AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora o Waitaha

HOSPITAL ADVISORY COMMITTEE MEETING
to be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
Thursday, 1 October 2020 commencing at 9:00am

Administration			
	Apologies		9.00am
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 6 August 2020		
3.	Carried Forward / Action List Items		
Presentation			
4.	Migration to Hagley	Lynne Johnson *ChCh Campus Director of Nursing* Yvonne Williams *Hagley Operational Team Project Manager*	9.05-9.25am
Reports for Noting			
5.	Hospital Service Monitoring Report: • Medical/Surgical; Women's & Children's Health; & Orthopaedics ESPIs • Older Persons Health & Rehabilitation • Mental Health • Hospital Laboratories • Rural Health Services	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*	9.25-10.00am

6.	Clinical Advisor Update (Oral) • Allied Health	Dr Jacqui Lunday Johnstone *Executive Director of Allied Health, Scientific & Technical*	10.00-10.10am
7.	Resolution to Exclude the Public		10.10am
Estimated Finish Time			**10.10am**
	Information Items: 2021 Meeting Schedule 2020 Workplan		

NEXT MEETING: Thursday, 3 December 2020 at 9:00am

ATTENDANCE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE MEMBERS

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

Executive Support

(as required as per agenda)

Dr Peter Bramley – *Acting Chief Executive*
Evon Currie – *General Manager, Community & Public Health*
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 Lead of Facilities*
Karalyn Van Deursen – *Executive Director of Communications*
Stella Ward – *Chief Digital Officer*

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	√	√		
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	√		
Sir John Hansen (ex-officio)	√		√	x		
Gabrielle Huria (ex-officio)	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	**To be advised.**
Sir John Hansen **Ex-Officio – HAC** Chair CDHB	**Bone Marrow Cancer Trust** – Trustee **Canterbury Clinical Network Alliance Leadership Team** - Chair **Canterbury Clinical Network Oxford and Surrounding Area Health Services Development Group** - Member **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, 6 August 2020, commencing at 9.00am

PRESENT
Jo Kane (Deputy Chair); Dr Rochelle Phipps; Ingrid Taylor; and Michelle Turrall.

Via Zoom – Andrew Dickerson (Chair); Catherine Chu; James Gough; and Naomi Marshall.

APOLOGIES
Apologies for absence were received and accepted from Barry Bragg, Jan Edwards; and Sir John Hansen (Ex-officio).
An apology for lateness was received and accepted from Ingrid Taylor (9.10am).

EXECUTIVE SUPPORT
Mary Gordan (Executive Director of Nursing); Carolyn Gullery (Executive Director, Planning Funding & Decision Support); Jacqui Lunday-Johnston (Executive Director, Allied Health, Scientific & Technical); Sue Nightingale (Chief Medical Officer); Kay Jenkins (Executive Assistant, Governance Support); and Anna Craw (Board Secretariat).

EXECUTIVE APOLOGIES
David Meates for absence.

IN ATTENDANCE
Pauline Clark, General Manager, Medical/Surgical; Women's & Children's Health; & Orthopaedics
Helen Skinner, General Manager, Older Persons Health & Rehabilitation
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
Norma Campbell, Director of Midwifery CDHB & WCDHB
Sonya Matthews, Charge Midwife Manger of Birthing Suite
Laura Aileone, Project Manager

The meeting was Chaired by Jo Kane, Deputy Chair of the Hospital Advisory Committee (*HAC*).

Hector Matthews opened the meeting with a Karakia and mihi to Michelle Turrall.

Andrew Dickerson, Chair of HAC, acknowledged the recent resignation of Sally Buck from the Board of the CDHB, thanking her for her valued contribution to HAC over several terms.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
Michelle Turrall is to provide her interests to the Board Secretariat.

There were no additions/alterations.

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

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

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (06/20)
(Moved: Dr Rochelle Phipps/Seconded: Andrew Dickerson – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 4 June 2020 be approved and adopted as a true and correct record."

Ingrid Taylor joined the meeting at 9.10am.

3. CARRIED FORWARD / ACTION ITEMS

The carried forward action items were noted.

4. MATERNITY ASSESSMENT UNIT – 9 MONTH UPDATE

Pauline Clark, General Manager, Medical & Surgical; Women's & Children's Health, & Orthopaedics, introduced Norma Campbell, Director of Midwifery CDHB & WCDHB; Sonya Matthews, Charge Midwife Manager of Birthing Suite; and Laura Aileone, Project Manager. Louise McKinney, Clinical Lead, and Emma Jackson, Clinical Director, were both apologies for today's meeting.

The paper provided a nine month overview of the newly established Maternity Assessment Unit (*MAU*), the first of a number of really positive changes to be reported. It was noted that it is positive for women and whanau, and it is positive for staff.

Ms Campbell noted the MAU was established in August 2019 with the purpose of being able to redirect as clinically appropriate antenatal activity to a dedicated assessment space. The initial goal being able to improve flow and redirect a quantum of antenatal attendances per month from the Birthing Suite environment, thus creating more capacity within Birthing Suite to deal with intrapartum care and acute presentations. This also brought Christchurch Women's Hospital (*CWH*) into a more nationally and internationally consistent model with a clearer pathway for presentation, assessment and treatment as required.

The MAU has seen positive results within the last nine months since establishment, including the following:

- Approximately 206 antenatal assessments per month have been taken off Birthing Suite.
- There are approximately 152 less women attending Birthing Suite for assessment per month – so antenatal assessment workload decreases for staff in this area.
- The average wait time for women having antenatal assessments has reduced by 47% (three hours 30 minutes to one hour 52 minutes). Previously, some women were waiting on Birthing Suite for up to seven hours for assessment.
- The MAU is costing less to run with fewer staff rostered than had previously been forecasted prior to implementation. Staffing numbers have been continually refined throughout the last nine months.
- There has been no additional cost to Birthing Suite for consumables (MAU consumables come from Birthing Suite).

- Overall, Lead Maternity Carers (*LMCs*) are more satisfied with the MAU than the previous Birthing Suite process.
- Consumer feedback has highlighted that women are happy with the care they receive through the MAU.
- The MAU is completely midwifery led.
- Medical staff feedback is highly supportive of this unit and the positive impact this has on the birthing suite workload.

Next steps for development include:

- Maintain the MAU as a unit.
- Expand the functionality to include Day Assessment Unit (*DAU*) activity and essentially have both planned and unplanned antenatal assessments in one space. This to be renamed Antenatal Assessment.
- Note the potential changes to greater primary assessments within the community (clinics now established at Lincoln and Rangiora, during COVID-19) with the Women's Outpatient Clinic realignment work, including greater use of telehealth from rural units (ie. Ashburton, Kaikoura and West Coast).
- Review what component of women could potentially have planned care (i.e. twice daily CTGs) through the MAU, rather than be admitted onto the Maternity Ward as an inpatient admission.
- Review what space may be required to be occupied to maintain MAU functionality, if the current Parkside location requires vacating.
- Note the current Misoprostol for Induction of Labour Project and the potential for a cohort of women to start their induction of labour (*IOL*) on MAU with the new regime. The MAU must be within the CWH footprint for this to occur.

The ethnicity of MAU attendees was noted as follows: 15% Asian, 62% European, 16% Maori, 2% Middle Eastern/Latin American/African; and 4% Pacific Peoples.

There was discussion on the Induction of Labour Project and the intention to shift away from the current drug used to a new drug, which will save around $120K a year, as well as meaning women will mostly go into labour within 24 hours resulting in better outcomes. It is a priority to do this piece of work for our population of women and their babies.

There was a query around the reduction in wait times for some significant presentations and whether there was data on reduction in harm. Ms Matthews advised there is anecdotal data. There have been no SAC 1s. This is a reflection of the more rapid assessments.

Ms Clark also noted the close working relationship with Dr Nicola Austin and the Neonatal Unit.

Ms Kane noted it was a very people centric initiative and encapsulates necessary partnerships and relationships – a very valuable piece of work. The Committee thanked those in attendance for the update and asked that the Committee's appreciation be passed to the rest of the team for the very positive start to this piece of work on the Maternity Strategy.

Resolution (07/20)
(Moved: Naomi Marshall/Seconded: Ingrid Taylor – carried)

"That the Committee:

i. notes the paper and outcome update of MAU; and
ii. notes the need to progress combining unplanned and planned antenatal activity in the same physical space."

5. H&SS MONITORING REPORT

Ms Kane congratulated Greg Hamilton on his recent appointment as General Manager of Specialist Mental Health Services.

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

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

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

- Had a very warm welcome from Mental Health and has found a division that is in very good heart, even better than hoped.
- Have continued growth particularly in Child, Adolescent and Family. That will remain an ongoing area where the increased volume has caused waiting times that are not acceptable. There is a lot of energy going on to make sure the right people are seen in a timely way. We are triaging and re-triaging that list of referrals coming onto the list, so that although the average wait time is not good, there has been quite a change in the active process to ensure that those who need early access are getting it. Have brought in a second tier of clinical support, some of whom have made it their life passion to get the wait lists down. A lot of effort and passion going into this, as the team recognises the risk factors.

There was a query around data for under 12s and over 12s being separated out, volumes continuing to rise and barriers associated with this. Mr Hamilton noted that the problem we have is a multi-sectorial problem, that is being referred to Mental Health to solve. There are a lot of children in the under 12s who have problem behaviours in a school environment that we are asking Mental Health teams to do an assessment of in order to access education support. A paper was requested providing further detail and analysis on CAF presentations, and in particular under 12s.

There was a query around an article relating to an increase in eating disorders in teenagers. Mr Hamilton advised this is a very specialised service. The increase in volume that has been reported is not what CDHB's clinical leader in that area is seeing.

Hospital Laboratories – Kirsten Beynon, General Manager, Laboratories

- Bowel Screen Readiness Audit: the DHB has had its audit from the MoH and peer review of Bowel Screening Readiness. Verbal feedback from the Clinical Director of Anatomical Pathology (*AP*) is that this has gone extremely well, with positive comments made on the preparedness of the overall project across the DHB and commitment to ensure its success.

  The assessors commented on our cramped facility and that in their opinion the only reason we cope with our workload in these circumstances is due to our high quality processes. They would like to see a timeline documented for facilities improvement.

- Equity of Access and Outcomes: A small team making visible lab testing information from across the system with business intelligence software. We have targeted some key conditions (eg. Diabetes) of which there are specific tests we can use as indicators of how well we are doing. We have been able to look at this information by ethnicity, including testing rates, abnormality rates and drug therapies. The prototype report was completed this week and we will now work with primary and secondary care clinicians, as well as our Executive Director of Maori and Pacific Health, to review our prototype and assumptions.
- COVID-19 remains front and centre for pathology and laboratories. CHL has taken an integrated approach to our COVID-19 diagnostic strategy and are playing a key role in supporting the system response in partnership with primary and secondary care. CHL is also focussed on ensuring we have robust business continuity plans for when we have another wave of COVID-19 to ensure we maintain essential services to support the health and wellbeing of our population, including cancer diagnostics and acute non-COVID-19 as well as COVID-19 testing services.

There was a query around supply and demand challenges with regard to COVID-19. Ms Beynon advised that everyone learnt a lot from the first wave. All laboratories around the country are working together, as well as closely with the MoH. Teams have done a lot of work around maximising the use of consumables and reagents. There is a Plan A,B,C & D.

There was discussion around the Bowel Screening Programme roll out. Carolyn Gullery, Executive Director, Planning Funding & Decision Support advised we are working towards a November 2020 rollout, but this is dependent on being able to demonstrate we can pull back the people who are long waits on the list (both diagnostic and surveillance). We need to provide a plan that shows that we are meeting our step down to reduce that.

There was a query whether COVID-19 had moved point of care testing initiatives forward. Ms Beynon advised there is point of care testing in Canterbury in support of our hospital and acute setting, and within specific criteria. This is an area where there is still a shortage in supply.

There was a query about the randomness of pop-up testing, as well as the testing of various staff working in quarantine facilities. Sue Nightingale, Chief Medical Officer, advised there is very good Infection Prevention and Control (*IP&C*) processes and rules about PPE. The IP&C team is circulating through the hotels regularly checking on people to make sure that things do not slip. There is surveillance testing being done at the hotels with staff. It was noted that mixed messages are being received from the MoH as to what they are requiring with regards to pop-ups. Most of the surveillance targets are directed by the MoH; we then work as a team (Labs, Primary Care, Emergency Management Team) to get these set up within 24 hours.

In response to a query about people who missed their cervical screening appointments during the lockdown period, Ms Gullery confirmed that these are all being picked up and are being managed through primary care.

Rural Health Services – Win McDonald, Transition Programme Manager

- Continuing to see an increase in end of life care across rural facilities.
- Working well with primary providers and tertiary facilities.
- Increased challenges with Chatham Islands, with a team (whole of stakeholders group) in place to provide assistance. It was noted a Chatham Islands update report is scheduled for the Committee's 1 October 2020 meeting.
- Services in rural facilities are being maintained at a high level and community need is being met.
- Working with Statistics NZ and the information coming from Decision Support on the equity of access across primary care in rural.

There was discussion around Ellesmere and Waikari hospitals, future capacity and sustainability of facilities to cope with the demand for end of life care given the aging population, as well as growing dementia rates. Ms Gullery noted it has always been the strategy to maintain access to end of life care in the rural communities. A paper was requested on initiatives to support the rural older population to remain in their own homes/communities into the future.

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

- Presentations of persons over 75 years to Acute Assessment Unit (*AAU*). Information presented is a watching brief – not tracking or seeing an increase post COVID-19 of presentations or admissions of people over 75 years into the Ashburton Area.
- The community remains concerned about access to primary care.
- Primary care is not necessarily understanding the restorative model of care being talked about. An opportunity for Allied Health, District Nursing and Clinical Nurse Specialist workforce to go into the primary care practice environment in order to build and sustain the level of community service delivery.
- Working closely with Garry Nixon, a doctor from Dunstan who is also partnered with the Otago of University, on determining a rural generalist model. A collaborative piece of work to design what is sustainable generalist delivery and how to partner with other rural hospitals. The intent is to keep people away from the tertiary centre by maintaining strong, stable and cost effective care in the local community.

There was discussion around presentations coming through to AAU, with it noted that triage 3 is where the growth level is.

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

- Whilst do not have influenza presentations, a number of other presentations are being experienced across Medicine and General Surgery.
- Contributing staff to quarantine and isolation facilities, and also contributed to the successful move on the West Coast into their new facility.
- National Bowel Screening Programme Rollout Readiness Assessment. The team was down from Wellington on 5 August 2020.
- Migration planning is well underway, with confirmation that the move into Hagley will commence on Monday, 16 November 2020.
- Strong focus on planned care ESPIs, with most services scheduled to meet compliance by the end of this calendar year. Coupled with this, is picking up on those people who were not seen during COVID-19.
- Focused on the Leave Care Programme.
- Experiencing a number of random requests from the MoH. All valid questions, but no coordination.

There was a query around staff being made available for the quarantine facilities. Ms Nightingale advised that five were working in other places, but that has now stopped – 76 others were not. Ms Nightingale noted that CDHB did not think this was necessary, given the IP&C structures CDHB has in place. CDHB sees people with infectious diseases in hospital all the time and nurses are not stood down after care has been provided to them. So whilst we are complying, we do not agree that it is necessary.

Older Persons Health & Rehabilitation Service – Helen Skinner, General Manager

Ms Kane welcomed Helen Skinner as the new General Manger of Older Persons Health & Rehabilitation Service, as well as maintaining her role as Chief of Service.

- Ongoing demand for older persons health beds. During COVID-19, were at high levels of occupancy and also providing increased numbers of community contacts, both virtually and at home. That demand in terms of need in the community has continued.
- Inpatient demand, particularly for older persons health beds has been driven predominantly around surgical and orthopaedic flow.
- Highlighted the floor line beds trial, one part of a piece of work being done around clinical governance, which has been a high priority for the division. An ongoing programme of work to reduce falls, has reduced falls, but in particular has reduced significant harm. Year to date has seen a reduction of more than 40% in significant harm in terms of SAC 2 events compared to the year prior.
  The floor line beds trial looks at falls and the ongoing reduction in significant harm for patients who fall, but also how from a cost point of view we continue to work on that. One of the challenges has continued to be around how safety is maintained as well as looking at things fiscally. Close observation in terms of hospital aides has been high as we continue to keep patients safe.
  The fall line beds trial initiative, led by one of the Nursing Directors in conjunction with the Clinical Director for Older Persons Health, started last month. It has been running for 2½ weeks. There have been no falls in terms of patients who have been using the floor line beds. There has been an estimated saving on two wards in two weeks of $1,700 on reduction in close observation. The trial will run for three months, with a potential roll-out dependent on the outcome.

Discussion took place on the floor line beds trial. It was noted that the driver behind the initiative is reducing patient harm, keeping patients safe. It is only one part of a piece of work to reduce harm. There is also a big project on pressure injury prevention; a lot of work on falls prevention; and work on medication instances.

There was a query around voice activated alarms, as opposed to call bells, and whether CDHB has trialled these. Ms Skinner advised that this has been trialled in an Older Persons Health ward, as well as the Spinal Unit. Unfortunately, for a number of reasons it was not well used by the patients. It was noted that a further trial is to be conducted in maternity services.

Resolution (08/20)

(Moved: Dr Rochelle Phipps/Seconded: Naomi Marshall – carried)

"That the Committee:

i. notes the Hospital Advisory Committee Activity Report."

6. CLINICAL ADVISOR UPDATE - NURSING

Mary Gordon, Executive Director of Nursing, provided updates on the following:

- CDHB would normally be taking 95 NETP graduates, but this intake has been reduced to 46, with only 34 on permanent contracts. This has sent shockwaves through the sector. A phone call had been received from the Chief Nursing Officer from the MoH saying that Minister Hipkins was wanting to know what was happening following media interest in Canterbury not taking new graduates. Ms Gordon advised that her response to the Chief Nursing Officer was that Canterbury was doing the same as Auckland – the Minister has sent very clear messages that the deficit was unacceptable. The Chief Nursing Officer noted the Minister has been very clear that there is to be no denigration in quality or

clinical outcomes, and that he is committed to the Care Capacity Demand Management (*CCDM*) programme and the nursing accord which was that all new nursing graduates got employment, to which Ms Gordon responded she could not do that at this particular point in time.

- 34 new NETP graduates have been hired within the DHB, 4 outside in community, ARC settings.
- 12 NETP graduates have been hired for the isolation / quarantine facilities with a wrap around process to support them on the programme being developed up.
- 11 NESP graduates for SMHS have been hired.
- All other graduates will be appointed into vacancy, or offered roles within the isolation / quarantine facilities if further staffing required.

- The Enrolled Nurse programme that the government is funding – our supporter programme has started. CDHB has not taken any graduates from the first round because our graduates have not graduated as yet.
- Postgraduate Nursing – we usually have a waitlist that cannot be met, however, this year have managed to fund all of the waitlist.
- Internationally, this is the year of the Nurse and Midwife. There is a nursing leadership development programme running across a number of countries. The programme is for nurses under 35 years and developing leadership capability for the future.

Ms Gordon provided a presentation on the Care Capacity Demand Management (*CCDM*) programme, which was mandated from the last MECA. The presentation highlighted the following:

- One aspect of the CCDM programme is the implementation of a nursing acuity system called Trendcare. It was noted that acuity is a measure of the severity of the hospitalised patient's illness and the level of nursing care they will require.
- CDHB has had its first phase, with the programme rolled out in medical and some surgical wards at Christchurch Hospital, as well as Burwood and Mental Health. A little behind implementation timeline, due to COVID-19, but expecting full rollout by the end of this calendar year. Have to do 12 months of collection of data, so full implementation is another 12 months away.
- Physical utilisation versus productivity index by ward.
- Ward daily hours graph detailing bed utilisation; and hours worked vs hours required.
- Nursing agency hours logged at Christchurch Hospital.
- Canterbury has the lowest actual cost per FTE nurse, $5K below the national average.
- Only one DHB has a lower overall cost per FTE (Hawkes Bay at $97K). CDHB is $98k versus a national average of $104k.
- CDHB has less beds, shorter length of stay and low readmission rates.
- The current inadequate hospital wards are very challenging to care within. For instance, frail elderly patients' access to appropriate ablutions, which further impacts on nursing time. This issue is not taken into account when entering the Trendcare data, yet we are still fully utilising all patient time allocated.
- The impact of high churn of full capacity wards is not being accounted for in the simple analysis. Becomes apparent in TrendCare.
- Nursing works at top of scope allowing for less medical workforce.
- Nursing does out-patient activity on wards, including own appointments.

There was discussion around CDHB's in-house nursing pool and its advantages. It allows CDHB to cover its own sick leave, which is not only good use of dollars, but ensures better care is being provided to the patient. CDHB staff know the system, whereas agency staff are not so familiar. This continuity of care reduces harm. If you get care right the first time, it is the cheapest you will ever get that care delivered for, because if you have to rework and have a lot of variation it costs you money.

Discussion took place around safari ward rounds and the impacts of these on staff, patients, and whanau. It was noted that today, as an example, General Medicine has 39 patients outside the General Medicine wards. This impacts the discharge process as well, significantly slowing it down. This highlights that when a hospital gets too tight it becomes inefficient. Ms Gordon noted that this is the reason why we need the next phase of the facility development on the Christchurch Campus site. Ms Gullery also reminded the Committee that CDHB has 30% lower acute admissions because of the way our primary care system works. If the primary care system stopped working in the way that it does and you had another 30% of patients in Christchurch Hospital, that would be another 15,000 to 20,000 patients per year. In addition, the Committee was reminded that CDHB is a tertiary centre, so needs to be in a state of readiness.

There was a query whether there is a point from a clinical basis that risk is too high and how that is assessed. Ms Gordon spoke of a "response variation", where if the number of nurses available is not sufficient to meet patient care needs on a ward, care given to each patient is prioritised. However, if this is happening on a day to day basis, this indicates that base staffing is wrong and needs to be readjusted. If advised that there are to be no more staff, then in this situation beds would have to be closed.

Ms Kane thanked Ms Gordon for the presentation, noting this was a critical piece of work. Ms Kane requested the presentation material be included as an appendix to the meeting minutes, as well as be provided to the Quality, Finance, Audit & Risk Committee for information. In addition, Ms Gullery, noted that its content would be addressed in Management's formal response to the EY report, which will be presented to the Board at its meeting on 20 August 2020.

A joint presentation from the Nursing Director of CCDM and Decision Support staff is to be scheduled for a future meeting.

The Nursing Clinical Advisor's Update was noted.

7. ED PRESENTATIONS – OVER 75 YEARS OLD – ANALYSIS PAPER

Carolyn Gullery presented the report which was taken as read, noting that an increase in over 75 years olds is being seen in presentations to the Emergency Department (*ED*) and inevitably the chance of being admitted is quite high – 65 to 75%.

Analysis has been undertaken. This is one of the initiatives that has been put up for the savings plan, because we do think that a number of the issues driving this can be mitigated.

Ms Gullery highlighted the ED presentation rates by practice, noting there are approximately 16 of the 117 general practices that have a rate above the average, but there are about 10 notable outliers – one being an extraordinary outlier which has one of the biggest populations of over 75 year olds enrolled and is managing to send 50% of that population to hospital in a year. Those practices will be invited to a meeting and asked how the DHB can help and what can be done differently to support them not having this number of people arriving in our hospitals.

We understand the issue, know we have a problem, and have a plan to start addressing the problem. This will have flow on benefits not only to our hospitals, but we also know from previous work that this triggers a cascade into aged residential care (*ARC*).

Mr Gullery noted that 73% of these patients arrive by ambulance, and 81% of these presentations are triage levels 1 to 3, so we are talking about people who are arriving unwell.

Resolution (09/20)
(Moved: Jo Kane/Seconded: Dr Rochelle Phipps – carried)

"That the Committee:

i. notes the ED Presentations – Over 75 Years Old – Analysis paper."

8. FASTER CANCER TREAMENT

Ms Gullery presented the report, noting it had been requested so people better understood how we measure Faster Cancer and how it flows through. The other question was whether Maori were being specifically disadvantaged in this process. Ms Gullery noted there is some risk around this, which is why some intentional interventions are being put in place. One of the risks we are seeing around particularly Maori in planned care generally, is that because quite often Maori have co-morbidities and that complicates their path, people end up navigating a winding path through the system instead of a straight path.

There are also less Maori going through the pathway than what might be expected. Ms Gullery noted that this is partly because cancer is directly related to age and the age profile for the Maori population is different to the age profile for the non-Maori population. When you look at the national registrations, Maori has a big cohort in the 40 to 55 age bracket. You do not see that same representation in non-Maori.

There was discussion around the Bowel Screening Programme and the issue that it starts at too late an age for the Maori population. Ms Gullery advised that what is planned for this cohort are some joined up plans to work with kaumatua to run an awareness programme to find people earlier and prompt symptom related referrals as opposed to screening related referrals. Working with Manawhenua on that to increase our chances of identifying people with symptoms earlier.

Resolution (10/20)
(Moved: James Gough/Seconded: Catherine Chu – carried)

"That the Committee:

i. notes the Faster Cancer Treatment report."

9. SOUTH ISLAND BARIATRIC SURGERY SERVICE – SUMMARY 2019/20

Ms Gullery presented this report, which was taken as read. For background purposes, Ms Gullery noted that there was some money put out by the MoH a few years back for Bariatric Surgery. It was allocated per DHB. The South Island in its alliance type process decided to do it differently, pulling all the money into one bucket and allocated access to bariatric surgery by clinical need of the patient irrespective from which DHB they came from.

Whilst acknowledging that we operate in a restrained environment, there was considerable discussion around the issue that there was not enough money being spent on this and it is currently falling behind. Ms Gullery noted that if you were making good decisions based on ability to benefit and outcomes you would be providing a lot more bariatric surgery through the public system.

Ms Gullery noted that although Maori and Pacifica are getting higher access than their population share, and it is being done on clinical priority and ability to benefit, she reiterated there are an awful lot more people who would benefit.

There was discussion around this being an investment, as an intervention at a point in time can avert health dollars spent later on. A very good investment strategy, but not enough focus being given to it from a national perspective. It is an equity of access issue, but also an investment return business case that stacks up. We continually talk about the aging population and implications on the health system, but we do not talk about the unmet need for bariatric surgery and the future impact of this on the system.

There was comment that the issue for the Board to consider in terms of a strategic plan for the future is how we shift a really constrained environment where there is a lot of pressure to reduce cost, to focus on preventative strategies which are an investment in the future.

Resolution (11/20)
(Moved: Michelle Turrall/Seconded: Ingrid Taylor – carried)

"That the Committee:

i. notes the South Island Bariatric Surgery Service – Summary 2019/20 paper."

Naomi Marshall retired from the meeting at 12.22pm.

Ms Kane noted this was Ms Gullery's last HAC meeting and offered the opportunity to members to speak. Members wished Ms Gullery all the best for the future, noting she would be a huge loss to the CDHB, as would the other members of the Executive team who were leaving. The opinion was voiced that this is "obviously shocking, concerning and a massive crisis for our community".

There was further comment that Ms Gullery's input has always been appreciated and she has done a lot to reform the health system. She will be missed.

As Chair of HAC, Mr Dickerson noted that Ms Gullery's input into CDHB and to HAC has been huge, and thanked her for her significant contributions.

10. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (12/20)
(Moved: Dr Rochelle Phipps/Seconded: Ingrid Taylor – carried)

"That the Committee:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2 and 3;
ii. notes that the general subject of each matter to be considered while the public is excluded and the reason for passing this resolution in relation to each matter and the specific grounds under Schedule 3, Clause 32 of the Act in respect to these items are as follows:

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of the minutes of the public excluded meeting of 4 June 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)
3.	CDHB Planned Care Plan 2020/21 and CDHB Improvement Action Plan 2020/21	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s 9(2)(j)

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

INFORMATION ITEMS

- Quality & Patient Safety Indictors – Level of Complaints
- 2020 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 12.27pm.

Approved and adopted as a true and correct record:

_____ _____

Andrew Dickerson Date of approval
Chairperson

HAC MEETING 6 AUGUST 2020 – MEETING ACTION NOTES

Item No	Item	Action Points	Staff
	Apologies	• Apologies for absence - Barry Bragg, Jan Edwards; and Sir John Hansen (Ex-officio). • Apology for lateness - Ingrid Taylor (9.10am).	Anna Craw
1.	Interest Register	Nil	
2.	Minutes – 4 June 2020	Adopted: *Dr Rochelle Phipps / Andrew Dickerson*	Anna Craw
3.	Carried Forward Items	Nil	
4.	Maternity Assessment Unit – 9 Month Update	Nil	
5.	H&SS Monitoring Report	• Paper on initiatives to support rural older population remaining in own homes/communities into the future**. Report to December HAC meeting – report due to Anna Craw 23 November 2020.** • Paper providing analysis on CAF presentations, and in particular under 12s. **Report to October HAC meeting – report due to Anna Craw 21 September 2020.**	Carolyn Gullery / Win McDonald Greg Hamilton
6.	Clinical Advisor Update - Nursing	• Presentation material be included as an appendix to the meeting minutes, as well as be provided to the Quality, Finance, Audit & Risk Committee for information. • Presentation content to be addressed in Management's formal response to the EY report, which will be presented to the Board at its meeting on 20 August 2020. • A joint presentation from the Nursing Director of CCDM and Decision Support staff is to be scheduled for 3 December 2020 meeting, in conjunction with six monthly CCDM update – **report/presentation material due to Anna Craw 23 November 2020**.	Anna Craw Carolyn Gullery / Justine White Mary Gordon / Carolyn Gullery

HAC MEETING 6 AUGUST 2020 – MEETING ACTION NOTES

7.	ED Presentations – Over 75 Years Old – Analysis Paper	Nil	
8.	Faster Cancer Treatment	Nil	
9.	South Island Bariatric Surgery Service – Summary 2019/20	Nil	
10.	Resolution PX	Adopted: *Dr Rochelle Phipps / Ingrid Taylor*	Anna Craw
	Info Items	Nil	

Distribution List:
Justine White
Carolyn Gullery
Mary Gordon
Win McDonald
Greg Hamilton

CC: Mary Howell; Regan Nolan; Jenna Manahi; Ralph La Salle; and Sharryn Sunbeam

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE
CARRIED FORWARD ITEMS AS AT 1 OCTOBER 2020

DATE RAISED		ACTION	REFERRED TO	STATUS
1.	30 Jan 2020	Chatham Islands	Ralph La Salle	Report to 3 December 2020 meeting.
2.	06 Aug 2020	Initiatives to support rural older population to remain in own homes/communities into the future.	Ralph La Salle	Report to 3 December 2020 meeting.
3.	06 Aug 2020	Analysis on CAF presentations	Dr Greg Hamilton	Today's Agenda – Item 5.


Hīkina to Hagley
MIGRATING TO CHRISTCHURCH HOSPITAL HAGLEY

Hīkina : the act of migrating

Hagley 2020

369 inpatient beds (+ 46 unresourced)

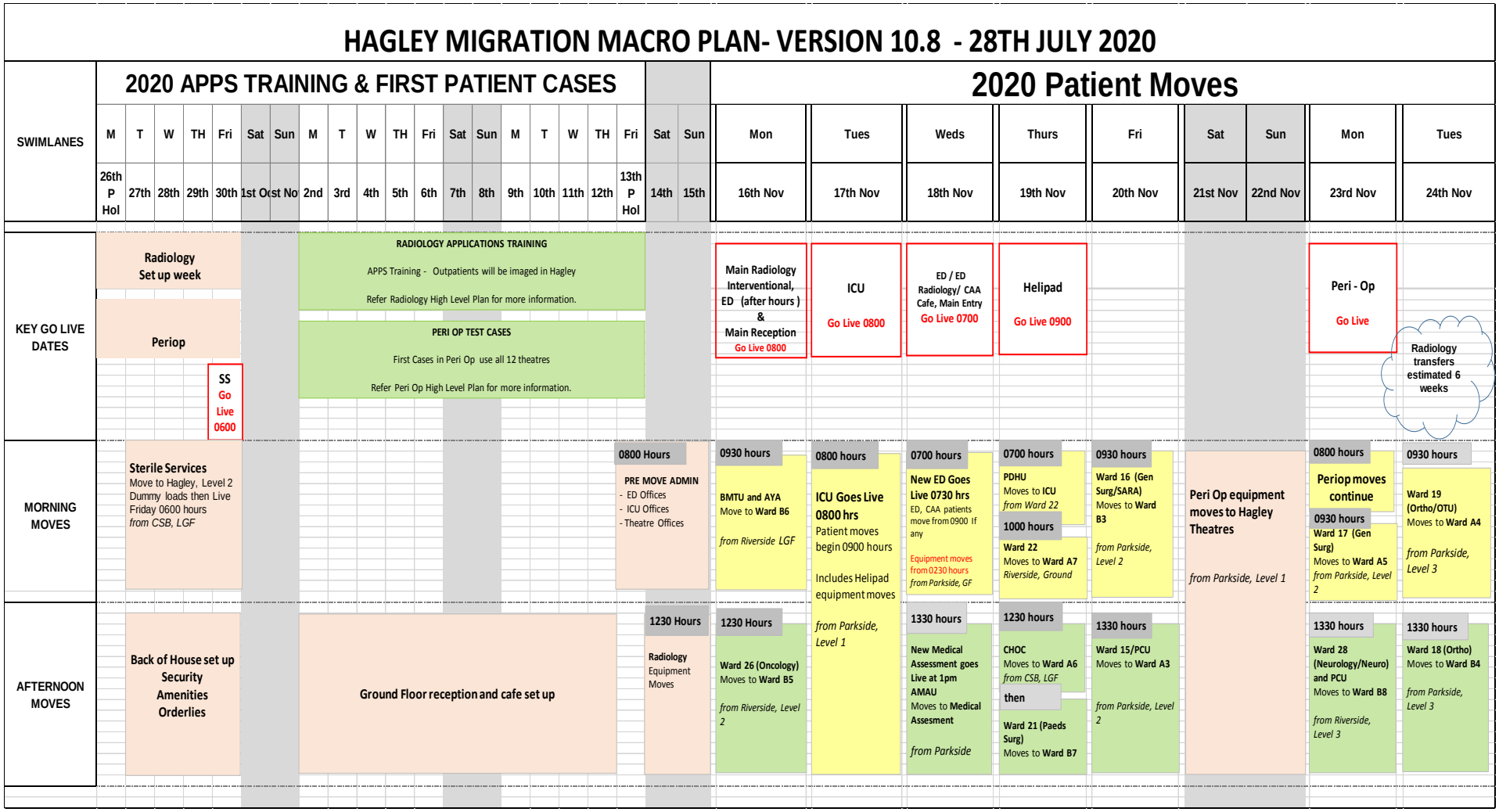
- Designed to provide privacy, natural light & sociability for patients, decentralised, lean model, nurses at bedside.
- 190 surgical beds – General surgery, orthopaedics, Neurosciences & vascular
- AMAU
- Stroke Unit
- Oncology & BMTU
- Purpose built childrens facilities
- Emergency Department – collocated acute orthopaedics & paediatric assessment
- ICU- 24 beds –adult and paediatric ICU
- 8 beds- Childrens High Care
- 12 theatres including adult and childrens admitting areas.

	Helipad					
Level 8	**Ward A8** Vascular and Stroke *(+ PCU)* (Ward 10) + (Ward 24)	**Shared**	**Ward B8** Neurology and Neuro Surgery (+ PCU) (Ward 28)			*Future Tower*
7	**Children's Ward A7** Children's medical (Ward 22)	**Shared**	**Children's Ward B7** Children's surgical (Ward 21)			
6	**Ward A6 CHOC** CHOC	**Shared**	**Ward B6** BMTU and AYA			
5	**Ward A5** General Surgery (Ward 17)	**Shared**	**Ward B5** Oncology (Ward 26)			
4	**Ward A4** Ortho + PCU (Trauma) (Ward 19)	**Shared**	**Ward B4** Ortho (Ward 18)			
3	**Ward A3** General Surgery + PCU (Ward 15)	**Shared**	**Ward B3** General Surgery + SARA (Ward 16)			
2	**ICU Clinical Support And Break Room**	**Periop Clinical Support And CSSD and Periop Break Room**	**Sterile Services**			**Plant**
1	**Intensive Care** (Incl Children's HDU/Progressive care)	**Operating Theatres 3, Recovery 3, Adult and Children's Surgical Admissions**				**Interventional Radiology**
G	**Emergency Monitored** (MonWU), **Resus, Observation**	**Emergency Radiology**	**Acute Care** (Orthopaedics/ ambulatory) and **Children's Emergency Care** (Children's ED/CAA)	**ED, AMAU and Radiology Break Room**	**Medical Assessment** (AMAU)	**Main Radiology**
LG	**ED Clinical Support Orderlies**	**Meeting and Training Rooms**	**Plant and Medical Gas store**	**Shared Changing Area**	**Equipment Store**	

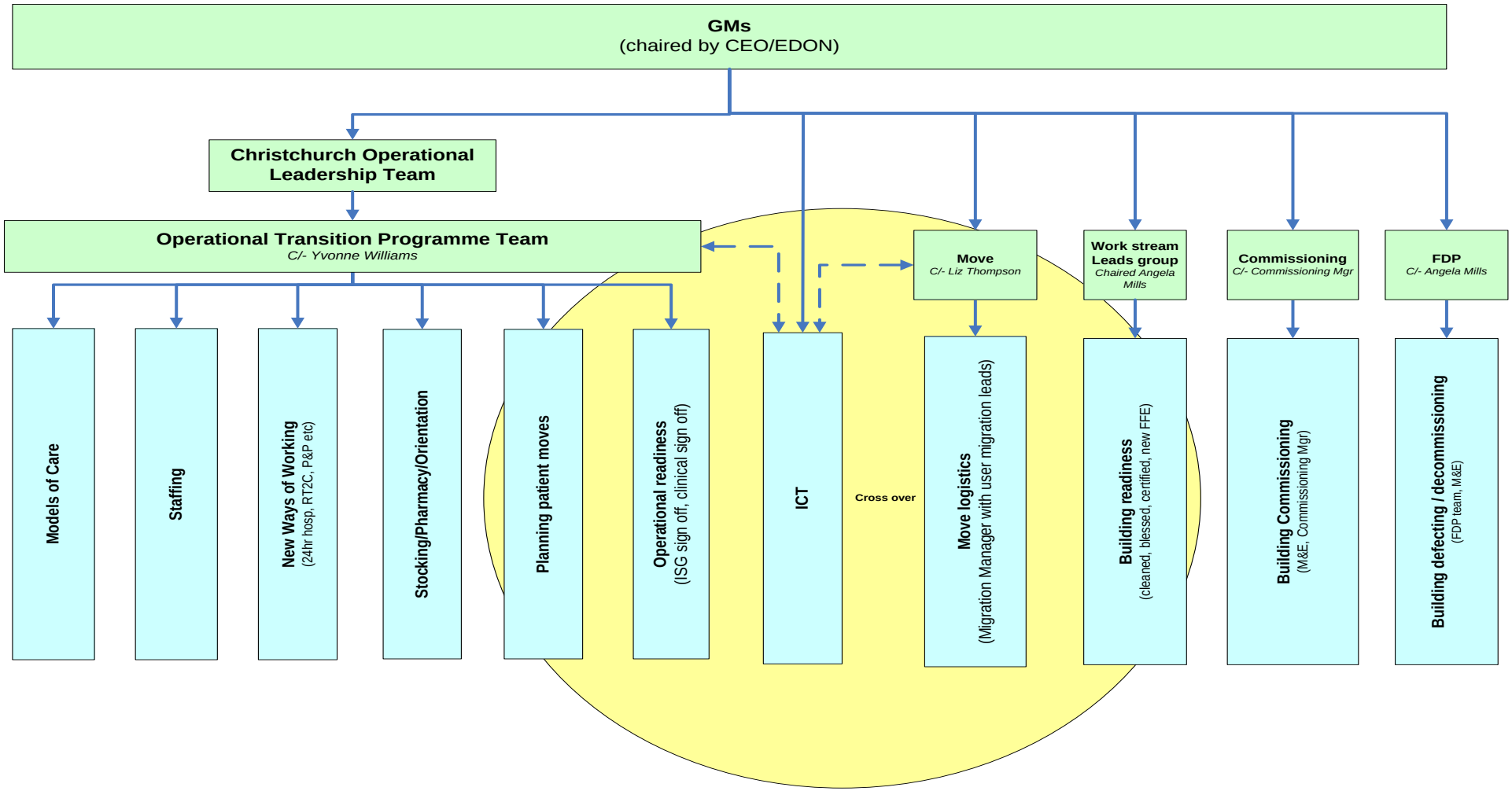
N.B. There are links to Main Hospital at LG, G and Level 1, (located approximately here on each level)

Key: **Red font** – new wayfinding name, **Black font** – existing service

N.B. Red underlined is the main department sign for area with internal signage for specialty areas within the department, where approved.


HAGLEY MIGRATION MACRO PLAN- VERSION 10.8 - 28TH JULY 2020
2020 APPS TRAINING & FIRST PATIENT CASES
2020 Patient Moves
SWIMLANES
M T W TH Fri Sat Sun M T W TH Fri Sat Sun M T W TH Fri Sat Sun
26th P Hol 27th 28th 29th 30th 1st Oct 2nd Nov 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th 13th P Hol 14th 15th
Mon Tues Weds Thurs Fri Sat Sun Mon Tues
16th Nov 17th Nov 18th Nov 19th Nov 20th Nov 21st Nov 22nd Nov 23rd Nov 24th Nov
KEY GO LIVE DATES
Radiology Set up week
Periop
SS Go Live 0600
RADIOLOGY APPLICATIONS TRAINING
APPS Training - Outpatients will be imaged in Hagley
Refer Radiology High Level Plan for more information.
PERI OP TEST CASES
First Cases in Peri Op use all 12 theatres
Refer Peri Op High Level Plan for more information.
Main Radiology Interventional, ED (after hours) & Main Reception
Go Live 0800
ICU
Go Live 0800
ED / ED Radiology/ CAA Cafe, Main Entry
Go Live 0700
Helipad
Go Live 0900
Peri - Op
Go Live
Radiology transfers estimated 6 weeks
MORNING MOVES
Sterile Services
Move to Hagley, Level 2
Dummy loads then Live Friday 0600 hours
from CSB, LGF
0800 Hours
PRE MOVE ADMIN
- ED Offices
- ICU Offices
- Theatre Offices
0930 hours
BMTU and AYA
Move to Ward B6
from Riverside LGF
0800 hours
ICU Goes Live 0800 hrs
Patient moves begin 0900 hours
Includes Helipad equipment moves
from Parkside, Level 1
0700 hours
New ED Goes Live 0730 hrs
ED, CAA patients move from 0900 If any
Equipment moves from 0230 hours
from Parkside, GF
0700 hours
PDHU
Moves to ICU
from Ward 22
1000 hours
Ward 22
Moves to Ward A7
Riverside, Ground
0930 hours
Ward 16 (Gen Surg/SARA)
Moves to Ward B3
from Parkside, Level 2
Peri Op equipment moves to Hagley Theatres
from Parkside, Level 1
0800 hours
Periop moves continue
0930 hours
Ward 17 (Gen Surg)
Moves to Ward A5
from Parkside, Level 2
0930 hours
Ward 19 (Ortho/OTU)
Moves to Ward A4
from Parkside, Level 3
AFTERNOON MOVES
Back of House set up
Security
Amenities
Orderlies
Ground Floor reception and cafe set up
1230 Hours
Radiology Equipment Moves
1230 Hours
Ward 26 (Oncology)
Moves to Ward B5
from Riverside, Level 2
1330 hours
New Medical Assessment goes Live at 1pm
AMAU
Moves to Medical Assesment
from Parkside
1230 hours
CHOC
Moves to Ward A6
from CSB, LGF
then
Ward 21 (Paeds Surg)
Moves to Ward B7
1330 hours
Ward 15/PCU
Moves to Ward A3
from Parkside, Level 2
1330 hours
Ward 28 (Neurology/Neuro) and PCU
Moves to Ward B8
from Riverside, Level 3
1330 hours
Ward 18 (Ortho)
Moves to Ward B4
from Parkside, Level 3

Canterbury DHB Hagley Migration
Governance Structure – August 2019



Roles and Responsibilities

Name	Role
Pauline Clarke and Lynne Johnson	Management lead – BAU and transition, media spokesperson
Yvonne Williams	Operational lead for transition - liaison and coordination clinical team – patient migration, staffing, Ways of working including support service Supply, linen etc.
Liz Thompson	Logistics of the move (excluding patients) coordinating linkages ISG, M&E, Clinical Engineering etc.
Angela Mills	Facility – ensuring building ready for occupation
George Schwass	Operations – support and liaison – security, parking, external agencies and orderlies Chair of Impact of Hagley on rest of site, work stream group
Nicky Topp	Oversight of BAU, 24 hour planning, patient flow Chair of Ways of Working and 24 hour hospital work stream groups
Heather Murray	RT2C – stock management, pre-stocking
Shannon Beynon	Communications
Wendy Botfield	Nurse Coordinator Facilities – decommissioning lead
Chanel Matthews and Renee Montgomery	Supply
Jo Batcup	Pharmacy
Tony Hampton	Sterile Services and Clinical Engineering
Terry Walker	M&E

Overarching Principles for Migration

Planning & Communication

- Comprehensive transition plans developed for all areas moving
- Orientation program for all staff
  - Those working in the building
  - Those who will be there sometimes

- Move guide developed for all areas
  - Preparation – people equipment
  - Move day - people equipment
  - Decommissioning

- Wards/departments complete final cleaning, pre-stocking and clinical sign off including ISG readiness prior to move to ensure the area is fully clinically capable on occupation.

Let's get ready to move

Hagley Operational Team - Responsibilities

Over the last two years HOT reps have:

- Worked together to ensure consistency and appropriate information exchange.
- Engaged with leadership teams about migration (patients and equipment) and orientation plans to ensure alignment and clear communication.
- Worked with service leaders to establish a user group structure within transitioning wards/depts/groups to inform the planning for migration.
- Worked with Project Manager Hagley Operational Transition and Migration Manager to develop specific migration plans (patients and equipment)
- Overseen and reported against the transition action plans for wards/depts/groups.

Let's get ready to move

OPERATIONAL WORK UNDERWAY

- Patient Move Planning
  - Migration meetings, testing of times
  - Migration plans for all areas-
  - Transfer of patients within SIPICS.
  - Plans developed for Food Trolley deliveries, Phlebotomy rounds etc over patient migration period
  - Dedicated team of Orderlies to move patients
  - Designated routes with lifts manned
  - Coordination Centre

- Pre-stocking (consumables, pharmacy, ISG and linen)
  - Location, levels, changes to ordering/delivery
  - ISG plans – PC, printer, phone, FloView, Radio Telephones

Let's get ready to move

OPERATIONAL WORK UNDERWAY (cont'd)

- Migration staff resourcing plans

- Ways of Working
- Decentralised model
  - Paperlite – clinical notes, review of clinical documentation and pamphlets- electronic and print on demand

- Environmental preparation
  - Stock & linen management
  - 'Dump the junk'

- And much more……

Let's get ready to move

ORIENTATION AND TRAINING

Estimated 3000 staff to orientate

- Train the Trainer model – Trainer sessions on equipment, area/dept specific and way finding.
- Scenario testing and dry runs – Periop, Heliport
- HealthLearn Orientation package – to date 1200 staff completed this, must be completed for booking into onsite sessions as below, over 1300 onsite sessions available over a 6 week period.
- Area/Dept Specific sessions including common patient flow routes e.g. to periop to pick up patients
- Specific Doctor sessions - to combine areas such as periop and ward.
- Way finding 2 hour sessions–for staff who are not part of a ward/dept moving to Hagley but will have to visit the Hagley Building for their work.

Let's get ready to move

Hikana to Hagley Communications Objectives

Staff are kept informed on progress of the building, orientation and migration to Hagley

Clear lines of communication with all involved, during and following the move.

Liaise with media, key partners and agencies to promote and celebrate achievements

Familiarise the public with the migration so they know when and how it will affect them.

Keep our patients well informed and prepared for any involvement they may inadvertently have around migration

Minimise disruption and distraction during migration through clear and precise information about what’s happening

Let's get ready to move


Hīkina to Hagley
MIGRATING TO CHRISTCHURCH HOSPITAL HAGLEY
Keep up to date:
cdhb.health.nz/hagley
Canterbury
District Health Board
Te Poari Hauora ō Waitaha

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: **1 October 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:

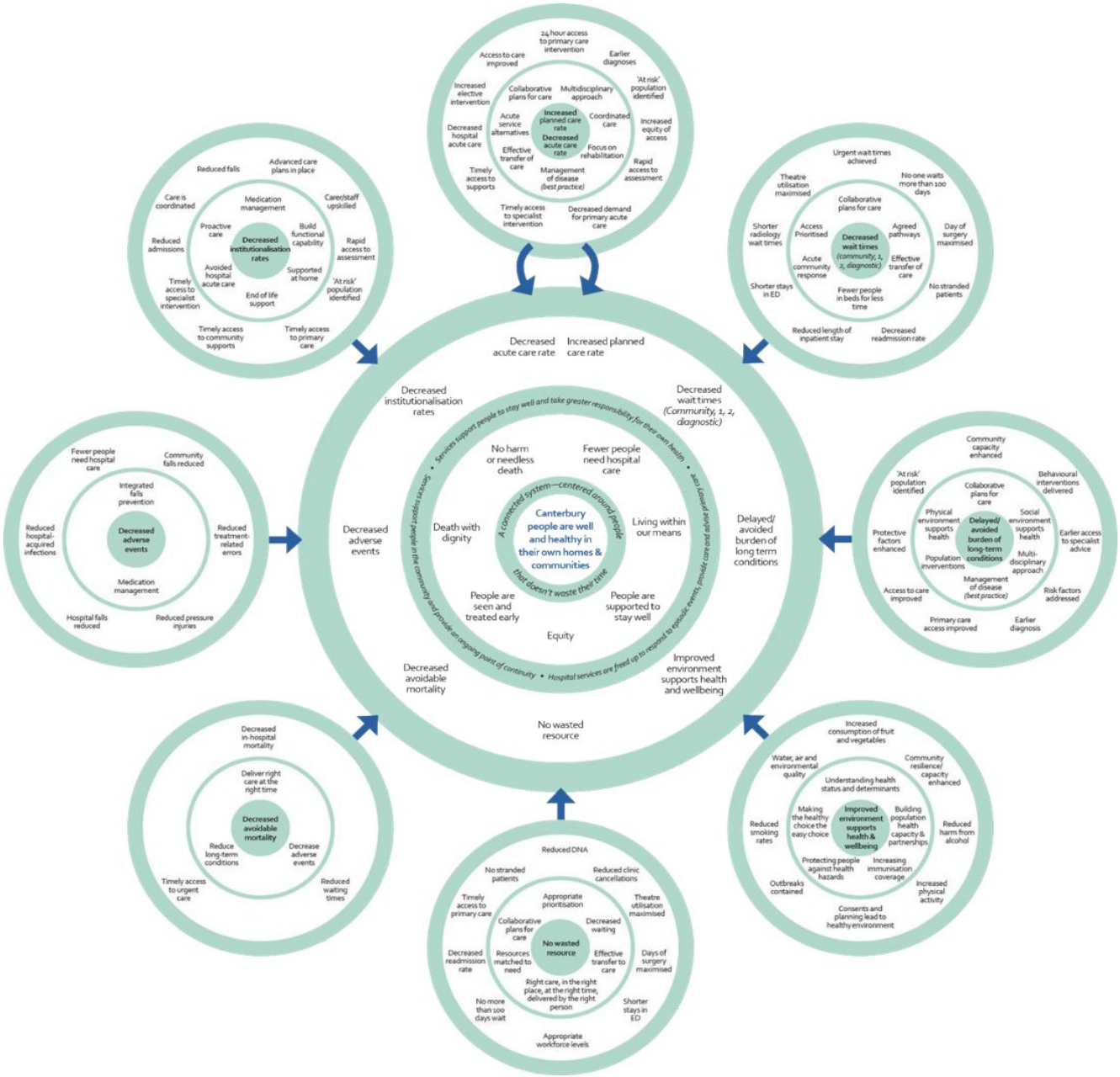
i. notes the Hospital Advisory Committee Activity Report.

3. APPENDICES

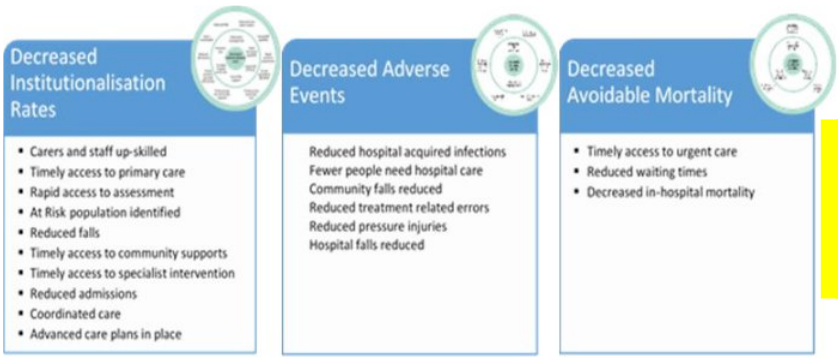
Appendix 1: Hospital Advisory Committee Activity Report –September 2020

Hospital Advisory Committee

Activity Report



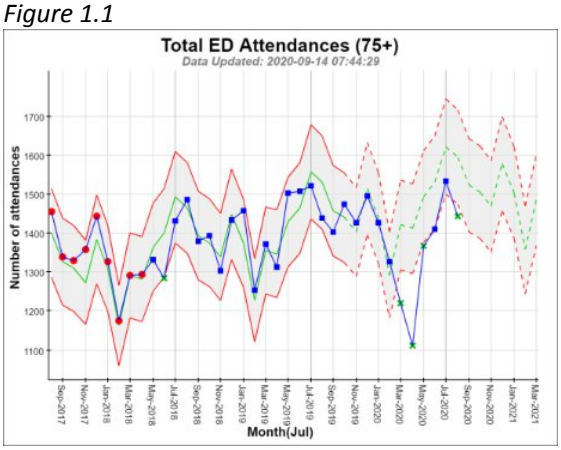
September 2020



Frail Older Persons' Pathway

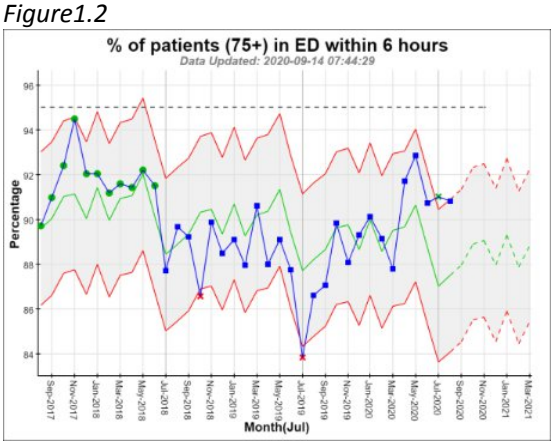
Outcome and Strategy Indicators

Figure 1.1



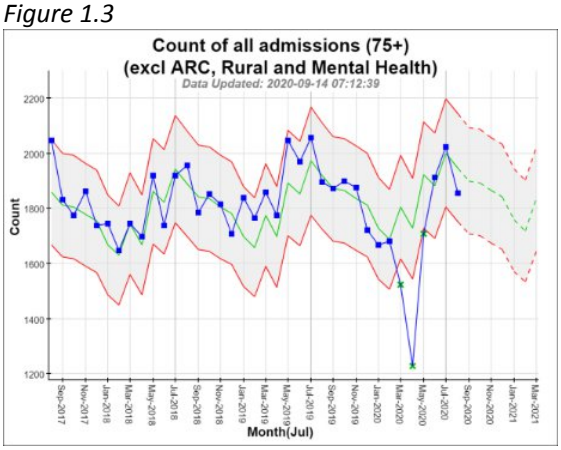
Covid 19 Alert Level restrictions led to a reduced number of ED attendances in March and April, increasing towards previously forecast levels in May – but remaining lower than recent trends indicate.

Figure1.2



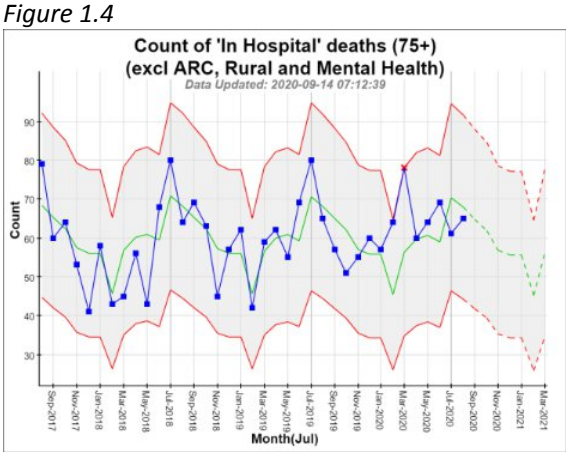
The reduced volumes have led to a faster turnaround in ED with more than 90% of older patients leaving ED within six hours during the past five months.

Figure 1.3



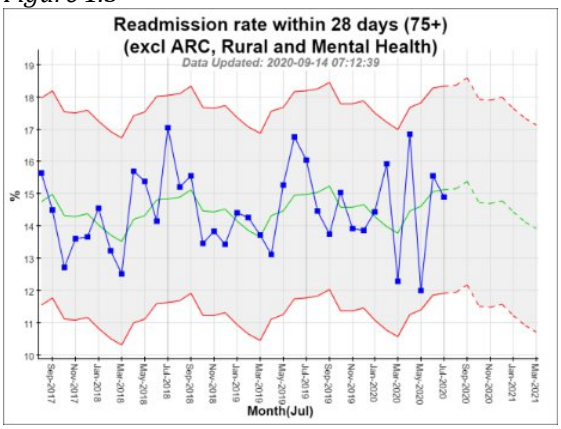
The number of older people admitted is generally within the forecast range but was reduced during the COVID lockdown period. Since then the monthly count of admissions has returned to within forecast range

Figure 1.4



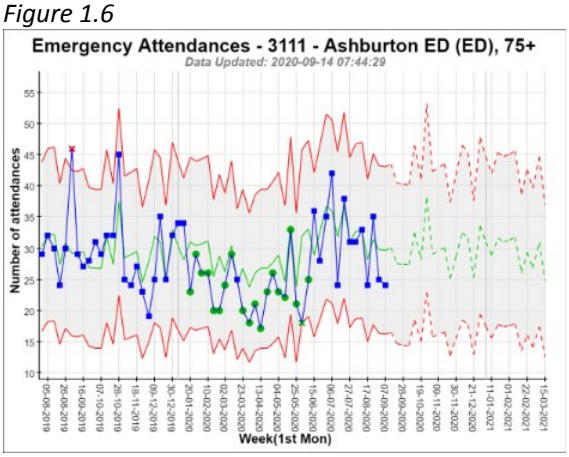
The number and rate of in hospital deaths against admissions was higher than forecast in March, reaching a rate not seen since winter 2014. Exploration of data has not explained this. Since then the monthly rate of deaths against admissions has fallen back to within forecast range, reflecting an underlying 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 in the 75+ age group is currently running below the mean number of expected attendances.

Achievements/Issues of Note

Older Persons Health Medication Management

Following a Health and Disability Commission complaint that arose from an error in discharge prescriptions a working group comprising Geriatricians, Pharmacists and Registered Medical Officers (RMOs) was established within Older Persons Health (OPH). The aim was to review the processes at Burwood Hospital for medication reconciliation to ensure safe and accurate prescribing for patients. This has resulted in a plan to alter the roles and responsibilities of prescribers and pharmacists with regards to medicines stewardship in Older Persons Health at Burwood Hospital. The changes include:

- On transfer from another CDHB facility the admitting doctor takes responsibility for documenting and checking the accuracy of the medications the patient is on currently and how and why that differs to the medicines the patient was last taking in the community. This will be documented on the Medication History on transfer template which will be available in the Medical handover shared drive and the RMO website on the OPH Intranet
- Pharmacists will no longer routinely complete medicines reconciliation at transfer but are able to do so on referral from the admitting doctor. This is intended to only occur for complex patients such as those with multiple medicines and multiple changes
- On direct admission from the community the pharmacist will complete a medicines history and medicines reconciliation in Heath Connect South (HCS) as per the existing process
- Where possible the pharmacist will review the patient's medication in MedChart on admission and note any medication issues, together with any items for follow up, in a progress summary note in HCS (or in the medicines reconciliation for community admissions). Urgent issues will also be directly communicated to the doctor/nurse as appropriate for immediate attention. Non-urgent issues will be left for follow up in the weekly medication review meetings.
- Medication review meetings have been be set up on all OPH wards where the Medical team and the Ward Pharmacist review all medication charts for current inpatients at a dedicated time away from the Ward. Documentation of the meeting will be via the progress notes in HCS for each patient.
- In preparation for discharge the doctor will complete the medication section of the discharge summary at least 24 hours before the planned discharge where at all possible.

- The pharmacist will double check the discharge medications for all discharges occurring during the weekdays. Where a patient is returning to their own home a medication card will be provided to the patient – the copy of the card stored in HCS is documentation of the double check being completed. Where a patient is discharging to a care facility the double check of the discharge will be documented as an entry in the progress summary.
- One month into each clinical rotation the Older Persons Health service will request the ward pharmacist's feedback on the performance of the RMO.

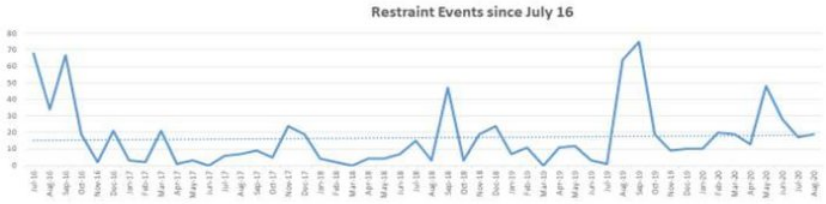
We believe this process will reduce the potential for errors, include the junior medical staff more in the process of medication reconciliation and allow the ward Pharmacists to use their resources more efficiently and effectively. The new process will be monitored and supported with a review meeting and audits.

Level of Care Assessments for Rest Home Care

Over the last 9 months approximately 20% of Rest Home to Hospital Level of Care assessments have been completed virtually by the Community Gerontology Nurses, with the majority of these being approved by the nurse undertaking the assessment on the phone. This has allowed assessments to be completed in a timelier manner than previously when a visit to the rest Home was involved. These resources have been directed to those more complex Aged Residential Care clients that do require a personal visit such as those clients with a diagnosis of dementia or with other complex care needs.

Bed Loop Replacement Project

Following a Coroner report in 2019 the Ministry of Health determined that a recall of a style bed lever was required, and a decision was made that DHBs would need to carry out this task utilising a risk assessment process to identify those patients most at risk. The Ministry acknowledged that this a large undertaking without additional resource and expectations it was delivered over time. The Community team staff immediately started replacing bed levers for patients which they were involved with currently. It was estimated that there were approximately 1600 bed levers issued across Canterbury for patients which we weren't currently involved with. Progress with this replacement is progressing well utilising Allied health Assistants. Utilising phone calls prior to visit to ensure visit is needed. All of the 1,119 Christchurch residents have been validated with approximately 650 of these people require a phone contact and a visit to replace if needed. The plan is to complete these by Christmas this year. The other 600 patients who reside outside of Christchurch will be worked through early 2021 due to additional travel time required with a plan to complete by July 2021.



Consistent efforts to manage without restraint have, in the main, proved successful over the past three years. Sporadic use of locked doors in AG due to patient safety issues. The only incident in July 19 was for a locked door. By contrast September 19 has been the highest month over the period of this graph. While this patient proved extremely challenging staff managed to avoid using seclusion which is to be commended. As per September 2018 restraint use revolved in the main around the presentation of one or two patients. Interestingly 3 out of the last 4 August/September periods have shown a peak in activity. All forms of mechanical restraint have been removed from wards. March 2020: 1 patient accounted for all 20 incidents for the month. May 2020 saw multiple patients with challenging behaviour admitted into both wards (during COVID lockdown). June 2020 in BG was very challenging due to aggressive presentations.

Ashburton Health Services

Reviewing the acute and inpatient flow into Ashburton Health Service, it is noted that a steady increase in presentations have occurred over the past quarter but we are still below the mean. Figure 1.8 demonstrates the increase is also reflected in patients over 65. Drilling further into this we experienced a spike in July, similar to July 2019 however our readmission rate in Figure 1.10 demonstrates we continue to have a low readmission rate for our over 75 cohort.

Figure 1.7

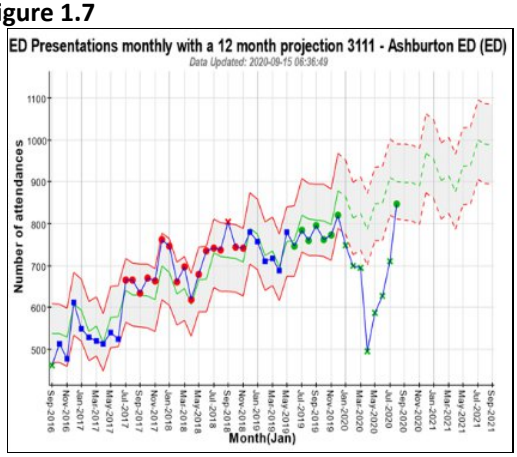


Figure 1.8

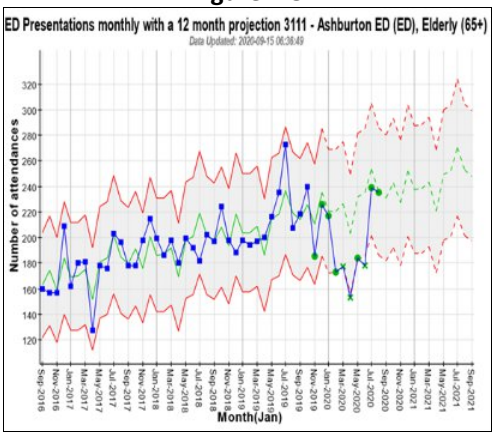


Figure 1.9

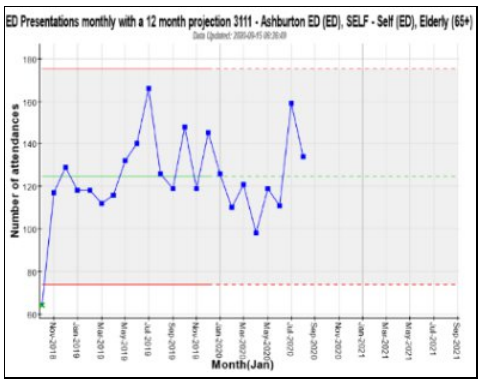
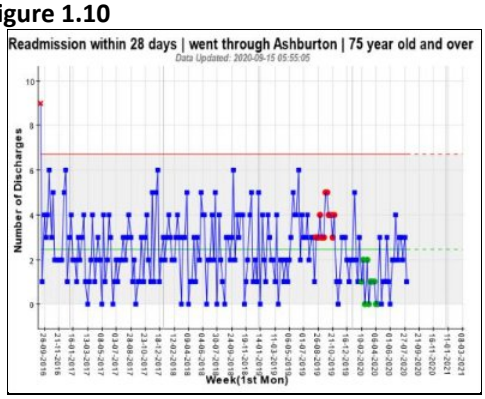
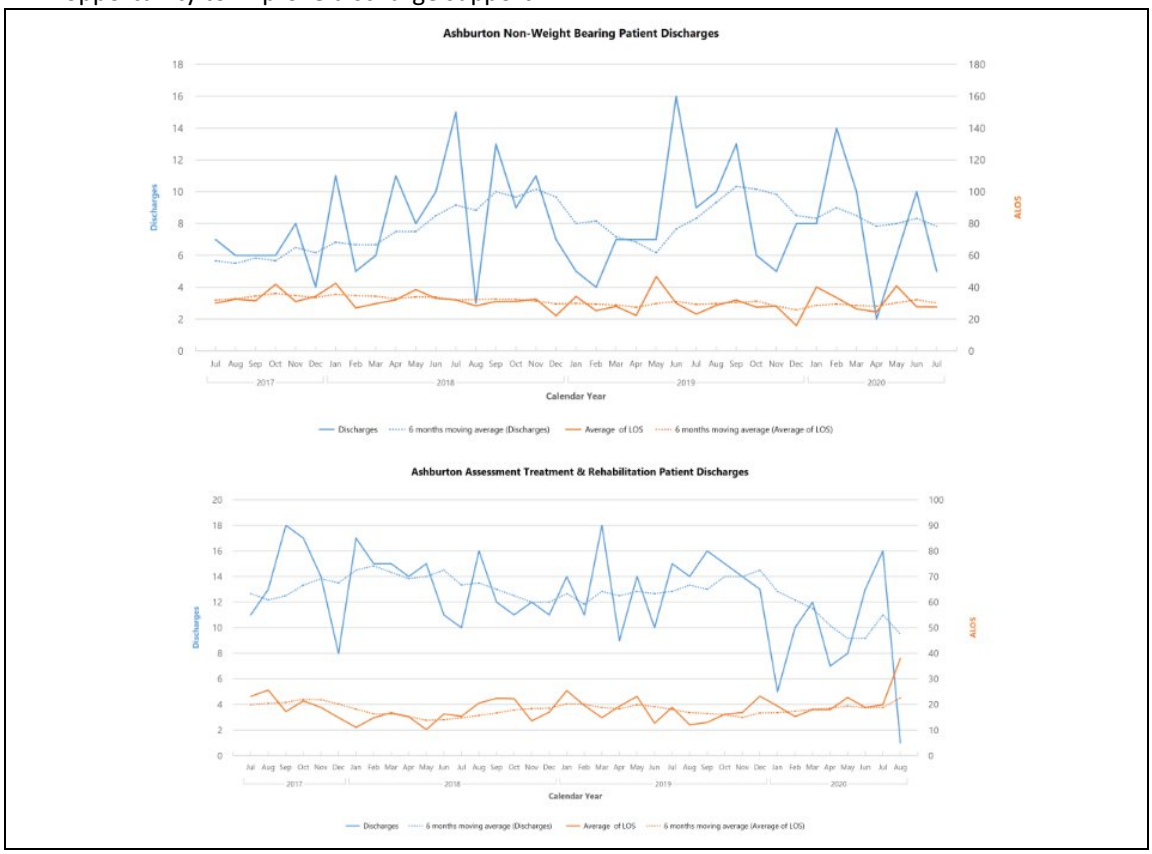


Figure 1.10



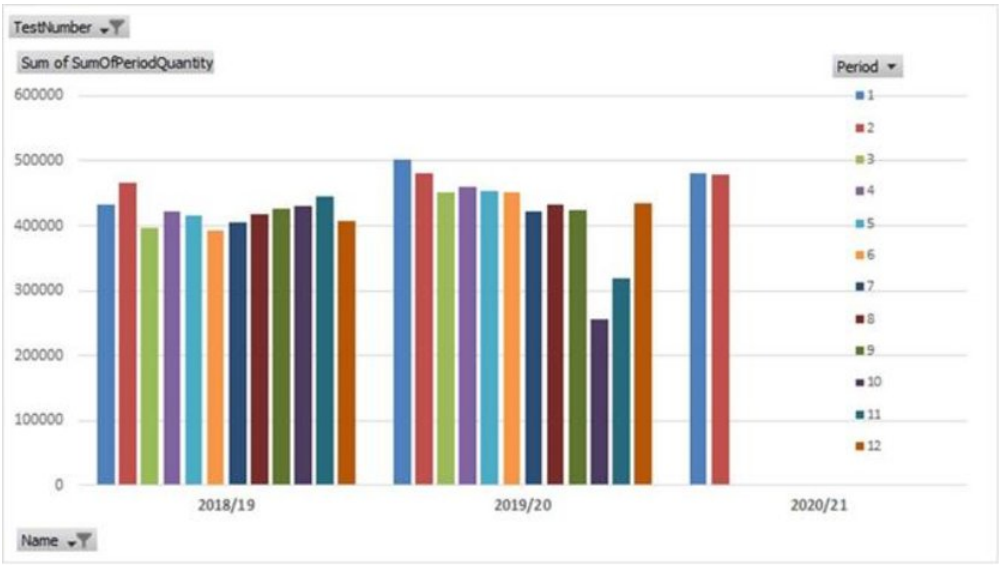
- The Directors of Nursing Ashburton and Rural, Older Persons Health and Rehabilitation (OPH) and Specialist Mental Health Services (SMHS) are collectively working through options on a nursing model of care and service delivery for OPMH in the Ashburton community. Building on the specialist-generalist nursing lens, the objective is to define the pathways and service model for the Ashburton Clinical Nurse Specialists and where referrals are best placed with specialist services of either OPMH or SMHS for acute care. The CNS workforce in Ashburton is well placed to work alongside NGOs and General Practice to support management of the older population in a community setting.
- The Allied Health workforce are working closely with the OPH and Med/Surg teams to ensure best practice and service development is aligned with the wider system. Professional leads are now in place for physiotherapy, occupational therapy, dietetics and work is under way to confirm the best model for social work.
- Ashburton operates a collaborative approach to rostering workforce across both Wards, whilst there is not a distinct boundary of patients per ward, we continue to cohort acute medical patients in Ward 1 as this is closer to the AAU and older persons /restorative care services in Ward 2. The

graphs below demonstrate the split in the occupancy of Ward between non-weight baring patients and assessment and treatment patients at 01 August 2020. Noting in this that the slight growth in length of stay, which is being monitored by the teams as they continually review opportunity to improve discharge support.



Canterbury Health Laboratory Testing Activity

Graph 1 - Monthly Test volume excluding COVID 19 testing to end August 2020.



Note- referral workload jumped back after easing of lockdown restrictions with full recovery by Aug 2020. Overall increase in Jul-Aug this year is 1.8% higher than same period last year.

National COVID-19 testing response support

Canterbury Health Laboratory (CHL) is providing up to 20% of national COVID19 testing. CHL has just completed 100,000 COVID-19 tests in support of the national response. This has been delivered over and above the volumes identified in graph 1. An article celebrating the 100,000 tests was published in the CEO update and was well received within labs and across the health system.

Close relationship with Community and Public Health, Defence and other partners continue to ensure a coordinated response to Regional Border and Managed Isolation requirements.

CHL's response continues to be praised by our national laboratory partners and the Ministry.

Extensive work is ongoing to build COVID-19 testing capacity before any next surge in demands for testing. Previous responses have been for a short period and risked exhausting staff. Recruitment of a pool of casual staff available to be stood up when required is being completed.

Equity of Access to Laboratory Services

Electronic Referral Management System (ERMS) Dashboard

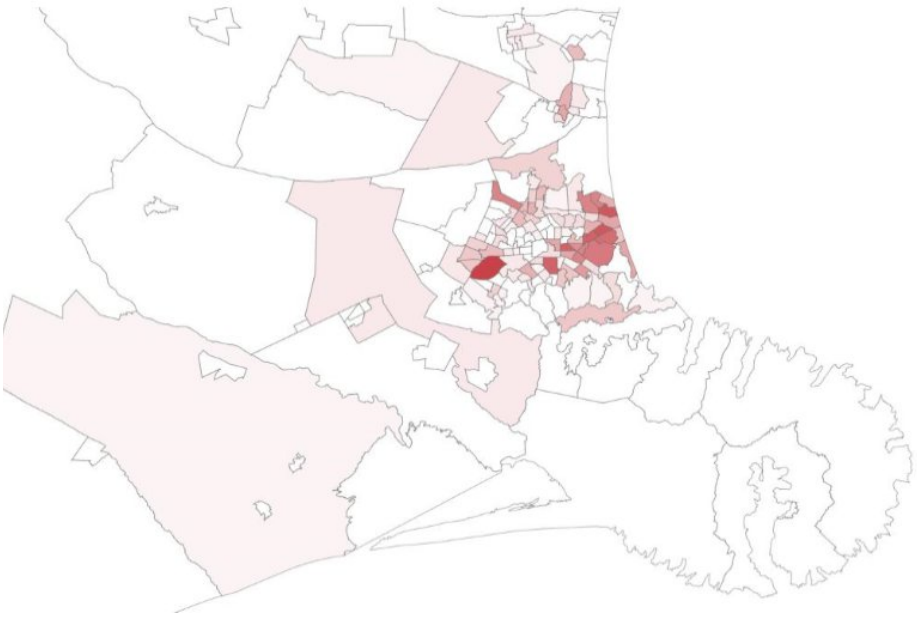
Since May 2020 the Electronic Referral Management System (ERMS) has been used as a further mechanism to electronically request laboratory tests. CHL has been able to add the order information from ERMS to its suite of dashboards, with a focus on equity of access to laboratory services.

The dashboard and data are in prototype form. ERMS lab requests currently reflect 5 – 10% of all community laboratory requests.

The HbA1c/diabetes data is a complete data set and is explained further in the next page.

Early indications are that a number of patients that are given an electronic laboratory request never present to a laboratory collection room. This rate of non-presentation is higher in Asian, Maori and Pacifika ethnic groups. The ERMS dashboard has a visual representation of geographic areas of where patient has presented (or lack of presentation) for a blood sample as depicted below.

Map 1: Location of patients identifying as of Maori ethnicity who have been provided a laboratory request by their GP but have not presented for the lab test. This is based on the ERMS data being collected since May 2020.



HbA1C Equity Dashboard:

CHL has also developed several dashboards that present laboratory results and the frequency of abnormalities. A variety of patient demographics are incorporated in addition to laboratory result data at an overview level. The example below of HbA1c data (a test used as a measure for how well a patient is controlling diabetes) shows some ethnic groups being tested less frequently than other groups. It shows that those ethnic groups tested less frequently (e.g. Maori and Pacifika) are also more likely to have an abnormal result (as shown by the column labelled PR).

Table 1: Testing frequency and abnormality rates of HbA1c tests within CDHB

Ethnicity	CDHB Pop	% of Pop	Tests	Normal	Abnormal	PR	Patients	% of Pop Tested	Normal Patients	Abnormal Patients	% of Pop Abnormal	PR (Patient)
Asian	58,427	10.75%	63,931	41,434	22,497	35.2%	24,282	41.56%	18,931	5,351	9.16%	22.0%
European	409,764	75.39%	646,769	465,113	181,656	28.1%	246,703	60.21%	203,436	43,267	10.56%	17.5%
Māori	47,066	8.66%	63,141	42,209	20,932	33.2%	24,909	52.92%	19,710	5,199	11.05%	20.9%
Middle Eastern/Latin American/African	7,634	1.40%	9,381	6,860	2,521	26.9%	3,790	49.65%	3,191	599	7.85%	15.8%
Other Ethnicity	4,826	0.89%	5,984	4,458	1,526	25.5%	2,396	49.65%	2,011	385	7.98%	16.1%
Pacific Peoples	15,824	2.91%	23,671	11,718	11,953	50.5%	7,893	49.88%	5,234	2,659	16.80%	33.7%
Total	**543,541**	**100.00%**	**812,877**	**571,792**	**241,085**	**29.7%**	**309,973**	**57.03%**	**252,513**	**57,460**	**10.57%**	**18.5%**

Utilising this data will allow the CDHB to target focus areas and/or alternate models of care to improve the delivery of health for all. Medicines data will also be incorporated in to this in future iterations.

CHL Facilities

The impacts that the recently announced car parking facility will have on the CHL facilities planning is being evaluated with Site Redevelopment to ensure service plans continue to be supported. The site will be busy during 2021-2022 with the Energy Centre and car park construction work happening in parallel and surrounding the facility. Previous building work has required close management to mitigate the impacts of vibration on staff and equipment.

Change to Cardiothoracic surgery patients admitting times

- Changes made to the admission process for Cardiothoracic patients releases ward capacity.
- Previously Cardiac Surgery patients were admitted at midday on the day before surgery. Changes to the admission process mean admission is now delayed to 3pm on the day before surgery.
- 62 patients were admitted the day before planned cardiac surgery during 2019/20. On this basis time spent in the hospital ward will be reduced by nearly 8 days in future years. Releasing the equivalent of over $27k in care capacity for other uses and slightly reducing the time that each patient spends away from home.

Day-case Abscess Pathway

- A new pathway has been developed and put in place for people referred by the Emergency Department or their General Practitioner with abscesses that require surgery.
- Previously patients were admitted for assessment and stayed until surgery was provided. This meant that patients often spent more time away from home than warranted by their condition.
- The new pathway has patients being assessed in SARA by a nurse and then doctor. Assessment includes clinical examination, seeking a short clinical history and taking of blood tests. This is provided in a treatment room, rather than a bed space and patients are not required to change out of their own clothes. Following assessment a day surgery booking is made, and the patient is sent home with antibiotics and pain relief if required, to return for the booked surgery as the first patient on the theatre list. Following surgery, the patient is provided with information about caring for themselves and their wound along with district nursing services. If it is safe and clinically appropriate to do so the patient is returned to their home later on the day of surgery.
- In the 22 weeks following the beginning of March there have been 226 people admitted matching the case definition saving an average of 15 bed nights per month.

- This is reducing the demand for acute hospital capacity while enabling patients to spend more time in their own homes.

Children's Respiratory Nurse Prescribing

- Children with chronic respiratory conditions often need prescriptions for acute infective exacerbations.
- Regular specialist care is provided at the hospital. However, when children are unwell with a new respiratory infection the CNS (Clinical Nurse Specialist) assesses children in their home, outpatient setting or over the phone. Previously, if a prescription was required, the CNS would seek out a consultant or registrar, explain the findings and ask for a prescription to be written. Alternatively, the child was brought to hospital for assessment by medical staff.
- Now the CNS provides a prescription to the family on the spot. It has improved patient access to treatment, reduced the requirement for patients to visit the hospital and reduced duplication of effort from the CNS and medical staff. Providing faster access to treatment for infective exacerbations is expected to reduce the requirement for hospitalisation and intravenous antibiotics.

Accessibility of Health Passports

- A health passport is a booklet that people can when going to hospital or another health and disability services. It contains the information that patients want people to know about how to communicate with and support them and helps healthcare workers know more about any disabilities or long-term conditions people might have.
- In the past patient passports have not been accessible to general practitioners via Health Connect South. This meant that we relied on the patient to hold on to their own passport, and any information the General Practitioners (GPs) needed was included in the Clinic letters. This proved to be unreliable as passports can be misplaced and patients may move GPs. Accordingly in an emergency situation patient details were hard to access which potentially created all sorts of problems if the patient was unable to advocate for themselves.
- Health Passports are now able to be attached, once up-dated to their Clinic letters, meaning that as well as the patient receiving a physical copy their GP receives electronic copy. Any other clinician working within the system can access this information electronically.
- The Clinical Nurse Specialist for the Child Haematology and Oncology Centre notes that this improves patient confidence and satisfaction as they feel their GP will be better informed and more aware of future scans and the follow-up required post their treatment. It also reduces the requirement for post-discharge follow up education appointments creating capacity.

Nursing handover in Child Haematology and Oncology Centre

- Accurate nursing handover is of great importance to the safety and continuity of care. If clinically relevant information is not shared accurately it may lead to adverse events, delays in treatment and inappropriate treatment and omission of care.

- Previously nursing handover was undertaken in the nursing station in the Child Haematology and Oncology Centre. This are is often busy, particularly during the morning to afternoon shift handover, with many other members of the multi-disciplinary team also using the space. Nurses found that this distraction added challenges to providing safe, efficient handover in a safe and efficient manner.
- This approach has been updated by booking the staff room for this function between 2.30-3.00pm for protected handover each day. This has enabled an accurate handover to occur without distractions, questions to be answered and education opportunities to take place. Following this initial introduction, nurses then perform bedside handover for each of their patients.
- Positive feedback has been received e.g- medications are delivered on time and bedside handover for staff, parents and patients is a great way for family to be able to comment and provide input regarding their child's care.

Children's outreach nursing: Neurology. Improving community management of epilepsy.

- Patients with diagnosis of chronic intractable epilepsy regularly need to call for help, resulting in frequent requirement for ambulance support and admission for medical observation and management.
- In Canterbury, these patients are now being provided with an individual complex seizure management plan of care. This is compiled in collaboration with the family and is provided to the school and immediate caregivers. It has the aim to primarily inform the management of care in the community setting. It includes a description of the patient's seizure type to ensure prompt recognition. General Practice and St. John have access to the plan
- Parents report decreased anxiety, and increased satisfaction. Confidence in self-management is increased via feeling well informed due to consistent guidelines being in place. Alongside this families are provided with access the CNS for guidance, phone support.
- The system prevents unnecessary admission to the Emergency Department and reduces the length of observation required, thus reducing length of stay in hospital
- While Christchurch has a high number of children with diagnosed epilepsy it now has lowest rate of ED admissions of children. This is due to enhanced community management in place via input from CNS outreach input.

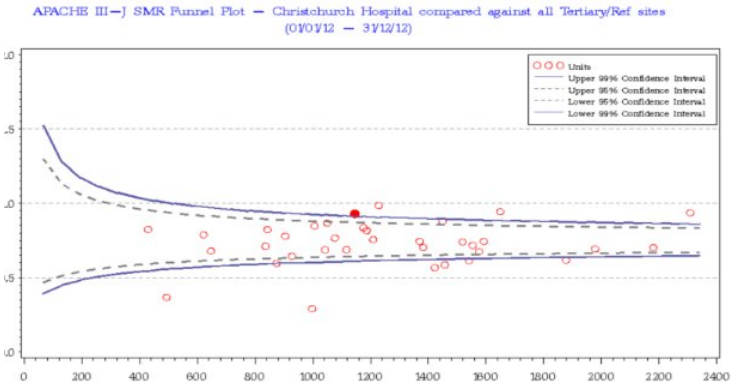
System improvements in the Intensive Care Unit (ICU)

- The ICU can be a complex, busy, stressful environment with the need for frequent/high stake decision making and meticulous patient care. The supporting systems, including IT are vital in supporting these functions.
- Since 2016 the team has been actively engaged with the CDHB Releasing Time to Care program. Work done includes:
    - the reorganisation and simplification of stores, supporting just-in-time delivery.
    - reorganisation of linen trolleys.
    - a focus on pressure area care, with a focus of mattress types.
    - introduction of a 'paper lite' system.
    - Reorganisation of patient/clinical information folders
    - Development of ICU specific CORTEX documents to streamline paperwork
    - Introduction of 'bundles' – constellations of cares required for specific patient populations/problems to standardise and optimise care.
    - A concept of 'a place for everything and everything in it's place', using floor placed location stickers for larger equipment. This has been adopted widely through the DHB
    - Adoption of CORTEX for documentation
    - Introduction of the VOCERA communication system

- The team has also been heavily involved with the preparation and planning of the new ICU in Hagley building.
- The quality group continues to develop and has a focus on patient safely within the ICU.

How do we know we are doing a good job in our ICU?

- ICU regularly contributes outcome data to the HQSC and the ANZICS Centre of Outcome and Resource Utilisation. This allows benchmarking against other centres within Australasia, and against internal performance over time.
- For the year July 2019-June 2020, Data shows that, compared to other Australasian units, Christchurch ICU patients have a shorter ICU and hospital length of stay, despite being 'sicker' (having a higher acuity of illness). This higher acuity of illness is reflected in higher rates of invasive ventilation, cardiovascular/inotropic support and mortality.
- At the beginning of this decade, ICU had a standardised mortality ratio (SMR) that was outside the 95% confidence of where we should be i.e. our mortality was unacceptably high. While this remains unexplained, more recent reports have shown a marked improvement in our outcomes, which we believe is due in part to some of our improvements and innovations



2012. SMR plots. Christchurch = red circle. Outside 95% confidence interval

Standardised approach to equipping ICU beds and spaces

- Within the past 12 months we have had a significant upgrade of vital equipment including our ventilator fleet, cooling machines, physiological monitors and medication delivery systems.
- A new method is being introduced, which clarifies and standardises bundles of equipment to be purchased for each additional bed space or area commissioned.
- For example, each bed space commissioned (a CIBB) requires the purchase of a bed, a monitor, 4 syringe drivers, 2 pumps and a ventilator. Each area (a CIAB) requires 1 dialysis machine, 1 temperature management system, 1 video laryngoscope and 1 ultrasound machine).
- This system will form the basis of our CAPEX requirements going forward, giving a robust and transparent system of purchases.

Improving after hours Neonatal Senior Medical staff coverage.

- Neonatal occupancy has continued to increase in Christchurch. During 2019 the service's Senior Medical Officer team increased to seven Senior Medical Officers (SMO). This increase enabled two consultants to be rostered to provide inpatient care during the week.
- By reducing additional hours payments along with one Senior Medical Officer reducing their FTE establishment the service has been able to appoint an eighth SMO this year.
- This change is cost neutral and allows evenings to be covered more evenly. It avoids the lead on-service consultant being on call during the week. It also allows two consultants to be on leave at a time without causing challenges in covering the roster. These improvements contribute significantly to SMO well-being.

Outcome and Strategy Indicators

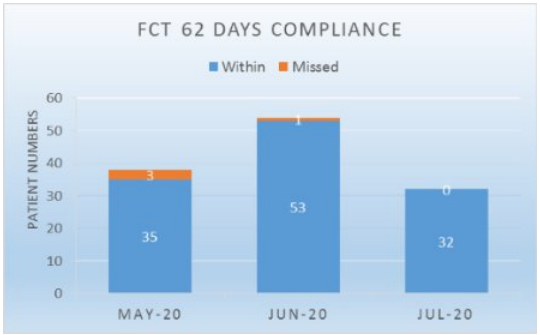
Key Outcomes - Faster Cancer Treatment Targets (FCT)

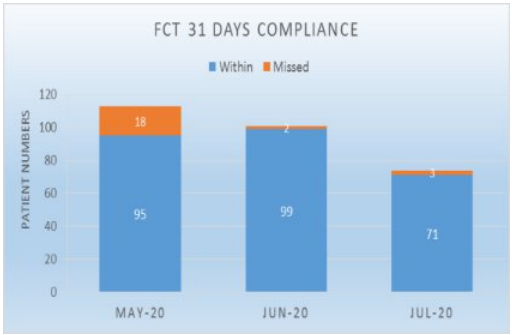
62 Day Target. In the three months to the end of July, of the 154 records submitted by Canterbury District Health Board – similar to the 153 for the three months to the end of June. 34 patients missed the 62 days target, 30 did so through patient choice or clinical reasons and are therefore excluded from consideration. With 4 of the 124 patients missing the 62 days target through capacity issues our compliance rate was 96.8%, once again meeting the 90% target.

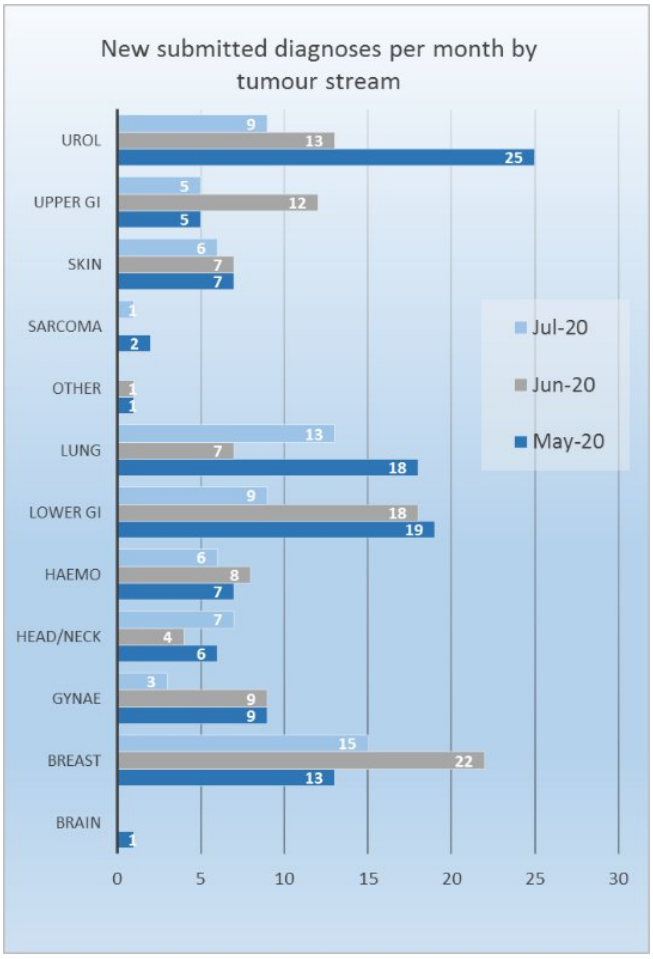
31 Day Performance Measure. Of 288 records submitted towards the 31-day measure 265 (92%) eligible patients received their first treatment within 31 days from a decision to treat, the CDHB continues to meet the 85% target. A total of 23 patients did not meet the 31 days target but it is worth noting that 5 missed it by 5 days or less and 3 through patient choice or clinical considerations.

FCT performance in CDHB

The dip in numbers in the last month of every report (July in this case) reflects the timing of when the report is compiled which is governed by the reporting requirements of the Ministry. A significant number of the patients who have a 1st treatment date in the period this report covers will be awaiting coding and will be picked up in following month's extract.





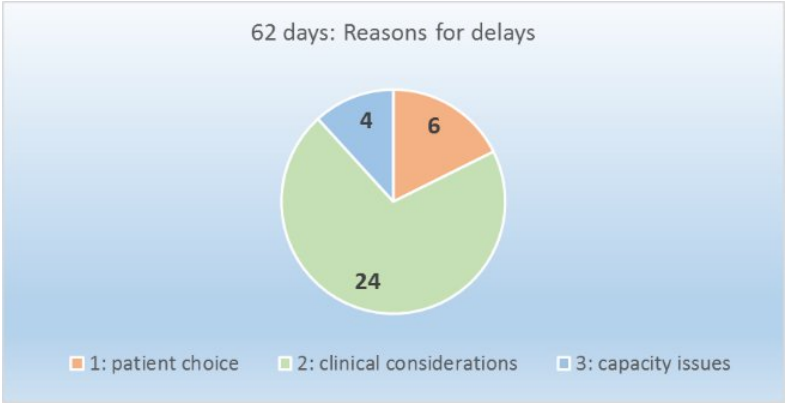


Note: The result for the head and neck tumour stream reflects 4 patients so only one patient failed to meet the target.

Patients who miss the targets

The Ministry of Health (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

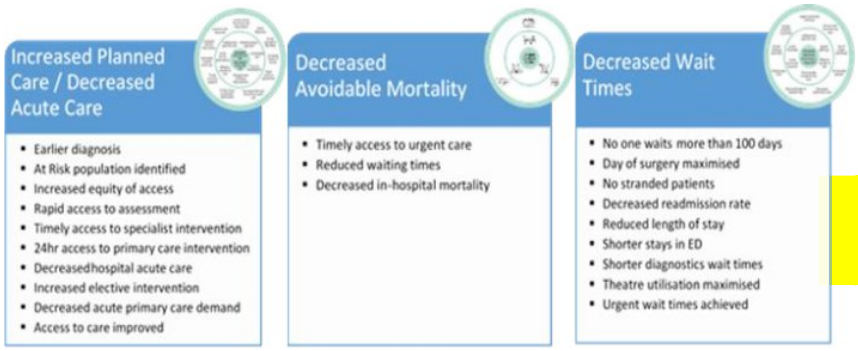
Bowel Screening in Canterbury

- The National Bowel Screening Programme was piloted by Waitemata DHB (2012-17) and national roll out of the screening programme began in July 2017. The programme is being offered in ten DHBs.
- Canterbury will join the programme in October after successfully demonstrating to the MOH its ability to deliver a clinically safe and effective bowel screening service.

- The Programme will detect around 100 cancers a year in Canterbury and, for the majority whose cancers are early stage, this test could be a lifesaver.
- Planning towards a new facility to increase CDHB endoscopy capacity is underway.
- As a part of preparing to enter the Programme endoscopy systems and scope reprocessing equipment have been updated.
- Along with this there has been an emphasis on reducing colonoscopy waitlists in preparation for the increase in volume of endoscopy that will occur as a result of screening.
- Members of the National Programme team visited Christchurch Hospital early in September to carry out a readiness assessment. Informal feedback provided was extremely positive and very complimentary of the preparation by the team.

High Dose Methotrexate Infusion

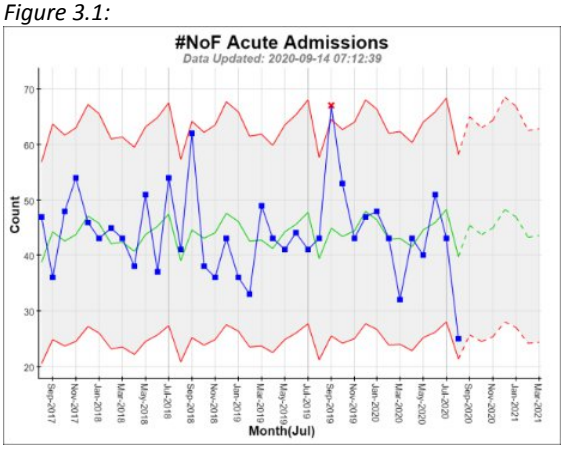
- High dose methotrexate (HDMTX) chemotherapy is administered over 24 hours via a central line. It is very important that it is delivered within the time frame prescribed to prevent significant toxicity. During this time strict fluid balance protocols are put in place and a range of measurements taken to ensure that the risk of toxicity is managed. Toxicity can result in acute damage to the patient's kidneys, harming their quality of life and requiring further health service intervention.
- Staff in the Child Haematology and Oncology centre noted that recent changes to the brand of intravenous pumps and giving sets was accompanied by the infusions no longer running to time.
- Protocol documentation has been updated to provide instructions about how to prepare the lines, volume required to prime and flush the set and prescriptions have been updated to stipulate the new rate. Education has been provided to staff at handover.
- This action has ensured the safety of our patients and improved the care we provide to our patients.



Enhanced Recovery After Surgery (ERAS)

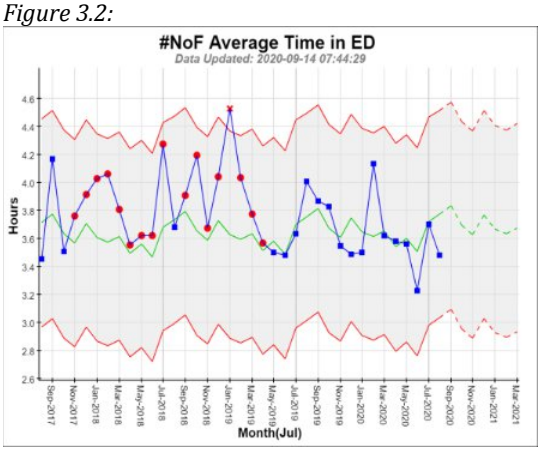
Outcome and Strategy Indicators – Fractured Neck of Femur (#NoF)

Figure 3.1:



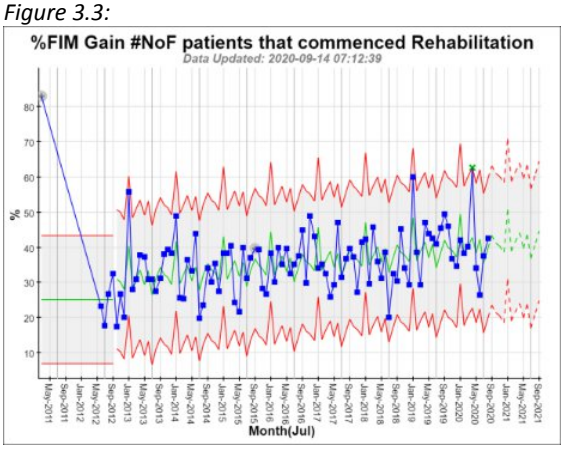
Admissions are generally following the expected mean count. Coding delay impacts the latest data point.

Figure 3.2:



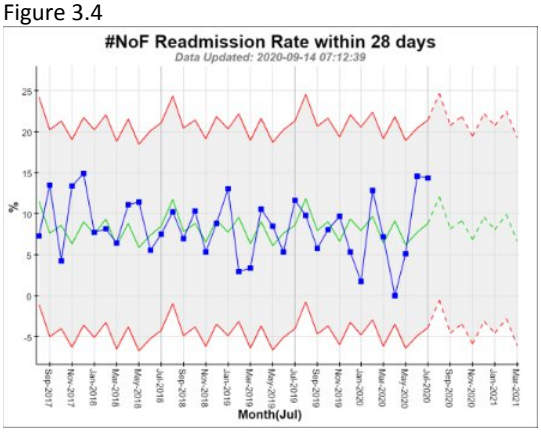
#NoF time in ED is generally following the expected mean times.

Figure 3.3:



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

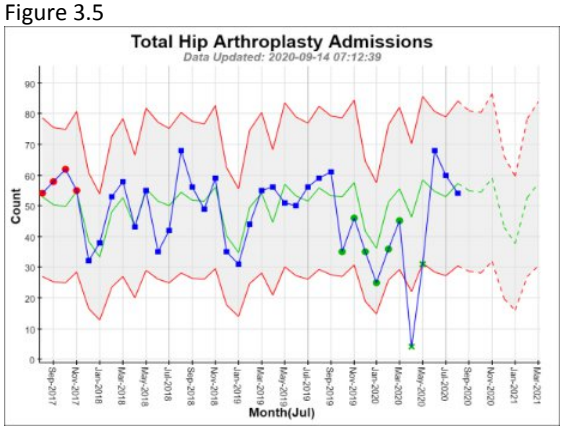
Figure 3.4



Readmissions continue to remain within expected mean values.

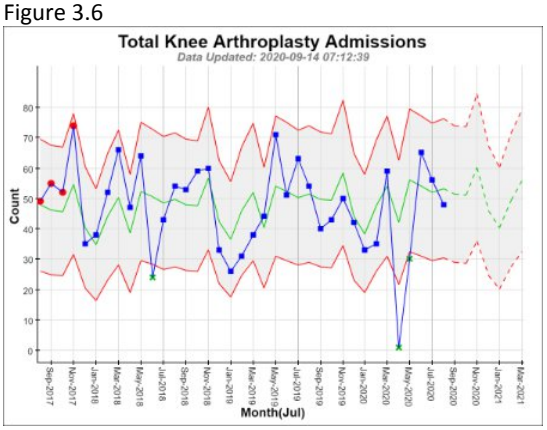
Outcome and Strategy Indicators – Elective Total Hip Replacement(THR) and Knee Replacement(TKR)

Figure 3.5



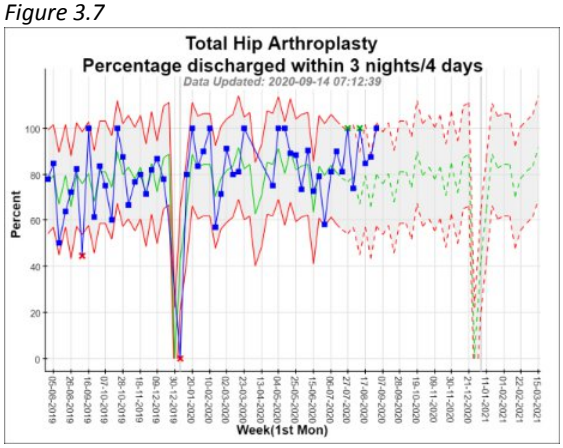
Admissions are trending within the expected range. April shows no record of planned admissions in line with NZ Covid 19 Alert Level 4 restrictions

Figure 3.6



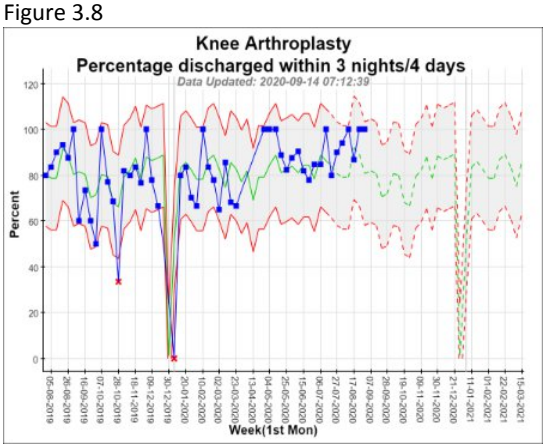
Admissions are trending within expected range. April shows no record of planned admissions in line with NZ Covid 19 Alert Level 4 restrictions

Figure 3.7



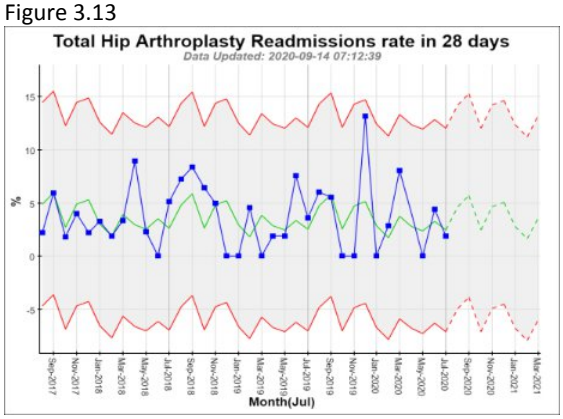
The percentage of patients clinically safe to be discharged is within 3 nights/ 4 days is trending above the mean expected discharge percentage.

Figure 3.8



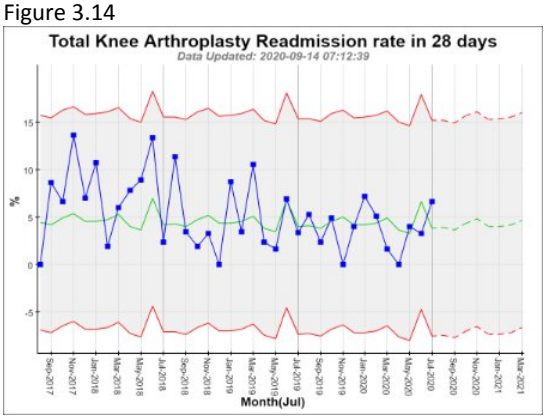
The percentage of patients clinically safe to be discharged within 3 nights/ 4 days is trending above the mean percentage expected to be discharged.

Figure 3.13

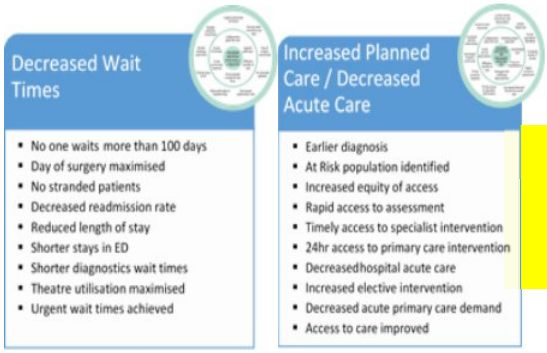


Readmission rates remain a low percentage.

Figure 3.14



Readmission rates are maintaining within tolerances.



Elective Surgery Performance Indicators 100 Days

Achievements/Issues of Note

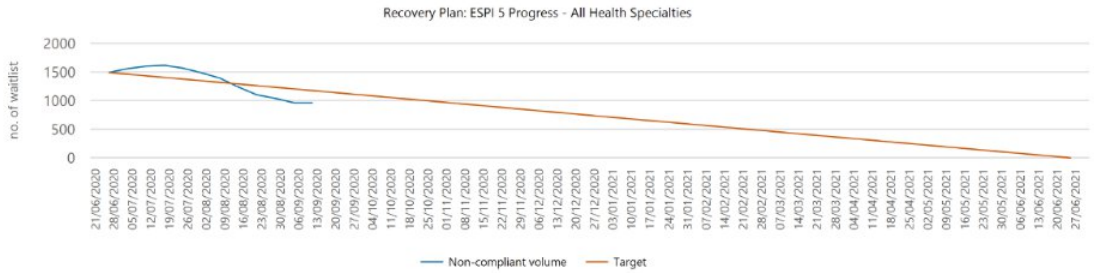
Elective Services Performance Indicators

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. Canterbury District Health Board is no exception to this.

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

	Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Apr		May		Jun		Jul	
	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %
1. DHB services that appropriately acknowledge and process patient referrals within the required timeframe.	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %
2. Patients waiting longer than four months for their first specialist assessment (FSA).	2633	22.5%	2542	22.7%	2383	21.7%	2042	19.5%	1501	15.4%	1627	16.4%	1546	15.8%	1537	16.5%	1964	23.6%	2244	28.7%	2273	28.9%	1815	21.5%
3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT).	88	0.5%	86	0.5%	24	0.1%	41	0.2%	72	0.4%	50	0.3%	2	0.0%	0	0.0%	1	0.0%	0	0.0%	0	0.0%	0	0.0%
5. Patients given a commitment to treatment but not treated within four months.	361	8.7%	410	10.5%	531	13.4%	628	16.1%	612	14.5%	741	17.4%	768	17.4%	916	18.8%	1433	26.9%	1384	28.6%	1236	25.8%	1373	27.2%
8. The proportion of patients treated who were prioritised using nationally recognised processes or tools.	0	100.0 %	0	100.0 %	2	99.8%	2	99.8%	0	100.0 %	0	100.0 %	0	100.0 %	3	99.8%	1	99.9%	0	100.0 %	1	99.9%	0	100.0 %

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 14th September seven specialty areas have no patients waiting for First Specialist Assessment for longer than 120 days, 26 are meeting their recovery plan target and ten are not. CDHB is also meeting improvement plan targets for waiting times for admission and treatment. As at 14th September one specialty area has nobody waiting longer than 120 days, eleven are meeting their recovery plan target and two are not.



Campus clinicians supported by operational teams are optimising the provision of clinic and theatre activity, rigorously managing acceptance of referrals against HealthPathways criteria.

Inpatient events cancelled due to Pandemic lockdown.

- 1,158 admitting events were cancelled due to the first COVID19 lockdown. Services have been working to provide the care that was deferred, events have been rebooked following clinical reprioritisation. As at 13th September all but 19 of these events have been closed and of those all except 8 have an admission rebooked. Reasons for the delay of those 8 have been examined. Only one relates to waiting for DHB capacity to become available, with the majority relating to patient need or desire to delay treatment or being related to ongoing, complex care journeys.

Dermatology Service update

- The Dermatology service has experienced a long-term shortage in its Senior Medical Officer Establishment. While there is a budget for 3.7FTE Senior Medical Officers, current staffing is one full time Senior Medical Officer and one full time Fellow.
- We have just offered a part-time role to a General Practitioner. They will provide weekly skin checks for patients who are immunosuppressed due to organ transplant. This will provide capacity and free the consultant dermatologist to see more new patients than currently.
- Despite SMO vacancies, the flexibility and work ethic of the current staff means that we are currently providing an adequate level of specialist medical dermatology. We are either accepting patients to be seen in clinic or providing advice to the referrer on how to manage the patient's condition in the community.
- We are seeing patients within 100 days of referral and virtual responses to referrals from Primary Care are higher than 50% of the Department's output.
- We are continuing to run the only dedicated skin cancer surveillance and surgical treatment clinics for immunosuppressed solid organ transplant patients in New Zealand, on a weekly basis.
- Between 250-280 ERMS and internal generated outpatient referrals have been addressed each month since April. 55% of all ERMS are accepted with virtual advice provided.
- A number of general practitioners are participating in post-graduate training in Dermatology, in order to increase these specific skill sets in primary care.
- We have replaced our old phototherapy machines with new ones and now have a state of the art, phototherapy suite.

Ongoing development of Multiple Sclerosis Clinical Nurse Specialist Service

- Since 2014 Pharmac has introduced funding for a range of drugs that significantly modify Multiple Sclerosis disease processes and their effects on patients.
- Since the introduction of this funding 343 people have been initiated on disease modifying treatments for multiple sclerosis in Canterbury, there are currently 263 people receiving these treatments.
- The CNS team has developed a medication presentation that leads patients, and their CNS through a standardised approach to initiation conversations about the specific medications used in the service. This has proved useful in standardising care and ensuring that important information is not missed.

Templated letters for Cystic Fibrosis clinics

- Children with cystic fibrosis are seen in clinic three monthly from birth to 17 years of age. It has proven difficult to keep track of patient's problems/issues, treatments, tests and investigations over the years.
- A standardised clinic letter has been templated, with important information being carried through from clinic to clinic and spaces for all members of the multidisciplinary team to provide input.
- This has led to patients and staff being well informed via a letter written in a familiar format no matter what changes in staff have occurred. Because information is carried through from clinic to clinic staff spend less time hunting for required information – all leading to better care.
- This paper lite approach has also ensured that information is available wherever required within the health system, enabled problems and interventions to be tracked, reduced the chance that issues will not be followed up and therefore reduced the risk of avoidable treatment costs or personal cost to the patient and their whānau.

Transition of Adolescent/Teenage Diabetes Patients

- Children with diabetes are regularly seen at paediatric diabetes clinics in the paediatric outpatients' area and are transitioned to the adult service between 15 and 16 years of age.
- A specific transition clinic has been initiated. It is held in the Christchurch Outpatients building, within the adult diabetes service area. The transition clinics are run by the paediatric endocrinologists, providing patients and whanau a chance to attend at least four clinics in the new environment before transitioning to the adolescent service.
- All adolescent patients now see a specialist endocrinologist allowing for a more experienced review, recognising that the adolescent age group have many more challenges to deal with than younger patients and we are preparing them for transition.
- The feed-back has been positive. Patients and whanau like the new environment, as they are meeting similar age patients.
- During the first few transition clinics we have had a lower rate of "did not attend" events. This will benefit both patients and the health system through improved control of a complicated, onerous, long term health condition.

Planned care targets have been provided to the Ministry of Health and we are awaiting feedback on these targets. As per last year, they incorporate planned inpatient operations as well as range of procedures provided to hospital inpatients, outpatients and patients in community settings.

As at year end our target is to deliver a total of 31,359 planned care interventions: 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 total volumes delivered are 7,572 – this is 1,581 ahead of the target of 5,991.

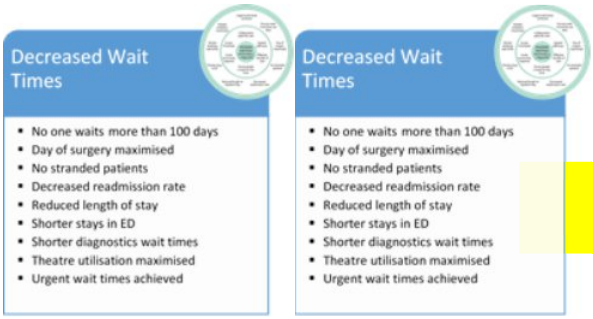
Within this, planned inpatient surgical discharges are 3,803 – 53 ahead of the phased target of 3,750.

Minor procedures delivered are 3,752, 1,575 ahead of our target of 2,177. Inpatient, outpatient and community provision are all ahead of target.

17 non-surgical interventions have been counted, 46 below target of 63.

Current theatre volumes

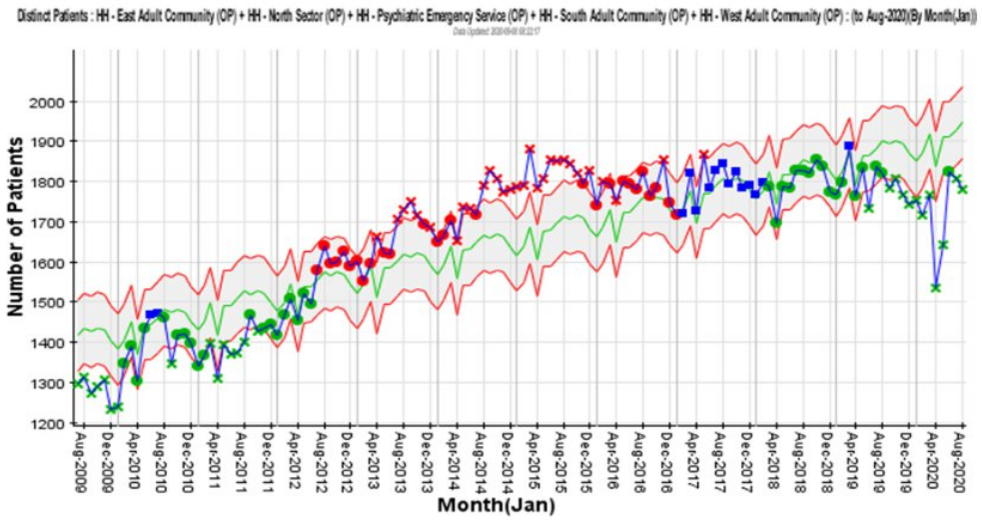
The number of events in Christchurch and Burwood theatres is at forecast levels during July and August and the number of operations carried out for CDHB patients in private hospitals is sitting around 20% higher than forecast during these months. During these months 1,108 planned operations were carried out in private Hospitals, around 28% of total planned operating compared with 22% in the same months in 2019.



Mental Health Services

Adult Services – Community demand

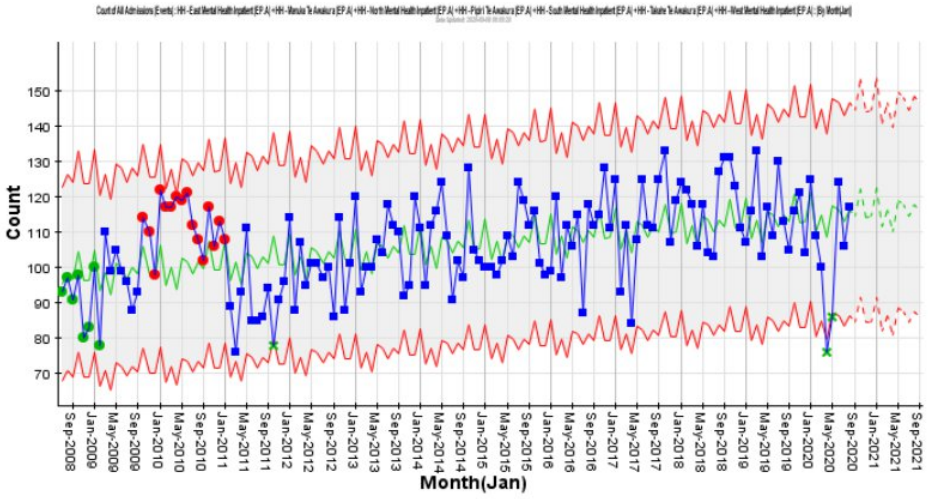
The number of people receiving adult community services is relatively constant with approximately 1,800 unique community-based mental health consumers contacted each month. This number fell during Covid 19, however similar volumes have returned.



Adult Services-Inpatient demand and flow

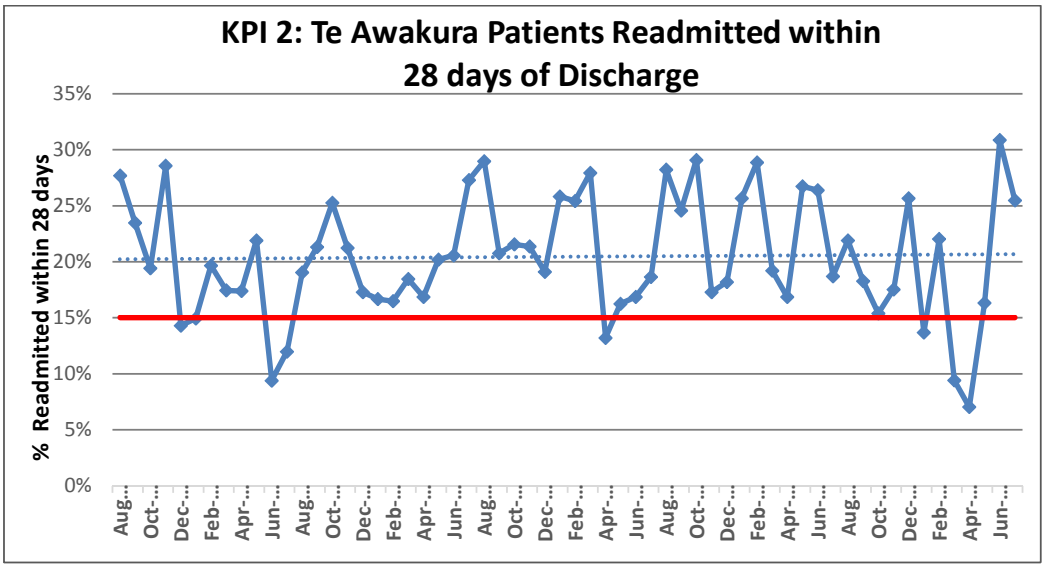
Te Awakura admissions by month

The graph below shows a monthly view of admissions to Te Awakura (adult inpatient services). There has been a sustained increase in admissions since 2008 and this increase is forecasted to continue despite the Covid 19 related dip in March-April-May.



KPI 2: Te Awakura patients readmitted within 28 days of discharge

The graph below shows the readmission rate within 28 days of discharge. Of the 110 Te Awakura consumers discharged in July 2020, 25.5%, were readmitted within 28 days. The reasons for a high readmission rate are multi-faceted including the increasing demand for inpatient services requiring flow and shorter lengths of stay (possibly related to Covid 19); the 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 increasing impact of substance misuse.



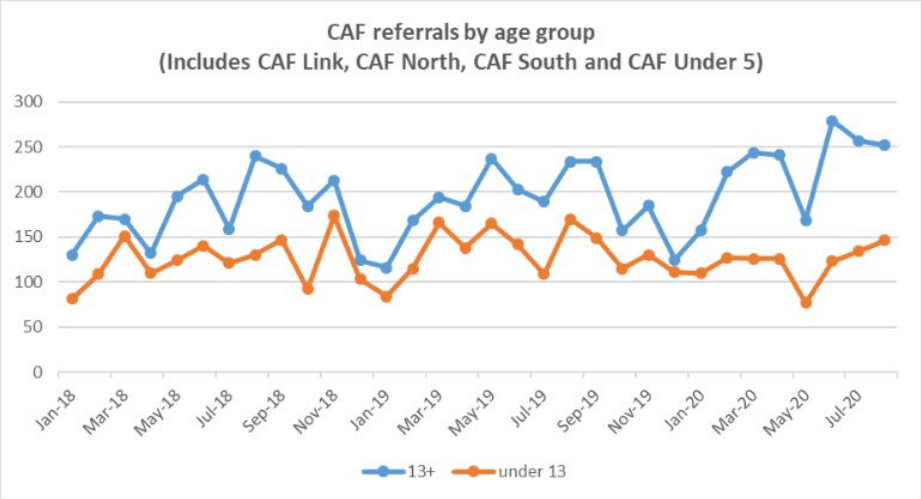
Child and Youth Service demand

While the demand for adult mental health services may have plateaued somewhat, there is still increasing demand for Child and Youth services. The greatest growth is those over 13 years of age. To address growing demand a number of active changes to service provision have been introduced:

- Internal staffing numbers have been directed to areas experiencing the most acute demand
- Enhanced triaging/ advice is in place to signpost people to treatment by community services where appropriate, retaining assessment and treatment services for those requiring specialist support.
- Everyone presenting in crisis is assessed and followed up according to the Mental Health Triage scale which details the clinical response required according to risk.
- Those identified as requiring urgent assessment are seen by the Child Adolescent and Family (CAF) Access Team or given an urgent appointment with a community team
- The Access team is now providing short term assessment and treatment for people who present in crisis and brief intervention before transferring people back to the community to continue treatment.
- People accepted for treatment are triaged by clinicians to determine clinical priority. Consumers and their whanau receive a letter advising who and how to contact CAF if the situation changes.
- CAF routinely telephone to check how the child/young person is managing and to re-prioritise as appropriate. An electronic patient management system provides information on when consumers were last contacted, their acuity and psychometric tests that have been sent.
- The CAF Access team has been working extended shifts to process the high volume of referrals.

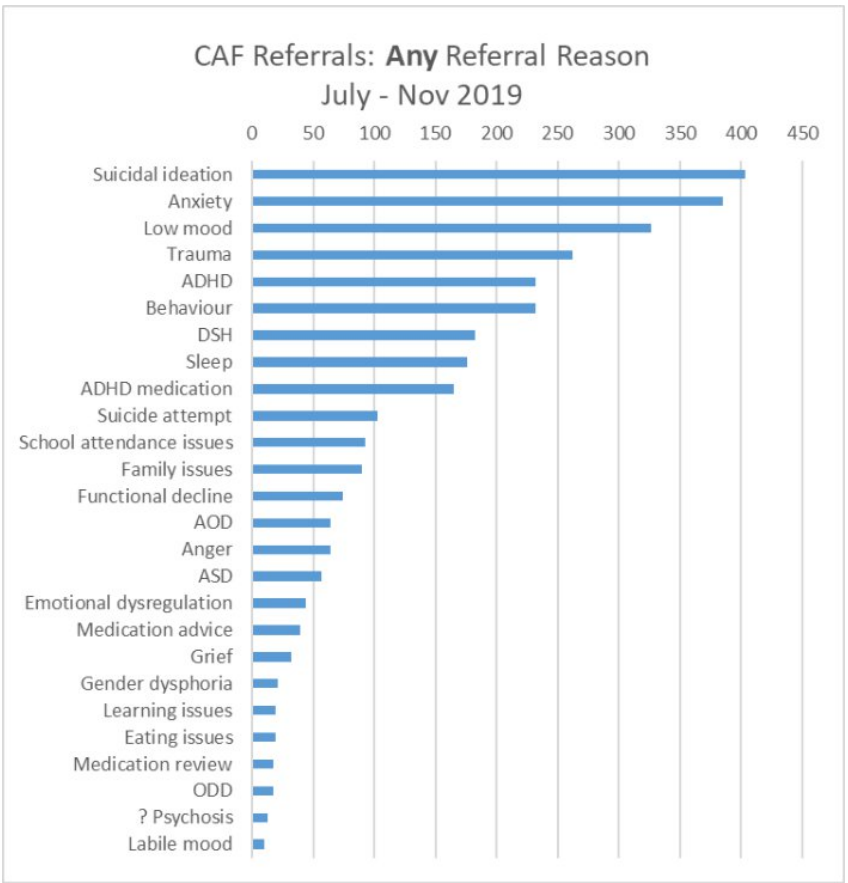
Volumes for Child and Youth Services

CAF referrals by age group



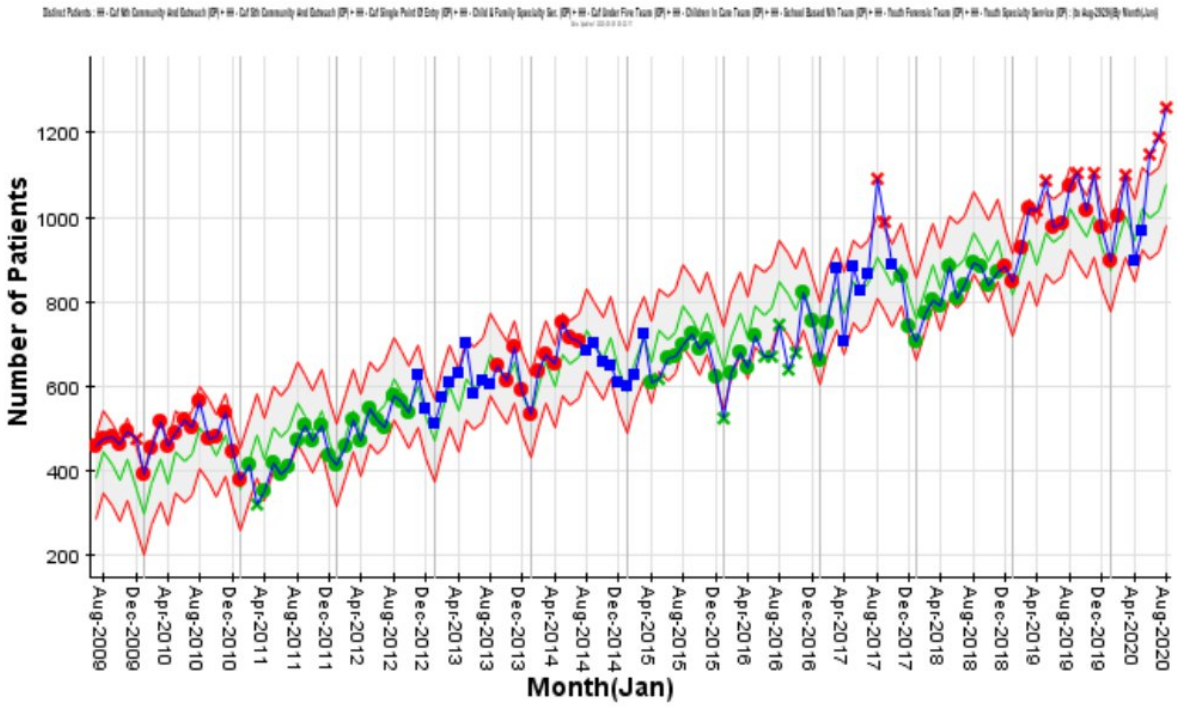
Reason for referral

An investigation into the most common reasons for referral between July and November 2019 was conducted. The three most frequently mentioned were suicidal ideation, anxiety and low mood. Referrals often contain multiple reasons for referral, a full break down is shown in the table below.



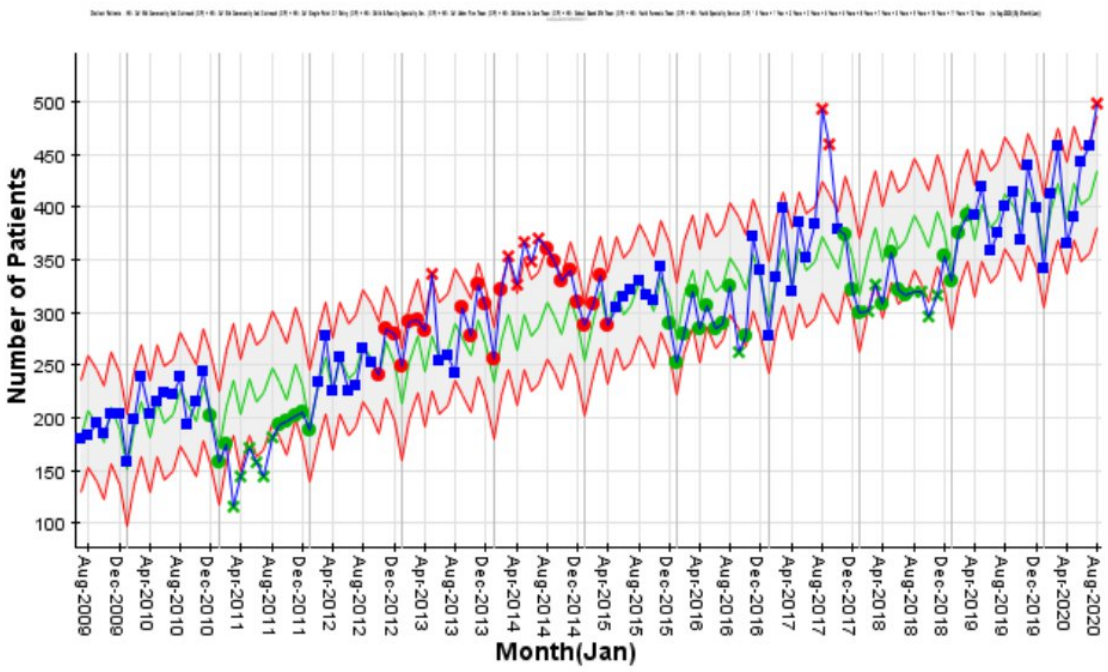
Note: ADHD = Attention Deficit Hyperactivity Disorder, DSH = deliberate self-harm, AOD = alcohol and other drugs, ASD = Autism Spectrum Disorder, ODD = Oppositional Defiant Disorder.

CAF unique patients by month – all ages

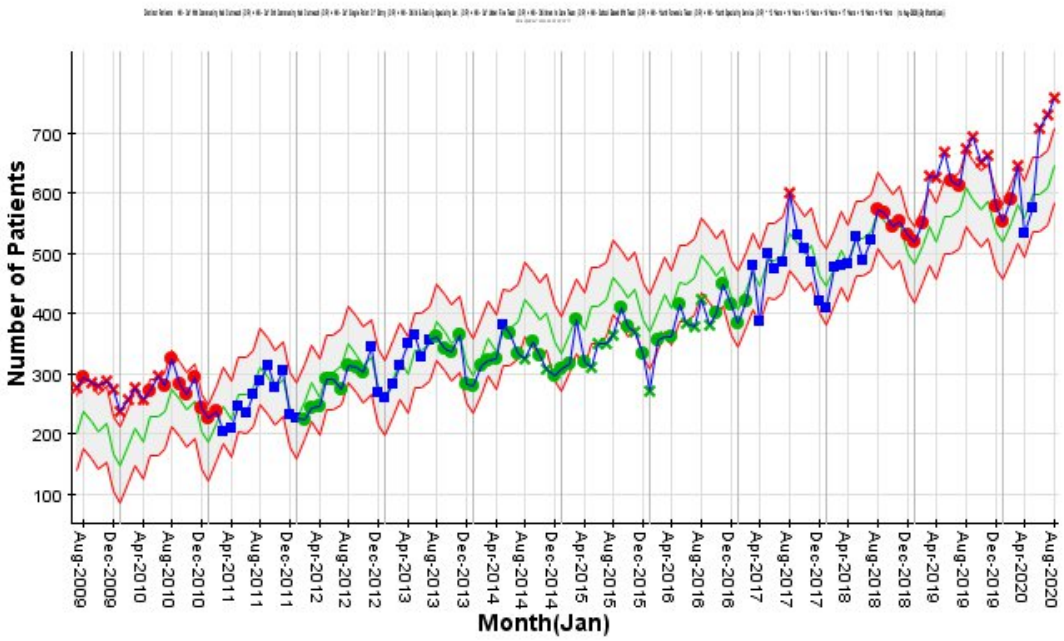


There were 1259 unique CAF consumers with at least one contact during the month of August 2020 and 1189 in September 2020. There has been an increase in the number of teenagers coming into contact with our service since the March 2020 Covid 19 lockdown with extraordinarily high volumes over the last three months (especially among those over 13 years of age).

CAF unique patients by month 12 years and under.



CAF Unique patients by month 13 years and over

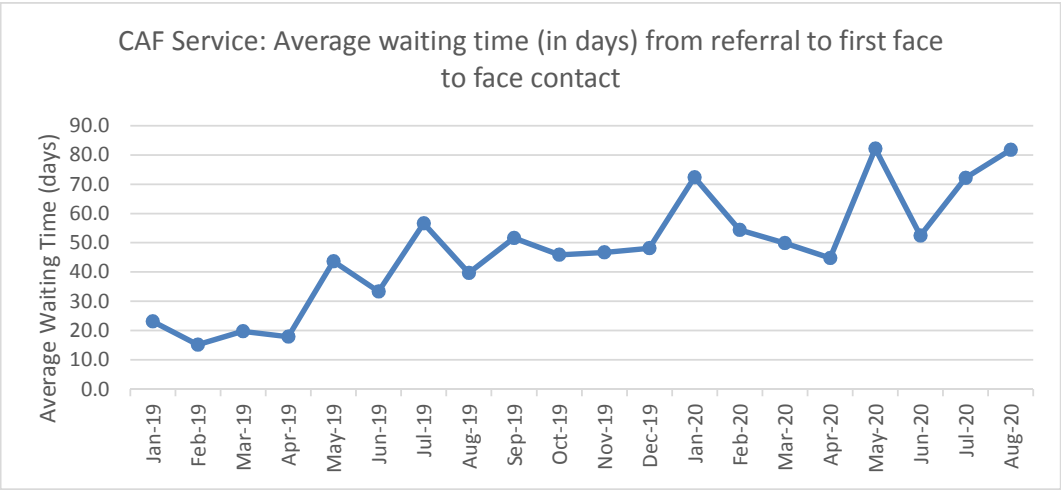


CAF Service average waiting times from referral

The CAF Service used to routinely conduct face to face Choice (triage) appointments within 21 days of referral. In response to feedback from families and primary care, the service changed to undertaking comprehensive triage over the phone, in the first quarter of 2019. Comprehensive triage involves calls with families, the consumer, primary care and other agencies.

This has meant the waiting time to first contact has reduced significantly, but the waiting time to first face to face contact has increased (as there is usually no longer a face to face Choice appointment).

The waiting time to first face-to-face contact and engagement in treatment shown in the graph below remains a focus of activity with the challenge of growing demand (71 days in July 2020 and 82 days in August 2020).



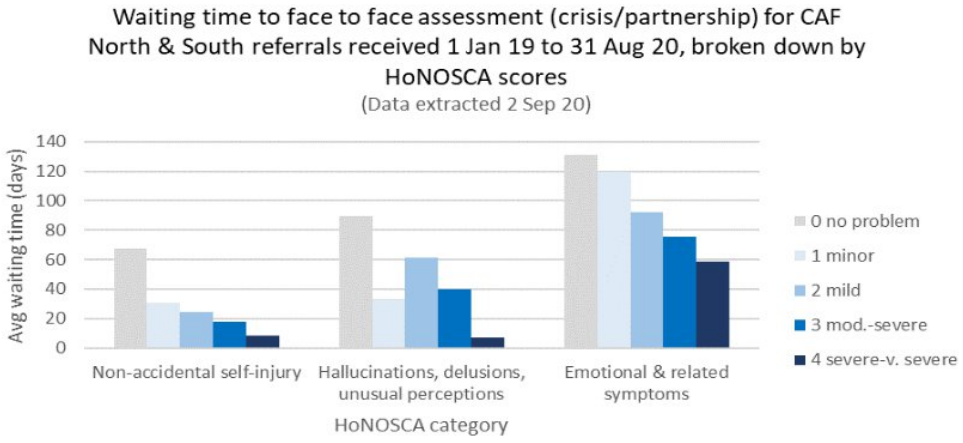
Addressing risks of waiting for care

While CAF services have made changes to prioritise and address the increased volume of referrals, some young people may be waiting longer than desirable for care. The following sections provide analyses of who is waiting and the risks associated with waiting. While there is more work to do, the teams are predominantly seeing those of highest acuity most quickly and those in crisis within a day.

Average waiting time by HoNOSCA scores

CAF Services prioritise children and adolescents most in need of treatment. The graph shows that those with the most severe mental health symptoms have a shorter average waiting time to face to face assessment, than those with no problem or minor symptoms. Children and adolescents who present following suicide attempts or non-accidental self-injuries are high priority for being seen face to face quickly.

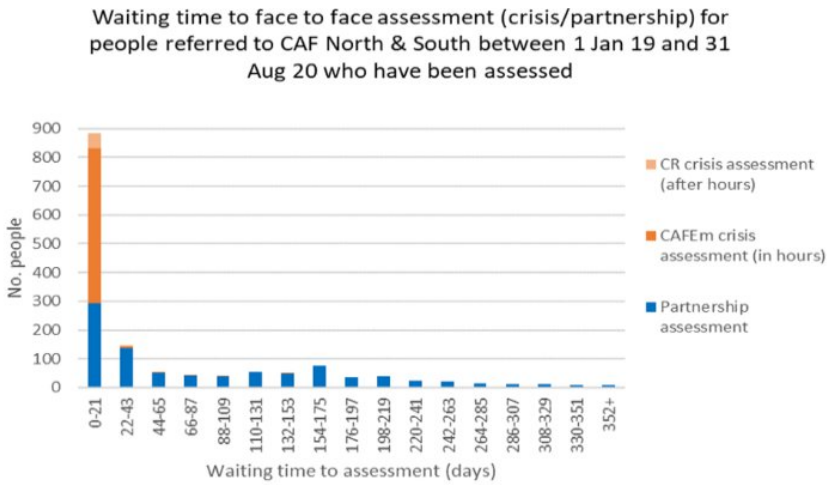
The graph below utilises Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) scores. The darker the coloured band, the more severe the symptoms.



Note: small numbers for hallucinations, delusions & unusual perceptions may create greater variability in the data.

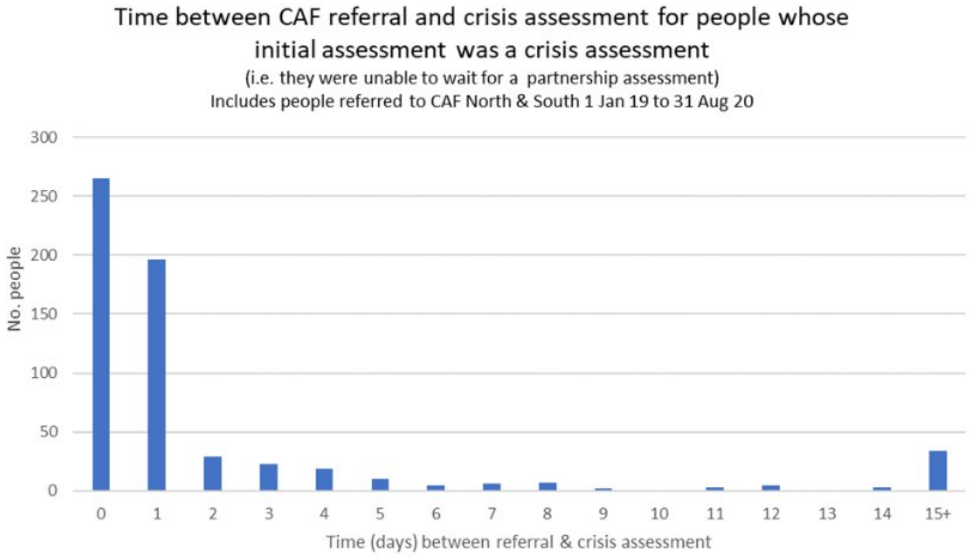
Distribution of waiting time

The figure below shows the distribution of waiting time to first face to face assessment (either crisis or partnership assessment). Of note, people scheduled for a non-urgent partnership assessment will have already had a comprehensive triage.



CAF referral and crisis assessment

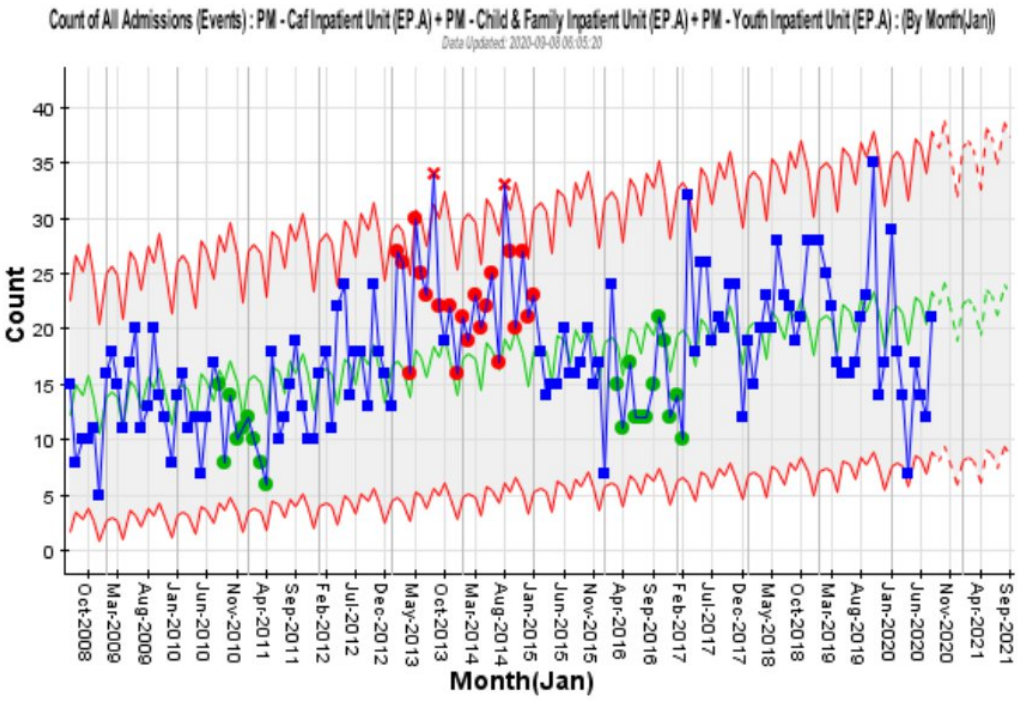
The graph below shows that people in need of a crisis assessment are typically being identified at the time of referral and assessed soon after – commonly within 0-1 days. In the 20-month period from 1 January 2019 to 31 August 2020 only 34 people deteriorated and required a crisis assessment while waiting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



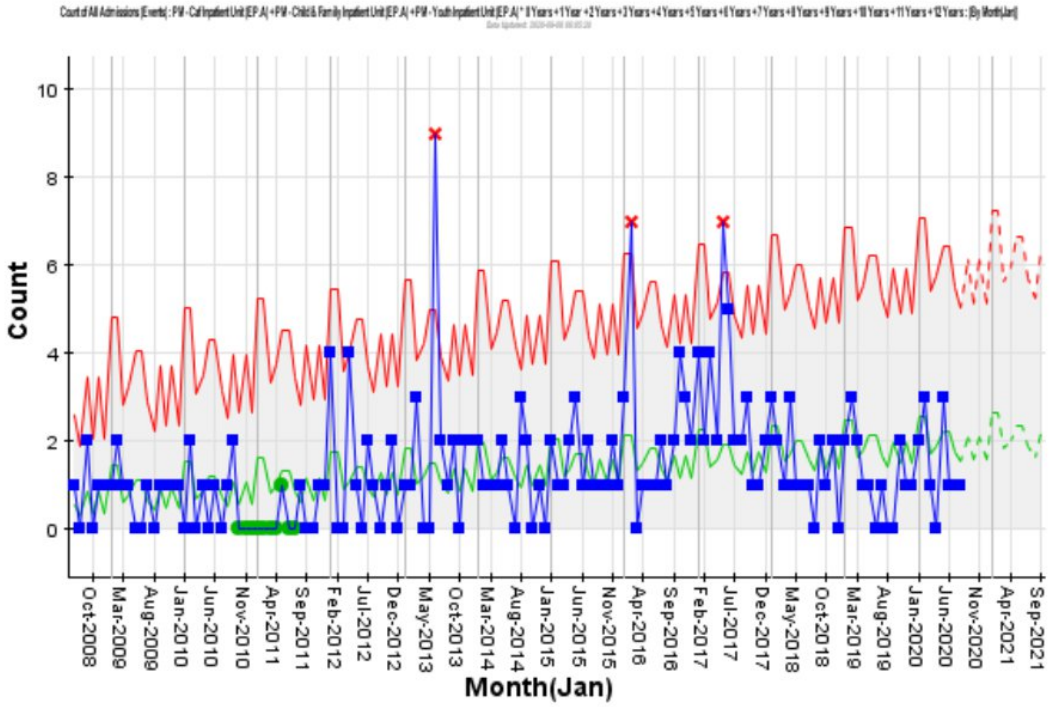
Admissions to the Child and Adolescent Unit

The number of admissions to the Child and Adolescent Unit and its predecessors, has shown a steady increase over time, particularly for adolescents. However, this trend has been interrupted by a Covid 19 related drop in April-May with numbers now returning to a more typical pattern.

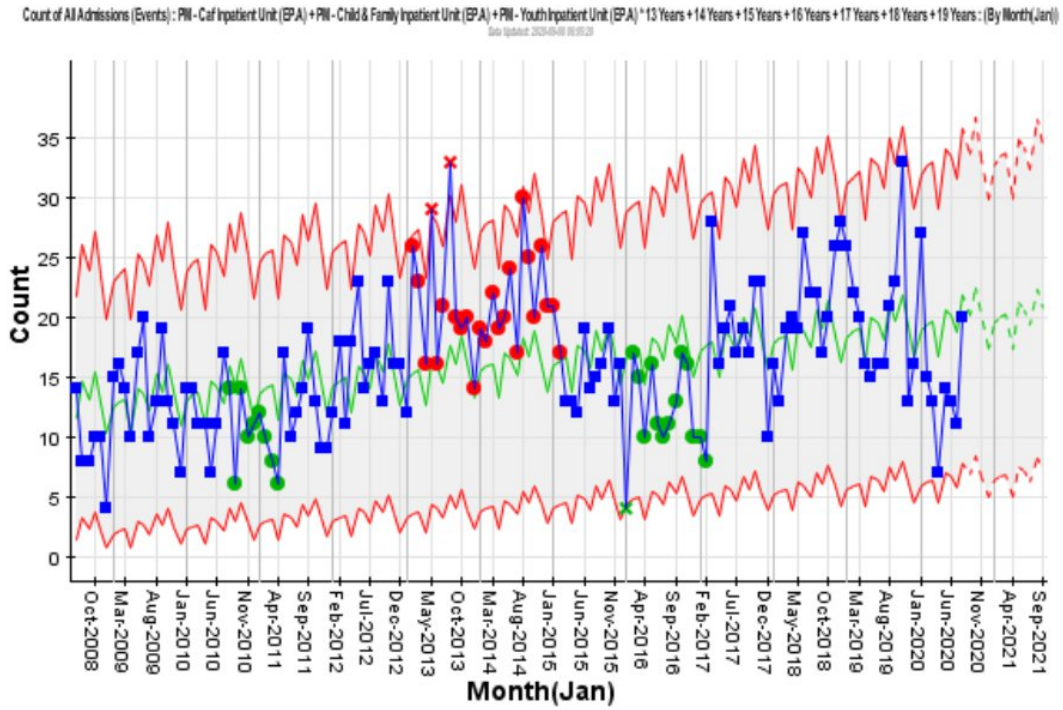
All admissions by month



All admissions by month 12 years and under



All admissions by month 13 years and over



Living within our means

Living within our Means, including No Wasted Resource

Financial Performance

Canterbury District Health Board

Statement of Financial Performance

Hospital & Specialist Service Statement of Comprehensive Revenue and Expense
For the 2 Months Ended 31 August 2020

MONTH $'000					YEAR TO DATE			
20/21 Actual $'000	20/21 Budget $'000	19/20 Actual $'000	20/21 vs 19/20 Variance $'000		20/21 Actual $'000	20/21 Budget $'000	19/20 Actual $'000	20/21 vs 19/20 Variance $'000
				Operating Revenue				
268	268	498	(230)	From Funder Arm	536	537	1,027	(491)
1,658	1,541	1,687	(29)	MOH Revenue	3,296	3,082	3,876	(580)
4,722	4,397	4,591	131	Patient Related Revenue	9,577	8,724	9,156	421
4,100	1,702	1,728	2,372	Other Revenue	6,237	3,412	3,799	2,438
10,748	7,908	8,504	2,244	**TOTAL OPERATING REVENUE**	19,646	15,755	17,858	1,788
				Operating Expenditure				
				Personnel Costs				
67,660	65,478	63,621	(4,039)	Personnel Costs - CDHB Staff	135,789	134,670	127,460	(8,329)
2,105	1,983	2,345	240	Personnel Costs - Bureau & Contractors	4,602	4,024	4,653	51
69,765	67,461	65,966	(3,799)	**Total Personnel Costs**	140,391	138,694	132,113	(8,278)
13,755	13,708	11,914	(1,841)	Treatment Related Costs	27,075	27,669	25,912	(1,163)
4,196	4,007	4,116	(80)	Non Treatment Related Costs	8,536	8,023	8,218	(318)
87,716	85,176	81,996	(5,720)	**TOTAL OPERATING EXPENDITURE**	176,002	174,386	166,243	(9,759)
(76,968)	**(77,268)**	**(73,492)**	**(3,476)**	**OPERATING RESULTS BEFORE INTEREST AND DEPRECIATION**	**(156,356)**	**(158,631)**	**(148,385)**	**(7,971)**
				Indirect Income				
-	1	(1)	1	Donations & Trust Funds	-	3	(1)	1
-	**1**	**(1)**	**1**	**TOTAL INDIRECT INCOME**	**-**	**3**	**(1)**	**1**
				Indirect Expenses				
2,626	2,494	2,551	(75)	Depreciation	5,412	5,005	5,110	(302)
2	-	-	(2)	Loss on Disposal of Assets	2	-	5	3
2,628	**2,494**	**2,551**	**(77)**	**TOTAL INDIRECT EXPENSES**	**5,414**	**5,005**	**5,115**	**(299)**
(79,596)	**(79,761)**	**(76,044)**	**(3,552)**	**TOTAL SURPLUS / (DEFICIT)**	**(161,770)**	**(163,633)**	**(153,501)**	**(8,269)**

Achievements/Issues of Note

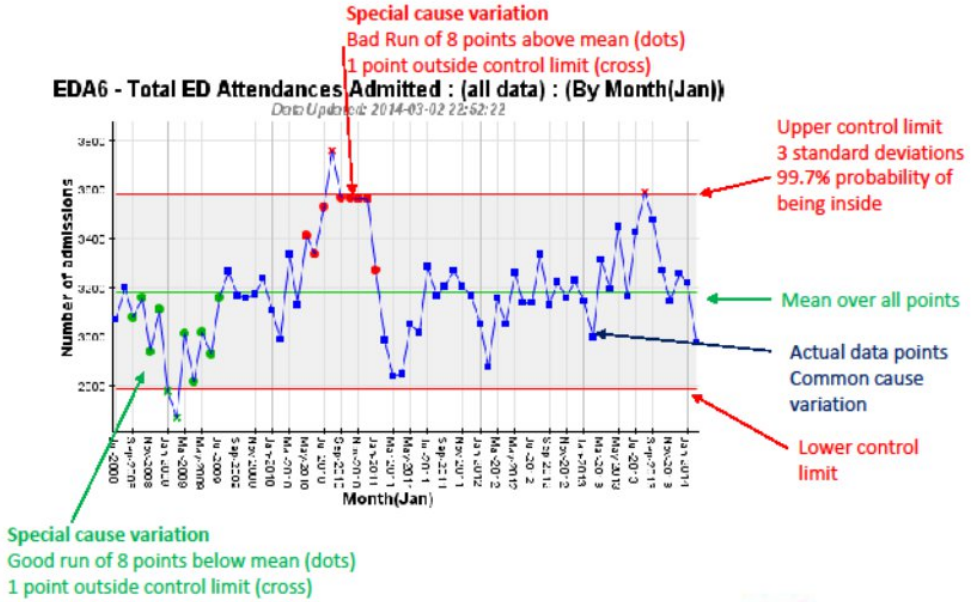
Diathermy system change

- Diathermy systems are used in theatre to seal the cut ends of blood vessels and preventing bleeding. Consumables for the brand predominantly used in our theatres cost approximately $800 per pack. An alternative brand has been identified that is close to 40% of the cost and is suitable for some of surgery carried out at Christchurch Hospital.
- Cardiothoracic surgery is changing to the new system – this will reduce a previous $54k spend to $20k per year.
- The system is also being partially rolled out or trialed in other services and further cost savings will be made.

Improved roster for Plastic Surgery Registrars

- There has been a longstanding issue with the Plastic Surgery roster for Registrars.
- Recent work between Registrars, the Resident Doctor Support Team and service leadership has resulted in a roster that creates benefits for all involved.
- Unions (both SToNZ and NZRDA) have been involved in the process since its outset and compliance with both MECAs has been achieved.
- The change addresses a long-standing non-compliant roster, mitigating the fatigue aspect previously there and all within a sustainable financial outcome.
- Fatigue risks associated with being on duty all day and then being called out multiple times overnight have been mitigated.
- Registrars being onsite overnight and on weekend days will be better for patient care.
- The roster will be more consistent with Plastics Registrars' rosters elsewhere in NZ ensuring this does not act as a barrier to recruitment of high-quality trainees.

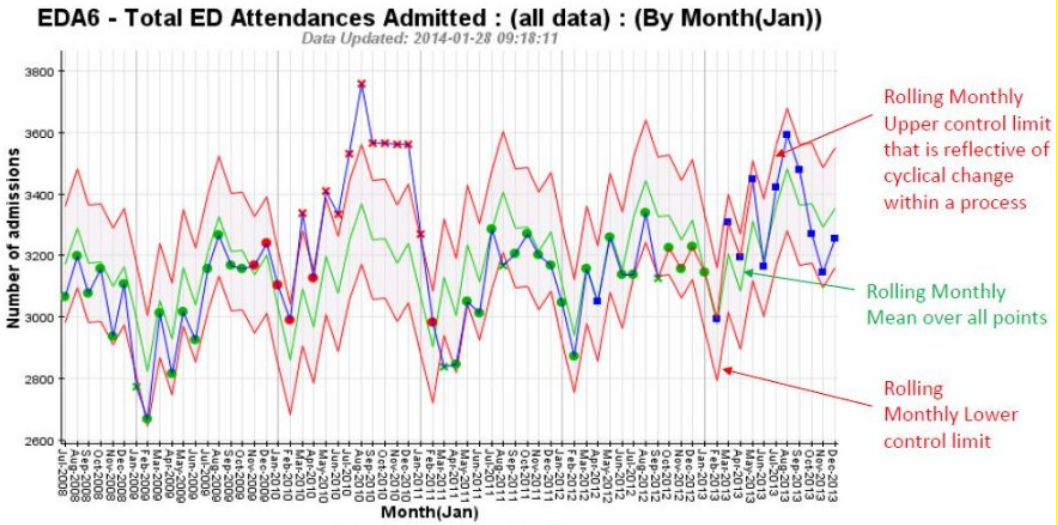
SPC: How to Interpret a Control Chart



sfn signals from noise

make it better

SPC: How to Interpret Cyclical and Trended Data



Criteria for a Cyclical Process:

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

sfn signals from noise

make it better

CLINICAL ADVISOR UPDATE – ALLIED HEALTH

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NOTES ONLY PAGE

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

DATE: **1 October 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 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.

3. SUMMARY

The Act, Schedule 3, Clause 32 provides:

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

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

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

Clause 33 of the Act also further provides:

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

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

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

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

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

	S/S	Mon	Tues	Wed	Thu	Fri	S/S	Mon	Tues	Wed	Thu	Fri	S/S	Mon	Tues	Wed
January 2021						NEW YEARS DAY 1	2/3	PUBLIC HOLIDAY 4	5	6	7	8	9/10	11	12	13
February		1	2	3	4	5	6/7	WAITANGI DAY OBSERVED 8	9	10	11	12	13/14	15	16	17
March		1	QFARC 9AM 2	3	CPH&DSAC 1PM 4		6/7	8	9	10	11	12	13/14	15	16	17
April					HAC 9AM 1	GOOD FRIDAY 2	3/4	EASTER MONDAY 5	6	7	8	9	10/11	12	13	14
May		31					1/2	QFARC 9AM 3	4	5	CPH&DSAC 1PM 6	7	8/9	10	11	12
June			QFARC 9AM 1	2	HAC 9AM 3	4	5/6	QUEEN'S BIRTHDAY 7	8	9	10	11	12/13	14	15	16
July					CPH&DSAC 1PM 1	2	3/4	5	6	7	8	9	10/11	12	13	14
August	1	2	QFARC 9AM 3	4	HAC 9AM 5	6	7/8	9	10	11	12	13	14/15	16	17	18
September				1	CPH&DSAC 1PM 2	3	4/5	6	7	8	9	10	11/12	13	14	15
October						1	2/3	4	QFARC 9AM 5	6	HAC 9AM 7	8	9/10	11	12	13
November		1	QFARC 9AM 2	3	CPH&DSAC 1PM 4	5	6/7	8	9	10	11	CANTERBURY ANNIVERSARY DAY 12	13/14	15	16	17
December				1	HAC 9AM 2	3	4/5	6	7	8	9	10	11/12	13	14	15

Thu	Fri	S/S	Mon	Tues	Wed	Thu	Fri	S/S	Mon	Tues	Wed	Thu	Fri	S/S	
14	15	16/17	18	19	20	21	22	23/24	25	QFARC 9AM 26	27	HAC 9AM 28	29	30/31	January 2021
CDHB BOARD 9.30AM 18	19	20/21	22	23	24	25	26	27/28							February
CDHB BOARD 9.30AM 18	19	20/21	22	23	24	25	26	27/28	29	QFARC 9AM 30	31				March
CDHB BOARD 9.30AM 15	16	17/18	19	20	21	22	23	24/25	ANZAC DAY OBSERVED 26	27	28	29	30		April
13	14	15/16	17	18	19	CDHB BOARD 9.30AM 20	21	22/23	24	25	26	27	28	29/30	May
CDHB BOARD 9.30AM 17	18	19/20	21	22	23	24	25	26/27	28	QFARC 9AM 29	30				June
CDHB BOARD 9.30AM 15	16	17/18	19	20	21	22	23	24/25	26	27	28	29	30	31	July
CDHB BOARD 9.30AM 19	20	21/22	23	24	25	26	27	28/29	30	QFARC 9AM 31					August
CDHB BOARD 9.30AM 16	17	18/19	20	21	22	23	24	25/26	27	28	29	30			September
14	15	16/17	18	19	20	CDHB BOARD 9.30AM 21	22	23/24	LABOUR DAY 25	26	27	28	29	30/31	October
CDHB BOARD 9.30AM 18	19	20/21	22	23	24	25	26	27/28	29	QFARC 9AM 30					November
CDHB BOARD 9.30AM 16	17	18/19	20	21	22	23	24	25/26	CHRISTMAS DAY OBSERVED 27	BOXING DAY OBSERVED 28	29	30	31		December

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	Clinical Advisor Update – Medical Care Capacity Demand Management Update
Presentations	Department of Anaesthesia		Elective Surgery Recovery Plan			
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)