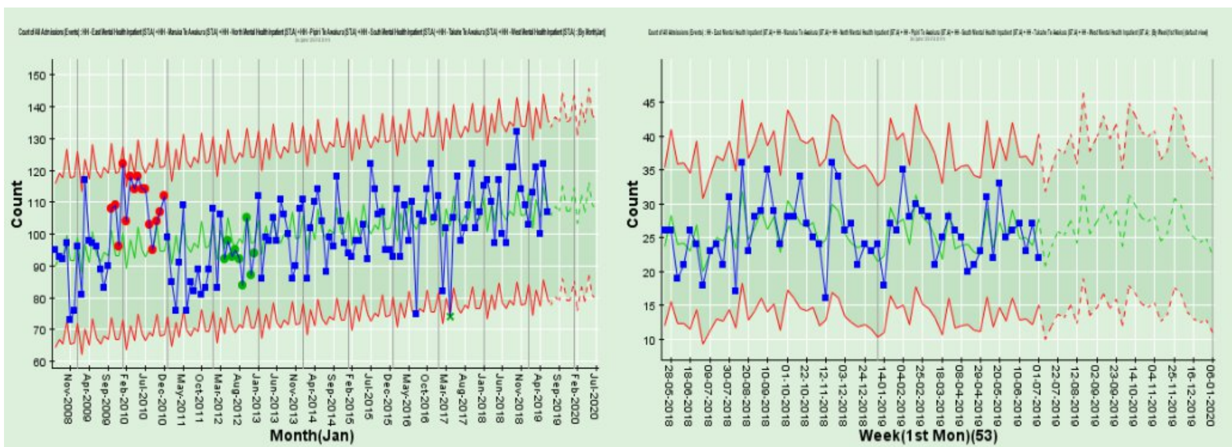
The average length of stay for consumers discharged from Te Awakura was 21 days for May 2019 and 22 days for June 2019. As at end June 2019 we have 45 people who have been an inpatient for longer than 15 days. We are undertaking further analysis to understand the reasons for this.



In May 2019, nine consumers experienced seclusion for a total of 715.7 hours. In June 2019, eight consumers experienced seclusion for a total of 219.4 hours. The recent increase is in the context of consumers presenting with drug related issues, consumers accessing drugs whilst an inpatient and an individual with a complex physical condition resulting in impulsive, aggressive outbursts.

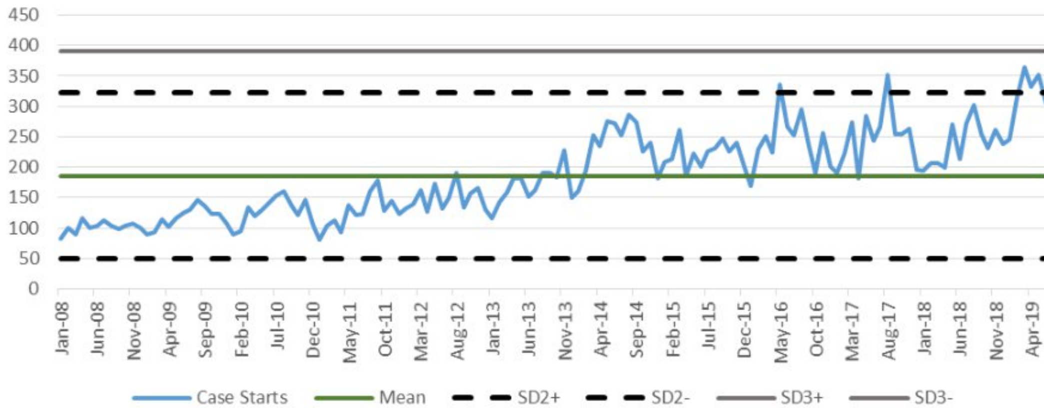
Our focus on reduction of seclusion in Te Awakura continues. Our 'Safer for All' initiative is part of the Health Quality and Safety Commission, Mental Health and Addiction quality improvement programme. This programme includes regionally based learning opportunities and co-design workshops related to seclusion reduction. Local initiatives have included working groups focused on reducing events involving violence and aggression, an evaluation of consumer, whanāu and staff experience of seclusion and regular collection and review of data including use of seclusion, use of restraint and use of sedatives.

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



Child and Youth

There has been a 147% increase in child and adolescent case starts in the past eight financial years and we are currently experiencing a significant increase in referrals (averaging 86 per week). An analysis is underway of the increasing number of referrals, this will enable us to understand trends and hopefully identify ways in which we can proactively target and address need.



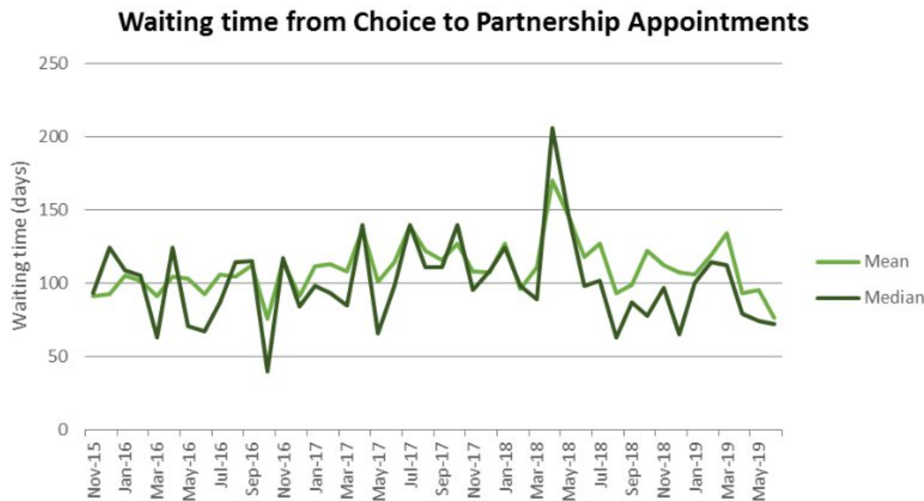
New cases were created for 352 children and adolescents (unique NHIs) in May 2019 and 305 in June 2019.

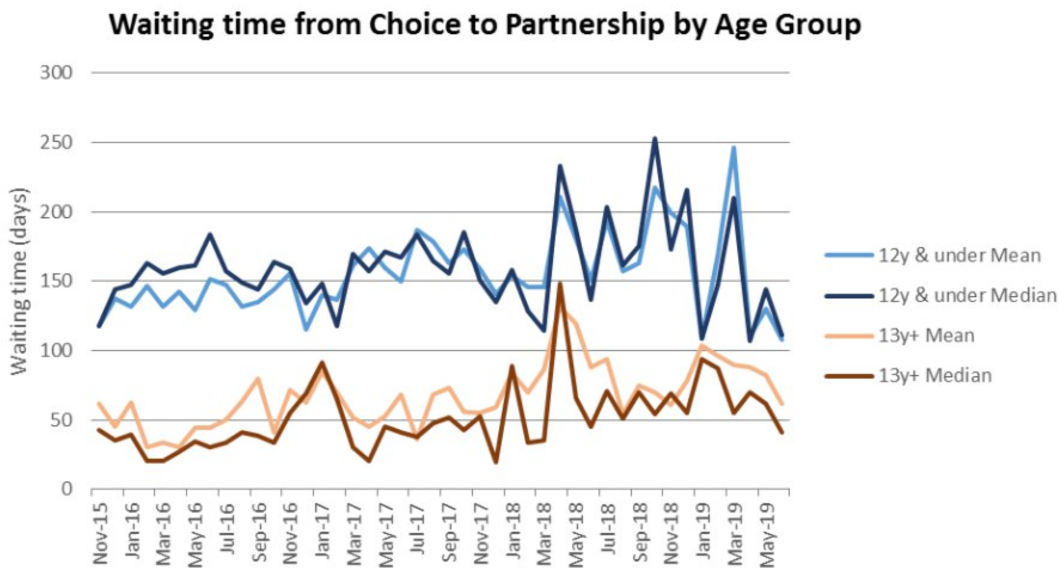
Reducing wait times in the child and adolescent services remains a key focus, with attention being paid to wait time from referral to first contact, wait time to first face to face contact and wait time to 3rd face to face contact (used as a proxy measure for wait time to treatment).

Being seen early for the first contact is important as it enables clinicians to make informed decisions about who is able to wait and who needs to be seen urgently. The reduction in time from referral to first contact is a reflection of a change in process within the CAF Access team. The CAF Service found that a proportion of children and young people attending a Choice (triage) appointment did not meet the service criteria for treatment. The new process includes comprehensive information gathering and triage by phone to avoid unnecessary assessment appointments, timelier re-direction of children and young people, resulting in increased clinician time for undertaking treatment. This has also resulted in a greater proportion of children and young people going straight to a Partnership appointment (full assessment)

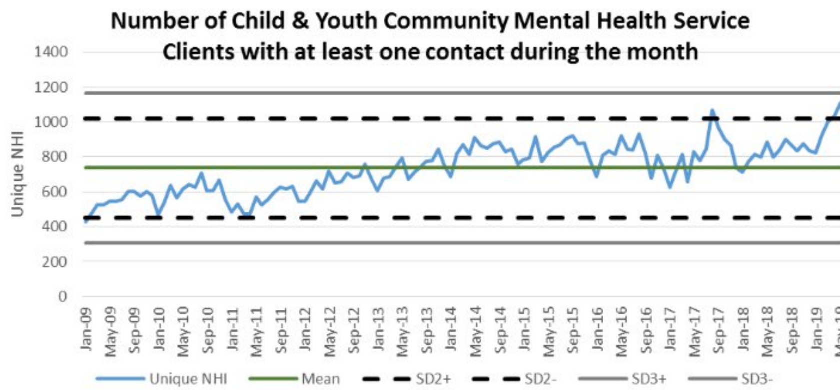
**Source: National KPI programme data which includes 0-19yrs*

The graphs below show the waiting time between Choice (triage/screening) and Partnership (full assessment) appointments.

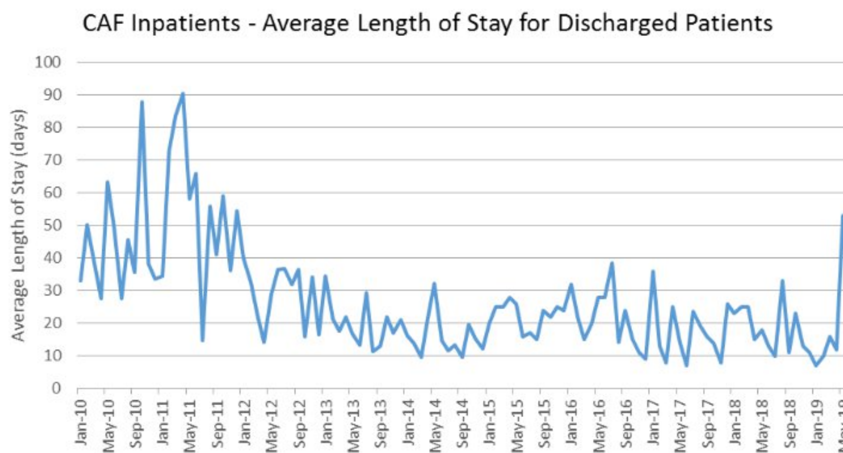




**Source: National KPI programme data which includes 0-19yrs*

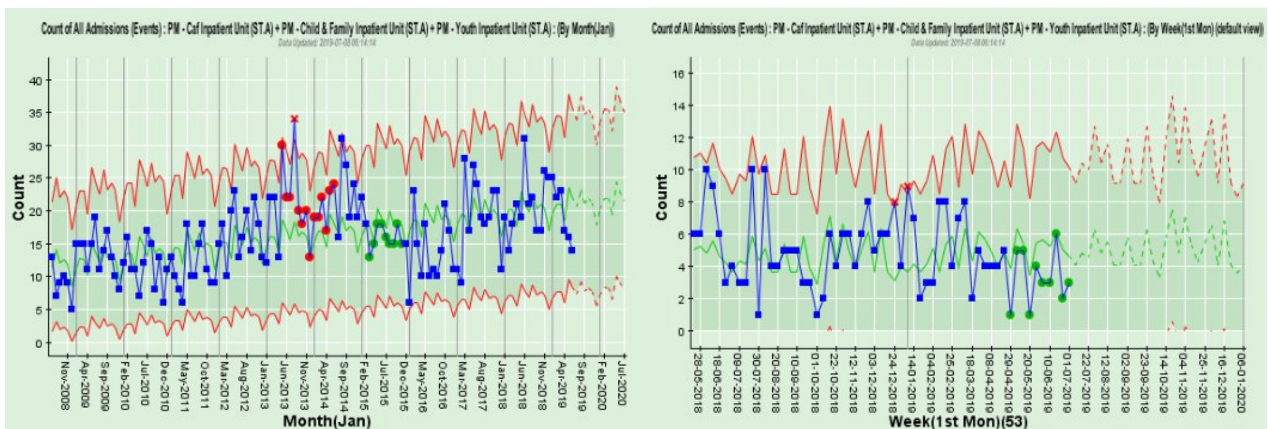


The number of unique clients with contacts above shows a similar pattern to new case starts graph, which demonstrates an increase in demand for Child and Youth community Mental Health Service. There were 1110 unique patients with at least one contact during the month of May 2019 and in June 2019 there were 983.



The average length of stay for discharged patients was 53 days for May 2019 and 19 days for June 2019.

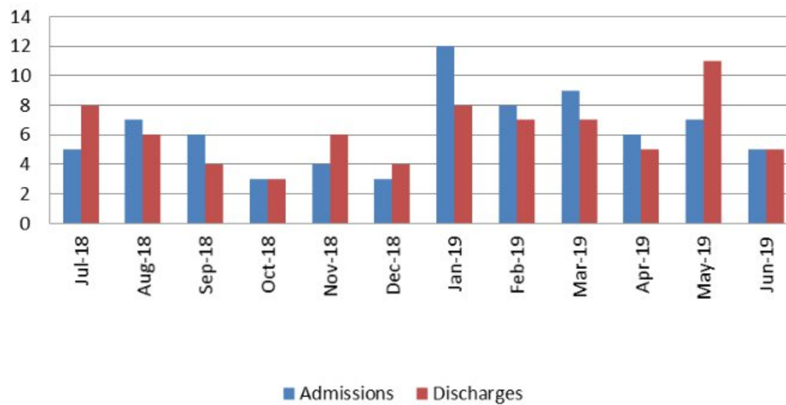
The graphs below show the number of admissions to the Child and Adolescent Unit and its predecessors. The first graph is a monthly view, and the second a weekly view.

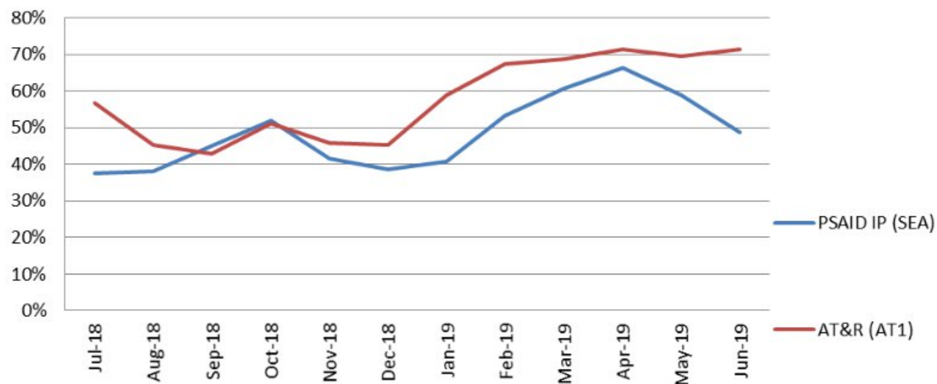


Intellectually Disabled Persons Health Service

The IDPH Service inpatient units comprise a secure unit, Assessment, Treatment and Rehabilitation (AT&R), currently operating as a 6 bed unit and a 15 bed dual disability unit, Psychiatric Service for Adults with Intellectual Disability (PSAID) within the Aroha Pai building , Hillmorton Hospital.

The Assessment, Treatment & Rehabilitation Unit is poorly configured to meet clinical and safety needs. Following a robust planning and approval process the building footprint will be extended to include four separate apartments for individuals who require this level of care environment. Building of these additions is due to begin in July 2019. Interim internal modifications to enable one individual to be treated in a separate area has resulted in a reduction in physical assaults and the requirement for seclusion for that person.

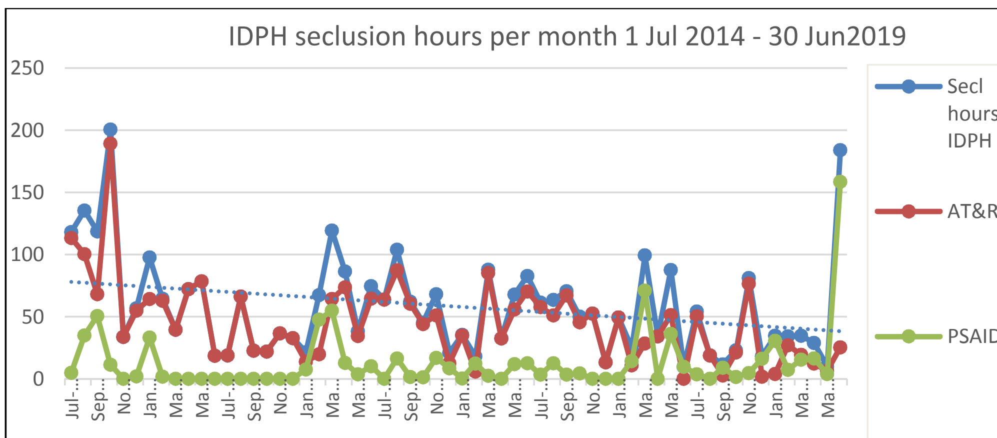


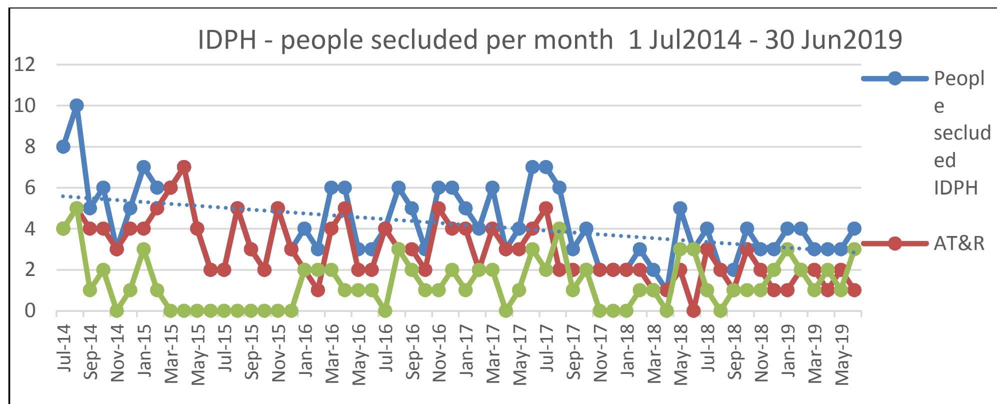


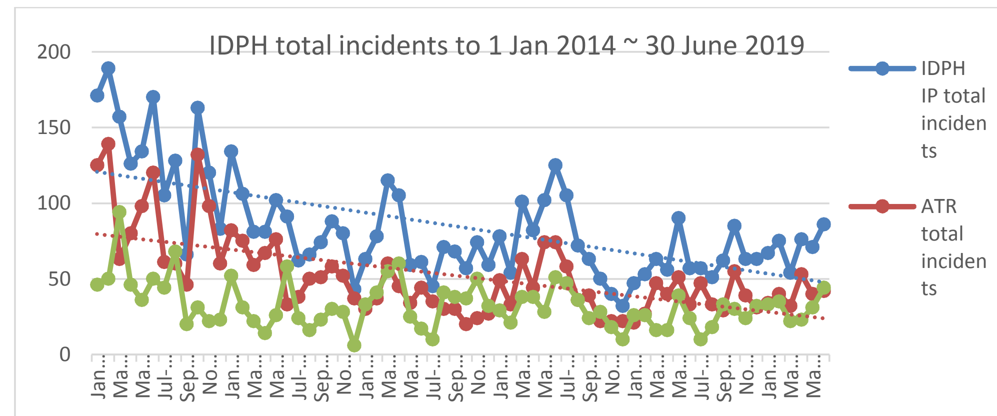
Occupancy in AT&R (AT1) was 70% for the month of May 2019 and 71% for June 2019. The figures for PSAID (SEA) were 59% and 49% respectively.

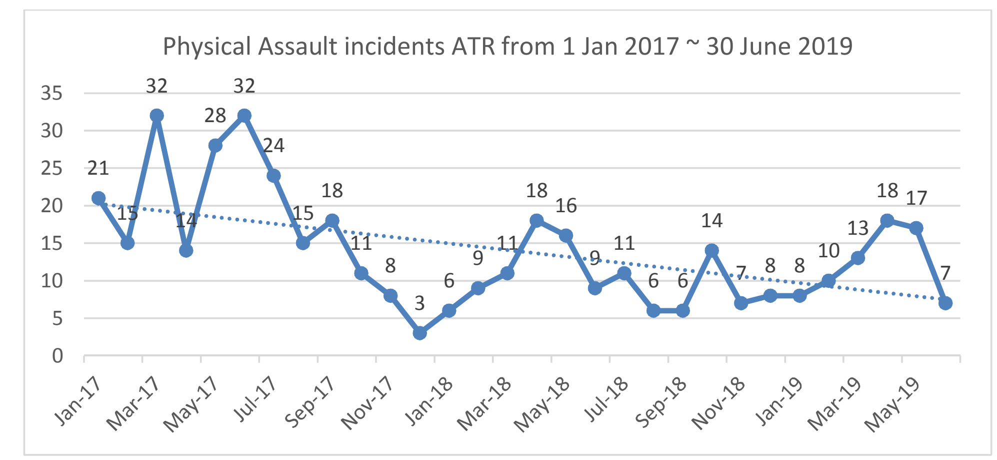
New admissions since February 2019 have seen an increase in inter-peer conflict which presents challenges to manage within the currently limited footprint.

The uncharacteristically high level of seclusion in PSAID Inpatient service in June 2019 was related to the aggressive behaviour of two individuals who presented with a high risk of harm to others.


IDPH seclusion hours per month 1 Jul 2014 - 30 Jun2019
Secl hours IDPH
AT&R
PSAID


IDPH - people secluded per month 1 Jul2014 - 30 Jun2019
People secluded IDPH
AT&R


IDPH total incidents to 1 Jan 2014 ~ 30 June 2019
IDPH IP total incidents
ATR total incidents


Physical Assault incidents ATR from 1 Jan 2017 ~ 30 June 2019

Workforce development

Our Specialist Mental Health Service offers a range of services that enable people to recover from serious mental illness. Our staff work together with the person and their family providing specialist assessment and treatment. Whilst we recruit people with in-depth clinical expertise there is a need to continuously build and develop capability, to invest in training and development, to build confidence in practice, to support effective clinical care delivery, and provide safety in practice.

Learning and Development within Specialist Mental Health Services includes formal teaching and education. In 2018, we had 2811 staff attend SMHS courses, delivered by SMHS clinicians, consumer or advisors family advisors, dedicated educators. We invest in teaching adult education principles to support clinician, family advisors and consumer advisors who deliver training.

Embedding learning into practice requires additional coaching, monitoring and practice development. We use the Kirkpatrick Model for analysing and evaluating the results of our training and educational programmes and to support education planning in line with our strategic vision. We provide Nurse Coach roles within our Adult Acute Inpatient services and Clinical Specialist clinicians to provide in-vitro support and guidance. We invest in resources to support new graduate clinicians who undertake new entrant into specialist practice programmes and we have developed programmes of support and workforce development for new to practice ENs and hospital aides

No Wasted Resource

- Reduce clinic cancellations
- Theatre utilisation maximised
- Timely access to primary care
- Shorter stays in ED
- No more than 100 days wait
- Appropriate workforce levels
- Days of surgery maximised
- Decreased readmission rate
- No stranded patients
- Reduced DNAs

Living within our means

Living within our Means, including No Wasted Resource

Financial Performance

Canterbury District Health Board

Statement of Financial Performance

Hospital & Specialist Service Statement of Comprehensive Revenue and Expense
For the 12 Months Ended 30 June 2019

MONTH $'000						YEAR TO DATE				
18/19 Actual $'000	18/19 Budget $'000	17/18 Actual $'000	18/19 Variance $'000	18/19 vs 17/18 Variance $'000		18/19 Actual $'000	18/19 Budget $'000	17/18 Actual $'000	18/19 Variance $'000	18/19 vs 17/18 Variance $'000
					Operating Revenue					
388	398	503	(10)	(115)	From Funder Arm	5,595	4,796	7,095	799	(1,500)
1,996	1,614	1,617	382	379	MOH Revenue	18,683	19,129	18,479	(446)	204
4,398	4,804	3,576	(406)	822	Patient Related Revenue	51,128	55,822	49,901	(4,694)	1,227
1,564	1,547	1,355	17	209	Other Revenue	18,653	16,310	16,286	2,343	2,367
8,346	8,363	7,051	(17)	1,295	**TOTAL OPERATING REVENUE**	94,059	96,057	91,761	(1,998)	2,298
					Operating Expenditure					
					Personnel Costs					
61,120	62,433	57,581	1,313	(3,539)	Personnel Costs - CDHB Staff	735,965	713,213	670,387	(22,752)	(65,578)
2,355	2,118	2,136	(237)	(219)	Personnel Costs - Bureau & Contractors	23,625	23,843	22,422	218	(1,203)
63,475	64,551	59,717	1,076	(3,758)	**Total Personnel Costs**	759,590	737,056	692,809	(22,534)	(66,781)
11,671	14,528	11,693	2,857	22	Treatment Related Costs	150,355	159,297	141,789	8,942	(8,566)
3,812	4,044	3,368	232	(444)	Non Treatment Related Costs	43,527	42,634	43,263	(893)	(264)
78,958	83,123	74,778	4,165	(4,180)	**TOTAL OPERATING EXPENDITURE**	953,472	938,987	877,861	(14,485)	(75,611)
(70,612)	**(74,760)**	**(67,727)**	**4,148**	**(2,885)**	**OPERATING RESULTS BEFORE INTEREST AND DEPRECIATION**	**(859,413)**	**(842,930)**	**(786,100)**	**(16,483)**	**(73,313)**
					Indirect Income					
5	456	-	(451)	5	Donations & Trust Funds	15	(2)	46	17	(31)
-	(1)	-	1	-	Interest & Dividends Received	-	(30)	-	30	-
5	**455**	**-**	**(450)**	**5**	**TOTAL INDIRECT INCOME**	**15**	**(32)**	**46**	**47**	**(31)**
					Indirect Expenses					
1,976	2,596	3,162	620	1,186	Depreciation	21,840	26,503	26,879	4,663	5,039
6	-	90	(6)	84	Loss on Disposal of Assets	3	-	136	(3)	133
1,982	**2,574**	**3,252**	**592**	**1,270**	**TOTAL INDIRECT EXPENSES**	**21,843**	**26,422**	**27,015**	**4,579**	**5,172**
(72,589)	**(76,879)**	**(70,979)**	**4,290**	**(1,610)**	**TOTAL SURPLUS / (DEFICIT)**	**(881,241)**	**(869,384)**	**(813,069)**	**(11,857)**	**(68,172)**

Achievements/Issues of Note

Deep Vein Thrombosis Prophylaxis in the intensive care unit

TED stockings were routinely used in the intensive care unit but following a review of best practice, reusable compression sleeves are now being used instead. As well as reducing the risk of deep vein thrombosis and reducing pressure injuries, this change is expected to save an estimated $25,000 per annum.

New Oral Care Regime for Ventilated Patients in ICU

At the end of 2018 the intensive care unit moved to full implementation of a new oral care regime for ventilated patients. This is an evidence based, clinically driven change that is anticipated to save approximately $80,000 per year.

Technology Assessment – improved information about the goods we purchase

Radiation Therapy is preparing for some significant investment in the coming years with two linear accelerators, and associated equipment, requiring replacement in 2020. Technology in this area is heavily vendor driven and there is significant information asymmetry with vendors knowing the complicated detail of their offerings and customers often in the dark about what questions should be asked.

Preparing for procurement of this technology has previously required Medical Physicists and Medical Radiation Therapists to commit a large amount of time in completing literature review so that the value and desirability of various technological improvements can be understood, and priority of various parameters set. This research will be much easier this time around as we are now making use of tools provided by the ECRI institute, included is a range of reports already on-line that provide a systematic, uniform approach to assessing new technology and comparing the offerings of different companies. Alongside this teams can ask for new reports to be generated if up to date and relevant information is not currently available. This will release time for other tasks while ensuring that the right questions are asked prior to engaging in the Procurement process for expensive equipment.

Canterbury District Health Boards Procurement Department, which runs the procurement processes for all services within Canterbury District Health Board, has also found the technology assessments provided by the ECRI institute useful in enhancing the procurement process.

The SELECTplus tool provided by ECRI allows the Procurement Department to benchmark tender proposals against those provided to other health providers internationally. Inclusion of consumable and service costs allows the Procurement Department to benchmark the relative costs of different products on a whole of lifetime (this is known as Total Cost of Ownership) against their own calculations relative to the New Zealand markets for capital purchases. It also provides alerts about recalls and unexpected maintenance requirements. The information provided by ECRI is analogous to that provided to New Zealand households by ConsumerNZ. This greatly simplifies the process of obtaining useful, information about intended purchases and helps in obtaining indicative value for money. This does not eliminate the requirement for the Procurement department to both sense check within the New Zealand market place and to manage mandatory procurement process.

Audit of leave patterns is leading to improvements

Appropriate management of annual and other leave is important within organisations. Taking regular leave is important for employee wellbeing, safety and efficiency. While recent events have challenged the ability of some people to take leave, they have also reinforced the importance of doing so. It is also important that leave taken is deducted from balances to ensure that the organisation does not falsely have the liability on its balance sheet. A recent audit of patterns of leave use and balances has identified some areas for improvement.

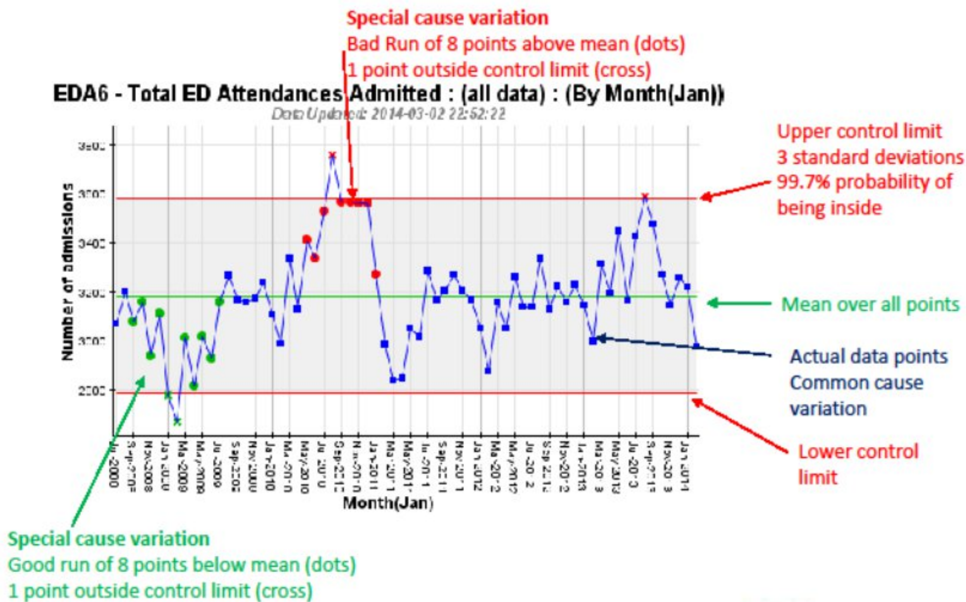
- An unexpected gap was discovered, with the internal processing of annual leave of ED fellows. Leave had been updated in the scheduling system which was not interfacing with the Microster system. This meant that the leave taken by one small group of Clinicians in the Emergency Department had not been recognised. The total value of the leave was the equivalent to a full time equivalent over the period of a year. Following a medically led process the backlog has now been identified and corrected as well as then process going forward.

- Reviewing patterns of leave taken in services has identified other areas where processing of leave forms were either being submitted late or were months behind. A focus on correcting these gaps has been successful.
- Microster is now being used across the campus to at least indicate the presence or absence of all workforces including Senior Medical Officers. This has improved the ability to recognise leave taken and ensure leave balances are appropriately debited. It has improved visibility and transparency, provided a single repository of information that feeds into a range of reporting systems and simplifies future audits.

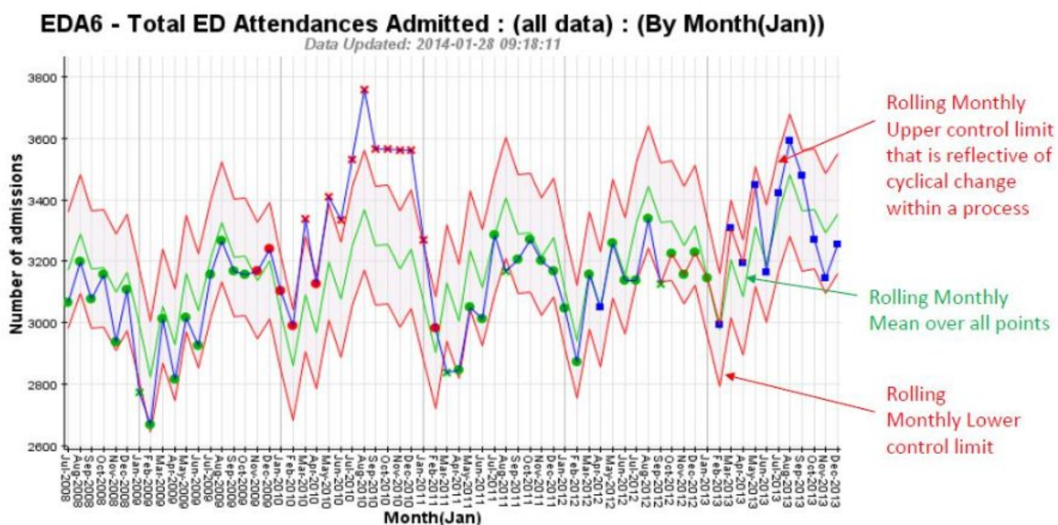
Review of pricing for inter-district flow.

The Christchurch Campus Finance team and Planning and Funding have combined efforts to focus on the prices attracted for inter-district flow versus the associated costs. It is estimated that there is a significant annual deficit in the area of Multidisciplinary Meetings and related to radiation oncology. These results will drive further analysis and discussions nationally as we seek resolution in these and other areas.

SPC: How to Interpret a Control Chart



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

CLINICAL ADVISOR UPDATE – ALLIED HEALTH

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

NOTES ONLY PAGE

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

SOURCE: **Corporate Services**

DATE: **1 August 2019**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Committee:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of the minutes of the public excluded meeting of 30 May 2019	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(if required)*	Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)

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

3. SUMMARY

The Act, Schedule 3, Clause 32 provides:

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

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

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

Clause 33 of the Act also further provides:

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

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

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

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

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

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

WORKPLAN FOR HAC 2019 *(WORKING DOCUMENT)*

9am start	31 Jan 19	04 Apr 19	30 May 19	1 Aug 19	3 Oct 19	5 Dec 19
Standing Items	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes
Standing Monitoring Reports	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report
Planned Items	Clinical Advisor Update – Nursing & Allied Health	Clinical Advisor Update - Nursing	Clinical Advisor Update – Medical 2019 Winter Planning Update	Clinical Advisor Update - Allied Health H&SS 18/19 Year Results	Clinical Advisor Update - Nursing	Clinical Advisor Update – Medical 2019 Winter Planning Review
Presentations	Sleep Health Services in Canterbury	Burwood Campus Avoidable Admissions in General Surgery	Christchurch Campus – Children's Haematology & Oncology Centre (*CHOC*)	SMHS	Christchurch Campus – ORL (ENT) TBC: Ashburton / Rural Health	New Treatments & Technologies Programme (NT&T) TBC: Christchurch Campus – Dept. of Anaesthesia TBC: Labs
Governance and Secretariat Issues						2020 Workplan
Information Items	2019 Workplan	2019 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 2019 Workplan	2019 Workplan	2020 Meeting Schedule 2019 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 2019 Workplan
Public Excluded Items	CEO Update (as required)	CEO Update (as required)	CEO Update(as required)	CEO Update (as required)	CEO Update (as required)	CEO Update (as required)