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, 3 December 2020 commencing at 9:00am

Administration			
	Apologies		9.00am
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 1 October 2020		
3.	Carried Forward / Action List Items		
Presentation			
4.	Pressure Injury Prevention Project	Dr Helen Skinner *General Manager & Chief of Service, Older Persons Health & Rehabilitation*	9.05-9.30am
5.	CDHB Allied Health Strategic Direction	Dr Jacqui Lunday Johnstone *Executive Director, Allied Health, Scientific & Technical*	9.30-9.55am
6.	Care Capacity Demand Management Update	Becky Hickmott *Acting Executive Director of Nursing*	9.55-10.20am
Reports for Noting			
7.	Accelerating Our Future Update	Dan Coward *General Manager, Programme Management Office*	10.20-10.30am
MORNING TEA			**10.30-10.45am**
8.	Chatham Islands Health Centre	Win McDonald *Transition Programme Manager, Rural Health Services*	10.45-10.55am
9.	Hospital Service Monitoring Report: • Rural Health Services • Mental Health	Win McDonald Berni Marra *Manager, Ashburton Health Services* Dr Greg Hamilton *General Manager, Specialist Mental Health Services*	10.55-11.40am

	• Hospital Laboratories • Medical/Surgical; Women's & Children's Health; & Orthopaedics ESPIs • Older Persons Health & Rehabilitation	Kirsten Beynon *General Manager, Laboratories* Pauline Clark *General Manager, Medical/Surgical; Women's & Children's Health; & Orthopaedics* Dr Helen Skinner *General Manager & Chief of Service, Older Persons Health & Rehabilitation*	
10.	Resolution to Exclude the Public		11.40am
Estimated Finish Time			**11.40am**
	Information Items: • Quality & Patient Safety Indicators – Level of Complaints • 2020 Workplan		

NEXT MEETING: Thursday, 28 January 2021 at 9:00am

ATTENDANCE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE MEMBERS

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

Executive Support

(as required as per agenda)

Dr Andrew Brant – *Acting Chief Executive*
Evon Currie – *General Manager, Community & Public Health*
Savita Devi – *Acting Chief Digital Officer*
David Green – *Acting Executive Director, Finance & Corporate Services*
Becky Hickmott – *Acting Executive Director of Nursing*
Paul Lamb – *Acting Chief People Officer*
Ralph La Salle – *Acting Executive Director, Planning Funding & Decision Support*
Dr Jacqui Lunday-Johnstone – *Executive Director of Allied Health, Scientific & Technical*
Hector Matthews – *Executive Director Maori & Pacific Health*
Dr Sue Nightingale – *Chief Medical Officer*
Dr Rob Ojala – *Executive Director for Facilities*
Karalyn Van Deursen – *Executive Director of Communications*

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

COMMITTEE ATTENDANCE SCHEDULE 2020

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NAME	30/01/20	02/04/20 Meeting Cancelled	04/06/20	06/08/20	01/10/20	03/12/20
Andrew Dickerson (Chair)	√		√	√	√	
Naomi Marshall (Deputy Chair) (Effective 17 Sep 20)	* 25/02/20		√	^	√	
Barry Bragg	√		√	x	√	
Sally Buck	√		~	** 08/07/2020		
Catherine Chu		* 16/04/20	√	√	x	
James Gough		* 16/04/20	√	√	√	
Jo Kane (Resigned as Deputy Chair 14 Aug 20)	√		√	√	√	
Ingrid Taylor	* 25/02/20		√	^	√	
Wendy Dallas-Katoa	√	** 01/06/2020				
Jan Edwards	√		√	x	√	
Dr Rochelle Phipps	√		√	√	√	
Trevor Read	√	** 01/06/2020				
Michelle Turrall		* 01/06/20	x	√	x	
Sir John Hansen (ex-officio)	√		√	x	#	
Gabrielle Huria (ex-officio)	x		√	x	x	

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

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

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

	The Terrace On Avon Limited – (Alternate) Director Property company – manages The Terrace.
Jo Kane Board Member	**Christchurch Resettlement Services** - Member Christchurch Resettlement Services provides a range of services to people from refugee and migrant backgrounds. It works alongside refugee communities in delivering services that aim to achieve positive resettlement outcomes. **HurriKane Consulting** – Project Management Partner/Consultant A private consultancy in management, communication and project management. Any conflicts of interest that arise will be disclosed/advised. **Latimer Community Housing Trust** – Project Manager Delivers social housing in Christchurch for the vulnerable and elderly in the community. **NZ Royal Humane Society** – Director Provides an awards system for acts of bravery in New Zealand. It is not anticipated any conflicts of interest will arise.
Dr Rochelle Phipps	**Accident Compensation Corporation** – Medical Advisor ACC is a Crown entity responsible for administering NZ's universal no-fault accidental injury scheme. As a Medical Advisor, I analyse and interpret medical information and make recommendations to improve rehabilitation outcomes for ACC customers. **OraTaiao: New Zealand Climate & Health Council** – Founding Executive Board Member (no longer on executive) The Council is a not-for-profit, politically non-partisan incorporated society and comprises health professionals in Aotearoa/New Zealand concerned with: • the negative impacts of climate change on health; • the health gains possible through strong, health-centred climate action; • highlighting the impacts of climate change on those who already experience disadvantage or ill health (equity impacts); and • reducing the health sector's contribution to climate change. **Royal New Zealand College of General Practitioners** – Christchurch Fellow and Former Board Member The RNZCGP is the professional body and postgraduate educational institute for general practitioners.
Ingrid Taylor Board Member	**Loyal Canterbury Lodge (*LCL*) – Manchester Unity** – Trustee LCL is a friendly society, administering funds for the benefit of members and often makes charitable donations. One of the recipients of such a donation may have an association with the CDHB. **Manchester Unity Welfare Homes Trust Board (*MUWHTB*)** – Trustee MUWHTB is a charitable Trust providing financial assistance to organisations in Canterbury associated with the care and assistance of older persons. Recipients of financial assistance may have an association with the CDHB. **Sir John and Ann Hansen's Family Trust** – Independent Trustee.

	Taylor Shaw – Partner Taylor Shaw has clients that are employed by the CDHB or may have contracts for services with the CDHB that may mean a conflict or potential conflict may arise from time to time. Such conflicts of interest will need to be addressed at the appropriate time. • I / Taylor Shaw have acted as solicitor for Bill Tate and family. **The Youth Hub** – Trustee The Youth Hub is a charitable Trust established to provide residential and social services for the Youth of Canterbury, including services for mental health and medical care that may include involvement with the CDHB.
Michelle Turrall Manawhenua	**Canterbury Clinical Network (CCN) Maori Caucus** - Member **Canterbury District Health Board** - daughter employed as registered nurse. **Christchurch PHO Ltd** – Director **Christchurch PHO Trust** - Trustee **Manawhenua ki Waitaha** – Board Member and Chair **Oranga Tamariki – Iwi and Maori** – Senior Advisor **Papakainga Hauora Komiti – Te Ngai Tuahuriri** – Co-Chair
Sir John Hansen **Ex-Officio – HAC** Chair CDHB	**Bone Marrow Cancer Trust** – Trustee **Canterbury Cricket Trust** - Member **Christchurch Casino Charitable Trust** - Trustee **Court of Appeal, Solomon Islands, Samoa and Vanuatu** **Dot Kiwi** – Director and Shareholder **Judicial Control Authority (*JCA*) for Racing** – Appeals Tribunal Member The JCA is an independent statutory authority constituted under the Racing Act. The JCA ensures that judicial and appeal proceedings in thoroughbred and harness racing are heard and decided fairly, professionally, efficiently and in a consistent and cost effective manner. **Ministry Primary Industries, Costs Review Independent Panel** **Rulings Panel Gas Industry Co Ltd** **Sir John and Ann Hansen's Family Trust** – Ingrid Taylor sits as independent Trustee; and provides legal services to the Trust and to Sir John and Ann Hansen.
Gabrielle Huria **Ex-Officio – HAC** Deputy Chair, CDHB	**Nitrates in Drinking Water Working Group** – Member A discussion forum on nitrate contamination of drinking water. **Pegasus Health Limited** – Sister is a Director Primary Health Organisation (*PHO*). **Rawa Hohepa Limited** – Director Family property company **Sumner Health Centre** – Daughter is a General Practitioner (*GP*) Doctor's clinic.

	Te Runanga o Ngai Tahu – General Manager Tribal Entity. **The Royal New Zealand College of GPs** – Sister is an "appointed independent Director" College of GPs.

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, 1 October 2020, commencing at 9.00am

PRESENT

Andrew Dickerson (Chair); Barry Bragg; Jan Edwards; James Gough; Naomi Marshall; Dr Rochelle Phipps; and Ingrid Taylor.

Via Zoom – Jo Kane.

APOLOGIES

An apology for absence was received and accepted from Sir John Hansen.

EXECUTIVE SUPPORT

Dr Peter Bramley (Acting Chief Executive); Becky Hickmott (Acting Executive Director of Nursing); Ralph La Salle (Acting Executive Director, Planning Funding & Decision Support); Dr Jacqui Lunday-Johnstone (Executive Director, Allied Health, Scientific & Technical); Kay Jenkins (Executive Assistant, Governance Support); and Anna Craw (Board Secretariat).

EXECUTIVE APOLOGIES

Dr Sue Nightingale (Chief Medical Officer); and Dr Rob Ojala (Executive Lead for Facilities) – absence.
Kirsten Beynon (General Manager, Laboratories) – lateness.

IN ATTENDANCE

Full Meeting

Pauline Clark, General Manager, Medical/Surgical; Women's & Children's Health; & Orthopaedics
Dr Helen Skinner, General Manager, Older Persons Health & Rehabilitation
Dr Greg Hamilton, General Manager, Specialist Mental Health Services
Kirsten Beynon, General Manager, Laboratories
Win McDonald, Transition Programme Manager Rural Health Services
Berni Marra, Manager, Ashburton Health Services

Item 4

Lynne Johnson, Christchurch Campus Director of Nursing
Yvonne Williams, Hagley Operational Team Project Manager

Andrew Dickerson, Chair, HAC, opened the meeting. He acknowledged that Naomi Marshall has recently agreed to take on the role of HAC's Deputy Chair.

1. INTEREST REGISTER

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

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

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

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (13/20)
(Moved: James Gough/Seconded: Dr Rochelle Phipps – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 6 August 2020 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION ITEMS

The carried forward action items were noted.

4. MIGRATION TO HAGLEY (PRESENTATION)

Pauline Clark, General Manager, Medical & Surgical; Women's & Children's Health, & Orthopaedics, introduced Lynne Johnson, Christchurch Campus Director of Nursing; and Yvonne Williams, Hagley Operational Team Project Manager, who presented on migration planning for the move to Hagley.

Ingrid Taylor joined the meeting at 9.07am.

The presentation highlighted:

- Facilities that Hagley will provide
- Detail of the migration planning
- Migration Governance structure
- Roles and responsibilities
- Overarching principles for migration
- Operational work underway
- Orientation and training
- Communication objectives with regards to the Hagley migration

There was a query around what work has been done, particularly in ED, to support staff to think differently regarding flow and removing duplicity. Ms Johnson advised there is an ED governance group looking at those issues.

A member queried from a risk matrix perspective what is likely to be problematic during the migration. What is the largest risk from an operational perspective and what steps are in place to mitigate the risk? The Committee was advised that everything has been planned around a worst-case scenario – all plans are geared towards that. It is also important to remember that we transport patients around the hospital every day in huge volumes. Reasonably confident with patient migration plans that we have planned to the nth degree. Ms Johnson noted a potential high risk is a patient having a medical event mid transfer – this has been planned for. The member queried whether there would be anything different done during the logistical phase. Ms Johnson advised there will be more staff on the day – to assist with transfers, check in points along the way, and at the destination area. In addition, it was also advised that for some areas (ED, AMAU, Children's Acute Admission Area) dual sites will be run for a period of time.

Ms Johnson noted another risk was if PCs did not work once shifted from one location to another. This is a critical thing, because we are dependent on electronic systems to function effectively. This ISG component is a high risk.

Ms Clark advised that at a General Manager level, highest risk is making sure other DHBs for whom we are the tertiary service, are aware and we are working together in that space. Also, that there is not another significant community event.

The Chair thanked Ms Johnson and Ms Williams for their attendance and wished them every success with the migration.

5. H&SS MONITORING REPORT

The Committee considered the Hospital and Specialist Services Monitoring Report for September 2020. The report was taken as read.

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

Older Persons Health & Rehabilitation Service – Dr Helen Skinner, General Manager
Highlighted ongoing work in the following areas:

- Older Persons Health Medication Management.
- Level of care assessments for rest home care.
- The bed loop replacement project.

A member noted concern that the Older Persons Health Medication Management work was as a result of an HDC complaint and had not been picked up internally. It was queried whether processes have been altered internally to try to detect these types of events prior to them happening. It was also queried whether this work was being spread around the hospital. Dr Skinner advised of doing continuous improvement on clinical governance and safety management. Previously have been reactive as opposed to going out and looking for things. Reporting has now changed to ensure that near misses are also reported. Much more proactive in trying to manage risk. There is whole process around what has been done and things have changed massively over the last three years. Dr Skinner confirmed that this does feed into the DHB as a whole.

Specialist Mental Health Services (*SMHS*) – Dr Greg Hamilton, General Manager
It was noted that previously the Committee had requested a deeper dive in the Child, Adolescent and Family Service (*CAF*), particularly around concerns of wait lists and the time that was taken for that particular group to be seen. Dr Hamilton noted a review of this was provided in the report, and further highlighted the following:

- We do not treat the list of people coming into our outpatient services as homogeneous. We have a very active triaging process and that triaging process puts into place supports along the way. Interestingly, only one third of people referred to our services get a therapeutic intervention from us. Have large numbers being referred not necessarily for a SMHS response. This is something we need to be dealing with in an intersectoral way, with our colleagues in Education and Oranga Tamariki. It is a collective problem. Need to be able to strengthen community response and work on this collectively. That will be an ongoing focus.
- Something that should give comfort is that when you look back at patient acuity, in terms of seriousness, the most serious cases are being seen quickly. If you are urgent, you will get a response from the team you are coming into either on the day or the next day, or are referred for an urgent response from our community teams.
- A 20% increase has been seen during Term 3 of the current school year. Teams have been working extra hours to provide the response to make sure we are not leaving people undifferentiated at the end of the day. Have had to put more resource into that, with more people and working some longer sessions. Dr Hamilton advised that Oranga

Tamariki and NGO partners have agreed around a workshop with regards to managing this group who end up in crisis and distress.

Mr Dickerson noted that at its meeting on Tuesday, the Quality, Finance, Audit and Risk Committee (*QFARC*) considered the future of the CAF outpatient area with a recommendation to come through to the Board. Mr Dickerson was concerned that the paper was constructed around an engineering perspective and just because you can do something from an engineering perspective, is it desirable from a clinical perspective? Mr Dickerson hoped when the paper goes to the Board, the paper would include commentary as to the clinical desirability of the recommendation. Dr Hamilton advised that in terms of the clinical desirability, it is considered as a great option, putting teams into a purpose refitted facility. The role the Maia Health Foundation can play in this is absolutely fabulous, from turning this from a bricks and mortar response into a therapeutic space. Absolutely delighted with the direction.

There was a query around current presentation rates, this not being sustainable for staff and whether resourcing issues will be a barrier to service for this population. Dr Hamilton advised he believed the resourcing for this is an across entity issue. SMHS will probably never be the best solution for people with acute distress at any point in time, but we are relying on SMHS to pick that up because there is no-one else. It is a broader problem and if we address that then we will have a sustainable workforce.

In response to a query, Dr Hamilton advised initiatives are being developed for additional resources to come through which will assist in picking up mild and moderate distress and behavioural presentations. Work continues in this space.

A member noted it was useful to see in the report that telephone triaging is happening quite quickly. It would be useful to see what the waiting time is from referral to telephone triage, and seeing that high acuity are being seen within two days.

The member queried whether or not things are put in place for children who are waiting for months, or even a year for their first face to face. Have they been referred on? Do they have other points of contact? An assurance that children are not being lost in the system and that someone is monitoring/overseeing them.

The member spoke about the graph showing the "average waiting time from referral to first fact to face contact", and noted it would be useful to see this broken down into age groups, as previously there was disparity in the age groups, particularly the Under 12s. Dr Hamilton advised it is largely a same day response and if it is afterhours it then defaults to the Crisis Resolution Team.

A member noted that the Board is under pressure to reduce its deficit and there has been talk about services that are not fully funded. There are a couple of services here that CDHB funds over and above what would be targeted funding from the MoH. The member queried whether there was anything here at risk. Dr Hamilton advised that these are all services that contribute to our Operational Policy Framework responsibilities. Any options that you have in terms of how you could change them would have to be reconfigurations of what is provided currently.

There was a query whether the data being seen post lock down, was the same across the country or if it was also related to Christchurch's traumatic events. Dr Hamilton advised the MoH has been encouraged to answer this question around the country. Half way through a piece of work, but there are definitely some concerns about both young people and emergency presentations post lockdown.

There was a query around the definition of "phone triage" and why technology of Zoom or Teams is not being used. Dr Hamilton advised technology such as Zoom and Teams is used when doing some of the clinical work. Phone triage is done by phone. Phone triage is about finding out what the situation is – talking to a number of people in quick succession. Have done over 100 referrals in a week. They are not a planned piece of work, they are reactive to what is coming through the door. Phone remains most appropriate for triage work.

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

- Clinical Director for Haematology, Dr Mark Smith, died unexpectedly last Wednesday. He will be greatly missed by all his colleagues.
- Have made an appointment for a Haematologist who will join CDHB reasonably quickly. This is not a replacement for Dr Smith, but for the retirement earlier in the year of Dr Ruth Spearing.
- In radiation oncology, are in the process of needing to do a replacement of one of the LINACs - T3.
- Medical Oncology continues to experience workforce challenges. In the process of recruiting for vacancies. Reasonably confident to have two medical oncologists joining CDHB by January 2021. At same time, working with remaining medical oncologists and with colleagues around NZ, relooking at our model of care, utilisation of other centres to help us, utilisation of nursing, and other opportunities to do a little more without overburdening our medical oncologists. At their request, we are undertaking additional, urgent clinics initially for a three week period while the impact is monitored on the medical oncologists and assisting staff. These will run from 12 October 2020.
- Had a series of meetings to ensure we are on track to bring back outplaced surgery. Migration period is for the two weeks starting 16 October 2020 and towards the end of the week we start to quietly bring back outplaced clients. All theatre lists will be slightly lighter than usual, just to allow everybody to settle into the new space and new ways of working.
- Everyone is focused on the migration, but are also very engaged in the Accelerating Our Future programme.
- Year to date production levels are ahead of where we said we would be. Also doing well on Faster Cancer Treatment times.
- Provision of annual leave being taken by people is statistically significantly more than it was for this time last year. In addition, have seen a reduction in the amount of sick leave being taken.

There was a query around Cancer Treatment targets, and whether in the next reporting period we will see a drop in the figures due to current workforce challenges. Ms Clark advised she did not believe so.

Mr Dickerson suggested it would be useful to have a presentation to a future HAC meeting or to the Board from the Medical Oncology team.

Hospital Laboratories – Kirsten Beynon, General Manager, Laboratories

- Had a weeklong visit from IANZ and peer reviewers for surveillance and peer review audits against a range of laboratory standards of which we hold accreditation for. This is significant in relation to resource commitment by our teams to prepare for and host the auditors. It is always an opportunity to show case the quality standards and assurance that the teams constantly work towards.
- The IANZ audit coincided with a major Laboratory System upgrade across our Lab net group that includes four DHB laboratories. It was a significant ask of teams to undertake the upgrade whilst testing is at high weekday volumes. This upgrade was essential to complete prior to the migration of Christchurch Hospital services into the

new Hagley. A massive effort and long hours have been put in by ISG, LIS and laboratory teams in partnership with the vendor. The focus is now on optimising performance post upgrade and staff adjustments to the new system. Staff have fed back that some of the improved functionality made available through the upgrade will make a big difference to processes.

- Acknowledged the passing of Dr Mark Smith. His contribution to Clinical and Laboratory Haematology within Canterbury and beyond has been significant and his passing is a great loss to NZ. We will continue to provide support in coming months to his clinical, nursing and laboratory colleagues as this will have a long lasting impact.
- Pleased to be working with our Maori and Pacifika colleagues Hector Matthews, Finau Heuifanga Leveni and Kiki Maoate, as well as primary and secondary care representatives re: labs equity dashboards - analysis of laboratory data and information to make visible equity gaps within our health system. This information shows lower uptake for Maori and Pacifika for testing and for the selected test groups we reviewed higher test abnormality rates for certain conditions. We look forward to working with our colleagues to fully review the lab data. Through this we hope to help identify specific initiatives/pilot projects that can help address the access issues identified and in turn improve outcomes for these ethnic groups.

Rural Health Services – Win McDonald, Transition Programme Manager

- Continuing to see an increase in end of life care across rural facilities. A few years ago it was one every three months, last year was averaging one every fortnight, and as at today have six people sitting across four facilities, with another eight sitting in the community. Finding that we have a change in the use of the community hospitals. People are being very well cared for in the primary sector – district nurses through Nurse Maude are doing a fantastic job with palliative care – usually find within the last three, two and one week of life, that is when stress comes onto the family and the individual becomes an inpatient. This is a heads up of what is coming our way. Still very early in meeting our large numbers of those aged over 85 coming through, so need to be thinking quite strategically about what we are going to do with this volume of people coming. We are getting referrals directly from Nurse Maude for us to pick up palliative care patients because they are already full and they cannot cope with the volumes. In remote rural it makes more sense to keep people as close to their homes as possible.
- In term of changes in service provision, have been working with general practice practitioners and have introduced Medimap in Oxford and Waikari Hospitals and are about to commence that into Ellesmere Hospital and one chart into Darfield. This will allow remote prescribing to happen from a GP in his/her home, for example, through a telephone consultation, which then takes it through to Pharmacy and then to Administration. Taking pressure off primary sector practitioners.
- On Chatham Islands, have seen significantly increased levels of anxiety in children as a result of COVID. The Chathams has been particularly hard hit by COVID, losing about 90% of its income since about January 2020. Been doing work with Oranga Tamariki to put in additional resourcing.
- Work is underway on a Darfield paper. There was a TAS audit nearly nine months ago which recommended we reduce or takeaway maternity services at Darfield Hospital. Have two beds there used for post-natal care. In the last 18 months we have not had any post-natal care patients. This has resulted from the midwives living in that area, now no longer living there, so they are no longer referring them through. CDHB cannot provide that level of midwifery care and service, so from a risk perspective it makes perfectly good sense to take those beds away and they will be put back into ARC and palliative care where there is huge demand.

There was a query whether a change in funding around end of life care was impacting the increase in end of life care across rural facilities. Ms McDonald advised no, it was to do with the share volume. She also noted that across all of rural there is a reducing workforce, an aging

workforce, a different type of workforce in the younger workforce, which is putting more pressure again on people in their homes and caring for their elderly.

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

- Attended the rural hospital network meeting last week, a national forum where all rural hospitals are brought together. One of the core concerns nationally is afterhours care. Interesting to see mixed models. Need to keep an eye on and start looking at how we maintain a sustainable community model that ensures there is no reduction in equity of access, particularly for our high needs community.
- Acute demand cannot be looked at in isolation from community resilience. There is a lot of work happening in that space. Pleased to report that primary care workers and navigators are working well in Ashburton.
- Blessed with a philanthropic community. A recent community and social recovery research report was funded through Advance Ashburton. Has identified some core themes that are not uncommon to population health needs.
- Interested in what future opportunities there are around the Tier 2 modelling from the Heather Simpson report around integrated communities of care/integrated services. Clinical governance needs to be embedded and partnered into both the primary care clinical governance and PHO clinical governance. It cannot be looked at in isolation with a hospital lens only. Many of our services in the hospital are outreach services into the community.

The Committee noted the Hospital Advisory Committee Activity Report.

6. CLINICAL ADVISOR UPDATE – ALLIED HEALTH

Dr Jacqui Lunday Johnstone, Executive Director, Allied Health, Scientific & Technical, provided members with a copy of the CDHB/WCDHB Allied Health 2020–2025 Strategic Plan and suggested that given time constraints, it would be appropriate to provide a presentation to the next meeting on this document and other dimensions.

Dr Lunday Johnstone noted this is a group of professions which are probably less visible than our medical and nursing colleagues, and who have significant value to play across the system. Looking to build a more coherent vision about how to build some of the building blocks to support this workforce development and to mobilise their skills, capacity, capability and talent and service of system. Is about having more coherence and also how we support, in particular WCDHB, to avoid unnecessary variation and differences, but also to recognise where there are opportunities to involve the non-medical leadership, and also that inter professional approach that builds around the person at the centre. This is an exciting piece of work for Allied Health and also allows us to then develop an improvement and implementation plan that supports some of current strategic priorities.

A presentation will be scheduled for HAC's 3 December 2020 meeting.

A member queried the "Living Within Our Means" section of the H&SS Monitoring Report, noting HAC should be providing support to QFARC in this area. The member noted there is not a lot of narrative in this section of the report and requested that Mr Dickerson look at the best way for HAC to track some of the relevant pieces of work. Mr Dickerson undertook to discuss with Barry Bragg (QFARC Chair), and David Green (Acting Executive Director, Finance & Corporate Services).

7. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (14/20)
(Moved: Andrew Dickerson/Seconded: Jan Edwards – 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 6 August 2020	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(if required)*	Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege.	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)

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

INFORMATION ITEMS

- 2021 Meeting Schedule
- 2020 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 10.40am.

Approved and adopted as a true and correct record:

Andrew Dickerson
Chairperson

Date of approval

HAC MEETING 1 OCTOBER 2020 – MEETING ACTION NOTES

Item No	Item	Action Points	Staff
	Apologies	Sir John Hansen – absence	Anna Craw
1.	Interest Register	Nil	
2.	Minutes – 6 August 2020	Adopted: James Gough / Dr Rochelle Phipps	Anna Craw
3.	Carried Forward Items	Nil	
4.	Migration to Hagley (Presentation)	Nil	
5.	H&SS Monitoring Report	• Provide commentary in Hillmorton Laundry / CAF Relocation paper around clinical desirability of the recommendations. **Board report - due to Anna Craw - Tuesday, 6 October 2020** • CAF – provide data on waiting time from referral to telephone triage, and data on high acuity being seen within two days. **Provide to 3 December 2020 HAC meeting.** • CAF – provide information on what is put in place for children who are waiting for months, or even a year for their first face to face. Have they been referred on? Do they have other points of contact? Provide an assurance that children are not being lost in the system and that someone is monitoring/overseeing them. **Provide to 3 December 2020 HAC meeting.**	Dr Greg Hamilton Dr Greg Hamilton Dr Greg Hamilton Dr Greg Hamilton

HAC MEETING 1 OCTOBER 2020 – MEETING ACTION NOTES

		• CAF - Graph showing "average waiting time from referral to first face to face contact" – provide this broken down into age groups. Wanting to ascertain if there is disparity in the age groups, particularly the Under 12s. **Provide to 3 December 2020 HAC meeting.** • Presentation to future HAC or Board meeting from Medical Oncology Team.	Pauline Clark / Anna Craw
6.	Clinical Advisor Update – Allied Health	Presentation to HAC's 3 December 2020 meeting on the Allied Health 2020-25 Strategic Plan. **Presentation material due to Anna Craw – 23 November 2020**	Dr Jacqui Lunday Johnstone
7.	Resolution PX	Adopted: Andrew Dickerson / Jan Edwards	Anna Craw
	General	"Living Within Our Means" section of the H&SS Monitoring report. Discussions to be held on developing this section of report.	Andrew Dickerson / David Green
	Info Items	Nil	

Distribution List:
Dr Greg Hamilton
Dr Jacqui Lunday Johnstone
Pauline Clark

CC: Sharryn Sunbeam; Jayne Stephenson; and Maree Millar

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE
CARRIED FORWARD ITEMS AS AT 3 DECEMBER 2020

DATE RAISED		ACTION	REFERRED TO	STATUS
1.	30 Jan 2020	Chatham Islands	Ralph La Salle	Today's Agenda – Item 8.
2.	06 Aug 2020	Initiatives to support rural older population to remain in own homes/communities into the future.	Ralph La Salle	To 28 January 2021 meeting.
3.	01 Oct 2020	CAF – provide addition data/information: • Waiting time from referral to telephone triage, and data on high acuity being seen within two days. • Graph showing "average waiting time from referral to first face to face contact" – broken down into age groups. • Information on what is in place for children waiting months/year for first face to face contact.	Dr Greg Hamilton	Today's Agenda – Item 9.
4.	01 Oct 2020	Allied Health 2020-25 Strategic Plan presentation	Dr Jacqui Lunday Johnstone	Today's Agenda – Item 5.
5.	01 Oct 2020	H&SS Monitoring Report – development of "Living With Our Means" section	David Green	Under action.
6.	01 Oct 2020	Accelerating Our Futures	Dan Coward	Today's Agenda – Item 7.

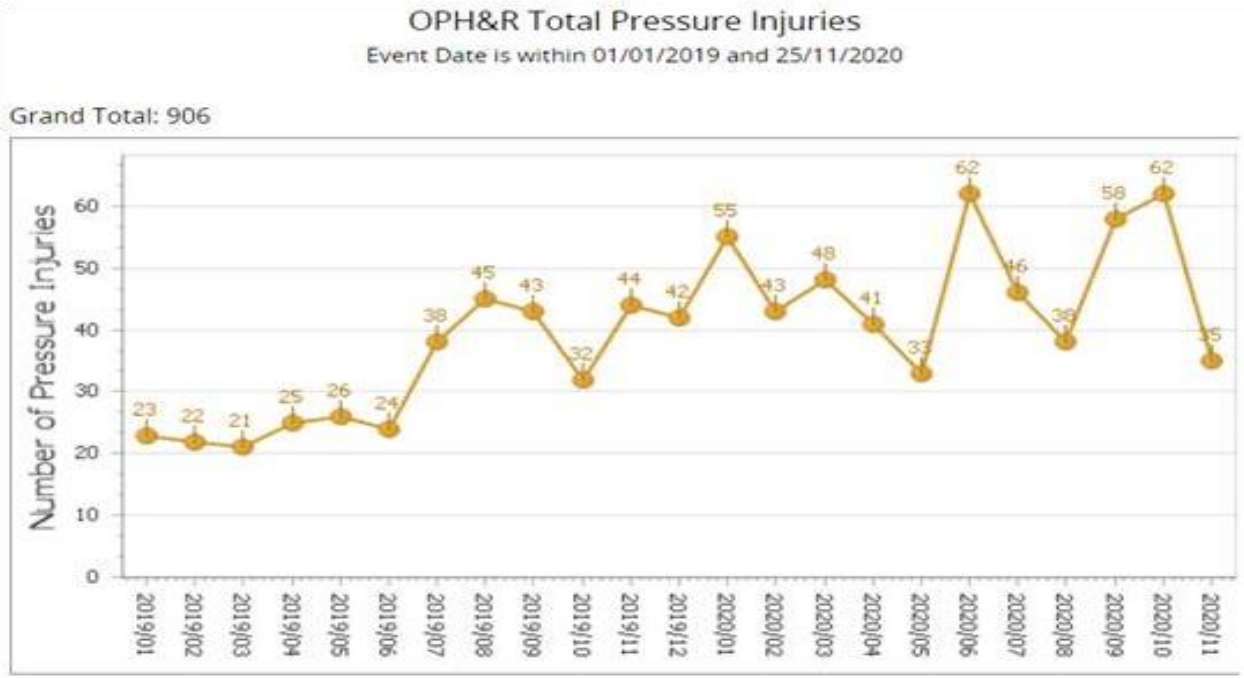
Pressure Injury Prevention Project

Older Persons Health and Rehabilitation

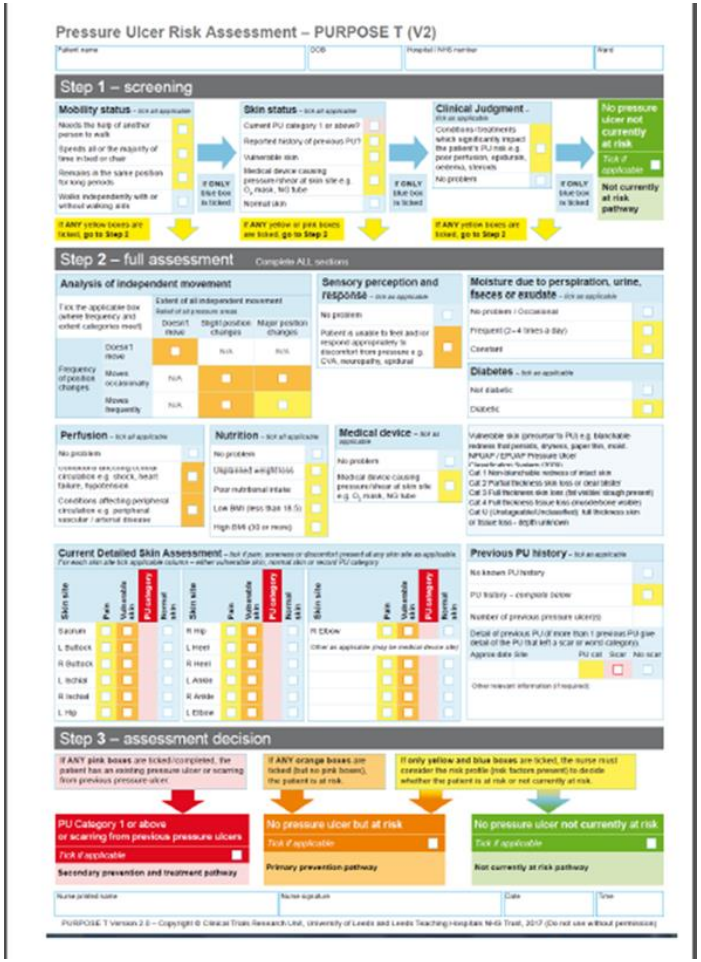
Dr Helen Skinner – Chief of Service/General Manager
Claire Pennington – Director of Allied Health/Operations Manager
Cherie Porter – Clinical Manager OT/AHP expert

Background

- Purpose-T risk assessment tool trialled at Burwood Hospital July 2019
- Led to a significant increase in Pressure Injury reporting both on admission and hospital acquired



Purpose-T



Pressure Ulcer Risk Assessment – PURPOSE T (V2)

Step 1 – screening

Mobility status

Skin status

Clinical Judgment

No pressure ulcer not currently at risk

Not currently at risk pathway

Step 2 – full assessment

Analysis of independent movement

Sensory perception and response

Moisture due to perspiration, urine, faeces or exudate

Diabetes

Perfusion

Nutrition

Medical device

Current Detailed Skin Assessment

Previous PU history

Step 3 – assessment decision

PU Category 1 or above or scarring from previous pressure ulcers

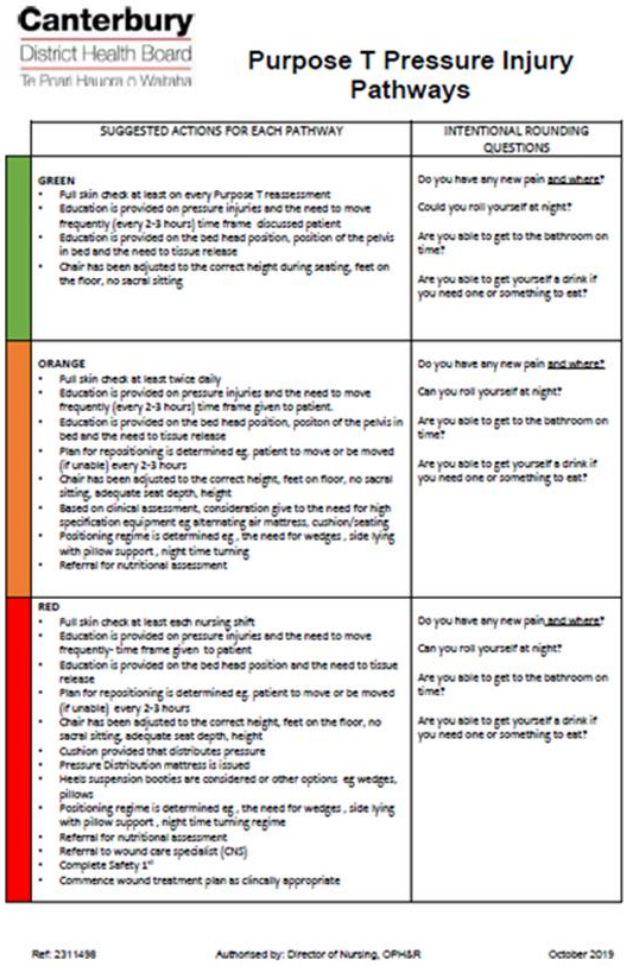
Secondary prevention and treatment pathway

No pressure ulcer but at risk

Primary prevention pathway

No pressure ulcer not currently at risk

Not currently at risk pathway



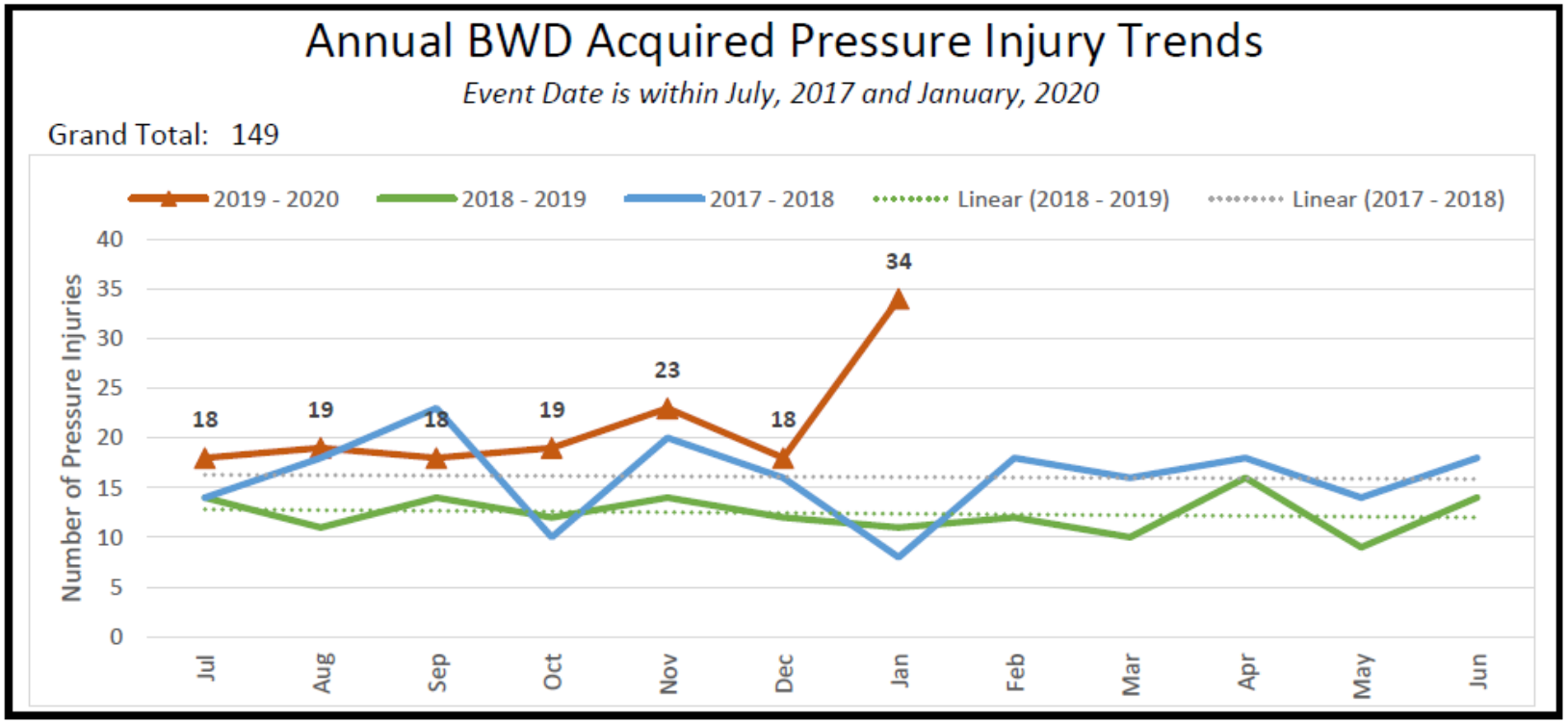
Canterbury District Health Board
Te Poari Hauora o Waitaha

Purpose T Pressure Injury Pathways

	SUGGESTED ACTIONS FOR EACH PATHWAY	INTENTIONAL ROUNDING QUESTIONS
	GREEN • Full skin check at least on every Purpose T reassessment • Education is provided on pressure injuries and the need to move frequently (every 2-3 hours) time frame discussed patient • Education is provided on the bed head position, positon of the pelvis in bed and the need to tissue release • Chair has been adjusted to the correct height during seating, feet on the floor, no sacral sitting	Do you have any new pain and where? Could you roll yourself at night? Are you able to get to the bathroom on time? Are you able to get yourself a drink if you need one or something to eat?
	ORANGE • Full skin check at least twice daily • Education is provided on pressure injuries and the need to move frequently (every 2-3 hours) time frame given to patient. • Education is provided on the bed head position, positon of the pelvis in bed and the need to tissue release • Plan for repositioning is determined eg. patient to move or be moved (if unable) every 2-3 hours • Chair has been adjusted to the correct height, feet on floor, no sacral sitting, adequate seat depth, height • Based on clinical assessment, consideration give to the need for high specification equipment eg alternating air mattress, cushion/seating • Positioning regime is determined eg , the need for wedges , side lying with pillow support , night time turning • Referral for nutritional assessment	Do you have any new pain and where? Can you roll yourself at night? Are you able to get to the bathroom on time? Are you able to get yourself a drink if you need one or something to eat?
	RED • Full skin check at least each nursing shift • Education is provided on pressure injuries and the need to move frequently- time frame given to patient • Education is provided on the bed head position and the need to tissue release • Plan for repositioning is determined eg. patient to move or be moved (if unable) every 2-3 hours • Chair has been adjusted to the correct height, feet on the floor, no sacral sitting, adequate seat depth, height • Cushion provided that distributes pressure • Pressure Distribution mattress is issued • Heels suspension booties are considered or other options eg wedges, pillows • Positioning regime is determined eg , the need for wedges , side lying with pillow support , night time turning regime • Referral for nutritional assessment • Referral to wound care specialist (CNS) • Complete Safety 1st • Commence wound treatment plan as clincally appropriate	Do you have any new pain and where? Can you roll yourself at night? Are you able to get to the bathroom on time? Are you able to get yourself a drink if you need one or something to eat?

Ref: 2311498 Authorised by: Director of Nursing, OPH&R October 2019

Why change was needed



What we did next

A deep dive was undertaken to all Burwood acquired PIs recorded in December

Findings

- Skin assessment not completed within 24 hours of admission
- Clinical diagnosis and associated risk factors not considered in mitigation plan
- Limited knowledge and use of equipment/ strategies to decrease risk
- Lack of understanding around Allied Health skill set in prevention of Pressure Injury
- Limited evidence of IDT accountability for reducing risk (seen as a nursing responsibility)

Key early objectives

- 41 actions associated with the overall project
- An additional 22 actions specifically for AHP expert

- The project will deliver something different from previous initiatives
- AHP expert as clinical lead & accountable
- Prevention – not treatment **'it's everybody's business.'**
- 90% reduction in Burwood acquired Pressure Injuries
- Partner with patients and whanau to challenge staff on regular movement, turns etc and discuss new areas of discomfort

Project progress so far

- Extraordinary meeting held to discuss ‘care failure’
- Grand round presentation and launch of project
- Inclusion of Purpose-T results and plan on SMO ward round sheet
- Tailored workforce education
- Every Burwood acquired PI reviewed by AHP expert or CNS/CNE
- All equipment located, labelled and pictures of how to use added
- Deep dives carried out on every Burwood PI for 3 months
- Follow up sessions by AHP expert with SMO, nursing and Allied health team
- Ward based audits carried out by DAH, DON and Chief of Service

Outcomes to date

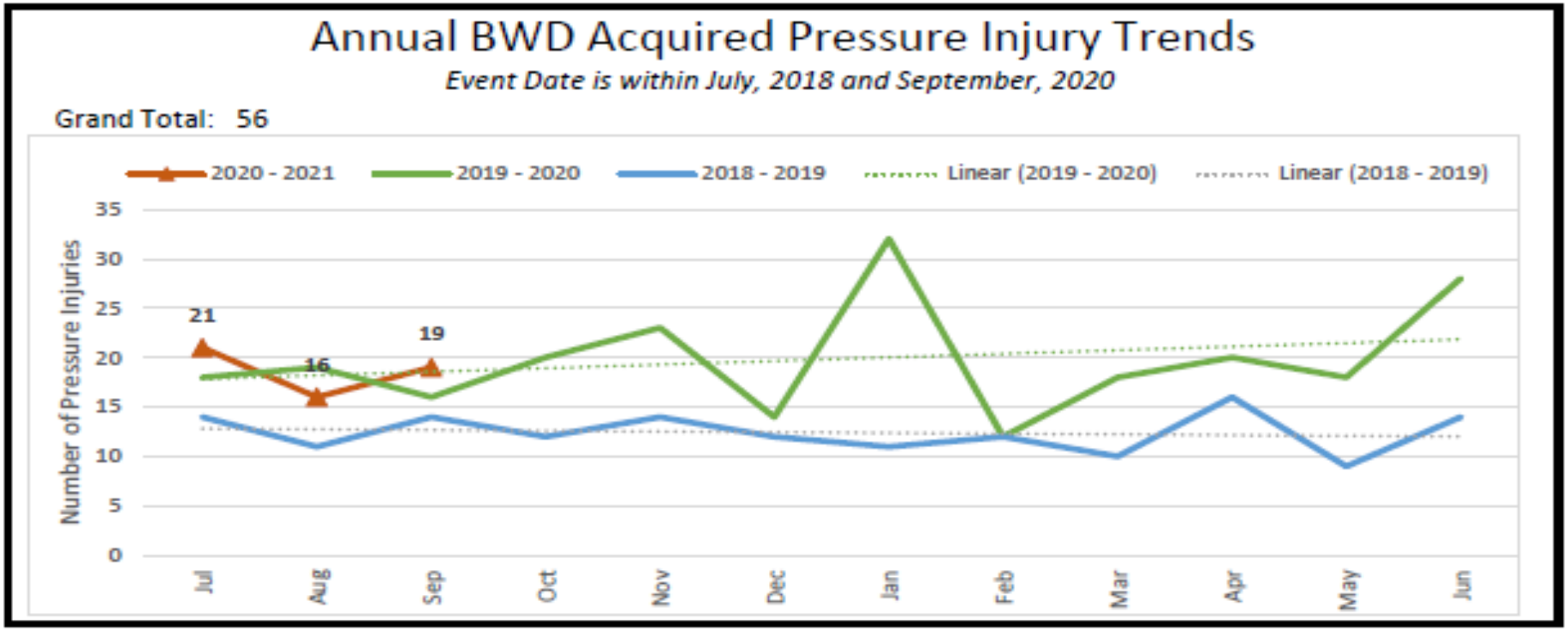
- Purpose-T within 6 hours of admission – improvement.
- Documented IDT involvement
- 100% response by AHP expert/CNS/CNE to Burwood acquired PI
- Strategies post PI show best practice
- Awareness across patient journey, e.g. orderlies changing seating used when transferring patients to Chch
- PIs discussed as ‘avoidable harm’
- Implemented post PI checklist for all Pressure Injuries recorded
- Collaborating with SfN to develop PI dashboard

Learnings so far

- Low knowledge base
- High variance in assessment timeframes and interpretation of policy
- High variance in staging decisions across staff
- Supervision/real time learning more impactful than education
- Lack of understanding of the roles and skills of Allied health professionals in this area
- Clear expectations of accountability

- Change from under reporting to over reporting!

What are our most recent findings?



- Over reporting of non PI – validated September data = 14 PI

What next?

- Promising early results

- Continued intensive focus on prevention of avoidable harm

- Focus on assessment within 6 hours
- Increase patient engagement
- Continue to investigate all Burwood acquired PI
- Link findings to further actions e.g. medical devices, continence and footstools!

CDHB Allied Health Strategic Direction

ALLIED HEALTH
West Coast
Whenu Whakaora

Allied Health
Canterbury District Health Board

ALLIED HEALTH
WHO ARE WE?

Diverse

16% of our workforce identify as Maori or Pasifika

Far Reaching

The Allied Health workforce consists of over 20 professions across Canterbury and West Coast with 2,212 staff

Forward Thinking

Allied Health professionals are an innovative and versatile group who help connect the system along each step of the care continuum

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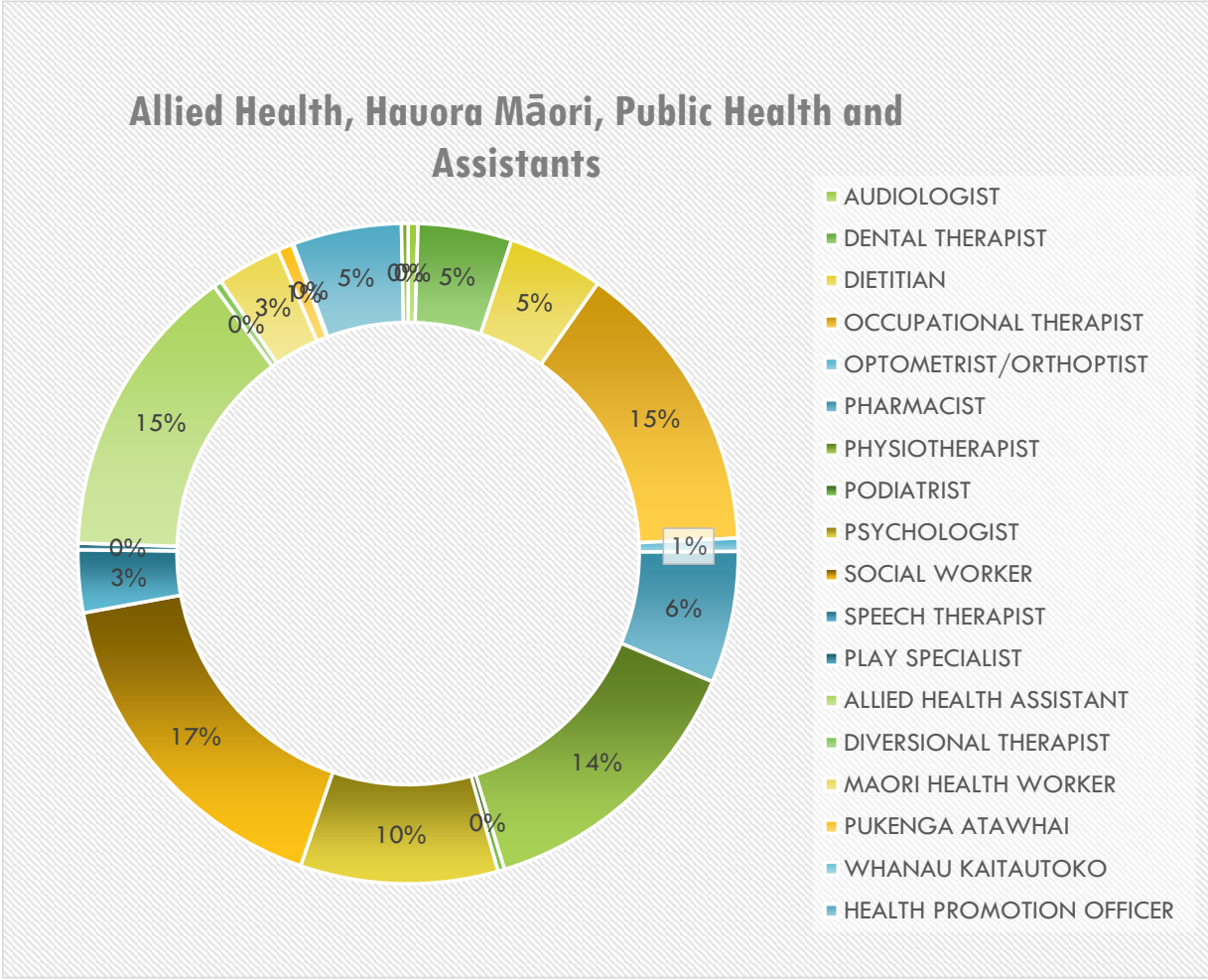
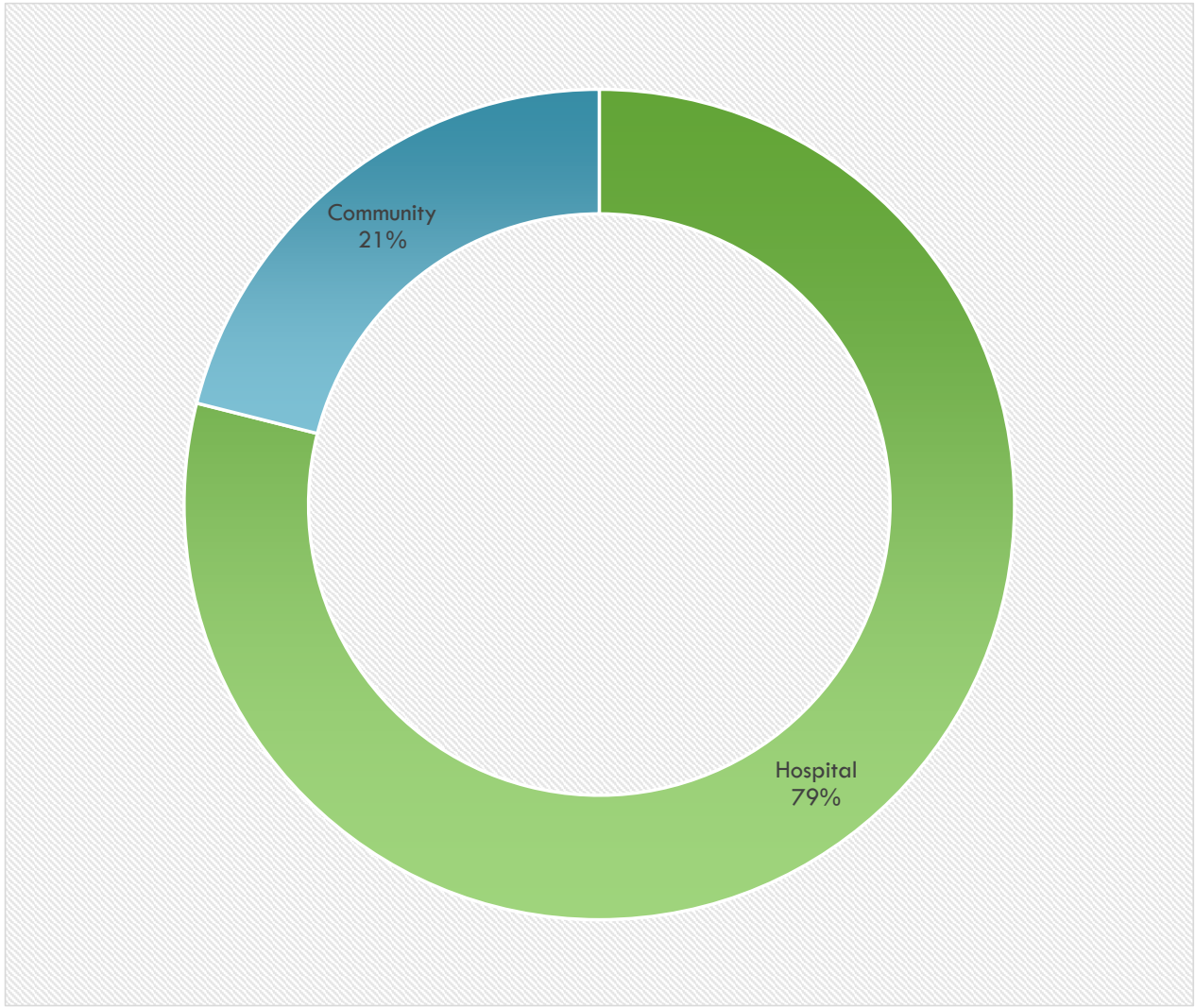
ALLIED HEALTH
WHO ARE WE?



WHERE ARE WE BASED?



ALLIED HEALTH STRATEGIC PLAN

In late 2019 we held an Allied Health Leaders workshop.

These results came from a series of questions on the current leadership and governance structure in Allied Health.

90% of survey respondents agree we need a unified approach to leadership across each profession for the system

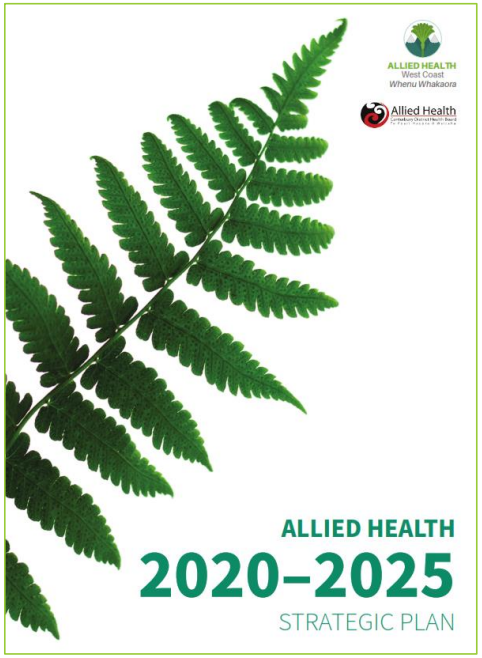
80% of survey respondents agree we need to create more opportunities for leaders to work outside of the box and gain experience beyond their profession

80% of survey respondents agree we need to develop integrated AH leadership roles to support change and focus on priority areas for change improvement

100% of survey respondents agree that leaders need an opportunity to develop skills in change management and/or improvement approaches

ALLIED HEALTH STRATEGIC PLAN

In July we launched our Allied Health Strategic Plan focussing on streamlining our processes, diversifying our skill mix and working together to deliver a step change in how we can work differently and more efficiently, while reducing duplication of effort and wastage. This will enable us to continue to become more proactive, preventative and community focused rather than reactive and somewhat hospital centric.



WHAT DO WE NEED?

Enhanced Leadership Structure

90% of survey respondents agreed an Allied Health programme of leadership development is needed to develop their skills

Cohesive Governance

70% of survey respondents recognise the need for streamlined, clear governance and leadership across professions

Increased Community Based Care

Currently, 79% of our workforce are hospital based

KEY PRIORITIES

1. WORKFORCE DEVELOPMENT

2. ENHANCING LEADERSHIP

3. PARTNERSHIP, PARTICIPATION AND EMPOWERMENT

4. DIGITAL OPTIMISATION

5. PROFESSIONAL PRACTICE & SKILLS DEVELOPMENT

6. RESEARCH, INNOVATION & IMPROVEMENT SCIENCE

WE ARE WORKING TOWARDS THIS BY

Enhanced Collaboration

Working in close collaboration with the community, stakeholders, people and whānau we serve

Digitally Enabled Workforce

Equitable focus on providing digitally enabled models of care across the Canterbury and West Coast to improve outcomes

Creating Opportunities

Maximise the contribution of Allied Health to priority areas to support transformation and enable the development of sustainable and resilient transalpine service delivery

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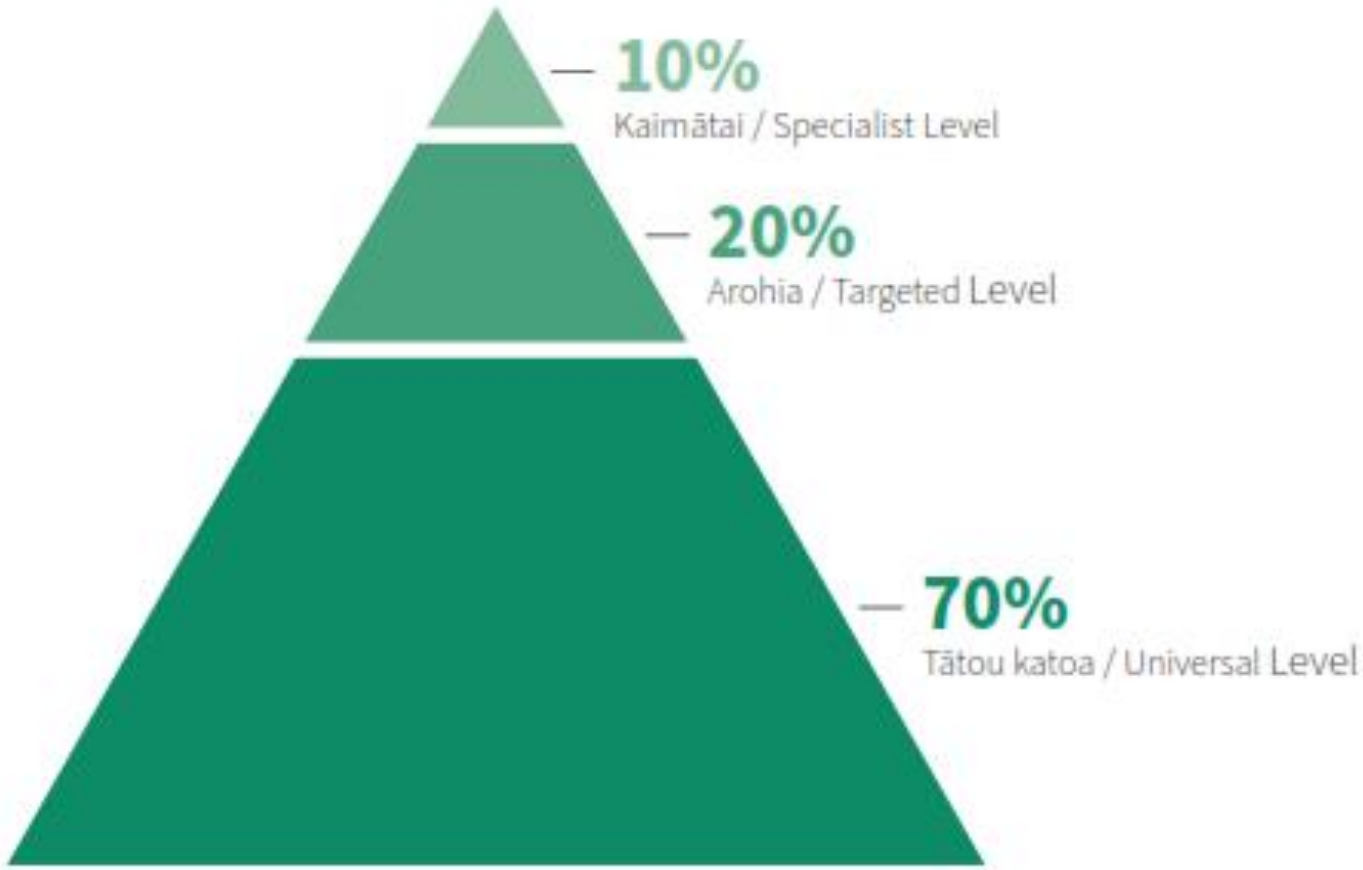
STEPPED MODEL OF CARE



ALLIED & PUBLIC HEALTH CAREER FRAMEWORK

In October 2020, we launched the Allied & Public Health Career in partnership with the PSA. The PSA-DHB MECA Terms of Settlement outlines a commitment to the development of local or regional Career Frameworks for Allied Health Professions.

The purpose of the career framework is to;

- **Create consistency and transparency around how people progress in their career**
- **Create clinical and leadership career pathways**
- **Provide clarity around the role of allied health professionals in a clinical setting.**

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CCDM
(CARE CAPACITY DEMAND MANAGEMENT)

Safe staffing CCDM is also a commitment for Allied Health – Variance Response

1. **Last DHB in NZ to implement work towards this**
2. **Commitment in principal to CCDM lead for CDHB/WC**
3. **Allied Health safe staffing is not straight forward**
4. **Last piece of the puzzle in terms of matching resource to activity and acuity**

Canterbury District Health Board
Te Poari Hauora o Waitaha

SAFE Staffing HEALTHY Workplaces CCDM Care Capacity Demand Management
NZ District Health Boards & Health Unions working together

TAS Kahui tuitui tangata

Whāia te pae tawhiti kia tata, ko te pae tata kia mau, kia tina.

Seek the distant horizon to bring it close, the horizon that is close, hold strong.

CARE CAPACITY DEMAND MANAGEMENT UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

SOURCE: **Janette Dallas, CCDM Programme Manager**

APPROVED BY: **Becky Hickmott, Acting Executive Director of Nursing**

DATE: **3 December 2020**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report has been generated for the committee as a bi-annual update on the Care Capacity Demand Management programme to better match nursing and midwifery supply to patient care demand, approved by the Board for implementation in August 2019.

2. RECOMMENDATION

That the Committee:

i. notes that the Care Capacity Demand Management programme is well underway to meeting the commitment as required by the New Zealand Nursing Organisation (*NZNO*), DHB and Ministry of Health (*MoH*) Accord to implement better match of nursing and midwifery supply to patient care demand; and

ii. notes the letter of acknowledgement from the National Safe Staffing Healthy Workplaces (*SSHW*) Unit of progress to date.

3. BACKGROUND

In July 2018 the NZNO, DHBs and MoH signed an Accord committing the parties to having sufficient nurses and midwives in public hospitals to ensure staff and patient safety. The Accord mandates a Care Capacity Demand Management (*CCDM*) programme be implemented by all DHBs by June 2021.

The implementation of the CCDM programme commenced in July 2019 at the CDHB. This required the investment of $3.465M for the software implementation and staff training costs that would be incurred. Staffing costs were allocated by the MoH for nine CCDM staff. Ongoing operational costs will be required to support the business as usual staff resourcing and software licensing.

4. UPDATE

The CCDM is governed by a Council, with representation from the whole of the Executive Management Team, Senior Nursing, Midwifery and Union Partners. This ensures that the CCDM programme is well planned, coordinated and appropriate for staff and patients and meets MECA contractual obligations.

Working groups as part of the CCDM requirements have also been established to commence the work plans for CCDM implementation. These are Variance Response Management and the Core Data Set Working Groups and a CCDM Directorate Group at each campus. The next group to be established will be the FTE Establishment working group.

The CCDM programme commenced with the first phase of work concentrated on the installation of TrendCare, a software tool to capture acuity and nursing or midwifery intensity. TrendCare is the

only validated acuity tool in Australasia and is being used by all DHBs within New Zealand. The tool measures patient acuity, provides ward profiles, predicts hours required based on ratios and targets to determine clinical hours required for care. It will also provide reporting functions to manage workloads and track variances.

TrendCare has been implemented with Training, Inter-Rater Reliability (*IRR*) testing and reports workshops held at Ashburton Hospital, Burwood Hospital, 14 wards at Christchurch Hospital and Specialist Mental Health Services. TrendCare Training workshops were held for Women's and Children's Health in August and IRR testing is underway for these areas.

Training workshops have been held for ED, AMAU and the remaining Christchurch Hospital inpatient wards in September, with Day Stay areas and ICU due for TrendCare implementation in February 2021.

The Covid-19 Pandemic lockdown of March/April 2020 resulted in a pause in the implementation timeline. The timeframes for delivery of the key milestones have been affected by this and the work plan has been amended. This has been acknowledged by the SSHW Unit and has proved problematic and impacted on timelines for all DHBs across the nation.

Since the implementation of TrendCare, the focus is now on the validation of the data captured in the tool, and the matching of staffing to demand. The data validation process occurs from the commencement of each clinical area to ensure they obtain reliable data. This occurs with comprehensive training, IRR testing, data integrity checks, reviews and benchmarking with SSHW Unit support. A year's worth of validated data is required for each ward before commencement of the FTE calculations can occur. The first round of FTE calculations will be early May 2021.

The work plan for the Core Data Set is proceeding quickly as we have a data rich environment established already at CDHB. Local Data Councils will be set up in each area and will consist of frontline clinical staff who meet monthly to jointly identify and resolve issues, set goals and measure results. Currently five Local Data Councils have been established, one at Ashburton Hospital and four at Christchurch Hospital. These councils are at the end of the design phase for visualising our Core Data Set (outcome measures) which will be shown on the intranet webpage.

The other component we are currently implementing is the Variance Response Management tools and processes. These tools and processes create visibility of the variance between the patient demand and the staffing resource, and the management of this variance. A stocktake of the SSHW Variance Response standards has been completed and we currently meet 36% of the standard and partially achieved 21%. We have already good visibility of hospital capacity with the hospital at a glance screens used by staff. Staffing demands within our clinical areas are well known and we have established hospital wide daily planning meetings, for example to meet these needs.

A Variance Indicator Score tool is in design and will be installed for trial by February 2021 with full implementation over the next six months. This will be a virtual tool with information visible across the areas to enable the mobilisation of resources as required.

The inpatient wards who have completed their IRR testing now have access to a Capacity at a Glance (*CaaG*) screen on Prism Seeing our System. This displays acuity variance and thus supports staffing decision making.

The key risks to the timeline of the implementation have been the move to Waipapa and the current Covid-19 Pandemic

5. APPENDICES

Appendix 1: Safe Staffing Healthy Workplaces (*SSHW*) Unit letter: dated 23 November 2020.

27 November 2020

Dr Andrew Brant
Interim Chief Executive
Canterbury District Health Board

Becky Hickmott
Acting Executive Director of Nursing
Canterbury District Health Board

Dear Andrew and Becky

As DHBs strive to meet the 30 June 2021 deadline for the implementation of the Care Capacity Demand Management (CCDM) programme it has been disappointing that the Safe Staffing Health Workplaces Governance Group has not been able to make the usual number of visits to District Health Boards (DHBs), to support the implementation of CCDM.

Although we get fulsome reports from the Safe Staffing Healthy Workplaces (SSHW) unit staff, we regret that as governors of the programme we have not been able to see first-hand the progress you are making. We are aware that your DHB has only relatively recently implemented the patient acuity tool TrendCare, which has been our concern ahead of the deadline of 30 June 2021. However, you are making a tremendous effort across all the CCDM Standards and making significant progress toward achieving our common goal.

Your DHB is a great example of the success that comes from a partnership which is built on trusted relationships. Of course, there will be disagreements, but we can see from the progress you are making that you are successfully working through your differences.

We congratulate you all. Our advice is, continue to use the strength of your partnership and always keep front of mind our end goals:

- quality patient care
- safe, healthy workplaces
- prudent use of precious health resources.

The SSHW Unit is there to support you so we urge you to use their advice and expertise when you encounter issues. Share with the SSHW Unit your successes so others can then learn from you. Equally, take the time to learn from other successful DHBs, as that might help increase the speed at which you are implementing CCDM.

Keep up the good work.

69 Tory Street, Wellington 6011, PO Box 23 075, Wellington 6140, New Zealand | Phone: +64 4 801 2430, Fax: +64 4 801 6230
Email: info@tas.health.nz Website: www.tas.health.nz

Yours Sincerely

Julie Robinson

Co-chair SSHWU Governance Group

Memo Musa

Co-chair SSHWU Governance Group

CC: CCDM Council Chair
SSHW Unit – Director & Programme Consultant

Nursing Update

CDHB TrendCare Staffing Report

- TrendCare is the CDHB's acuity tool which measures efficiency and productivity of the ward environment. It is internationally validated and used by all of NZ.
- It forms part of the Care Capacity Demand Management (CCDM) Programme. It is the only validated acuity tool available and is utilised in all DHBs across New Zealand.
- CDHB commenced late 2019 and are progressively implementing sequentially throughout all inpatient areas.
- Some wards have already completed their Inter-rater Reliability (IRR) testing (the extent that two or more nurses or midwives agree on the acuity), averaging a score of over 98% with external testing completed by the CCDM Coordinators for robustness.

Graphs

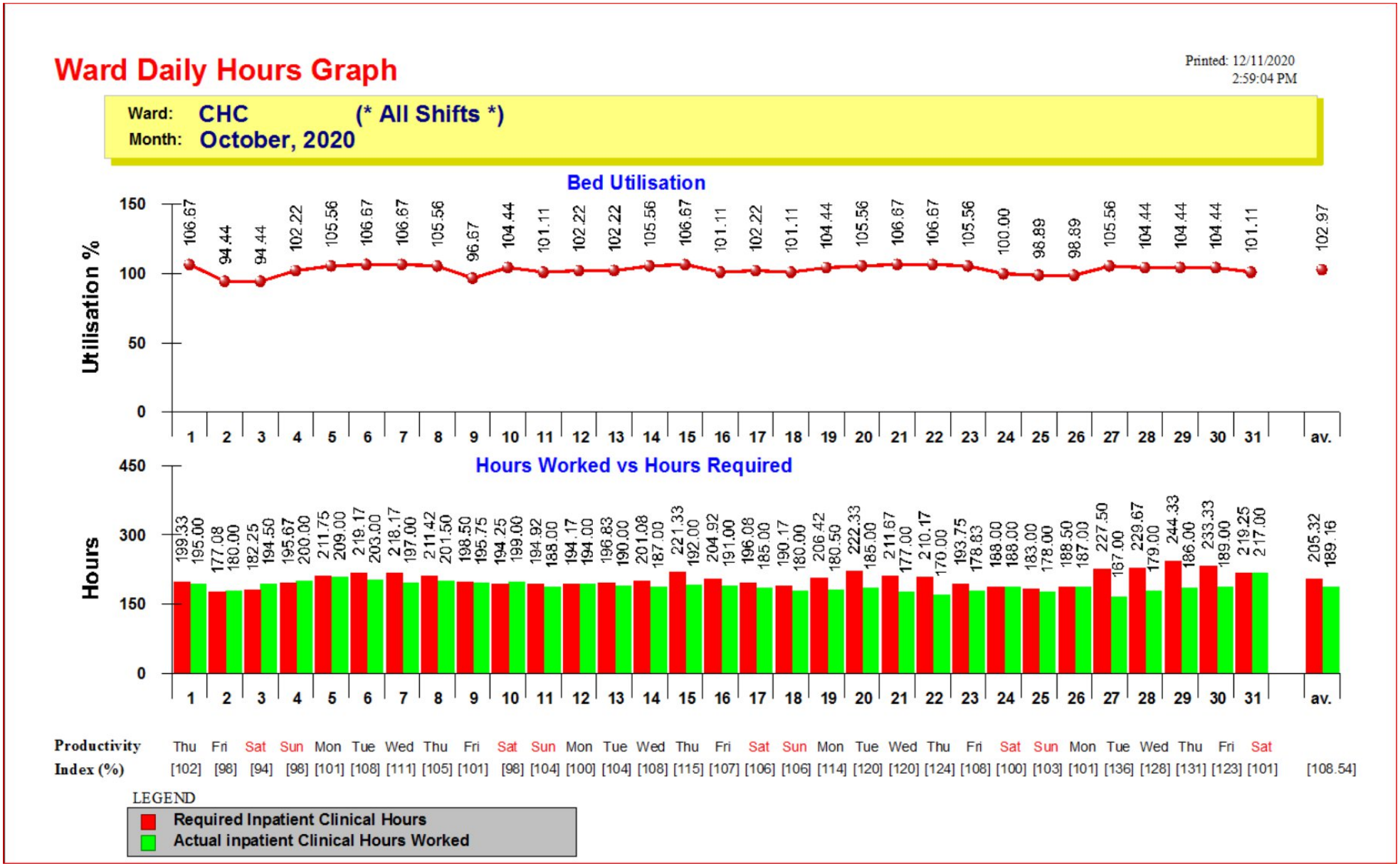
- The graphs below display the efficiency for the wards that are live and have completed IRR.
- The **top graph** displays the bed throughput by percentage of physical beds that have occupied for each day of the selected month. This percentage can be more than 100% if the bed has had two patients in the bed over the 8- hour shift.
- The **bottom graph** displays the daily clinical nursing or midwifery hours (HH.mm) required by acuity for inpatient care (**Red**) against the nursing or midwifery hours worked (**Green**) over the 8-hour shift, in the selected ward for the month of July.
- The **productivity index** is the ratio of actual nursing or midwifery hours available to actual nursing hours required by acuity.
- Safe Staffing Healthy Workplaces Unit recommends that wards should have a **productivity index** of approximately between 85-95% during the day and 75-85% in the afternoon shift and the night shift to ensure all care can be delivered during the shift.
- The small amount of spare capacity that should be there ensures wards can receive patients at any time and increases the ability for them to support the broader hospital **variance response management**. It allows flexibility to move staff across the service.
- The **average productivity** for the month is represented at the right-hand side of the table.

Physical Utilisation versus Productivity Index by Ward
Christchurch Campus - October 2020

Ward	Physical Utilisation %	Productivity Index %
Ward xx	98.05	103.33
Ward xx	91.52	83.51
Ward xx	99.75	91.13
Ward xx	93.33	90.35
Ward xx	87.67	90.18
Ward xx	101.94	99.97
Ward xx	79.57	100.92
Ward xx	102.97	108.54
XXXX Unit	90.18	86.32
XXX	69.89	124.26

A **productivity index** near 100% would suggest that delivery of care may have be missed due to the lack of available nursing or midwifery hours. **This indicates that staffing is exceedingly tight** in those wards above the 85-95% mark.

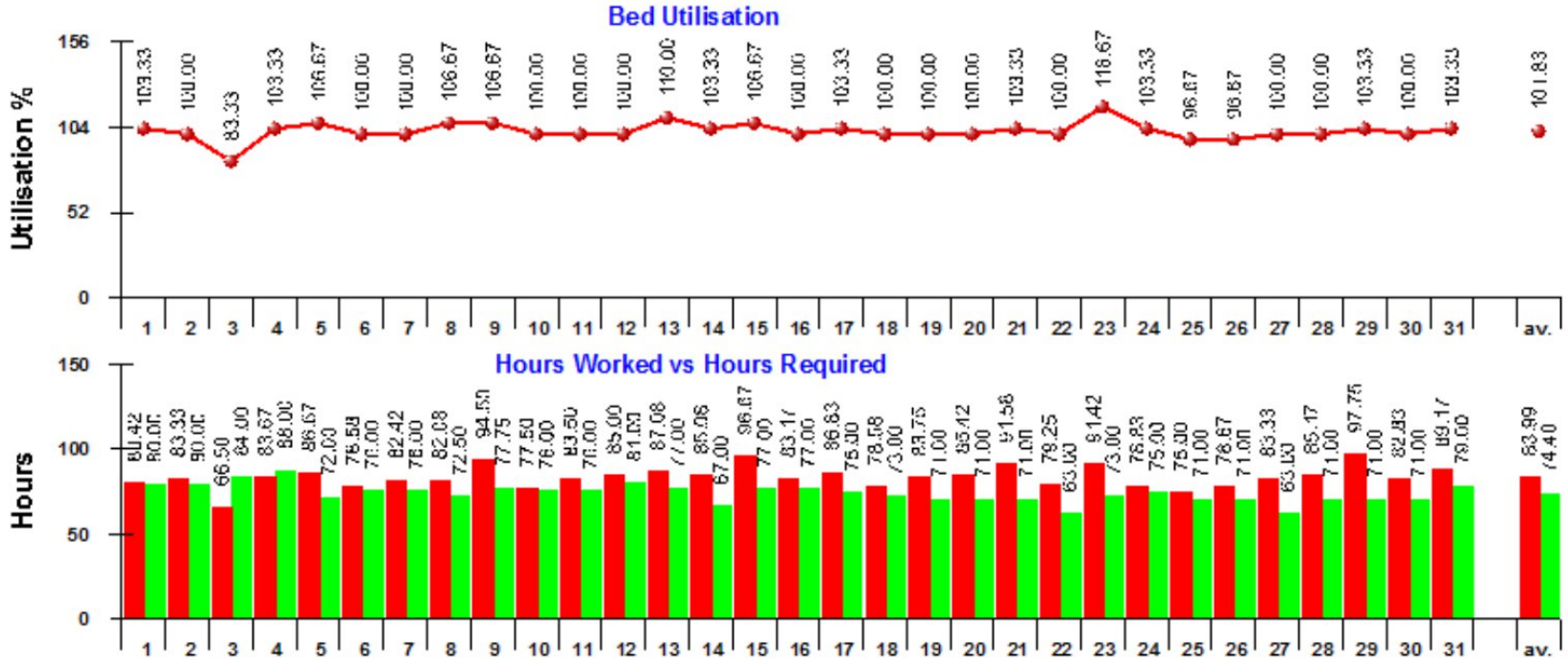
Note: the productivity index (nursing or midwifery hours available and required to deliver safe care) data is combined for the three shifts. You will see in the next slides that when shifts are viewed individually there are some significant nursing or midwifery hours deficits. The next slides are samples of different wards and their physical bed utilisation graphs as well as their actual nursing hours available compared to actual nursing hours required by acuity


Ward Daily Hours Graph
Printed: 12/11/2020
2:59:04 PM
Ward: CHC (* All Shifts *)
Month: October, 2020
Bed Utilisation
Utilisation %
150
100
50
0
106.67 94.44 94.44 102.22 105.56 106.67 106.67 105.56 96.67 104.44 101.11 102.22 102.22 105.56 106.67 101.11 102.22 101.11 104.44 105.56 106.67 106.67 105.56 100.00 98.89 98.89 105.56 104.44 104.44 104.44 101.11 102.97
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 av.
Hours Worked vs Hours Required
Hours
450
300
150
0
199.33 195.00 177.08 180.00 182.25 194.50 195.67 200.00 211.75 209.00 219.17 203.00 218.17 197.00 211.42 201.50 198.50 195.75 194.25 199.00 194.92 188.00 194.17 194.00 196.83 190.00 201.08 187.00 221.33 192.00 204.92 191.00 196.08 185.00 190.17 180.00 206.42 180.50 222.33 185.00 211.67 177.00 210.17 170.00 193.75 178.83 188.00 188.00 183.00 178.00 188.50 187.00 227.50 167.00 229.67 179.00 244.33 186.00 233.33 189.00 219.25 217.00 205.32 189.16
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 av.
Productivity Index (%)
Thu [102] Fri [98] Sat [94] Sun [98] Mon [101] Tue [108] Wed [111] Thu [105] Fri [101] Sat [98] Sun [104] Mon [100] Tue [104] Wed [108] Thu [115] Fri [107] Sat [106] Sun [106] Mon [114] Tue [120] Wed [120] Thu [124] Fri [108] Sat [100] Sun [103] Mon [101] Tue [136] Wed [128] Thu [131] Fri [123] Sat [101] [108.54]
LEGEND
Required Inpatient Clinical Hours
Actual inpatient Clinical Hours Worked

Ward Daily Hours Graph

Printed: 23/11/2020
9:02:36 AM

Ward: CHC (Day Shift)
Month: October, 2020



Productivity Index (%)	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	
	[101]	[104]	[79]	[95]	[120]	[103]	[108]	[113]	[122]	[102]	[110]	[105]	[113]	[127]	[126]	[108]	[116]	[108]	[118]	[120]	[129]	[126]	[125]	[105]	[106]	[111]	[132]	[120]	[138]	[117]	[113]	[112.90]

LEGEND

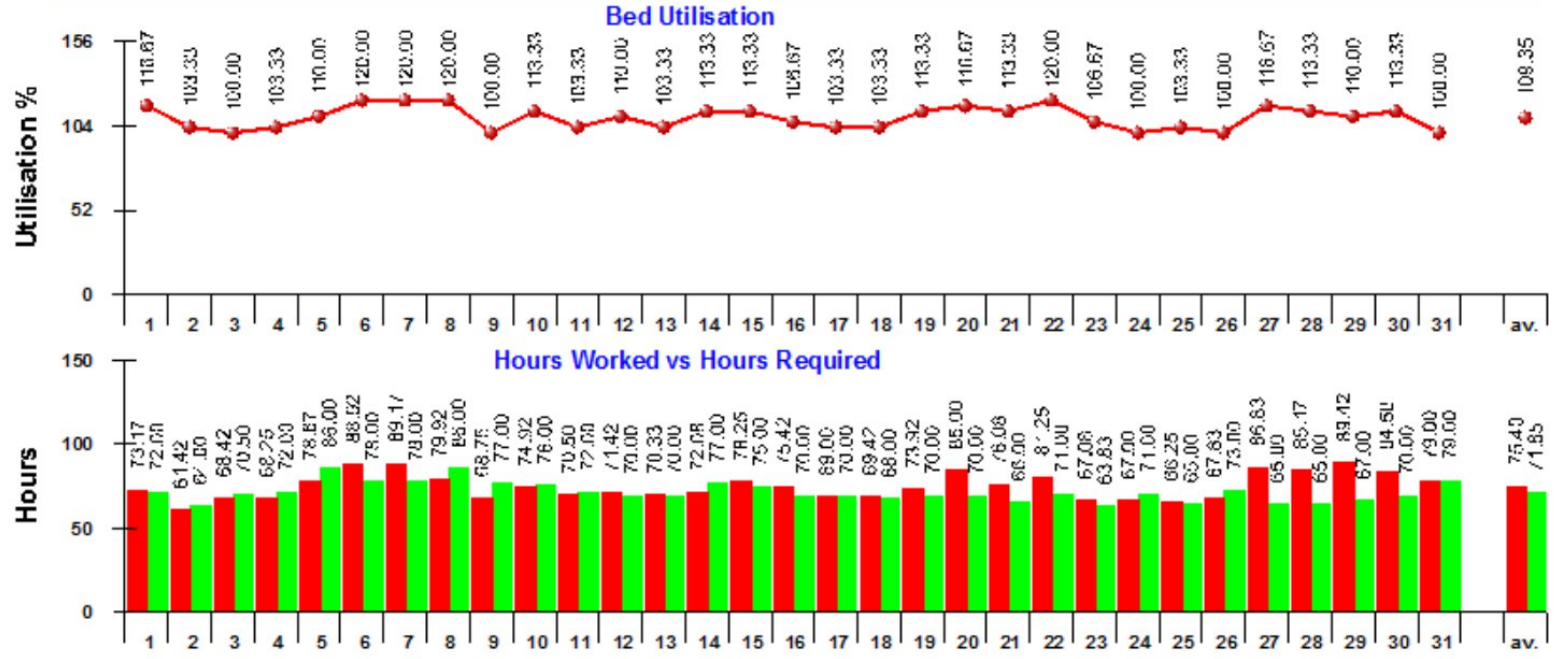
- Required Inpatient Clinical Hours
- Actual inpatient Clinical Hours Worked

NOTES: • This graph displays bed utilisation, the daily clinical hours required for inpatient care and the hours provided for inpatient care in the selected ward/department for the selected month. The productivity index is displayed for each day and rounded off to the closest whole precentage.

Ward Daily Hours Graph

Printed: 23/11/2020
9:02:36 AM

Ward: CHC (Evening Shift)
Month: October, 2020



Productivity Index (%)	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	
	[102]	[96]	[97]	[95]	[91]	[114]	[114]	[93]	[89]	[99]	[98]	[102]	[100]	[94]	[104]	[108]	[99]	[102]	[108]	[121]	[115]	[114]	[105]	[94]	[102]	[93]	[134]	[131]	[133]	[121]	[100]	[104.94]

LEGEND

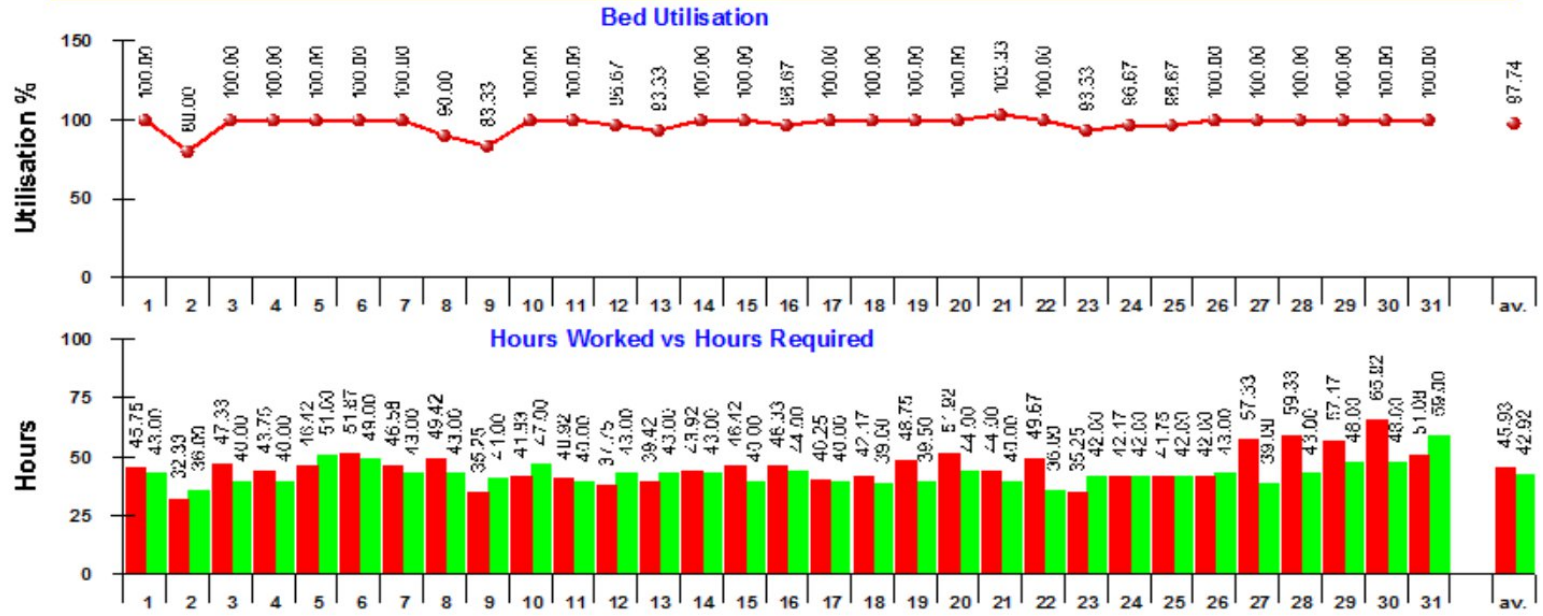
- Required Inpatient Clinical Hours
- Actual inpatient Clinical Hours Worked

NOTES: • This graph displays bed utilisation, the daily clinical hours required for inpatient care and the hours provided for inpatient care in the selected ward/department for the selected month. The productivity index is displayed for each day and rounded off to the closest whole precentage.

Ward Daily Hours Graph

Printed: 23/11/2020
9:02:36 AM

Ward: CHC (Night Shift)
Month: October, 2020



Productivity Index (%)	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	
	[106]	[90]	[118]	[109]	[91]	[105]	[108]	[115]	[86]	[89]	[102]	[88]	[92]	[102]	[116]	[105]	[101]	[108]	[123]	[118]	[110]	[138]	[84]	[100]	[99]	[98]	[147]	[138]	[119]	[137]	[87]	[107.01]

LEGEND
- Required Inpatient Clinical Hours
- Actual inpatient Clinical Hours Worked

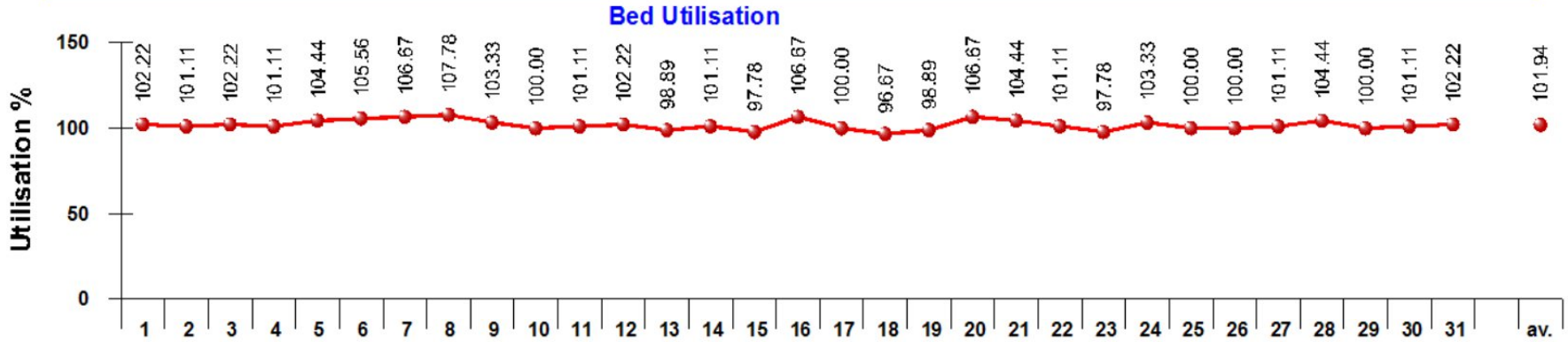
NOTES: • This graph displays bed utilisation, the daily clinical hours required for inpatient care and the hours provided for inpatient care in the selected ward/department for the selected month. The productivity index is displayed for each day and rounded off to the closest whole precentage.

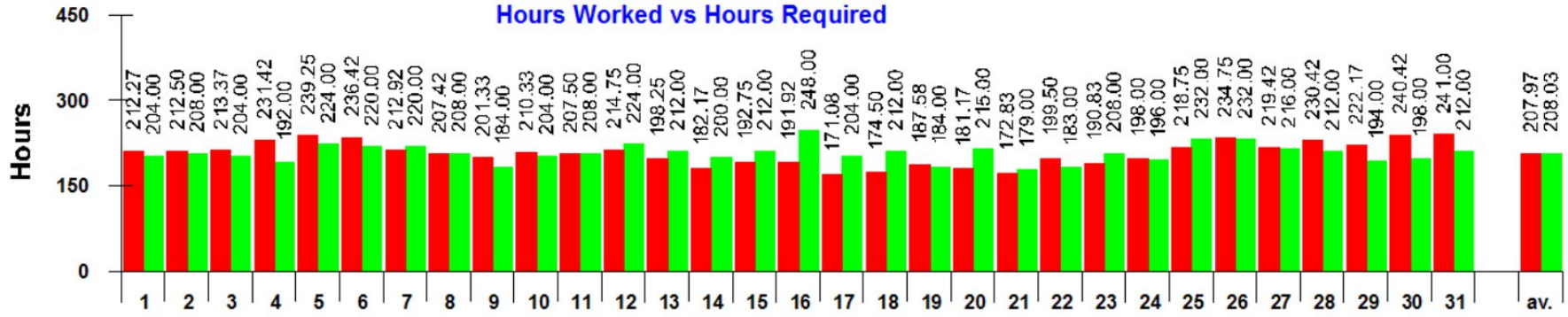
Ward Daily Hours Graph

Printed: 12/11/2020
2:35:30 PM

Ward: CHC (* All Shifts *)
Month: October, 2020

**Bed utilisation - actual physical beds throughput*





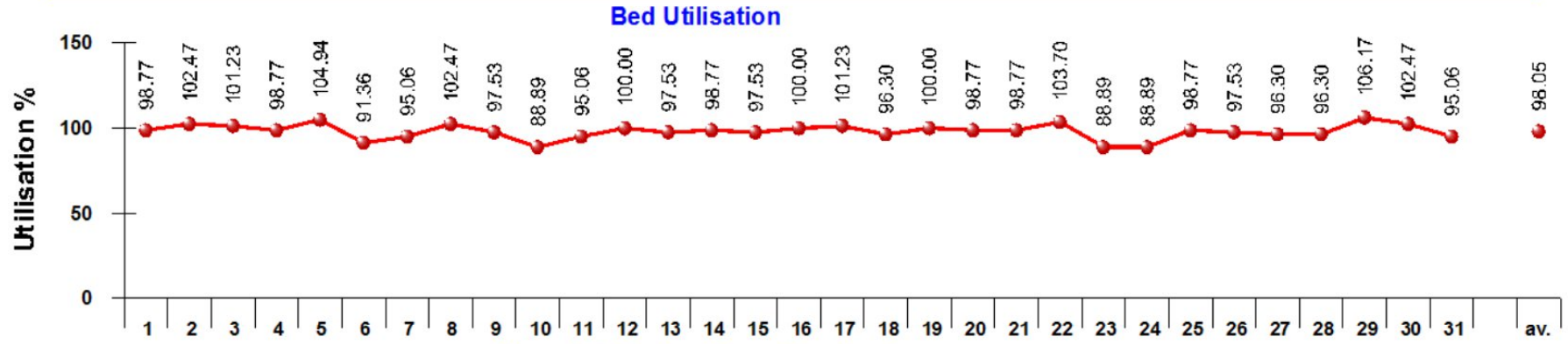
Productivity	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	
Index (%)	[104]	[102]	[105]	[121]	[107]	[107]	[97]	[100]	[109]	[103]	[100]	[96]	[94]	[91]	[91]	[77]	[84]	[82]	[102]	[84]	[97]	[109]	[92]	[101]	[94]	[101]	[102]	[109]	[115]	[121]	[114]	[99.97]

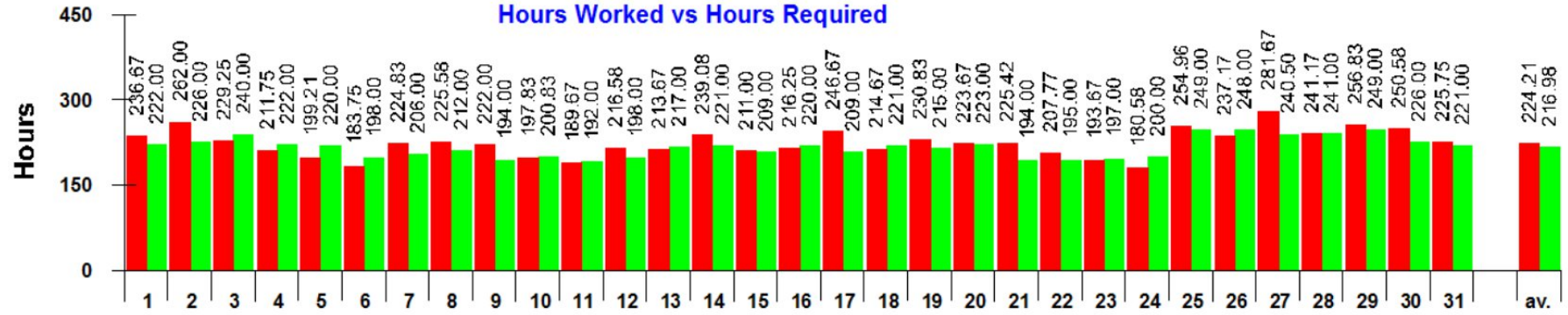
LEGEND
- Required Inpatient Clinical Hours
- Actual inpatient Clinical Hours Worked

Ward Daily Hours Graph

Printed: 12/11/2020
2:41:11 PM

Ward: CHC (* All Shifts *)
Month: October, 2020





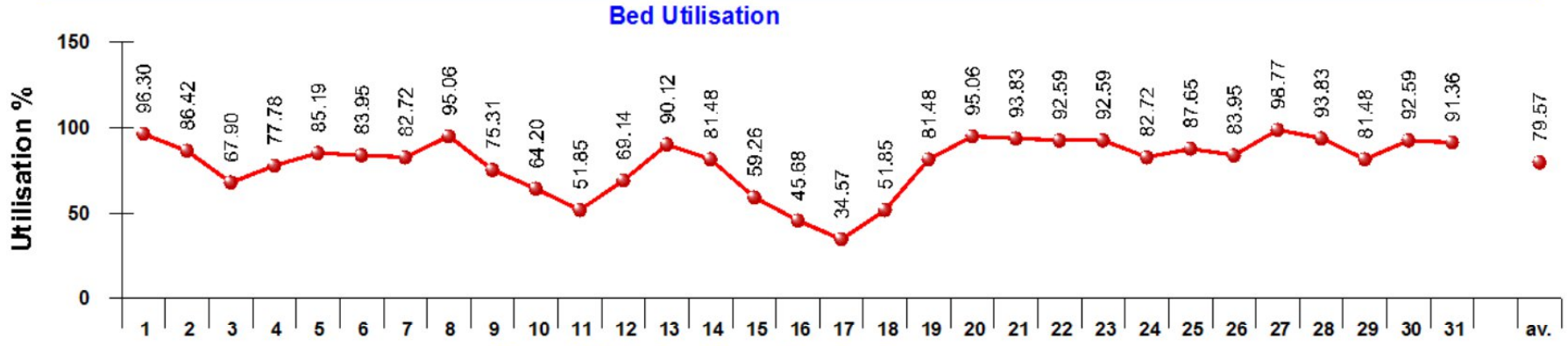
Productivity	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	
Index (%)	[107]	[116]	[96]	[95]	[91]	[93]	[109]	[106]	[114]	[99]	[99]	[109]	[98]	[108]	[101]	[98]	[118]	[97]	[107]	[100]	[116]	[107]	[98]	[90]	[102]	[96]	[117]	[100]	[103]	[111]	[102]	[103.33]

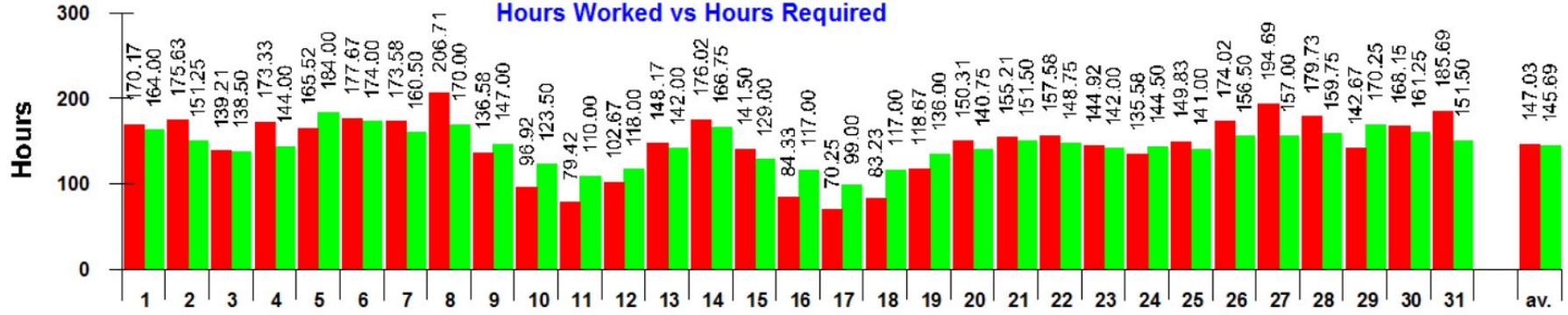
LEGEND
- Required Inpatient Clinical Hours
- Actual inpatient Clinical Hours Worked

Ward Daily Hours Graph

Printed: 12/11/2020
2:42:08 PM

Ward: CHC (* All Shifts *)
Month: October, 2020





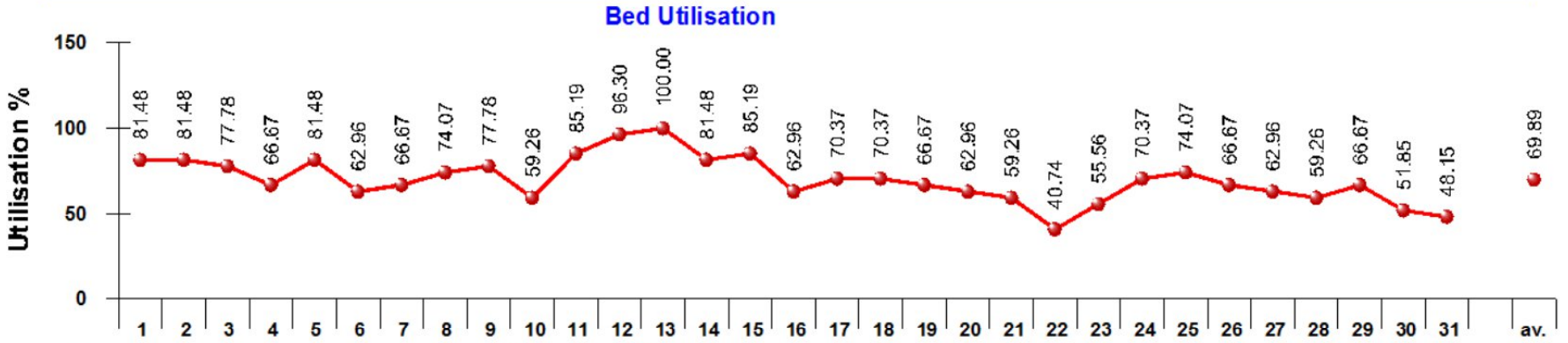
Productivity	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	
Index (%)	[104]	[116]	[101]	[120]	[90]	[102]	[108]	[122]	[93]	[78]	[72]	[87]	[104]	[106]	[110]	[72]	[71]	[71]	[87]	[107]	[102]	[106]	[102]	[94]	[106]	[111]	[124]	[113]	[84]	[104]	[123]	[100.92]

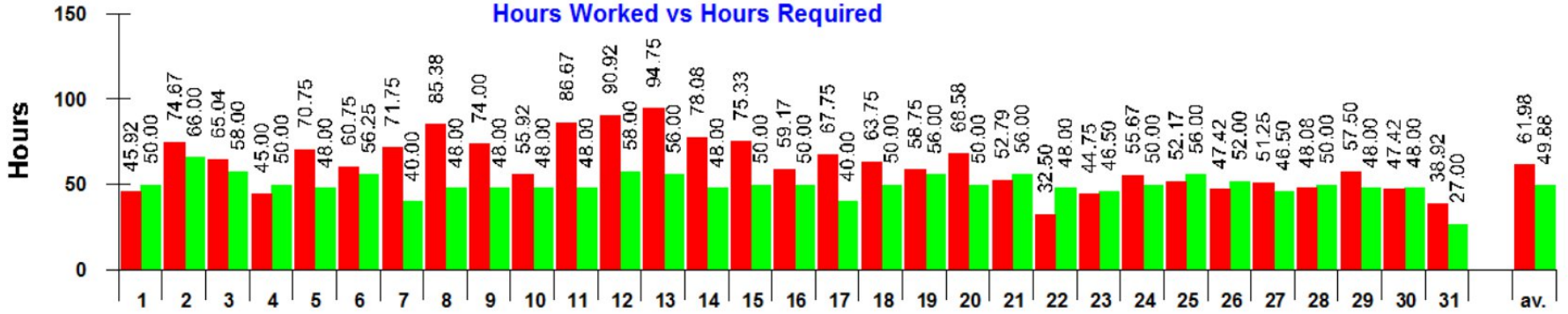
LEGEND
- Required Inpatient Clinical Hours
- Actual inpatient Clinical Hours Worked

Ward Daily Hours Graph

Printed: 12/11/2020
2:59:03 PM

Ward: CHC (* All Shifts *)
Month: October, 2020





Productivity	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	
Index (%)	[92]	[113]	[112]	[90]	[147]	[108]	[179]	[178]	[154]	[116]	[181]	[157]	[169]	[163]	[151]	[118]	[169]	[128]	[105]	[137]	[94]	[68]	[96]	[111]	[93]	[91]	[110]	[96]	[120]	[99]	[144]	[124.26]				

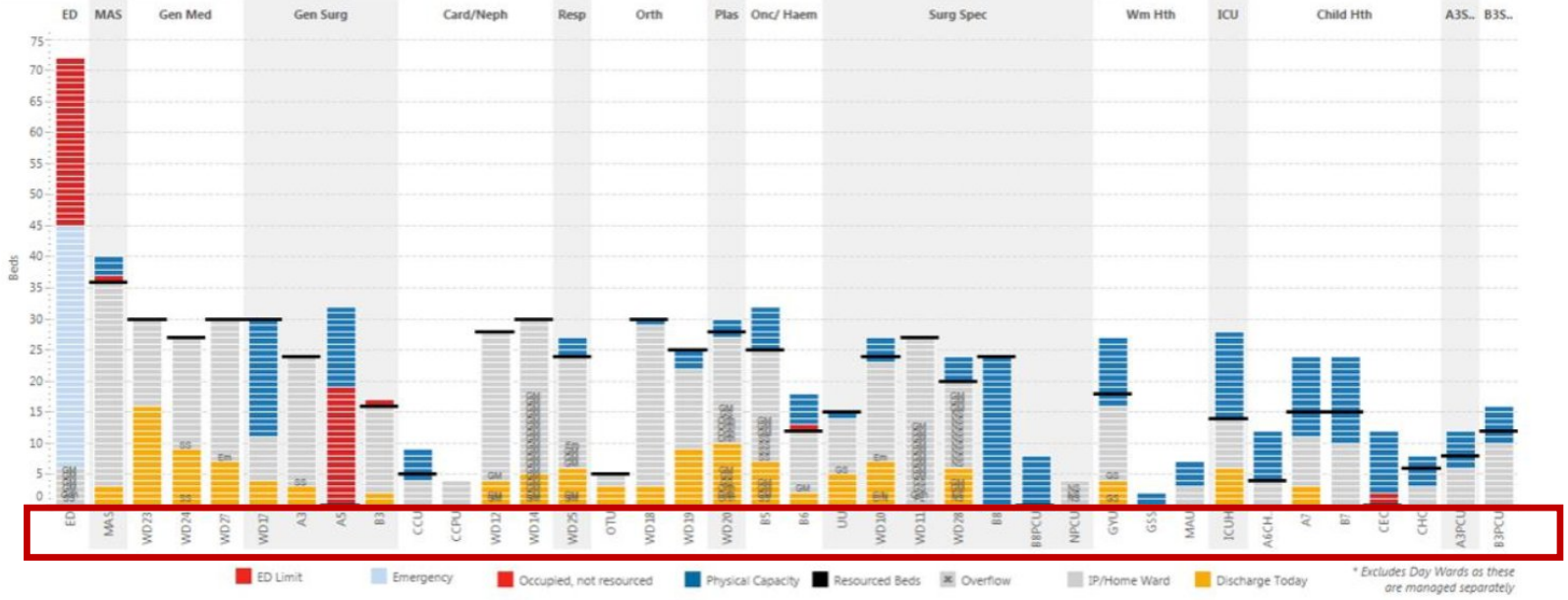
LEGEND
- Required Inpatient Clinical Hours
- Actual inpatient Clinical Hours Worked

What the data shows

- Canterbury has the lowest actual cost per FTE nurse $5K below the national average.
- Hospital wards in both Riverside and Parkside are challenging to care within. E.g. frail elderly patients' access to appropriate ablutions further impacts on nursing time.
- Transfer of patients from these above areas into Waipapa theatres or procedure areas also means approximately 20-30 minutes away from ward. These issues are not taken account when entering the TrendCare data, yet we are already fully utilising all patient time allocated
- The impact of high churn of full capacity wards becomes apparent in TrendCare
- CDHB has less beds, shorter length of stay

Christchurch Hospital Inpatient Wards at a Glance at 11:04 am

295 / 216	140	540	95%	134%	107%	76%	12 / 4
Forecast ED Arrivals 12am to 12am / now to 12am	ED Overload Score: Severe Overload	Occupied Beds (Med Surg patients unless in ICU)	Resourced Bed Occupancy (Med Surg patients unless in ICU)	General Medicine Physical Occupancy	Orthopaedics Physical Occupancy	Physical Bed Occupancy	Admissions / Discharges (since 7am)



Monitored Alerts

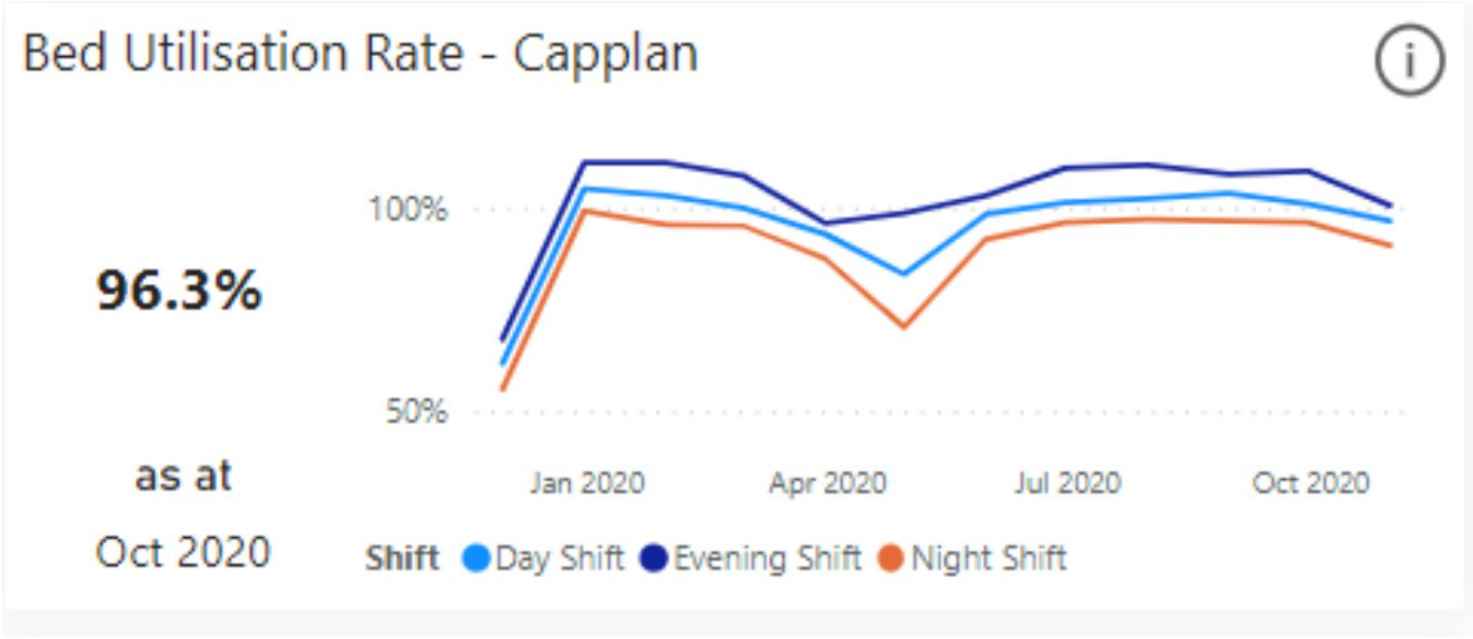
	ED	MAS	WD23	WD24	WD27	WD17	A3	A5	B3	CCU	CCPU	WD12	WD14	WD25	OTU	WD18	WD19	WD29	B5	B6	UU	WD10	WD11	WD28	B8	B8PCU	NPCU	GYU	GSS	MAU	ICUH	A4CH	A7	B7	CEC	CHC	A3PCU	B3PCU	
Influenza like illness	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Norovirus like infection	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Expected Discharges

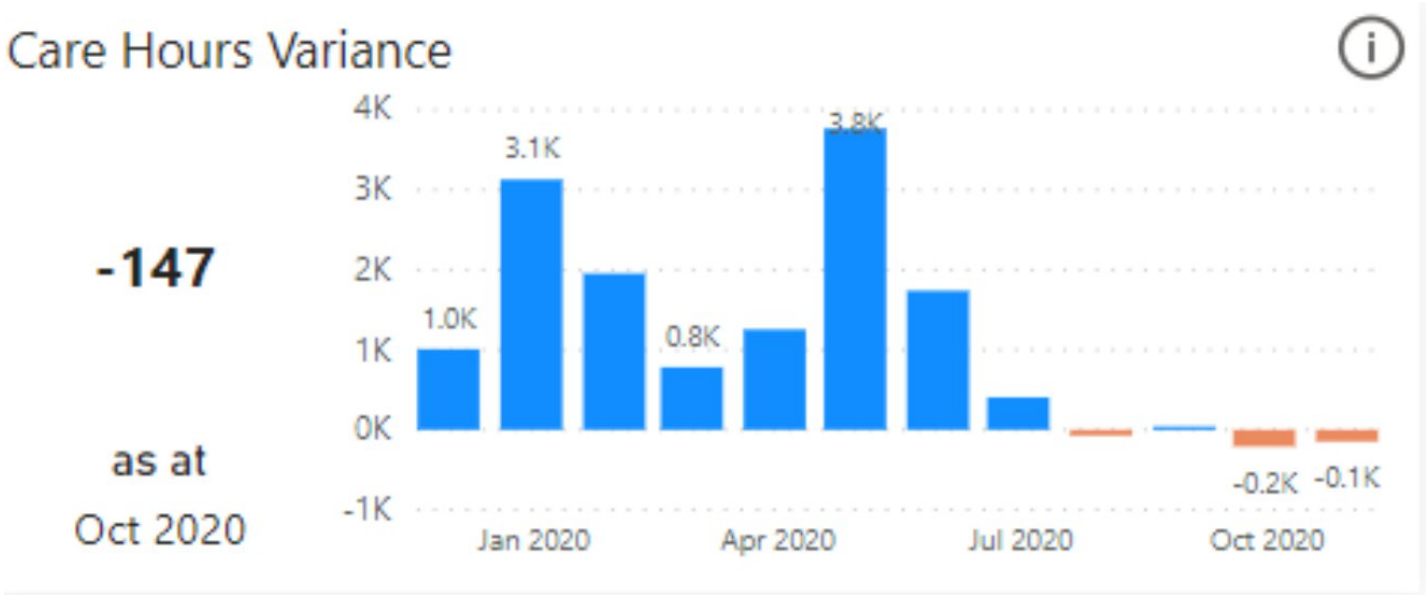
	ED	MAS	WD23	WD24	WD27	WD17	A3	A5	B3	CCU	CCPU	WD12	WD14	WD25	OTU	WD18	WD19	WD29	B5	B6	UU	WD10	WD11	WD28	B8	B8PCU	NPCU	GYU	GSS	MAU	ICUH	A4CH	A7	B7	CEC	CHC	A3PCU	B3PCU	
Today	3	16	9	7	4	2	-	-	4	5	6	3	3	9	10	7	2	5	7	-	6	-	-	-	4	-	-	6	-	-	-	-	128
Tomorrow	1	8	8	7	2	5	1	-	3	14	2	-	5	1	2	4	3	5	9	15	3	-	-	-	7	-	-	1	3	-	-	-	120

Dashboard Last Refreshed : 23/11/2020 11:04, Last Data Received : 23/11/2020 10:38

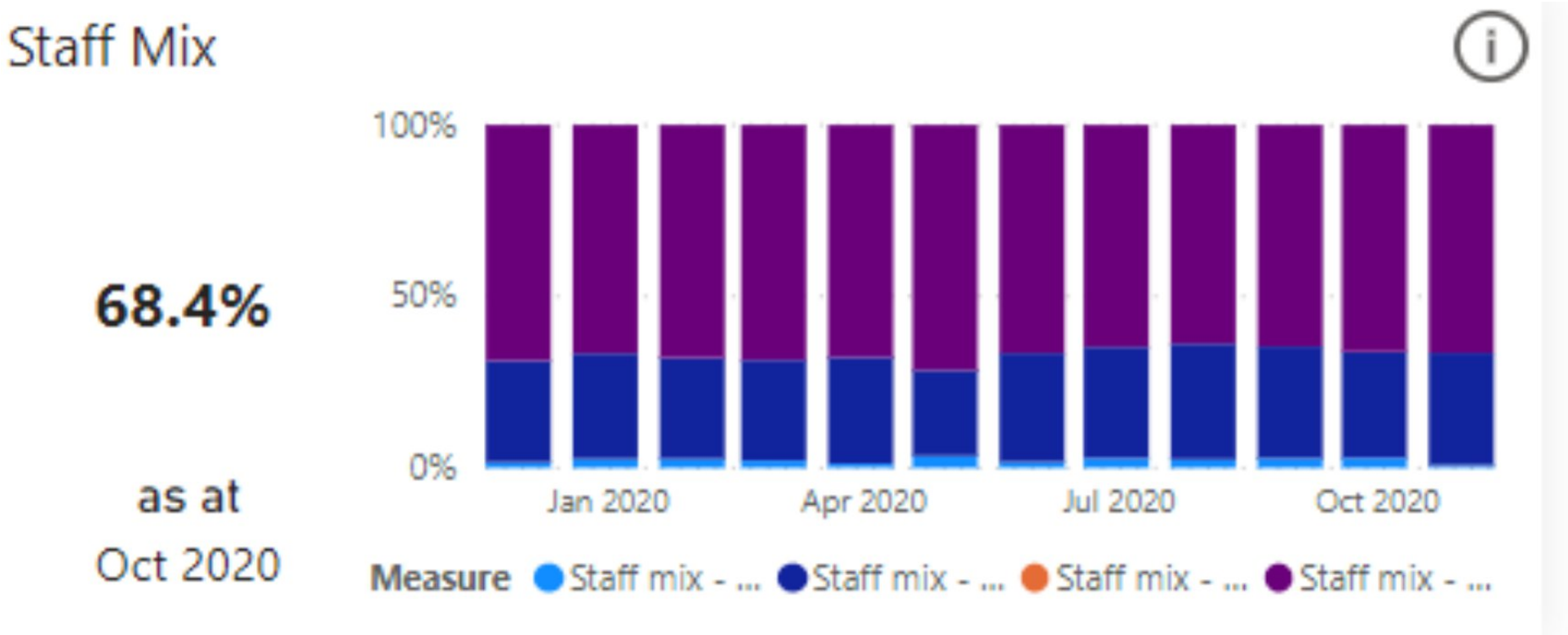
Ward xx: bed utilisation



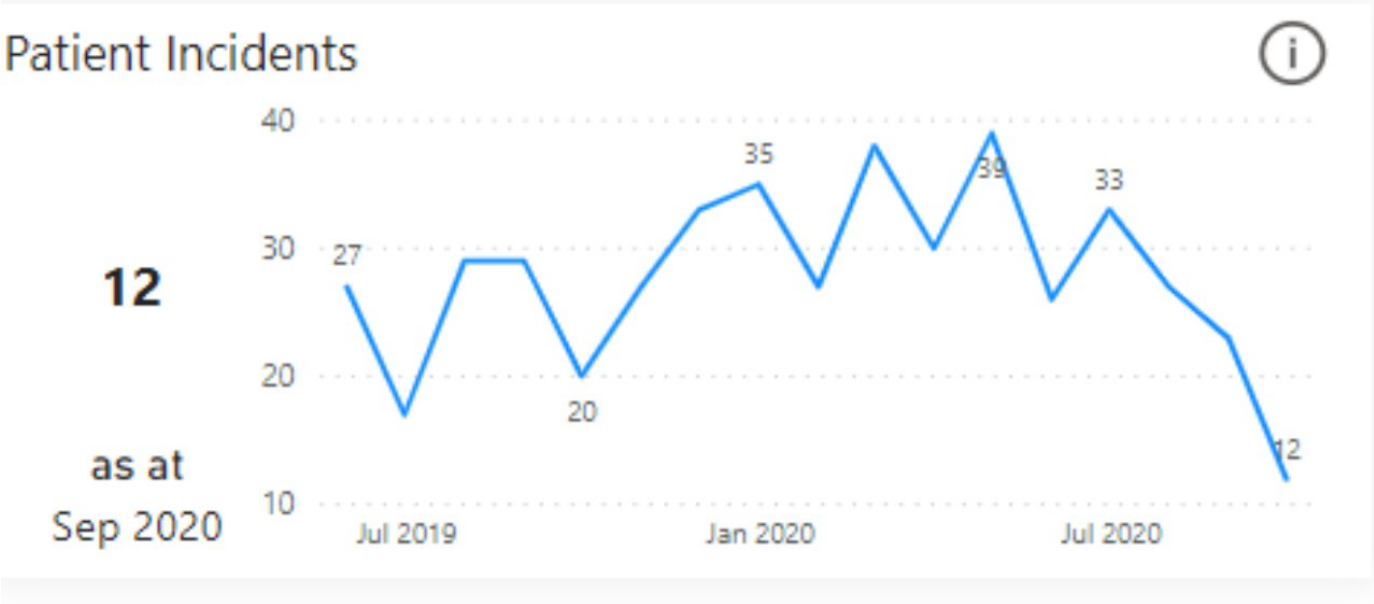
Ward xx: care hours variance



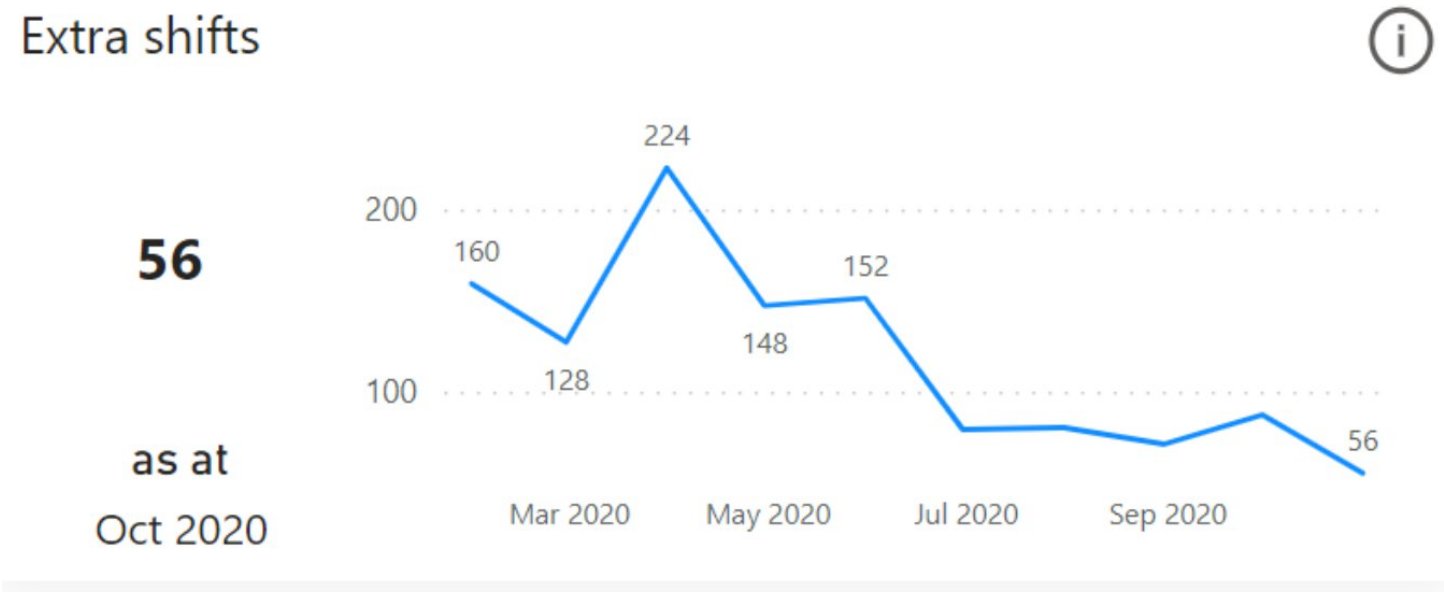
Ward xx: Regulated vs unregulated staff



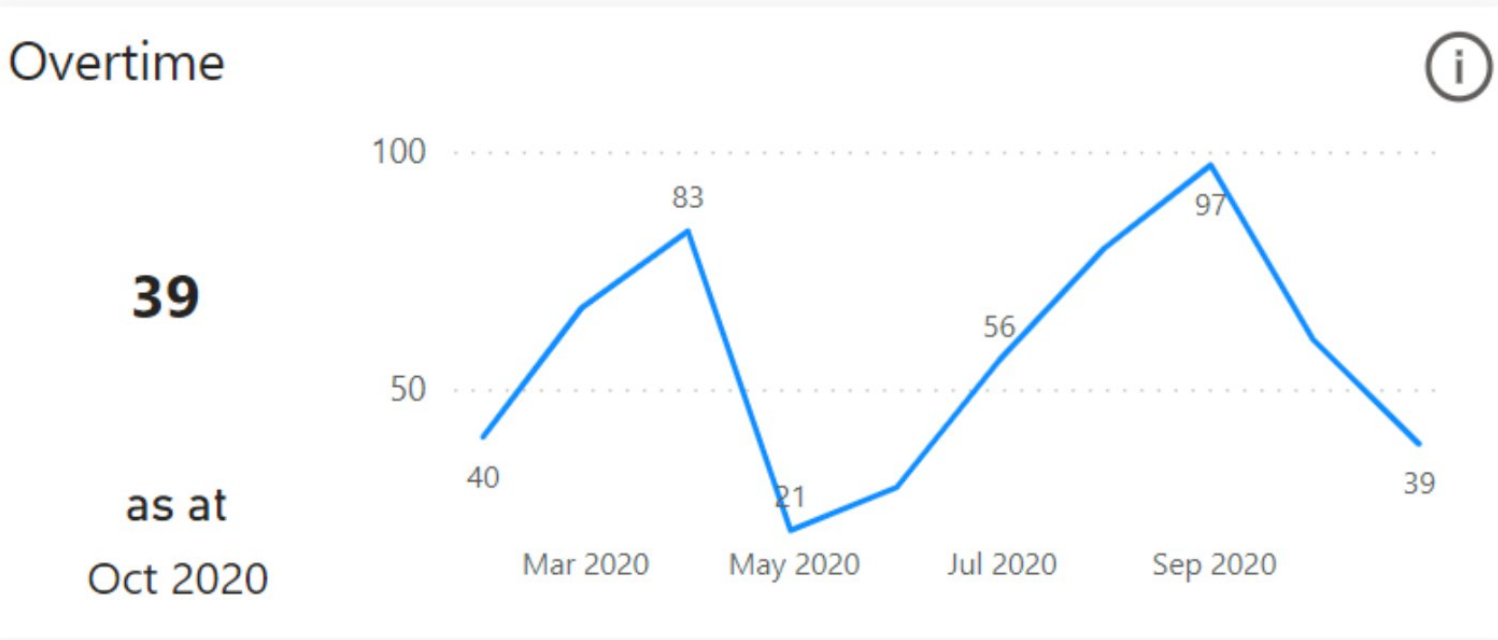
Ward xx - Patient Incidents



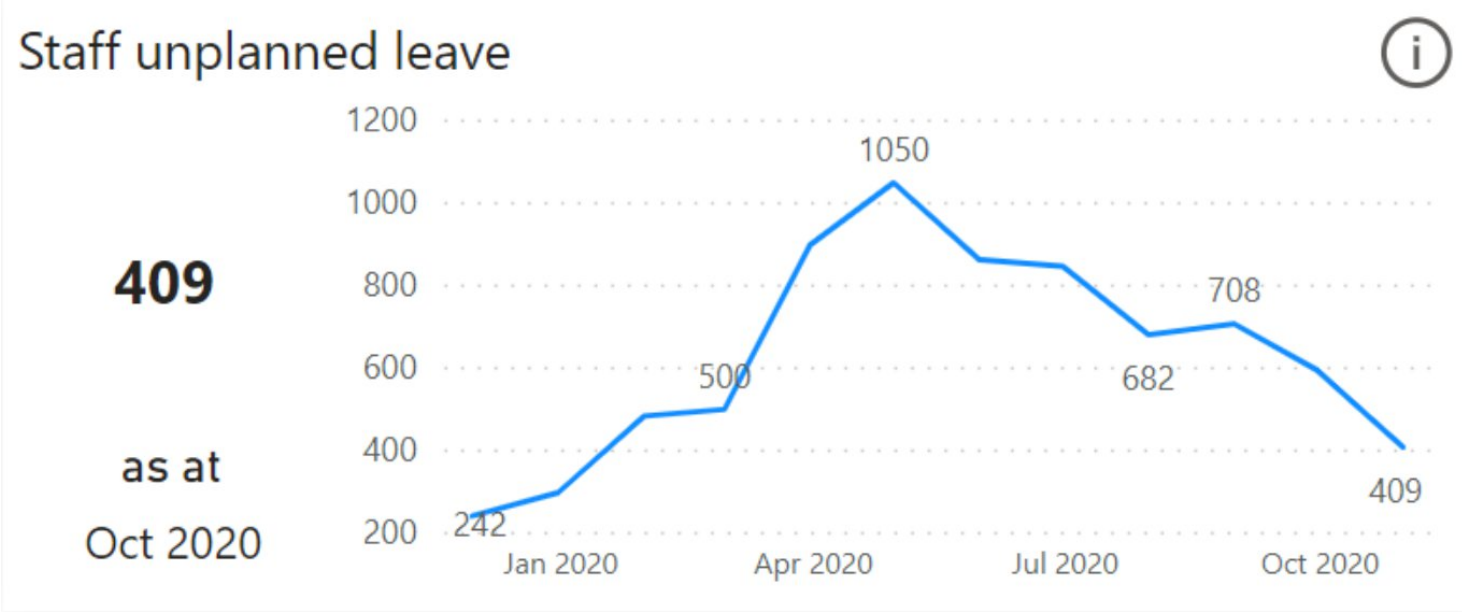
Ward xx: Extra Shifts additional to normal hours



Ward xx: Overtime



Ward xx: Unplanned leave



ACCELERATING OUR FUTURE UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **Dan Coward General Manager, Programme Management Office**

APPROVED BY: **Dr Andrew Brant, Acting Chief Executive**

DATE: **3 December 2020**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is to provide the Committee with an update of the activity undertaken in the Accelerating Our Future programme.

2. RECOMMENDATION

That the Committee:

i. notes the update provided on activity undertaken in the Accelerating Our Future Programmes.

3. SUMMARY

The established Accelerating our Future (*AoF*) programme team have a focus on supporting areas identifying additional initiatives that contribute to AoF activity, and understanding risks and issues related to workstreams. Processes have been established for monitoring and tracking of validated savings recognised, alongside cost growth avoidance. Significant work by the operational divisions have contributed to revising activity, with Programme Management Office (*PMO*) support to those areas to deliver.

4. DISCUSSION

Six focus areas were identified for change and improvements as part of the development of our Annual Plan 2020/21, looking at how Canterbury DHB could operate more sustainably for the long term and achieve the targeted savings within twelve months. This formed the basis of the Accelerating Our Future programme.

These six areas remain the focus:

- **Work working better** – improving and simplifying how we work and interact with patients and stakeholders.
- **Clinical resourcing** – having the right resource, in the right place, and at the right time to provide sustainable patient-centric care.
- **Senior Medical Officer (*SMO*) engagement** - making sure our rostering and remuneration practices are fair, consistent, transparent and compliant.
- **Continuous improvement** – capturing the ongoing clinically-led work delivering better patient care decisions, and amplifying it where possible.
- **External provider contract review** - ensuring our service agreements meet expectations and deliver the highest value impact in the most efficient, effective and sustainable manner possible.
- **Other savings initiatives** - working with the organisation to support new and existing ideas around spending wisely.

The total number of initiatives continues to evolve as the organisation, at every level, is encouraged to share their cost saving ideas.

An example of a new way of working, which does not impact patient care, yet reduces costs, is a focus on overtime and better ways of working across Christchurch Campus. Instead of having Allied Health staff on call, CHCH Campus have introduced a new system where staff are on site 24/7 which has reduced the need for overtime by having a team on site. This has saved on overtime and penal costs without reducing the service.

Another initiative is the electronic delivery of outpatient clinic letters to GPs. We will soon be piloting a new way of working with General Surgery in providing electronic delivery of letters, to assess performance, before planning further rollout to remaining services. This automation project is expected to release significant capacity across our system and generate considerable operational savings alongside our commitment to sustainability at the completion of the roll out.

Smarter procurement of medical devices and supplies is another area with significant savings potential. Building on our New Treatments and Technology approach has significant buy in and support from operational and clinical areas and we are looking to a fixed term resource to accelerate the activity identified within this area.

5. CONCLUSION

Accelerating our future activity is progressing well with great engagement across the divisions. Majority of focus is on tightening our controls through our expenditure, while focusing on continuous improvement activity.

CHATHAM ISLANDS HEALTH CENTRE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **Win McDonald, Transition Programme Manager, Rural Health Services**

APPROVED BY: **Ralph La Salle, Acting Executive Director, Planning Funding & Decision Support**

DATE: **3 December 2020**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

The purpose of this report is to provide an update to the Committee on health care service delivery on the Chatham Islands.

2. RECOMMENDATION

That the Committee:

i. notes the Chatham Islands Health Centre report.

3. SUMMARY

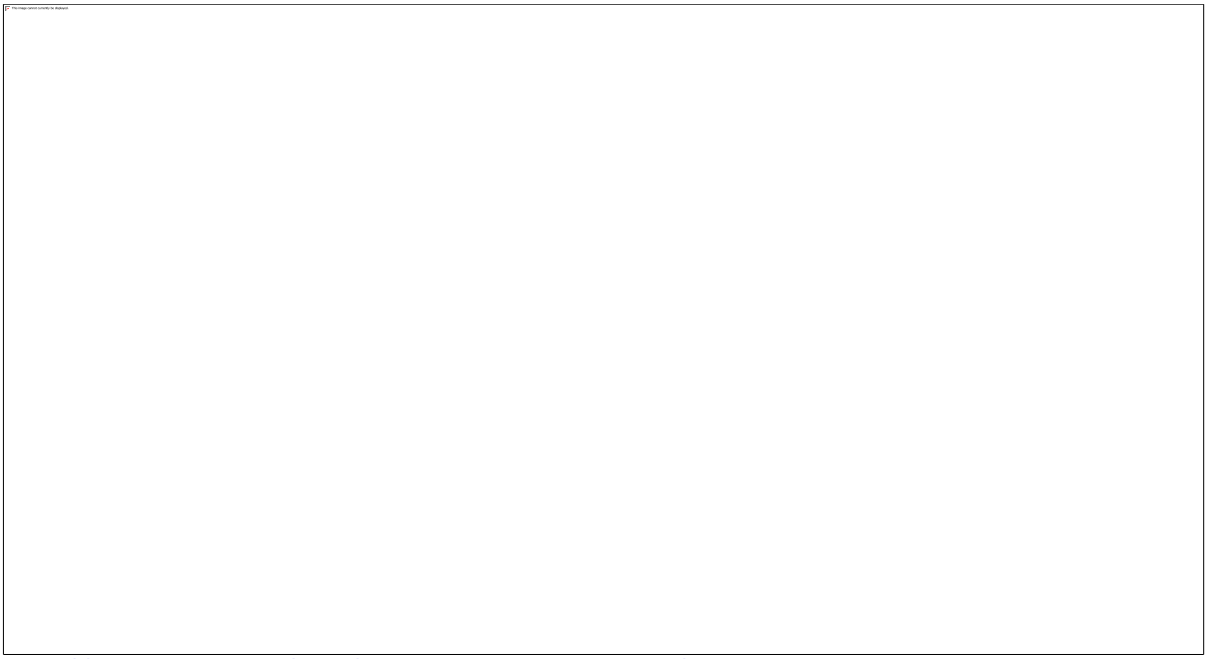
The demand for health care on the Chatham Islands is increasing as the population continues to age and the birth rate remains steady. Caring for the elderly population in their homes enables people to stay on-Island, reducing the need for life-flights and Aged Residential Care on the mainland. The increasing demand for care in the home is requiring a corresponding increase in staffing.

The social and economic impact of COVID-19 on the Chatham Islands community has been significant. Fishing and farming industries suffered the most with exports to China ceasing in January 2020. The Ministry of Fisheries, Social Development, Inland Revenue and Te Puni Kokori, alongside other government and NGO organisations have provided additional financial and well-being support to the community. While industry is beginning to recover with exports to China recommencing, not all quotas will be fished and this is not recoverable. Financial recovery is slow and this is affecting the well-being of the Chatham Islands community with an increase in mental health presentations that are being met by increased service delivery.

4. DISCUSSION

The Canterbury DHB continues to deliver health care to Chatham Islanders and to meet peoples' health needs in a timely manner, through planned management of patients with chronic conditions, increased service delivery to patients in the community and short-term inpatient admissions for observation, stabilisation and care.

The population identifies predominantly as Maori (66%) and the age distribution is unlike other remote areas of New Zealand; with a lower percentage of 13-50 year olds on-Island than the national average. All health services on Island are delivered by the health centre, including emergency response (111-calls) and primary health care. There are three permanent nursing staff, complemented by locum and casual staff. Ensuring equity of access to health care for this population is a priority, with proactive management of patients with co-morbidities to mitigate the risk of unplanned treatments requiring life flights to the mainland.



https://www.stats.govt.nz/tools/2018-census-place-summaries/chatham-islands-territory

The table below summarises the changes in service utilisation over time; note the reduction in Life Flights.

	2015-16	2016-17	2017-18	2018-19	2019-20	*2018-19 to 2019-20 movement*
GP Consults	2,255	3,497	3,010	2,878	3,268	*+390*
Nurse Consults (including Community)	2,968	2,650	2,362	1,864	2,488	*+624*
Personal Cares/Home Support	149	1,069	1,184	1,201	1,050	*-151*
Midwife	75	99	108	156	138	*-18*
Nurse Escorts Commercial Flights	5	4	2	4	2	*-2*
Bed Nights	127	112	66	35	88	*+53*
Life Flights	36	13	20	15	12	*-3*
Telehealth	39	21	22	21	8	*-13*

Housing is generally in poor repair, impacting on the health of the population with high numbers of presentations for asthma and COPD.

COVID-19

During the COVID-19 lockdown there was a decrease in acute medical and accident presentations. The number of specialist clinics delivered on the island by visiting specialists was affected by COVID-19, with Orthopaedic and associated radiology clinics planned for June cancelled and the dental and women's health clinics postponed until July and August respectively.

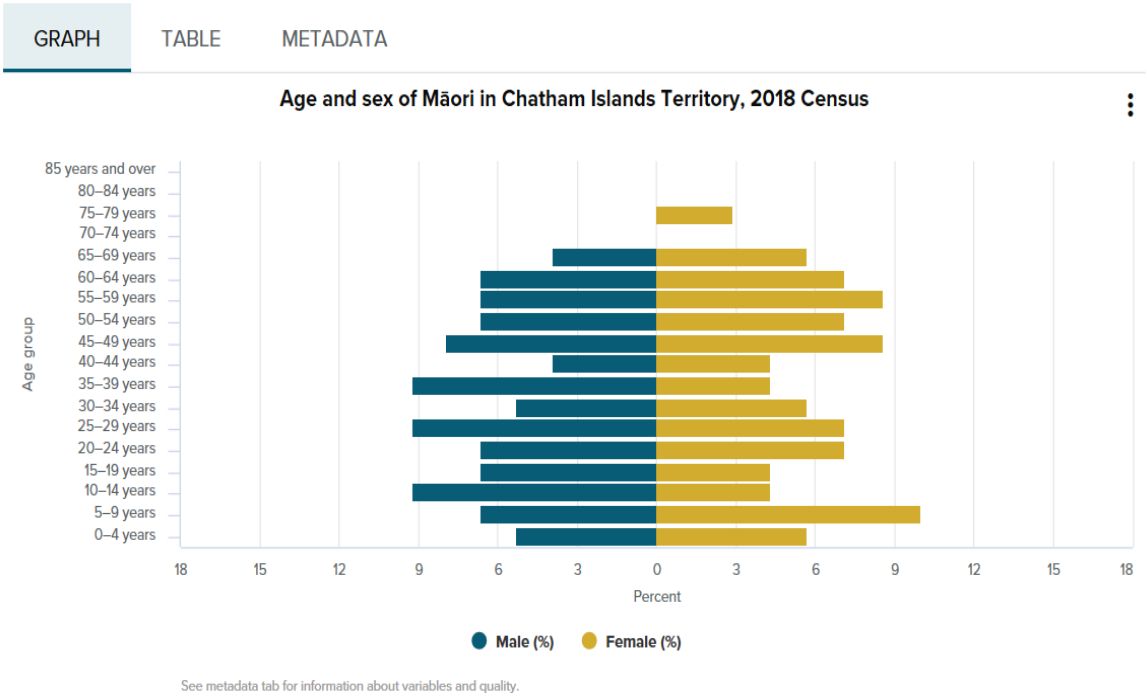
The Chatham's community has been significantly impacted by the pandemic with the economy effectively coming to a standstill with income from the fishing, farming and tourism industries substantially reduced. This has significantly affected the health and well-being of everyone on the Chatham Islands with an increase in mental health presentations across both children and adults. Brief Intervention Counselling purchased through a contract with Waitaha Primary Health Organisation (*PHO*) is being well utilised, with over 500 client contacts in the 2019-2020 year.

The CDHB continues to work with the four main on-Island entities and government and NGO agencies to coordinate health and well-being service delivery; with a strong focus on building community resilience and sustainable service delivery.

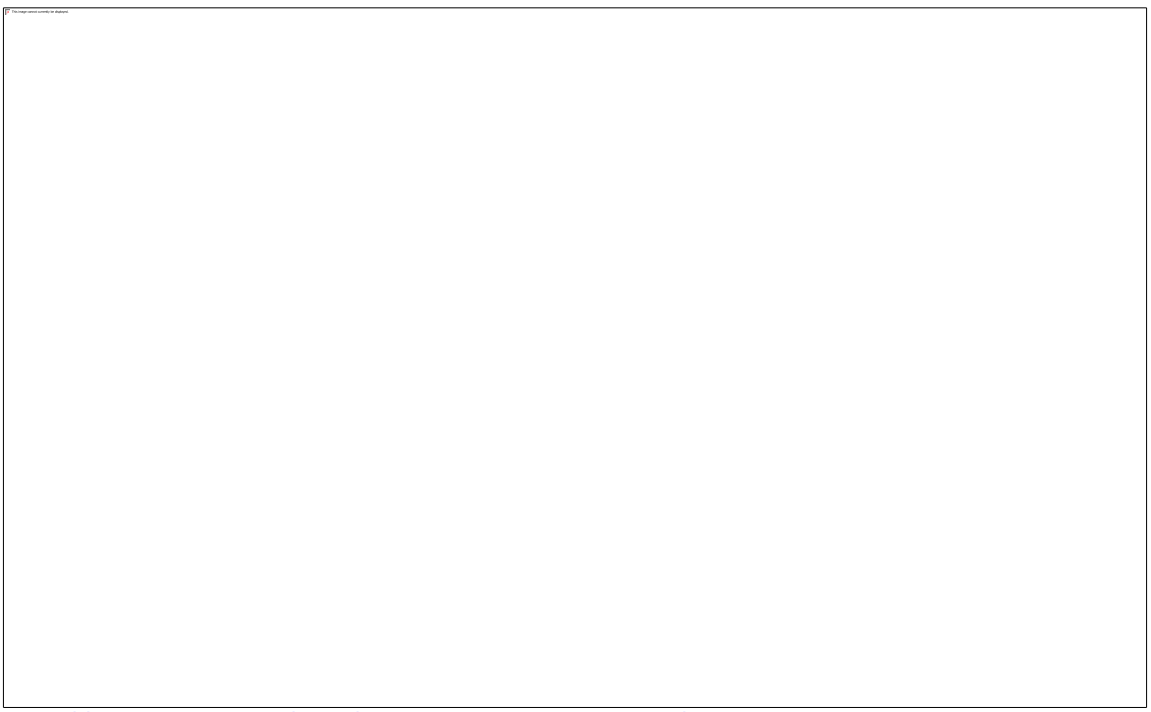
We have increased the frequency of visits by our contracted mental health provider and engaged support from the suicide postvention team. The Ministry of Social Development and Oranga Tamariki are also supporting with relationship counselling and family violence prevention.

Aging Population

The ageing population is requiring additional care and support in their homes with more clients opting to stay on the Island rather than move into Aged Residential Care (*ARC*) on the mainland. InterRAI needs assessments undertaken in August 2020, identified 16 complex and nine non-complex clients over 65 years; six of whom are eligible for permanent residential care (across dementia, hospital and rest home level of care). Increased registered nurse, health care assistance and home support staffing costs are off-set by a decrease in ARC costs on the mainland.



Twenty-seven percent of the >65 years population has activity limitations; reflective of the high manual labour content of their work.



https://www.stats.govt.nz/tools/2018-census-place-summaries/chatham-islands-territory

Case Study

An elderly, complex-care patient nearing the end of her life was cared for in her home for six months before coming to the health centre for end-of life care. She wanted to remain on Island to die and be surrounded by her mokopuna and whanau. She was cared for at the health centre for her last four weeks; requiring 24hr care. This avoided the need for a Life Flight, and Aged Residential Care away from her whanau and homeland.

Operating Costs

The increase in tourism while positive for the economy is putting pressure on local infrastructure, accommodation and supplies. There is currently a water ban in place, accommodation is unobtainable, the hotel is no longer supplying patient or visiting staff meals, and there is no petrol on Island for the 12th time this calendar year.

To mitigate these risks we are now purchasing and shipping food supplies directly and will be seeking to replace our petrol powered emergency vehicles with diesel fuelled vehicles; reducing the need to hire diesel vehicles.

5. CONCLUSION

The effect of COVID-19 on the Chatham Islands Community is significant and a whole of government approach to supporting the recovery is underway. The health centre is taking the lead on supporting mental health recovery, working closely with all other agencies. The staff are under pressure to meet the increasing demand for in-home services and additional locum staff are being engaged to provide much needed leave relief for permanent staff.

H&SS MONITORING REPORT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

DATE: **3 December 2020**

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

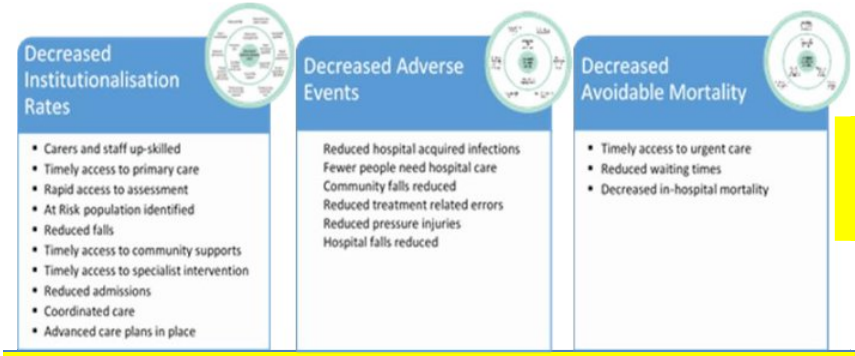
Appendix 1: Hospital Advisory Committee Activity Report –November 2020

Hospital Advisory Committee

Hospital Activity Report

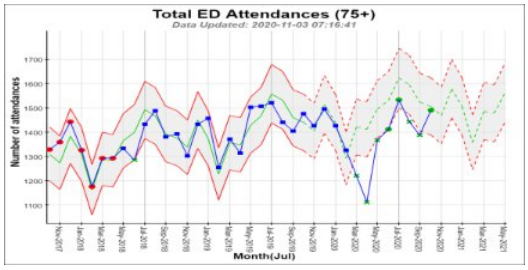
November 2020

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



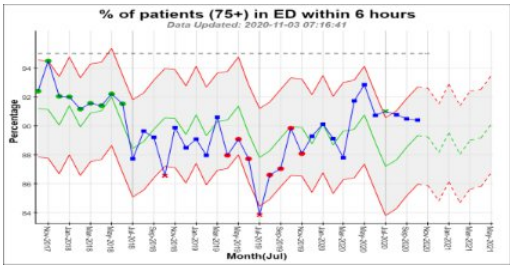
Outcome and Strategy Indicators

Figure 1.1



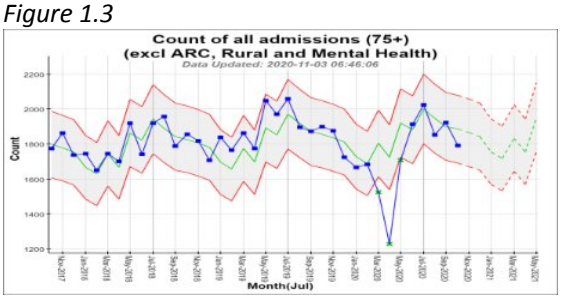
Covid 19 Alert Level restrictions led to a reduced number of ED attendances in March and April, increasing towards previously forecast levels in May – but remaining lower than recent trends indicate.

Figure1.2



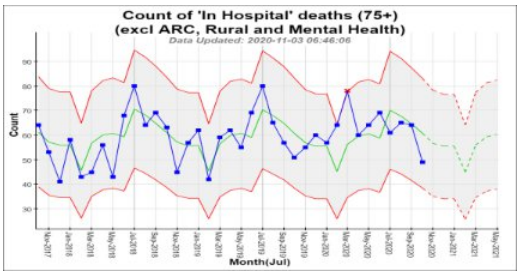
The reduced volumes have led to a faster turnaround in ED with more than 90% of older patients leaving ED within six hours during the past seven months.

Figure 1.3



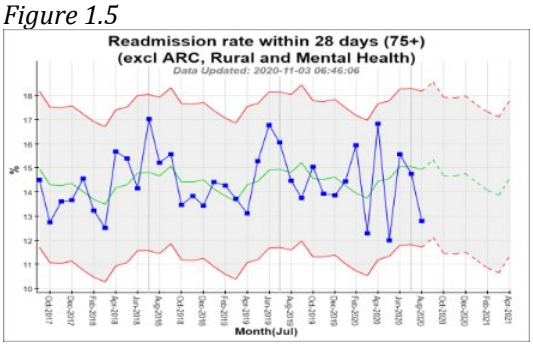
The number admitted is generally within the forecast range but was reduced during the COVID lockdown period. Since then the monthly count of admissions has returned to within forecast range

Figure 1.4



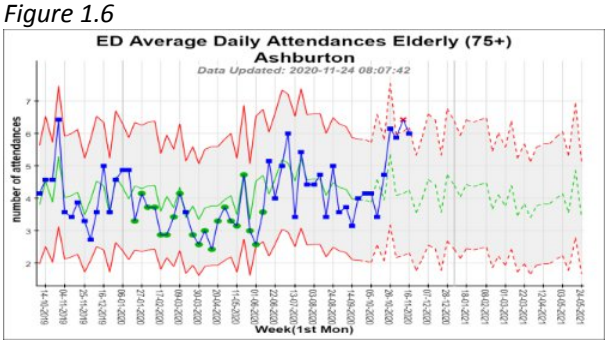
During the last six months the number and rate of in hospital deaths against admissions has been within forecast range, which reflects an underlying reducing trend.

Figure 1.5



Readmissions remain within the expected range, although latest months show increased variation in the percentage readmitted.

Figure 1.6



Ashburton rate of attendances,75+ age group, has been running in line with expected attendance growth, except for the latest records in October-November which is slightly above mean but the same the same time in 2019.

Achievements/Issues of Note

Burwood Day Clinic

The Older Persons Mental Health Service have implemented a plan to commence early attendance at Burwood Day Clinic (BDC) during inpatient admission to Ward AG. This plan is to try and facilitate an earlier successful discharge from the ward and support the introduction of day clinic continuing treatment following discharge. Historically in-patients started at the Day Clinic following their discharge with only an introductory visit, usually a week before discharge.

In this plan a patient identified by the clinical team as needing BDC will commence attendance in the weeks prior to discharge. The current trial is with patients who have had a lengthy hospital stay with unsuccessful trial leaves home. With shared clinical personnel (physiotherapy and psychology) across both services the identified patients are also seeing the same clinicians who work across both services, so continuity of clinical care is established.

Wheelchair and Seating

Older Persons Health & Rehabilitation (OPH&R) on behalf of the CDHB has implemented a formal Transalpine service for Complex Wheelchair and Seating services with the first visit to the West Coast scheduled for November 2020.

There is a recognised skills gap across the South Island for Allied health therapists holding the appropriate credentials to perform complex assessments and prescription of wheeled mobility and positioning equipment. Training and competency accreditation for this work can take up to two years and due to factors, such as ad hoc demand resulting in inadequate numbers of patients to meet competency requirements, the cost of training and limited access to appropriate supervision during the training phase, many small DHBs struggle to recruit appropriately trained staff to provide this service. In addition, due to the range of conditions that may require specialist solutions to postural management and wheeled mobility, it is even more challenging for DHBs to have access to a clinician who is able to provide the full range of assessment and prescription. CDHB are fortunate to have the capability and expertise in this area of care due to it's size, regional services and focus on building a sustainable model of training and supporting staff to have, and retain, these skills.

To ensure that the residents of the West Coast have access to this care in a sustainable way, CDHB have implemented a formal Transalpine Complex wheelchair and seating service. This service will provide appropriately credentialed CDHB therapists to undertake quarterly clinics on the West Coast to support the assessment of patients requiring this care. To ensure that the West Coast is fully supported through the trial of equipment and associated follow up, CDHB therapists will provide telehealth support for clinicians on the West Coast as joint clinics which in turn will enhance the overall capability and confidence of the local workforce.

This Transalpine service achieves the Allied Health vision of a connected workforce across both DHBs, ensuring sustainability through ensuring the right person provides the right care at the right time and ensures that West Coast residents can receive this specialist care closer to home. This approach also could provide a baseline structure and process for future opportunities for CDHB to provide regional Complex Wheelchair and Seating services to reduce inequity of access for this care whilst allowing CDHB further opportunities to continue to increase our staff's expertise in this area.

Burwood Hospital Dementia Friendly Working Group

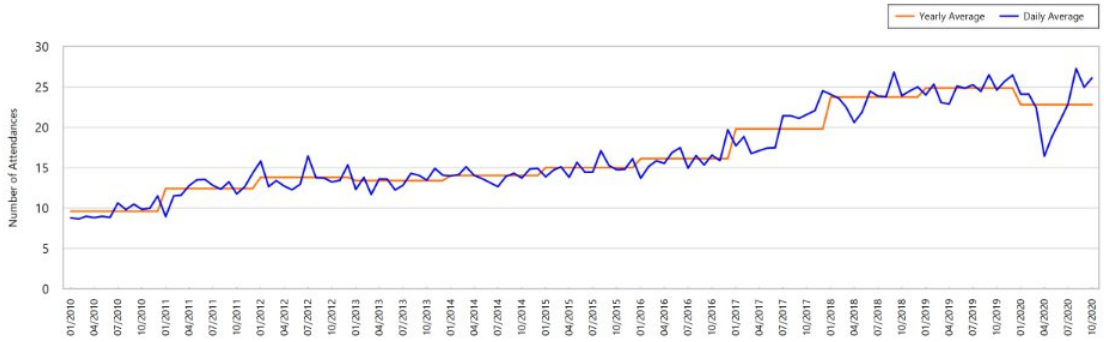
As we are aware dementia is on the increase. The latest forecast estimates indicate that more than 170,000 people in NZ will have dementia by 2050. Alzheimer's New Zealand's Dementia Friendly Recognition Programme offer businesses and organisations the option to be recognised for their commitment to becoming dementia friendly.

A working group [Dementia Friendly Burwood Hospital Working Group] formed in 2019. This brought together likeminded individuals who are committed to making life easier to those living with dementia and those caring for them. The Burwood group have met regularly in 2020; gathered evidence to meet the standards of the Alzheimer's NZ Dementia Friendly Recognition Programme and will be applying for the Working to be Dementia Friendly status early in 2021.

This piece of work looks to embed dementia friendly principles into the delivery of care/service models at Burwood Hospital, reflect best practice in relation to dementia, as well as strengthen the links between Dementia Canterbury and Burwood Hospital services.

Ashburton Health Services

The increase in acute presentations in the 75+ age group is in line with the an overall increase in presentations to AAU in the past two months. The graph below demonstrates the trend in the total daily average number of presentations, which has returned to the pre- COVID consistency of 26 patients per day. The admission rate remains consistent at 30% with a re-admission rate within 28 days of 1.



There has been a slight increase in requests for urgent respite care. To ensure a smooth transition for these requests and provide a more proactive approach to older persons health in the community, the gerontology nurse specialist and Needs Assessment Care Coordination (NASC) team are connecting with primary care to the identification of high-risk patients who have not been referred for an InterRAI assessment and define a planned approach to completing these. This approach will support a managed approach to the NASC demand and limit the requirement for urgent NASC referrals. With a completed InterRAI in place, access to urgent respite can be approved verbally by the on-call geriatrician creating a smooth and rapid transition to the appropriate care, reducing the risk of representation to AAU and potential admission.

Complementing this, work continues with Older Persons Mental Health (OPMH) to develop a robust approach to acute and longitudinal care in rural settings.
A full review of the community health pathways and associated ERMS referral practice is underway for the services delivered by the community nursing team in Ashburton. The objective is to streamline the referral practice a single referral form, connecting with the implementation of STRATA. The objective of this quality improvement approach is to reduce duplication in referrals due to lack of updated information, ensure access to appropriate services are streamlined and improve our ability to report on service demand.

The quality improvement programme embedded following the audit of our Home-Based Support Services (HBSS) continues on track, reviews of all existing client packages of care as per the framework of short- and long-term care are underway with a completion date expected of end of November. The partnership with NASC, District Nursing, Gerontology CNS clinical leadership within the Ashburton Health Service has enabled us to maximise the resources available across the Division to complete timely clinical reviews within the existing team. The HBSS ongoing education is led by the Nurse Education team, improving the focus and implementation of restorative care practice and connection to shared learning opportunities with nursing and hospital based Health Care Assistants.

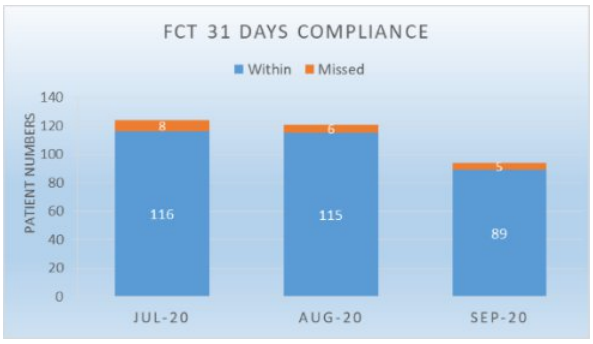
Outcome and Strategy Indicators

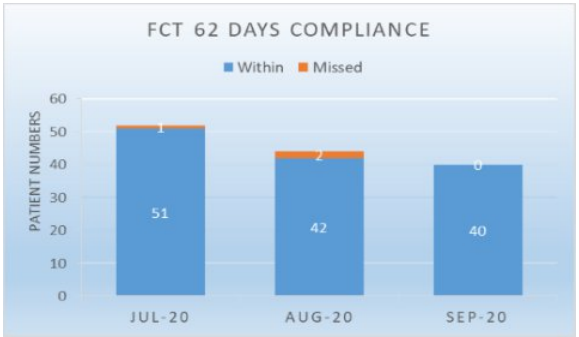
Key Outcomes - Faster Cancer Treatment Targets (FCT)

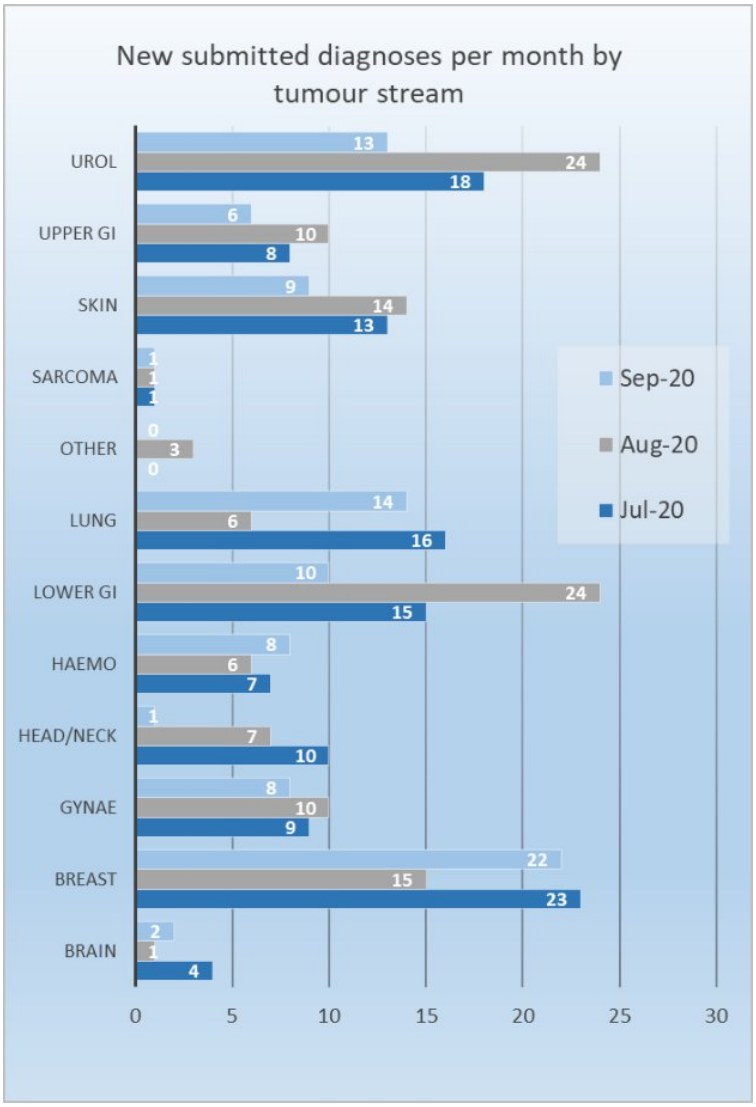
62 Day Target. In the three months to the end of September, of the 161 records submitted by Canterbury District Health Board – down from 167 for the three months to the end of August. 28 patients missed the 62 days target, 25 did so through patient choice or clinical reasons and are therefore excluded from consideration. With 3 of the 143 patients missing the 62 days target through capacity issues our compliance rate was 97.8%, once again exceeding the 90% target.

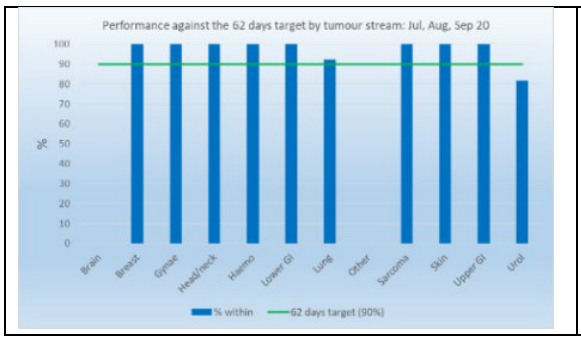
31 Day Performance Measure. Of 339 records submitted towards the 31-day measure 320 (94.4%) eligible patients received their first treatment within 31 days from a decision to treat, the CDHB continues to exceed the 85% target. A total of 19 patients did not meet the 31 days target. Nine of these missed it by 5 days or less and 2 through patient choice or clinical considerations.

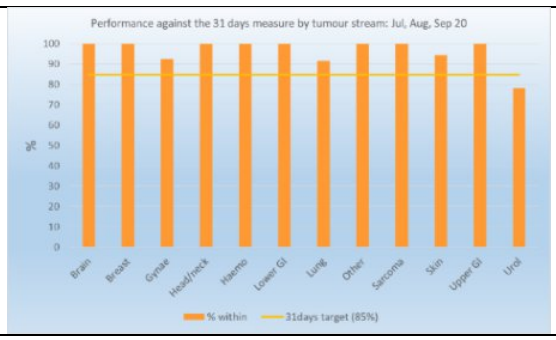
The dip in numbers in the last month of every report (September in this case) reflects the timing of the report being compiled to meet Ministry deadline. A significant number of the patients who have a first treatment date in the period this report covers will be awaiting coding and will be picked up in the following month's extract.

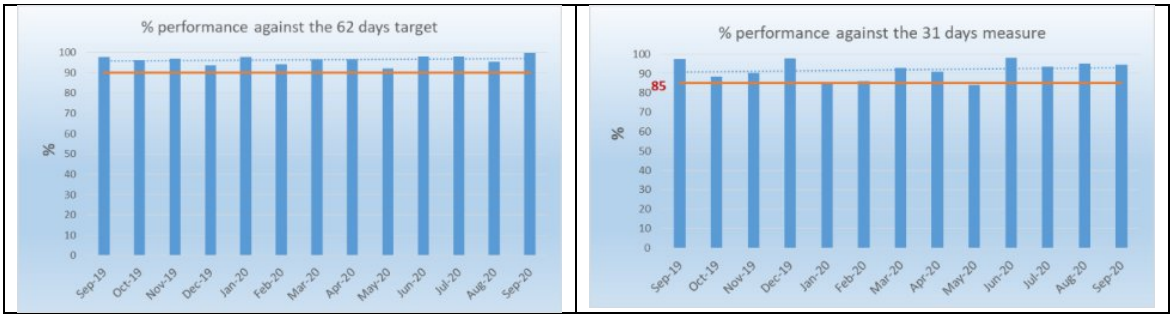





New submitted diagnoses per month by tumour stream
UROL
UPPER GI
SKIN
SARCOMA
OTHER
LUNG
LOWER GI
HAEMO
HEAD/NECK
GYNAE
BREAST
BRAIN
13
24
18
6
10
8
9
14
13
1
1
1
0
3
0
14
6
16
10
24
15
8
6
7
1
7
10
8
10
9
22
15
23
2
1
4
0
5
10
15
20
25
30
Sep-20
Aug-20
Jul-20


Performance against the 62 days target by tumour stream: Jul, Aug, Sep 20
%
Brain
Breast
Gynae
Head/neck
Haemo
Lower GI
Lung
Other
Sarcoma
Skin
Upper GI
Urol
% within
62 days target (90%)


Performance against the 31 days measure by tumour stream: Jul, Aug, Sep 20
%
Brain
Breast
Gynae
Head/neck
Haemo
Lower GI
Lung
Other
Sarcoma
Skin
Upper GI
Urol
% within
31days target (85%)

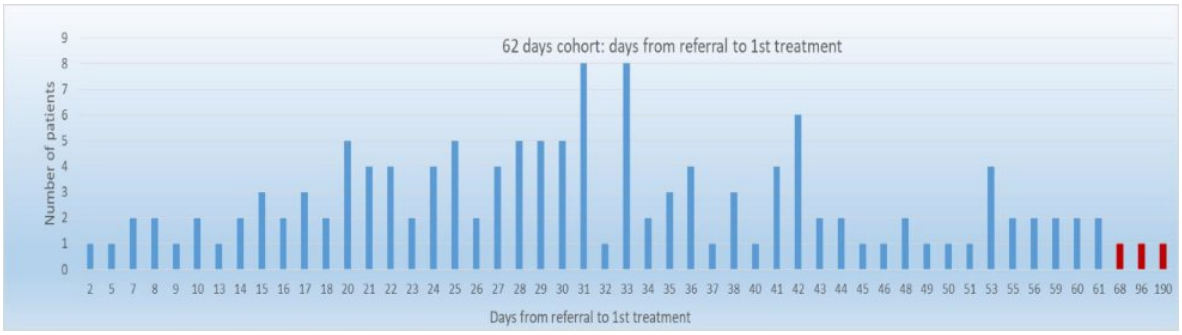


Patients who miss the targets

The MoH requires DHBs to allocate a code (referred to as a delay code) to all patients who miss the 62 days target. There are three codes but only one can be submitted, even if the delay is due to a combination of circumstances, which is often the case. When this happens the reason that caused the greatest delay is the one chosen.
The codes are:

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

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



Achievements/Issues of Note

New Breast Cancer Marker Introduced

The Surface Markers section in the Canterbury Health Laboratories (CHL) use flow cytometry technology for the detection and classification of leukaemia and lymphoma. This month they introduced CD30 flow cytometry testing to assist with the rapid identification of breast implant-associated anaplastic large cell lymphoma. The first positive case has been identified which has enabled rapid clinical intervention.

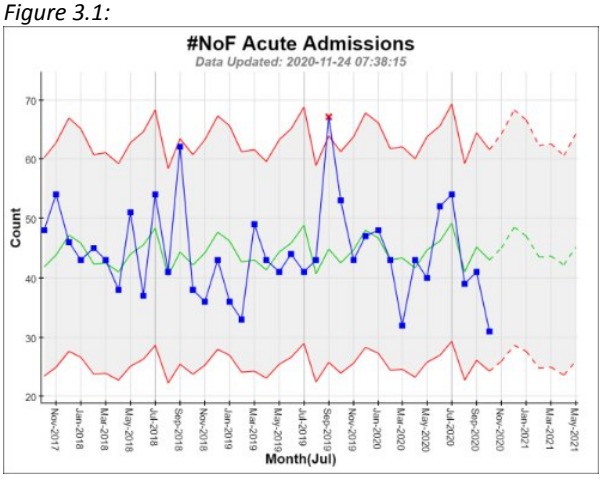
Bowel Screening Programme – Go Live

With the go-live for the Canterbury DHB from the Ministry of Health for the Bowel Screening Programme (BSP) from the 29 October 2020. Invitations to the programme for Canterbury patients will start from the 3 November, and the Anatomical Pathology (AP) Department is expecting the first delivery of colonoscopy/histology specimens towards the end of November. As occurs with the National Cervical Screening and Breast Screening Programmes, this programme has its own set of operational and reporting standards which were audited prior to the decision to Go Live. Patients aged 60-74 are eligible for the programme with the goal of detecting cancers early and allowing treatment options to be undertaken. At present around 3000 New Zealanders are diagnosed with bowel cancer each year with 1200 dying from the disease. The AP Department is looking forward to participating in this important programme of work for Canterbury patients and their families.

Enhanced Recovery After Surgery (ERAS)

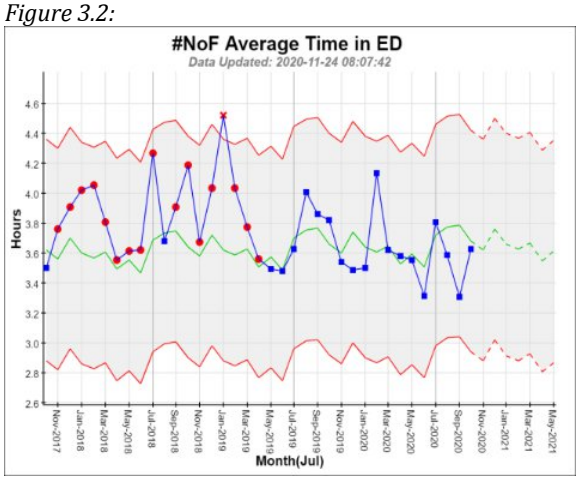
Outcome and Strategy Indicators – Fractured Neck of Femur (#NoF)

Figure 3.1:



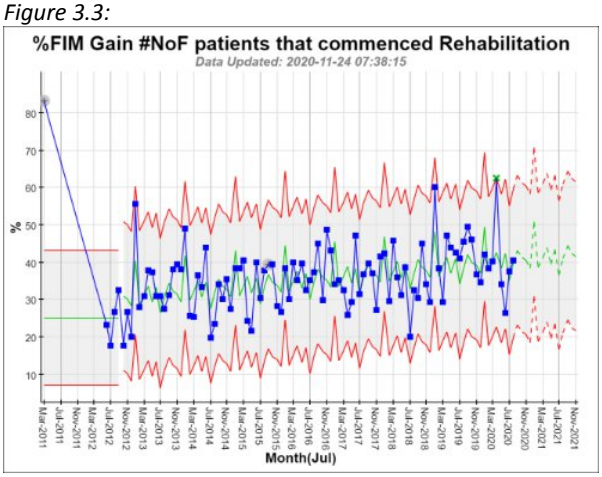
Admissions are generally following the expected mean count. Coding delay impacts the latest data point.

Figure 3.2:



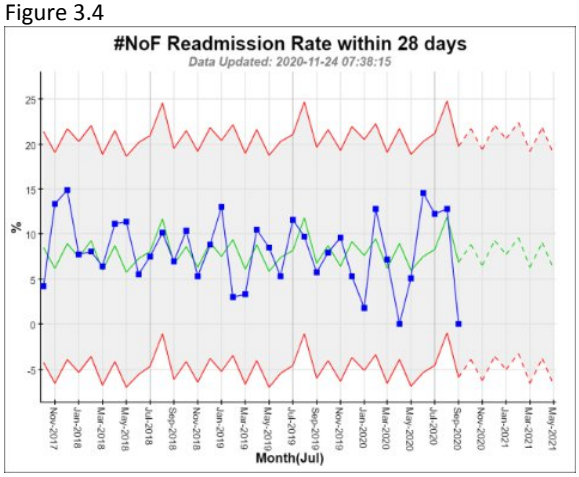
#NoF time in ED is generally following the expected mean times.

Figure 3.3:



The Functional Independence Measure (FIM) is a basic indicator of severity of disability.

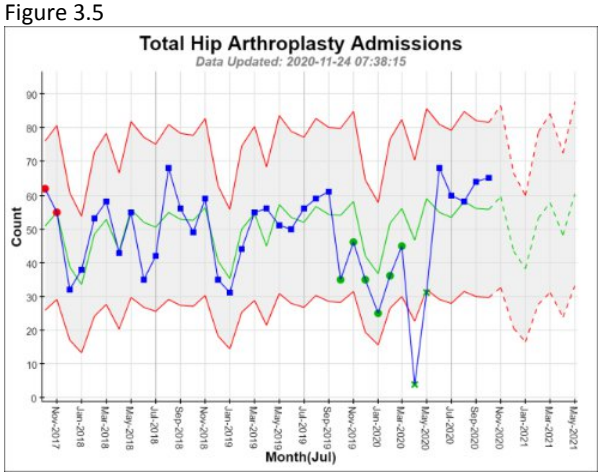
Figure 3.4



Readmissions continue to remain within expected mean values.

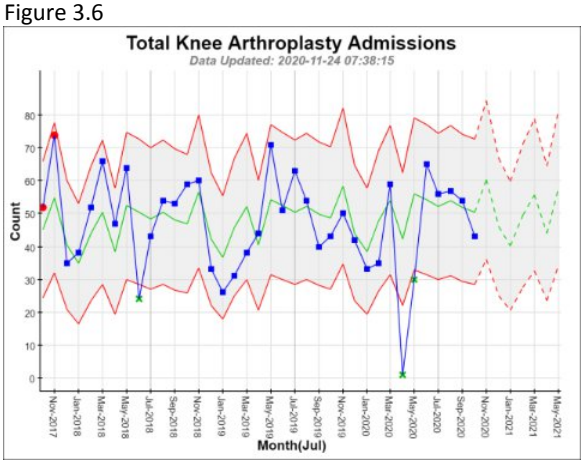
Outcome and Strategy Indicators – Elective Total Hip Replacement (THR) and Knee

Figure 3.5



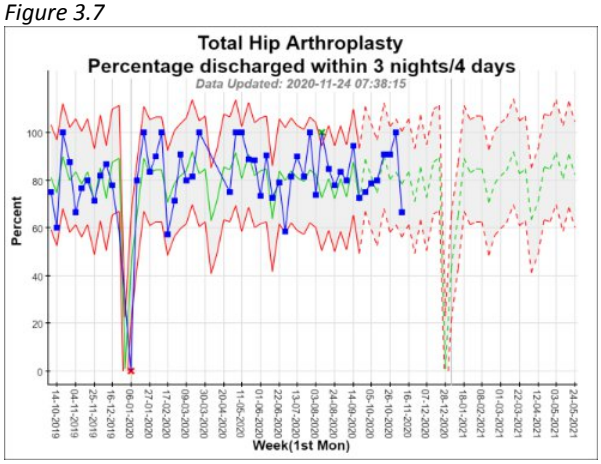
Admissions are trending within the expected range. April shows no record of planned admissions in line with NZ Covid 19 Alert Level 4 restrictions

Figure 3.6



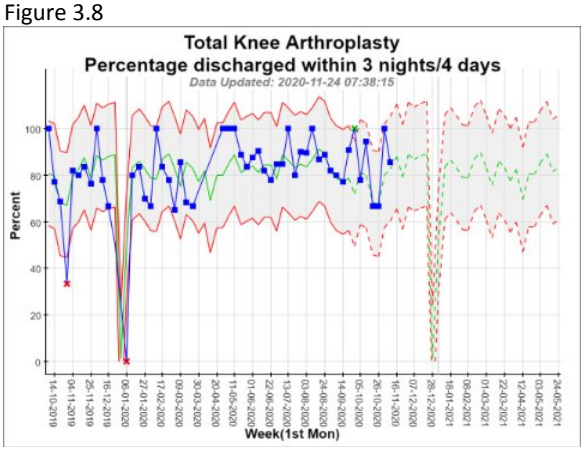
Admissions are trending within expected range. April shows no record of planned admissions in line with NZ Covid 19 Alert Level 4 restrictions

Figure 3.7



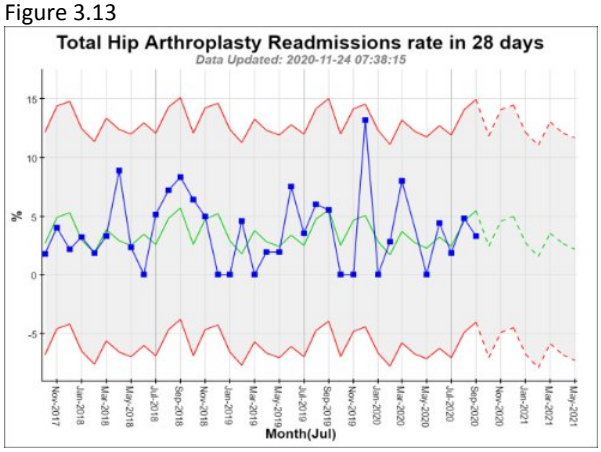
The percentage of patients clinically safe to be discharged is within 3 nights/ 4 days is trending above the mean expected discharge percentage.

Figure 3.8



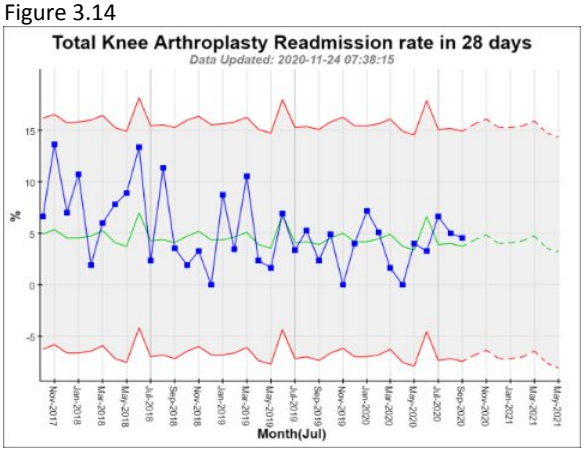
The percentage of patients clinically safe to be discharged within 3 nights/ 4 days is trending above the mean percentage expected to be discharged.

Figure 3.13

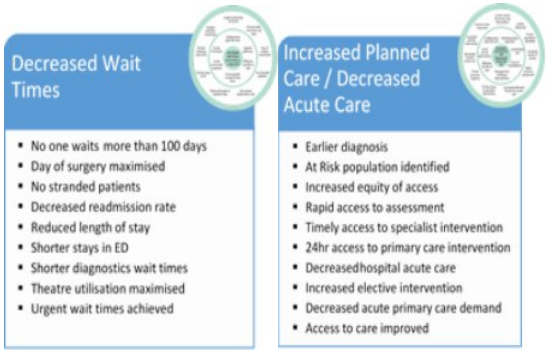


Readmission rates remain a low percentage.

Figure 3.14



Readmission rates are maintaining within tolerances.



Elective Surgery Performance Indicators 100 Days

Elective Services Performance Indicators

Summary patient flow indicators show District Health Boards across New Zealand are experiencing challenges in maintaining compliance with ESPI 2 and 5 – these measure provision of First Specialist Assessment and Treatment respectively within 120 days. While Canterbury District Health Board is no exception to this, significant improvement is evident over recent months.

MoH Planned Care Measurement

Summary of Patient Flow Indicator (ESPI) results

DHB: Canterbury

	Jul-20		Aug-20		Sep-20	
	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %
1. DHB services that appropriately acknowledge and process patient referrals within the required timeframe.	28 of 28	100.00%	28 of 28	100.00%	28 of 28	100.00%
2. Patients waiting longer than four months for their first specialist assessment (FSA).	1815	21.5%	1200	13.3%	910	88.6%
3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT).	0	0.0%	0	0.0%	0	0.0%
5. Patients given a commitment to treatment but not treated within four months.	1303	26.5%	944	19.0%	741	15.3%
8. The proportion of patients treated who were prioritised using nationally recognised processes or tools.	0	100.00%	0	100.00%	8	99.5%

ESPI Compliance Levels:
1. DHB Level 'Non-compliant Red' staus for ESPI 1 is temporarily removed so from July 2016 ESPI 1 will be Green if 100%, and Yellow if less than 100%.
2. ESPI 2 will be Green if 0 patients, Yellow if greater than 0 patients and less than or equal to 10 patients or less than 0.39%, and Red if 0.4% or higher.
3. ESPI 3 will be Green if 0 patients, Yellow if greater than 0 patients and less than or equal to 10 patients or less than 4.99%, and Red if 5% or higher.
4. ESPI 5 will be Green if 0 patients, Yellow if greater than 0 patients and less than or equal to 10 patients or less than 0.99%, and Red if 1% or higher.

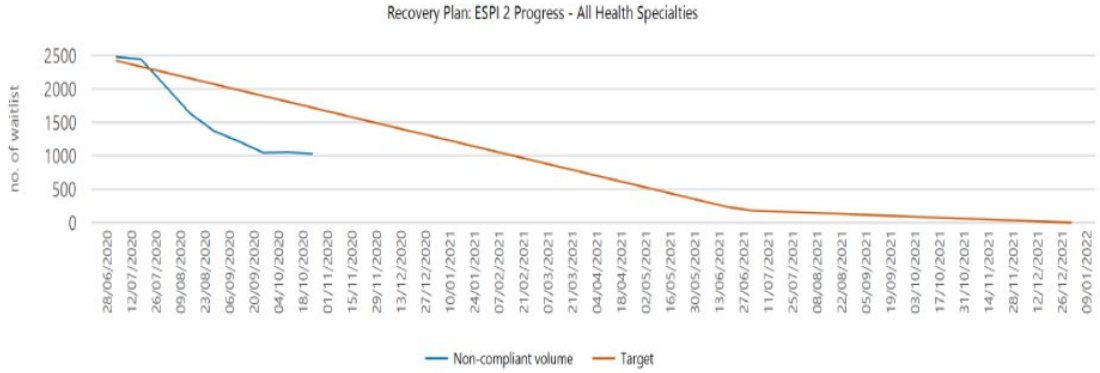
Data Warehouse Refresh Date: 1/11/2020
Report Run Date: 2/11/2020 Data up to: Sep 2020

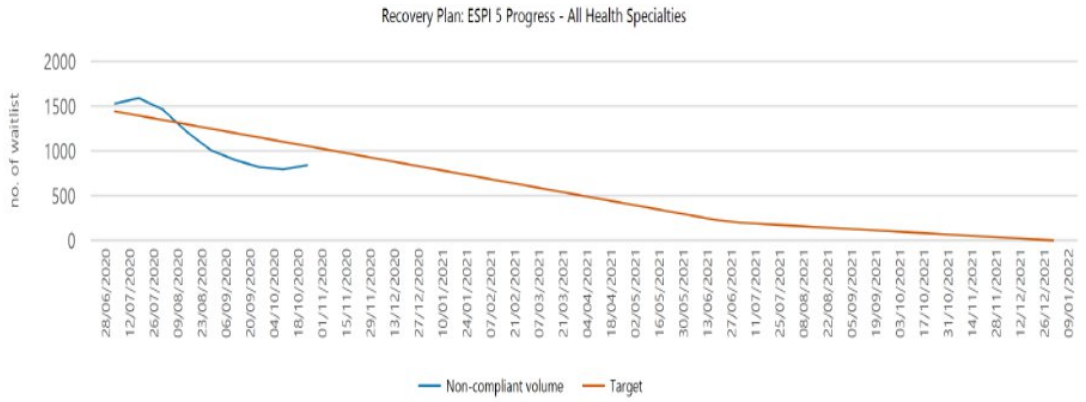
Summary of ESPI 2 Performance - From MoH Final Summary September 20 (published on 2 November)

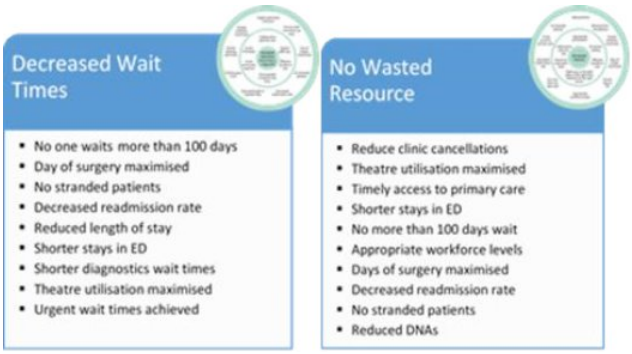
	Jul-20		Aug-20		Sep-20	
ESPI 2 (FSA)	Improvement required	Status%	Improvement required	Status%	Improvement required	Status%
Cardiothoracic Surgery	3	20.0%	2	9.5%	1	4.8%
Ear, Nose and Throat	137	15.0%	53	6.1%	21	2.4%
General Surgery	185	25.9%	37	53.0%	14	1.6%
Gynaecology	5	1.8%	6	2.0%	7	2.3%
Neurosurgery	0	0.0%	0	0.0%	0	0.0%
Ophthalmology	169	25.9%	68	9.4%	27	2.8%
Orthopaedics	49	12.4%	31	5.1%	36	5.1%
Paediatric Surgery	4	2.8%	2	1.4%	3	2.1%
Plastics	253	52.7%	196	37.1%	188	32.5%
Thoracic	0	0.0%	0	0.0%	0	0.0%
Urology	1	2.0%	1	2.0%	1	0.2%
Vascular	111	37.5%	93	35.2%	81	31.4%
Cardiology	15	4.3%	7	1.8%	7	1.9%
Dermatology	3	4.1%	1	1.5%	0	0.0%
Diabetes	7	5.6%	3	2.1%	3	2.1%
Endocrinology	9	5.1%	7	3.4%	6	2.2%
Endoscopy	512	37.4%	418	30.2%	311	22.5%
Gastroenterology	3	1.6%	2	0.8%	0	0.0%
General Medicine	10	8.8%	3	2.6%	1	0.7%
Haematology	2	6.7%	0	0.0%	1	1.8%
Infectious Diseases	0	0.0%	0	0.0%	1	5.9%
Neurology	79	21.4%	34	9.0%	9	2.7%
Oncology	6	3.3%	8	5.1%	7	3.1%
Paediatric Medicine	226	43.8%	210	37.2%	165	29.9%
Pain	4	33.3%	1	16.7%	1	20.0%
Renal Medicine	1	2.6%	2	4.4%	5	12.8%
Respiratory	20	10.6%	15	7.0%	12	4.9%
Rheumatology	1	4.0%	0	0.0%	0	0.0%
Total					908	9.3%
ESPI 5 (Treatment)						
Cardiothoracic Surgery	0	0.0%	0	0.0%	0	0.0%
Dental	144	41.6%	138	40.9%	100	31.3%
Ear, Nose and Throat	164	30.5%	145	24.4%	108	17.5%
General Surgery	273	37.4%	228	31.7%	214	30.2%
Gynaecology	64	18.8%	48	14.2%	46	13.2%
Neurosurgery	0	0.0%	0	0.0%	0	0.0%
Ophthalmology	213	4.9%	118	24.2%	70	16.7%
Orthopaedics	167	25.1%	92	13.0%	64	9.4%
Paediatric Surgery	31	24.6%	29	24.6%	19	16.8%
Plastics	163	19.0%	68	7.6%	58	6.7%
Urology	8	2.4%	7	2.1%	6	1.7%
Vascular	8	7.9%	5	5.6%	6	6.7%
Cardiology	68	23.1%	66	24.9%	50	19.2%
Total	1303	26.5%	944	19.0%	741	15.3%

Note - ESPI 5 figures and ESPI2 figures for July and August are taken from the MoH ESPI Finals report for September 2020, published 2 November 2020. An error in the data submitted means that MoH ESPI 2 report for September is incorrect, those figures have been replaced with those from the corrected data file.

The CDHB Improvement Action Plan 20/21 is in place and focusses on CDHB achieving ESPI/Planned Care compliance in the majority of services within six months. As at 30th October seven specialty areas have no patients waiting for **First Specialist Assessment** for longer than 120 days, 26 are meeting their recovery plan target and twelve are not. CDHB is also meeting improvement plan targets for **waiting times for admission and treatment**. As at 30th October one specialty area has nobody waiting longer than 120 days, eight are meeting their recovery plan target and five are not.







Theatre Capacity and Theatre Utilisation

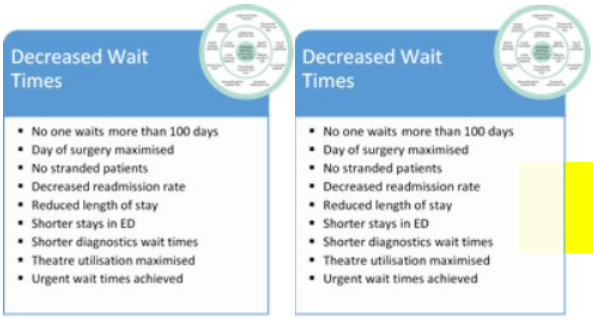
- Our target is to deliver a total of 31,359 planned care interventions during 2020/21: made up of 19,614 surgical discharges, 11,409 minor procedures and 336 non-surgical interventions. This is 2% higher than the 2019/20 target of 30,675.
- Internal reporting to the week ending 4 September shows that we have provided 14,266 planned procedures and discharges in total – this is 3,644 ahead of the target of 10,622.
- Within this, 6,842 planned inpatient surgical discharges have been provided – 281 ahead of the phased target of 6,561.
- We have provided 7,403 minor procedures, 3,462 ahead of our target of 3,941. Inpatient, outpatient and community provision are all ahead of target.
- 21 non-surgical interventions have been counted, 98 below target of 119.

Current theatre volumes

Christchurch and Burwood theatres provided the forecast volume of theatre events during September. Burwood also provided the forecast volume of theatre events during October with Christchurch sitting at 86% of forecast volume.

The number of operations carried out for CDHB patients in private hospitals is 32% higher than forecast in September and 17% higher in October. During these months 1,184 planned operations were carried out in private Hospitals, around 31% of total planned operating compared with 25% in the same months in 2019.

This is because, over time, acute operating demand has displaced planned operating from our fixed Christchurch Hospital theatre capacity with resulting increases in outplacing and outsourcing required in order to achieve our planned care targets, which also increase each year.

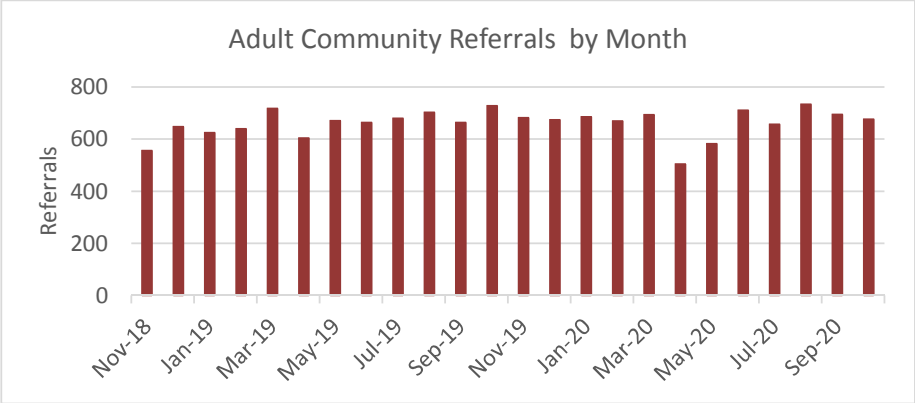


Mental Health Services

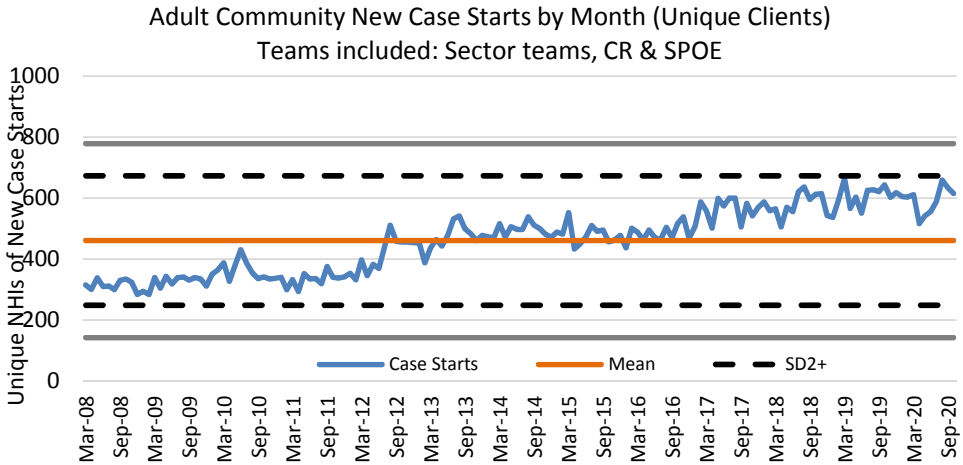
Specialist Mental Health Services – Focus Adult Cohort

Adult Community Services – Referrals and Case Starts

Adult community services have seen an increase in demand, which appears to now be plateauing. Further analysis is required to understand the drivers for the levelling of demand. The impact of the COVID lockdown on demand is clear in April and May followed by a subsequent rebound in activity.



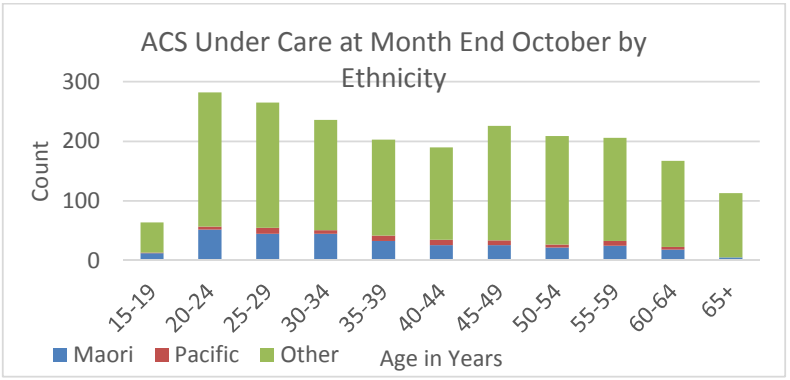
New cases were created for 673 individual adults (unique NHIs) in September 2020 and 614 in October 2020.

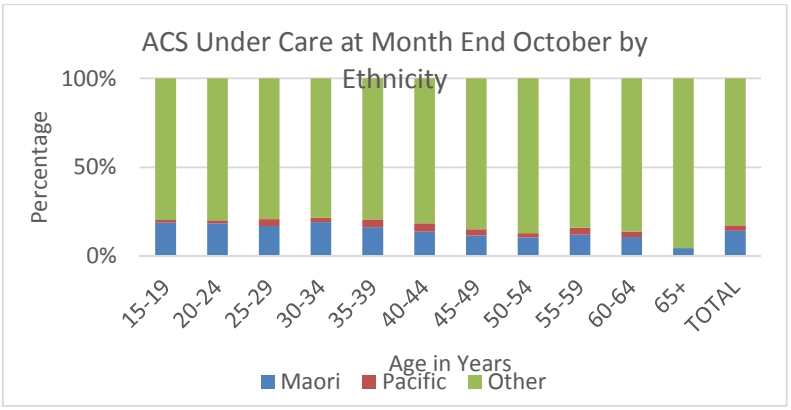


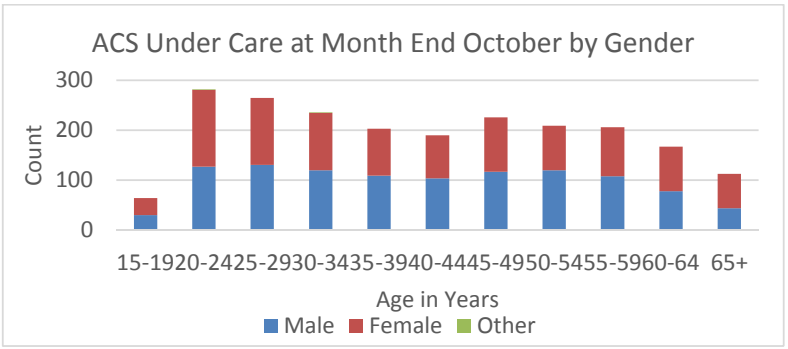
Adult Community Services – Population by Age, Ethnicity and Gender

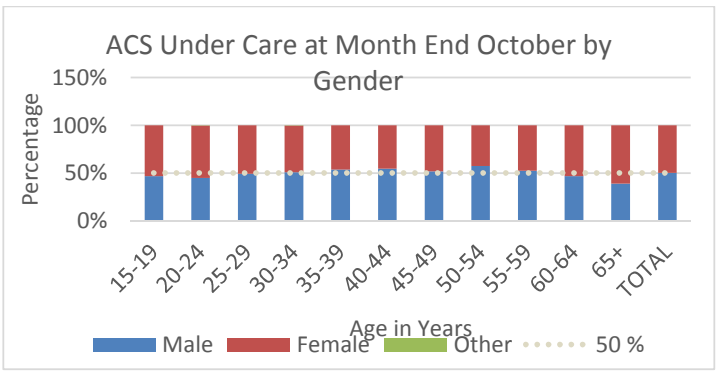
The adult community service has 2161 patients under care as at the end of October (including people who have not had contact during this month).

The figures below show the population under care at month end by age ethnicity and gender.



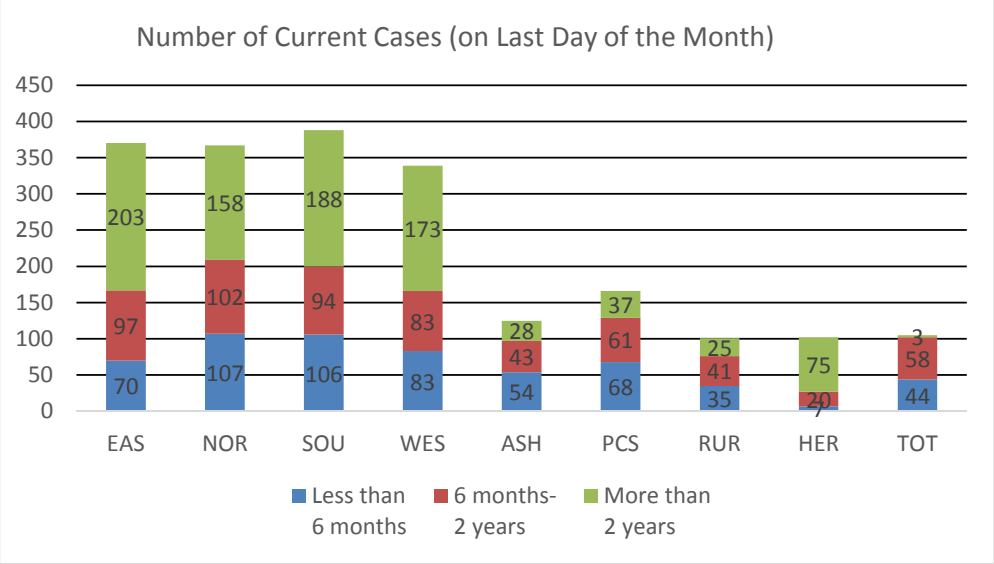




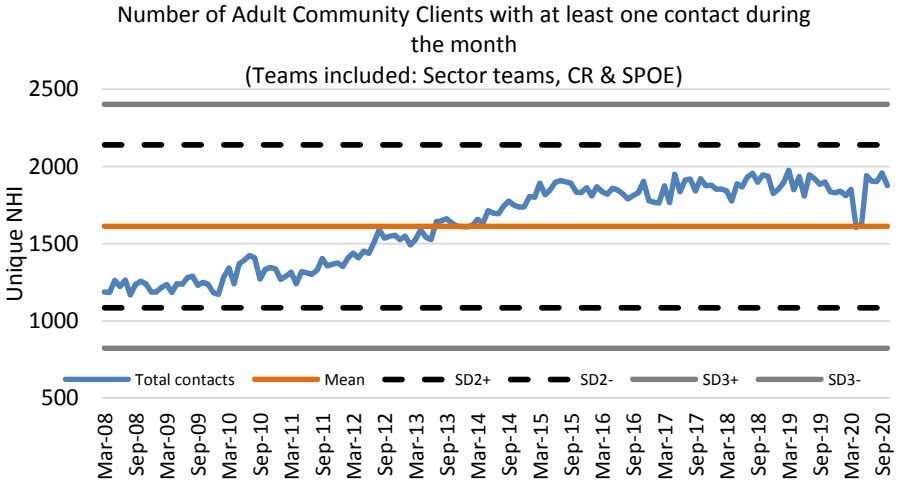


Adult Community – Case Management Activity

The graph below shows the number of people under case management by Adult Community teams, with case duration current as at the end of October.

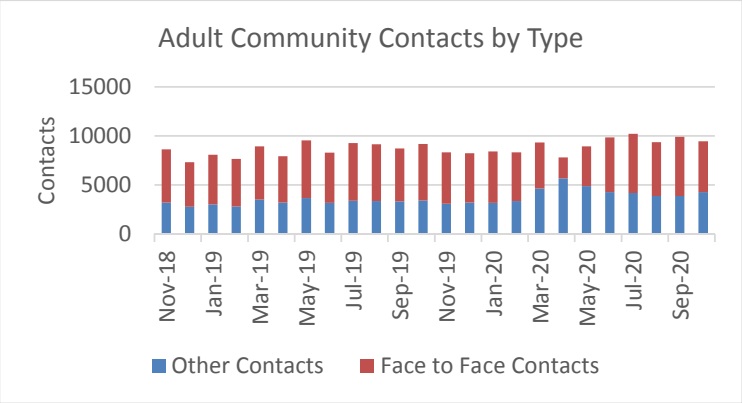


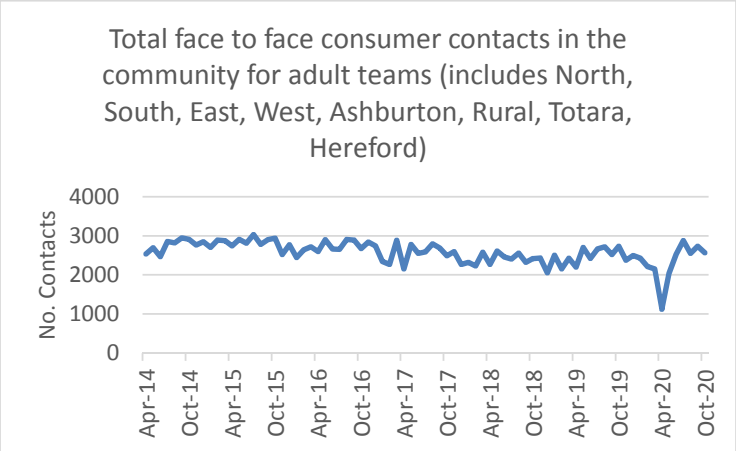
In September 2020 there was at least one contact recorded for 1957 unique adult community mental health consumers and 1875 in October 2020.



Community case management is most often provided face to face, but an increased proportion of this activity is now conducted by phone or audio visual contact (which peaked during COVID lockdown). This may be directly with the consumer or by consultation with whanau, primary care or other services involved in care of our consumers.

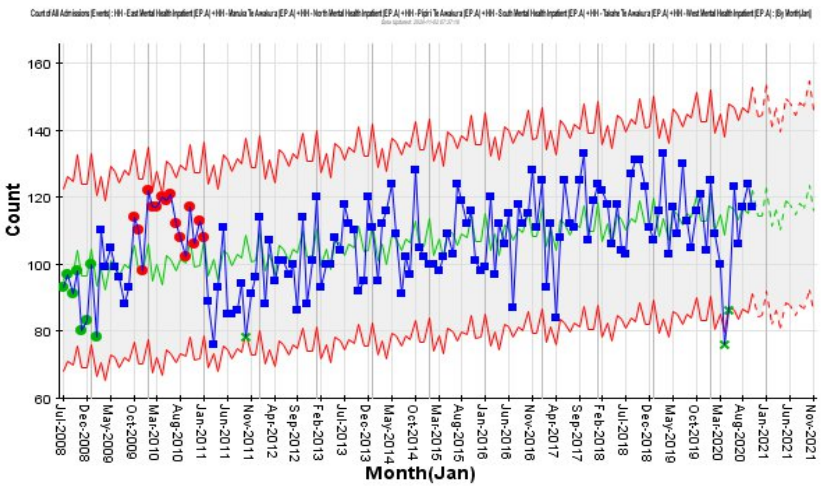
The figures below show the proportion of face to face and non-face to face contacts, and the number of face to face contacts with consumers in non-DHB staffed settings. These settings include home visits, residential providers, rest homes, educational facilities, court, prison, maraes and other community locations (eg: cafes, patient workplaces,)





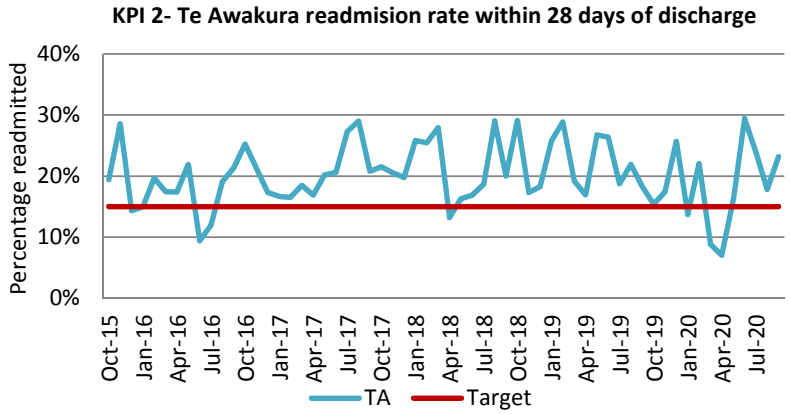
Adult Inpatient Services – admission and readmission

The figure below shows a monthly view of admissions to Te Awakura. There has been a sustained increase in admissions since 2008 and this increase has slowed growth is forecasted to continue despite the Covid 19 related dip in April-May.

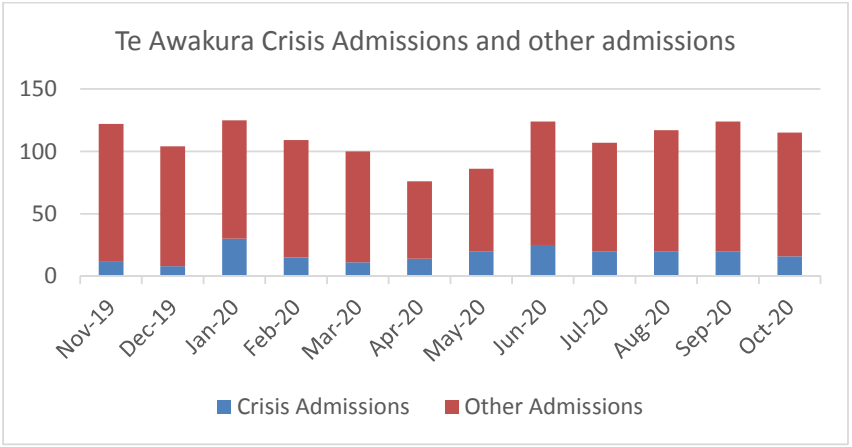


The graph below shows the readmission rate within 28 days of discharge. Of the 110 Te Awakura consumers discharged in September 2020, 23.1%, were readmitted within 28 days. The reasons for a high readmission rate are multi-faceted including the increasing demand for inpatient services requiring shorter lengths of

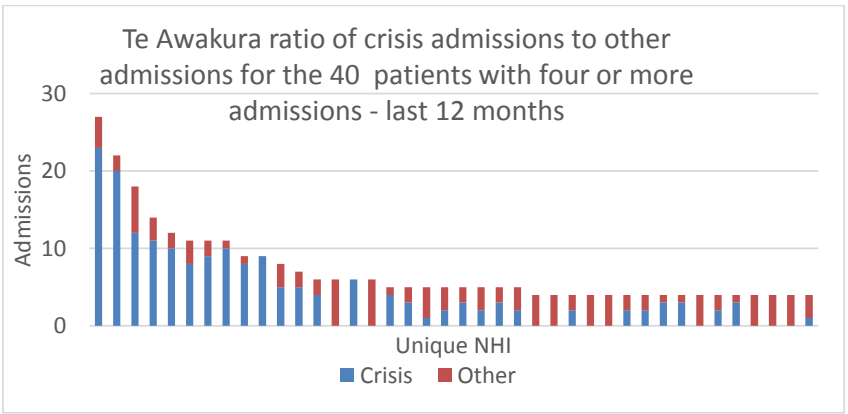
stay; the more frequent use of crisis admissions (a brief pro-active intervention to manage risk factors during an immediate crisis); the level of acuity in the community; and an increasing impact of substance misuse.



Crisis admissions are admissions under an established crisis management plan agreed between the service and the service user. They are generally for a period of two days or less.



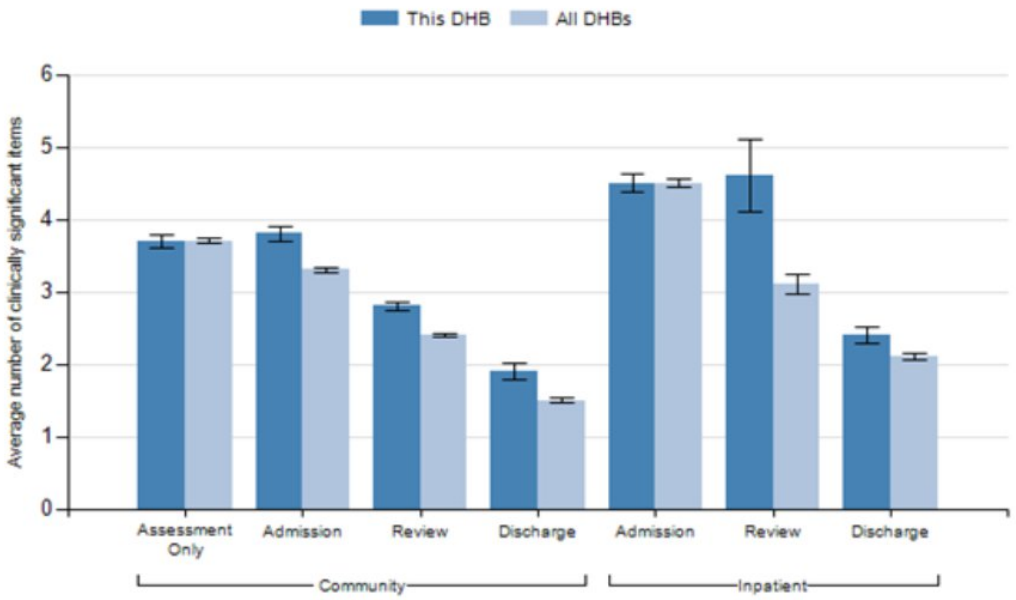
Crisis admissions to Te Awakura make up a high proportion of repeat admissions as the graph below shows. While crisis admissions are 20% of all admissions, they are only 2% of total occupancy (last 12 months admissions length of stay to date data).



Adult Services – Health of the Nation Outcomes Scales (HoNOS)

HoNOS measures the health and social functioning of people experiencing severe mental illness. It is an outcome tool mandated for specialist mental health services which provides an indication of changes that

have occurred for service users between entering and leaving the service and the overall severity of service users who use different services.

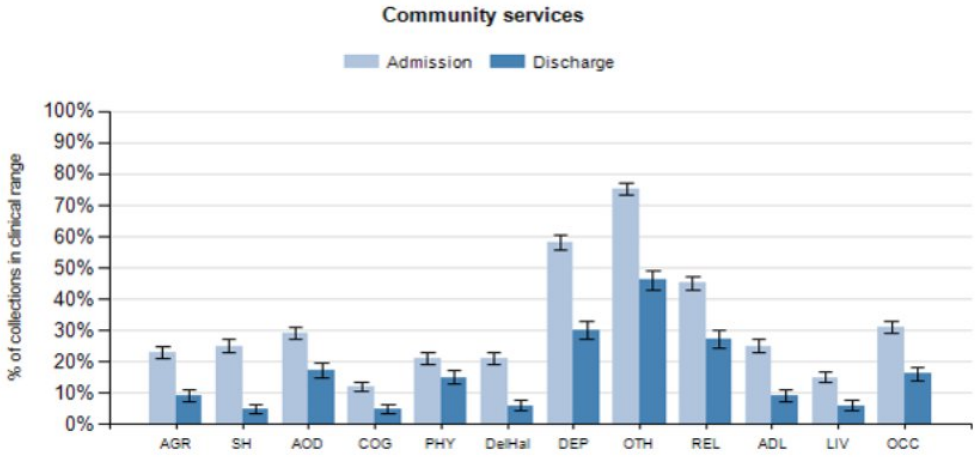


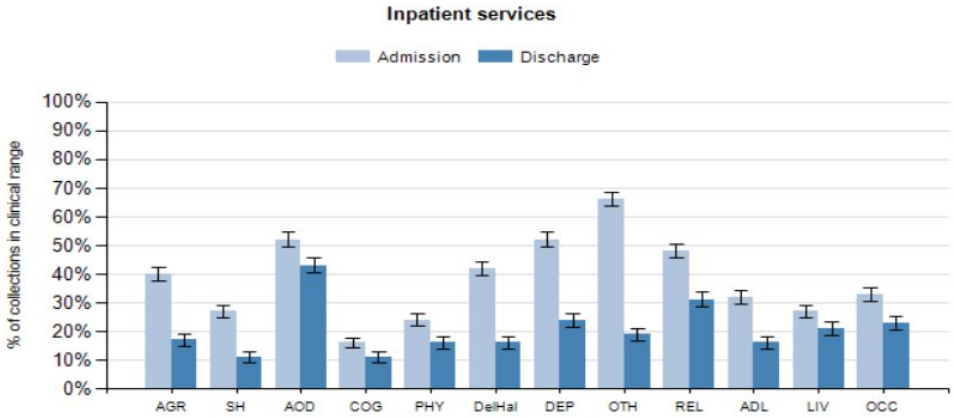
The graph above shows the average number of items in the clinically significant range (2, 3 or 4).

I**nterpretation:** A decrease between admission and discharge is an indication of positive outcomes achieved by the service and service user.

The graphs below show the proportion of people with HoNOS items in the clinical range.

I**nterpretation:** The longer the bar, the greater proportion of service users who exhibit this difficulty. A greater decrease in the length of the bar between admission and discharge suggests a better outcome for the difficulty.





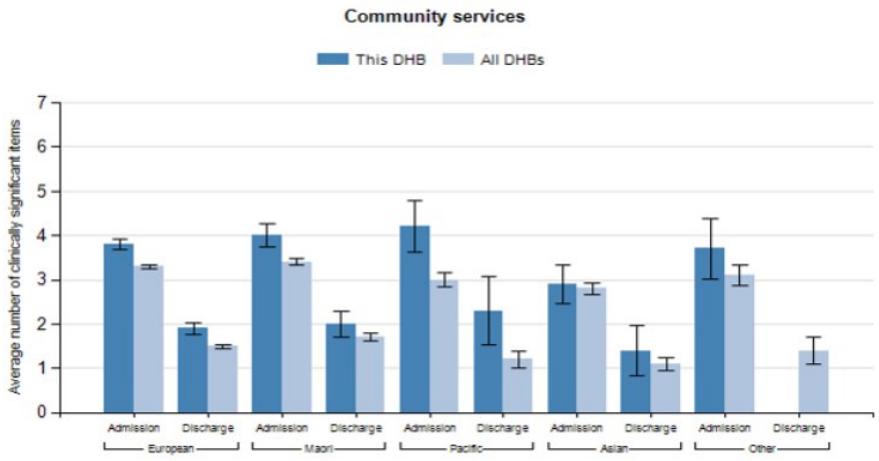
Individual item scales in HoNOS are as follows:

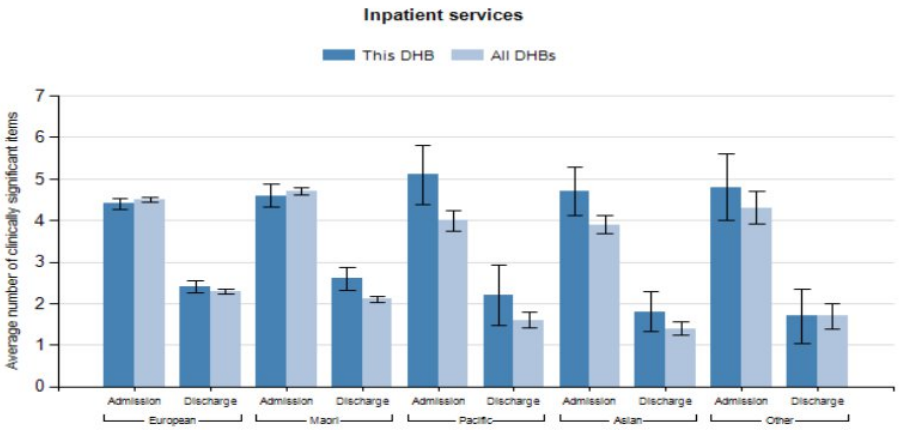
AGR	Overactive or aggressive behaviour	SH	Non accidental self injury
AOD	Problem drinking or drug–taking	COG	Cognitive problems
PHY	Physical illness or disability problems	DeHal	Problems associated with hallucinations and delusions
DEP	Problems with depressed mood	OTH	Other mental and behavioural problems
REL	Problems with relationships	ADL	Problems with activities of daily living
LIV	Problems with living conditions	OCC	Problems with occupation and activities

Average number of clinically significant HoNOS items at admission and discharge by ethnic group: Canterbury DHB, 2019/20

For most European, Māori and Pacific, Canterbury has a higher number of clinically significant HoNOS items than other DHBs on entry to community services. Significant benefits are achieved for all ethnicities between admission and discharge. For inpatient admissions, Canterbury is similar to other DHBs on entry for all ethnicities except Pacific and achieves significant improvements before discharge.

Interpretation: A greater decrease between admission and discharge indicates a better outcome. Decrease between admission and discharge is an indication of the outcomes achieved by the service and service user (points are significantly different if error bars don't overlap).



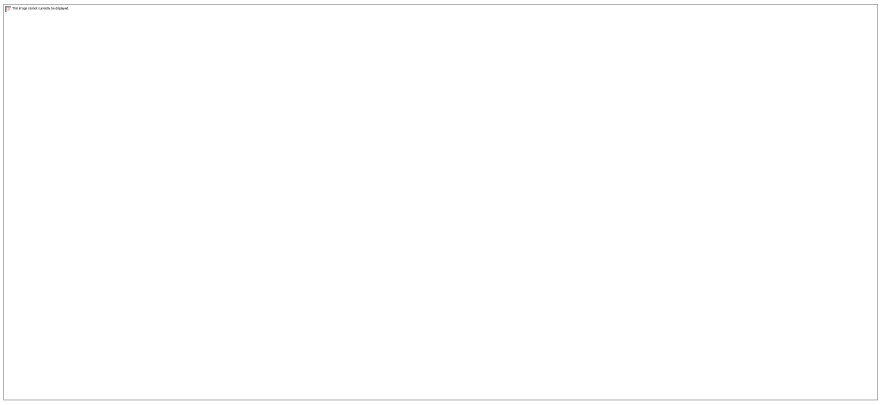


Supplementary CAF data

In response to outstanding action points from the previous meeting

Action point 1a

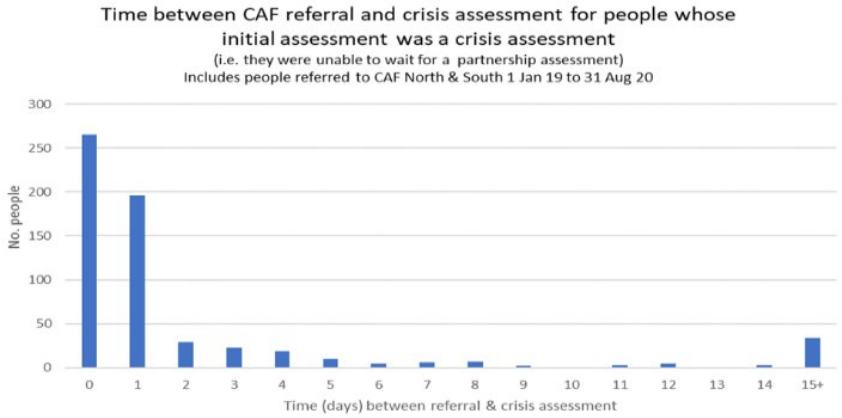
CAF: data on waiting time from referral to telephone triage



Action point 1b

CAF data on high acuity being seen within two days

As per the previous report, the graph below shows that people in need of a crisis assessment are typically being identified at the time of referral and assessed soon after – commonly within 0-1 days. In the 20-month period from 1 January 2019 to 31 August 2020 only 34 people deteriorated and required a crisis assessment while waiting 15 or more days to be seen.



Action point 2: Information on what is put in place for children who are waiting for months, or even a year for their first face to face.

The wait time to first face to face is provided in the graph below. The average time from referral to partnership (treatment) is 12 weeks.

We carry a waitlist system within clinical systems, which logs every person waiting to be seen by CAF. The waitlist includes brief information regarding the risk and the referral reason.

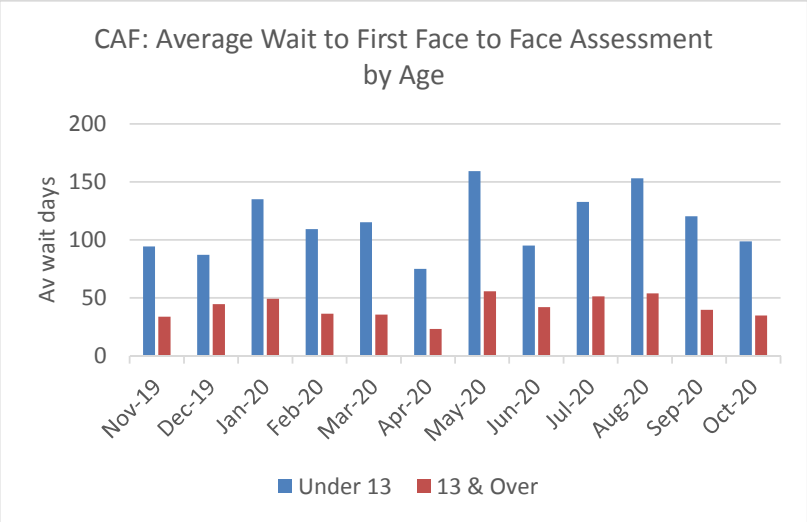
Often the team are waiting on additional information from carers, teachers and others in order to progress assessments (eg: ADHD assessments). The log notes this and a date is recorded for next contact. The system flags any overdue contacts and the CAF Associate Clinical Managers prompt follow ups.

All people waiting are telephoned by a clinician every three months to assess the situation, including risk and acuity. Everyone has information on how to call us, including in hours and out of hours.

Action point 3

Graph showing "average waiting time from referral to first face to face contact"

The disparity relates to the ADHD wait time, as the majority of people referred for ADHD assessment (includes time waiting for carer and teacher reports) are under 13.



Living within our means

Canterbury District Health Board

Statement of Financial Performance

Hospital & Specialist Service Statement of Comprehensive Revenue and Expense
For the 4 Months Ended 31 October 2020

MONTH $'000				YEAR TO DATE		
20/21 Actual $'000	20/21 Budget $'000	20/21 Variance $'000		20/21 Actual $'000	20/21 Budget $'000	20/21 Variance $'000
			Operating Revenue			
284	267	17	From Funder Arm	1,070	1,078	(8)
1,209	1,541	(332)	MOH Revenue	6,192	6,261	(69)
4,186	4,421	(235)	Patient Related Revenue	18,746	17,630	1,116
2,746	1,700	1,046	Other Revenue	11,770	6,831	4,939
8,425	7,929	496	**TOTAL OPERATING REVENUE**	37,778	31,800	5,978
			Operating Expenditure			
			Personnel Costs			
68,696	69,534	(838)	Personnel Costs - CDHB Staff	271,819	271,984	(165)
1,781	1,996	(215)	Personnel Costs - Bureau & Contractors	8,467	8,003	464
70,477	71,530	(1,053)	**Total Personnel Costs**	280,286	279,987	299
13,488	13,756	(268)	Treatment Related Costs	56,010	55,167	843
4,090	3,935	155	Non Treatment Related Costs	16,456	15,957	499
88,055	89,221	(1,166)	**TOTAL OPERATING EXPENDITURE**	352,752	351,111	1,641
(79,630)	**(81,292)**	**1,662**	**OPERATING RESULTS BEFORE INTEREST AND DEPRECIATION**	**(314,974)**	**(319,311)**	**4,337**
			Indirect Income			
1	1	-	Donations & Trust Funds	49	5	-
1	**1**	**-**	**TOTAL INDIRECT INCOME**	**49**	**5**	**-**
			Indirect Expenses			
2,653	2,485	168	Depreciation	10,730	9,982	748
-	-	-	Loss on Disposal of Assets	2	-	2
2,653	**2,485**	**168**	**TOTAL INDIRECT EXPENSES**	**10,732**	**9,982**	**750**
(82,282)	**(83,776)**	**1,494**	**TOTAL SURPLUS / (DEFICIT)**	**(325,657)**	**(329,288)**	**3,587**

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

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

Achievements/Issues of Note

Kailo Electronic Consent Forms and Worksheets

- Paper forms have been previously used to obtain consent from patients for the administration of intravenous iodinated contrast used for many CT scans.
- This process has been made electronic for nearly all procedures, with forms now being completed on iPads. Forms are now automatically uploaded to the CDHB systems within one minute of completion. Previously it could take up to 24-36 hours under the manual process.
- Initially this was rolled out to Christchurch Hospital Radiology and will be put in place at Burwood and Ashburton Radiology sites, along with being expanded to MRI safety and consent forms.
- Alongside this ultrasound has already introduced electronic worksheets across the service improving accuracy, legibility and in some cases reducing Radiologist reporting time for normal scans from approx. 10 minutes down to 2 minutes.
- The changes in CT and Ultrasound has saved $3,000 a year in consumables and released staff time estimated at being worth $19,000 for other purposes each year.

Peripherally inserted venous catheter projects

- The Infection Prevention and Control service and Nurse Consultant Vascular access are working on a range of interventions to address a trend in healthcare acquired blood stream infections linked to peripherally inserted intravenous catheters. Costs directly associated with these cases have mounted to over $690,000.
- Improvements to the way we work and add value but do not have a large resource requirement will be rolled out incrementally over time.
- The first of these improvements is the introduction of generic IV Starter Kits for cannulation. This pre-packaged 3M product costs $2.95 and includes all items required for cannulation. Each kit costs $1.03 less per cannulation when compared with the previous approach (where staff members picked all of the individual items required). Total savings of $206,000 per annum are created by this change which has already been adopted in Ashburton Hospital, Radiology and ED and, with the assistance of the procurement team, is being rolled out across the organisation.

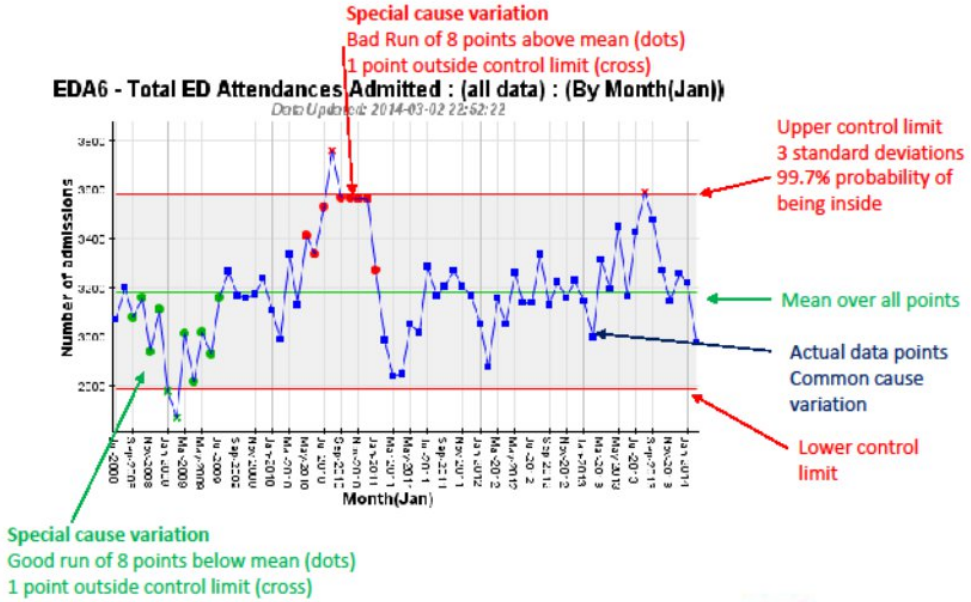
Change in chest drain removal dressing for cardiothoracic patients

- A change in practice for cardiothoracic patients has resulted in a 64% reduction in costs for wound dressing products applied after chest drain removal.
- Before the change a combination of products including a silver based product called Aquacel Ag was used. The total of this combo equalled $9.67. This has changed and now involves the use of a single product called Mepilex Border, saving a minimum of $6.17 per dressing.
- On an annual basis this will save over $8k

Proposed change of supplier for haemodialysis consumables

- Following expiry of our contract for the provision haemodialysis consumables we have been unable to negotiate a contract that fulfilled both party's needs. Without a contract in place the cost of consumables was set to increase by over $250k a year.
- The Dialysis service and Procurement have worked together to assess alternatives and have been able to enter into an arrangement with another provider whose consumables are compatible with our existing equipment.
- Over the next six months we will retrain patients, reconfigure the machines and move to the new products.
- This will provide cost savings of over $69,000 per year on current costs – and will be more than $325,000 cheaper than staying with the alternative approach.

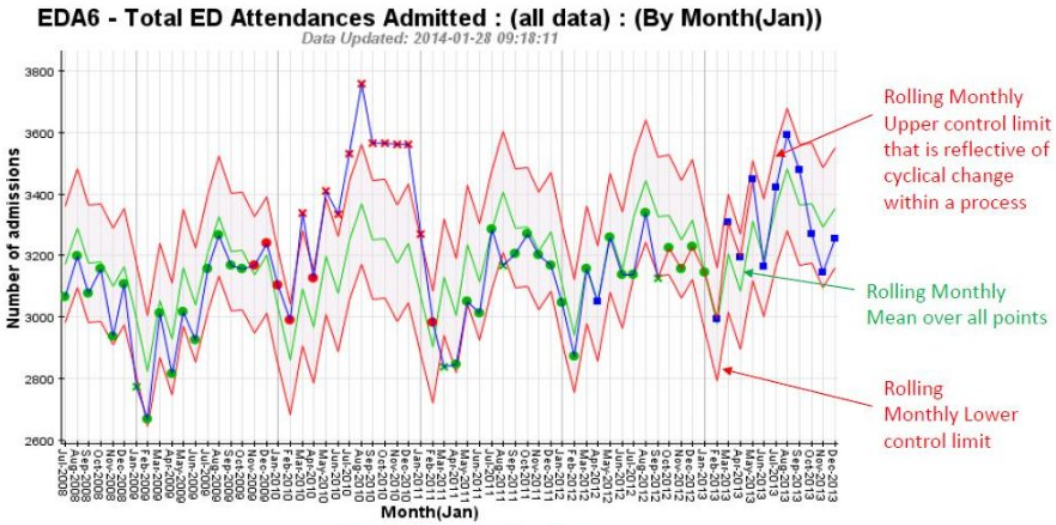
SPC: How to Interpret a Control Chart



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 & Members, Hospital Advisory Committee**

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

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

DATE: **3 December 2020**

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 1 October 2020	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(if required)*	Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege.	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)

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

3. SUMMARY

The Act, Schedule 3, Clause 32 provides:

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

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

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

Clause 33 of the Act also further provides:

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

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

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

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

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

QUALITY & PATIENT SAFETY INDICATORS – LEVEL OF COMPLAINTS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **Irena de Rooy, Quality & Patient Safety Manager**
Susan Wood, Director, Quality & Patient Safety

APPROVIED BY: **Becky Hickmott, Acting Executive Director of Nursing**
Dr Jacqui Lunday Johnstone, Executive Director of Allied Health, Scientific & Technical
Dr Sue Nightingale, Chief Medical Officer

DATE: **3 December 2020**

Report Status – For:	Decision ☐	Noting ☐	Information ☑

1. ORIGIN OF THE REPORT

The purpose of this report is to place before the Committee information on the patient experience, from feedback gained through survey and the complaints system. This is a regular six-monthly information report on the Committee's work plan.

2. DISCUSSION

The Canterbury District Health Board is committed to providing quality healthcare. Understanding how people experience healthcare gives us valuable insight. Feedback is used by teams to monitor care provided and assists in identifying what went well, and what could be done better.

This report provides an overview of patient experience feedback and complaints data as well as examples of improvement actions.

- The survey asks questions about four areas - communication, partnership, co-ordination and physical and emotional needs.
- Number of complaints received are related to the total number of: admissions; ED attendances (where the patient was not subsequently admitted); and outpatient attendances in the period at all Canterbury DHB hospitals. The total complaints rate data includes complaints to the office of the Health and Disability Commissioner (*HDC*) about care provided by the Canterbury DHB.

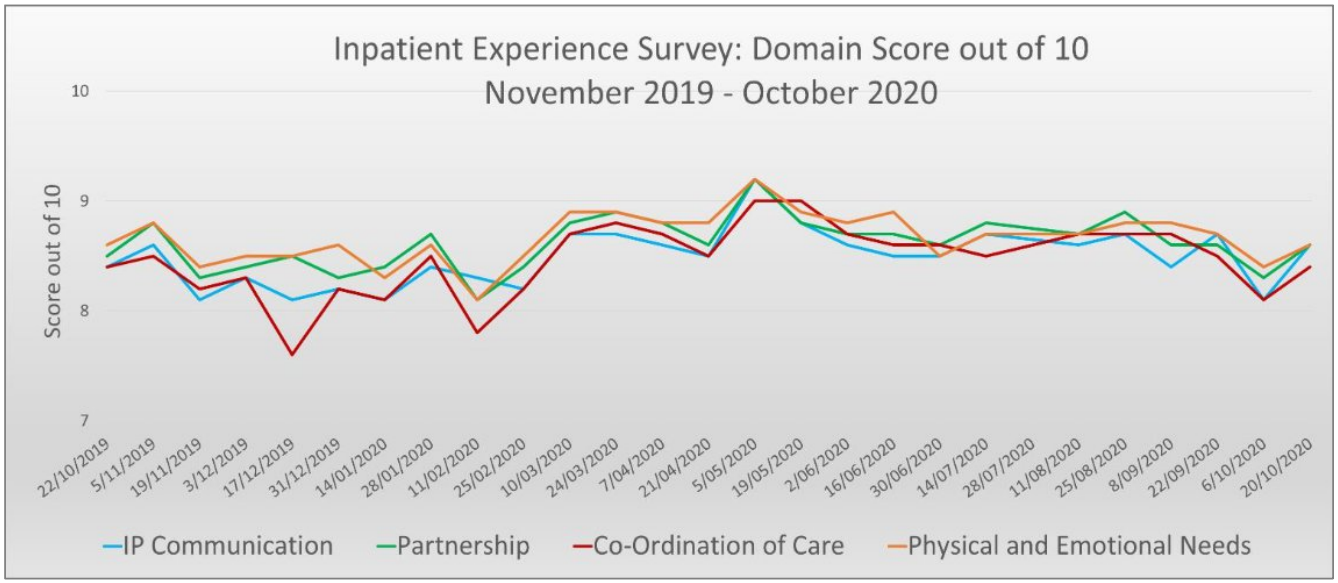
3. APPENDICES

Appendix 1: CDHB Complaint Rate and Categories to October 2020

APPENDIX 1

PATIENT EXPERIENCE: Survey Feedback

Patient experience is one of a core set of measures used together to ascertain service quality. Understanding how people experience healthcare gives us valuable insight. Feedback is used by teams to monitor care provided and assists in identifying what went well, and what we need to do better. Taking part is voluntary and feedback is anonymous.



Services have access to both inpatients and outpatients' feedback. These data are able to be analysed by age, gender, ethnicity, and self reported disability. The feedback is available to all CDHB staff in the patient experience portal in Seeing our System on the intranet. They are able to drill in and review the written comments made as well as the quantitative results.

Note: Given the 4-year investment of effort by the organisation to have patient experience information integrated at area and department as well as service level, Canterbury DHB has continued to seek feedback using the pre-existing patient experience survey services from December 2019, while the Health Quality and Safety Commission transition providers for the National Survey inpatient survey. This service is not yet to be available.

In and Outpatient Surveys
All patients (>16 years) who have spent a night in hospital or who have accessed our outpatient services who have an email address of SMS messaging are invited to participate in the patient experience survey excluding Paediatrics and Specialist Mental Health Services; a proposal is under consultation.

Inpatients

Over the 12 months 15,348 discharged patients were invited and 5,075 responded to the survey (32%), with respondents reporting the following ethnicities - Maori 6.1%, Pasifika 1.5%, Asian 2%, Indian 1.3%, NZ European 77.9%, other 6.4%. In all 61% were female and 39% were male. Forty percent of respondents were over 65 years (23.4% were over 65 – 74 years,14.4% were over 75 and less than 80, and 3% were over 80 year of age). Most people completed the survey for themselves, with a very small number having another person complete the survey for them (2.9%). In all 32% of respondents reported they had difficulty climbing steps, 19% reported difficulty remembering or concentrating, and 16.9% of respondents think of themselves as disabled. Respondents provided 16489 comments for staff to read.

Question Domain results for October 2020

The lowest rated question at **65%** is did a staff member tell you about medication side effects to watch for when you went home. Promoting the need for this activity was the focus of Medicines Safety Week.

The highest rated questions evenly at **95%** were confidence and trust in staff treating you and before the operation staff explained the risks and benefits in a way that was understood.

Outpatients

Over the 12 months 99,703 outpatients were invited and 1,4370 responded to the survey (14%), with respondents reporting the following ethnicities - Maori 6.6%, Pasifika 1.1%, Asian 1.2%, Indian 0.7%, NZ European 82%, other 8.4%. In all 54.8% were female, 44.8% were male and 0.4% were gender diverse. Forty nine percent of respondents were over 65 years (29.8% were over 65 – 74 years,13.9% were over 75 and less than 80, and 2.4% were over 80 year of age). Most people completed the survey for themselves, with a very small number having another person complete the survey for them (2%). In all 31.8% of respondents reported they had difficulty climbing steps, 23.6% reported difficulty remembering or concentrating, and 13.3% of respondents think of themselves as disabled. Respondents provided 36,390 comments for staff to read.

Domain results for October 2020

The lowest rated question at **80%** was “where possible did staff include your family/whanau or someone close to you in discussion about your care?” The highest rated questions evenly at **96%** were staff treated with dignity and respect and staff listened to what patient said.

Example of improvement actions following Patient Feedback

Patients Indicate We Need to Improve Family Involvement
Clinical teams need to have accurate family/whanau contact details, so they always know who and how they can contact. Following moderate rating by respondents in the adult inpatient experience survey question to the question ***'Where possible did staff include your family/whānau or someone close to you in discussions about your care?'*** Ward 27, General Medicine was the pilot ward for the Always Event research project, conducted by Sapere and sponsored by the HQSC, to define the aspects of family experience important to patients and their family and whānau that health care providers must aim to perform consistently for every individual every time, so they feel involved (Picker Institute). It was found there was no shared and agreed process for staff to know who to the patient wanted to involve on their care and no clear ‘team’ role expectation provided to the “family”. There are many people who potentially could be viewed as the person staff should communicate with.

Focus groups were held with whanau/family members who had provided support during a recent admission of their loved ones. The consistent themes were:

- to strengthen the information available for the 'family', mitigate the cognitive burden of tracking the many staff, and frequently given information that felt too much and unorganized, no supporting material for later review
- reinforce information later along with a plea for simple and consistent messaging and language
- being able to be involved in ward rounds
- knowing about discharge well in advance
- consistent organizational approach to family/whanau involvement.

CDHB has learned from Southern, MidCentral and Bay of Plenty DHBs that had developed the role of the nominated contact person and re implementing this internally. **A nominated contact person:** is available to be contacted in case of an emergency or a change in condition, supports the patient’s personal needs while in our care, keeps other family/whānau members informed and updated.

The following resources have been developed thus far:

- **Patient and Family/whanau information** Nominated contact formation
- **Procedure** Nominated contact procedure

The term "nominated" has been chosen to align with the Health Records NZS 8153:2020 nominated contact representative standard. The term and role were introduced as part of the visitor management process during the level 4 Covid lockdown. Progress is being made to have the nominated contact term in the district wide SPICS administration system following consultation with SI DHBs.

The **Canterbury Covid-19 Managed Isolation Facilities Guest Survey** is now in its thrid month. The questions are similar to the current patient experience questionnaires used for inpatient, outpatients and general practice, with specific service additions. The Canterbury Managed Isolation Facilities team is committed to providing the best possible experience for guests in our isolation facilities. Understanding how people experience their stay gives us valuable insight into what went well and what could be done better. CDHB is undertaking this survey on behalf of all agencies that contribute to their stay.

Covid Managed Isolation domain results:

While the lowest rating question related to consistent information by staff (58%) overall feedback was that their stay was coordinated (90%). The highest rated questions at 96% were that guests felt staff treated with respect and dignity while in isolation and treated you with kindness and understanding.

PATIENT EXPERIENCE: COMPLAINTS

DEFINITION: Any expression of dissatisfaction relating to a specific episode of care of an individual about the service offered or provided which has not been resolved to the complainants' satisfaction at the point of service for which Canterbury DHB has responsibility. A complaint may be received in a number of ways such as verbal, written, electronic or through a third party including an advocate.

In the last 12 months Canterbury District Health Board provided a total of 1,219,697 admissions, ED attendances and outpatient attendances and a total of 1410 people made complaint (1 complaint :865 service).

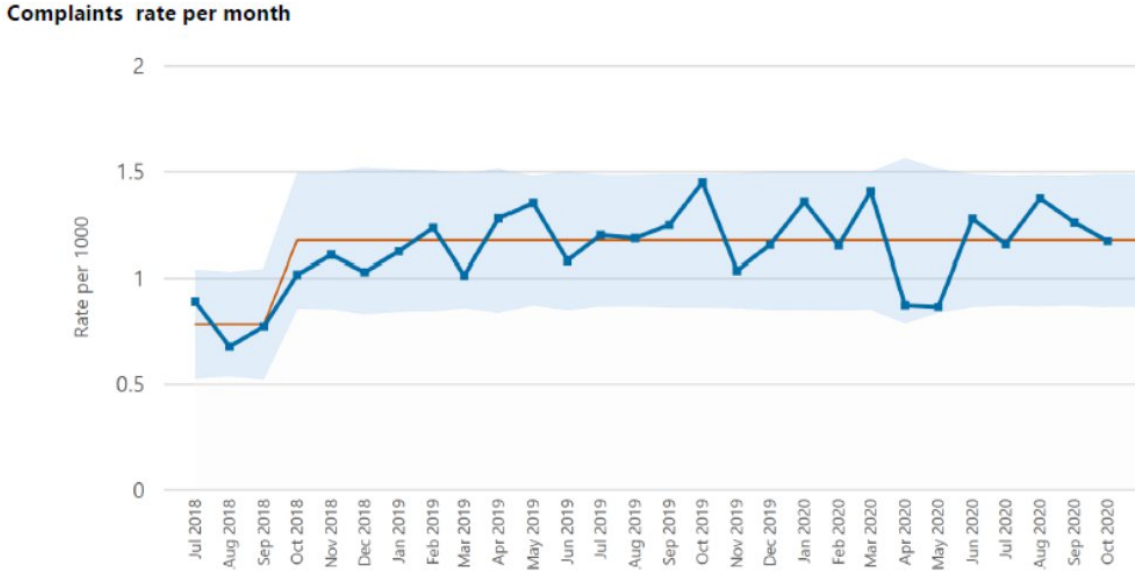
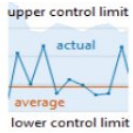


Figure 1. Outcome Indicator: **Complaints Rate**

Numerator: Total number of complaints received in the period.

Denominator: The sum of the:
- total number of admissions in the period, plus
- total number of ED attendances (where the patient was not subsequently admitted) in the period, plus
- total outpatient attendances in the period

Calculated as a rate per 1,000



Year	Range of Total Complaints reported per month
15/16	50 to 72
16/17	36 to 98
17/18	63 to 107
18/19	79 to 156

The complaints rate indicates normal variation since the step up with the introduction of Safety1st Feedback module. The April May 2020 result coincides with Lockdown. In making the complaint most people complained about more than one topic (78%), see figure 2 on the next page.

The highest 4 categories for the last 12 months were:

1. Care/Treatment 662
2. Communication/Information 481
3. Patient/Staff Relationships 311
4. Access /Funding 296

For the same period last year, the highest categories were the same but in a different order: Care/Treatment, Patient/Staff relationships, Access and Funding and Communication/Information.

A question was included in the Feedback database in March to capture if the complaint related to a Covid activity. To date58 have been recorded.

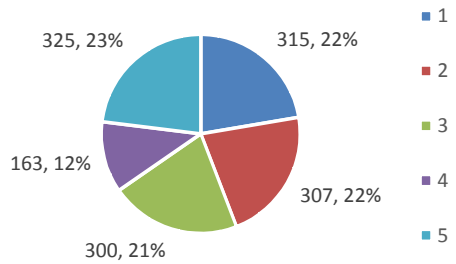


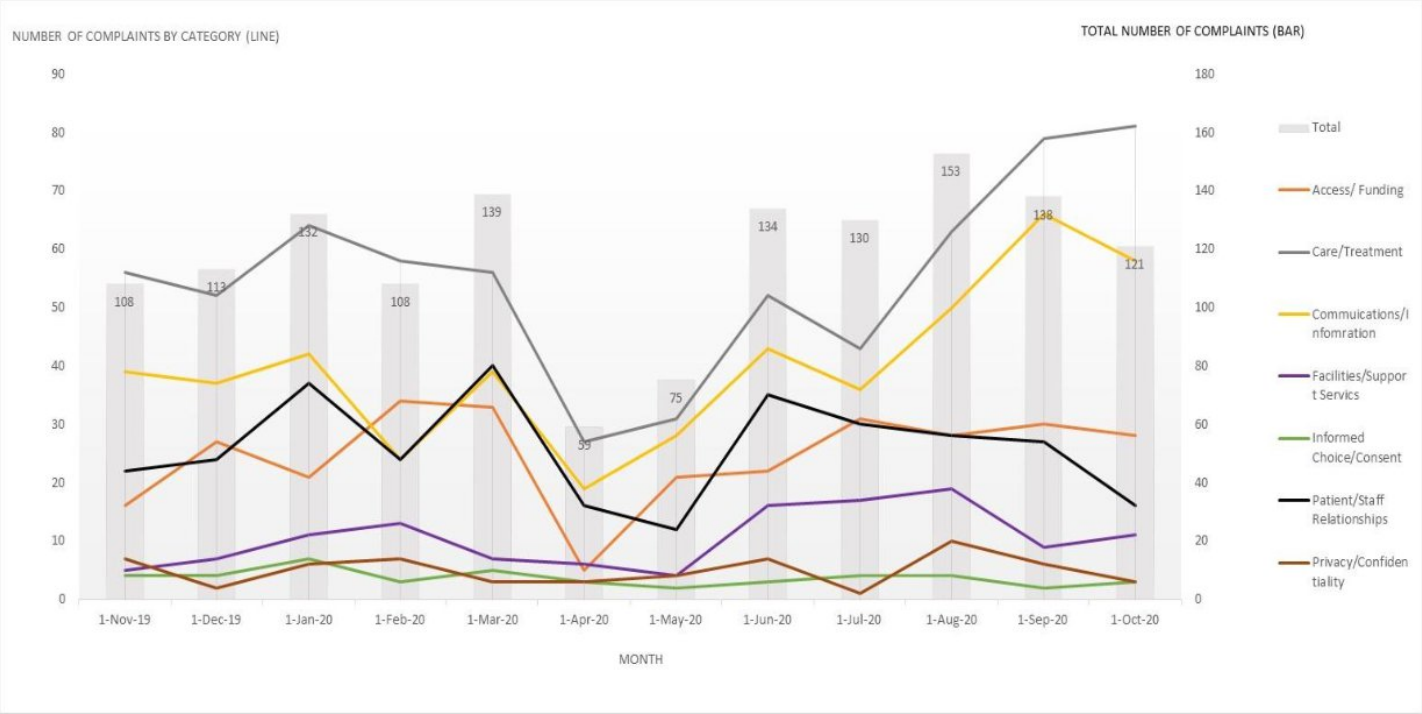
Fig 2 Number of Categories Included by People

Breakdown of Complaints Categories[1] November 2019 to October 2020

Start Date: 1/11/2019	1/11/2019	1/12/2019	1/01/2020	1/02/2020	1/03/2020	1/04/2020	1/05/2020	1/06/2020	1/07/2020	1/08/2020	1/09/2020	1/10/2020	TOTAL
Total Complaint Forms	108	113	132	108	139	59	75	134	130	153	138	121	***1410***
Total Number of Categories Recorded													
1	23	27	20	27	26	11	17	22	30	28	36	48	***315***
2	15	22	31	28	26	9	15	43	26	36	29	27	***307***
3	14	30	43	23	30	13	12	27	42	39	14	13	***300***
4	12	10	15	10	22	10	12	14	12	15	19	12	***163***
>5	44	24	23	20	35	16	19	28	20	35	40	21	***325***
Is this feedback related to COVID-19 activity?	0	0	0	0	4	14	11	11	3	7	6	2	***58***
Access/Funding	16	27	21	34	33	5	21	22	31	28	30	28	***296***
Care/Treatment	56	52	64	58	56	27	31	52	43	63	79	81	***662***
Communication/Information	39	37	42	24	39	19	28	43	36	50	66	58	***481***
Facilities/Support Services	5	7	11	13	7	6	4	16	17	19	9	11	***125***
Informed Choice/Consent	4	4	7	3	5	3	2	3	4	4	2	3	***44***
Patient/Staff Relationships	22	24	37	24	40	16	12	35	30	28	27	16	***311***
Privacy/Confidentiality	7	2	6	7	3	3	4	7	1	10	6	3	***59***

Graphical View of Complaints Categories from 1 November 2019 to 31 October 2020

[1] The Breakdown of Complaints Categories data is refreshed monthly, reports are generated in the first week following the close of the month – hence the 'Total Complaints Forms' numbers may differ to the complaints numerator data as this is refreshed weekly.



Examples of Complaints Reviews Related Improvement Activity

Diabetes Service

Following receipt of two complaints related to same issue a review was undertaken by multidisciplinary cross functional team. The parents in case 1 were included in this team.

Complaint Summary

1. Parents of the patient with type one diabetes (pump and continuous glucose monitoring technology user) unhappy with his diabetes care on the ward both during and following his surgery.
2. Patient and her family unhappy with the care she received. The family believe front line staff need more training in managing someone with type 1 diabetes complications.

Improvement Actions

- Specific education programme for nursing rolled out August 2020.
- Awareness raised of risk with complex patients in overflow areas, not specialised/home wards.
- Awareness raised by Chief of Surgery at CD meeting of staff needing to avail and utilise themselves of Health Pathways. Hospital Health Pathways and perioperative care for diabetes further reviewed, and as part of continuous cycle of review.
- Health Info (for patients) and Community Health Pathways (for GPs) was reviewed with minor adjustments made.
- Discussion underway re use of acute plan to highlight specialist needs of people with diabetes with specialist technology in situ. Use of acute plan / health passport.
- Anonymised case distributed for future nursing and medical education. Specific diabetes teaching does occur routinely annually as part of teaching programme for new graduated doctors (PGY1 and PGY2) into CDHB.
- A review of HealthLearn diabetes modules planned to be undertaken.
- Consideration is being given to inclusion of diabetes plan, infusion pump setup to peri-operative check list
- Food service responded to concerns re diet codes utilised for one patient and explanation of standard process to utilise carbohydrate counting menu.

Haematology Service

Complaint Summary

Concern phlebotomy wait times prior to Haematology clinic appointments

Improvement Actions

Over the last 8 months the following has been actioned:

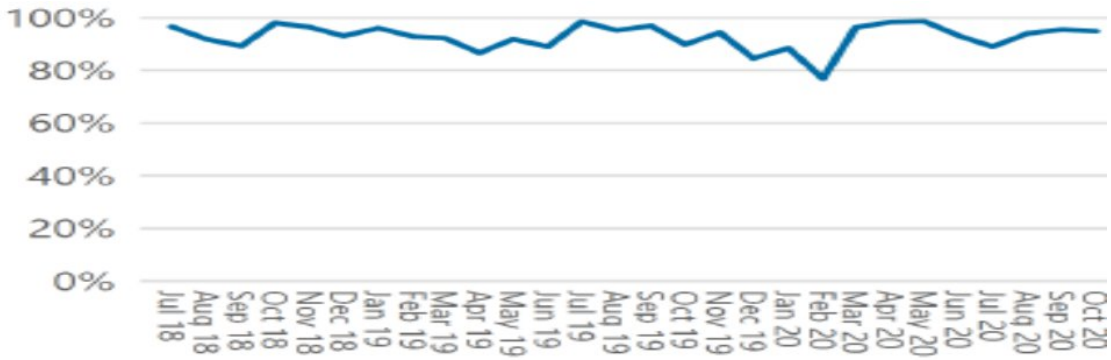
- Reviewed the criteria for when patients require blood testing for example, one week prior to clinic appointment or same day as clinic appointment, ensuring that this is clear to all staff through staff education and by having this information on relevant in-house documentation.
- Education of our patients for when and where they require a blood test, ensuring that patients are having blood tests out in the community as appropriate, and only having blood tests on campus as required. SMO's, nursing staff and administrative team have been involved in delivery of this education to Haem patients. This is embedded in practice.

In progress

- Same day blood test results are sometimes not available at the outpatient clinic appointment. This can have an impact on patient flow and flow of work streams within the outpatient area.

5-day Compliance[2]

Percentage of complaints acknowledged in writing within 5 working days of receipt



Numerator: Number of complaints acknowledged in writing within 5 working days, (excluding HDC/Privacy Commissioner/ Ombudsman/ Minister of Health Complaints)[3] within the period.

Denominator: Number of complaints received in the period (excluding HDC/Privacy Commissioner/Ombudsman/Minister of Health Complaints).
Calculated as a percentage

Data for 2020/2021 year to date:

Percentage of complaints acknowledged in writing within 5 working days of receipt

Measure	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
Numerator	113	140	126	91									470
Denominator	127	149	132	96									504
Percentage	89%	94%	95%	95%	0%	0%	0%	0%	0%	0%	0%	0%	93%

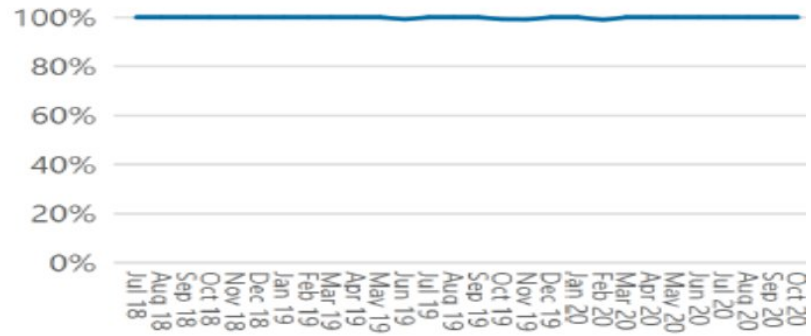
Comments for four month reporting period of 1 July to 31 October 2020

The percentage of complaints acknowledged in writing within 5 working days varies below the expected level of 100%. Following investigation.

[2] The percentage of complaints for the 5day acknowledgment does not relate to the same complaint in the % 20-day responses.
[3] HDC/Privacy Commissioner/Ombudsman/Minister of Health Complaints have different timeframes for responding and are excluded from this indicator.

20-day Compliance[4]

Percentage of complaints responded to or resolved within 20 working days



Numerator: Number of complaints resolved or responded to within 20 working days, (excluding HDC/Privacy Commissioner/Ombudsman/Minister of Health Complaints)[5], within the period.

Denominator: Number of complaints received in the period (excluding HDC/Privacy Commissioner/Ombudsman/Minister of Health Complaints).
Calculated as a percentage

Data for 2020/2021 year to date:

Percentage of complaints responded to or resolved within 20 working days

Measure	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
Numerator	112	131	145	76									464
Denominator	112	131	145	76									464
Percentage	100%	100%	100%	100%									100%

Notes: All Facilities without date organisation notified unable to be recorded.

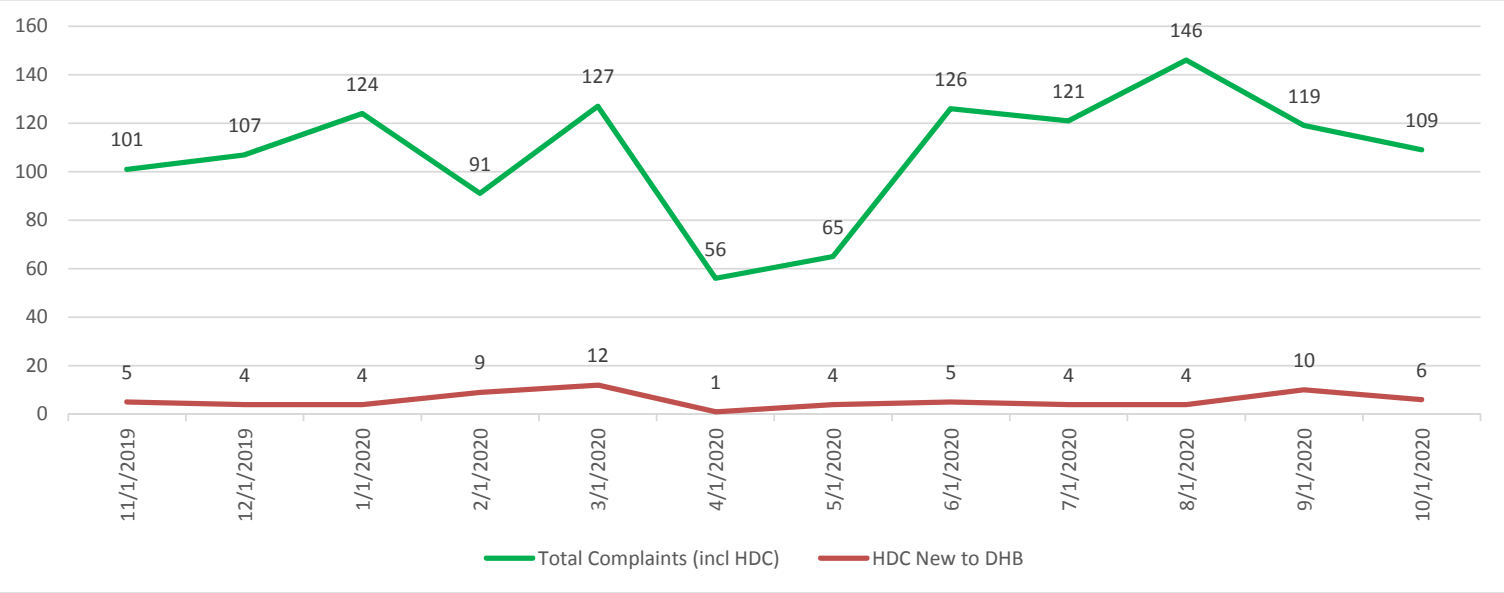
Comments for four month reporting period of 1 July to 31 October 2020

100% of complaints were responded to or resolved within 20 working days during the last four months.

[4] The percentage of complaints for the 5-day acknowledgment does not relate to the same complaint in the 20-day responses.
[5] HDC/Privacy Commissioner/Ombudsman/Minister of Health Complaints have different timeframes for responding and are excluded from this indicator.

Health and Disability Commissioner CDHB Complaints

CDHB HDC Complaint Trend Reports 1 November 2019 to 31 October 2020



This graphs shows the number of Health and Disability Complaints as part of the Total Complaints

WORKPLAN FOR HAC 2020 *(WORKING DOCUMENT)*

9am start	30 Jan 20	02 Apr 20	04 Jun 20	06 Aug 20	01 Oct 20	03 Dec 20
Standing Items	Interest Register Confirmation of Minutes	Meeting Cancelled	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes
Standing Monitoring Reports	H&SS Monitoring Report			H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report
Planned Items	Clinical Advisor Update – Nursing		COVID-19 Update	Clinical Advisor Update – Nursing Maternity Assessment Unit – 9 Month Update ED Presentations – Over 75 Years Old – Analysis Paper Faster Cancer Treatment South Island Bariatric Surgery Service – Summary 2019/20	Clinical Advisor Update – Allied Health	Care Capacity Demand Management Update CDHB Allied Health Strategic Direction Accelerating Our Future Chatham Islands Health Centre
Presentations	Department of Anaesthesia		Elective Surgery Recovery Plan		Migration to Hagley (Tour of Hagley at conclusion of meeting)	Pressure Injury Prevention Project
Governance & Secretariat Issues	2020 Workplan					
Information Items			HAC Terms of Reference - Amended 2020 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 2020 Workplan	2021 Meeting Schedule 2020 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 2020 Workplan
Public Excluded Items	CEO Update (as required)		CEO Update(as required)	CEO Update (as required) CDHB Planned Care Plan 2020/21 and CDHB Improvement Action Plan 2020/21	CEO Update (as required)	CEO Update (as required)