# AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora o Waitaha

## HOSPITAL ADVISORY COMMITTEE MEETING

**To be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch**
**Thursday, 4 October 2018 commencing at 9:00am**

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| | Apologies | | 9.00am |
| 1. | Conflict of Interest Register | | |
| 2. | Confirmation of Minutes – 2 August 2018 | | |
| 3. | Carried Forward / Action List Items | | |
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| 4. | Ophthalmology Department – Presentation | Dr Rebecca Stack<br>Alison Watkins | 9.05am |
| 5. | Ashburton Health Services – Presentation | Bernice Marra | 9.30am |
| 6. | Clinical Advisor Updates<br>6.1 Nursing<br>6.2 Allied Health | <br>Mary Gordon<br>Helen Little | <br>9.55am<br>10.05am |
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| **MORNING TEA** | | | **10.15am** |
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| 7. | Hospital Service Monitoring Report<br>7.1 Appendix 1: Hospital Service Monitoring Report | | 10.30am |
| 8. | Resolution to Exclude the Public | | 11.30am |
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| **ESTIMATED FINISH TIME – PUBLIC MEETING** | | | **11.30am** |
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| | Information Items<br>• 2018 Workplan | | |

**NEXT MEETING: Thursday, 29 November 2018 at 9.00am**

# ATTENDANCE LIST - PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

## HOSPITAL ADVISORY COMMITTEE MEMBERS

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

## Executive Support

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

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

# 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)*

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| **Andrew Dickerson**<br>**Chair – HAC**<br>Board Member | **Accuro (Health Service Welfare Society)** - Director<br>Is a not-for-profit, member owned co-operative society providing health insurance services to employees in the health sector and (more recently) members of the public. Accuro has many members who are employees of the CDHB.<br><br>**Canterbury Health Care of the Elderly Education Trust** - Chair<br>Promotes and supports teaching and research in the care of older people. Recipients of financial assistance for research, education or training could include employees of the CDHB.<br><br>**Canterbury Medical Research Foundation** - Member<br>Provides financial assistance for medical research in Canterbury. Recipients of financial assistance for research, education or training could include employees of the CDHB.<br><br>**Heritage NZ -** Member<br>Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance and Heritage NZ has already been involved with CDHB buildings.<br><br>**Maia Health Foundation -** Trustee<br>Is a charitable trust established to support health care in the CDHB area. Current projects include fundraising for a rooftop helipad and enhancements to the children's wards at Christchurch Hospital.<br><br>**NZ Association of Gerontology** - Member<br>Professional association that promotes the interests of older people and an understanding of ageing. |
| **Jo Kane**<br>**Deputy Chair – HAC**<br>Board Member | **HurriKane Consulting** – Project Management Partner/Consultant<br>A private consultancy in management, communication and project management. Any conflicts of interest that arise will be disclosed/advised.<br><br>**Latimer Community Housing Trust** – Project Manager<br>Delivers social housing in Christchurch for the vulnerable and elderly in the community.<br><br>**NZ Royal Humane Society** – Director<br>Provides an awards system for acts of bravery in New Zealand. It is not anticipated any conflicts of interest will arise. |
| **Barry Bragg**<br>Board Member | **Canterbury West Coast Air Rescue Trust** – Trustee<br>The Trust has a services agreement with Garden City Helicopters for the provision of air rescue and air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB. |

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| | **CRL Energy Limited** – Managing Director<br>CRL Energy Limited provides air quality testing and asbestos sampling and analysis services; methamphetamine contamination testing; dust; gas and noise workplace monitoring services in New Zealand. There is the potential for future work with the CDHB.<br><br>**Farrell Construction Limited** - Chairman<br>Farrell's Construction Limited is a commercial and light commercial construction company based in Christchurch.<br><br>**New Zealand Flying Doctor Service Trust** – Chairman<br>The Trust has a services agreement with Garden City Helicopters for the provision of air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB.<br><br>**Ngai Tahu Property Limited** – Chairman<br>Potential for future property development work with the CDHB. Also, Ngai Tahu Property Limited manage first right of refusal applications from the CDHB on behalf of Te Runanga o Ngai Tahu. |
| **Sally Buck**<br>Board Member | **Christchurch City Council (*CCC*)** – Community Board Member<br>Chair of the Central/Linwood/Heathcote Community Board which has delegated responsibilities from the CCC.<br><br>**Registered Resource Management Act Commissioner**<br>From time to time, sit on Resource Management Act panels for the CCC. Specific interests will be declared at the time.<br><br>**Rose Historic Chapel Trust** – Member<br>Charitable voluntary body managing the operation of the Rose Historic Chapel, a CCC owned facility. |
| **Dr Anna Crighton**<br>Board Member | **Christchurch Heritage Limited** - Chair - Governance of Christchurch Heritage<br>**Christchurch Heritage Trust** – Chair - Governance of Christchurch Heritage<br>**Heritage New Zealand –** Honorary Life Member<br><br>CDHB owns buildings that may be considered to have historical significance. |
| **Jan Edwards** | **Integrated Family Health Service Programme, Canterbury Clinical Network** – Project Manager<br>The programme supports primary care teams to develop integrated models of care that better support at risk individuals in their own communities. The programme is hosted by Pegasus Health (Charitable) Ltd and funded by CDHB. Should a conflict arise, this will be discussed at the time. |
| **David Morrell**<br>Board Member | **British Honorary Consul**<br>Interest relates to supporting British nationals and relatives who may be hospitalised arising from injury related accidents, or use other services of CDHB, including Mental Health Services. A conflict of interest may also arise from time to time in respect to Coroners' inquest hearings involving British nationals. In addition, the British Foreign and Commonwealth Office (*FCO*) may expect Honorary Consuls to become involved in trade initiatives from time to time.<br><br>**Canon Emeritus - Christchurch Cathedral**<br>The Cathedral congregation runs a food programme in association with CDHB staff. |

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| | **Friends of the Chapel** - Member<br><br>**Great Christchurch Buildings Trust** – Trustee<br>The Trust seeks the restoration of key Christchurch heritage buildings, particularly Christchurch Cathedral, and is also involved in facilitating the building of social housing.<br><br>**Heritage NZ –** Subscribing Member<br>Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance.<br><br>**Hospital Lady Visitors Association** - Wife is a member of this, but no potential conflict of interest is expected. Should one arise it will be declared at the time.<br><br>**Nurses Memorial Chapel Trust** – Member<br>(CDHB Appointee) Trust responsible for Memorial Chapel on the Christchurch Hospital site. Note the chapel is now owned by the Christchurch City Council. |
| **Dr Rochelle Phipps** | **Accident Compensation Corporation** – Medical Advisor<br>ACC is a Crown entity responsible for administering NZ's universal no-fault accidental injury scheme. As a Medical Advisor, I analyse and interpret medical information and make recommendations to improve rehabilitation outcomes for ACC customers.<br><br>**OraTaiao: New Zealand Climate & Health Council** – Founding Executive Board Member (no longer on executive)<br>The Council is a not-for-profit, politically non-partisan incorporated society and comprises health professionals in Aotearoa/New Zealand concerned with:<br>• the negative impacts of climate change on health;<br>• the health gains possible through strong, health-centred climate action;<br>• highlighting the impacts of climate change on those who already experience disadvantage or ill health (equity impacts); and<br>• reducing the health sector's contribution to climate change.<br><br>**Royal New Zealand College of General Practitioners** – Christchurch Fellow and Former Board Member<br>The RNZCGP is the professional body and postgraduate educational institute for general practitioners. |
| **Trevor Read** | **Lightfoot Solutions Ltd** – Global Director of Clinical Services<br>Lightfoot Solutions has contracts with CDHB, and other health providers who have contracts with CDHB, to provide business intelligence tools and related consulting services. Should a conflict arise, this will be discussed at the time. |
| **Ana Rolleston** | **Christchurch PHO** – Board Member<br>The Christchurch PHO is mostly funded by either the Ministry of Health and/or the CDHB. The Christchurch PHO supports General Practitioners delivering primary health care in Christchurch.<br><br>**Manawhenua ki Waitaha** – Trustee<br>Representative of Wairewa Rūnanga. Manawhenua ki Waitaha is a collective of health representatives of the seven Ngāi Tahu Papatipu Rūnanga that are in the CDHB area. There is a Memorandum of Understanding between Manawhenua ki Waitaha and CDHB. |

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| | **Māori Women's Welfare League** – Member<br>The Māori Women's Welfare League has contracts through the Ministry of Health for the delivery of health services for Māori.<br><br>**Te Kàhui o Papaki Kà Tai** – Member<br>A Canterbury-wide combined group of primary care organisations, clinicians, community organisations, Manawhenua, Maori community provider and District Health Board. The group is supported by Pegasus Health. |
| **Ta Mark Solomon**<br>**Ex Officio – HAC**<br>Deputy Chair CDHB | **Claims Resolution Consultation – Senior Maori Leaders Group** – Member<br>This is an Advisory Board to MSD looking at the claims process of those held under State care.<br><br>**Deep South NSC (National Science Challenge) Governance Board** – Member<br>The objective of Deep South NSC is set by Cabinet, and is to understand the role of the Antarctic and Southern Ocean in determining our climate and our future environment. Building on this objective, the mission was developed to guide our vision, research priorities and activities.<br><br>**Greater Christchurch Partnership Group** – Member<br>This is a central partnership set up to coordinate our city's approach to key issues. It provides a strong, joined up way of working and ensures agencies are travelling in the same direction (so they do not duplicate or negate each other's work).<br><br>**He Toki ki te Rika / ki te Mahi** – Patron<br>He Toki ki te Rika is the next evolution of Māori Trade Training re-established after the earthquakes to ensure Maori people can play a distinguished role in the Canterbury rebuild. The scheme aims to grow the next generation of Māori leadership in trades by building Māori capability in the building and infrastructure industries in Canterbury.<br><br>**Liquid Media Operations Limited** – Shareholder<br>Liquid Media is a start-up company which has a water/sewage treatment technology.<br><br>**Maori Carbon Foundation Limited** – Chairman<br>The Maori Carbon Foundation has been established to deliver environmental, social and economic benefits through the planting of permanent carbon forestry, to Maori and New Zealand landowners throughout the country.<br><br>**Ngāti Ruanui Holdings** – Director<br>Ngati Ruanui Holdings is the Investment and Economic Development Arm of Ngati Ruanui established to maximise profits in accordance with Te Runanga directions in Taranaki.<br><br>**NZCF Carbon Planting Advisory Limited** – Director<br>NZCF Carbon Planting Advisory Limited is a company that carries out the obligations in respect of planting and upskilling relating to the Maori Carbon Foundation Limited.<br><br>**Oaro M Incorporation** – Member<br>'Oaro M' Incorporation was established in 1968. Over the past 46 years successive Boards have managed and maintained the whenua, located at 'Oaro M', Kaikōura, on behalf of its shareholders. Over time shareholders have requested the Board consider establishing an education grant in order to assist whānau with their |

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| | educational aspirations.<br><br>**Police Commissioners Māori Focus Forum** – Member<br>The Commissioner of Police has a group of senior kaumatua and kuia who meet with him regularly to discuss issues of mutual interest and concern. Known as the Commissioner's Māori Focus Forum, the group helps guide policing strategy in regard to Māori and provides advice on issues of the moment. The Māori Focus Forum developed The Turning of the Tide with help from Police. The forum plays a governance role and helps oversee the strategy's implementation.<br><br>**Pure Advantage** – Trustee<br>Pure Advantage is comprised of business leaders who believe the private sector has an important role to play in creating a greener, wealthier New Zealand. It is a not-for-profit organisation that investigates and promotes opportunities for green growth.<br><br>**QuakeCoRE** – Board Member<br>QuakeCoRE is transforming the earthquake resilience of communities and societies through innovative world-class research, human capability development, and deep national and international collaborations. They are a Centre of Research Excellence (CoRE) funded by the New Zealand Tertiary Education Commission.<br><br>**Rangitane Holdings Limited & Rangitane Investments Limited** - Chair/Director<br>The Rangitāne Group has these two commercial entities which serve to develop the commercial potential of Rangitāne's settlement assets. A Board of Directors oversee the governance of the commercial entities, and are responsible for managing Crown lease properties and exploring commercial development opportunities to support the delivery of benefits to Rangitāne members.<br><br>**SEED NZ Charitable Trust** – Chair and Trustee<br>SEED is a company that works with community groups developing strategic plans.<br><br>**Sustainable Seas NSC (National Science Challenge) Governance Board** – Member<br>This is an independent Board that reports to the NIWA Board and operates under the Terms and Conditions specified in the Challenge Collaborative Agreement. The Board is responsible for appointing the Director, Science Leadership Team, Kāhui Māori, and Stakeholder Panel for projects within the Sustainable Seas NSC. The Board is also responsible for approving projects within the Research and Business Plan and for allocating funding.<br><br>**Te Ohu Kai Moana** – Director<br>Te Ohu Kai Moana is an organisation that works to advance Maori interests in the marine environment, including customary commercial fisheries, aquaculture and providing policy and fisheries management advice and recommendations to iwi and the wider Maori community.<br><br>**Te Waka o Maui** – Independent Representative<br>Te Waka o Maui is a Post Settlement Governance Entity. |
| **Dr John Wood**<br>**Ex Officio – HAC**<br>Chair CDHB | **Advisory Board NZ/US Council** – Member<br>The New Zealand United States Council was established in 2001. It is a non-partisan organisation, funded by business and the Government, and committed to fostering and developing a strong and mutually beneficial relationship between New Zealand and the United States. The Advisory Board supports the day to day |

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| | work of the Council by providing strategic and operational advice to both the Executive Board and the Executive Director.<br><br>**Member of the Governing Board of the Office of Treaty Settlements, Ministry of Justice (as Chief Crown Treaty of Waitangi Negotiator)** – Ex-Officio Member<br>The Office of Treaty Settlements, Ministry of Justice, are responsible for negotiating the settlement of historical Treaty of Waitangi claims, and the administration of the Marine and Coastal Area (Takutai Moana) Act 2011. They also advise and help claimant groups so they are ready to enter negotiations.<br><br>**Chief Crown Treaty Negotiator for Ngai Tuhoe**<br>Settlement negotiated. Deed signed and ratified. Legislation enacted.<br><br>**Chief Crown Treaty Negotiator for Ngati Rangi**<br>Settlement negotiated. Deed signed and ratified. Legislation awaiting enactment.<br><br>**Chief Crown Treaty Negotiator, Tongariro National Park**<br>Engagement with Iwi collective begins July 2018.<br><br>**Chief Crown Treaty Negotiator for the Whanganui River**<br>Settlement negotiated. Deed signed and ratified. Legislation enacted.<br><br>**Chief Crown Negotiator & Advisor, Mt Egmont National Park Negotiations**<br>High level agreement in principle reached. Aiming for deed of settlement end of 2018.<br><br>**Governing Board, Economic Research Institute for ASEAN and East Asia (ERIA)** – Member<br>ERIA is an international organisation that was established by an agreement of the leaders of 16 East Asia Summit member countries. Its main role is to conduct research and policy analysis to facilitate the ASEAN Economic Community building and to support wider regional community building. The governing board is the decision-making body of ERIA and consists of the Secretary General of ASEAN and representatives from each of the 16 member countries, all of whom have backgrounds in academia, business, and policymaking.<br><br>**Kaikoura Business Recovery Grants Programme Independent Panel** – Member<br>The Kaikoura Business Recovery Grants Programme was launched in May 2017 and is intended to support local businesses until State Highway One reopens by way of grants which can be applied for by eligible businesses. This programme is now closed.<br><br>**School of Social and Political Sciences, University of Canterbury** – Adjunct Professor<br>Teach into graduate and post graduate programmes in political science, trade policy and diplomacy – pro bono appointment.<br><br>**Te Urewera Governance Board** –Member<br>The Te Urewera Act replaces the Te Urewera National Parks Act for the governance and management of Te Urewera. The purpose of the Act is to establish and preserve in perpetuity a legal identity and protected status for Te Urewera for its intrinsic worth, its distinctive natural and cultural values, the integrity of those values, and for its national importance. Inaugural term as a |

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| | Crown appointment, re-appointed as a Ngai Tuhoe nominee.<br><br>**University of Canterbury (*UC*)** – Chancellor<br>The University Council is responsible for the governance of UC and the appointment of the Vice-Chancellor. It sets UC's policies and approves degree, financial and capital matters, and monitors their implementation.<br><br>**University of Canterbury Foundation** – Ex-officio Trustee<br>The University of Canterbury Foundation, Te Tūāpapa Hononga o Te Whare Wānanga o Waitaha, is dedicated to ensuring that UC's tradition of excellence in higher education continues. From its earliest beginnings in 1873, philanthropic support and the generosity of donors and supporters has played a major part in making the university the respected institution it is today. The UC Foundation is dedicated to continuing that tradition.<br><br>**Universities New Zealand** – Elected Chair, Chancellors' Group<br>Universities New Zealand is the sector voice for all eight universities, representing their views nationally and internationally, championing the quality education they deliver, and the important contribution they make to New Zealand and New Zealanders. |

**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, 2 August 2018, commencing at 9.00am**

## PRESENT
Andrew Dickerson (Chair); Jo Kane (Deputy Chair); Barry Bragg; Sally Buck; Dr Anna Crighton; Dr Rochelle Phipps; Trevor Read; and Ta Mark Solomon.

## APOLOGIES
Apologies for absence were received and accepted from Jan Edwards; David Morrell; Ana Rolleston; and Dr John Wood.

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

## IN ATTENDANCE

### Item 4
Norma Campbell – Director of Midwifery
Nicola Austin – Neonatal Paediatrician
Jen Coster – Maternity Consumer Representative
Nicky Smithies – Project Specialist, Planning & Funding
Wayne Turp – Project Specialist, Planning & Funding

### Item 5
Justine White – Executive Director – Finance & Corporate Services

### Item 6
Kirsten Beynon – General Manager, Laboratories
Sally Nicholas – Group Operations Manager, Burwood Hospital
Toni Gutschlag – General Manager, Specialist Mental Health Services
Berni Marra – Manager, Ashburton Health Services
Win McDonald – Transition Programme Manager, Rural Health Services
Heather Gray – Director of Nursing, Christchurch Campus

### Item 7
Linda Wensley – CCN Programme Manager
Lynley Cook – Continuous Improvement Lead, Population Health Specialist, Pegasus Health Ltd
Nicky Smithies

## 1. INTEREST REGISTER

**Additions/Alterations to the Interest Register**
Sally Buck – Addition
Member, Rose Historic Chapel Trust – Charitable voluntary body managing the operation of the Rose Historic Chapel, a Christchurch City Council owned facility.

There were no other additions/alterations to the Interest Register.

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

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

## 2. CONFIRMATION OF PREVIOUS MEETING MINUTES

**Resolution (12/18)**
(Moved: Trevor Read/Seconded: Sally Buck – carried)

"That the minutes of the meeting of the Hospital Advisory Committee held on 31 May 2018 be confirmed as a true and correct record."

It was noted that the spelling of Colin Peebles was incorrect. This will be corrected.

## 3. CARRIED FORWARD/ACTION ITEMS

The Committee noted the carried forward items.

*Rochelle Phipps arrived at 9.04am.*

## 4. UPDATE ON DEVELOPMENT OF MATERNITY STRATEGY – PRESENTATION

Norma Campbell, Director of Midwifery; Nicola Austin, Neonatal Paediatrician; and Jen Coster, Maternity Consumer Representative presented an update on the development of CDHB's Maternity Strategy. Also in attendance were Nicky Smithies, Project Specialist, Planning & Funding; and Wayne Turp, Project Specialist, Planning & Funding.

The presentation provided an overview of the service, which focuses on women taking greater responsibility for their health whilst pregnant; staying well in their own homes and communities; ensuring women and/or babies receive timely and appropriate care when they are unwell; and that there is equity of access to maternity services for all Canterbury women.

*Jo Kane arrived at 9.11am.*

There was a query on what is being done to improve a woman's health once they are pregnant, particularly around obesity, diabetes etc. It was noted that once a woman is pregnant it is too late to actively reduce their weight, and this is something that should start at the GP level and managed in the maternity setting.

A Committee member asked for the number of stillbirths and neonatal deaths (mother and/or baby) in 2017 for both Christchurch and the Canterbury region. These numbers will be provided by the team.

It was noted that occupancy rates of primary facilities have increased, but not to a large extent. Midwives are the conduit for this change and it is important to educate women away from going to tertiary facilities unless it is medically required.

A Committee member questioned whether any work had been done to source a location for a primary birthing facility. It was noted that there is work underway in this area, with a range of options being considered.

There was discussion around whether the protocols for induction of labour are being adhered to and if maternity providers are reminded of it. It was noted that there is work being done with clinical leaders to maintain consistency in following protocols.

The Chair thanked the team for their attendance and presentation.

*The meeting moved to Item 6.*

## 6. H&SS MONITORING REPORT

The Committee considered the Hospital and Specialist Services Monitoring Report for July 2018. The report was taken as read.

General Managers spoke to their areas as follows:

**Medical/Surgical & Women's & Children's Health – Heather Gray (for Pauline Clark, General Manager, Christchurch Hospital)**

- Ms Gray provided an update on winter planning, stating that many facilities are now operating at capacity. There is a high rate of operational input and this is expected to continue for the next six weeks.
- Christchurch Hospital is busy, with a high rate of admissions in the midnight-6am period, currently sitting at three times the standard.
- High rate of flow from mental health and GPs, as well as referrals via ambulance, to ED.
- Plans are in place for all contingencies.

There was a query around whether there was a rise in cases of pneumonia this year. It was noted that the rate is not higher than normal, but more people are presenting in ED, particularly the elderly and/or frail.

**ESPIs**

- Currently still red for both counts, and is not expected to recover for several months, due to complex issues.

**Hospital Laboratories –Kirsten Beynon, General Manager**

- There has been a flow on effect in activity due to demand on the Christchurch Campus, with a significant shift in the last week of July.
- A pilot was implemented to provide rapid influenza/respiratory test results, which is anticipated to have an impact on patient flow and decision making. Previously, tests were batched with results only being provided once or twice a day. Data will be available at the end of the season.

There was a query around progress of the lab building. It was noted that currently this is tied up in the strategic assessment with the Capital Investment Committee. Labs are working with the Site Redevelopment Unit and the School of Medicine on a range of contingencies.

**Older Persons, Orthopaedics & Rehabilitation Service – Sally Nicholas (for Dan Coward, General Manager)**

- Work around falls and pressure injuries continues, including looking at environment and communication at handover.
- A Safe Recovery programme will be implemented and a programme educator position has been advertised in order to roll it out to OPH. The pilot will run until the end of September, with data and analysis available after that.
- Burwood is close to capacity, but the teams are working well and coping.

There was a query around the definitions of SAC 1 and SAC 2.

There was a comment from the Committee around limitations on reporting frailty scores and whether there is a way to identify those at greater risk of falls. Cases are looked at on an individu al basis. The Safe Programme being piloted is an evidence based programme, and will work closely with patients to identify their individual risks and needs.

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

- Highlighted the work the Child, Adolescent and Family (*CAF*) Unit has been doing around the ADHD pathway.
- Six auditors from the office of the Ombudsman conducted an unplanned five day audit last week, visiting AT&R, PSAID, Te Whari Manaaki and one ward of Te Awakura. Their verbal feedback was positive, with comments that the staff engage well with consumers and their families. However, there was concern around the adequacy of buildings and the pathway for people with intellectual disabilities and challenging behaviour in the service. The final report will be available in around eight weeks' time.
- AT&R is continuing to work closely with the Ministry of Health (*MoH*) on managing capacity and the number of secure beds. There are currently four consumers in the unit, which is low, but these consumers are challenging.
- Te Awakura is at 100% occupancy, but are currently under 60 consumers, which makes a big difference to staff morale. There is work being done with frontline staff and the clinical leaders in reducing violence and verbal abuse in the unit. Early reports are that this change is positive and it is making things better.
- Staff are having ongoing discussions with Corrections in regards to increasing prison populations and the demand on mental health services.

The Committee discussed the Christchurch City Council's (*CCC*) indication to begin taking refugees and what impact this will have on mental health services. There has been extensive engagement with CCC and the challenges this presents. It is crucial that refugees taken into Christchurch have networks/structures in place, rather than those with no existing framework. Any changes will be staged over a period of time so as not to create a burden on SMHS.

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

- Ward 6 is moving in September, with discussions being held around non-weight bearing and AT&R patients, re-defining the workforce required to support their needs.
- Ward 1 medical occupancy is fluctuating, with the average stay sitting around 2.6 days.
- A successful workshop was held with community providers at the end of June, looking at challenges and opportunities in improving the older patient journey. Five GPs attended, and they expressed their interest in doing things differently. Work to provide a Service Level Agreement (*SLA*) is underway.

**Resolution (13/18)**
(Moved: Ta Mark Solomon/Seconded: Sally Buck – carried)

"That the Committee:

i. notes the Hospital Advisory Committee Activity Report."

*The meeting moved to Item 5.*

## 5. HOSPITAL AND SPECIALIST SERVICES (*H&SS*) 2017/18 YEAR RESULTS - PRESENTATION

Justine White, Executive Director, Finance & Corporate Services, presented an update on the H&SS 2017/18 financial year results.

There was a query from a Committee member around the nurses MECA and whether any can be clawed back from central funding. It was noted that any adjustment will be made in the 2018/19 financial year, as there is no agreed settlement at this stage.

Discussion was held around the running costs of The Princess Margaret Hospital (*TPMH*) and if they are included in the figures for mental health. It was confirmed that they are not included, as the operational costs are kept separate.

*The meeting adjourned for morning tea at 10.30am, reconvening at 10.45am.*
*The meeting moved to Item 7.*

## 7. SYSTEM LEVEL MEASURES FRAMEWORK

Linda Wensley, CCN Programme Manager; Lynley Cook, Continuous Improvement Lead, Population Health Specialist, Pegasus Health Ltd; and Nicky Smithies presented on the implementation of the System Level Measures (*SLM*) framework.

There was a question from a Committee member around whether the smokefree household data is just people that live in the household or whether it includes other members of the family. It was confirmed that it only includes people that live in the same house as the baby.

There was a query around the ethnic disparity in preschool dental enrolments, and whether these ethnicities are targeted to enrol and attend appointments. It was noted that the SLM adds impetus, and also that there is work being done behind the scenes to ensure people who do not attend appointments are re-contacted. The LinKIDS process also works to ensure enrolment in Community Dental Services.

The Committee asked if the SLM data can be viewed. It can be accessed via the SLM viewer, and information on how to access the viewer will be distributed to the Committee. The team was congratulated on the progress made, and how Canterbury is used as an exemplar to other DHBs.

**Resolution (14/18)**
(Moved: Sally Buck/Seconded: Trevor Read – carried)

"That the Committee:

i. notes Canterbury's Implementation of the System Level Measures Framework;
ii. notes Canterbury continues to trend favourably against the System Level Measures;
iii. notes the work underway to finalise Canterbury's 2018-19 System Level Measures Improvement Plan; and
iv. notes Canterbury's 2018-19 focus on wider health provider engagement in actions to progress Canterbury's performance."

## 8. RURAL HOSPITALS - PRESENTATION

Win McDonald – Transition Programme Manager, Rural Health Services, presented on rural hospitals.

There was a query around the Hurunui catchment area. It was confirmed that the population base is identified depending on GP services in the area.

A question was asked about the new Hurunui Model of Care. Carolyn Gullery, Executive Director, Planning, Funding & Decision Support, confirmed that GPs, staff and the community are all on board with the model and it will be cost effective in the long run.

There was further discussion around changing the mindset of identifying rural facilities as hospitals, and looking at changing the language and communication around this.

A Committee member asked if there was a lack of GPs in Amberley, as there is some evidence of long wait times in the town. Further detail will be provided to Ms Gullery, who undertook to look into this.

## 9. CLINICAL ADVISOR UPDATE

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

- David Gibbs, Oncologist, has been confirmed as the Haematology/Oncology Chair.
- Anja Werno has been confirmed as the Chief of Labs.
- There is a vacancy in Obstetrics and Gynaecology.
- SMO credentialing is ongoing, with highly engaged teams. There is some pressure on the service due to high demand.
- A guidance document has been produced looking at how SMO non-clinical time is spent in order to add value to the organisation.
- There is a new Resident Doctors Association (*RDA*) contract for RMOs, in order to make rosters compliant. CDHB is further ahead with compliance compared to other DHBs, but there are ongoing issues with continuity.
- A senior clinical leadership team has been set up to look at the Medical Education Training Unit (*METU*) and the Resident Doctors Support Team (*RDST*): how things can be done differently.
- Richard French, Clinical Director, is working to reduce non-sign off of lab and radiology results.
- There has been a lot of work around quality and clearing the backlog of Serious Event Reviews (*SERs*).
- A stocktake has been undertaken to improve quality processes and how staff can work smarter. A Clinical Governance Committee for the provider arm has been set up to assist in this process.
- A governance group has been set up to work on infection prevention and control, with review recommendations available soon.
- A review of the Research Committee and office has been held, with new Terms of Reference approved. The Committee will meet at the end of September.
- A Canterbury initiative around discharge summaries has begun, looking at what they contain and how these are sent to GPs.
- There is now a three tier process for introduction of new technologies, with the need for evidence based reviews for complex cases.
- Work is being done around the health emergency portfolio and business continuity planning, looking at how the work can be divided between the Executive Management Team.

A Committee member queried the gaps in the dermatology workforce. Ms Nightingale confirmed extended training has been offered to GPs to offer dermatology services, as well as expanding the nurse input in this field.

## 10. RESOLUTION TO EXCLUDE THE PUBLIC

**Resolution (15/18)**
(Moved: Trevor Read/Seconded: Ta Mark Solomon – carried)

"That the Committee:

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

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

| | GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED | GROUND(S) FOR THE PASSING OF THIS RESOLUTION | REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9) |
|---|---|---|---|
| 1. | Confirmation of the minutes of the public excluded meeting of 31 May 2018. | For the reasons set out in the previous Committee agenda. | |
| 2. | CEO Update *(If required)* | Protect information which is subject to an obligation of confidence.<br>To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).<br>Maintain legal professional privilege | s 9(2)(ba)(i)<br>s 9(2)(j)<br>s 9(2)(h) |

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

## INFORMATION ITEMS

- 2019 Meeting Schedule
- 2018 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 11.51am.

Confirmed as a true and correct record.

_____ _____

Andrew Dickerson Date
Chairperson

# CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

## HOSPITAL ADVISORY COMMITTEE
## CARRIED FORWARD ITEMS AS AT 4 OCTOBER 2018

| DATE | | ISSUE / ACTION | REFERRED TO | STATUS |
|---|---|---|---|---|
| 1. | 02 Aug 2016 | AT&R Unit Update | Toni Gutschlag | Verbal Update. |
| 2. | 29 Mar 18 | Ashburton Health Services - Presentation | Bernice Marra | Today's agenda – Item 5. |
| 3. | 19 Apr 18 (Board) | Ophthalmology Department - Presentation | Carolyn Gullery | Today's agenda – Item 4. |

# CLINICAL ADVISOR UPDATE – NURSING

Canterbury District Health Board
Te Poari Hauora ō Waitaha

**NOTES ONLY PAGE**

# CLINICAL ADVISOR UPDATE – ALLIED HEALTH

Canterbury District Health Board
Te Poari Hauora ō Waitaha

**NOTES ONLY PAGE**

# H&SS MONITORING REPORT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

**DATE:** **4 October 2018**

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

## 1. ORIGIN OF THE REPORT

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

## 2. RECOMMENDATION

That the Committee:

i. notes the Hospital Advisory Committee Activity Report.

## 3. APPENDICES

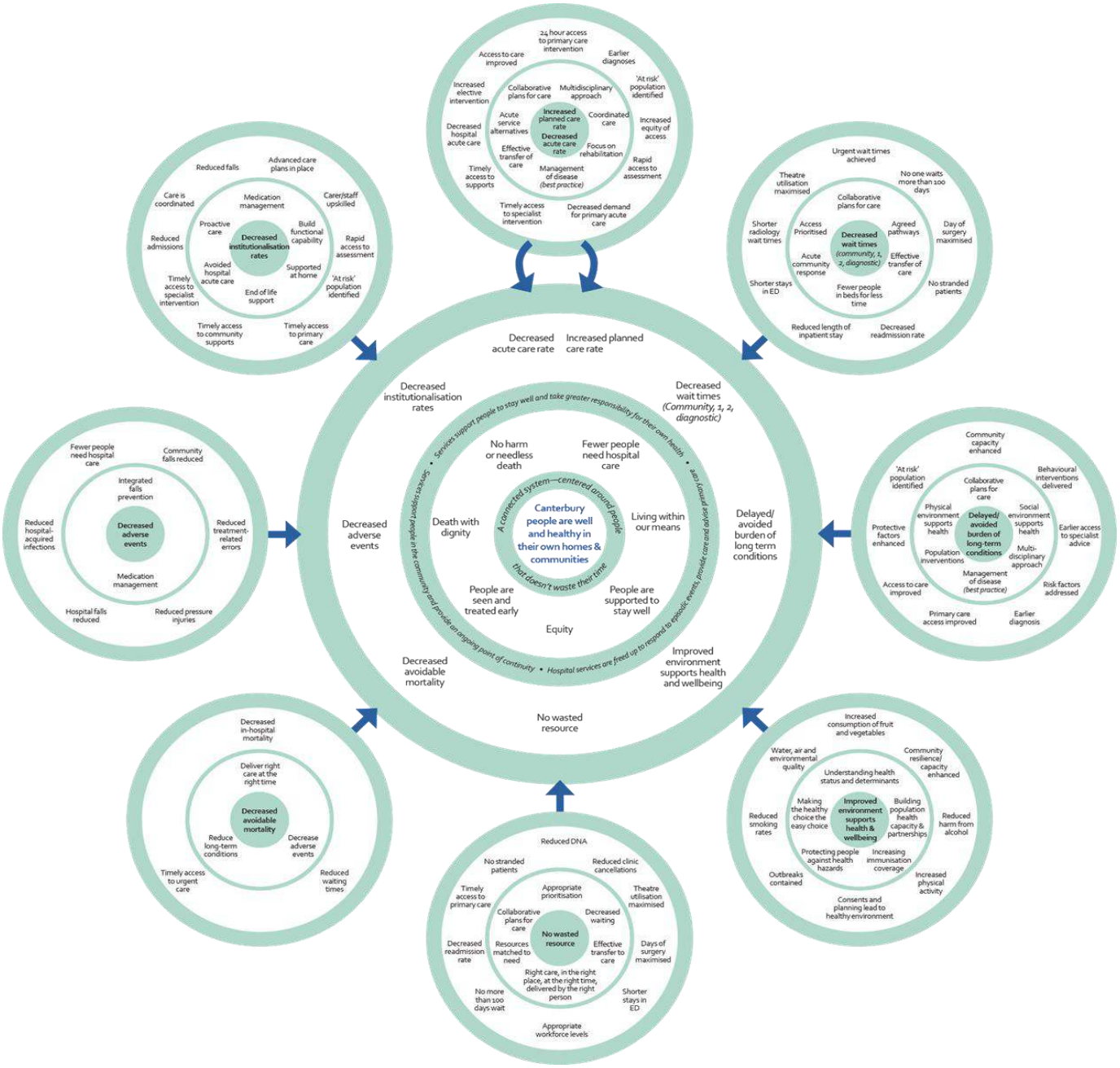
Appendix 1: Hospital Advisory Committee Activity Report – September 2018

Report prepared by: General Managers, Hospital and Specialist Services

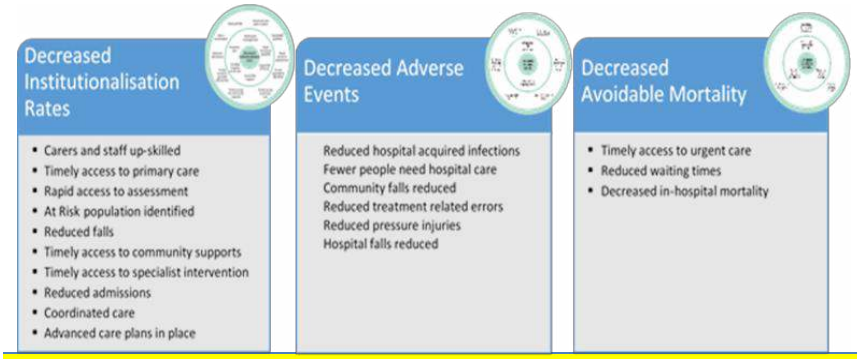
Report approved for release by: Justine White, GM, Finance and Corporate Services

# *Hospital Advisory Committee*

# Activity Report



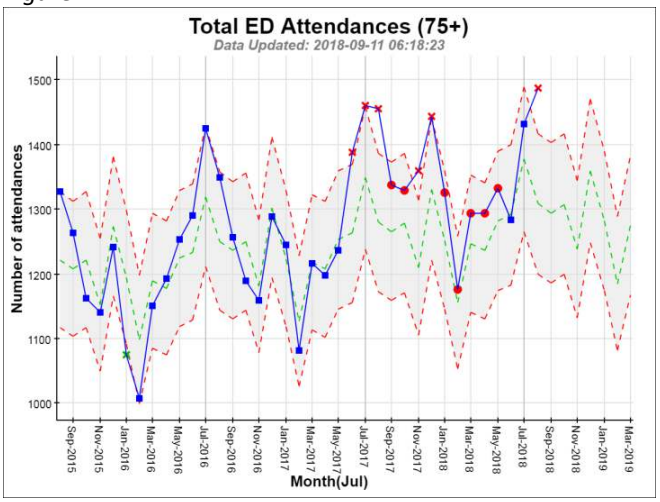

# September 2018




# Frail Older Persons' Pathway

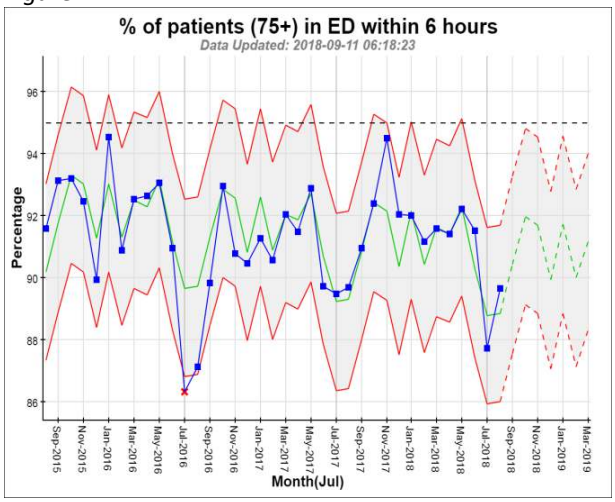
## *Outcome and Strategy Indicators*

*Figure 1.1*



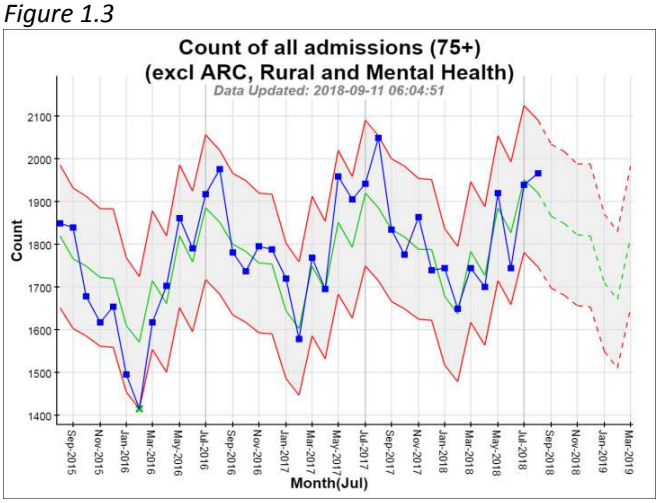

Total ED attendances of people over 75 has increased at a higher rate than the established trend. This increase is consistent with that seen for the overall population

*Figure1.2*



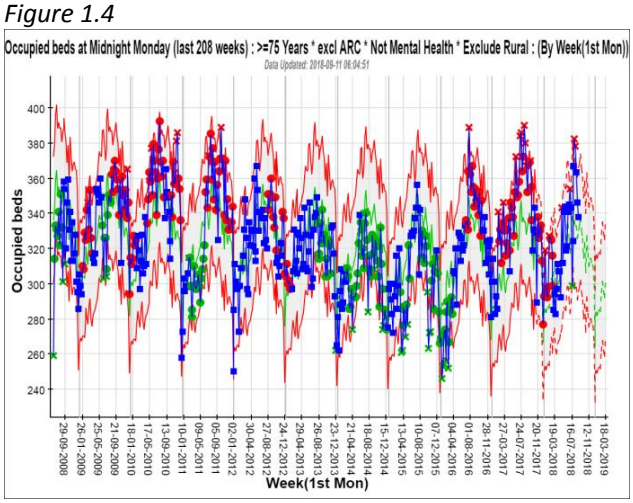

Patients 75+ leaving ED within the 6 hour target is tracking within the forecast range, although is below target, despite the high ED attendance rate

*Figure 1.3*



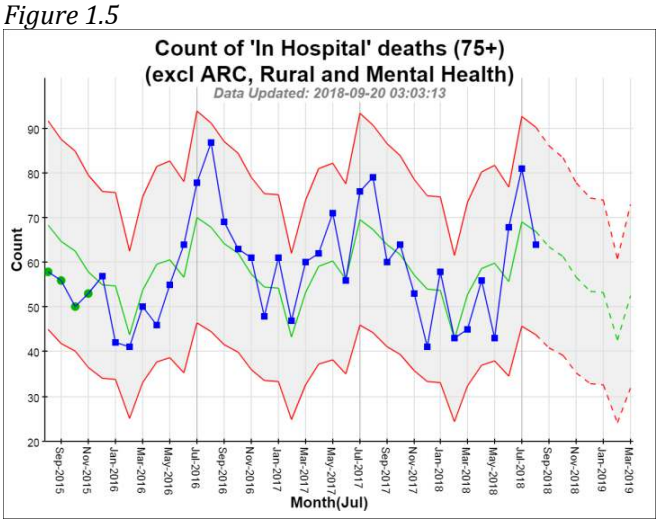

The count of all admissions for people 75 years and over continues to increase consistent with the established trend.

*Figure 1.4*



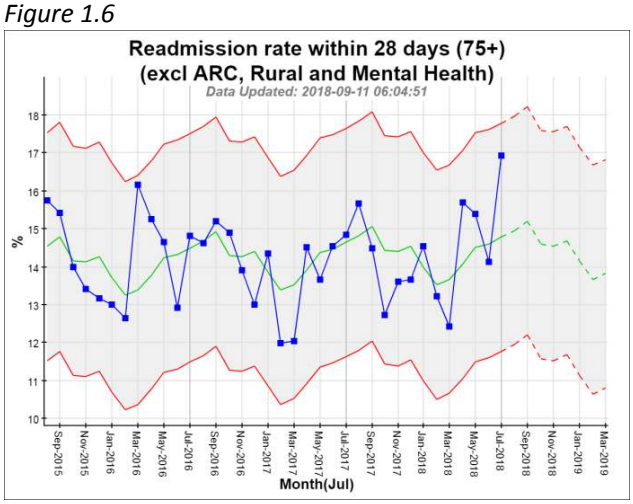

In winter 2017 and 2018 Older Persons' Health increased the number of beds across the inpatient environment to support flow. Levels return to lower levels outside of this period.

*Figure 1.5*



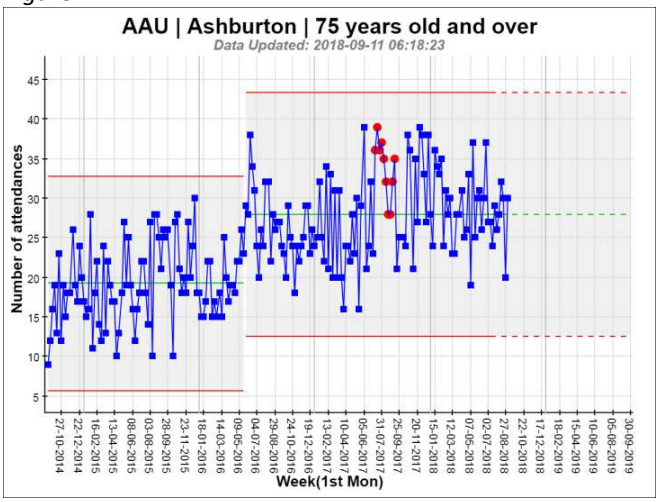

The number of in hospital deaths is within the forecast range.

*Figure 1.6*



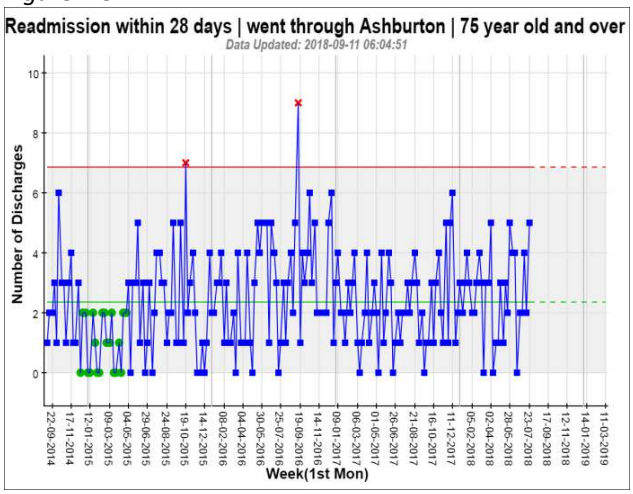

The readmission measure (balancing metric) for people aged 75 years and over continues to be within the expected range.

*Figure 1.7*




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

*Figure 1.8*




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

*Achievements/Issues of Note*

## E-handovers making transfers between CDHB wards and facilities easier and safer

As a part of the releasing time to care programme a series of admission, transfer and discharge workshops were held throughout Canterbury District Health Board's facilities. At these workshops it was identified that handover processes are fraught with issues and risks. Ideally telephone handover occurs between the nurse currently providing care, and the nurse who was receiving the patient at the other end. However finding a time when both nurses are available to talk can be very tricky and takes a lot of time. Because of this, the phone handover often ends up being taken by a nurse other than the one who was receiving the patient, requiring that messages be passed with an associated risk to the accuracy of the information. Fax handovers have been used in some areas however these also are imperfect with their associated privacy risks, and the risk that the information will not make it to the right person or into the patient notes.

In response, an electronic handover has been put in place, modelled on that which was already being provided for patients being admitted from the emergency department. This was initially introduced for patients being transferred from the Acute Medical Assessment Area, or Surgical Assessment and Review Area and to other

inpatient wards at Christchurch Hospital. It is now being used for patients transferring between any areas at Christchurch, Burwood or Ashburton Hospitals.

A range of templates have been developed, ensuring that it is easy to provide appropriate, relevant information. This method ensures that accurate information is available to the person providing care to the patient at the time it is needed. The handover document can be started at any point of the patient's care and completed in time for handover ensuring that complete information can be provided in a timely manner. It becomes a part of the patient's enduring record on Health Connect South, ensuring the approach is in line with Canterbury District Health Board's paperlite approach.

Nurses have taken easily to this new practice as it takes less time and is more efficient. Nurses in the busiest areas of Christchurch Hospital have been active at promoting it to colleagues across the system. Next developments include putting in place an electronic alert, so that a phone call does not need to be made to let the receiving unit know that they have a handover document to read and introducing its use to other hospitals throughout the South Island that receive patient transfers from Canterbury.

## Spinal wedges improve safety of patients and nurses in the Orthopaedic Trauma Unit

Patients who are unable to move independently require regular turning or repositioning to prevent the development of pressure ulcers which can create significant pain, suffering and the risk of infection for patients. Pillows are typically used to position patients so that pressure on their sitting areas is reduced, however this system is far from perfect with patients often sliding, or migrating, towards the base of the bed over time. The regular re-positioning of patients creates risk for nurses with a high proportion of nurses experiencing back, shoulder or wrist injuries from regularly turning or moving patients. A range of solutions are in place to ensure the safety of both nurses and patients.

These risks are particularly acute in the Orthopaedic Trauma Unit where many of our existing solutions are not suitable for some patients with multiple traumatic injuries. Nursing leadership in the unit is working with an expert from a medical technology to introduce a system that will be useful for a particularly high needs cohort within the unit. The system involves a glide sheet, incorporating handles and absorbent layers to keep the skin dry, and a pair of wedges. Unlike other systems, the glide sheet stays under the patient. It serves to keep the wedges in place, reduces the risk of patients' skin being torn while they are being positioned and the risk of injury to nurses by reducing the effort required to move patients. The wedges assist in positioning the patient naturally, reducing pressure on their sacrum, preventing migration down the bed and holding them in a stable, comfortable position.

An audit in the Unit shows that turning and repositioning patients using the current practice required over 80% more perceived effort by nurses than the Sage Turning and Positioning System.

A patient with a dislocated shoulder, chest injuries and broken limbs following a car accident who had been refusing to be repositioned using conventional methods due to the pain caused noted that this system made great improvements to his care.

It is expected that this system will be used for around three patients per month in the Orthopaedic Trauma unit. A regular audit will ensure that its use is limited to those for whom conventional methods are not useful and that the agreed criteria are being adhered to. Pressure injury, staff health and safety data and input from the patients in the ward will be considered throughout the trial which will be completed prior to October this year. The system's potential use in other high intensity areas of the hospital will be considered based on the findings of the trial.

## Ward 24 Medical & Stroke Patients spending less time in bed

Providing patients with a good reason to leave their beds and move around is an important part of helping them to recover following strokes and other medical events. Even simple activity such as getting out of bed and walking from one room to another can be a challenging but important part of a patient's recovery.

Patients who are in Ward 24 following a stroke, or other medical events, will be spending less time in bed and more time getting involved. The Allied Health Assistant based on the ward, managed to secure a generous amount of money from the Volunteer Service. Working with the volunteer team to select appropriate games and activities to help with patient recovery. She will use the equipment, which includes an iPad operating current recovery apps, during her sessions with the patients. Future ideas include developing groups and 'patient' tournaments.

## Information about patients with viral infections being made visible.

A series of recent changes to the systems we use throughout the day to help us manage flow and resourcing within Christchurch Hospital are focussed on providing information about the impact of common infectious diseases in the hospital. New icons have been put in place within FloView that are used by nurses to identify patients suffering from influenza or norovirus like illnesses. Use of these icons enables teams involved in the care of these patients to understand some of the care implications.

This information from FloView is reflected in our Hospital at a Glance dashboard, providing visibility about how many patients in the various wards throughout the hospital have influenza or norovirus like illness. This enables well informed staffing decisions to be made, recognising the increased complexity in caring for patients with these illnesses.

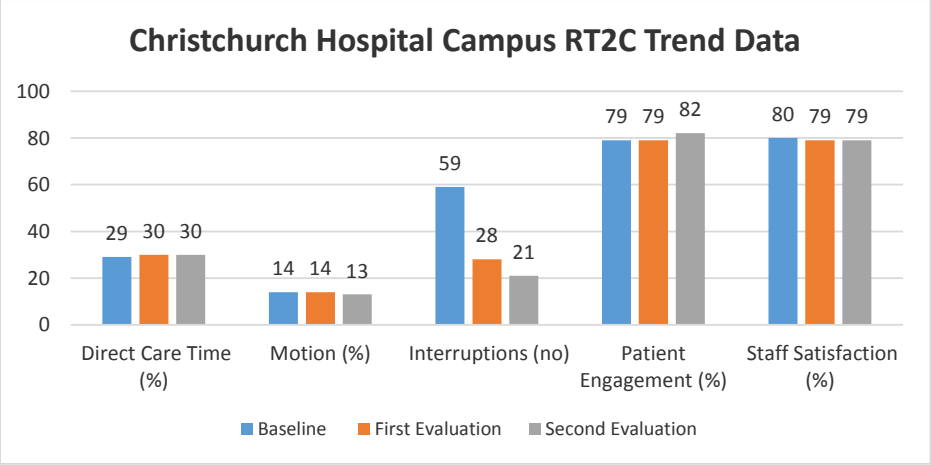
Alongside this a new screen has been introduced on CapPlan showing information from the ICNET system detailing the number of people in each area with laboratory confirmed influenza or norovirus.

## Releasing Time to Care

The Releasing Time to Care programme is a framework to support change and develop a robust process for improvement. It supports ward based quality improvement to help ward/unit teams redesign and streamline the way they work – releasing more time to care for patients.

The Programme is being used to guide staff to new facilities – the Christchurch Outpatients and The Hagley buildings. This update provides some brief highlights from recent measures and activities.

Key safety metrics and survey results are displayed in each ward/unit on the '**Knowing How We are Doing**' Boards which are available for staff, patients, whānau and other members of the healthcare team to view. Combined data for all areas progressing from their baseline evaluation through to two years after the programme's commencement are shown in the graph below.




The direct care time (time spent by nurse directly with the patient/family) has remained at 30%, largely due to constraints within the current environment which encourages a centralised way of working. Our new facilities are designed to facilitate more tasks being provided at the point of care.

This is also affected by the current facility design and changes are expected as we shift.

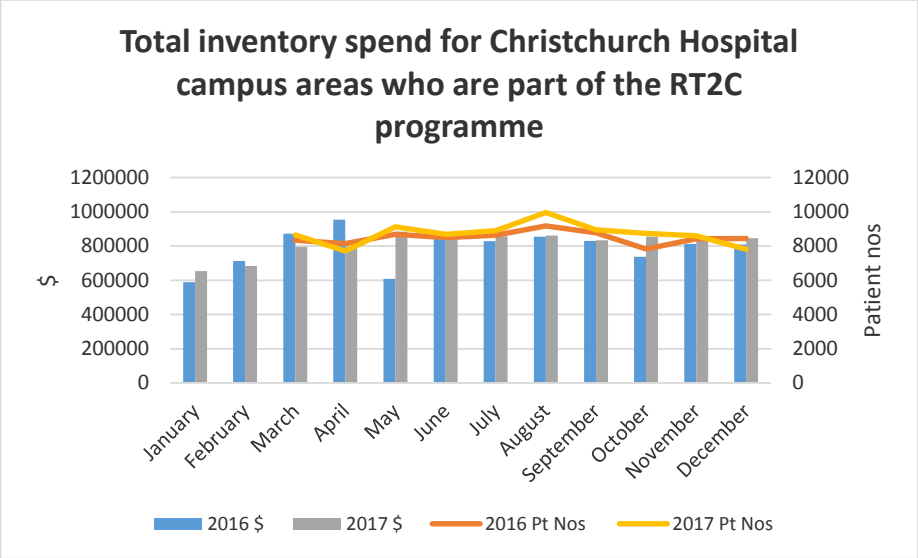
The average number of interruptions a nurse experiences on an 8.5 hour shift has dropped by over half due to a number of quality initiatives that have been implemented such as Assertive Board Rounds, medication related initiatives, environmental changes through Well Organised Workplace initiatives, bedside handover and introduction of new tools such as FloView.

Patient engagement (in response to the question – "I know what is happening to me today and tomorrow") remains high at 82%.

Staff satisfaction (in response "I would recommend the ward I am working in as a great place to work") remains high at 79%.

A specialist wound group was set up to look at the number of dressings that the Canterbury District Health Board was purchasing. The group evaluated all of the wound care products ordered and reduced our use from 462 to 195 products. The group has also established a pathway/process so that the number of dressing can be monitored and managed.

The total inventory spend for areas which are part of the programme has remained static despite increased patient numbers.




**"Patient Status at a Glance"** has involved the introduction of visual management tools to show important patient information so it can be updated regularly, seen 'at a glance' and used effectively. This work includes the design, use and placement of Bedside Patient Status at a Glance Boards (inclusive of safe mobility plans), use of FloView across all wards and units and introduction of assertive Board Rounds/huddles –into all areas where this was not regular practice.

The aim of the **Nursing Service Delivery** work is to provide teams with a framework that will assist with service integration to the new facilities to embed ways of working that are patient centred and encourage patient involvement their care. This includes the introduction or enhancement of patient focused team nursing with geographical patient allocation, bedside handover and incorporation of key questions into nurse's regular interactions with patients.

A series of Admission/Discharges/Transfers workshops have led to a range of changes including a review of the material provided to patients when we welcome them onto wards and the development of a modified eHandover template and process. The system has reduced the time taken to share information, decreased interruptions and provides a permanent record.

Releasing time to care will continue to be the framework to support the transition of areas to new facilities.

## Improving the way that we work – requests for Orderly services.

Orderlies are a critical part of the clinical team, delivering services which are absolutely essential to the care we provide. Requesting the services of an Orderly has involved the use of a screen in the Homer Patient Management System at Christchurch Hospital, with the impending transition to the new Patient Information Care System a new way of carrying out this task was required.

The Max development team from People and Capability has worked with orderly, nursing, administration and technology teams, to develop a new system based on the same technology and platform that has been used to create Max. The new system was released on 31st August, only five weeks following the initial workshop called to

begin its design. By 2pm of the day it was launched the new application had processed over 300 requests. The system is 100% mobile responsive, and allows our clinicians and others to submit requests on the go through the device of their choice. The Orderly workforce will be equipped with smartphones to enable on the move receipt and fulfilment of requests. Use of this system will improve visibility and drive insights into how we're deploying and supporting our orderly workforce.

The efforts of all involved to achieve this target have been nothing short of remarkable and they're absolutely consistent with our shared commitment to making work, work better for our people.

Initially the service has been made available for the Christchurch Campus, with roll-out plans for Burwood and Ashburton. As with all services we release, enhancements and continual improvement will be delivered based on new requirements gathered from the feedback received from users of the service.

## Occupational Therapy Equipment Store

Ongoing changes to the way that we provide care for frail elderly patients and those following trauma means that rather than keeping people in hospital for unnecessarily long periods we are providing them with the support to return to full health in their own homes. This includes the provision of equipment to enable toileting, bathing and other day to day tasks during recovery. The Occupational Therapy Department at Christchurch Hospital loans out around 300 items per week, having around 2,000 items of equipment on loan in any giving month.

Equipment is provided to patients and their families before they leave hospital so that they can become familiar with it and so that waiting for equipment does not delay their return home once they are clinically ready. Until recently equipment was returned to trolleys at the Christchurch Hospital main entrance, before being washed and stored in the Occupational Therapy Department in the Riverside Building. Returned equipment at the front door provided an infection control risk as visitors and patients would often lean against the trolleys. The rooms and facilities used for washing and storing equipment were cramped and unsuitable for disassembling and washing equipment creating a health and safety risk for staff and the storage space was not safely able to hold the volume of equipment required. Equipment was left drying in the corridor and the paths for clean and dirty equipment were the same, once again posing infection control risks.

After many years of seeking a better solution, during August 2018 the Occupational Therapy store was shifted to the site of the old Riley Day Hospital at The Princess Margaret Hospital. Families are able to return equipment either directly there or to Blenheim Road and we will phase out return of equipment to Christchurch Hospital over time. There is now adequate space for washing, drying and storing equipment in a safe manner. Having this space means that there will be less reliance on hiring equipment from external providers.

This solution will serve us into the future, continuing to enable us to provide the support patients required to continue their recovery at home.

## Improving multi-service care of trauma patients

People admitted to hospital with multiple traumatic injuries are often cared for by several different medical and surgical services to ensure that each type of injury they have receives the best possible care. Often these patients have a suspected spinal injury and are cared for in a ward or unit that do not routinely care for patients with these injuries.

In order to ensure that the right precautions and other aspects of care are provided, the trauma committee has been working on a new form that will be filled in following the Orthopaedic assessment in the Emergency Department and will accompany the patient to the ward that they are admitted to. The form provides key information about the care of the patient including the type of spinal precautions required, the other teams involved in the patient's care and the types of observations and review required. It is just one example of health professionals from different areas collaborating to ensure that we can systematically provide the right care to patients with complex care requirements, ensuring that the right care is provided first time, the care is documented effectively and that recovery occurs as smoothly as possible.

## Pressure injury prevention in the intensive care unit

In March this year an update was provided covering actions occurring across the system to prevent pressure injuries. These injuries cause pain, disability, extended hospitalisation and sometimes death for those that are affected by them. Providing care to people in the Intensive Care environment has its own special set of challenges.

Nursing staff in this environment actively use Safety 1st to log when pressure injuries occur. This information is used to track the context and care being provided to each patient so that patterns of factors causing pressure injuries can be evaluated and preventative responses put in place. Some findings include:

- Patients who are unconscious/sedated for extended periods depend on nursing staff to regularly turn them in order to prevent the development of pressure areas. However the act of turning patients can injure the skin, creating the conditions for pressure sores to develop. Good turning technique receives constant focus in the intensive care unit. The department has also sought feedback from nursing staff regarding the turning sheets available. An alternative product has been purchased to ensure staff have options when handling the very dependent patient.
- Electrical leads from equipment and various forms of tubes can create pressure injuries for patients. For example nasogastric tubes are associated with pressure injuries to the nose. This insight has led us to trial various forms of fixing tubes to minimise this risk. Progress has been made but the issue remains problematic and we continue to seek alternative options for securement.
- We've found that compression stockings, when worn for an extended period, can create pressure areas on patient's toes. This has led us to remove these stockings early in a patient's stay to prevent this. This was done after evidence demonstrated that TEDS are largely ineffective as thromboprophylaxis in the Intensive Care patient group-but did have the negative side effects of compromised tissue perfusion.
- As with patients in other parts of the hospital heels are at particular risk of developing pressure sores. Heel lifts have been sourced, trialled and purchased and these plus heel protection dressings are used to minimise this.

There are currently patients in the Intensive Care Unit who have been cared for in the unit for a very long time. Diligence around these aspects of their care means that their skin is intact and no iatrogenic infections have developed. These patients provide clear examples of great nursing care providing better outcomes for patients.

Through regular review of information we are able to fine tune the way that we provide care for patients, reducing the risk of pressure sores developing, along with reducing the associated discomfort and additional care they require.

## Christchurch Hospital – Improving Hand Hygiene compliance

It is recognised that hand hygiene improvement initiatives aim to reduce the harm and cost of healthcare associated infections. New Zealand District Health Boards are working with the Health Quality and Safety Commission on a structured approach to monitor and improve this area of our performance. The national hand hygiene target is set at 80% and average achievement nationally in June 2018 was 85.6%.

Christchurch hospital has increased its hand hygiene compliance from 77.6% in October 2017 to 79.4% in June 2018. The October 2018 quarter is tracking well at 82.2% for Christchurch hospital after the first month. Christchurch Hospital Medical Surgical Division's improvement in hand hygiene compliance has been due to the following:

- Hand hygiene is a standard agenda item at bi-monthly service quality meetings. The most recent quarters' hand hygiene compliance percentage is discussed and initiatives and interventions explored.
- There has been an increased interest from a clinical governance perspective. CD's and Chairs of quality meetings are looking at the stats and coming up with innovative ways to raise awareness within their service. It is seen as critical that front line staff have ownership of these improvements.
- There are annual update self- learning packages that staff access through Health learn.
- As with other divisions some staff on the floor are gold auditors
- Some services have established a team of gold auditors who work across all shifts promoting correct hand hygiene; complete audits and email a summary report on the day of the audit explaining what is going well and where improvement is needed

- In services where patients may be immunocompromised, patients and their visitors are constantly educated on hand hygiene
- Services have completed environment audits resulting in improving the location and number of Alcohol Based Hand Rub dispensers and locating clearly visible posters and signage near the service area entrance.
- Two areas, the Acute Renal Dialysis Unit and the Bone Marrow Transplant Unit (BMTU) have consistently been over the 80% compliance goal for hand hygiene at Christchurch Hospital for the last three quarters.
- In the last full quarter (June 18) Ward 25, Ward 20, Ward 19 and Orthopaedic Trauma Unit, Ward 11, BMTU and Acute Renal were all over the 80 % compliance.

## Diet information shifted from Homer to FloView

Patients' dietary requirements often change throughout their time in hospital due to changes in their condition. Until the end of May this year Christchurch Hospital used the Homer Patient Management System to enter current information about patient's dietary requirements and allergies. This system is not easily available to clinical staff in the ward on a constant basis and so there was some inefficiency involved in ensuring that up-to date information was being passed to the kitchen team.

Christchurch Hospital's transition out of Homer will occur this year which required us to put in place another system. This has been successfully done within FloView. The system developed in FloView has a number of drop down dietary options that enable staff to easily describe the current requirements for each patient. The system is constantly available to clinical staff and easy to use. These factors have led to a highly successful transition with no emerging issues. Reports are sent to the kitchen from each ward three times a day showing the requirements for each patient with any changes since the last report being highlighted. This enables the kitchen to successfully support the dietary requirements of each patient in Christchurch Hospital.

## Simulation course trains physiotherapists for complex work in intensive care.

Having a range of people from all of the staff groups that contribute to a patient's care in the Intensive Care Unit is particularly important given the highly specific nature of the skills required and the level of dependence of the patients. Training for this work requires a range of approaches.

Canterbury DHB has hosted New Zealand's first ever Intensive Care Unit (ICU) physiotherapy simulation course. The Physiotherapy and Critical Care Management Course, known as PaCCMan, aims to increase participants' confidence and competence, using simulation training to improve quality of care, communication, decision making and patient management. The Christchurch Hospital Physiotherapy Department collaborated with the Queensland Health Clinical Skills Development Service to bring PaCCMan to New Zealand. Participants from Canterbury DHB as well as other DHBs nationwide attended the course which was held in the Manawa Building. The state of the art facilities meant we were able to replicate an ICU environment, with the help of the coordinators and technical staff of the Clinical Skills Unit. The simulation suite and staff at Manawa were critical in the running of this course.

Canterbury DHB has been granted licencing rights to run the course for the training of our own physiotherapists and physiotherapists from across New Zealand. CDHB staff were trained in running the course so they will able to facilitate it again in the future. The aim is to run the course for both internal and external physiotherapists at least twice a year.

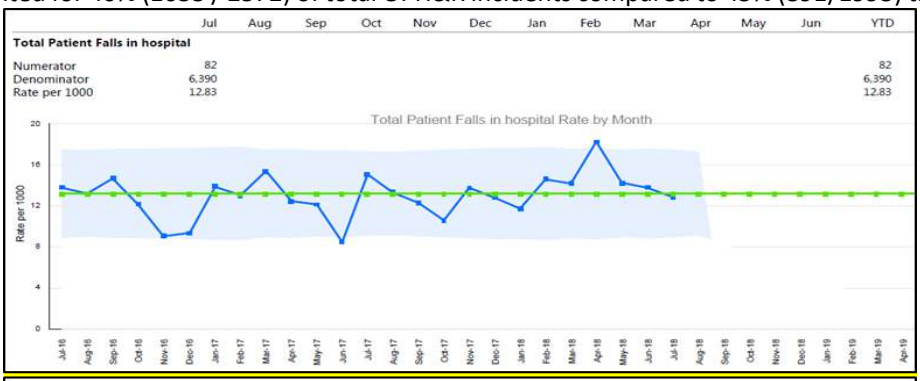
PaCCMan contributes to the learning and development of physiotherapists for work in the intensive care environment and expands their knowledge of contemporary, safe clinical practice. It includes practical sessions on assessment and clinical skills, as well as simulated experiences in providing respiratory care and rehabilitation. It is designed for physiotherapists who have limited exposure to intensive care patient management, or want to update their knowledge of assessment and treatment processes. It allows participants to understand the complexity of interdisciplinary working within the Intensive Care Setting. This puts us in a unique position that ensures we can provide simulation training to all physiotherapists who work in this environment after hours and during weekends, ensuring that patients' recovery continues to be effectively supported through these periods.

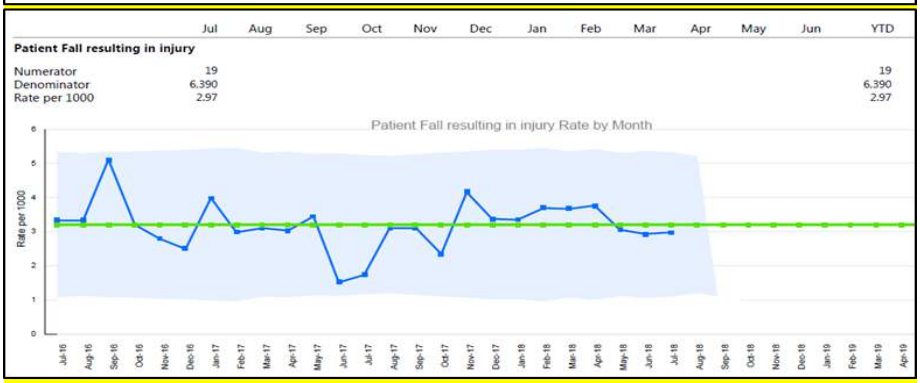
## Older Persons Health & Rehabilitation (OPH&R)

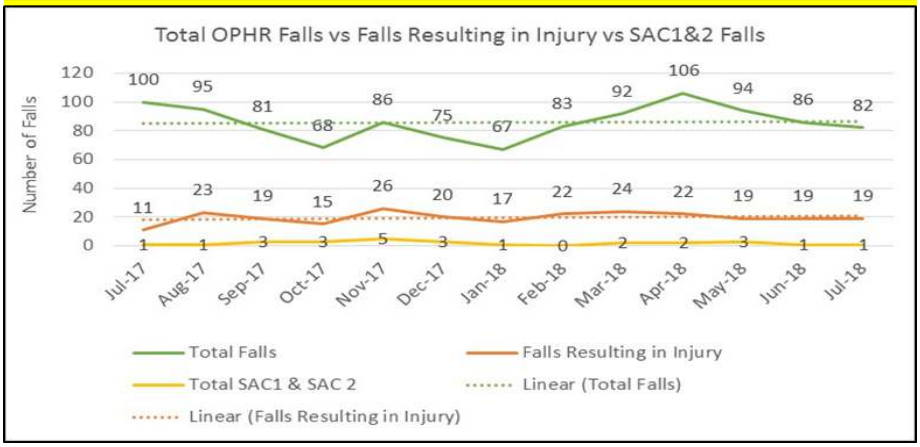
Overall, the reporting of Safety1st incidents remains consistently high with the graphs below illustrating an increase in falls and pressure injuries. The number of Serious Events (SAC 1 & 2) have also increased from 13 events in 2015

– 2016 to 21 events (2016 – 2017) and 33 events (2017 – 2018). Since July 2018, there has been 5 SAC 2 events reported. A factor for the increase since July 2016 has been the inclusion of Stage III and above hospital acquired pressure injuries of which there was 4 reported in 2016 – 2017 and 3 reported in 2017 – 2018.
The Serious Events investigations and resulting recommendations are monitored weekly and discussed by OPH&R Management and Leadership and Clinical Governance Groups. All SAC 3 and 4 incidents are also monitored weekly and are seen by Serious Event Review, Nursing Governance (including Nurse Educator and Clinical Nurse Specialist) as well as Clinical Directors.
Falls Prevention: Year to date(YTD) (July 2017 to June 2018) comparison to previous YTD (July 2016 to June 2017)

- 1033 falls compared to 891 the previous year period (increase 16%)
- 25 SAC 1 or 2 fall events compared to 16 the previous year period (increase 56%)
- 23% of falls resulted in injury compared to 25% the previous year period
- Falls accounted for 40% (1033 / 2572) of total OPH&R incidents compared to 45% (891/1993) the previous year



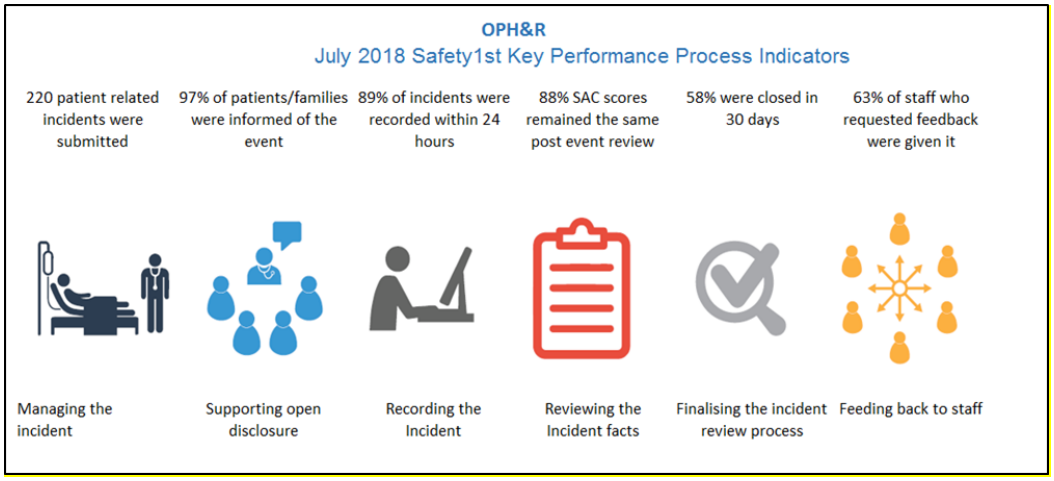



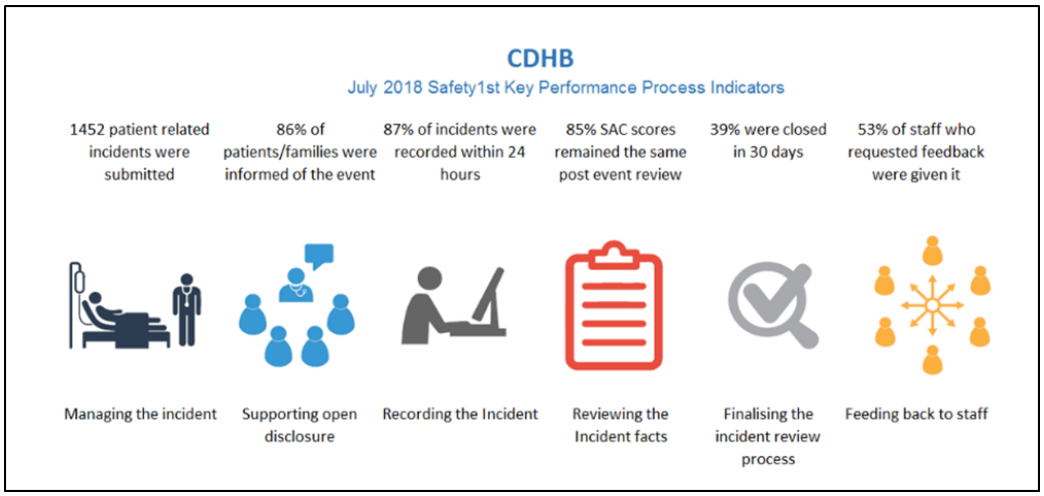




Intentional Rounding initiative based on the 4 P framework asking patients about their experience with their positioning, personal needs, pain and placement. This is currently trialled in two OPH wards as part of the Nursing Service Delivery project (will also tie in with Bedside Handover initiative).

Safe Recovery pilot is currently underway in four OPH wards and is a patient-focused education program aimed at modifying their own intrinsic risk taking behaviour, and empower them with safe strategies for mobilisation and seeking assistance. The pilot will also include the trial use of ex-nursing trained volunteers to deliver part of the education intervention. This is to help consider alternative roles for the large number of volunteers available to the OPH service that may be able to improve patient care

CDHB Inpatient Close Observation policy (and associated Inpatient Close Observation Record) has replaced divisional documentation and is providing clear guidelines for staff to document the rationale for assigning the task for close observation (including the level of observation required). As well as the rationale for discontinuing the need for close observation that can be indicative of a reduced risk of falling.




## Winter Flow

Winter flow continues to be focus for the teams across OPH&R. Beds increased and daily interaction between CHCH Campus and Burwood has maintained the flow. Winter flex (additional beds and staff) have been used and will change at the end of September. During October a review of the winter planning process and outcomes will be undertaken. A report being furnished back to the system on further lessons learnt for the process of planning for winter 2019 actions to benefit from. Planning for Winter 2019 is underway and is part of system planning process.

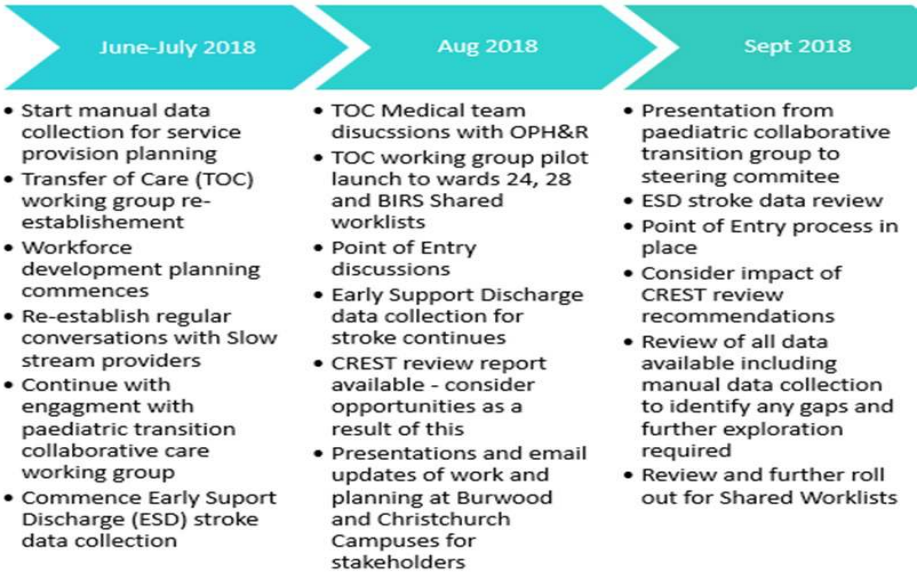
In support of wider system flow a quality improvement piece of work surrounding the OPH CREST team has been undertaken. The review has identified that there are great things occurring within the team and focus however areas where we can make changes to continue to support flow. This has been shared with our CREST team and in partnership with both Planning and Funding and the Community services Service Level Alliance we have also shared

and met with our providers within the community. Further feedback is being sort to enable a focus on the right flow and process will commence during the remainder of the year.

## Adult Rehab Update

The Steering Group have met to review progress with activities and ensuring that we have an understanding and connection to all the connected pieces of work, including CREST Review, ACC/Non Acute Rehab Project, Spinal Cord Impairment Action Plan, Traumatic Brain Injury ACC Contracts, Restorative Care framework development, Community re-design, Technology, Equipment Projects including short term loan and Bariatric, Disability Support Services Meetings. The comprehensive nature of aligning and supporting transformation for an enhanced journey across the system. Work streams have commenced in relation to:

- Transition from child health to adult services – OPH&R continues to contribute to this work stream to support the transition process from paediatric care to adult services.
- Point of Entry – we are currently in week 2 of a pilot using health connect south creating a virtual ward and team for assessment of patients to determine the right location of transfer. The team made up of consultants across the varying services are able to virtually update notes and assessments to make timely and appropriate decision making for rehab, especially complex ones, have a cross service assessment for appropriate care.
- Transfer of Care – enhancing the transfer of care for patients between Christchurch and Burwood Hospitals. Trialling the use of Floview to improve the communication and information transfer. Also looking at the option of trialling Collaborative worklists.
- Workforce – keeping visible the workforce issues across the adult rehab services, whilst we work through the future needs related to the project.
- Funding Pathways for community placements – continuing progress on developing relationships across the stakeholder to understand, identify and address barriers to discharge.
- Stroke patients – exploring options and opportunities in relation to early Supported Discharge opportunities to support patient flow and rehabilitation.

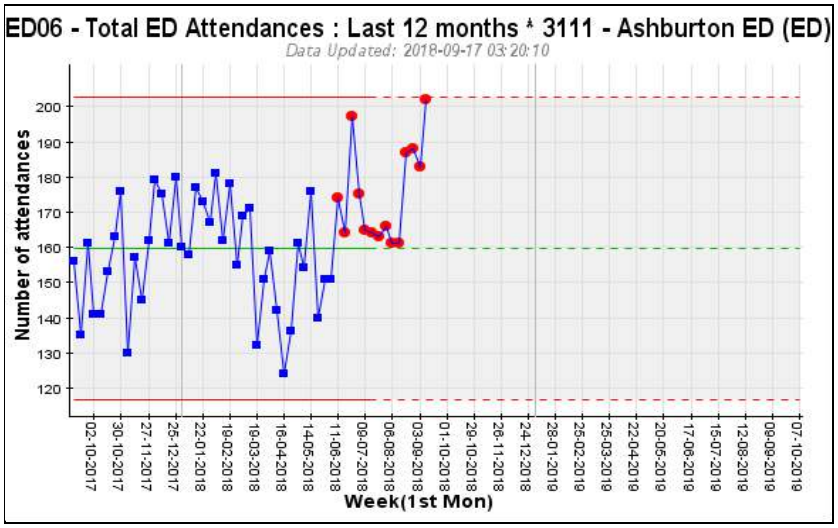



## Ashburton Health Services

**Decreased institutionalisation rates, decreased avoidable mortality**

As previously reported, the hospital team are working closely with our consumers, primary care and community partners to develop our localised Frail Older Persons Patient Journey. The objective in developing the work plan is linking the activities we are bringing together to they ensure they influence the outcome measures agreed to in our CDHB Frail Older Person Pathway.

**Timely access to primary care, timely access to urgent care**




The Acute Assessment Unit (AAU) continues to experience increased presentation volumes, in hours and afterhours. Whilst the above graph incorporates all age groups, Figure 1.7 demonstrates the number of attendances for people over 75 is also increasing. The presentation provided by the Ashburton clinical team at this meeting will outline the complexity of care that is provided in the unit and how these volumes are being managed.

Our primary care colleagues are reporting corresponding increase in presentations to primary care, collectively we continue to investigate options to improve early access to primary care and reduce the pressure in urgent care. This includes improved uptake of Acute Demand in primary care and utilisation of Acute Plans. The objective is to support the practices to identify systematic approaches to improve their utilisation of these programmes, with a specific emphasis on working with their and our nursing teams. The current practice with Home Care Medical (HML) is that all calls are triaged, and appointments made at the primary care practices who is rostered to provide afterhour's clinic on the weekend. The notable concern from HML is the maximum appointments this provides, namely 12, as the clinic is only available for three hours.

In partnership with the Ashburton Service Level Alliance (ASLA), we have explored the concept of vouchers, in line with the current system in place in Christchurch and Burwood as part of the winter plan response. Initial feedback from primary care was cautious. It was agreed we need to be clear how the voucher would reduce pressure on the system, given both areas are experiencing high demand. The AAU were responsive to a system that reduced repeat presentations, but in reviewing our data on presentations we could not identify this as significant issue. The AAU team raised concerns that the voucher could create a perverse incentive, that patients presented to the unit for initial assessment with the anticipation they also gain a voucher for free primary care.

Our complaints regarding waiting times continue to be the significant outlier, compared to other areas. Comments consistently report satisfaction with level of care, but we need to build on communication about the wait time. We are wanting to complete further work with our consumer forum about expectations when attending the unit and how this is different than attending a general practice appointment.

**The patient perspective**

We have undertaken a patient feedback process in an attempt to understand the key drivers on why patients are presenting to the Assessment Unit. We record the reason for presentation as part of our clinical reporting process, but this information is defined by our system or clinical information and does not include the patient's perspective.

Our initial effort was to adapt the presentation from asking the patient "what brought you here today" Our first attempt recognises we need to reshape the question, but information gathered identifies an interesting trend that patients consider the AAU as the best place to provide their treatment. We were surprised that cost was not the most significant driver, which we had assumed it would be higher on the list.

| What brought you here | August | September |
|---|---|---|
| | | |
| Home Care Medical referred me | 23 | 31 |
| GP referred me | 49 | 40 |
| No available Clinic at GP | 13 | 20 |
| Cost | 5 | 0 |
| Ambulance | 60 | 59 |
| Chch Hospital | 1 | 3 |
| Other | 11 | 12 |
| Self - best place for me | 62 | 199 |
| Total | 224 | 364 |

Our consumer forum has discussed and provided some feedback to reshape the questions slightly. We will continue to gather and report this information to our clinical governance team and the ASLA with the objective of it influencing our communication plans and intervention activities.

**Rapid Access to assessment**

To enhance our NASC (Needs Assessment Service Coordination) team, one of our social workers has recently trained and able to progress InteRai assessments. Often the social worker is involved with patients experiencing complex social issues in the change in care requirements, it is a natural fit to carry on with the InteRai assessment rather than pass on this component.

The Gerontologist has settled into her role providing a clinic in Ashburton once a fortnight. There has been a number of changes in the virtual "older persons health team" in Ashburton, the team are working on a collective approach to triage, updating the primary care health pathways and meeting with local primary care providers. Ongoing feedback continues to identify the increasing challenge in community and acute presentations with older persons mental health support.

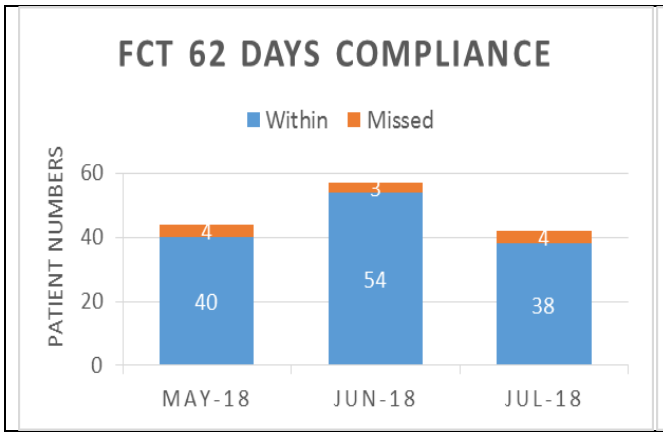
We are also facing an increasing challenge in people identified as requiring hospital level aged residential care wanting to locate to an Ashburton facility, but we are unable to identify a general practice to accept them for enrolment as ongoing care provider. This includes people moving back to be closer to family, or moving from the outer rural areas. This has resulted in unsolicited increase in people moving into our Tuarangi facility, as medical cover is provided via the Rural Hospital Medical Specialist. Frustrations are experienced by family, complaints are laid by the private Aged Residential Care (ARC) Facilities. The Ashburton Health Services community team have been impressed with the ARC Nurse Liasion role that Three Rivers Medical centre have established. This role works on behalf of the general practice visiting the patients within the ARC facilities managing the careplans and liaison with the practice. Through the SLA we are exploring how this can be expanded and other practices combine to introduce a similar model and subsequently may be able to enrol more patients.

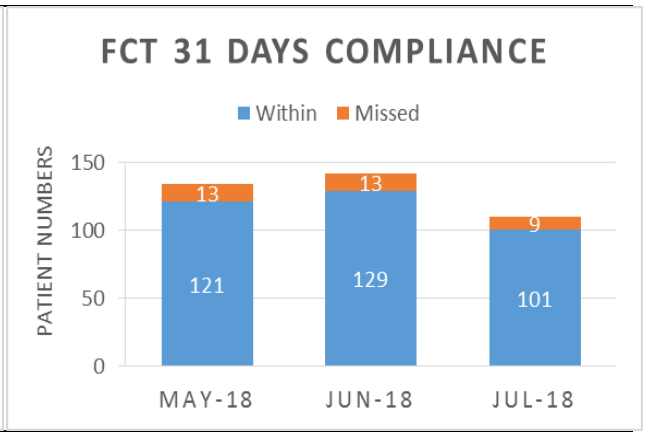

*Outcome and Strategy Indicators*

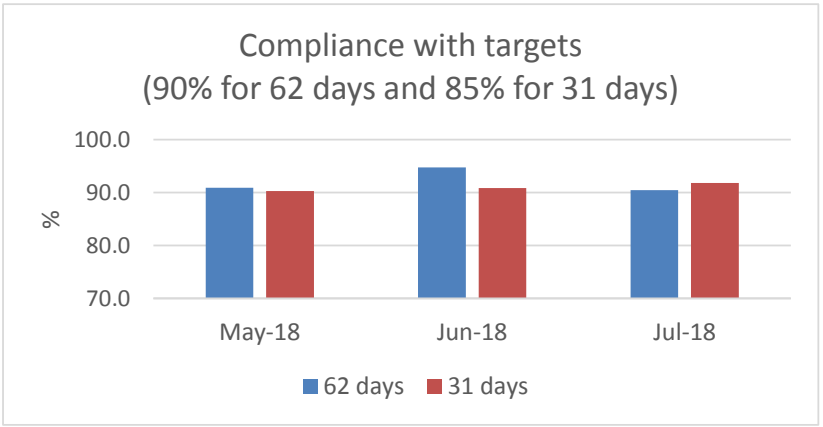
## Key Outcomes - Faster Cancer Treatment Targets (FCT)

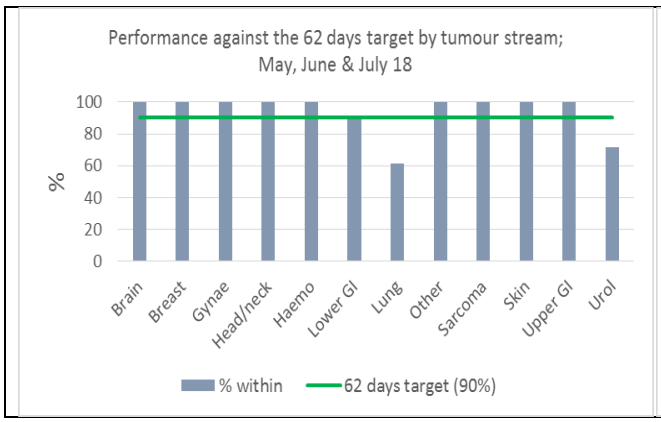
**62 Day Target.** For the 3 months of May, June and July 2018 Canterbury District Health Board submitted 167 records to the Ministry with 35 missing the 62 days target. Of these 24 missed the target through patient choice or clinical reasons leaving 143 patients included in the target cohort. Canterbury District Health Board once again met the target of having at least 90% of patients receive their first treatment within 62 days of referral with 92.3 % of eligible patients being treated within 62 days.

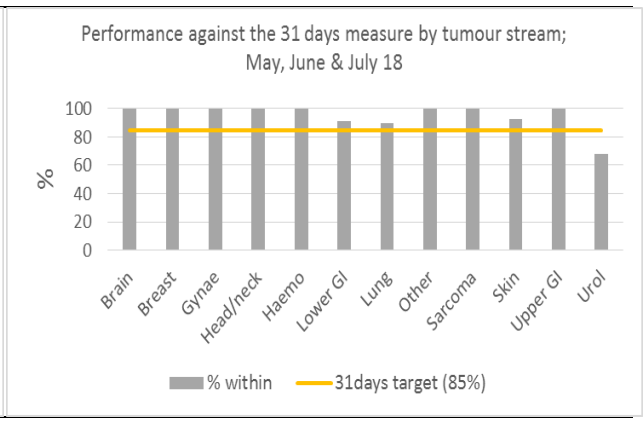
**31 Day Performance Measure.** CDHB submitted 386 records towards the 31 day measure in the same 3-month period. Unlike the 62 days target all reasons for missing the target are included: there are no exceptions made for patient choice or clinical considerations but the threshold remains at 85%. With 90.9% of eligible patients receiving their first treatment within 31 days from a decision to treat, the CDHB met the 85% target.

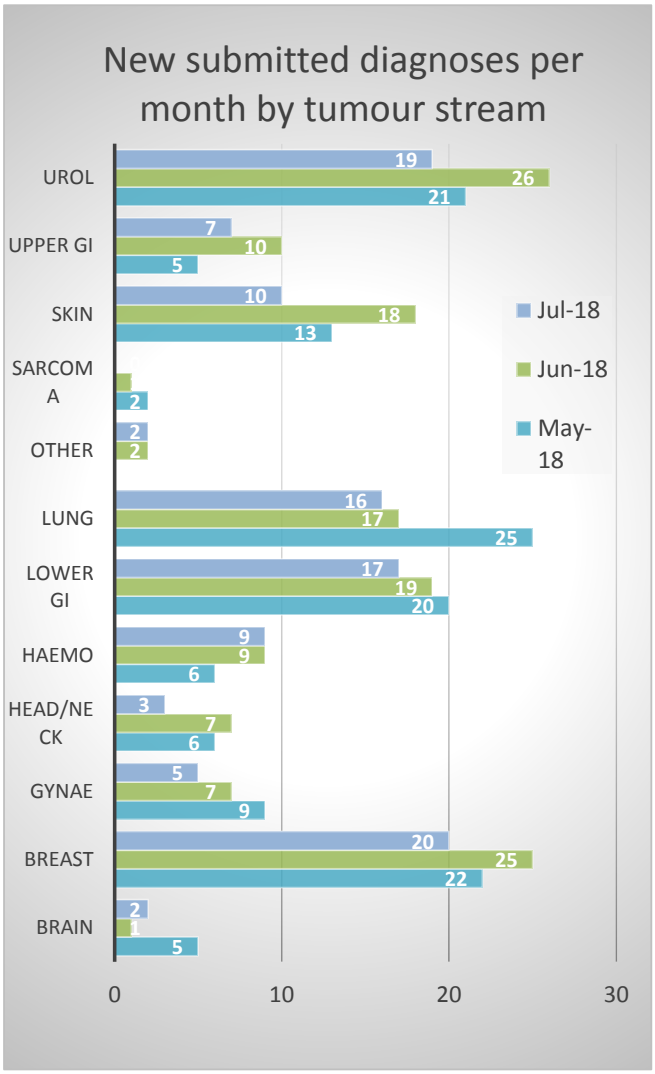




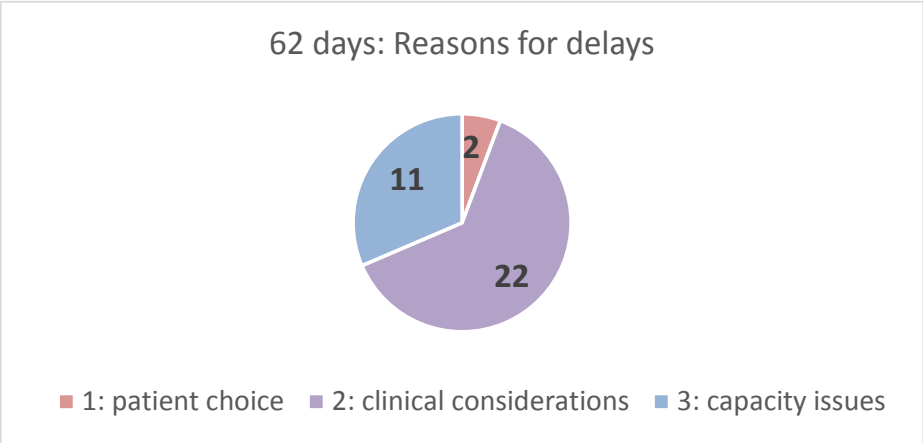

## Patients who miss the targets

The Ministry of Health requires District Health Boards to allocate a “delay code” to all patients who miss the 62 days target. There are 3 codes and only one can be used even when delay is due to a combination of circumstances.In this circumstance the reason that caused the most delay is the one chosen.

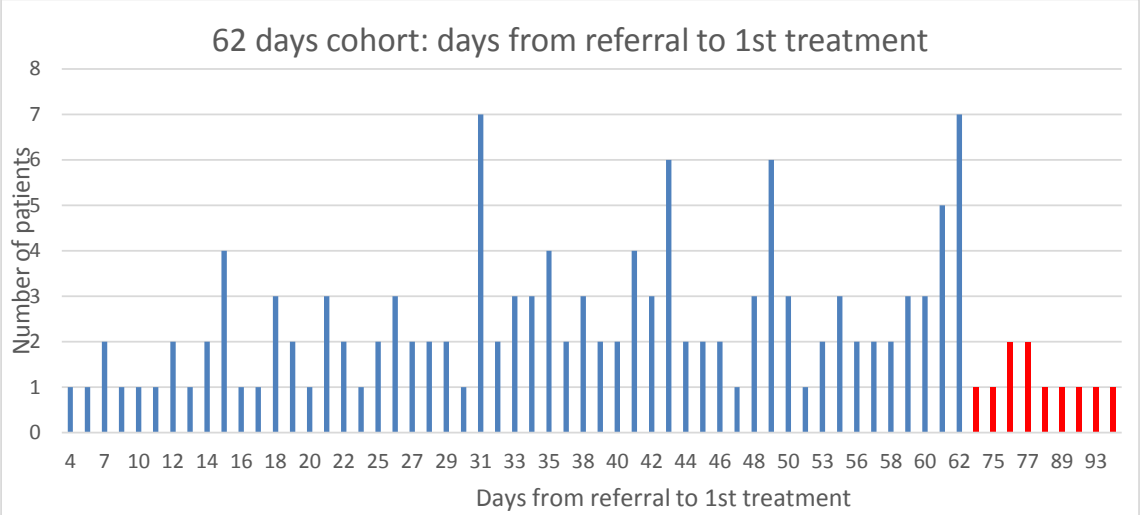
The codes are:

1. Patient choice: e.g. the patient requested treatment to start after a vacation or wanted more time to consider options

2. Clinical considerations: includes delays due to extra tests being required for a definitive diagnosis, or a patient has significant co-morbidities that delays the start of their cancer treatment
3. Capacity: this covers all other delays such as lack of theatre space, availability of key staff and process issues.




Patients who missed the 62 days target and were non-compliant through choice or because of clinical considerations are not included in the graph below, aligining it with MoH reporting requirements.




Each patient that does not meet the target is reviewed to see why. This will have happened in order to assign a delay code, but where the delay seems unduly long then a more in-depth check is performed. These cases are usually discussed with the Service Manager to see if any corrective action is required.

## Improved booking of new head & neck cancer patient appointments

We discovered that there was variation in waiting times between Radiation Oncologist First Specialist Assessments and booking for Computed Tomography scans for patients living outside of Christchurch and referred to Christchurch for treatment for head and neck cancer.

Referral letters are now scanned into, the information system used within Oncology, notifying Radiation Oncologists that patients from out of town are booked into their clinics.

Providing this information has improved coordination of radiotherapy simulation and other appointments that those patients have with other specialties. Following this change in practice the average time between the Radiation Oncologist First Specialist Assessment and Computed Tomography scan decreased by 1.8 days and the average time between the Radiation Oncologist and Medical Oncologist First Specialist Assessments decreased by 5 days between 2017 and 2018.

## Radiation Oncology - new electronic booking form

A stand-alone system has been used to refer patients being seen by the Oncology Service for radiation treatment. This involved e-mailing appointment booking forms to the booking coordinators who then manually entered this information into the system used to manage our radiation oncology processes. Human error such as incorrect transcription of information including patients' National Health Index number has been an intermittent problem. Along with this the stand-alone system was not available in peripheral clinics and visibility of the referral information was relatively restricted within the department. In order to fix these problems, an electronic solution has been introduced where booking forms are generated within patients' health records. This means that the process is more efficient, streamlined, with all bookings aligned with demographic data and the patient's clinical record. Referrals are visible to all staff and access is universal. This is in line with our paperlite approach, ensuring that the right information is provided at the point that it is required.

## Stereotactic Radiation Therapy for brain metastases

In 2017 the standard of care at Christchurch Hospital for patients with brain metastases was to treat the whole brain with radiation. New research published showed better patient outcomes with similar disease control and survival rates could be achieved using stereotactic radiation therapy to focus radiation on the tumour and tumour bed only.

A group leading the implementation of this approach, involving all key stakeholders, has assessed the resource requirements, upskilling requirements, led implementation and evaluated this change in practice.

The process has been evaluated and refined after each patient and is now fully implemented for single brain metastases. We are continuing to develop the technique, meaning we can now offer it to more complex patients.

## Improved radiation therapy technique for breast cancer

The existing standard of care when providing radiation treatment to the breast, nodes and internal mammary chain involved patients being treated with a sequence of around six treatment beams, using a custom made shield to define the shape of the treatment area. The treatment appointments took around one hour a day for 25 days. The creation of the custom made shield, or cutout, takes approximately 30-40 minutes with additional time for checks and was made with a toxic material that requires careful handling throughout treatment to avoid staff exposure. It complicated the treatment process and was cumbersome to mount part way through the treatment.

A group made up of Radiation Oncologists, Radiation Therapists and Physicists has worked together to research and implement Volumetric Modulated Arc Therapy (VMAT), a type of Radiation Therapy that delivers a precisely shaped dose of radiation. This method was introduced for patients receiving radiation treatment to the breast, nodes and internal mammary chain.

It has:

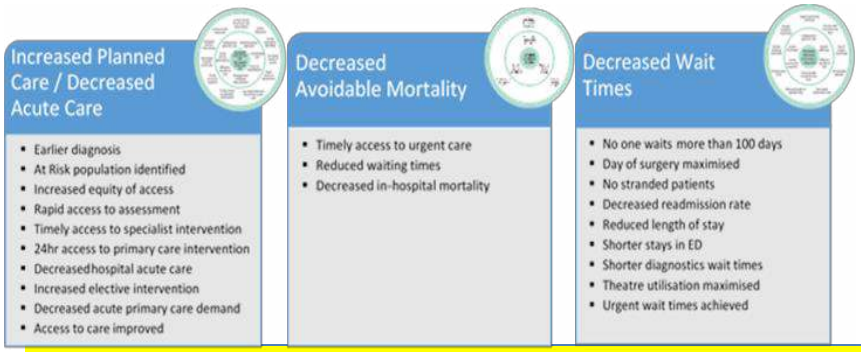
- Saved patients time and minimised the time spent in an uncomfortable treatment position;
- Reduced daily appointments to 30 minutes (a reduction of 50% / 12.5 hours of linac time per treatment course);
- Removed the need to handle toxic Cerrobend;
- Saved Radiation Therapist time involved in creating the cut out and mounting it during treatment;
- Reduced the risk of under/over dosing;
- Brought Christchurch in to line with the treatment delivered at other NZ centres.

## Scientists identify bacteria likely to cause bowel cancer

New Zealand scientists led by a Canterbury District Health Board surgeon, have identified a toxic bug they believe may cause bowel cancer and could lead to a life-saving vaccine or early detection test for the too-often deadly disease. The University of Otago, Christchurch, researchers found a toxic form of a bacteria called *Bacteroides fragilis* in the gut of almost 80 percent of people with a pre-cancerous lesion – a precursor to the disease. *Bacteroides fragilis* is a common bug in our gut, and for the most part, helps with digestion and the general health of the colon. However in some people the bug produces a toxin that disrupts the cells that line the gut and starts the process of cancer in the bowel.

More than 1,300 New Zealanders die of bowel cancer every year. The disease is becoming increasingly common in people under the age of 50, which could be due to changes in our diet. Diet has a direct influence on our gut health, and the microorganisms living there. A Canterbury DHB bowel cancer surgeon describes the study findings as a 'game-changer'. "It gives us a clue as to what is actually driving the cancer, and in doing so, it gives us a possible means of being able to manage it." With further time and money, the discovery could be used to screen for people with the bug, and it could be used to develop a lifesaving vaccine.

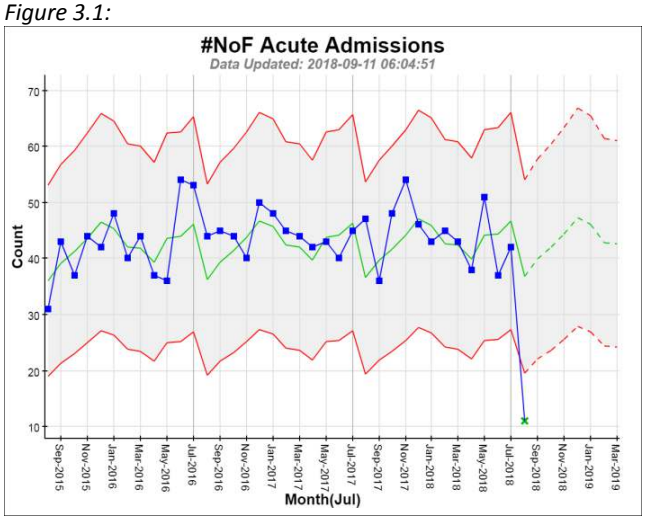
In another breakthrough, Frank and his team were first to show differences in the gut microbiome were linked to different types of bowel cancer. The discovery could mean in future clinicians can give patients the treatments, surgery or medications shown to work best for particular types of cancer.




Enhanced Recovery After Surgery (ERAS)

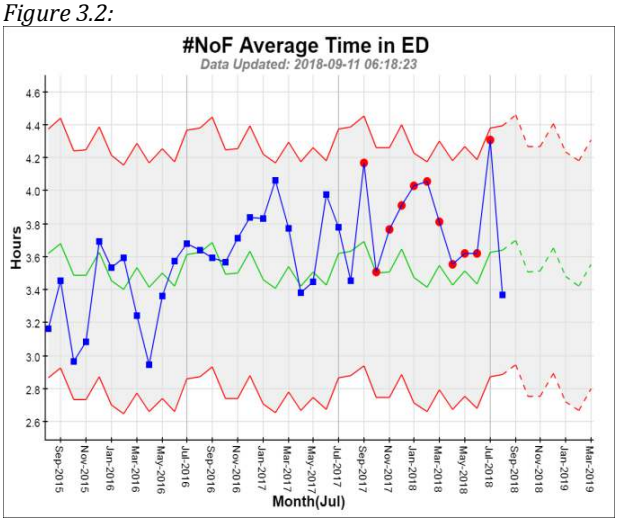
*Outcome and Strategy Indicators – Fractured Neck of Femur (#NoF)*

*Figure 3.1:*



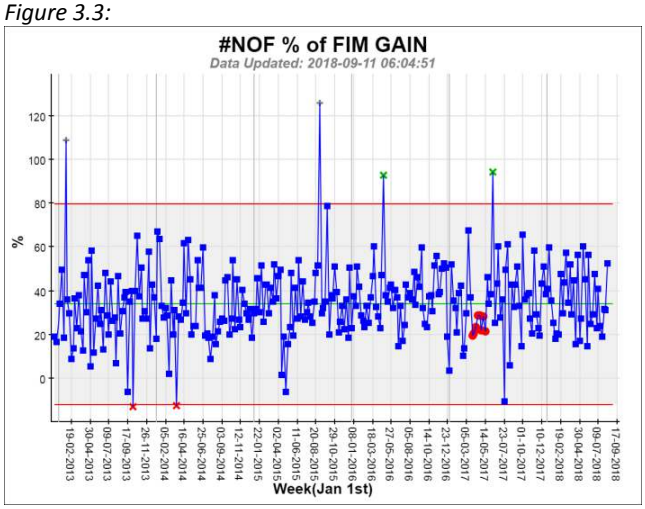

The number of #Nof admissions per month continues at the expected rate. The apparent reduction in August is expected to correct when all discharges are coded.

*Figure 3.2:*



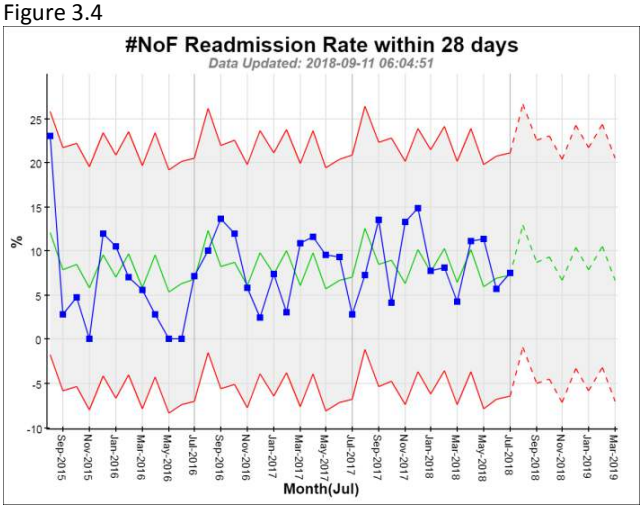

Patients with #NOF show a variable length of stay in ED. The red signals show that a statistically significant increase in the time spent in ED has occurred.

*Figure 3.3:*




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

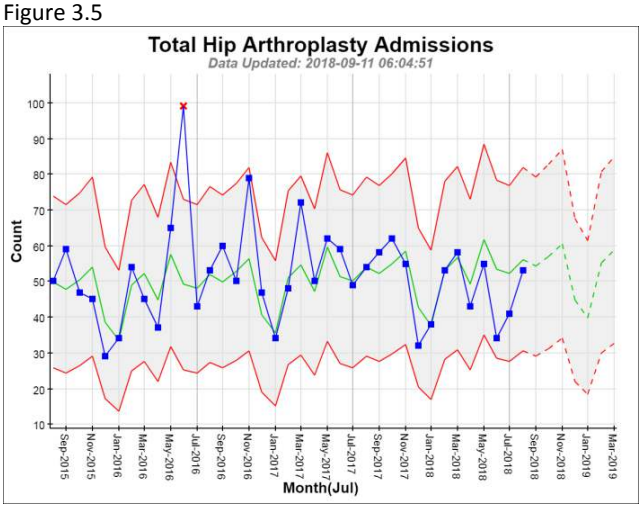
Figure 3.4




Readmissions continue to remain within expected mean values.

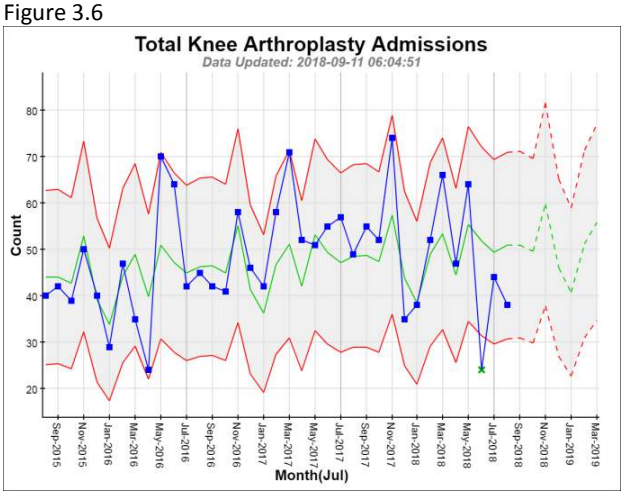
## *Outcome and Strategy Indicators – Elective Total Hip Replacement(THR) and Knee Replacement(TKR)*

Figure 3.5



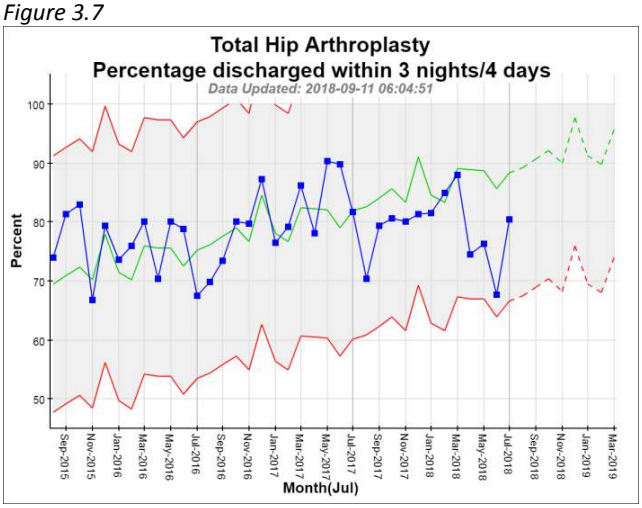

In recent months hip replacements have been tracking within projected levels.

Figure 3.6



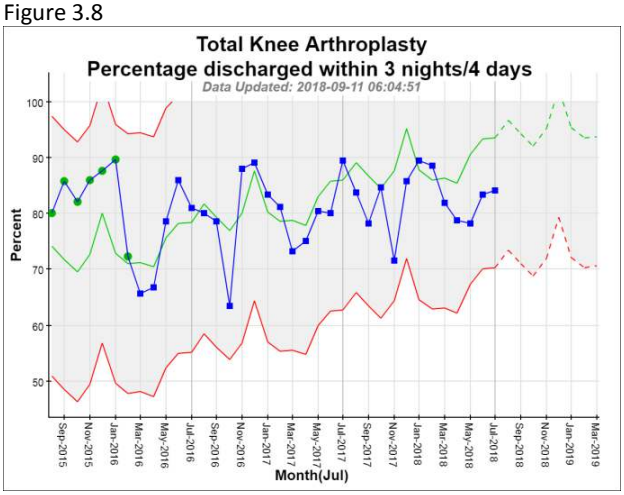

Knee replacement admissions over the previous twelve months have been at or above projected levels, with the exception of June 2018 when it was significantly lower than forecast.

*Figure 3.7*



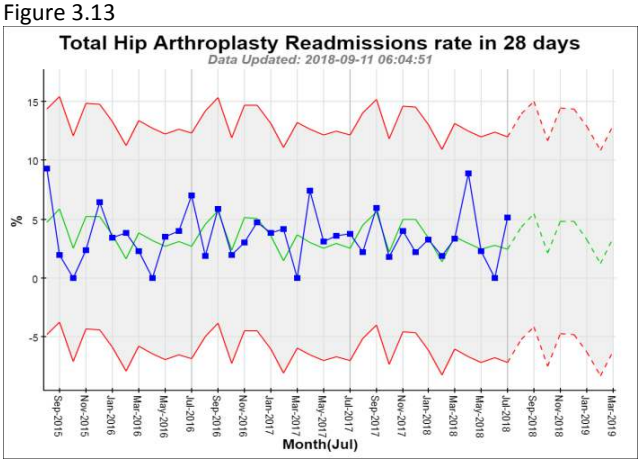

The proportion of patients clinically safe to be discharged within 3 nights/4 days is within the forecast range.

Figure 3.8



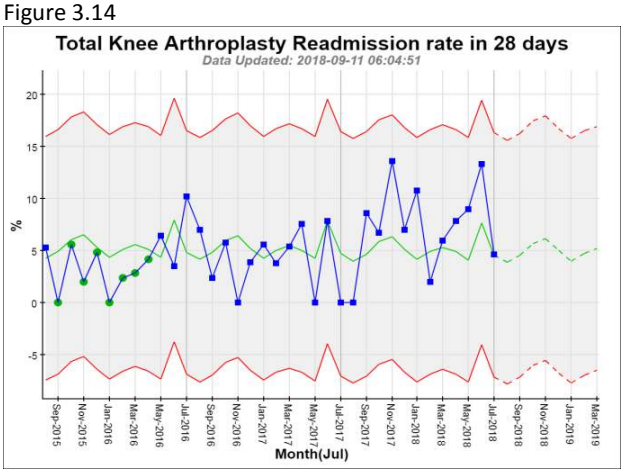

The proportion of patients clinically safe to be discharged within 3 nights/4 days is following established, increasing trend.

Figure 3.13




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

Figure 3.14




Readmission rates are maintaining within tolerances.

*Achievements/Issues of Note*

## ERAS

Overall trend for both Elective Hips and Knees seeing improvement in the percentage of patients discharged within the target (refer Fig 3.7 & 3.8). While achieving a good consistency, we continue to audit outcomes as a balancing metric. Readmissions range has narrowed demonstrating further consistency in our approach. We have made changes to theatre access for Orthopaedics which will make changes to fractured neck of femur (#NOF) surgery. An additional ten sessions have been made over the four week schedule. The changes will support flow to theatre with additional capacity. The flow on effect will be a reduction in elective sessions converted at Burwood Hospital to accommodate increased acute activity. During the 2017/2018 year over 350 acute cases were undertaken at Burwood.

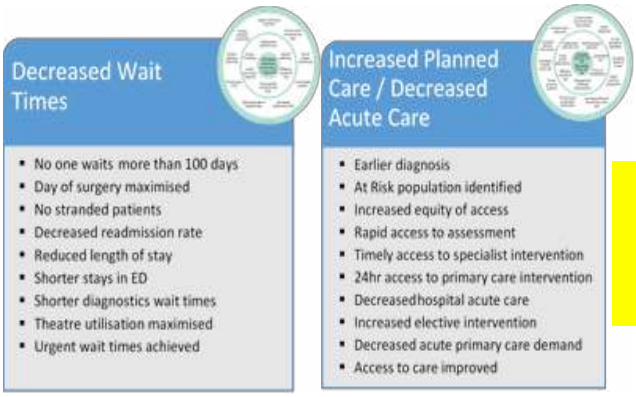
## Spine Service

Work continues with the spine service delivery. Changes to our orthopaedic acute rosters have resulted in the separation of spine acute trauma and general acute trauma. This is to maximise our constrained resources of spine surgeons into their sub specialty roster. Ongoing work is occurring around our elective capacity which is significantly reduced. Recruitment plans include the advertising through the NZ and Canadian Orthopaedic Society in an effort to source additional spine surgeons. A joint work group with the Ministry of Health and NZ Orthopaedic Association is occurring with representation from Canterbury and Waikato DHB to look at future workforce and focus areas.

## Review of Colorectal pathways to further enhance recovery after surgery

Several years ago two pathways to enable enhanced recovery after colorectal surgery were introduced by General Surgery. This provided for a more predictable patient journey and supported a faster recovery for patients. A systematic review of the literature has recently been carried out by one of our senior registrars and discussed by the department. Based on this the service is updating its colorectal pathways with input from the range of workforce groups that provide care to this group of patients. Our quality facilitator has collated all existing data in this area, this will be used as a comparator as the new pathways are implemented and fine-tuned.

A further update will be provided as these changes are introduced and take effect.




# Elective Surgery Performance Indicators 100 Days

## *Outcome and Strategy Indicators*

*Figure 4.1:*

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

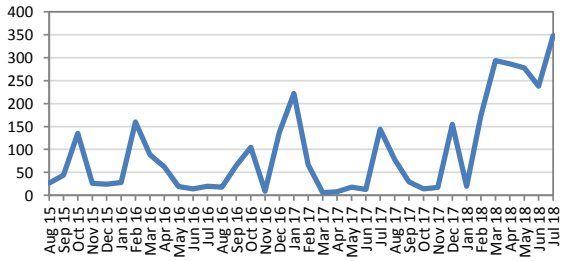



*Figure 4.2:*

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

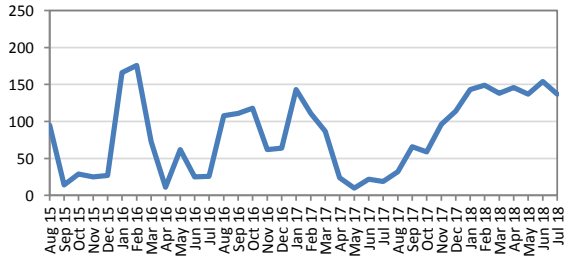



*Figure 4.3:*

**ESPI 2 Result By Specialty – Surgical**

| Specialty | Number | % | Change |
|---|---|---|---|
| Cardiothoracic | 0 | 0.0% | 0 |
| ENT | 113 | 8.3% | 98 |
| General Surgery | 0 | 0.0% | 0 |
| Gynaecology | 1 | 0.1% | 1 |
| Neurosurgery | 0 | 0.0% | 0 |
| Ophthalmology | 3 | 0.4% | 1 |
| Orthopaedics | 16 | 8.8% | -7 |
| Paediatric Surgery | 0 | 0.0% | 0 |
| Plastics | 8 | 2.2% | 6 |
| Urology | 23 | 2.7% | -11 |
| Vascular | 14 | 5.7% | -13 |

**ESPI 2 Result By Specialty - Medical**

| Specialty | Number | % | Change |
|---|---|---|---|
| Cardiology | 0 | 0.0% | 0 |
| Dermatology | 0 | 0.0% | 0 |
| Diabetes | 0 | 0.0% | 0 |
| Endocrinology | 5 | 2.3% | 1 |
| Endoscopy | 0 | 0.0% | 0 |
| Gastroenterology | 128 | 23.6% | 5 |
| General Medicine | 0 | 0.0% | 0 |
| Haematology | 0 | 0.0% | 0 |
| Infectious Disease | 0 | 0.0% | 0 |
| Neurology | 0 | 0.0% | -2 |
| Oncology | 0 | 0.0% | 0 |
| Paediatric Medicin | 34 | 7.8% | 28 |
| Pain | 0 | 0.0% | 0 |
| Renal | 1 | 1.9% | 1 |
| Respiratory | 2 | 1.1% | 2 |
| Rheumatology | 0 | 0.0% | 0 |

*Figure 4.4*

**ESPI 5 Treatment by Specialty**

| Specialty | Number | % | Change |
|---|---|---|---|
| Cardiothoracic | 3 | 7.3% | 0 |
| Dental | 1 | 0.7% | 0 |
| ENT | 5 | 1.3% | -13 |
| General Surgery | 4 | 1.1% | -3 |
| Gynaecology | 1 | 0.3% | -2 |
| Neurosurgery | 0 | 0.0% | 0 |
| Ophthalmology | 10 | 2.5% | 5 |
| Orthopaedics | 93 | 15.6% | 0 |
| Paediatric Surgery | 2 | 2.3% | 1 |
| Plastics | 3 | 0.4% | 3 |
| Urology | 0 | 0.0% | -1 |
| Vascular | 12 | 21.8% | 4 |
| Cardiology | 3 | 1.4% | 0 |

## ESPI Results

**Waiting > 120 Days**

| | Number | % | Status |
|---|---|---|---|
| ESPI 2 (FSA) | 348 | 3.6% | |
| ESPI 5 (treatment) | 137 | 3.7% | |

*Achievements/Issues of Note*

## Elective Services Performance Indicator (ESPI) Outcomes

Latest preliminary reporting from the Ministry of Health shows that Canterbury District Health Board achieved a red result for elective services performance indicator two (covering first specialist assessment) at the end of July 2018. This is the sixth month that this indicator has shown as red.

The same report shows that Canterbury District Health Board achieved a red result for elective services performance indicator five (covering waiting time for surgery) at the end of August 2018 for the twelfth month in a row. The Ministry of Health has provided Canterbury District Health Board with dispensation for Elective Services Performance Indicator achievement between January 2018 and June 2019 to recognise the pressures associated with facility limitations and issues associated with data transition. These measures will continue to be published and Canterbury District Health Board remains committed to working towards its goal that patients will not wait longer than 100 days for elective services they have been offered.

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

## Antenatal Physiotherapy group classes

Women are provided with information teaching specific strengthening and stretching exercises by a physiotherapist during their antenatal period. However demand for these services often meant that there was a waitlist for this service that constrained other aspects of the care we provide during this time.

In order to improve this we are now offering this information as part of a group session. Five sessions are provided every four weeks – with a combined capacity of 36 women. There is at least one physiotherapist or assistant for every three women. Midwives are encouraged to refer women to these classes as soon as possible.

Information provided includes a short educational presentation that is followed by tuition on specific strengthening and stretching exercises. Women then receive an individual assessment and are provided with an opportunity to ask questions about strategies to self-manage for their personal situation. If necessary, women are provided with a one on one follow-up appointment and are supported to phone the physiotherapy department themselves if they require a follow-up until six weeks following childbirth without requiring a new referral.

This has enabled us to improve patient flow and reduce our waitlist time. We aim to have each woman in a group within 3 weeks of receipt of referral.

## Keeping patients up to date with parking information

Recent changes to parking availability for patients attending appointments at Christchurch Hospital highlighted the importance of being able to provide up to date information to patients. Relying on traditional methods, providing printed material via the post, is not agile enough and creates a risk that patients will not have up to date information when they come to their appointment.

Patient appointment letters encourage people to use one of two sources of information to find the most up to date information. For patients that have internet access comprehensive, up to date parking information is found at cdhb.health.nz/parking including information about shuttle services, how to pay for parking, drop off zones, mobility parking and alternative transport options. For other patients a dedicated Christchurch Hospital Car Park Information Line 0800 555 300 has been established, enabling patients to make a free call and listen to the latest Christchurch Hospital Car Park Information. This provides information about where to park, access to and operating hours of shuttles that run between the car park and hospital. The new phone service was introduced on 13th June 2018. Over the subsequent 11 weeks 513 calls were made to the service.

## Pre-exposure prophylaxis for Human Immunodeficiency Virus

In March 2018 PHARMAC announced it would fund pre exposure prophylaxis medication for HIV from April. This was well publicised and potential clients were keen to receive this care, so the pressure was on the Sexual Health Service had to develop an effective model of care within a month. Initial prescriptions must be written by a named specialist and subsequent prescriptions can be made by suitably trained GP's. Patients must have testing for HIV,

syphilis, a full Sexually Transmitted Infection (STI) screen and renal function testing in the two weeks before the prescription is given.

To reduce the time taken for each visit the Service developed a sampling kit which enables clients to do testing (not involving blood) at home and take their sample kit to Canterbury Health Laboratories for processing. Canterbury Health Laboratories have been extremely helpful in helping the Service in developing the service change. Building the General Practitioner prescriber capacity has involved working with Infectious Diseases Service and Canterbury Initiative to develop and provide small and large group General Practice teaching sessions put written material on Health Pathways. This range of activity has meant that we have managed to avoid generating a waiting list for this specialist service.

## Sexual Health Test 'N Go Clinic

To meet increased demand within existing resources the Sexual Health Service has developed a streamlined testing model for sexually transmitted infection checks on asymptomatic patients. Test 'N Go is fast paced clinic that enables patients to be screened sooner with minimal waiting time. Various times and days of the week have been trialled to ensure this clinic is scheduled on the optimal day. Patients have been surveyed and have communicated that they are delighted with the lack of waiting time and the 'can do attitude' from the staff. This initiative has not required any increase in staff resources as it uses the available staffing in a more productive way and has helped to reduce the overall non-attendance rate at the Sexual Health Clinic.

## Urology Clinics

Patients receiving care from specialist services often require a number of tests and procedures that are provided by other services. This can mean that it takes some time for a patient to receive a diagnosis and intervention which is frustrating for patients. It can mean that patients spend significant time at a range of appointments.

To help address this, the Urology service has implemented an additional service within certain clinics that help reduce the wait time for patients that need help with stress incontinence. Stress incontinence is the unintentional loss of urine and occurs physical movement or activity puts pressure, or stress, on the bladder.

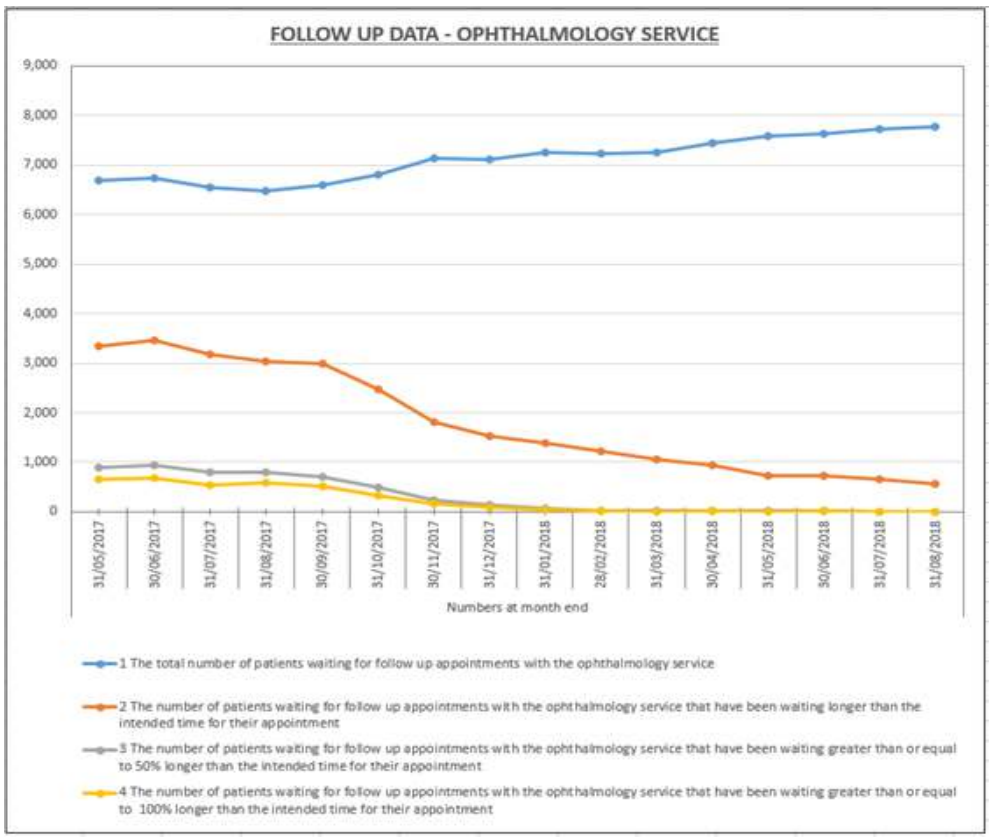
The Urology team wanted to help patients move through their diagnosis and treatment more quickly and so has set up a specific clinic that incorporates the use of ultrasound scanning to assist with the diagnostic process.

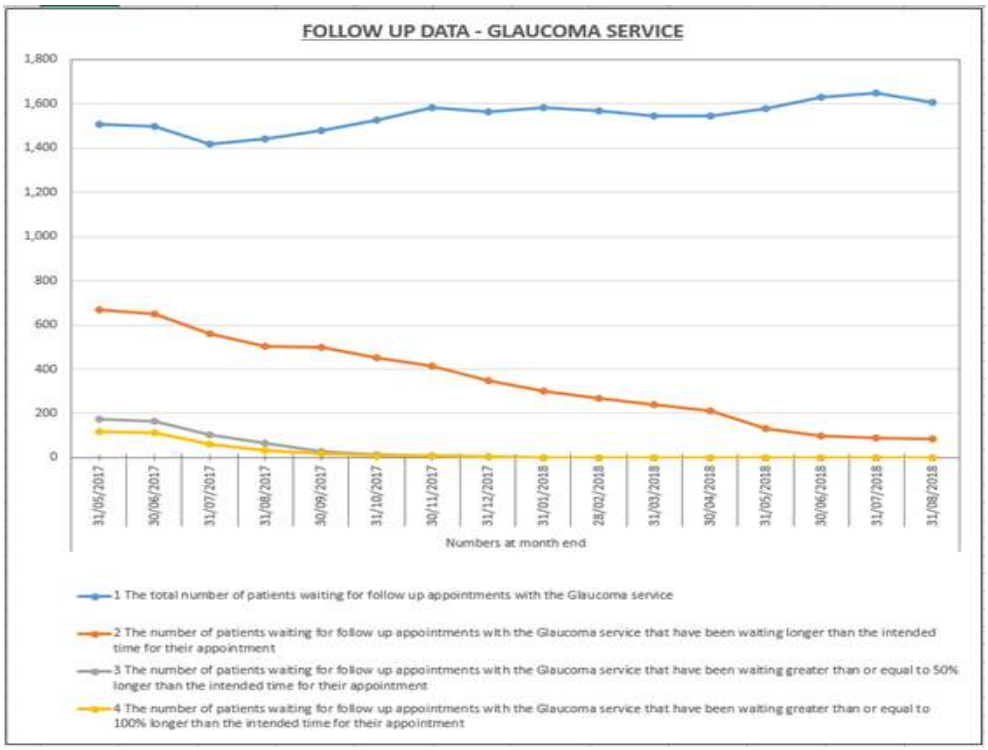
These clinics continue to provide this service to up to six patients per month and continues to improve patients' flow through our health system by reducing the need for extra procedures with different departments.

## Eye Health Project

An update was provided in the March report providing information about some improvements in the follow-up of people with glaucoma at the CDHB eye department. This was a result of a project that the Ministry of Health contributed to following a recognition that there was a nationwide problem in the follow-up of this disease. While the aim of the project was to address the glaucoma backlog a systematic approach was taken to all of the work carried out in the eye service as it was recognised that you cannot succeed in addressing this problem without making improvements in the way that we approach our work across the service.

The figures provided in the March report related solely to those people with glaucoma, whereas this update provides a fuller picture focussing on all people waiting for follow-up care in the eye department. Long term care is required for a number of eye diseases including glaucoma and macular degeneration.




At the beginning of the project 6,688 people were waiting for follow-up appointments. 3,347 (50%) were waiting longer than the intended time for their appointment. Of these 886 (13%) were waiting at least as much as 50% longer than intended, with 649 waiting 100% longer than intended. Of those patients who were overdue and seen in the additional follow-up clinics, 102 patients (5%) had experienced some level of harm as a result of having waited longer than intended.

In order to address this a number of changes have been introduced to systems used within the Eye Department, these include:

- Information entered into our system about follow-up dates and the level of priority assigned to them has been improved;
- Systems have been developed to enable collection and storage of all relevant clinical outcome information. This enables the department to have any suitable Senior Medical Officer (SMO) see patients at their appointments, thus improving waitlist management;
- All patients booked from one waitlist to provide equity of access and ensure follow-up times are met;
- Triage criteria have been tightened to match the resource available;
- Models of care have been developed that provide a clear schedule covering which health professionals in the team patients see at each point in their journey. This frees up clinician time,saves patient time, and provides greater scope for ensuring patients are reviewed on time. The model includes technical staff running tests and reviewing results within local guidelines. The system is overseen by an SMO.
- The glaucoma model of care includes clearer referral and triage criteria.
- A production planning system is being developed that supports planning required resource capacity to meet forecast needs, and monitoring of our performance. Work is also underway to ensure that the department's information technology needs are well defined.

Along with these systematic changes we have put in place [temporary] additional senior medical officer capacity and increased technical staff numbers in order to address the existing backlog.

ALL OPHTHAOLMOLOGY

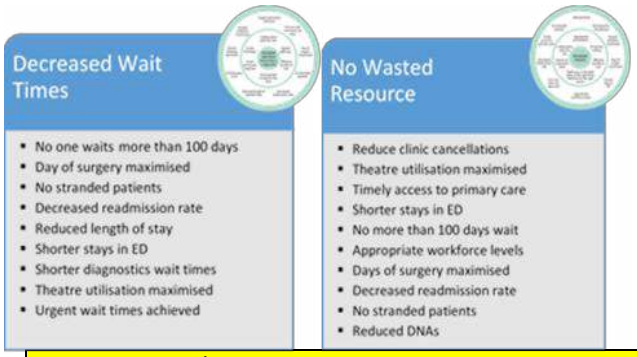
| FOLLOW UP DATA - OPHTHALMOLOGY SERVICE | | Numbers at month end | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Indicator | Description | 31/05/2017 | 30/06/2017 | 31/07/2017 | ..... | 30/06/2018 | 31/07/2018 | 31/08/2018 |
| 1 | The total number of patients waiting for follow up appointments with the ophthalmology service | 6,688 | 6,735 | 6,552 | | 7,641 | 7,737 | 7,764 |
| 2 | The number of patients waiting for follow up appointments with the ophthalmology service that have been waiting longer than the intended time for their appointment | 3,347 | 3,453 | 3,190 | | 719 | 649 | 553 |
| 3 | The number of patients waiting for follow up appointments with the ophthalmology service that have been waiting greater than or equal to 50% longer than the intended time for their appointment | 886 | 937 | 787 | | 20 | 2 | 3 |
| 4 | The number of patients waiting for follow up appointments with the ophthalmology service that have been waiting greater than or equal to 100% longer than the intended time for their appointment | 649 | 692 | 547 | | 11 | 1 | 1 |
| 2 | Percentage of patients waiting for FU with the ophthalmology service waiting longer than the intended | 50.0% | **51.3%** | 48.7% | | 9.4% | 8.4% | **7.1%** |
| 3 | Percentage of patients waiting for FU with the ophthalmology service waiting greater than or equal to 50% longer than the intended | 13.2% | **13.9%** | 12.0% | | 0.3% | 0.0% | **0.0%** |
| 4 | Percentage of patients waiting for FU with the ophthalmology service waiting greater than or equal to 100% longer than the intended | 9.7% | **10.3%** | 8.3% | | 0.1% | 0.0% | **0.0%** |

GLAUCOMA ONLY

| FOLLOW UP DATA - GLAUCOMA SERVICE | | Numbers at month end | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Indicator | Description | 31/05/2017 | 30/06/2017 | 31/07/2017 | ..... | 30/06/2018 | 31/07/2018 | 31/08/2018 |
| 1 | The total number of patients waiting for follow up appointments with the Glaucoma service | 1,508 | 1,499 | 1,417 | | 1,629 | 1,648 | 1,608 |
| 2 | The number of patients waiting for follow up appointments with the Glaucoma service that have been waiting longer than the intended time for their appointment | 668 | 650 | 561 | | 97 | 91 | 82 |
| 3 | The number of patients waiting for follow up appointments with the Glaucoma service that have been waiting greater than or equal to 50% longer than the intended time for their appointment | 176 | 166 | 101 | | 0 | 0 | 0 |
| 4 | The number of patients waiting for follow up appointments with the Glaucoma service that have been waiting greater than or equal to 100% longer than the intended time for their appointment | 115 | 113 | 62 | | 0 | 0 | 0 |
| 2 | Percentage of patients waiting for FU with the Glaucoma service waiting longer than the intended | 44.3% | **43.4%** | 39.6% | | 6.0% | 5.5% | **5.1%** |
| 3 | Percentage of patients waiting for FU with the Glaucoma service waiting greater than or equal to 50% longer than the intended | 11.7% | **11.1%** | 7.1% | | 0.0% | 0.0% | **0.0%** |
| 4 | Percentage of patients waiting for FU with the Glaucoma service waiting greater than or equal to 100% longer than the intended | 7.6% | **7.5%** | 4.4% | | 0.0% | 0.0% | **0.0%** |

At the end of the project the total eye department waiting list had increased to 7,641. Those waiting longer than intended had reduced to 719, almost a fifth of the starting value. 20 (0.3%) of these were waiting at least as much as 50% longer than intended, 11 for at least twice as long as intended. Within this there are no people with glaucoma waiting for 50% or more longer than the intended time.

The service now has a robust, systematic approach to the work it does that enables planning and monitoring of its workload.



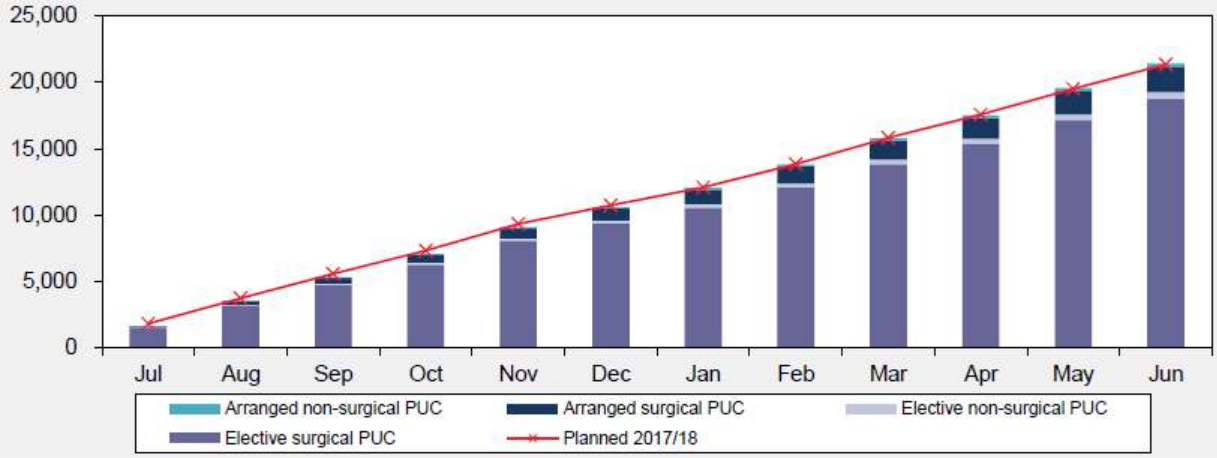

# Theatre Capacity and Theatre Utilisation

*Achievements/Issues of Note*

## Elective Health Target Delivery

**Health Target** ▼ **100.4%**

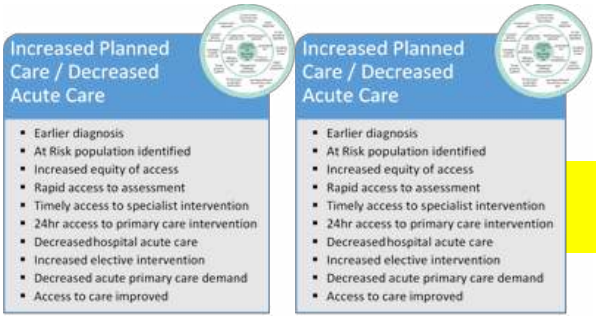
| | 2017 | | | | | | 2018 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
| Planned | 1,824 | 3,742 | 5,574 | 7,330 | 9,335 | 10,737 | 12,073 | 13,827 | 15,808 | 17,556 | 19,489 | 21,330 |
| Actual | 1,625 | 3,541 | 5,323 | 7,058 | 9,076 | 10,622 | 12,058 | 13,802 | 15,791 | 17,514 | 19,568 | 21,406 |
| Variance | -199 | -201 | -251 | -272 | -259 | -115 | -15 | -25 | -17 | -42 | 79 | 76 |
| %Achievement | 89% | 95% | 95% | 96% | 97% | 99% | 100% | 100% | 100% | 100% | 100% | 100% |




Reporting from the Ministry of Health shows that Canterbury District Health Board has exceeded its Electives Health Target for 2017/18 having produced 21,406 elective and arranged discharges, 76 more than its target of 21,330.

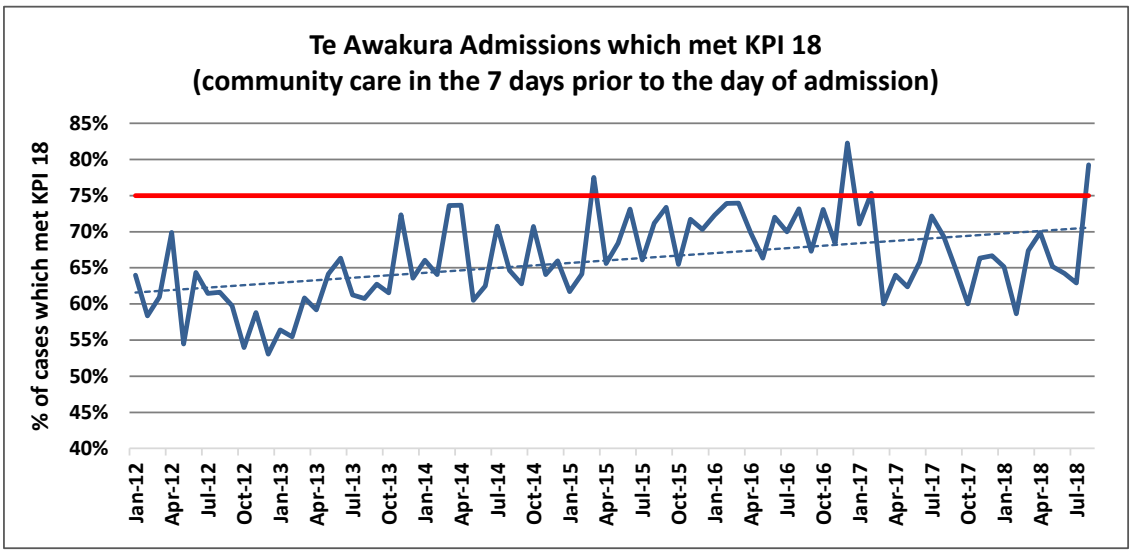
| | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|---|---|---|---|
| Target | 15,478 | 16,110 | 16,110 | 16,861 | 17, 484 | 20,474 | 20,982 | 21,330 |
| Achieved | 14,974 (97%) | 16,494 (102%) | 17,066 (106%) | 16,961 (101%) | 17, 714 (101%) | 21,039 (103%) | 21,456 (102%) | 21,406 (100%) |

In 2018/19 there is no longer a health target relating to elective discharges. We have agreed an objective with the Ministry of Health to provide 21,782 elective services discharges.

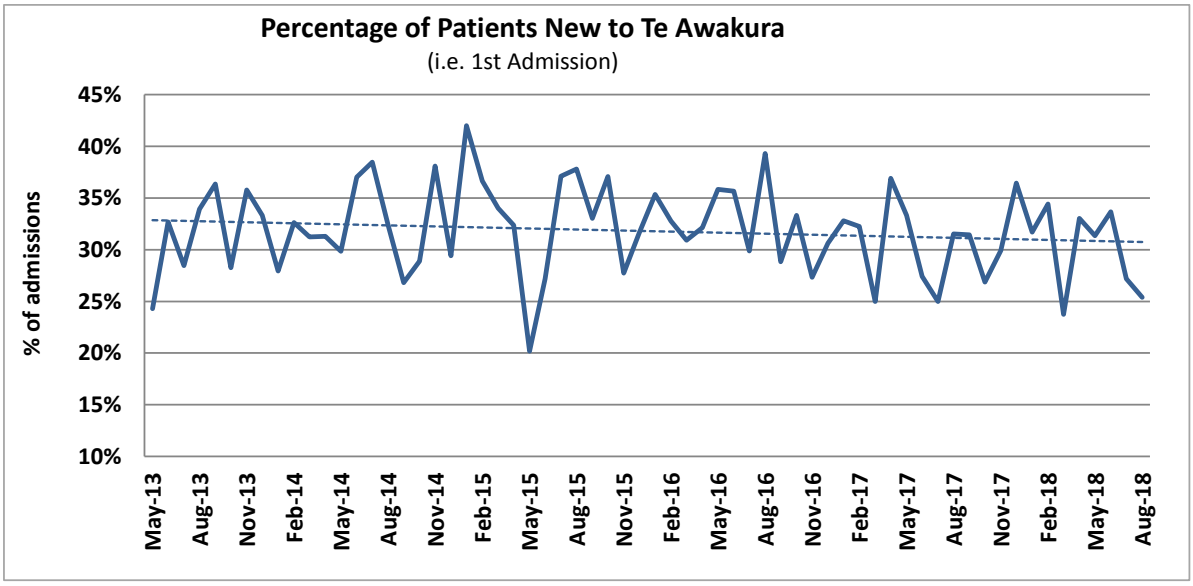



# Mental Health Services

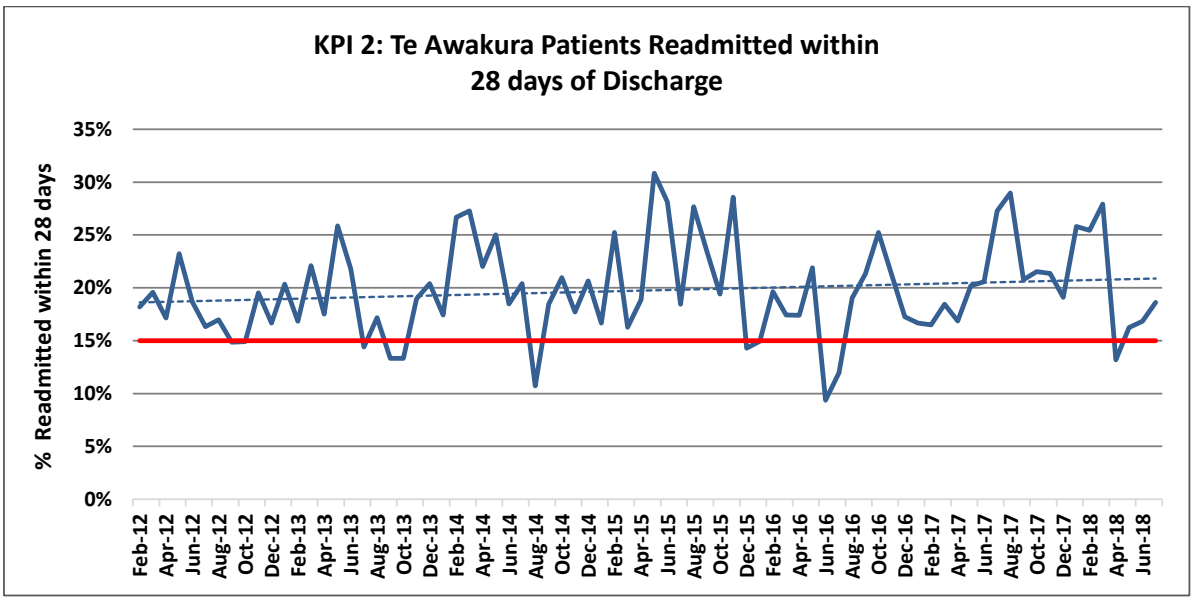
## Adult Services



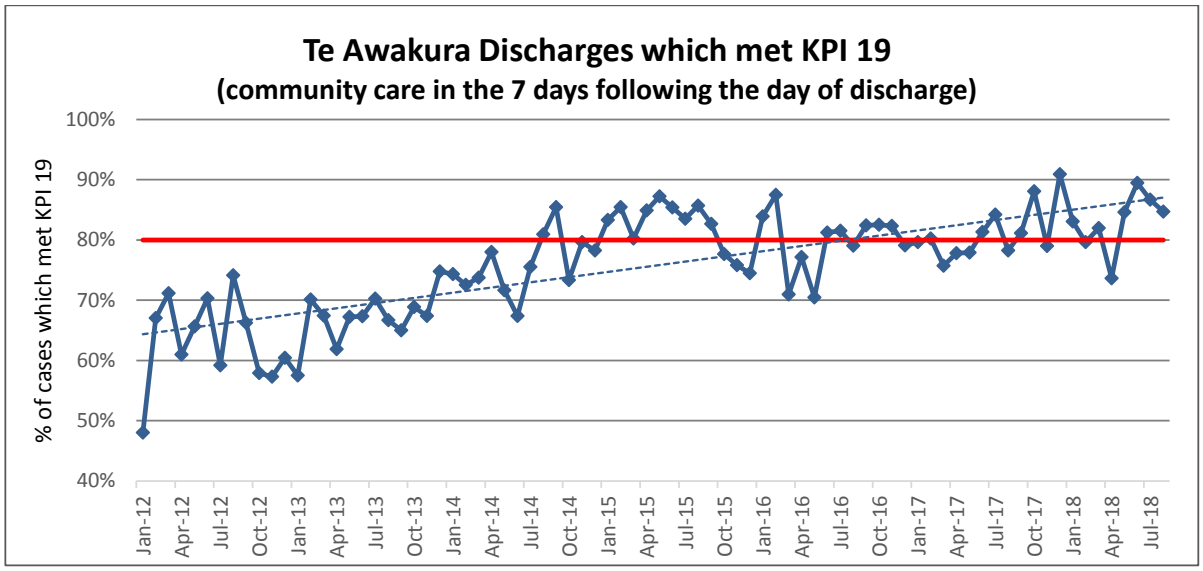

KPI 18 is an indicator of how well engaged we are with the consumers in our services. In July 2018, 62.9% of acute admissions to Te Awakura had a community contact in the seven days prior to the date of their admission. In August 2018, the figure was 79.2%.



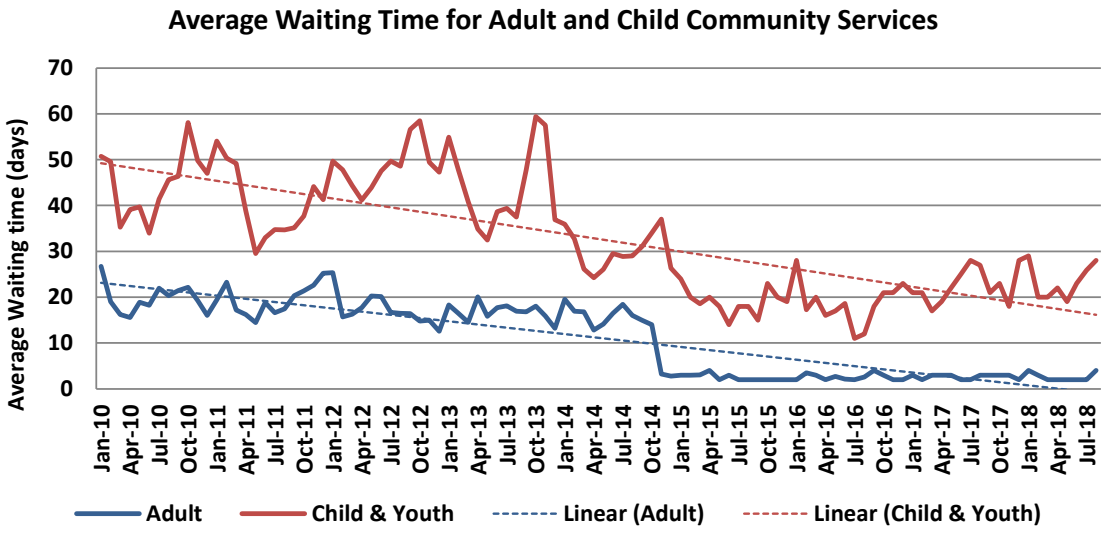

In July 2018, 34% of people admitted to Te Awakura were new (had not been admitted there previously), in August 2018, the figure was 25%.




The graph above shows the readmission rate within 28 days of discharge. Of the 103 Te Awakura consumers discharged in July 2018, 18.6% were readmitted within 28 days. Readmission rates are closely monitored.

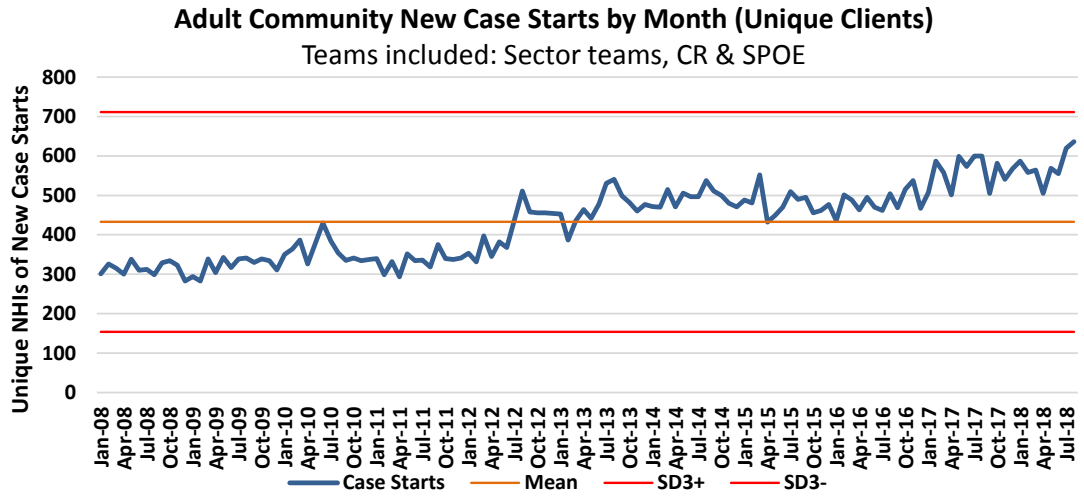



KPI 19 is a key suicide prevention activity and patient safety measure. In July 2018, 86.7% of consumers discharged from Te Awakura received a community care follow-up within seven days of discharge, and so met KPI 19. In August 2018, the figure was 84.7%.

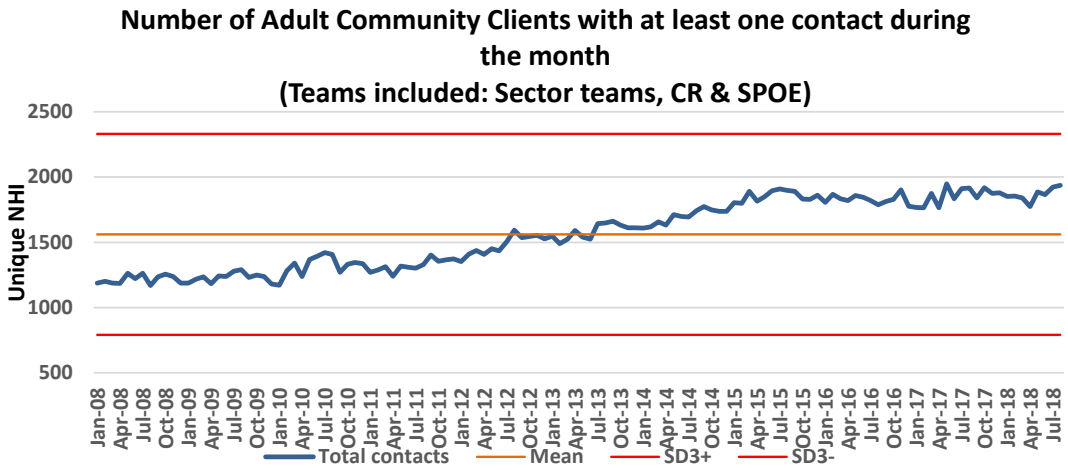



The graph above shows there has been an overall reduction in the time people spend waiting. Ministry of Health targets for these services require 80% of people to be seen within 21 days and 95% of people to be seen within 56 days. The average waiting time for adults was 2 days for July 2018 and 4 days for August 2018. Our results for the Adult General Mental Health Service show 95.8% of people were seen within 21 days of referral in July 2018 and 99.5% were seen within 56 days of referral. In August 2018, these figures were 93.7% and 99.0% respectively. These results are occurring in the context of significant increase in demand.

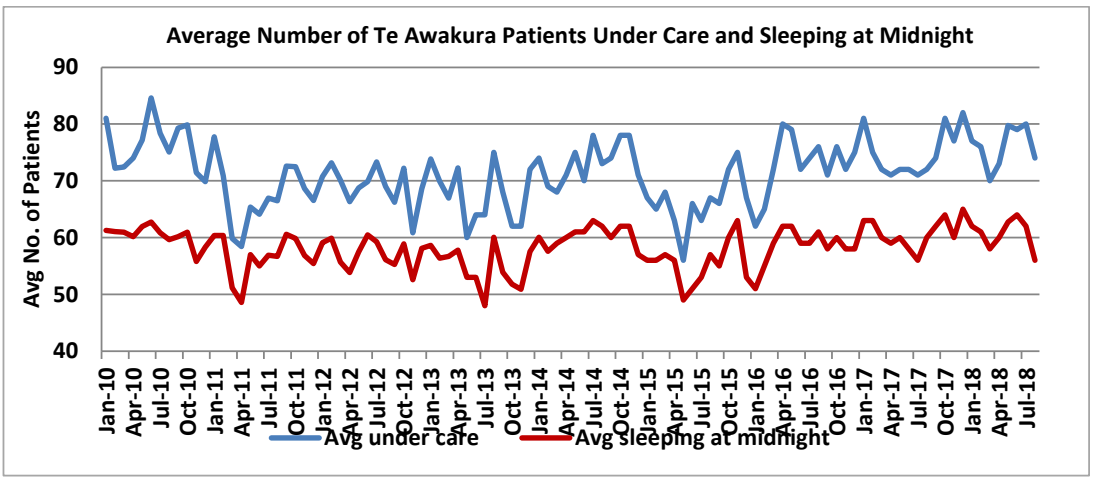
For child and family services, the average waiting time was 26 days for July 2018 and 28 days for August 2018. Reducing wait times has been a key focus for CAF services. Our results show 53.1% of people were seen within 21 days of referral in July 2018 and 87.7% were seen within 56 days of referral. In August 2018, these figures were 59.5% and 82.6% respectively.




New cases were created for 620 individual adults (unique NHIs) in July 2018 and 636 in August 2018.

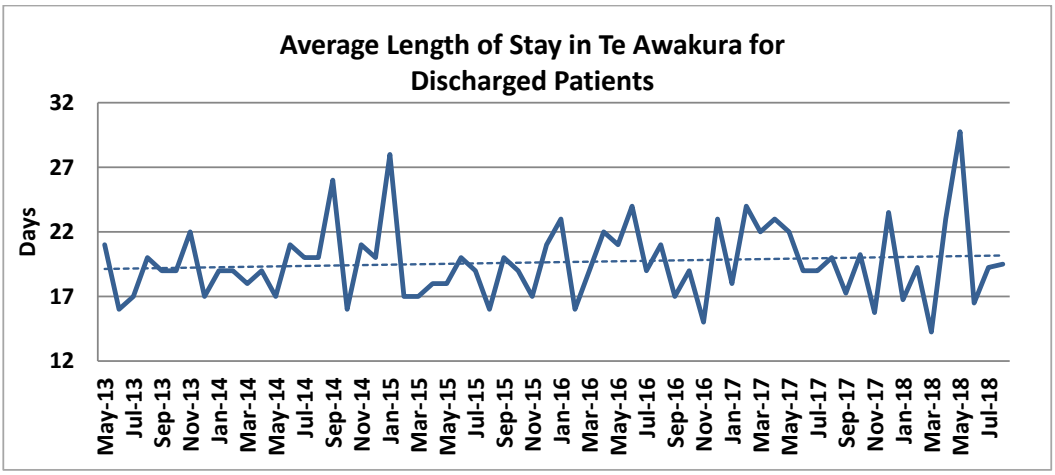



In July 2018 there was at least one contact recorded for 1923 people and 1936 in August 2018.

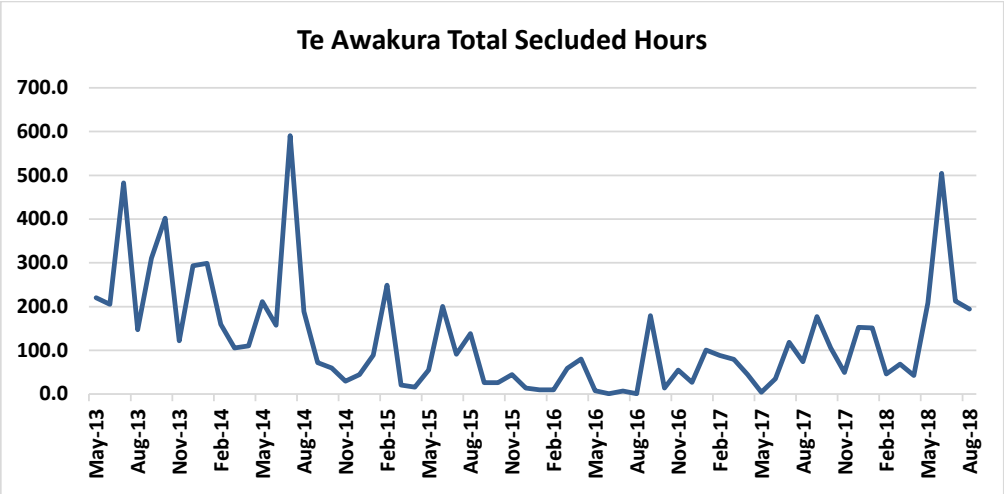



85% occupancy is optimal for mental health acute inpatient services. Occupancy in Te Awakura (the acute inpatient service) remains above this figure. Occupancy was 97% in July 2018 and 88% in August 2018.

The average number of consumers under care in this 64 bed facility was 80 in July 2018 and 74 in August 2018. There were 12 sleepovers during July 2018 and 18 sleepovers during August 2018.

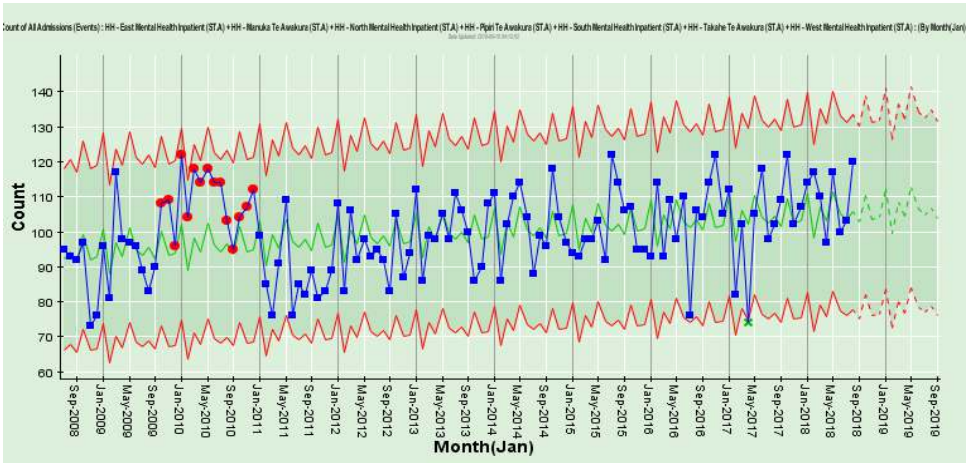


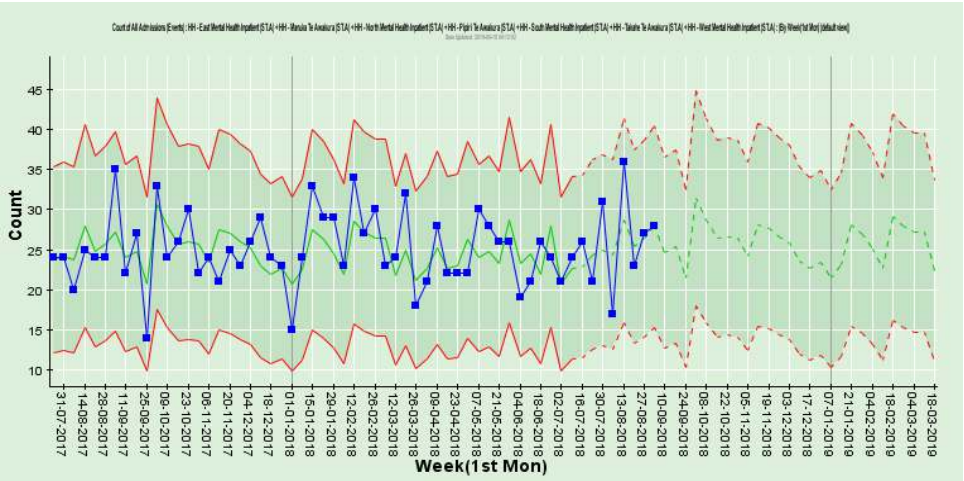

The average length of stay for consumers discharged from Te Awakura was 19 days for both July 2018 and August 2018. We are closely monitoring length of stay in terms of difficulties with accommodation supply in Christchurch.




Our focus on reduction of seclusion in Te Awakura continues with a significant reduction overall. In July 2018, nine consumers experienced seclusion for a total of 212.4 hours. In August 2018, seven consumers experienced seclusion for a total of 194.2 hours. There is strong and effective nursing leadership and staff dedication and commitment to maintain the focus of reduction.

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



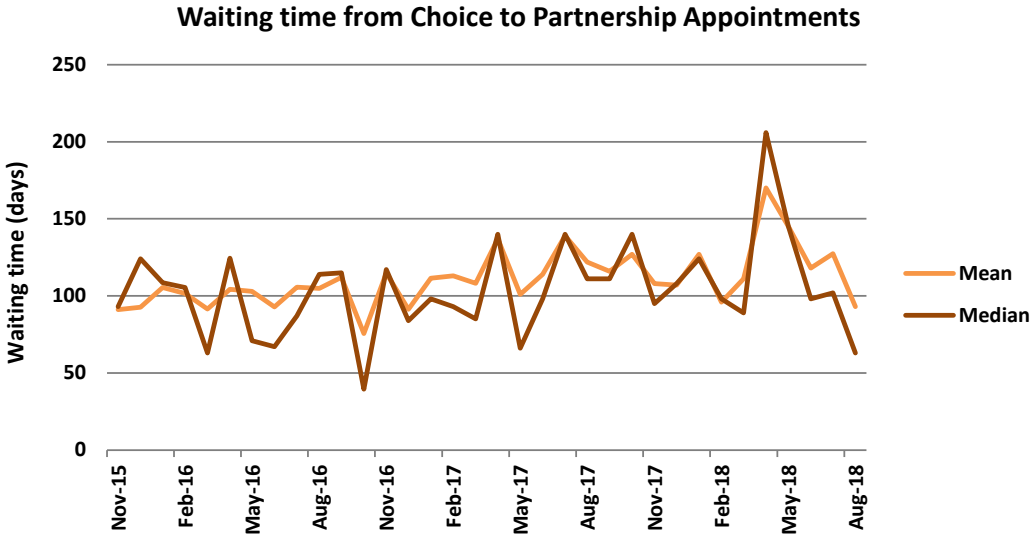



## Child and Youth

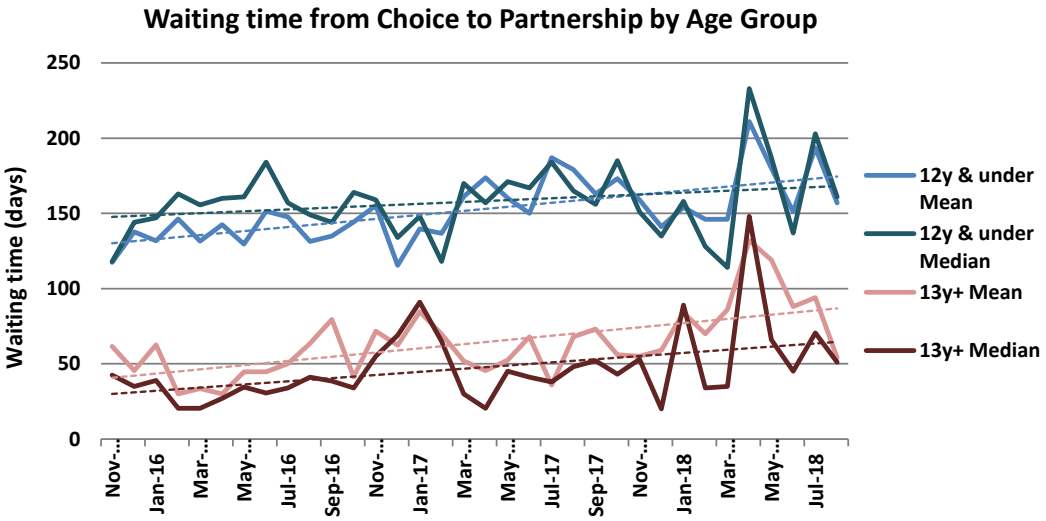
There has been a 98% increase in child and adolescent case starts in the past six financial years.

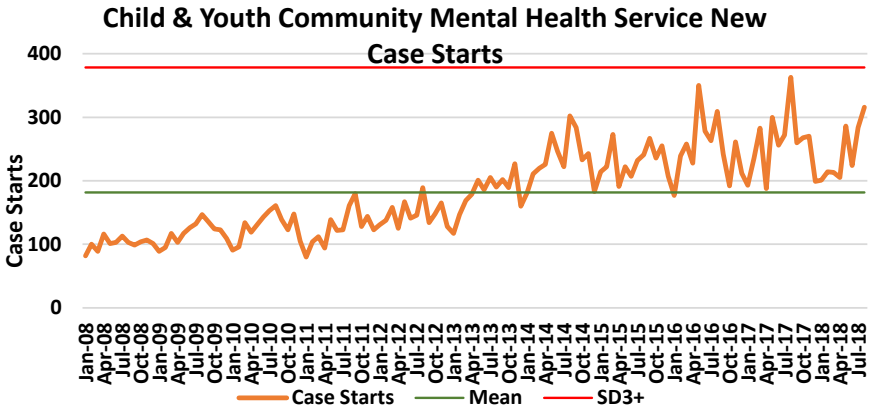
The focus on reducing wait times in the child and adolescent services is resulting in an internal wait of 20 weeks for some children and their families. Being seen early for the first contact is still important as it enables clinicians to make informed decisions about who is able to wait and who needs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

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

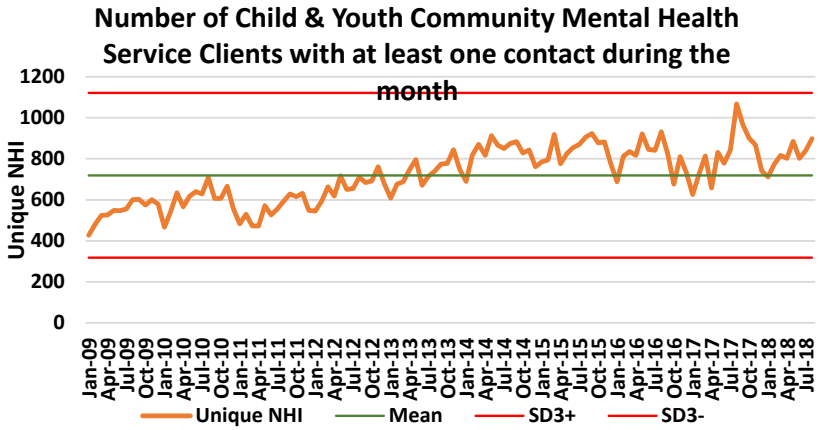



Lately Child, Adolescent and Family Services has been identifying consumers with possible ADHD and sending them straight to a Partnership appointment in an effort to reduce their waiting list. In April 2018 the majority of CAF North consumers who attended a Partnership appointment had not attended a Choice appointment (only five CAF North consumers are included in the April 2018 figure above). This was not the case for the CAF South team, who have a greater number of consumers waiting, and a longer average waiting time from Choice to Partnership. CAF South have been actively trying to target their consumers waiting the longest. As a result there is a marked increase in waiting time shown in the graph above for April 2018.

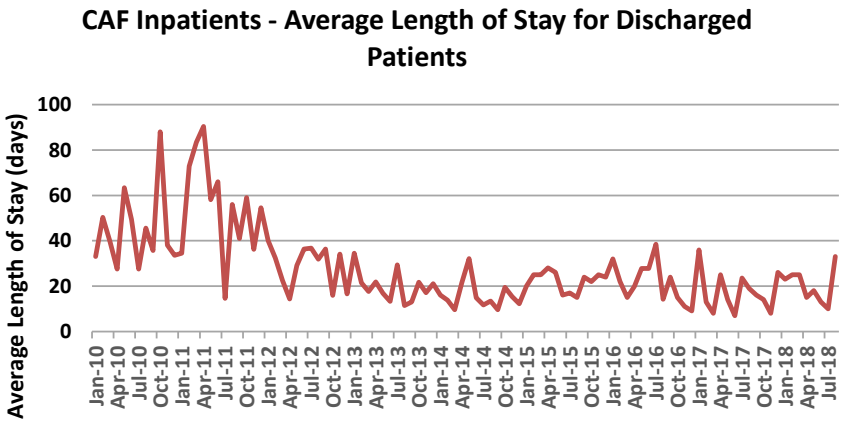





There were 284 new CAF case starts in July 2018 and 316 in August 2018. CAF services are making good progress with implementation of a Direction of Change that supports more integrated services across the age ranges.

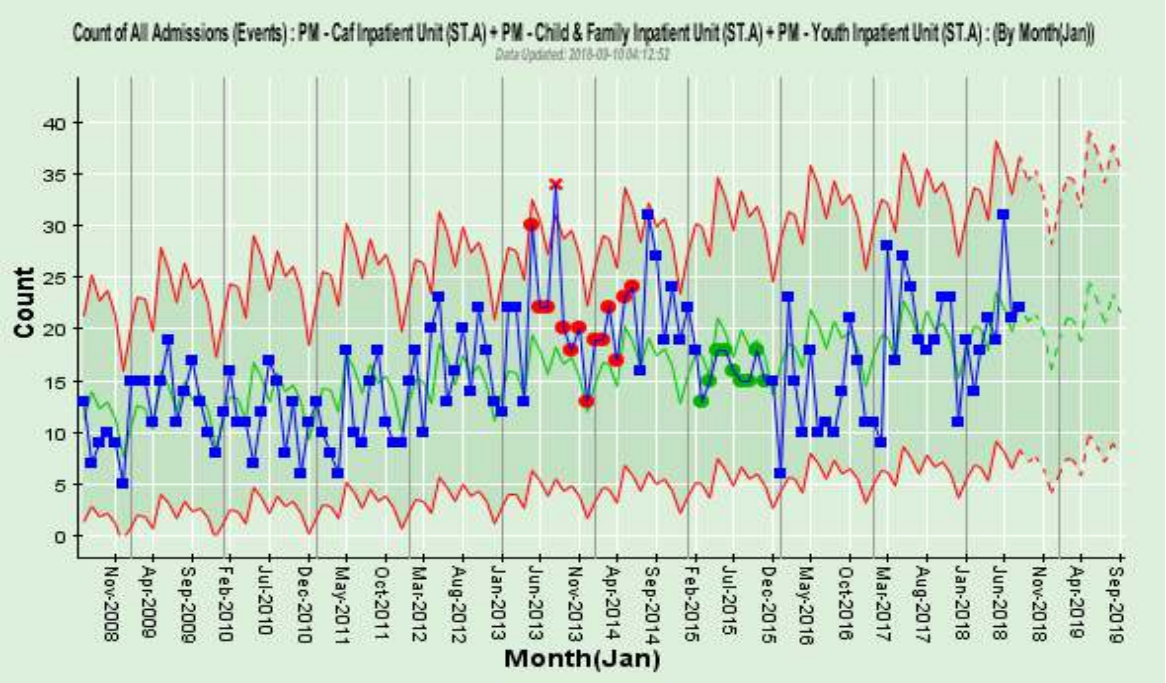


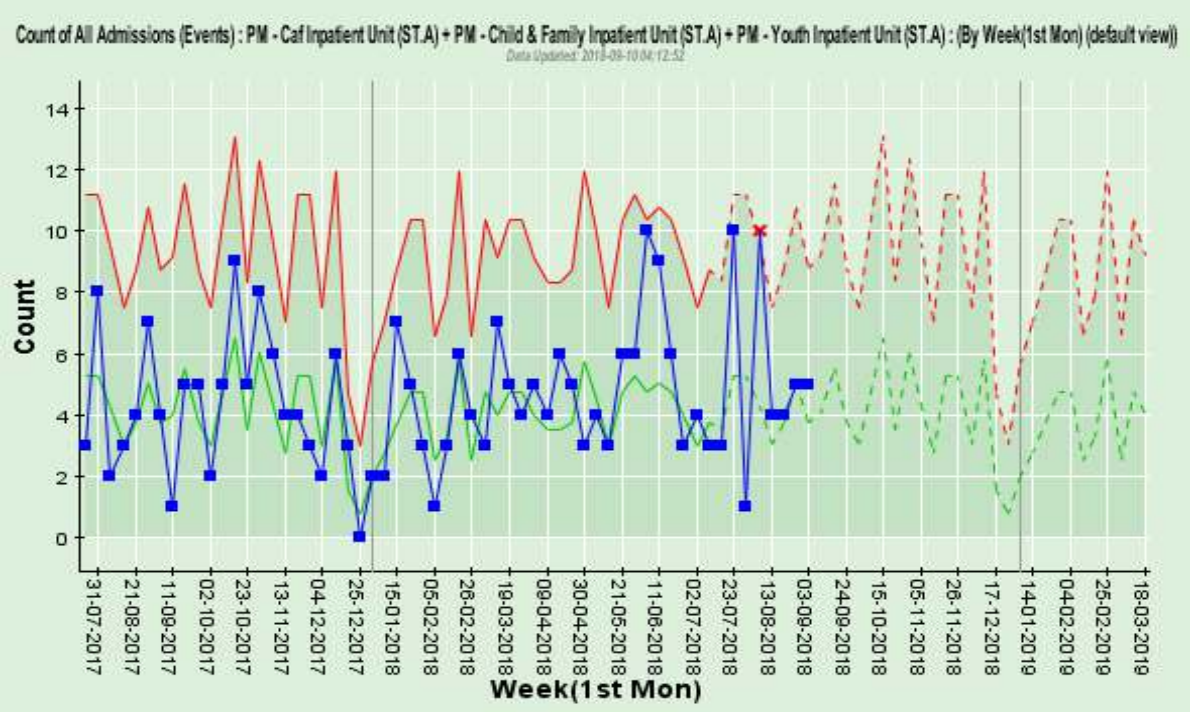

The number of unique clients with contacts above shows a similar pattern to new case starts graph, which demonstrates an increase in demand for Child and Youth community Mental Health Service. There were 839 unique patients with at least one contact during the month of July 2018 and in August 2018 there were 898. In August 2017 the CAF Service ran a drive on improving data accuracy and ensuring all contacts were being entered into the patient information system in a timely manner.




The average length of stay for discharged patients was 10 days for July 2018 and 33 days for August 2018.

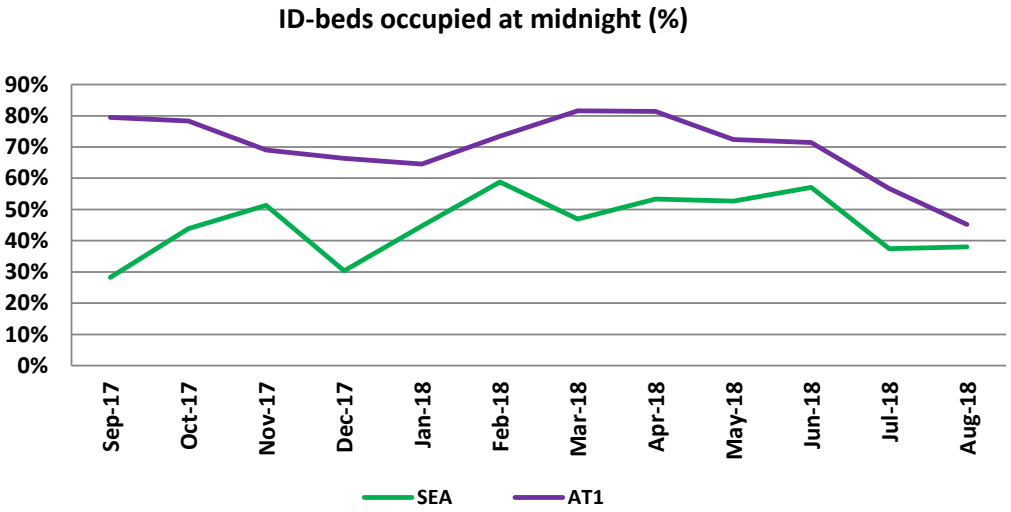
The graphs below show the number of admissions to the Child and Adolescent Unit and its predecessors. The first graph is a monthly view, and the second a weekly view.



## Intellectually Disabled Persons Health Service

The IDPH Service inpatient units comprise a 7 bed secure unit, Assessment, Treatment and Rehabilitation (AT&R), and a 15 bed dual disability unit, Psychiatric Service for Adults with Intellectual Disability (PSAID) within the Aroha Pai Unit, Hillmorton Hospital.

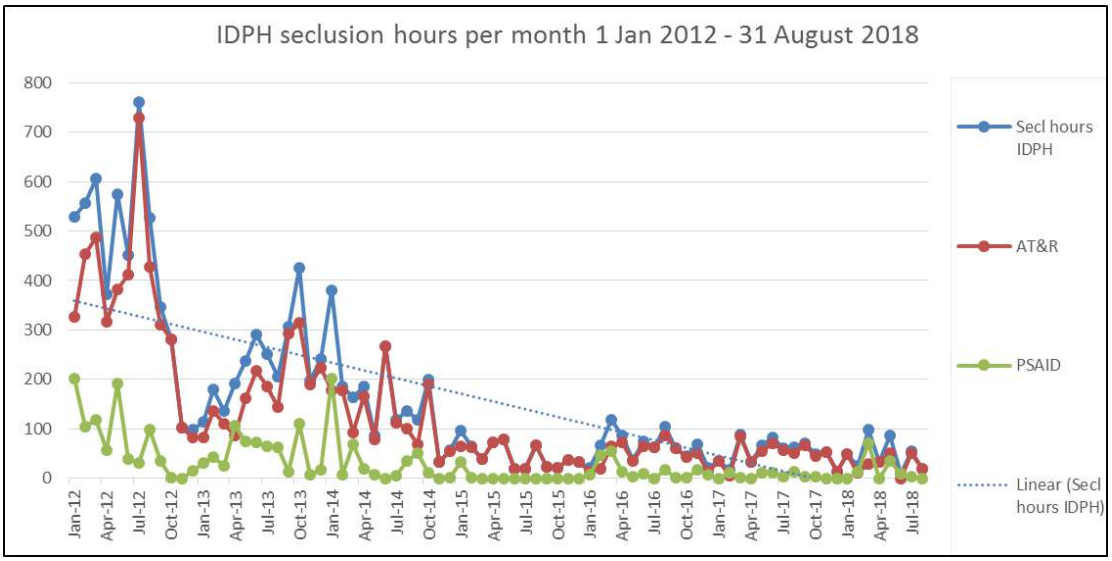


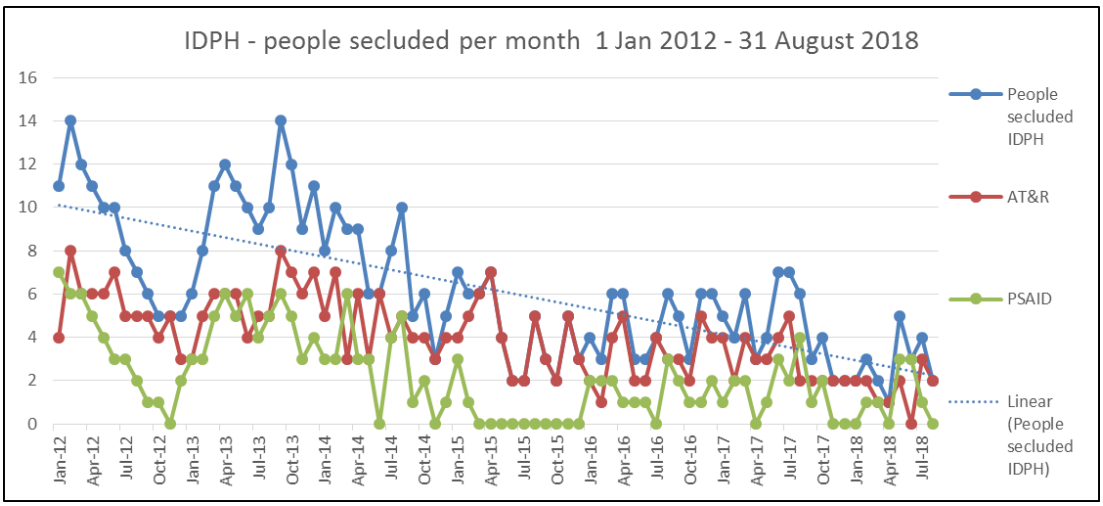

Occupancy in AT&R (AT1) was 57% for the month of July 2018 and 45% for August 2018. The figures for PSAID (SEA) were 37% and 38% respectively.

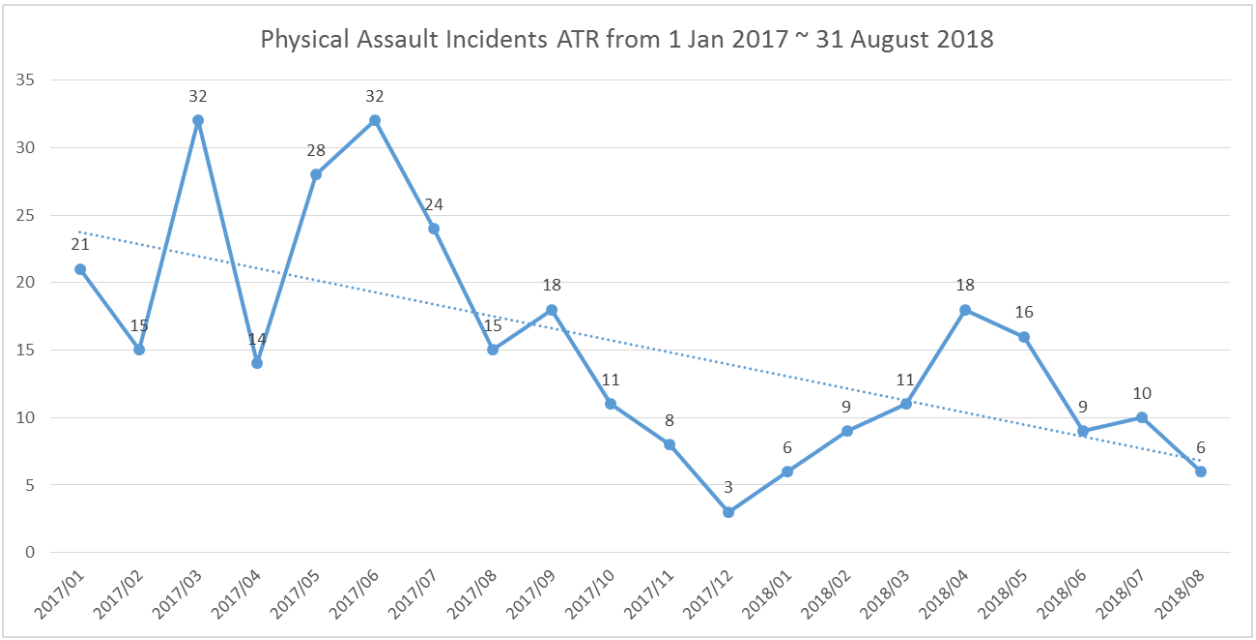
There have been longstanding delays in discharge for patients in the AT&R Unit. The delays continue to place pressure on the service and, for some of the patients, can lead to a deterioration in their presentation, affecting their readiness for discharge.

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

The Assessment, Treatment & Rehabilitation Unit has recently completed an interim environmental modification to address significant health and safety concerns. Whilst this has reduced the admitting capacity of the unit, there has been a significant improvement in seclusion reduction, a reduction in physical assaults and improved safety for patients and staff.




IDPH - people secluded per month 1 Jan 2012 - 31 August 2018
People secluded IDPH
AT&R
PSAID
Linear (People secluded IDPH)


Physical Assault Incidents ATR from 1 Jan 2017 ~ 31 August 2018


Living within our means

## Living within our Means, including No Wasted Resource

### Financial Performance

# Canterbury District Health Board

## Statement of Financial Performance

### Hospital & Specialist Service Statement of Comprehensive Revenue and Expense
### For the 2 Months Ended 31 August 2018

| MONTH $'000 | | | | | | YEAR TO DATE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 18/19 Actual $'000 | 18/19 Budget $'000 | 17/18 Actual $'000 | 18/19 Variance $'000 | 18/19 vs 17/18 Variance $'000 | | 18/19 Actual $'000 | 18/19 Budget $'000 | 17/18 Actual $'000 | 18/19 Variance $'000 | 18/19 vs 17/18 Variance $'000 |
| | | | | | **Operating Revenue** | | | | | |
| 483 | 403 | 943 | 80 | (460) | From Funder Arm | 920 | 805 | 1,222 | 115 | (302) |
| 1,619 | 1,553 | 1,336 | 66 | 283 | MOH Revenue | 3,084 | 3,103 | 3,142 | (19) | (58) |
| 3,990 | 4,404 | 5,241 | (414) | (1,251) | Patient Related Revenue | 8,794 | 8,549 | 9,058 | 245 | (264) |
| 1,778 | 1,416 | 1,580 | 362 | 198 | Other Revenue | 2,989 | 2,826 | 3,060 | 163 | (71) |
| 7,870 | 7,776 | 9,100 | 94 | (1,230) | **TOTAL OPERATING REVENUE** | 15,787 | 15,283 | 16,482 | 504 | (695) |
| | | | | | **Operating Expenditure** | | | | | |
| | | | | | **Personnel Costs** | | | | | |
| 59,617 | 58,408 | 55,237 | (1,209) | (4,380) | Personnel Costs - CDHB Staff | 116,551 | 118,433 | 107,320 | 1,882 | (9,231) |
| 1,935 | 1,672 | 2,287 | (263) | 352 | Personnel Costs - Bureau & Contractors | 3,632 | 3,348 | 4,184 | (284) | 552 |
| 61,552 | 60,080 | 57,524 | (1,472) | (4,028) | **Total Personnel Costs** | 120,183 | 121,781 | 111,504 | 1,598 | (8,679) |
| 13,237 | 12,007 | 12,550 | (1,230) | (687) | Treatment Related Costs | 24,642 | 24,004 | 23,833 | (638) | (809) |
| 3,631 | 3,510 | 4,350 | (121) | 719 | Non Treatment Related Costs | 6,818 | 7,070 | 8,292 | 252 | 1,474 |
| 78,420 | 75,597 | 74,424 | (2,823) | (3,996) | **TOTAL OPERATING EXPENDITURE** | 151,643 | 152,855 | 143,629 | 1,212 | (8,014) |
| **(70,550)** | **(67,821)** | **(65,324)** | **(2,729)** | **(5,226)** | **OPERATING RESULTS BEFORE INTEREST AND DEPRECIATION** | **(135,856)** | **(137,572)** | **(127,147)** | **1,716** | **(8,709)** |
| | | | | | **Indirect Income** | | | | | |
| - | 1 | 1 | (1) | (1) | Donations & Trust Funds | 3 | 3 | 1 | - | 2 |
| - | - | - | - | - | Interest & Dividends Received | - | - | - | - | - |
| - | - | - | - | - | Gain on Disposal of Assets | - | - | - | - | - |
| **-** | **1** | **1** | **(1)** | **(1)** | **TOTAL INDIRECT INCOME** | **3** | **3** | **1** | **-** | **2** |
| | | | | | **Indirect Expenses** | | | | | |
| 2,214 | 1,884 | 2,146 | (330) | (68) | Depreciation | 4,264 | 3,748 | 4,303 | (516) | 39 |
| 1 | - | - | (1) | (1) | Loss on Disposal of Assets | 1 | - | - | (1) | (1) |
| **2,215** | **1,884** | **2,146** | **(331)** | **(69)** | **TOTAL INDIRECT EXPENSES** | **4,265** | **3,748** | **4,303** | **(517)** | **38** |
| **(72,765)** | **(69,704)** | **(67,469)** | **(3,061)** | **(5,296)** | **TOTAL SURPLUS / (DEFICIT)** | **(140,118)** | **(141,317)** | **(131,449)** | **1,199** | **(8,669)** |

## Summary of initiatives

### Indication of Latest Efficiencies (including costs avoided)

| | | Core Financial Benefit | | | Ancillary Benefit | |
|---|---|---|---|---|---|---|
| | | Budgetary Benefits | | | Non Budgetary Benefits | |
| Service | Name of initiative/project | Investment for project | $ savings | Financial year of savings | Costs avoided to date | Non-Financial Efficiency |
| Eyes | Customised intravitreal injection packs created for the eye service | | $72,578 pa | 2018/19 | | |
| Christchurch Campus | Improved processes lead to increased capture of ACC funding | | $130,000 (earnings) | 2018/19 | | |
| Eyes | Coding outpatient activity and finding lost income | | $12,000 (earnings) | 2018/19 | | |

*Achievements/Issues of Note*

## Customised intravitreal injection packs created for the eye service

Age related macular degeneration is a chronic condition that causes loss of sight in older people. It can be managed through regular injection of drugs into the eye. This service is largely provided during dedicated clinics. In order to ensure smooth process the range of consumable items required to provide this care are provided in pre-sterilised packs. Until recently these packs contained a number of items that were not used in our clinics and did not contain other items, such as the draping material used during treatment.

One of the General Practitioner Injectors working with Canterbury District Health Boards Eye Service identified an opportunity to improve this and the service has worked with a provider who now provides us with customised packs, designed specifically for these clinics. These contain the drape and other consumable equipment required. These packs have been trialled in the service and found acceptable by the clinicians providing the service.

This avoids wasting a significant amount of sterile consumable material that was not used, and has provided us with significant savings. Around 2,650 packs will be purchased in the coming year, saving nearly $73k a year compared with previous practice, this represents a 43% saving.

## Improved processes lead to increased capture of ACC funding

It had been noted that there were many instances where prior approval for surgery was not being sought from the Accident Compensation Corporation (ACC), depriving Canterbury District Health Board of income that it is entitled to. The Finance ACC team has worked with departments to change some internal processes, so that initiation of processes to collect ACC claim information now comes from the ACC team as well as from departments. Whether or not we successfully claim for these events from ACC they are excluded from our elective health target volumes.

Campus Finance has put in place a campaign to increase awareness within those departments where we have traditionally had higher numbers of unfunded surgeries. This has included a series of meetings as well as e-mails providing updates to areas to help maintain knowledge about the processes and progress being made.

The information provided to departmental teams includes contact numbers for the Campus Finance team to ensure that people know where to seek help on the new processes. Administration teams within services have embraced the process, taking ownership for the successful filing of the required information.

During 2017 the Campus Finance team identified 12 missed claims totalling $157k. As at mid-June 2018 only two missed claims had occurred, totalling $12k, representing a significant reduction in lost income.

An improvement area has been identified and the Finance Team have met with the Maxilo Facial consultants and dental assistants to further improve the communication and processes of capture of clinical supplies/hardware etc.

## Roll-on, Roll-off trolleys improving linen management at Christchurch Hospital

Traditional methods of linen management at Christchurch Hospital have involved a manual ordering process with linen room staff visiting each ward to order all items of linen that they could possibly need from the laundry and then storing them on the ward. This has used significant nurse and hospital aide time to decant items delivered to the ward, storing them in various places throughout the ward and in some instances "hoarding" linen within areas. Considerable storage space was dedicated in each ward to store these supplies and items that were not used commonly have been stored in each ward.

To resolve this issue Canterbury Laundry Services and nursing teams at Christchurch Hospital have implemented a system utilising roll-on, roll-off trolleys to make the entire process much more efficient. Each ward receives one or more fresh trolleys, stocked with a pre-agreed number of each item that it regularly uses. Linen is used directly from the trolley rather than being decanted into storage areas throughout each ward. Trolleys, along with any unused linen are returned to the laundry the next day after delivery of the next lot of fresh stock. Regular analysis of the number of used and returned items enables fine tuning of the stock levels that are provided to each ward, with the aim that >80% of items will be used from each trolley. Emergency linen supplies are available from a small stock room in the hospital to cater for uncommonly used items or for unexpected variation in use.

This has delivered a number of benefits. It ensures that the right linen items are available in the right place at the right time. It has freed up time previously used each day for ordering and decanting linen supplies, processes and spaces are tidy and staff now know exactly where to find the supplies they need. Storage space has been released in the wards which has created advantages in our design of Christchurch Hospital Hagley and the new Outpatient building, as a space has been custom made for the trolleys with other linen storage space not being required. The large linen storage and decanting space previously required at Christchurch Hospital has been released, replaced with a small emergency stock room. There is clarity and transparency of information about the linen required in each area enabling us to continually improve the amount of stock provided to each area. As confidence is developed this will help us to ensure that we own and provide the right number of items of linen – helping us to avoid the cost associated with owning more linen than we need.

## Coding outpatient activity and finding lost income

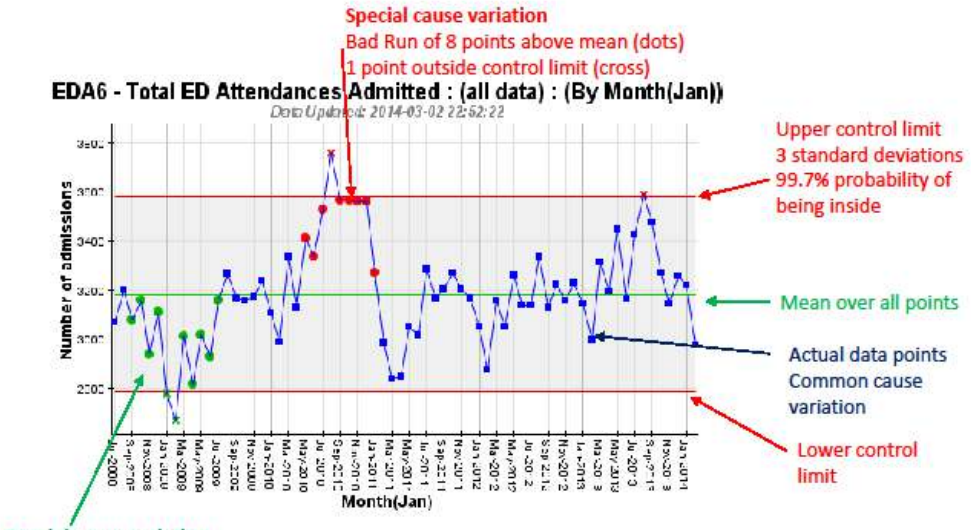
Following an inpatient stay the Clinical Coding team reviews the patient's clinical records, rendering various aspects of the patient's engagement with the hospital into a series of codes. These codes help us to understand the demands on the system including indications that patients present to hospital with and the procedures provided to patients during their stay. However codes that enable us to count the effort put into care provided within an outpatient are entered into our patient management system by the department providing the care, this depends on reliable processes and routines being developed and maintained within each department. When these processes fall off over time, for example where we have high staff turnover in a busy service, we lose the ability to understand the impact that changing demand or practice has on the amount of work carried out as a part of outpatient events. This it often means that we miss out on a flow of income associated with patients who live in other districts.

During our planning round for 2018/19 some gaps in coding have been identified. A conservative estimate is that in one service alone, during 2017/18, we missed counting approximately 1,000 procedures. 31 of these provided to patients from other districts, the missed inter-district flow income being worth around $12k.

New processes are being developed in this service that involve clinicians noting key information onto a clinic list template, ensuring that the booking team has access to key information including key procedures carried out, updated diagnosis, outcome, required review period and priority of review. The booking team will then ensure this information is updated in our information system so that key information required to direct future care and understand the work done by the service is easily available from the data.

Campus Finance and Decision Support are working to assist other departments to monitor the volume of procedures coded in the system to both to ensure that we have good information to support planning and that relevant inter district flow is quantified. This support includes provision of reports clearly showing the volume of each Purchase Unit Code entered by each specialty and ongoing discussions between finance team members and service managers.

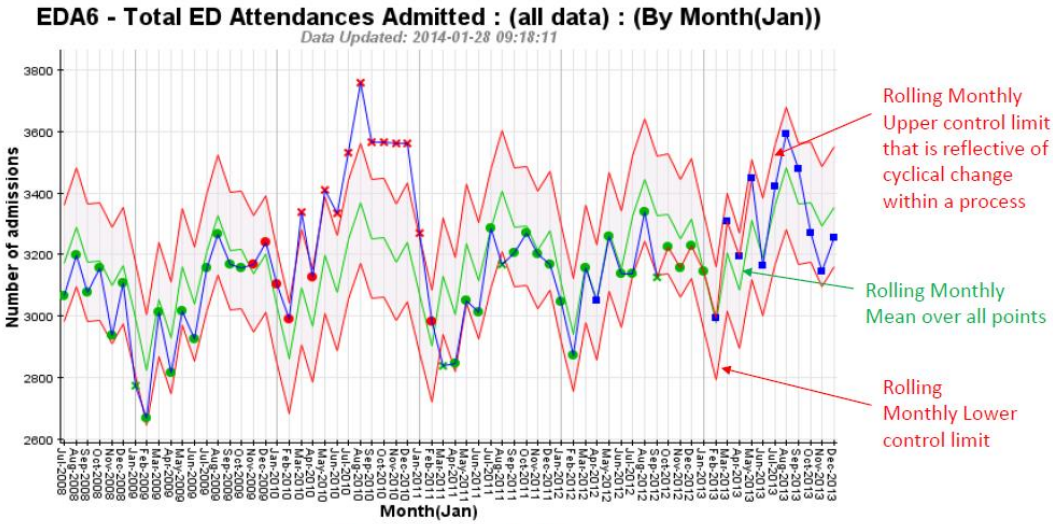
# SPC: How to Interpret a Control Chart




sfn signals from noise

make it better

# SPC: How to Interpret Cyclical and Trended Data




**Criteria for a Cyclical Process:**

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

sfn signals from noise

make it better

# RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

**SOURCE:** **Corporate Services**

**DATE:** **4 October 2018**

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

## 1. ORIGIN OF THE REPORT

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

## 2. RECOMMENDATION

That the Committee:

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

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

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

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

## 3. SUMMARY

The Act, Schedule 3, Clause 32 provides:

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

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

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

Clause 33 of the Act also further provides:

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

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

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

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

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

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

# WORKPLAN FOR HAC 2018 *(WORKING DOCUMENT)*

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