AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora o Waitaha

HOSPITAL ADVISORY COMMITTEE MEETING
to be held via Zoom
Thursday, 7 October 2021 commencing at 9:00am

Administration			
	Apologies		9.00am
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 5 August 2021		
3.	Carried Forward / Action List Items		
Presentation			
4.	H&SS 2020 / 21 Year Results	David Green *Acting Executive Director, Finance & Corporate Services*	9.05-9.20am
Reports for Noting			
5.	Hospital Service Monitoring Report: • Medical/Surgical; Women's & Children's Health; & Orthopaedics ESPIs • Specialist Mental Health Service • Older Persons Health & Rehabilitation • Hospital Laboratories • Rural Health Services	Pauline Clark *General Manager, Medical/Surgical; Women's & Children's Health; & Orthopaedics* Dr Greg Hamilton *General Manager, Specialist Mental Health Services* Kate Lopez *Acting General Manager, Older Persons Health & Rehabilitation* Kirsten Beynon *General Manager, Laboratories* Win McDonald *Transition Programme Manager Rural Health Services* Berni Marra *Manager, Ashburton Health Services*	9.20-10.30am
6.	Clinical Advisor Update (Oral) • Allied Health	Dr Jacqui Lunday-Johnstone *Executive Director of Allied Health, Scientific & Technical*	10.30-10.40am

7.	Resolution to Exclude the Public		10.40am
ESTIMATED FINISH TIME			**10.40am**
	Information Items: • 2022 Meeting Schedule • 2021 Workplan		

NEXT MEETING: Thursday, 2 December 2021 at 9:00am

ATTENDANCE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE MEMBERS

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

Executive Support

(as required as per agenda)

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

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

COMMITTEE ATTENDANCE SCHEDULE 2020

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

Andrew Dickerson **Chair – HAC** Board Member	**Canterbury Health Care of the Elderly Education Trust** - Chair Promotes and supports teaching and research in the care of older people. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Canterbury Medical Research Foundation** - Member Provides financial assistance for medical research in Canterbury. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Heritage NZ -** Member Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance and Heritage NZ has already been involved with CDHB buildings. **Maia Health Foundation -** Trustee Is a charitable trust established to support health care in the CDHB area. Current projects include fundraising for a rooftop helipad and enhancements to the children's wards at Christchurch Hospital. **NZ Association of Gerontology** - Member Professional association that promotes the interests of older people and an understanding of ageing.
Naomi Marshall **Deputy Chair - HAC** Board Member	**College of Nurses Aotearoa NZ** – Member **Riccarton Clinic & After Hours** – Employee Employed as a Nurse. Riccarton Clinic & After Hours provides general practice and after-hours care. It is part privately and PHO funded. The PHO receives funding from the CDHB.
Barry Bragg Board Member	**Air Rescue Services Limited** - Director Subsidiary of the Canterbury West Coast Air Rescue Trust. Has gaming licenses with specified purpose of fundraising for air rescue services. **Canterbury West Coast Air Rescue Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air rescue and air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB. **CMUA Project Delivery Limited** - Director 100% owned by the Christchurch City Council and is responsible for the delivery of the Canterbury Multi-Use Arena project within agreed parameters. **Farrell Construction Limited** - Shareholder Farrell's Construction Limited is a commercial and light commercial construction company based in Christchurch.

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

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

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

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

MINUTES – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE HOSPITAL ADVISORY COMMITTEE MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
on Thursday, 5 August 2021, commencing at 9.00am

PRESENT

Andrew Dickerson (Chair); Barry Bragg; Jan Edwards; Naomi Marshall; Ingrid Taylor; and Michelle Turrall.

Attending via Zoom: James Gough; and Jo Kane.

APOLOGIES

Apologies for absence were received and accepted from Catherine Chu, Dr Rochelle Phipps; and Sir John Hansen (Ex-officio).

EXECUTIVE SUPPORT

Becky Hickmott (Executive Director of Nursing); Kay Jenkins (Executive Assistant, Governance Support); and Anna Craw (Board Secretariat).

APOLOGIES

Apologies for absence were received from Dr Peter Bramley (Chief Executive); Dr Jacqui Lunday-Johnston (Executive Director, Allied Health, Scientific & Technical); Tracey Maisey (Executive Director, Planning Funding & Decision Support); and Dr Helen Skinner (Chief Medical Officer). An apology for early departure was received from Becky Hickmott (Executive Director of Nursing).

IN ATTENDANCE

Kirsten Beynon, General Manager, Laboratories
Pauline Clark, General Manager, Medical/Surgical; Women's & Children's Health; & Orthopaedics
Dr Greg Hamilton, General Manager, Specialist Mental Health Services
Kate Lopez, Acting General Manager, Older Persons Health & Rehabilitation
Berni Marra, Manager, Ashburton Health Services
Michael O'Dea, Secondary Care Team, Planning & Funding

Item 4

Dr Clare Doocey, Chief of Child Health and Clinical Director for General Medicine for Paediatrics
Tracy Jackson, Nursing Director for Women's & Children's
Dr Tony Walls, Paediatric Infectious Diseases Specialist

Andrew Dickerson, Chair, HAC, opened the meeting welcoming those in attendance. He took the opportunity to acknowledge the recent death of Dr Robert Crawford. Dr Crawford was the Medical Superintendent of the Queen Mary Hospital in Hanmer Springs, a Residential Alcohol and Drug Treatment Centre, from 1976 to 1991. Under his leadership, the hospital became a centre of excellence for expanding the treatment modalities for families affected by addiction, and the training of people working in treatment and rehabilitation. Dr Crawford established a successful Kaupapa Māori/Taha Māori programme, Te Aroha o to Hau Angiangi. He authored a number of publications and served in various national governance and advisory roles.

1. INTEREST REGISTER

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

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

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

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (06/21)
(Moved: Barry Bragg/Seconded: Naomi Marshall – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 3 June 2021 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION ITEMS

The carried forward action items were noted.

4. RSV & IMPACTS

Pauline Clark, General Manager, Medical/Surgical, Women's & Children's Health, & Orthopaedics, introduced Dr Clare Doocey, Chief of Child Health and Clinical Director for General Medicine for Paediatrics; Tracy Jackson, Nursing Director for Women's & Children's; and Dr Tony Walls, Paediatric Infectious Diseases Specialist.

The Committee received a presentation on the Respiratory Syncytial Virus (*RSV*) and its impact on the Canterbury health system in July 2021. The presentation provided an overview of:

- What RSV is.
- The spectrum of illness and severity across all ages.
- Hospital management – a supportive role through observation, feeding and breathing.
- International Post COVID-19 Lockdown RSV Experience.
- The spike in Canterbury presentations in the last week of July.
- CDHB & WCDHB RSV positive samples 2012 – 2021.
- GP after hours & health line calls / 24 hours: < six years with RSV symptoms.
- 24 hour surgery presentations in July.
- Christchurch Emergency Department respiratory presentations July.
- Children's Acute Assessment Admissions July 2015 – 2021.
- The impact on Paediatrics and Associated Services.
- Gratitude.
- Reflections; including
    - challenges of a lean system;
    - the importance of a whole of system approach; and
    - the need to be prepared for a resurgence of non-COVID infections (influenza, and a continued focus on childhood immunisations).
- Children's Emergency Care area and the importance of having the right people, in the right place, to care for children.

Dr Doocey and Ms Walker thanked staff for their support of the organisation, as it would not have been possible to care for this number of children without the generosity of staff in terms of doing extra work.

Becky Hickmott, Executive Director of Nursing, acknowledged the significant leadership provided by Dr Doocey and Ms Walker in this space. The whole of system approach was phenomenal. At a time when there was enormous pressure on the system, their leadership was stellar. Ms Hickmott also took the opportunity to note that the 24 Hour Surgery, Urgent Care in Ricccarton and Moorhouse, also provided amazing leadership.

Members had the opportunity to discuss the presentation and ask questions. There was discussion around the following:

- Winter flex.
- The impact on staff and sustainability for the remainder of the winter season.
- Staff sickness and the availability of discretionary leave.
- Rapid testing of staff by Labs, across the system.
- Vulnerability once borders are opened with respect to the resurgence of other infections.

In response to a query around the need to commission some extra space (the Children's Emergency Centre (*CEC*)), Ms Hickmott advised that there is a meeting currently being coordinated between ED and CEC to plan for bringing the teams together to see what can be done. She commented that we have proven our capabilities, so are now looking at how to acquire the necessary resources.

Mr Dickerson thanked Dr Doocey, Ms Walker and Dr Walls for the informative presentation and the work that they are doing.

The meeting moved to Item 6.

6. CLINICAL ADVISOR UPDATE (ORAL)

Becky Hickmott, Executive Director of Nursing, provided the following updates:

- Nursing is under quite considerable pressure, but this is not a local issue, it is a national and also international issue.
- NZ has a history of an over-reliance on the international qualified nursing (*IQN*) workforce. 50% of all of our registrations make up IQNs. The IQN workforce has significantly dropped due to COVID, partly due to nursing not being on the high priority list at the moment apart from a couple of small areas; and the second issue is that many countries are holding back their nursing teams due to what is happening within their borders (eg, the Philippines). 30% of our 50% IQNs are Filipino nurses, so this is having a major impact.
- Nursing across the nation is approximately 1,500 FTE down. All health roles are approximately 3,500 FTE down. A letter has been sent by the CEOs across NZ asking for healthcare to be prioritised, especially nursing.
- 900 FTE down across the nation for Aged Residential Care (*ARC*), and this is growing. Aged care is in a challenging space. Nationally, in some areas, wings have been closed due to an inability to staff. Aged care teams seem to be migrating into other areas.
- Strike action is scheduled for 19 August 2021. Huge efforts are going into contingency planning and negotiations with the Union will continue for the rest of this week.
- Challenge and mood - the moral distress that nursing is feeling at the moment. They feel they need to speak out for safety and for their patients. Again, this is across the nation.
- Working closely with teams to support nurses, with daily monitoring in place.

- CCDM – just starting first FTE calculations.

Ms Hickmott provided a shout out to all colleagues. It has been a very interdisciplinary response; a whole of system response; all of the system is under pressure; and private hospitals are struggling to get staff for the first time in many years.

The Clinical Advisor Update was noted.

The meeting moved to Item 5.

5. H&SS MONITORING REPORT

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

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

Hospital Laboratories – Kirsten Beynon, General Manager, Laboratories

- Week long IANZ audit peer review and surveillance for pathology and laboratories this week, with reaccreditation against NZISO15189 and multiple other standards.
- High volume Chemistry Analyser Installation happening next week.
- The labs team are focussing in on a Paiaka Ora reset post the Board's decision to pause. This includes a reset and adjustment of financials/budget forecast, review of planned service models to support community referrers, fleet business case with a move to hybrid vehicles and optimisation of courier networks for the whole system, ceasing and modifying procurement – business cases, RFPs and contracts, reassessment of workforce and needs, anatomical pathology shift of work back to community, reset of acute demand service models, investment of new ways of working to support community referrers. The team has undertaken a significant programme of work and is extremely proud of it. It is a piece of work that can be handed over to anyone leading into the transition and health reforms.
- RSV as per presentation from Paediatrics is a learning and warning to our health systems throughout NZ of what we need to continue to be prepared for as pathogens are reintroduced as borders open, this also includes Measles and Bordetella Pertussis (whooping cough). Whilst the greatest impact was on paediatrics laboratory data showed it has affected our entire population and across all age groups.
- Every winter (except for lock down) we see peaks in RSV, however, our peaks for influenza are always much larger and have a greater impact on the system. Our systems need to be prepared. The shutdown of our borders again for COVID also lessons the likelihood of the introduction of influenza. Therefore, when it is re-introduced the impact will be significant.
- RSV figures - noting we do not test all patients:
  - At current peak 77% of patients tested positive for RSV.
  - 0-4 years positive – this age group 39% positive.
  - Patients tested >80 years old 39% positive for RSV.
  - Non European 60-65% positivity rate.
  - Europeans tested 40% positivity rate.
- To support the pressure on our hospital we have placed phlebotomists into ED. SMOs from ED have fed back that this has had a very positive impact on stretched resources. Labs continues to review and grow its rapid testing capacity for the three main virus groups that are in need of urgent results in an acute care context.
- Labs will continue to work with ED leads and the Office of Clinical Leaders on other triage/testing opportunities that will assist with patient flow and clinical decision making.

- Lab figures:
  - There has been a significant increase in demand for tests out of hours over the last 12 months. Community volumes referred to CHL out of hours (excluding COVID) have increased by 20% (19/20 to 20/21 years).
  - TNI (cardiac marker) test demand is increasing (ED, Acute Demand Service, and 24 Hour Surgery). There has been an upward trend in Maori and Pasifika Peoples.
  - Acute Demand test service to CHL is continuing to go up and up, year on year. Quick turnaround time is required to support primary care with this service. Couriers and logistics in the community need review to ensure we are meeting the needs of primary care to support patients in the acute care space.
- COVID. CHL processed the highest volumes in a month last month. This is reflective of a range of factors including other viruses circulating in the community due to similar symptom presentations, changes in border restrictions, and contact tracing of returnees from Australia due to the current resurgence of the virus there. We will see an increase with our returning Olympians and support teams filling up the MIQs.

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

- MERAS, the Union for Midwives, are taking industrial action next week. This will have a significant clinical impact. MERAS is also signaling further industrial action for the same day as NZNO action – 19 August 2021. This will have a huge impact and requires a great deal of planning.
- ASMS which represents SMOs is scheduling two hour stop work meetings in August.
- Currently in orange on the escalation pathway, so are challenged from a resourcing perspective. Need to right size the hospital. Some planned surgery is being deferred. Where we can, we are swapping out planned surgery that would require an overnight stay, with day stay surgery. ICU is full today.
- The provider arm certification visit has taken place. Very positive feedback was received.
- Selwyn Health Hub is progressing – on time and on budget – and is looking to be occupied in late January 2022. Planning for the opening and occupation of the facility is on track.
- Acknowledged the recent passing of Gary Barbara, who was a Service Manager with the DHB for many years.
- Shout out to the Clinical Coding Team.

A member expressed concern that whilst we continue to tinker around the edges, the reality is that we are constrained. Ms Clark acknowledged the point made, but commented that some of the work being done from a systems perspective, and certainly came to the forefront at the weekend, is that if we can get SMO or senior registrar engagement early and into ED, we can either pull or turnaround. We need to be really careful that the answer to volume demand is not simply to say we need more beds, more space, or more staff. It is likely that there is something to that, but if we went for a model that had some KPIs and time allocated to SMOs to get in amongst it in ED, we may see something different. In addition to that, if we can engage with General Medicine colleagues on a trial of a different way of working, it is possible to release medical capacity to have a greater role in ED. The member applauded Ms Clark's optimism.

Ms Hickmott commented that there has been a huge amount of analysis conducted on what is coming through the front door of ED. During this period of RSV, the admission rate has gone from 25% up to 35-39%, and there is no doubt there is quite considerable pressure on the system. However, we are also seeing a number of people presenting at ED who should not be. That is the area of opportunity to turn around. We are looking at changing the model of care at the moment. There are resource constraints, there is no doubt about that, but there are also opportunities that we have not yet done that need to be tried first before we look at anything

else. If we can take that noise out, we are hoping to perhaps take the pressure off the ED team. We have invested too – have put more resources into different areas, have increased some beds within the medical area and have increased staffing in relation to that. We have also increased staffing for the ED team and continue to look at that.

ESPIs

Ms Clark commented that for the last two to three weeks, with school holidays and RSV, we have slipped back. However, for the last five working days, we can see progress towards compliance resuming.

Michael O'Dea, Secondary Care Team, Planning & Funding, commented that when the MoH recently visited, they noted our performance against the Planned Care targets. We achieved 97% against our original plan of 100%, but over the 95% that ensured we got the full funding. They intimated that CDHB was one of four DHBs that achieved that.

Mr O'Dea noted that the way the MoH funds us for Planned Care comes through bulk funding and what is called the PCI; its $44M. We have to achieve 95% of our target to be able to access all of that $44M and do the wash-up. We have achieved that on a year on year basis. The MoH have also put in Improvement Action Plan funding. Last year that was based on volume, not on ESPI. We over achieved on that, which ended up resulting in about $2.7M additional revenue over cost. This year, the MoH turnaround is based on ESPI - $6M total, $4M available (basically $1M per quarter), with a $2M bonus at the end on ESPI achievements. It will be a big challenge for all DHBs, which the MoH have already recognised.

In relation to the physiotherapy – conservative management of prolapse and incontinence work, a member queried whether there had been any thought about assessment of women six week post-partum, as this would go a long way in preventing women to get to prolapse and incontinence. Ms Clark noted that this is picked up in ante-natal classes. Ms Hickmott noted there is a service just new in primary care, which she would come back to the member on.

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

- Still under strong demand for Mental Health Services. The two services at the forefront of that are the Child & Adolescent Service and Eating Disorders Service.
- Integration across the system is working very well, both within the division but also with NGO partners. Look forward to the continued rollout of the primary care measures, as that is yet to have a true impact on the system at this point in time.
- Staffing remains a problem in Mental Health Services. There are more choices for mental health staff, who want to rotate out.
- Whaikaha AT&R was occupied early last week. Consumers are relatively settled and staff are adapting to a new environment.
- New builds are on time and on budget.
- The Programme Business Case does not feel like quite such good news – still in ongoing negotiations with the Health Infrastructure Unit. There is another meeting on Friday that will be looking at master planning. We are in the unusual position of being offered a chunk of money, but that does not fit within our Programme Business Case, our master planning, or what we can do on site. We are looking at what are the best solutions to help us get something on the ground, which the MoH are desperate to do in terms of new beds, but also allows us to have a master planning process within it.
- Yesterday we negotiated the Life Preserving Services for the NZNO strike scheduled for 19 August 2021.
- This month's report highlights the various sources of information that are used across the system to keep improving services. There is a really strong drive in terms of quality and service improvement.

There was discussion around the Clinical Audit Program and opportunities for improvement.

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

- Whilst not impacted to the same degree as Christchurch Hospital by the increase in volume of presentations, OPH&R have been impacted by sickness amongst staff across all workforces. This has been a significant challenge.
- Holding daily incident management meetings connected to the whole system. In the last week, have been heightening the focus on what can be done to support flow by fully utilising campus capacity as much as possible.
- Heavily involved in the Making Our System Flow work that is being led by the Clinical Executive.
- Taking an assertive approach to discharge.
- Community Dental Service. Gains are being made, but there remains opportunity for further improvement.

In response to a query, Ms Lopez undertook to provide some longitudinal data in the next report with regards to the percentage of Canterbury children overdue for dental examinations.

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

- Ashburton Health Services are 50% primary care. 50% of working week is operating as the acute primary care.
- 72% of presentations are self-referrals.
- People need timely access to acute care. Our opportunity is to look at how longitudinal care, preventative care, participation and keeping the community well, is connected.
- Primary care locality workforce. This provides a framework to think about what we have been wanting to progress through the Ashburton Service Level Alliance – moving from the delineation of primary care, PHOs and hospitals, to a service lens for the community that we can coordinate and deliver collectively.
- One of the significant challenges that will have to be addressed in any satellite community service delivery, is the delivery of transport and St John.

The H&SS Monitoring report was noted.

The meeting moved to Item 7.

7. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (07/21)
(Moved: Jan Edwards/Seconded: Naomi Marshall – 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 3 June 2021	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(if required)*	Protect information which is subject to an obligation of confidence. 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

- Making Our System Flow (ex Board 15 July 2021)
- 2021 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 11.03am.

Approved and adopted as a true and correct record:

_____ _____

Andrew Dickerson
Chairperson

Date of approval

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE
CARRIED FORWARD ITEMS AS AT 7 OCTOBER 2021

DATE RAISED		ACTION	REFERRED TO	STATUS
1.	01 Oct 2020	H&SS Monitoring Report	Dr Peter Bramley / Andrew Dickerson	Under action
2.	05 Aug 2021	Longitudinal data on percentage of Canterbury children overdue for dental examinations	Kate Lopez	Today's Agenda – Item 5

H&SS MONITORING REPORT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

DATE: **7 October 2021**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Committee:

i. notes the Hospital Advisory Committee Activity Report.

3. APPENDICES

Appendix 1: Hospital Advisory Committee Activity Report –September 2021

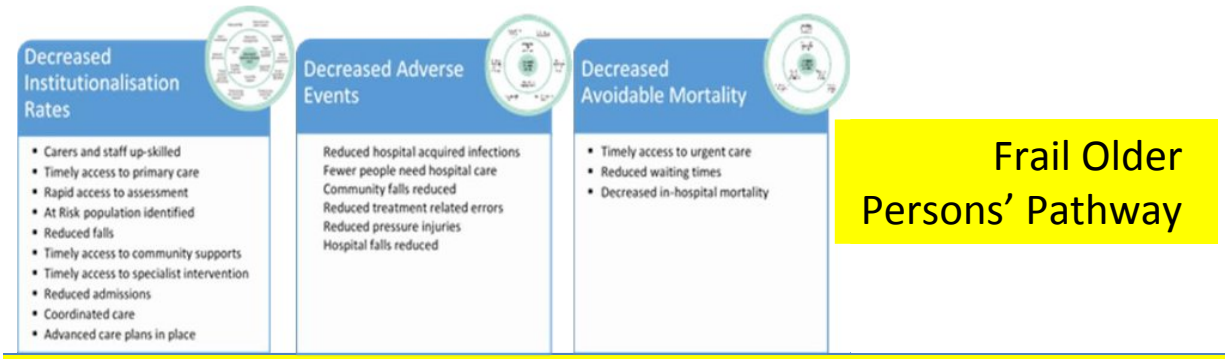
Hospital Advisory Committee

Hospital Activity Report

September 2021

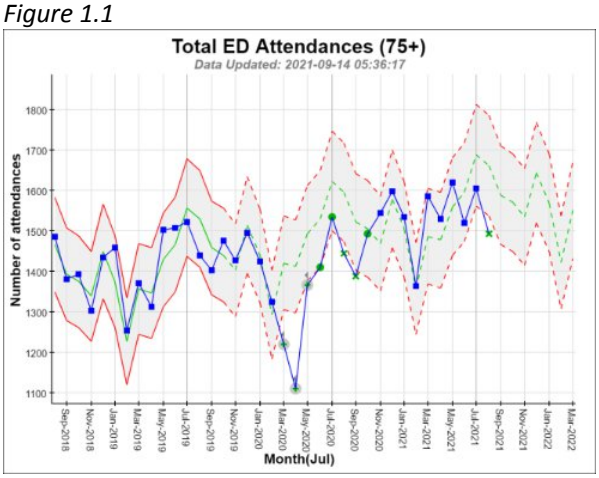
Based on the CDHB Outcomes Framework and Five Focus areas plus Specialist Mental Health

INDEX



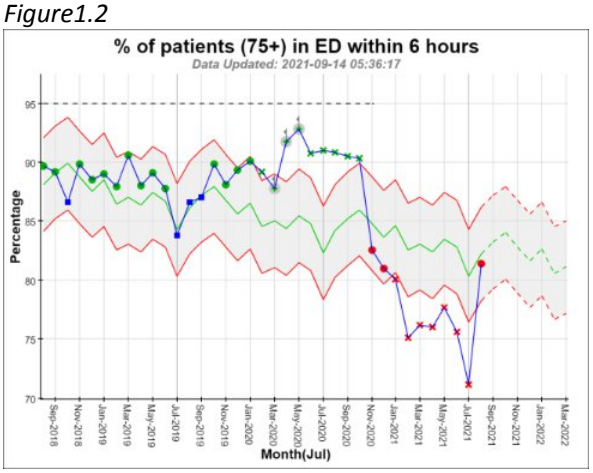
Outcome and Strategy Indicators

Figure 1.1



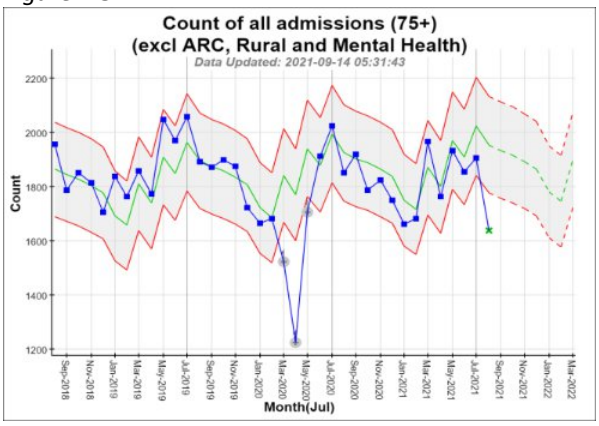
Covid 19 Alert Level restrictions led to a reduced number of ED attendances by people over 75 years in March and April 2020 and August 2021 and with a volume at forecast levels between these periods.

Figure1.2



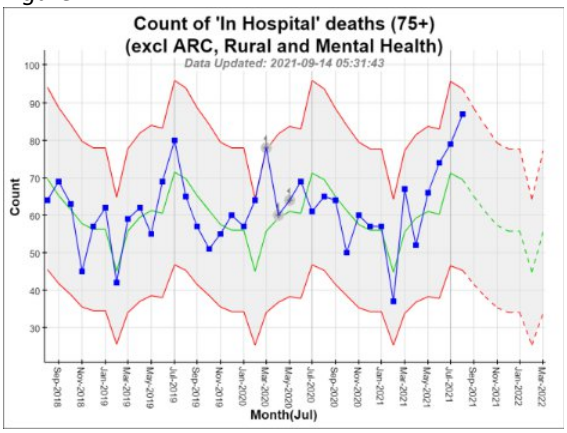
The number of people spending >6 hours in the department has reduced due to lower volumes since the lockdown commenced. Speed of flow into the hospital has improved because of lower hospital occupancy. While the proportion of people spending less than six hours in the Emergency Department increased, it is still short of the 95% target and rates achieved prior to November 2020.

Figure 1.3



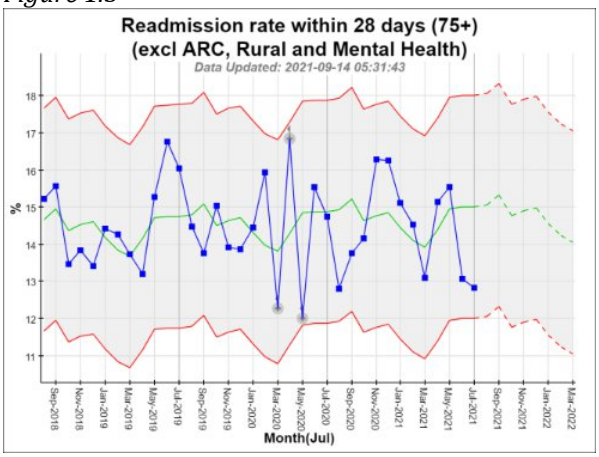
The number of older people admitted was reduced during the COVID lockdown period.

Figure 1.4



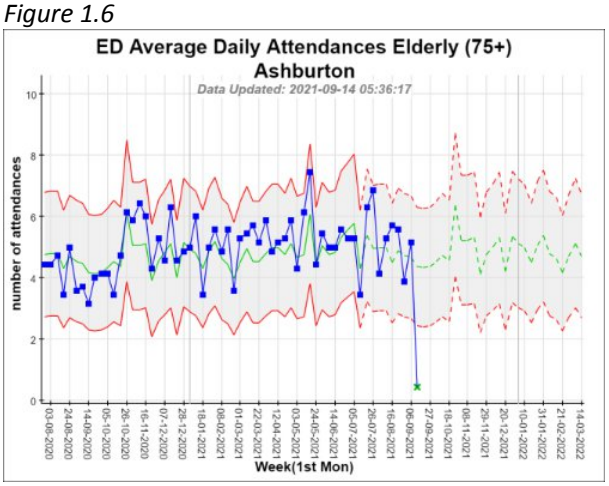
The number of in hospital deaths has increased in each of the past four months. While this has not yet reached a statistically significant threshold this measure is being evaluated in further detailed and escalated to clinical leaders for further consideration.

Figure 1.5



Readmissions remain within the expected range.

Figure 1.6



Ashburton rate of attendances, 75+ age group, are within the expected range of forecast attendances.

Achievements/Issues of Note

Report on actions being taken to improve flow through the emergency department and wider system: with a focus on reducing the ED stay of patients >75years

Action item	Progress status	Comments
Actions being taken within the Emergency Department to speed up flow		
Seeking support to open the Children's Emergency Care area and Emergency Observation area. Children's Emergency Care area was prioritised	➲	The additional 10FTE nursing and health assistant resource approved earlier in the year has been recruited to. However subsequent resignations mean that recruitment for a further 10 FTE nurses and healthcare assistants is underway. Discussions on further recruitment to the Children's Emergency Care area are progressing, especially in light of the high acute volumes seen prior to lockdown related to RSV.
Refinements of all models of care as the department settles into the facility, including the "Front of House model"	➲	Attempted minor changes to the way staff are rostered have been frustrated by the vacancies noted above. The Department continually fine tunes its models of care to maximise efficiency.
Working with other services to improve timely registrar review of patients likely to be admitted	➲	The ED team is working alongside inpatient teams via the Christchurch Campus Flow Group to establish internal and inter-specialty time standards. These will link to Escalation Plans and include agreeing an appropriate timeframe for patients to be worked up in the ED, reviewed by the admitting specialty and transferred out of the ED. Once agreed, these 'measures for improvement' will be monitored to identify opportunities to improve patient flow.
Working with community partners to reduce the presentation rate to the Emergency Department.	➲	A Community Flow workstream has been established with key members from the CDHB Older Person's Health team alongside the Canterbury Initiative and Canterbury Clinical Network.
Promoting the idea of a communications campaign to	✓	A communications campaign was launched prior to lockdown overseen by the Urgent Care SLA, reiterating alternatives to

educate the public on the appropriate use of acute health care options and which facility is best suited to their needs		the ED. Screens displaying average wait times and alternatives to ED listing the key urgent care centres across the city have been put up in ED's Front of House.
Partnering with Cardiology, Orthopaedics, Midwives and others to improve clinical models, reducing presentations to and increase flow through the department.	➲	Guidance for community referrals for acute assessments has been developed and sent to the Rangiora Health Hub and LMCs to encourage appropriate use of the Gynaecology Assessment Unit, the Maternity Assessment Unit and the Emergency Department.
Actions being taken within the broader hospital being taken to speed up flow of patients out of the Department		
An improvement programme has been established focussing on acute flow of patients pre, post and during hospital stays to address high occupancy and demand seen across the Canterbury system Key focus areas are ED flow, flow within surgical and medical teams, flow between facilities, and flow pre and post hospital stays A clinician led group has been established with a data diagnostic to be developed to understand bottlenecks and changes in flow. This along with further staff engagement will provide a consolidated programme of work / improvements Deliverables will be defined in separate lines once a plan is formed.	➲	All workstreams under this programme have started, with the first 'Making Our System Flow' Governance meeting last month. These workstreams are: Community Flow, ED Flow, Medical Flow, Surgical Flow and Flow Between Facilities. Pre-lockdown, the Flow Between Facilities workstream demonstrated some early positive trends, showing a reduction in variation in the number of patients transferred between Christchurch and Burwood. A focused review of long stay patients, facilitated by the service manager at Burwood, was noted as a key enabler for this improvement.

Key – status indicators

Result	Meaning		
✓	We have completed the target.	✘	We will not complete the action in this area.
➲	Positive progress is underway towards delivering the output.	⬚	Progress has been stalled

Older Persons Health & Rehabilitation (OPH&R) - Making our System Flow

OPH&R continues to focus on identifying and addressing barriers to flow and engage in the Making Our System Flow project lead by our clinical executive. Work to date as previously reported has included development of a SFN dashboard; and implementation of an audit tool to support understanding why our patients remain in our hospital on any given day, to support clinical teams to address any opportunity to minimise delay for the patient, and for our leadership to identify of trends, barriers and opportunities for improvement across our hospital.

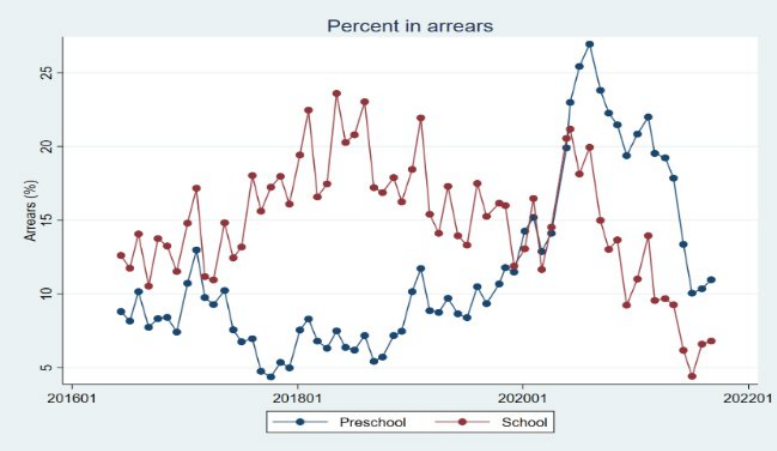
To further support system flow and improving the patient journey OPH&R has established a Long Length of Stay Panel which met for the first time in August. The Panel will provide a collaborative leadership, operational and clinical forum for discussion, problem solving and where required, escalation pathways. The panel meets weekly, with all patients identified as having a long length of stay for that service presented to the panel by the Charge Nurse Manager. Discussion focuses on barriers to discharge and plans in place to assist with the patient journey towards discharge, including identification of what support may be needed to achieve this goal. The panel is convened by the Service Manager – Patient Flow, and membership includes clinical and operational leadership from across OPH&R, as well as representation from Planning and Funding to support discussions where complex packages of care may be required on discharge. We expect this process should also provide a learning opportunity for clinical and leadership team to support them to mitigate avoidable barriers to discharge and foresee complexities before they arise.

Community Dental Service - Children overdue for dental examinations

At the last HAC meeting the Committee requested information on historical trends in the number of children overdue for dental examinations – children overdue for dental examinations are referred to as being in "arrears" by the Community Dental Service.

Reports are run monthly which show the numbers overdue, broken down by age group (preschool and school aged) and by the number of months overdue. Data from monthly reports provided by Decision Support are appended to a table that contains records from June 2016 – note: these reports include data for both Canterbury and South Canterbury DHBs. Unlike the reports on children overdue for examinations, provided quarterly to the Ministry of Health, these monthly reports are not broken down by ethnicity.

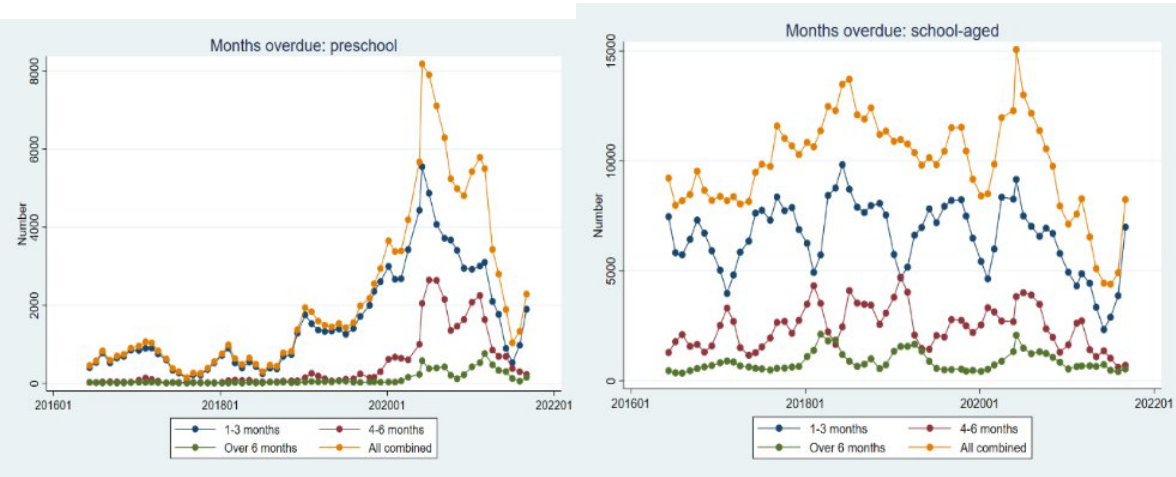
There is considerable month-to-month movement in the number of children overdue, as shown below. This is primarily caused by the impact of school holidays when dental examinations in mobile dental units at schools cease and services for preschoolers are scaled back due to most staff being on leave during school holidays. Long-term trends are driven by factors such as staffing levels and resource allocation.



Prior to early 2018, arrears for school-aged children had been steadily climbing with low numbers of preschool children overdue. To bring the percentages closer together plans were implemented to improve the utilisation of the mobile dental units, reduce the time allocated for examinations for preschoolers and

increase the period between dental examinations for children at low risk of tooth decay from 12 to 18 months. This had been achieved by the end of 2019 when 11% of preschoolers and 12% of school children were overdue. Unfortunately, the Covid-19 lockdowns in early 2020 led to a rapid increase in arrears for both groups. By the end of July 2020 arrears for preschool children had increased to 27% -- well past those for school children -- largely because booking patients for dental treatment that had been postponed due to the lockdown had been prioritised over examinations. In the latter part of 2020 careful balancing of resources and, in particular, a switch from annual to biannual mobile dental unit visits to most schools, led to a sustained fall in the number overdue in both age groups.

The total number overdue is less important than how long children are overdue for dental examinations. Short delays are not a clinical risk however long delays may lead to late diagnosis and poorer outcomes – such as the need for extraction or root canal treatment instead of simple fillings. The number overdue for each age group by 1-3 months, 4-6 months and more than 6 months overdue are shown below. The majority of children are less than 4 months overdue – the number more than six months overdue are closely monitored, and resources are continuously reallocated to minimise that number.



Periodic increases in the number more than six months overdue have been due to a number of factors, these include:

- The long summer school holiday which sees no school-based examinations for approximately six weeks;
- Building works at schools preventing access for mobile dental units for prolonged periods. Several strategies have been used to mitigate the impact of this including the use of a portable generator and asking parents to book appointments for their children at community dental clinics (few follow through on this);
- Covid-19 lockdowns.

Ashburton Health Services

Table 1

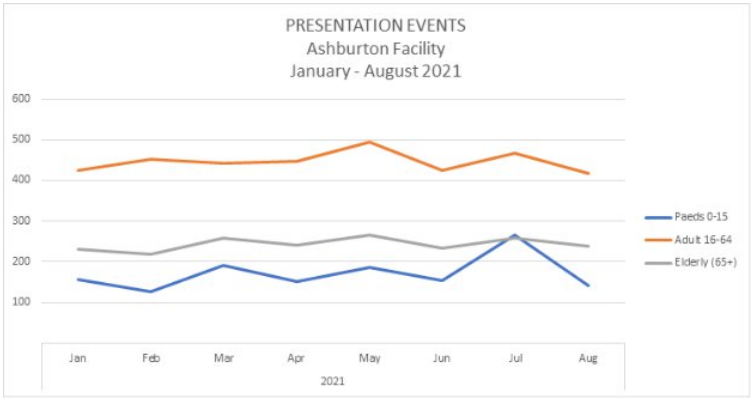
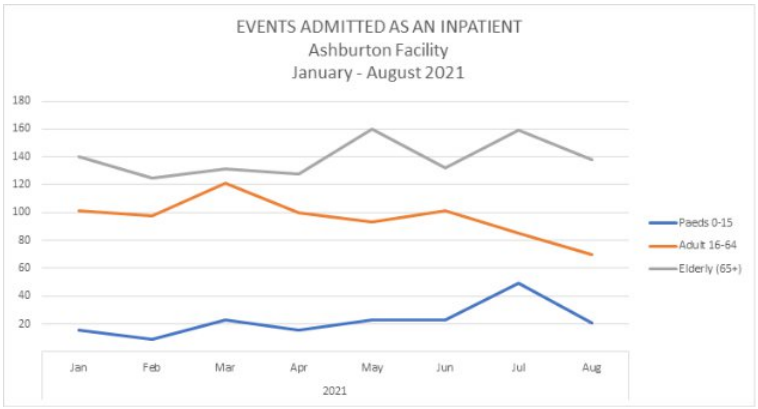


Table 2

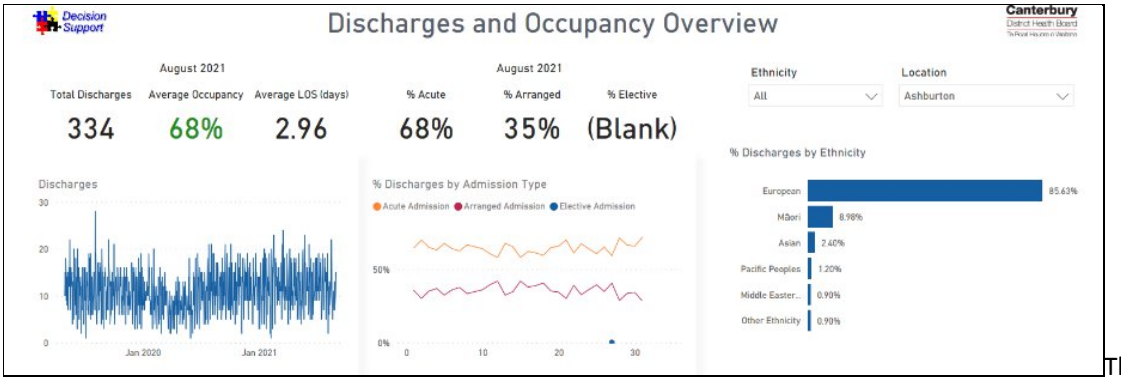


Whilst the overarching presentations to the AAU dropped during lock down, a quick comparative to the previous Level 4 noted we did not drop in presentation rate as significantly as previously.

The admission data above includes the practice of admitting to our short stay unit (SSU) and so does not provide a fully accurate picture of the true inpatient (Ward 1 & 2) admissions, eg the paediatric admissions identified in this data set are all admissions to SSU. Now that we are no longer reporting AAU as ED data to the Ministry of Health, we can refocus the SSU practice to provide a more accurate picture.

In response to the CDHB Alert Level, the facility moves into a model of triage outside of the building and implements a CURB assessment framework that enables redirection to the CBAC for those who are symptomatic and require swabbing but are not acutely unwell. This model is required due to the layout of the facility and inability to have a clear red and green stream within the Acute space and that there isn't a separate triage area in the open plan layout. There is a full change in the staff flow throughout the building and comprehensive set of actions that identify the facility is in RED if a person presents aligning to the criteria – all staff in AAU move to n95 masks.

In our discussion through the alert response and in reviewing further improvements to our screening practice, we remain vigilant to the inequity a screening system introduces to our more vulnerable community members. Messages to our community that indicate people are required to stay in their car until screened, that they will need to text or call a number on presentation and general fear on the questions asked at presentation can contribute to vulnerable community members holding off presenting for acute care. We will continue to work with our community partners and review our service design to ensure we are mitigating this risk and create safe and accessible access to acute care.

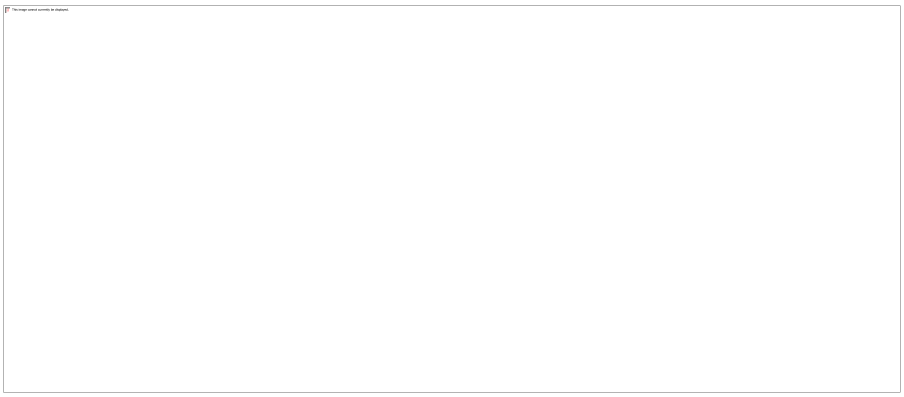


The above graph confirms the context of our acute service delivery but also notes the admissions of patients transferring from Christchurch. Patients identified as *arranged* admissions include non-weight baring and rehabilitation patients transferred from Christchurch.

Transfers

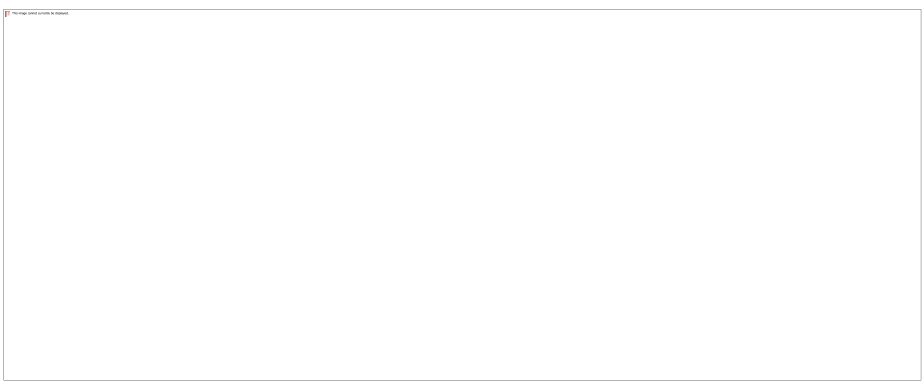
Effective and efficient patient transfer is a core component of rural health service delivery models. Graph 1 below demonstrates these continued throughout the Covid response without any additional challenges.

Graph 1



Prior to the COVID response, we were conscious of the increasing pressures that transfers were placing on our nursing workforce with the historical model of all transfers requiring registered nursing or HCA assist. With the support of the CD, DON and St John Clinical leads we established the practice of best use of the double crew ambulance, only providing additional nursing at the request of the SMO on duty. Table 3 demonstrates that acute transfers may continue to require RN support, but proportionately the double crew (identified as blank in the table) are increasingly used.

Table 3



Frail Elderly and Localities

We have progressed local discussion with the operational leadership team in Ashburton on design modelling and options that would reflect and respond to the framework for Localities as outlined by the Transition Unit presentations.

The core themes in discussions to date include there is agreed support on the value and opportunity to collate services and redesign in partnership as a community, with prompts from primary care if this could provide the opportunity to re-address the role out of urban centric programmes and enable effective models and services led by the Locality itself but reporting to standard agreed frameworks.

By consolidating as a team of services currently operating as DHB employees and local primary care, along with the NGOs and District Council, we can move away from duplicated roles and dislocated funding of roles that result in roles based in Christchurch or further, nominally providing service for the Ashburton community.

Transition Unit Alignment: Every locality will have a consistent range of core services, but how these services are delivered will be based on the needs and priorities of the local communities. People will be empowered to engage in planning and commissioning of community-based care to ensure that the services in each locality reflect the needs of the community.

Enhancing the core primary care team and linking to other services. The key cohorts that could benefit most from locality provider networks

- Whanau with complex health and social care needs: joining up social service providers (NGO/kaupapa Maori/Pasifika) with general practice
- First 2000 days, joining up primary birthing, maternity, wellchild/tamariki ora, child development and general practice
- Last years of life, joining up NASC, home care, District Nursing, palliative care, ARC and general practice
- People with distress/mental illness, joining up primary, NGO and specialist mental health services and general practice
- People with complex long term conditions, joining up care across providers with general practice teams and Hospital & Specialist Services

During Alert Level 4, the second phase of evaluation of the local Caring for Communities, council sponsored community response group was completed. Sarah Wylie, the social researcher reported a strong interest from the feedback in the group continuing but evolving to a new phase to support the move towards Health NZ, utilizing Collective Impact workshops and processes to explore community voice and inform design options.

Outcome and Strategy Indicators

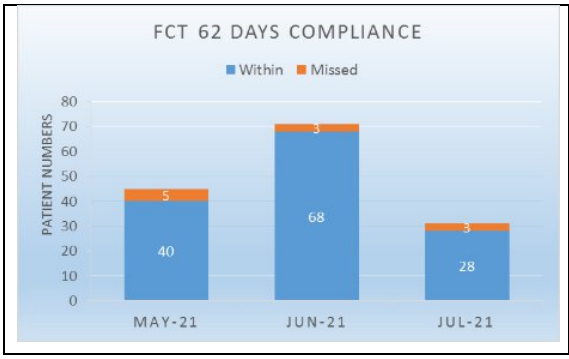
Key Outcomes - Faster Cancer Treatment Targets (FCT)

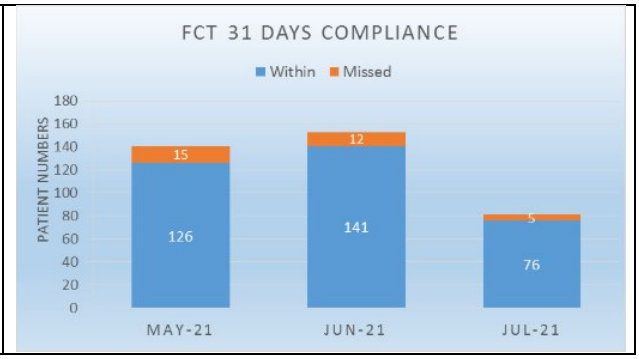
62 Day Target. In the three months to the end of July 2021 there were 184 records submitted by Canterbury District Health Board – slightly down on the 193 submitted for the three months to the end of June. Canterbury District Health Board missed the 62 days target for 48 patients, of those 37 were through patient choice or clinical reasons and are therefore excluded from consideration. Target was not met for 11 of the 147 remaining patients due to capacity issues thus Canterbury District Health Board's compliance rate was 92.5%, once again meeting the 90% target.

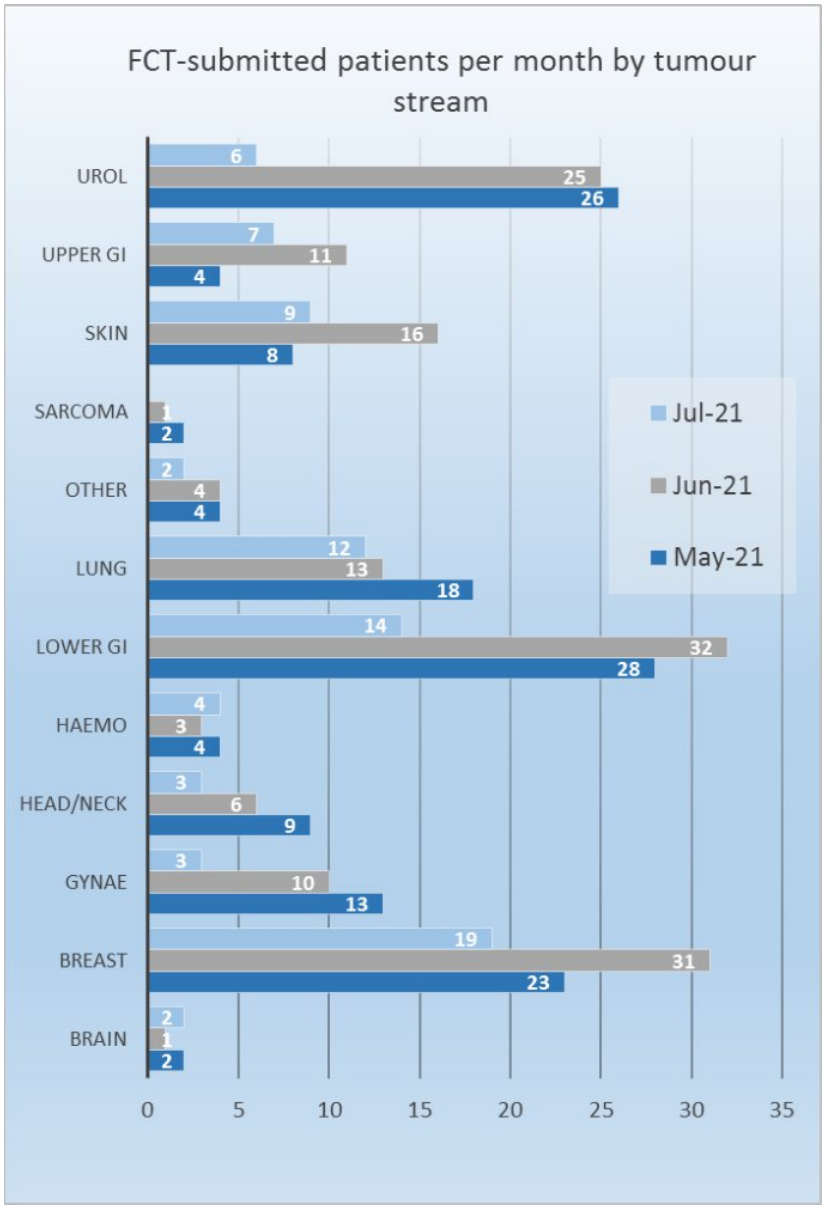
31 Day Performance Measure. Of 375 records submitted towards the 31-day measure Canterbury District Health Board met the target of providing first treatment within 31 days of a decision to treat for 343 (91.5%) eligible patients. Canterbury District Health Board continues to meet the 85% target. Of the 32 patients not provided with treatment within 31 days, 12 were missed by five days or less, 5 were due to clinical reasons and 1 through patient choice.

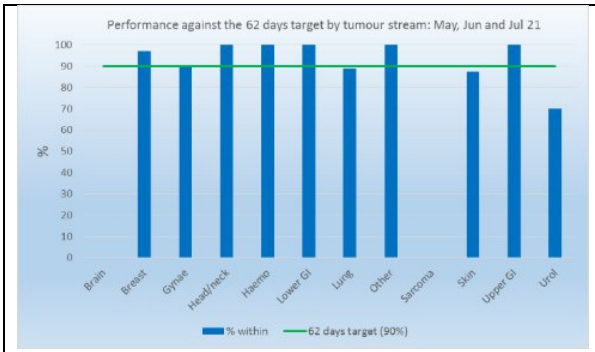
FCT performance in CDHB

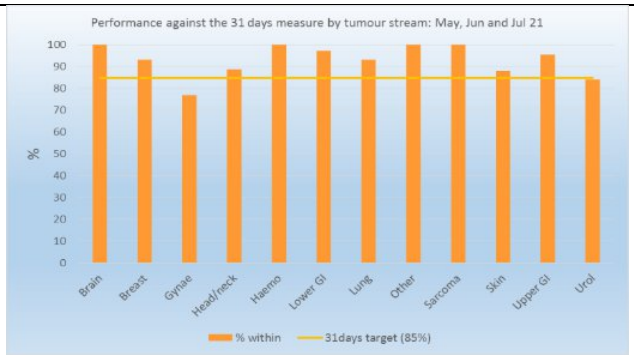
The dip in numbers in the last month of every report (May in this case) reflects the timing of report compilation which is governed by the reporting requirements of the Ministry. A significant number of the patients who have a first treatment date in the period this report covers will be awaiting coding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

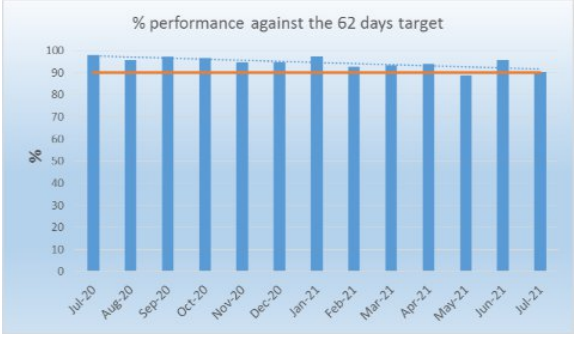


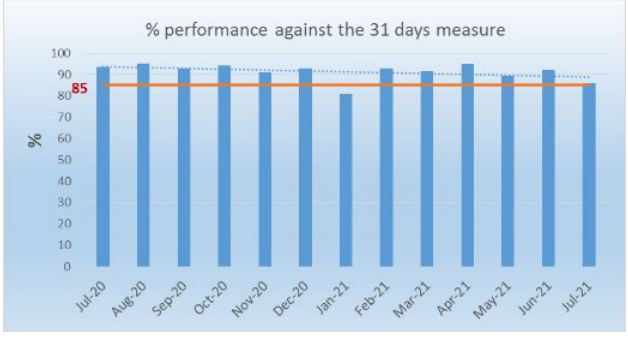



FCT-submitted patients per month by tumour stream
UROL
UPPER GI
SKIN
SARCOMA
OTHER
LUNG
LOWER GI
HAEMO
HEAD/NECK
GYNAE
BREAST
BRAIN
6
25
26
7
11
4
9
16
8
1
2
2
4
4
12
13
18
14
32
28
4
3
4
3
6
9
3
10
13
19
31
23
2
1
2
Jul-21
Jun-21
May-21
0
5
10
15
20
25
30
35


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


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





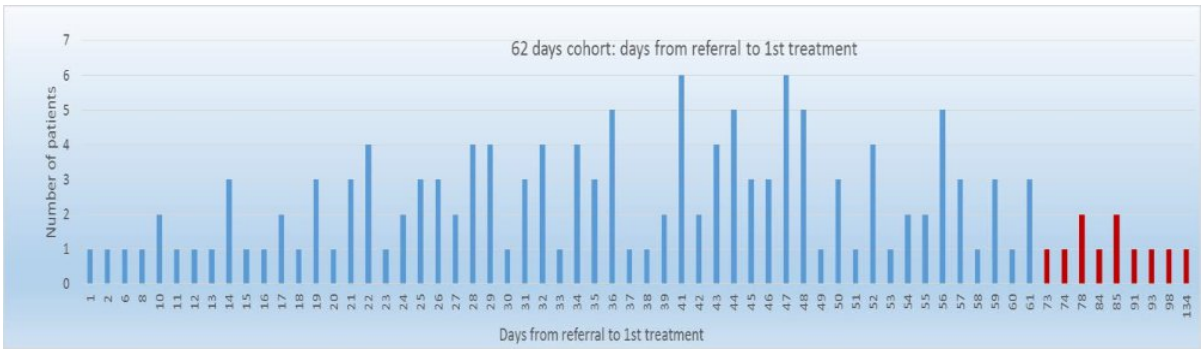
Patients whose treatment does not meet target.

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

The codes are:

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

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



Achievements/Issues of Note

Medical Oncology Service Development Project Update

During August:

- The service is again experiencing a mismatch in demand and capacity due to a surge in new patient referrals, unexpected leave, unfilled Senior Medical Officer vacancies (2.8 FTE) and delays implementing the proposed new model of care.
- New patient wait time to First Specialist Assessment is currently six weeks – which is an increase from four weeks in July. It will likely further increase if changes to the model of care do not occur this year.

During July and August, the project's focus has been on:

- Bringing Mosaiq data into the shared data warehouse to improve reporting functions and data accountability.
- Data improvements will enable provision of a dashboard report, including key performance indicators which will allow Medical Oncology to benchmark against typical performance.
- Evaluation of the new outpatient clinic structure, which includes refining and automating the current schedule will be completed in August.
- Attempts to recruit into the vacant Senior Medical Officer roles during 2021 have been unsuccessful and plans to address this capacity shortfall have been proposed through the planned new model of care, utilising nursing, Allied Health and administration capacity.
- Capacity planning remains an active component of service forecasting and this has allowed the service to communicate the impending capacity challenge.
- Additional nurse-led clinics for specific tumour streams are being undertaken to assist with the current capacity shortfall for Medical Oncology, however, these are not resourced with certainty to address the capacity deficits.

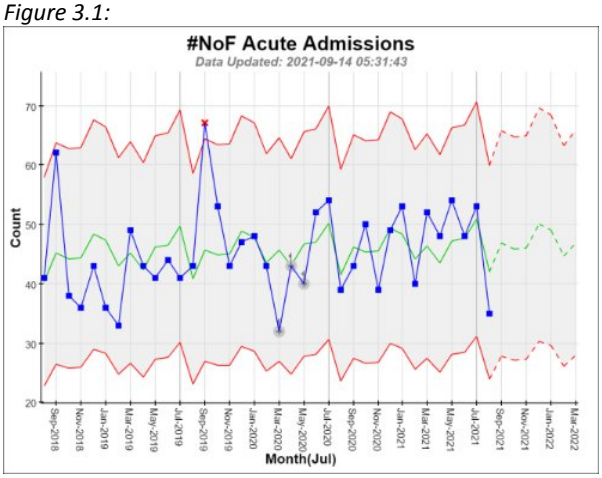
Project updates:

- Progress is underway towards the elimination of patient paper letters with a move to electronic communications.
- In conjunction with People and Capability, actions have been defined to assist with the development of the multi-disciplinary Medical Oncology team.
- Capacity planning meetings are being held weekly and continue to refine and develop forecasting, clinic utilisation and planning tools.

Enhanced Recovery After Surgery (ERAS)

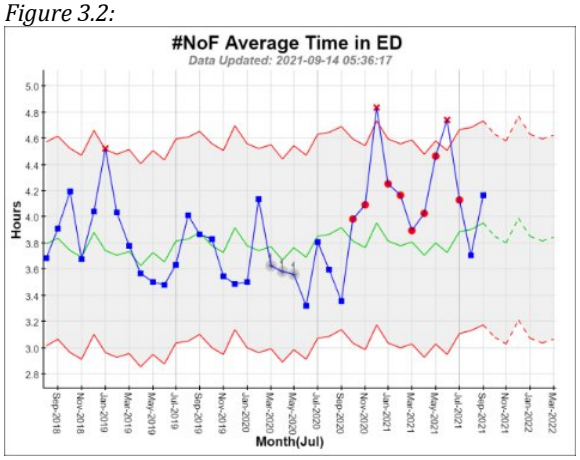
Outcome and Strategy Indicators – Fractured Neck of Femur (#NoF)

Figure 3.1:



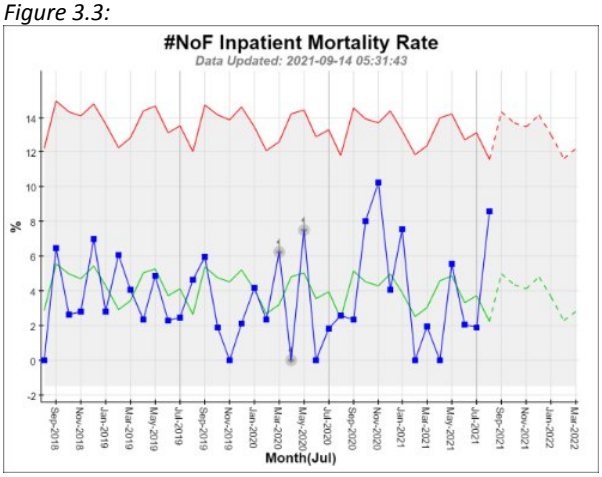
The number of admissions generally follows the projection. The time taken to code discharges impacts the latest data point.

Figure 3.2:



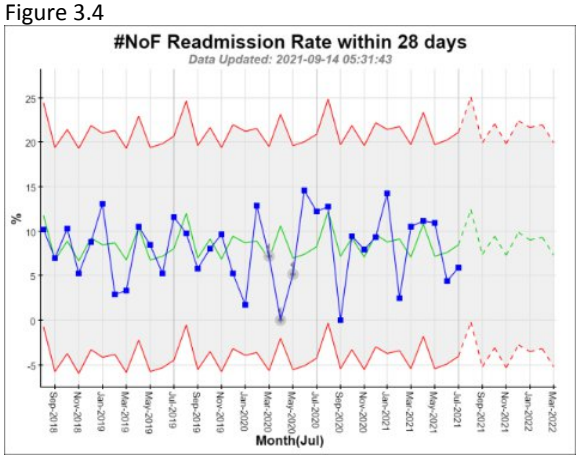
The number of people presenting at the Emergency Department and the number of people admitted for acute orthopaedic care reduced during the COVID-19 lockdown period commencing on 18 August and has been associated with a reduction in the time spent in ED.

Figure 3.3:

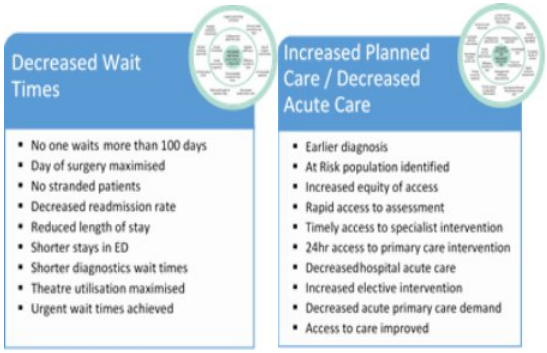


The #NoF inpatient mortality rate while variable follows the projected values.

Figure 3.4



Readmissions continue to remain within the expected range.



Elective Surgery Performance Indicators 100 Days

Elective Services Performance Indicators

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

	Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Apr		May		Jun		Jul	
	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %
1. DHB services that appropriately acknowledge and process patient referrals within the required timeframe.	27 of 27	100.0 %	27 of 27	100.0 %	27 of 27	100.0 %	27 of 27	100.0 %	27 of 27	100.0 %	27 of 27	100.0 %	27 of 27	100.0 %	27 of 27	100.0 %	27 of 27	100.0 %	27 of 27	100.0 %	27 of 27	100.0 %	27 of 27	100.0 %
2. Patients waiting longer than four months for their first specialist assessment (FSA).	1200	13.3%	908	9.3%	995	9.6%	1076	9.8%	1313	11.6%	1877	15.7%	1864	15.5%	1815	15.2%	1952	15.9%	1694	14.1%	1499	13.1%	1578	13.6%
3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT).	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
5. Patients given a commitment to treatment but not treated within four months.	885	18.8%	659	14.7%	700	15.3%	734	15.7%	937	19.2%	1216	23.2%	1227	23.1%	1116	20.1%	1135	19.8%	1027	18.4%	1060	18.7%	1359	22.6%
8. The proportion of patients treated who were prioritised using nationally recognised processes or tools.	0	100.0 %	8	99.5%	1	99.9%	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %	1	99.9%	1	99.9%

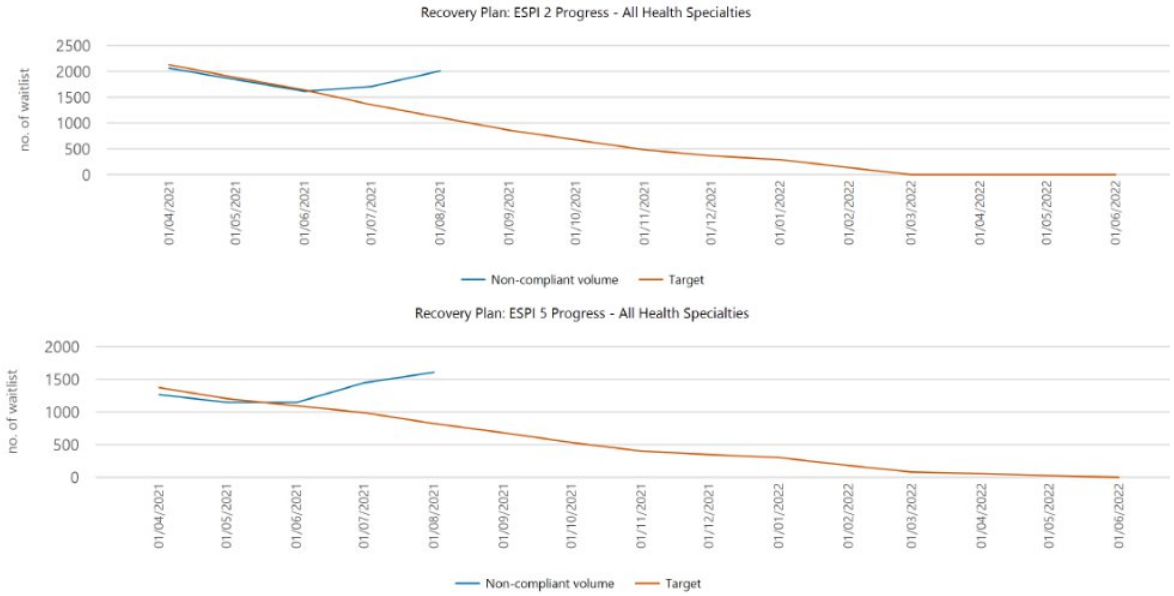
Summary of ESPI 2 Performance - From Moh Final Summary July 2021 (published on 6 Sept)

	May-21		Jun-21		Jul-21	
ESPI 2 (FSA)	Improvement required	Status %	Improvement required	Status%	Improvement required	Status%
Cardiothoracic Surgery	1	4.8%	0	0.0%	0	0.0%
Ear, Nose and Throat	137	12.1%	156	13.6%	166	14.3%
General Surgery	70	8.0%	24	3.3%	17	2.0%
Gynaecology	75	11.8%	95	14.0%	120	19.0%
Neurosurgery	0	0.0%	0	0.0%	1	0.6%
Ophthalmology	304	21.2%	268	20.7%	305	23.0%
Orthopaedics	28	3.0%	26	2.8%	27	3.0%
Paediatric Surgery	1	1.0%	1	1.0%	5	4.3%
Plastics	139	36.8%	79	25.4%	81	23.4%
Thoracic	0	0.0%	0	0.0%	0	0.0%
Urology	13	1.9%	5	80.0%	31	4.4%
Vascular	27	16.6%	10	12.3%	7	8.0%
Cardiology	60	10.8%	59	10.8%	49	9.5%
Dermatology	0	0.0%	0	0.0%	0	0.0%
Diabetes	4	3.7%	1	0.9%	1	0.9%
Endocrinology	12	4.9%	0	0.0%	2	1.0%
Endoscopy	512	26.1%	595	30.1%	481	28.1%
Gastroenterology	17	5.8%	6	2.0%	25	8.0%

	May-21		Jun-21		Jul-21	
ESPI 2 (FSA)	Improvement required	Status %	Improvement required	Status%	Improvement required	Status%
General Medicine	8	4.9%	11	6.1%	12	7.2%
Haematology	1	1.5%	1	1.5%	1	1.4%
Infectious Diseases	0	0.0%	0	0.0%	3	100.0%
Neurology	98	20.4%	26	6.3%	103	23.1%
Oncology	9	2.7%	8	1.8%	5	0.9%
Paediatric Medicine	140	27.2%	112	22.5%	111	22.9%
Pain	16	48.5%	1	33.3%	0	0.0%
Renal Medicine	0	0.0%	2	4.8%	5	9.6%
Respiratory	13	3.5%	12	3.3%	18	7.1%
Rheumatology	9	2.9%	1	0.4%	2	0.7%
Total	**1694**	**14.1%**	**1499**	**13.1%**	**1578**	**13.6%**
ESPI 5 (Treatment)						
Cardiothoracic Surgery	6	11.8%	5	9.3%	9	15.8%
Dental	90	20.5%	130	29.0%	174	35.4%
Ear, Nose and Throat	244	36.0%	204	32.0%	255	38.5%
General Surgery	271	31.0%	272	30.9%	312	33.6%
Gynaecology	26	9.9%	35	13.8%	34	9.7%
Neurosurgery	0	0.0%	0	0.0%	0	0.0%
Ophthalmology	43	7.0%	66	10.8%	136	20.2%
Orthopaedics	61	9.6%	50	7.4%	65	9.2%
Paediatric Surgery	13	11.9%	18	17.1%	23	19.2%
Plastics	109	9.9%	114	10.1%	186	15.9%
Urology	24	6.9%	48	11.8%	48	13.5%
Vascular	19	17.0%	4	3.4%	14	9.4%
Cardiology	121	37.1%	114	34.8%	103	32.2%
Total	**1027**	**18.4%**	**1060**	**18.7%**	**1359**	**22.6%**
Note - ESPI 5 figures and ESPI2 figures are taken from the MoH ESPI Finals report for July 2021, published 6 Sept 2021.						

Internal reporting provides a more up to date view:

- The CDHB Improvement Action Plan 20/21 is in place and focusses on CDHB achieving ESPI/Planned Care compliance. As at 10 September the overall target is not being met with 2,265 people waiting longer than 120 days for their **first specialist assessment**. This an increase of 824 since the last HAC report which showed 1,441 long waits as at 9th July. At the end of August two specialty areas have no patients waiting for First Specialist Assessment for longer than 120 days, five are meeting their target and 22 are not meeting their recovery plan targets.
- When considering patients **waiting times for admission and treatment** as at 10th Sept CDHB is not meeting the plan's targets with 1,631 people have waiting longer than 120 days. This has increased by 400 since the last update to the HAC which reported there were 1,231 people waiting longer than 120 days on 9th July. One specialty area has no long-waiting patients and twelve are not meeting their recovery plan target.



(note that the graph's date markers are incorrect – and should state the last day of the named month.)

- As expected, school holidays were associated with an increase in the number of patients waiting longer than 120 days. The usual post school holiday reduction was interrupted by COVID-19 lockdown. While many appointments continued to be provided virtually, this method is only applicable in some services and is less likely to be suitable for first specialist assessment than it is for follow up appointments.

COVID cancellations and catch-up

- In line with the national Hospital COVID-19 Escalation Framework, the Canterbury District Health Board continued to provide appointments face to face where these were essential and could not be provided virtually (i.e. by telephone or computer).
- Many outpatient appointments were provided virtually – data has not yet stabilised and so is not detailed here.
- Acute, non-deferrable and urgent elective surgery continued during the level 3 and 4 lockdown period. Detail is provided below in the section covering theatre capacity and utilisation
- The need to postpone booked surgery has been driven by a requirement for people to isolate as per COVID-19 alert levels, rather than by hospital capacity.

Between 18 August and 7 September there were:

- 359 planned surgical inpatient admissions deferred.
- 23 planned medical inpatient admissions deferred
- 4,615 planned outpatient appointments deferred:
  - 858 were for Allied Health Services;
  - 195 for Older Persons Health or other rehabilitation;
  - 1,870 for medical or oncology services (including endoscopy)
  - 92 for Nursing services
  - 6 for maternity associated appointments
  - 1,594 surgical appointments.

In relation to endoscopy:

- During the 21 days of level 3 and 4 lockdown 308 outpatient endoscopy appointments were provided, including provision of 191 colonoscopies (including colonoscopy plus gastroscopy) and 117 gastroscopies were provided by Canterbury District Health Board
- 107 outpatient appointments for colonoscopy and 57 for gastroscopy to be provided by Canterbury District Health Board clinicians were delayed.

- Provision of outsourced colonoscopy by contracted providers was also deferred, reducing capacity by approximately 150 procedures.

As at Friday 10 September

- Of the 382 admissions cancelled 85 (22%) have been completed or otherwise had the referral or waitlist entry closed and a further 154 have bookings made already, with most of these during September 2021.
- Of the 4,615 planned outpatient appointments that were deferred, 923 (20%) have already received their appointment or otherwise had the referral or waitlist entry closed. A further 2,311 have rebooked dates.
- Monitoring of these cancelled cases is occurring at a service level, and centrally to ensure that provision of this care is planned and tracked.

Achievements/Issues of Note

Continuous Positive Airway Pressure therapy review waitlist project

- The Sleep Health Services provides trials of continuous positive airway pressure trials for patients diagnosed with sleep disordered breathing within the Canterbury, South Canterbury and West Coast districts.
- Demand for trials has been consistent averaging 16-18 per week over more than the past 4 years. Capacity of the Nurse Specialist follow up appointments has been between 8-11 per week, resulting in an ongoing net gain in the waiting list.
- To resolve this the combined resources of the Sleep Health Services and the Canterbury Clinical Network will be used to review adherence data from the machines and provide a tiered response depending on adherence resulting in discharge, face to face or telehealth review. This will provide for discharge or review of up to 850 service patients. As at 2 September the review is approximately 50% completed and is achieving as expected.

Review of a streamlined process for Transarterial Chemoembolisation of Hepatocellular Carcinoma

- The transarterial chemoembolisation protocol in Christchurch Hospital has been streamlined. Review shows it has led to an improvement in service delivery.
- It was shown that introduction of the streamlined protocol has led to a mean reduction in delay to treatment by 20 days – from 50 to 30 days. The number of outpatient specialist appointments was also reduced by 1.2 per patient from 2.0 to 0.8.
- Complete treatment response was significantly higher in the group provided with treatment according to the new protocol (0 vs 36%), likely associated with the change in chemotherapy agent in 2020.

Employment of Allied Health Assistants – Social Work

- Social Work is recruiting Allied Health Assistants to support Social Workers in handling appointments, coordinating health and welfare programs and managing the administrative aspects of patient care.
- For the same cost the capacity of the service to provide the required care can be increased through the introduction of Allied Health Assistants into Social work.
- Two Allied Health Assistants are currently being recruited utilising existing vacant Social Work FTE. These roles will be integrated into an existing Social Work team.

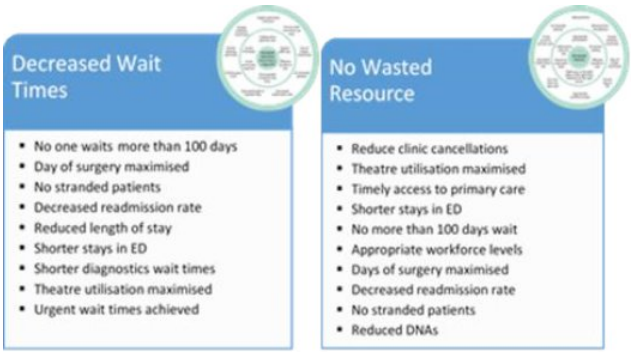
Health Literacy for Māori Communities

- Hauora Māori is looking at ways to improve Health Literacy for Māori communities. The purpose of the project is to constructively provide Māori communities with information relating to current affairs using a technology-based approach.
- By establishing a platform that is easily accessible by whānau, Māori will be encouraged to have a voice and confidently break existing barriers that have historically prevented Māori from receiving quality care.

- Establishing a Kaupapa Māori project that specifically targets whānau who rely on technology as a source of information will enable meaningfully engagement with various collectives within the Māori community.
- The concept has been shared with medical staff who have indicated that they support alternative ways of connecting with Māori. It is acknowledged that whānau can become misinformed due to false information and have expressed that they are happy to explore strategies that prevent this from occurring.

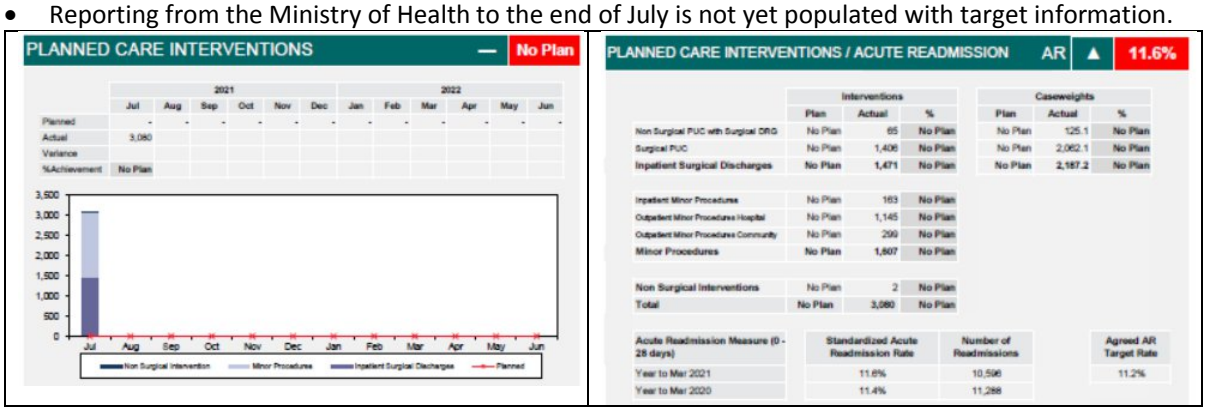
MyMedicines Patient Information Leaflets – Clinical Pharmacology

- The MyMedicines team working within the Clinical Pharmacology service produces patient information leaflets about medicines for both local audiences and those throughout New Zealand. It able to do this through combined funding from Canterbury District Health Board, New Zealand Formulary and MIMS (Monthly Index of Medical Specialities).
- MyMedicine leaflets on commonly used medicines have been translated into Te Reo Māori with the support of the Health Quality Safety Commission. This has included the recently added spoken translation of the information sheets for those who prefer to hear Te Reo rather than read it. This improvement is being highlighted during the Te Wiki o Te Reo Maori by the Health Quality Safety Commission.



Theatre Capacity and Theatre Utilisation

- Planned care targets agreed with the Ministry of Health include planned inpatient operations as well as procedures provided to hospital inpatients, outpatients and patients in community settings. The target for 2021/22 is unchanged from 2020/21 and is to deliver a total of 31,345 planned care interventions: made up of 19,614 surgical discharges, 11,409 minor procedures and 322 non-surgical interventions.
- Reporting from the Ministry of Health to the end of July is not yet populated with target information.



- **Internal reporting** to the end of week 11 (10 Sept) shows 6,459 planned care events have been provided, this is 144 behind the phased target of 6,603.
- Within this 3,220planned **inpatient discharges** were provided – 957(22.9%) below the target of 4,177.
- There are several events that have contributed to this deficit:
    - 100 cases were deferred because the response to respiratory syncytial virus constrained bed and nursing capacity, particularly for children.
    - 56 cases were deferred during the week ending 6 July due to bed constraints at Christchurch Hospital.
    - During the three weeks of COVID-19 lockdown (to 3/9/2021) 541 planned care discharges were provided against a target of 1,217, a deficit of 676
    - These together account for a deficit of 832 cases – 87% of the total deficit, some of which may be explained by wind-down in preparation for strike action.
- Work is underway to finalise outsourcing and outplacing contracts for the July – December period and strong signals will be provided to services as this is completed.
- Updated forecasts will be developed for internal delivery from February when new Anaesthetist capacity arrives. This information is being incorporated analysis of the gap between internal capacity and the target to develop solutions including the purchase of longer term outsourcing and outplacing arrangements.
- Anaesthetic Technician capacity continues to constrain theatre capacity to below the scheduled level. This has been one factor considered in planning towards achieving internal production capacity for 2021/22.
- Best case projections for resolution of Anaesthetic Technicians's availability do not have us fully staffed until the last quarter of 2021/22.

- 3,237 **minor procedures** have been provided 896 ahead of the target of 2,341. Inpatient, outpatient and community provision are all ahead of target.

Achievements/Issues of Note

Current theatre volumes

- **Overall**, when all operating by or on behalf of Canterbury DHB is considered (in house, outplaced and outsourced), fewer operations were provided in both July and August 2021 than in prior years. There were 2,559 operations provided in July 2021 compared with 2,779 in 2020 (an 8% reduction) and 2,269 in COVID-19 affected August 2021, 16% less than August 2020.
- There were 2,433 planned operations (following **arranged and acute** admissions) during July and August 2021 6% more than during those months in 2020.
- More **elective surgery** was provided at **Christchurch Hospital** during both July and August than in the two prior years. 933 elective theatre events were provided in July 2021 and 768 in August 2021 compared with 839 in July 2020 and 743 in August 2020.

COVID period

- Acute, non-deferrable and urgent elective surgery continued during the level 3 and 4 lockdown period.
- The need to postpone booked surgery has been driven by a requirement for people to isolate as per COVID-19 alert levels, rather than by hospital capacity.
- Decisions about which cases met the criteria to proceed during the lockdown period were made according to an agreed prioritisation schedule based on acuity and the likelihood of deterioration or loss of function associated with delay to surgery. The process has been closely overseen the Chief of Surgery and has been consistent with local, regional and national guidelines.

Based on this approach, during the period between 18 August and 7 September:

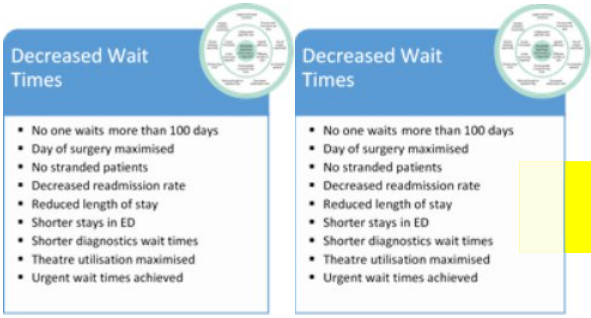
- 713 planned operations were provided at Christchurch Hospital, this is only 40 less than for the analogous 21 days in 2020
- 101 operations were provided at Burwood Hospital, this is approximately half of the normal volume.
- Operating for Canterbury DHB at the city's private hospitals was significantly curtailed with 29 discharges during this period.
- Altered community behaviour during the lockdown reduced demand for acute operating.

Provision of planned care has returned to expected levels with more planned surgical discharges than plan in the week ending 10 September.

Creating a timely electronic surgical prioritisation process to enable agile decision making and accurate planning:

- A refined process has been implemented for all planned care theatre cases to ensure agile, safe, consistent and collaborative surgical services' response to changes in COVID-19 alert levels.
- Agreement was reached to determine what clinical priority was given to all planned procedures. Alongside this, other key factors need to be considered including; underlying disease process, number of surgeons or physicians required, whether the patient is currently an inpatient, what post procedure requirements are and if there is any specific equipment or implants required for the planned care case.
- All of this information is now entered into the theatre operating list on scOPe. Making all this information available electronically has revolutionised the planned care prioritisation process for all services.
- An agreed matrix for prioritising planned care procedures and conditions was developed during the COVID -19 lockdown in early 2020. Until recently implementing the prioritisation defined in the matrix required a paper heavy, time consuming manual process that risked inconsistent outcomes. It was necessary to upgrade the process by making sure that the required information about each case is easily and reliably available.

- All services are now required to capture all of the relevant patient details in scOPe so that clinical prioritisation information is available for each case. Service Managers and Clinical Directors are responsible for leading services to accurately enter these data so that all services are accountable for advocating and making visible their planned care patient activity.
- This accountability has ensured that, even in an environment of constraint or risk, surgical services can be confident of continuing to provide planned care to patients that require time critical treatment and to those patients that are at risk of inequitable access to health care.
- With all planned theatre activity being captured electronically decision makers now have complete visibility of planned care patient activity and the total available resourced surgical capacity of the CDHB. This means that decisions are made regarding which planned care patient procedures are given access to services during COVID-19 alert levels with confidence.
- Development continues to ensure that this electronic process is maintained by all services at all times, to optimise the ability to manage the use of theatre capacity in an agile way at all times.



Mental Health Services

Specialist Mental Health Services

Reports to the Hospital Advisory Committee over the previous 12 months have provided in-depth information about each of the mental health service clusters. This report addresses key areas of demand growth and pressures that Specialist Mental Health Services are facing and mitigating.

The growth in mental health need has been well document after a series of local and more recently global events which have impacted on our population's health. Mental health has been particularly impacted by these events:

2010-2011	Earthquake sequence including over 15,000 after shocks
2013	Two significant floods
2016	Kaikoura earthquake
2017	Port Hills fires
2019	Mosque attacks
2020	Covid – lockdown
2021	Covid - lockdown

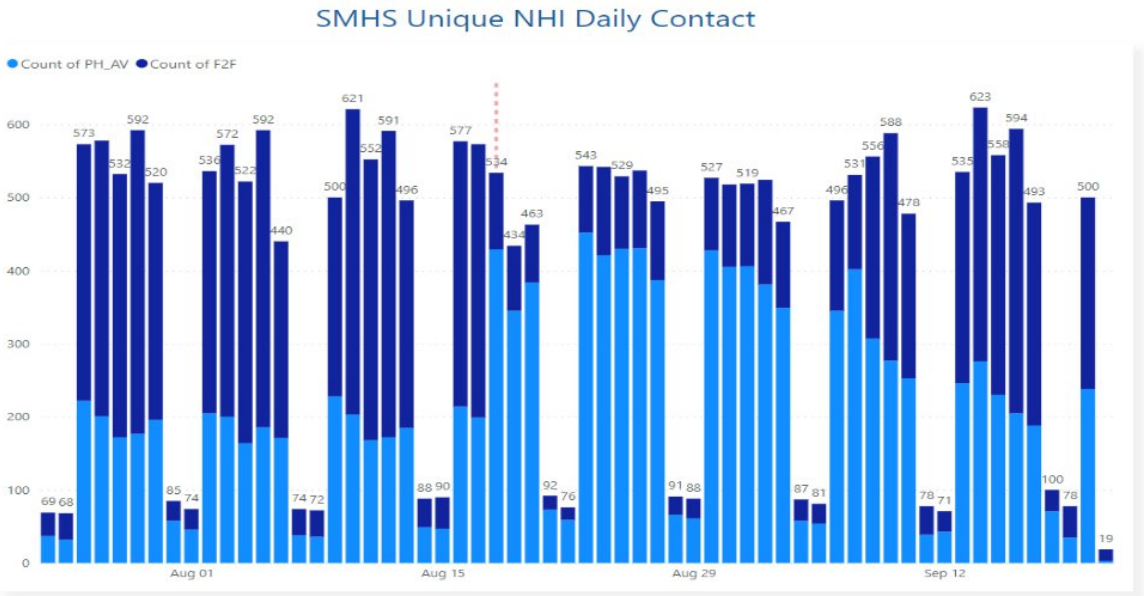
The latest COVID-19 outbreak appears to have had a greater impact on the mental health of our population. We have not seen the decline in demand that was evident during the 2020 lockdown. On the weekend of 11/12 September we had 15 admissions, an unprecedented nine of whom were having their first admission. However, this report highlights the growing demand in community-based services as these services are not artificially constrained by capped bed capacity.

Demand for mental health services has risen in Canterbury over a period of time. This has been managed through increasing integration (more so than in other DHBs) and innovation supported by new resourcing to address most local disasters. In a constrained system our ability to invest in further innovation is limited.

Demand – Community Services Affected by COVID-19

Specialist Mental Health Services continues to see an increase in demand for services, particularly in the Child, Adolescent and Family (CAF) Service, the Eating Disorders Service, and the Community Alcohol and Drug (CADS) Service. While demand decreased during the 2020 COVID-19 lockdown period, demand has increased in some specialties and remained constant in others during the recent 2021 lockdown. The trends of significant increases in demand for CAF, Eating Disorders and CADS have been reported across New Zealand and around the world.

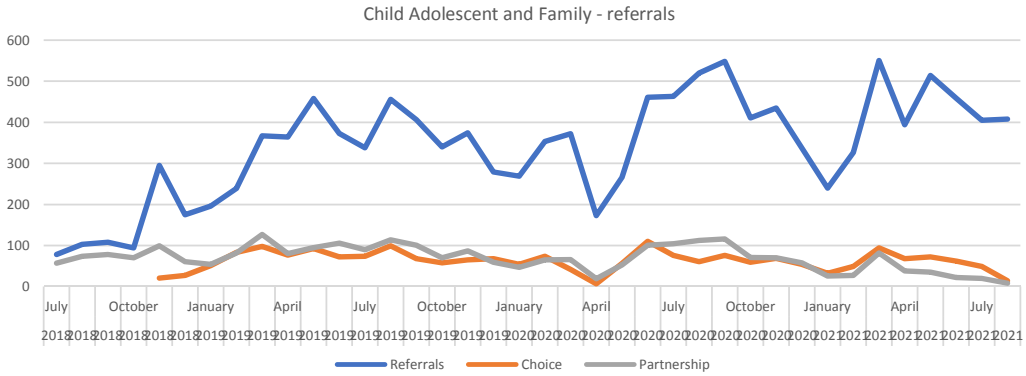
Many face-to-face appointments were replaced with telehealth contacts to reduce the risk of COVID transmission.



Displays the number of individual consumers with one or more contacts for the day by Face to Face and Phone / AV. Enables tracking change in access rates

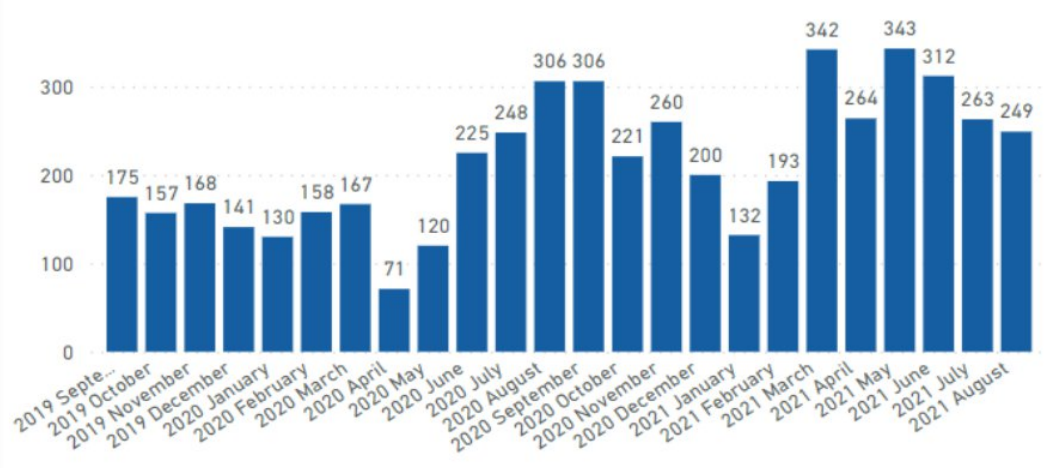
Child, Adolescent & Family Service

Referrals to the Child, Adolescent and Family Service have increased by 82% over the last two years.

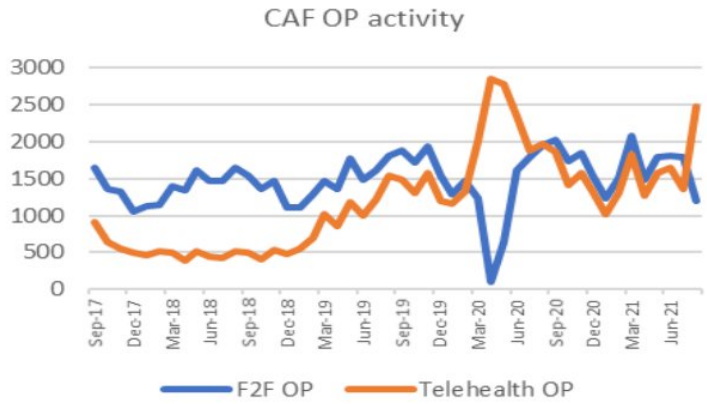


The majority of the increase in referrals has been for young people under the age of 14 years.

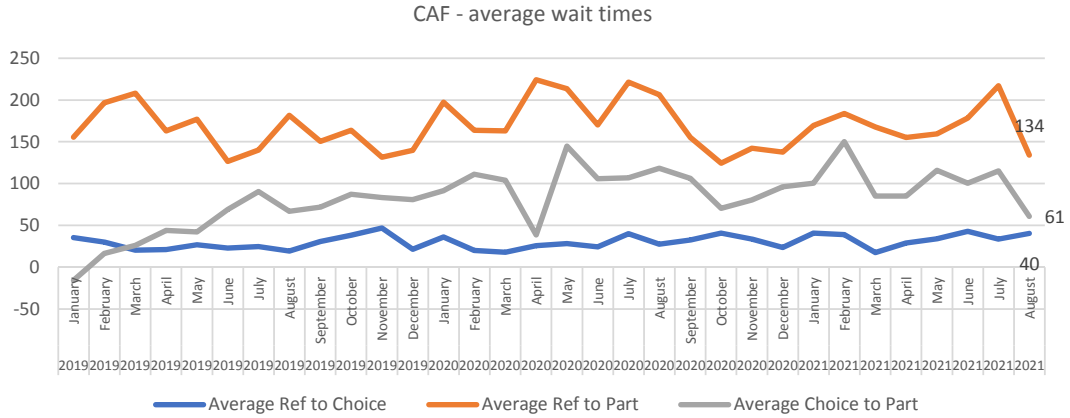
Referrals for Children & Young People aged 14 years and under



Within the CAF service there has been a 22% increase in face-to-face contacts and a 128% increase in telehealth contacts over the past two years. The team has introduced a number of strategies to address the increases in demand.

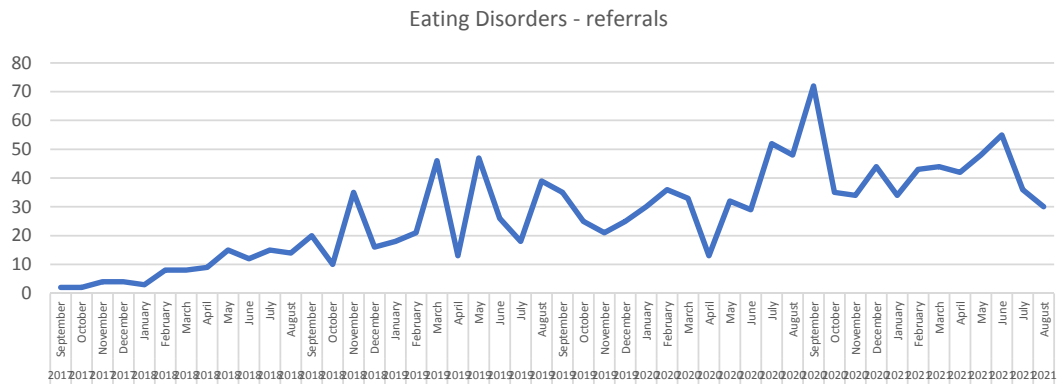


Aside from periods of COVID-19 lockdowns, waiting times for initial triage appointments (Choice) and full assessments (Partnerships) remain longer than desirable. Despite rapid and robust triaging processed to make sure those at highest risk are seen as quickly as possible, residual risk remains associated with those triaged as lower acuity during their waiting period.

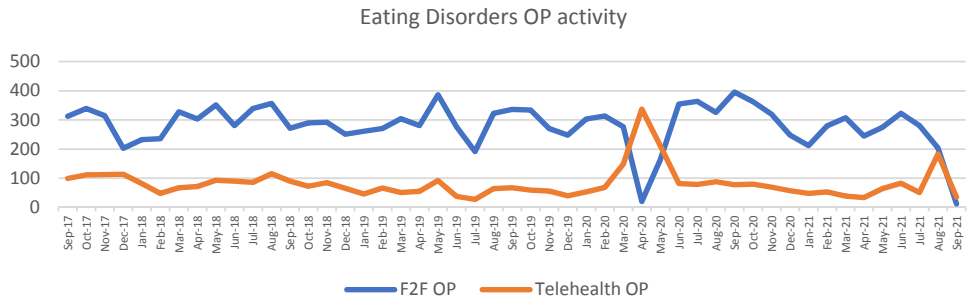


Eating Disorders Service

Referrals to the Eating Disorders Service have increased by 96% over the last two years.



The long-term trend shows significant increases in referrals to Eating Disorders but the COVID-19 lockdowns have further accelerated referrals in a well reported global phenomenon. The capacity of the Eating Disorders Team has not been able to keep pace with the increased demand. The ratios of outpatient events to referrals decreased by 49% over the past two years with people either waiting longer for appointments or increasing numbers of referrals for people with moderate presentations being declined.

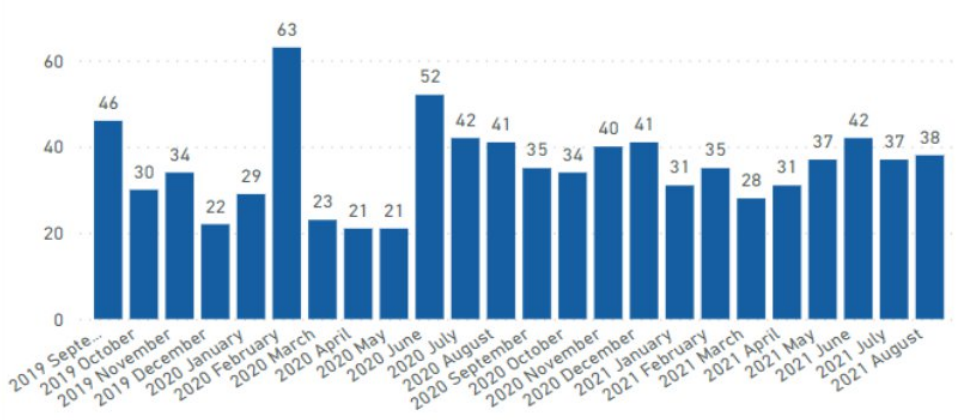


In addition to increased risk managing this cohort there have been a number of complaints regarding the lack of access to Eating Disorders treatment and this has been a consistent theme in the media nationally.

Community Alcohol and Drug Service

Following the 2020 COVID 19 lockdown there has been an increase in the number of people referred to the Community Alcohol and Drug Service. Our clinicians have reported that unlike the 2020 lockdown period, in the 2021 lockdown they are seeing high numbers of people with illicit drug affected presentations.

Referrals to the Community Alcohol and Drug Service



Staffing

Specialist Mental Health Services is carrying a large number of nursing vacancies, particularly in Crisis Resolution and the inpatient wards. The table below shows a shortage of 31 nurses compared to what was budgeted in August.

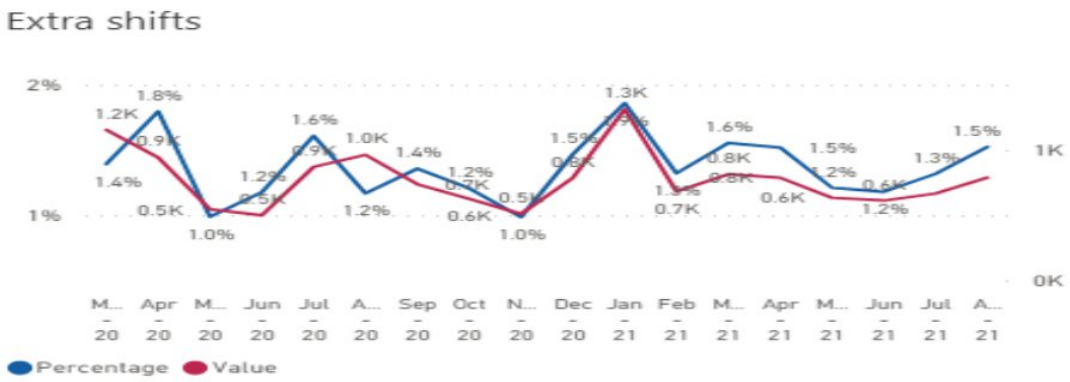
	YTD FTE	YTD Budget	Variance
Allied Health	227.9	230.4	2.5
Medical	101.8	102.3	0.5
Management and Admin	97.1	95.2	(1.9)
Nursing	599.7	630.8	31.1
Support	3.3	3.0	(0.3)
Grand Total	1,029.8	1,061.7	31.9

While some staffing gaps can be filled with casual pool or agency staff, in many instances existing staff are committing to our consumers by working additional shifts to ensure basic care needs are met.

Overtime hours for August were as follows:

- Forensic Inpatient Units (5.7 FTE)
- Adult Community Teams which include Crisis Resolution (4.9 FTE)
- Intellectually Disabled Person's Health (IDPH) Inpatient Units (5.9 FTE)
- Adult Acute Inpatient Units (Te Awakura) (7.6 FTE)

The graph below shows the value and percentage of extra shifts undertaken at Hillmorton and Princess Margaret Hospitals.



Longer working hours put our staff under pressure and can often flow on to increased sick leave. There were 19,788 sick leave hours paid in August. This exceeds the same period last year by 1,911 hours.

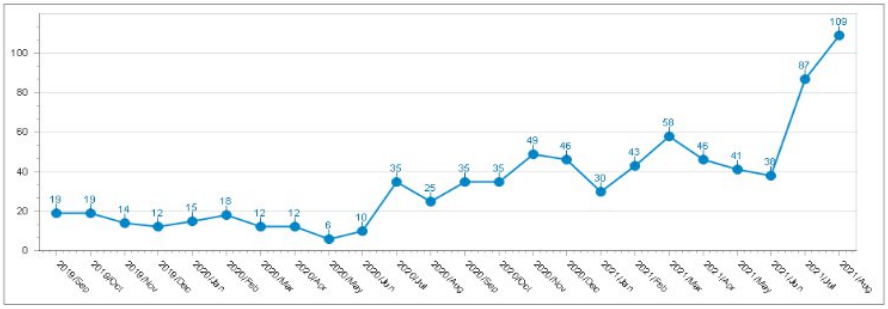
The gaps in staffing mean that currently we need to find nurses to fill up to 40 shifts per day. There are frequently too few staff (pool, overtime and agency) available to fill all gaps.

Provision of Care

Safety 1st is Canterbury DHB's incident management system. Provision of Care forms are completed in Safety 1st by staff when a person's plan of care has not been followed as planned. The number of provision of care forms completed by staff has increased markedly. Eighty six percent of provision of care forms completed by staff in the past three months related to insufficient staffing. A sample of the descriptions below:

> *Three staff available when 8 staff required to complete rostered FTE. Patient cares neglected as staff prioritised tasks due to low staff numbers.*
>
> *Nursed in seclusion due to no other alternative areas/environments/ staff able to provide care and support.*
>
> *Unable to complete essential cares due to staffing shortage. Unable to facilitate community activities or quality of life initiatives due to this.*

Number of Safety 1st Provision of Care forms completed



Living within our means

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

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

Canterbury District Health Board

Statement of Financial Performance

Hospital & Specialist Service Statement of Comprehensive Revenue and Expense For the 2 Months Ended 31 August 2021

MONTH $'000				YEAR TO DATE $'000		
21/22 Actual $'000	21/22 Budget $'000	21/22 Variance $'000		21/22 Actual $'000	21/22 Budget $'000	21/22 Variance $'000
			Operating Revenue			
122	293	(171)	From Funder Arm	349	589	(240)
1,656	1,607	49	MOH Revenue	3,426	3,215	211
4,988	4,831	157	Patient Related Revenue	10,162	9,669	493
4,168	1,948	2,220	Other Revenue	6,382	3,830	2,552
10,934	8,679	2,255	**TOTAL OPERATING REVENUE**	20,319	17,303	3,016
			Operating Expenditure			
			Personnel Costs			
72,609	70,593	(2,016)	Personnel Costs - CDHB Staff	141,135	140,877	(258)
2,133	1,806	(327)	Personnel Costs - Bureau & Contractors	3,989	3,611	(378)
74,742	72,399	(2,343)	**Total Personnel Costs**	145,124	144,488	(636)
14,558	14,325	(233)	Treatment Related Costs	29,019	28,645	(374)
5,397	4,911	(486)	Non Treatment Related Costs	9,958	9,849	(109)
94,697	91,635	(3,062)	**TOTAL OPERATING EXPENDITURE**	184,101	182,982	(1,119)
(83,763)	**(82,956)**	**(807)**	**OPERATING RESULTS BEFORE INTEREST AND DEPRECIATION**	**(163,782)**	**(165,679)**	**1,897**
			Indirect Income			
-	1	(1)	Donations & Trust Funds	-	2	(2)
-	**1**	**(1)**	**TOTAL INDIRECT INCOME**	-	**2**	**(2)**
			Indirect Expenses			
6,346	6,474	128	Depreciation	12,920	12,924	4
-	-	-	Net (Gain) Loss on Disposal of Fixed assets	-	-	-
6,346	**6,474**	**128**	**TOTAL INDIRECT EXPENSES**	**12,920**	**12,924**	**4**
(90,109)	**(89,429)**	**(680)**	**TOTAL SURPLUS / (DEFICIT)**	**(176,702)**	**(178,601)**	**1,899**

Achievements/Issues of Note

Allied Health Nutrition and Dietetics

- Free Fluid diet review and reduction of oral nutritional supplements from three to one daily; has resulted in cost savings of approximately $10K per year.

Child Health

- Paediatric Surgery partnered with Medical Engineering to manufacture specific surgical instruments that required replacing in house rather than purchasing. This resulted in a significant cost reduction (from $27,000 to less than $5,000) with access to more sets than previously, thereby enabling use in outreach centres.
- Paediatric Oncology's participation in international clinical trials and departmental quality initiatives has led to changes in treatment protocols including reducing the frequency and length of use certain chemotherapeutic agents, altering monitoring investigations and how certain drug side effects are managed all resulting in cost savings and no compromise to care.

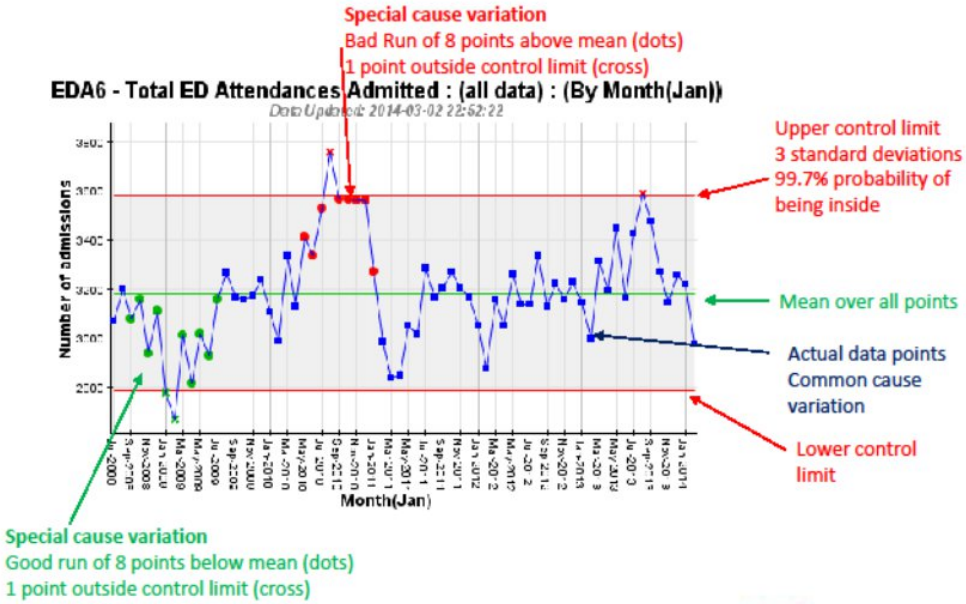
Department of Nursing - Oncology Nursing

- Work between Baxter Health Care, pharmacy and other campus parties towards introducing the pre-spiking of all chemotherapy bags continues. This will reduce gown utilisation, saving approximately $30k per year in adult services. Rollout is planned for October 2021.

RDST

- **RMO Meals.** RDST is working with WellFood and People and Capability to implement some of the suggestions from Resident Medical Officers to reduce costs and food/packaging waste.

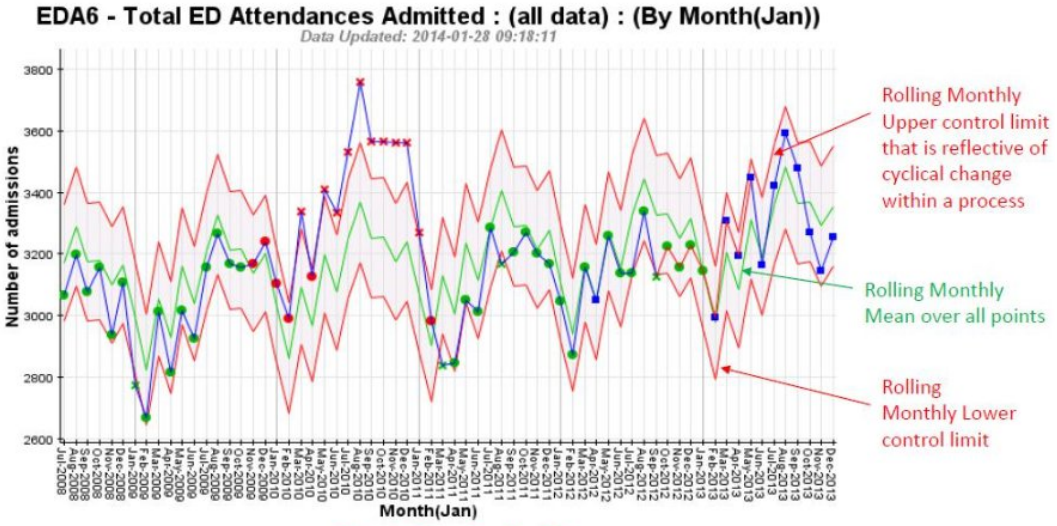
SPC: How to Interpret a Control Chart



sfn signals from noise

make it better

SPC: How to Interpret Cyclical and Trended Data



Criteria for a Cyclical Process:

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

sfn signals from noise

make it better

CLINICAL ADVISOR UPDATE – 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 & Members, Hospital Advisory Committee**

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

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

DATE: **7 October 2021**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Committee:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of the minutes of the public excluded meeting of 5 August 2021	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(if required)*	Protect information which is subject to an obligation of confidence. 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"

	S/S	Mon	Tues	Wed	Thu	Fri	S/S	Mon	Tues	Wed
January 2022		31					1/2	NEW YEAR'S DAY - DAY OFF 3	DAY AFTER NEW YEAR'S DAY - DAY OFF 4	5
February			QFARC 9AM 1	2	HAC 9AM 3	4	5/6	WAITANGI DAY - DAY OFF 7	8	9
March			QFARC 9AM 1	2	CPH&DSAC 1PM 3	4	5/6	7	8	9
April						1	2/3	4	QFARC 9AM 5	6
May		30	QFARC 9AM 31				1	2	QFARC 9AM 3	4
June				1	HAC 9AM 2	3	4/5	QUEEN'S BIRTHDAY 6	7	8

Thu	Fri	S/S	Mon	Tues	Wed
6	7	8/9	10	11	12
10	11	12/13	14	15	16
10	11	12/13	14	15	16
HAC 9AM 7	8	9/10	11	12	13
CPH&DSAC 1PM 5	6	7/8	9	10	11
9	10	11/12	13	14	15

Thu	Fri	S/S	Mon	Tues	Wed	Thu	Fri	S/S	Mon	Tues
13	14	15/16	17	18	19	20	21	22/23	24	25
CDHB BOARD 9.30AM 17	18	19/20	21	22	23	24	25	26/27	28	
CDHB BOARD 9.30AM 17	18	19/20	21	22	23	24	25	26/27	28	29
14	GOOD FRIDAY 15	16/17	EASTER MONDAY 18	19	20	CDHB BOARD 9.30AM 21	22	23/24	ANZAC DAY 25	26
12	13	14/15	16	17	18	CDHB BOARD 9.30AM 19	20	21/22	23	24
CDHB BOARD 9.30AM 16	17	18/19	20	21	22	23	MATARIKI 24	25/26	27	28

Wed	Thu	Fri	S/S	
26	27	28	29/30	January 2022
				February
30	31			March
27	28	29	30	April
25	26	27	28/29	May
29	30			June

WORKPLAN FOR HAC 2021 *(WORKING DOCUMENT)*

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