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, 29 November 2018 commencing at 9:00am

	Apologies		9.00am
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 4 October 2018		
3.	Carried Forward / Action List Items		
4.	Hospital Service Monitoring Report		9.05-10.00am
5.	Planning & Funding Electives Plan 2018/19	Ralph La Salle	10.00-10.15am
6.	2018 Winter Planning Review	Dan Coward	10.15-10.25am
7.	Clinical Advisor Update – Medical – Oral	Sue Nightingale	10.25-10.35am
8.	Draft 2019 Workplan	Anna Craw	10.35-10.40am
9.	Resolution to Exclude the Public		10.40am
ESTIMATED FINISH TIME – PUBLIC MEETING			**10.40am**
	Information Items Quality & Patient Safety Indicators – Level of Complaints 2018 Workplan		

NEXT MEETING: Thursday, 31 January 2019 at 9.00am

ATTENDANCE LIST - PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE MEMBERS

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

Executive Support

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

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

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

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

	CRL Energy Limited – Managing Director CRL Energy Limited provides air quality testing and asbestos sampling and analysis services; methamphetamine contamination testing; dust; gas and noise workplace monitoring services in New Zealand. There is the potential for future work with the CDHB. **Farrell Construction Limited** - Chairman Farrell's Construction Limited is a commercial and light commercial construction company based in Christchurch. **New Zealand Flying Doctor Service Trust** – Chairman 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 Property Limited** – Chairman Potential for future property development work with the CDHB. Also, Ngai Tahu Property Limited manage first right of refusal applications from the CDHB on behalf of Te Runanga o Ngai Tahu.
Sally Buck Board Member	**Christchurch City Council (*CCC*)** – Community Board Member Chair of the Central/Linwood/Heathcote Community Board which has delegated responsibilities from the CCC. **Registered Resource Management Act Commissioner** From time to time, sit on Resource Management Act panels for the CCC. Specific interests will be declared at the time. **Rose Historic Chapel Trust** – Member Charitable voluntary body managing the operation of the Rose Historic Chapel, a CCC owned facility.
Dr Anna Crighton Board Member	**Christchurch Heritage Limited** - Chair - Governance of Christchurch Heritage **Christchurch Heritage Trust** – Chair - Governance of Christchurch Heritage **Heritage New Zealand –** Honorary Life Member CDHB owns buildings that may be considered to have historical significance.
Jan Edwards	No conflicts at this time.
David Morrell Board Member	**British Honorary Consul** Interest relates to supporting British nationals and relatives who may be hospitalised arising from injury related accidents, or use other services of CDHB, including Mental Health Services. A conflict of interest may also arise from time to time in respect to Coroners' inquest hearings involving British nationals. In addition, the British Foreign and Commonwealth Office (*FCO*) may expect Honorary Consuls to become involved in trade initiatives from time to time. **Canon Emeritus - Christchurch Cathedral** The Cathedral congregation runs a food programme in association with CDHB staff. **Friends of the Chapel** - Member **Great Christchurch Buildings Trust** – Trustee The Trust seeks the restoration of key Christchurch heritage buildings, particularly Christchurch Cathedral, and is also involved in facilitating the building of social

	housing. **Heritage NZ –** Subscribing Member Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the 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. **Hospital Lady Visitors Association** - Wife is a member of this, but no potential conflict of interest is expected. Should one arise it will be declared at the time. **Nurses Memorial Chapel Trust** – Member (CDHB Appointee) Trust responsible for Memorial Chapel on the Christchurch Hospital site. Note the chapel is now owned by the Christchurch City Council.
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.
Trevor Read	**Lightfoot Solutions Ltd** – Global Director of Clinical Services Lightfoot Solutions has contracts with CDHB, and other health providers who have contracts with CDHB, to provide business intelligence tools and related consulting services. Should a conflict arise, this will be discussed at the time.
Ana Rolleston	**Christchurch PHO** – Board Member The Christchurch PHO is mostly funded by either the Ministry of Health and/or the CDHB. The Christchurch PHO supports General Practitioners delivering primary health care in Christchurch. **Manawhenua ki Waitaha** – Trustee Representative of Wairewa Rūnanga. Manawhenua ki Waitaha is a collective of health representatives of the seven Ngāi Tahu Papatipu Rūnanga that are in the CDHB area. There is a Memorandum of Understanding between Manawhenua ki Waitaha and CDHB. **Māori Women's Welfare League** – Member The Māori Women's Welfare League has contracts through the Ministry of Health for the delivery of health services for Māori.

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

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

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

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

MINUTES – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE HOSPITAL ADVISORY COMMITTEE MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch,
on Thursday, 4 October 2018, commencing at 9.00am

PRESENT

Andrew Dickerson (Chair); Jo Kane (Deputy Chair); Barry Bragg; Dr Anna Crighton; Jan Edwards; David Morrell; Dr Rochelle Phipps; and Ta Mark Solomon.

APOLOGIES

Apologies for absence were received and accepted from Trevor Read and Dr John Wood.
Apologies for lateness were received and accepted from Sally Buck (9.30am).

EXECUTIVE SUPPORT

Mary Gordon (Executive Director of Nursing); Helen Little (Interim Executive Director of Allied Health, Scientific & Technical); Dr Sue Nightingale (Chief Medical Officer); Charlotte Evers (Assistant Board Secretariat); and Kay Jenkins (Executive Assistant, Governance Support).

IN ATTENDANCE

Item 4

Dr Rebecca Stack, Clinical Director, CDHB Eye Service
Alison Watkins, Service Manager, Ophthalmology
Ralph La Salle, Team Leader, Secondary Care, Planning & Funding
Boyd Cornere, Information Analyst, Decision Support
Helen Solomons, Administrator, CDHB Eye Service
Sharen Paine, Project Manager/Facilitator, Ophthalmology Project, Canterbury Initiative

Item 5

Dr Scott Wilson, Rural Hospital Medical Specialist
Jane Harnett, Acting Director of Nursing
Janette Balfe, Clinical Manager Allied Health
Bernice Marra, Manager, Ashburton Health Services

Item 7

Bernice Marra
Sally Nicholas – Operations Manager, Burwood Hospital
Barbara Wilson – Quality Manager, Specialist Mental Health Services (*SMHS*)
Dr Peri Renison – Chief of Psychiatry, SMHS
Pauline Clark – General Manager, Medical/Surgical and Women's & Children's Health

Andrew Dickerson, Chair, extended a welcome to Helen Little, attending her first meeting.

1. INTEREST REGISTER

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

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

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

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (16/18)
(Moved: Dr Anna Crighton/Seconded: Dr Rochelle Phipps – carried)

"That the minutes of the meeting of the Hospital Advisory Committee held on 2 August 2018 be confirmed as a true and correct record."

3. CARRIED FORWARD/ACTION ITEMS

The Committee noted the carried forward items.

Progress on access to the SLM data viewer was queried. This will be followed up.

4. OPHTHALMOLOGY DEPARTMENT - PRESENTATION

Dr Rebecca Stack, Clinical Director, CDHB Eye Service, presented information on the Ophthalmology's overdue follow-up project. Also in attendance were Alison Watkins, Service Manager, Ophthalmology; Ralph La Salle, Team Leader, Secondary Care, Planning & Funding; Boyd Cornere, Information Analyst, Decision Support; Helen Solomons, Administrator, CDHB Eye Service; and Sharen Paine, Project Manager/Facilitator, Ophthalmology Project, Canterbury Initiative.

The presentation provided an overview of the project, which focused on reducing overdue glaucoma follow-ups, developing and implementing a new model of care and establishing systems and processes to improve demand and capacity mismatch.

Ta Mark Solomon arrived at 9.21am.

A Committee member queried triage criteria for new patients and how this impacts access for existing patients. The criteria was set at the beginning of the project, and is available to clinicians on HealthPathways. Dr Stack emphasised the responsibility to current patients.

There was discussion around how the overdue project arose. Due to advances in treatment of macular degeneration, this creates lifelong treatment pathways, thereby increasing patient load. Lacking department processes, as well as isolation from the main hospital, were also found to have had an impact.

Discussion was held around how data can be extrapolated to show future trends and success rates. The data is provided to the eye team weekly, and shows capacity, demand and space. The main aim for this project was to manage and reduce overdue patients, and ongoing data shows confidence and success in this area. The data will continue to be monitored in order to plan for future staffing and technology availability.

A Committee member queried the involvement of community GP practices and optometrists. Dr Stack commented most of the department's referrals come from private optometry practice (around 60%), with the remaining coming from GPs.

There was discussion around cataract surgery and whether this is represented in the data. Due to the surgical nature of cataract operations, and the fact they don't require any follow-up treatment, these are not represented in these figures. The department is ESPI compliant for surgery.

The Chair commended the team on their work and thanked them for the presentation.

5. ASHBURTON HEALTH SERVICES – PRESENTATION

Bernice Marra, Manager, Ashburton Health Services; Dr Scott Wilson, Rural Hospital Medical Specialist; Jane Harnett, Acting Director of Nursing; and Janette Balfe, Clinical Manager, Allied Health, presented an update on Ashburton Health Services.

The presentation covered the service's current challenges, opportunities and model of care, focusing on increasing Acute Assessment Unit admissions, an ageing population, isolated populations and developing the nursing and allied health workforces to meet future demand.

The Chair acknowledged a dramatic change in the service in the last five years, with a clear direction and clarity for the future.

A Committee member requested follow-up figures on the capacity of the hospital.

There was discussion around the approach to the challenges faced in the district nursing workforce. Ms Marra commented work is ongoing in this area.

There was a query around GP coverage during the weekend. There are three hour GP clinics run on both weekend days, on a roster system. Not all practices are involved. The service is currently working with GPs to meet demand. The Hurunui Model of Care was acknowledged as a good base for the Ashburton area, and there is opportunity here.

There was further discussion around whether GPs are happy. There is high engagement, but opportunities exist for better conversations and having a consistent approach.

The Chair thanked the team for their presentation.

6. CLINICAL ADVISOR UPDATES

Nursing

Mary Gordon, Executive Director of Nursing, provided an update as follows:

- There has been a follow-on effect from the nurses MECA in other areas of the health system, particularly in aged residential care. The DHB is working with providers and internally.
- Canterbury's competency assessment programme figures are climbing, while the rest of New Zealand is plateauing.
- Ara has reported a 60% increase in their nursing intake, closing the January intake for this programme. A post-graduate nursing student has been studying why Ara is seen as such a good provider, with the preliminary results showing that the programme has a good reputation, sets a high standard and their partnership with the CDHB for clinical practicums is a major drawcard. Ms Gordon is looking at how to capture graduates before

they finish their placements and stream them into the DHB, specifically into aged residential care.

- The NZNO accord has been signed to provide immediate nursing relief, with registered nurses, midwives and health care assistants being provided locally. The final decision will be made in Wellington, after practical and collaborative meetings with the NZNO and the union.
- Work has been ongoing in care capacity demand management. An initial meeting has been held between NZNO and a former CDHB employee, who gave their assessment of the four care standards.
- Two new nurse practitioners have been appointed – one in Cardiology and one in Sleep Studies.
- CDHB, Ara, University of Canterbury and University of Otago have developed an alliance in nursing research programmes.
- The move into Manawa has gone well, with staff and students settling into their new environment. The governance structure is underway.
- The Calderdale framework has its first two nurses training as facilitators.
- Ms Gordon recognised the passing of two longstanding nursing leaders – Jane Brosnahan and Craig Cowie.

Allied Health

Helen Little, Interim Executive Director of Allied Health, Scientific & Technical, provided an update as follows:

- The new Executive Director of Allied Health, Jacqui Lunday-Johnstone, commences 5 November.
- The new Director of Allied Health, Older Persons Health & Rehabilitation, Claire Pennington, commenced 18 July following Wendy Fulton's retirement.
- The new Clinical Manger of Social Work, Christchurch Campus, Dr Catherine Hughes, commences 19 November.
- Social workers start new ED overnight (2130-0800, seven days/week) shifts 7 October.
- Physiotherapy primary contact role starts in ED 0930-2000 seven days/week commencing 15 October.
- Single Point of Referral for physiotherapy aims to go live late October/early November, with the aim to keep GP and ACC referrals out of the acute hospital setting.
- AlliedHealthways has been live for one year, with 16 live pathways and resources; most recently chronic pain, falls prevention and glaucoma. A further 15 pathways to go live this month including the shoulder/musculoskeletal area.
- Falls prevention programme at Burwood – safe recovery physio and nurse-led.
- Developed a career framework aligned with South Island regions, providing a structure for other clinical roles.
- Calderdale Framework cohort 4 training in November and extending into nursing.
- South Island Alliance Leadership Team considering a proposal for a regional ketogenic diet therapy service run out of the CDHB.
- Health workforce development fund for new initiatives – CDHB is putting forward two proposals for regional roles, i.e. complex wheelchair and seating and SLT paediatric dysphagia.
- Cortex E-notes development is in the next phase for initial assessments.
- Allied Health input into discharge summaries will go live in December.
- PSA bargaining is ongoing – Allied Health Science & Technology and MRT.
- Leadership proposals – Specialist Mental Health Services and WCDHB. Anaesthetic technicians and pharmacy to follow shortly.
- There are ongoing workforce projects, including Career and Salary Progression (*CASP*), top of scope, physiotherapy review and designated roles.

- Planning for new facilities – Outpatients and Hagley Hospital.

A Committee member queried how the social worker in ED placement will work. Ms Little confirmed there are three CDHB social workers rostered on.

There was discussion around the connection between community GP care and social workers. An Allied Health workshop covering this will be held early in 2019.

7. H&SS MONITORING REPORT

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

General Managers spoke to their areas as follows:

Ashburton Health Services – Bernice Marra, Manager Ashburton Health Services
The report was taken as read. There was no discussion.

Rural Health Services – Mary Gordon (for Win McDonald, Transition Programme Manager, Rural Health Services)

- Kaikoura Hospital's use of SI PICS will be wound back, due to it being a GP-led practice. They will move to MedTech.

Older Persons, Orthopaedics & Rehabilitation Service – Sally Nicholas, Operations Manager (for Dan Coward, General Manager)
The report was taken as read.

There was discussion around growing demand for the service and what work is being done to accommodate this. Dr Greg Hamilton, Team Leader, Intelligence & Transformation, Planning & Funding, confirmed that while demographics are changing, the demand has not grown. Ongoing work is being done on systems.

The Chair queried the recent decanting of the Spinal Unit and refurbishments at Burwood Hospital. Ms Nicholas confirmed there is a significant amount of earthquake repairs still to be undertaken, with work continuing for around 18 months.

Specialist Mental Health Services (*SMHS*) – Barbara Wilson, Quality Manager, SMHS; and Dr Peri Renison, Chief of Psychiatry (for Toni Gutschlag, General Manager)
The report was taken as read.

The Committee discussed the recent issues with synthetic cannabis and the impacts this has on SMHS. Ms Renison confirmed this is an issue across all areas of SMHS, having a flow-on effect to addiction services and the Child and Family Unit. Discussion took place around the lack of Customs at the Port of Timaru.

The status of the SMHS DBC was raised. A new resolution will be put to the October Board meeting, and will then go through the Capital Investment Committee in November.

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

- Ms Clark advised the Committee that the Christchurch Hospital campus is a busy place, with ongoing building work.
- The Outpatients building will be blessed on Friday morning, with the first wave of occupants moving in at the end of October.

- SI PICS will go live at 4am Saturday morning, with contingencies in place to manage the changeover.

There was a query around the ICU department and what is driving the busyness. There are several patients who have been in the ward for over 100 days; the effectiveness of "roadside to bedside" transitions is also a factor; as well as complex surgeries which require extra time in ICU.

ESPIs

- These remain red, driven by several complex issues including industrial negotiations.
- Some services will be compliant within six-eight weeks, but other services will remain red longer. It was important to note that most other DHBs are not compliant.

A Committee member queried what work is being done to lessen the impact when the ESPI dispensation ends. This is ongoing, with conversations held between Clinical Directors and Planning & Funding.

There was discussion around how patients are informed of their wait times. This is done by way of phone calls, letters and in-patient conversations.

There was further discussion around Customs at the Port of Timaru. The Chair undertook to raise this at the Board meeting.

Resolution (17/18)
(Moved: Jan Edwards/Seconded: Jo Kane – carried)

"That the Committee:

i. notes the Hospital Advisory Committee Activity Report."

8. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (18/18)
(Moved: Ta Mark Solomon/Seconded: David Morrell – carried)

"That the Committee:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of the minutes of the public excluded meeting of 2 August 2018.	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(If required)*	Protect information which is subject to an obligation of confidence.	s 9(2)(ba)(i) s 9(2)(j)

		To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege	s 9(2)(h)

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

INFORMATION ITEMS

- 2018 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 11.30am.

Confirmed as a true and correct record.

_____ _____

Andrew Dickerson Date
Chairperson

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE
CARRIED FORWARD ITEMS AS AT 29 NOVEMBER 2018

DATE		ISSUE / ACTION	REFERRED TO	STATUS
1.	02 Aug 2016	AT&R Unit Update	Toni Gutschlag	Verbal Update
2.	04 Oct 2018	SLM Data Viewer – provide access to committee members	Nicky Smithies	Verbal Update
3.	04 Oct 2018	Ashburton Health Services – provide capacity numbers of Ashburton Hospital	Bernice Marra	Today's Agenda – Item 4

H&SS MONITORING REPORT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

DATE: **29 November 2018**

Report Status – For:	Decision	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Committee:

i. notes the Hospital Advisory Committee Activity Report.

3. APPENDICES

Appendix 1: Hospital Advisory Committee Activity Report – October 2018

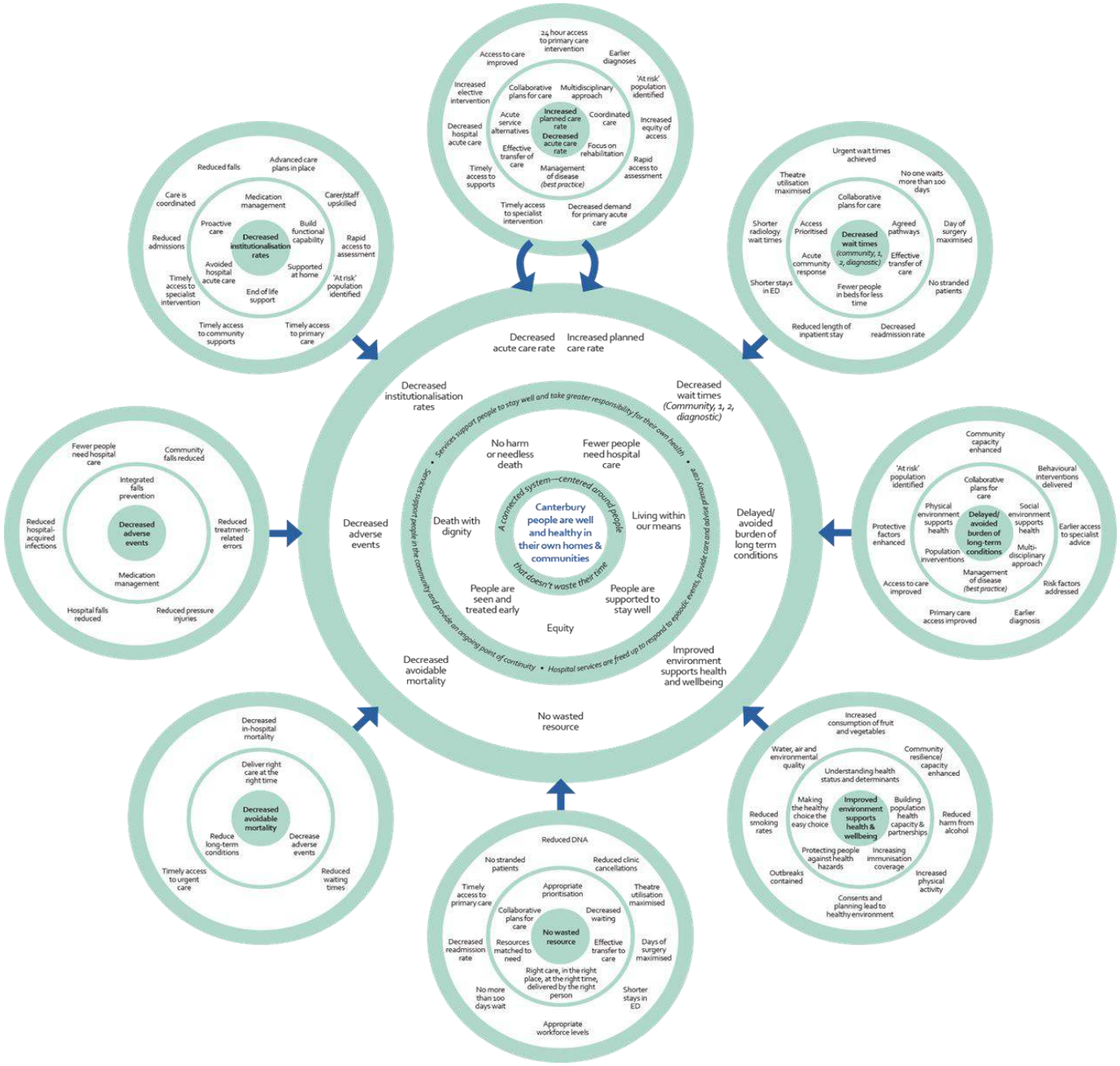
Report prepared by: General Managers, Hospital and Specialist Services

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

APPENDIX 1

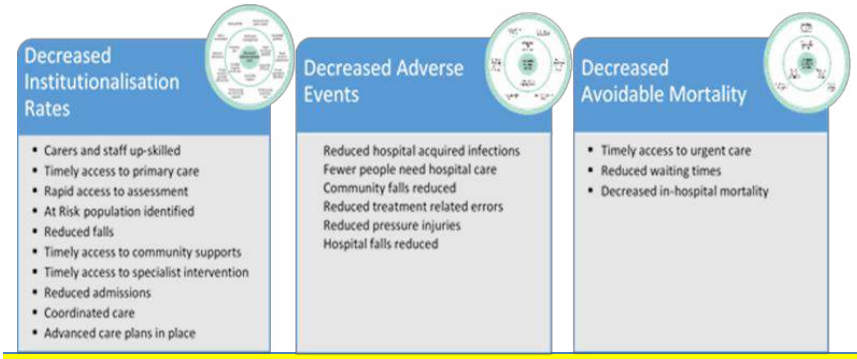
Hospital Advisory Committee

Activity Report



October 2018

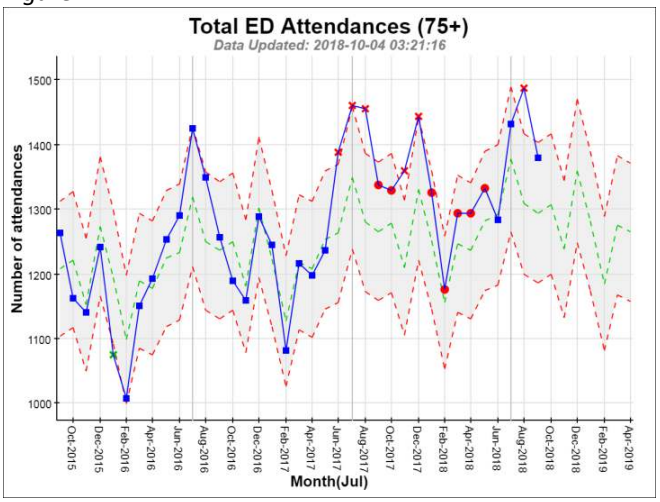
APPENDIX 1



Frail Older Persons' Pathway

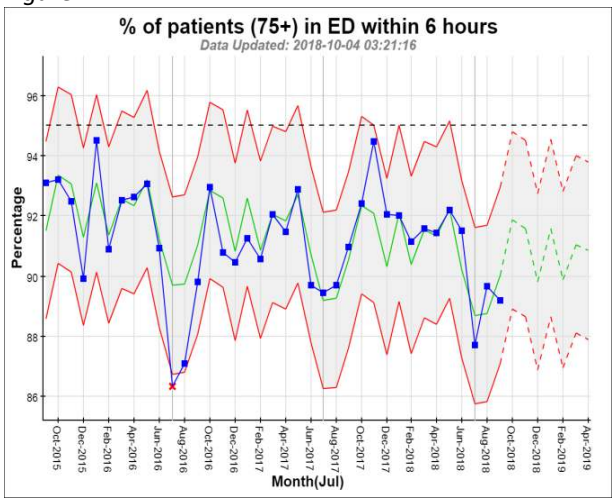
Outcome and Strategy Indicators

Figure 1.1



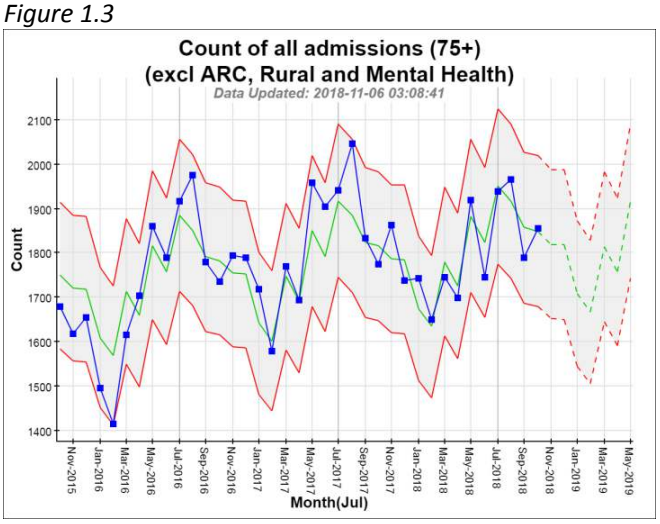
Total ED attendances of people over 75 has increased at a higher rate than the established trend. This increase is in line with that seen for the overall population.

Figure 1.2



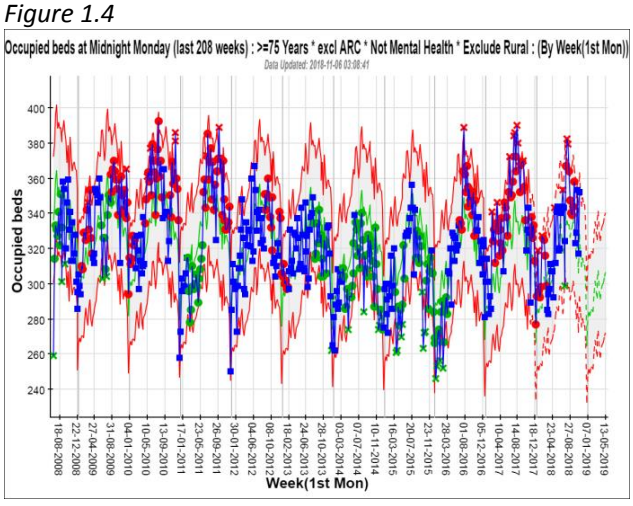
The proportion of patients 75+ leaving ED within the 6 hour target is tracking within the expected range despite the high ED attendance rate, but falls short of the 95% target.

Figure 1.3



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

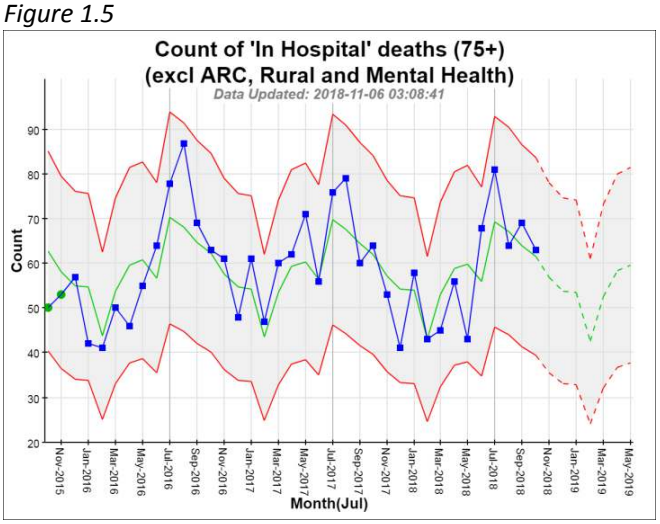
Figure 1.4



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

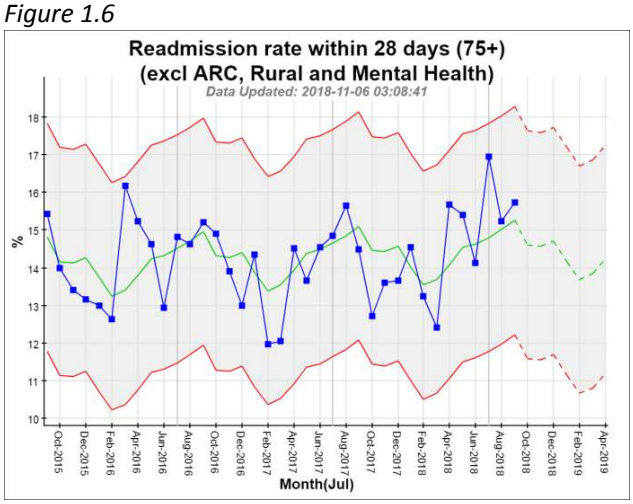
APPENDIX 1

Figure 1.5



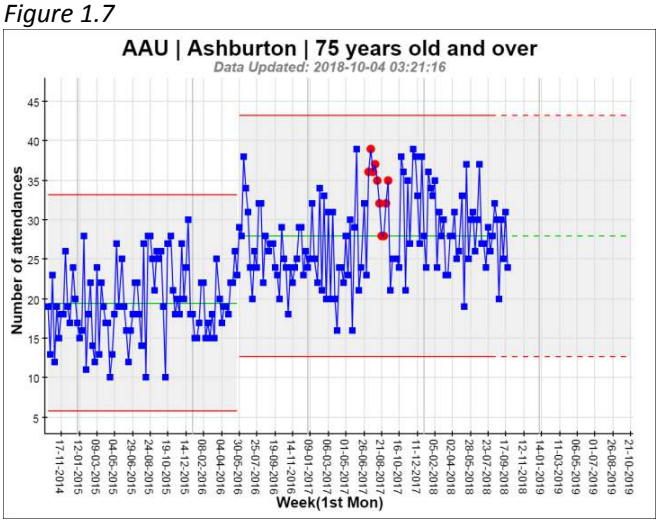
The number of in hospital deaths is within the expected range and continues the established trend of reducing rates of in hospital mortality.

Figure 1.6



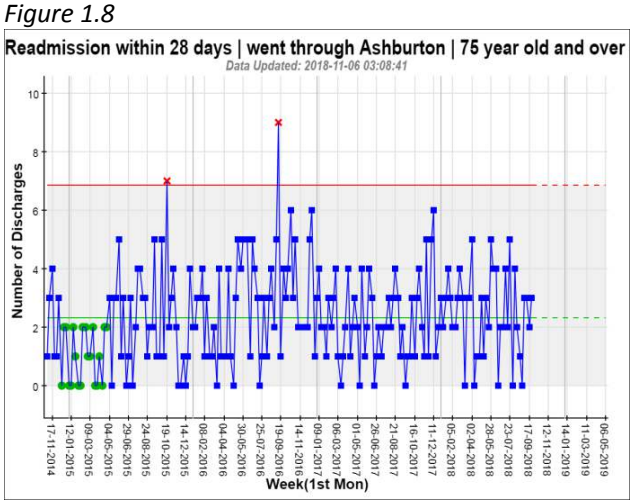
The readmission measure (balancing metric) for people aged 75 years and over continues to be within the expected range.

Figure 1.7



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

Figure 1.8



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

Achievements/Issues of Note

Community Nurses strengthen relationships with the cardiothoracic nurse team

Provision of specific, well planned post-discharge care to people who have had heart surgery is important to ensure that they are supported in the community to return to the best health possible following their surgery. Over the last twelve months a Clinical Nurse Specialist from Healthcare NZ and a Clinical Nurse Specialist from the Cardiothoracic service have been working collaboratively to improve patient outcomes, and reduce post-operative complications and readmissions into hospital.

During this time the two Clinical Nurse Specialists have:

- established monthly meetings with the team to provide education, and to review and discuss the complex cardiothoracic patients receive care from the two services
- visited St George's hospital to improve the discharge process and information provided
- provided Coagucheck training also so that the nurses could encourage the use of this testing technology and provide education in the community
- supported a Cardiothoracic Surgeon to meet the district nurses and provide a joint presentation with the Cardiothoracic Clinical Nurse Specialist at a practice nurse evening about cardiothoracic surgery. These in-service meetings improve knowledge around heart surgery, and develop better working relationships.

All cardiothoracic referrals are reviewed by the Healthcare NZ Clinical Nurse Specialist prior to admission into the community service to highlight any potential complications that may occur. Clinical issues are brought to the attention of the visiting nurse to ensure that this information is clearly understood. Healthcare NZ has also developed a small team of nurses who had an interest in this area to manage the complex patients that are referred, those nurses also do the initial complex admissions. Direct liaison occurs between the two Clinical Nurse Specialists when there are direct concerns or issues requiring review, to ensure that any potential issues are identified and the patient is referred to the appropriate place.

These changes have helped to reduce post-op complications in the community, and improve communication and ensure smooth communication between the two teams.

Family violence enquiry a part of routine practice

The Child and Family Safety Service, based at Christchurch Hospital, carries out a range of tasks to help ensure the health system plays its role towards ensuring the wellbeing of children and other family members in a systematic way.

There is a clear association between experiencing child abuse, neglect or family violence and other adverse experiences on people's requirements for a wide range of health services both immediately, and in the case of children for the remainder of their lives. Many of these increased health needs may at first view seem unrelated to the causative factors. So it is important that screening for family violence is one of the factors considered during the diagnosis of a wide range of health needs.

It is also known that such experiences are common in our community with evidence showing that as many as 30% of women experience physical or sexual violence at some point during their life, amongst some groups this is known to be as high as 50%.

On these bases health professionals are required by the Ministry of Health to screen all women sixteen years and older for indications of family violence. This is given especially high priority in Mental Health, Children's Health, Women's Health, Sexual Health and the Emergency Department. There is a clear expectation that all staff in these areas are trained to enquire about such indications and to provide care based on the answers. It is expected that a routine family violence enquiry occurs for at least 80% of patients.

The Child and Family Service supports these areas to provide this care by ensuring policies and procedures are in place, staff are educated and supported to carry out these enquiries and that regular audit occurs every three months. The service is planning to adopt a paperlite approach in this area that will make collection and analysis of this information easier.

Results of these audits show Sexual Health, Public Health Nurses and the Gynaecology Procedure service regularly ranking very highly. Ashburton Hospital has a consistent high level of completion of this audit across all of its services. Improvements are being seen across many of the audited areas and we are seeing this activity expanded throughout more of our clinical units.

Results are fed back and create some enthusiasm amongst staff members to continually improve the way that we systematically carry out these enquiries so that we have a clear understanding of a person's situation and can provide the best care possible.

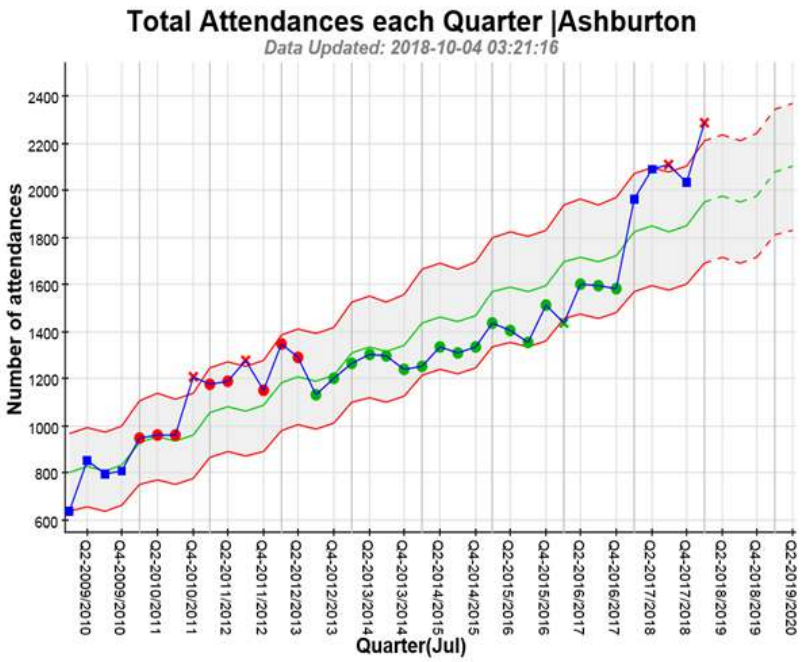
Trauma Nurse Coordinator awarded

The Trauma Nurse Coordinator working at Christchurch Hospital has been awarded a Canterbury Road Trauma Award for their work to improve co-ordination of care of Canterbury trauma patients suffering from multiple problems and being looked after by several different specialist teams. Their work supports improved communication between the various teams, resulting in more efficient care of patients. The passion to see each patient receive the care they deserve and to improve our systems is a key component in the development and day to day running of this service.

Recent developments in our trauma system have been shown to ensure that patients access the full range of care required in a more streamlined way, improving outcomes for these patients and their families. The time spent in hospital by people following a motor vehicle accident has reduced by a full day since the Trauma Nurse Coordinator role was put in place in 2016.

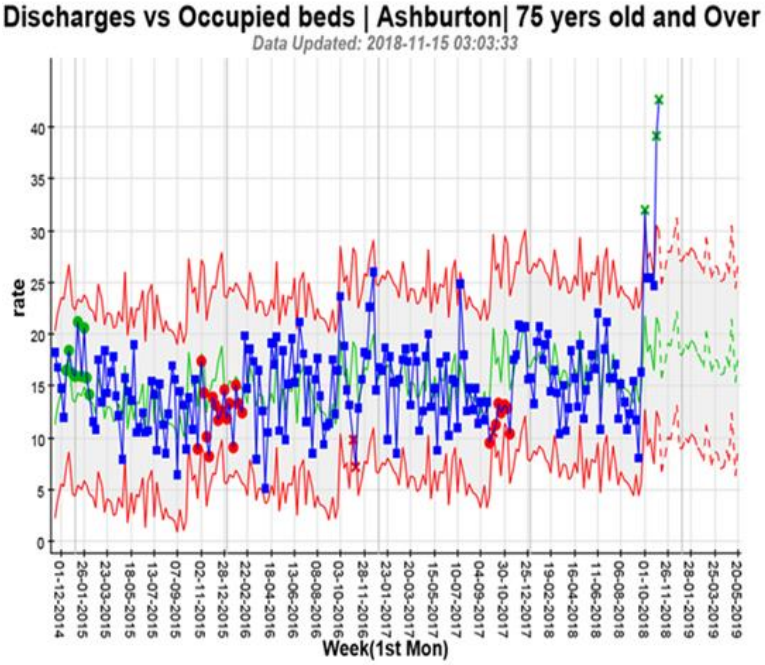
Ashburton Health Services

The trend in presentations continues for the Acute Assessment Unit, with a corresponding occupancy in the Acute Medical Ward (Ward 1). In response to the Hospital Advisory Committee's (HAC) request for further information on the ward occupancy, we are progressing appropriate SFN graphs to demonstrate trends in occupancy for both Ward 1 and Ward 2 (previously known as ward 6). In the interim the table below demonstrates the daily range of patient numbers in Ward 1 and daily patient flow in and out of the ward.



APPENDIX 1

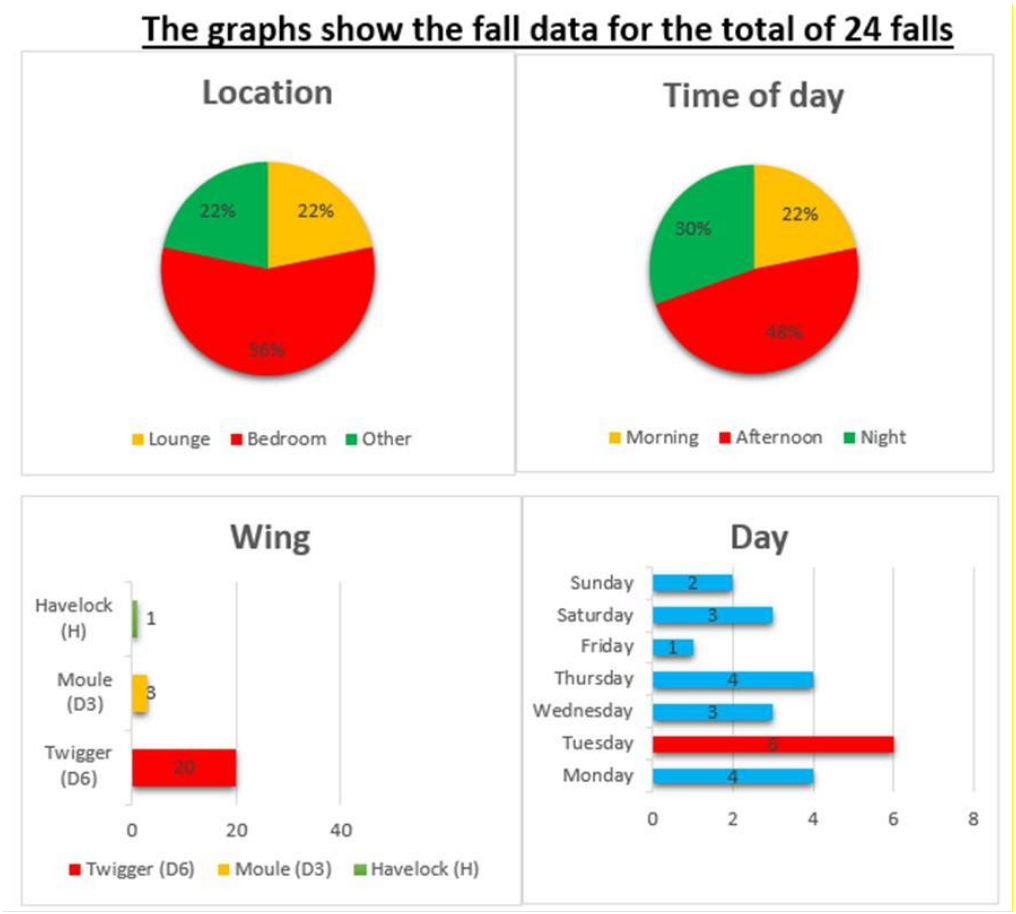
Graph 2 provides information on discharge versus occupied beds, this incorporates data from our Short Stay Unit, Ward 1 and Ward 2 inpatient areas. The table confirms the cohort of patients presenting to AAU has a corresponding trend in admissions and discharges.



- Data on presentation and subsequent admissions by primary care practice is in the final stages of collation. In partnership with the Ashburton Service Level Alliance (ASLA) clinical representation from hospital and PHO are meeting with each of the practices locally to discuss the trends in presentation and subsequent admissions, exploring opportunities to turn the curve in this area. Added to this is the uptake of Acute Demand by the practice. As this requires a careful narrative and is not intended as a judgement of primary care, the data sourced has been reviewed and will be approved by the ASLA meeting in November.
- Of equal attention for frail elderly in Ashburton is the prevention and response to falls. The Ashburton Event Review Committee (ERC) meeting in October discussed in detail the increasing falls rate in Tuarangi facility. As an aged residential care facility, the cohort of residents provides a different challenge for ongoing care provision than an acute medical or Assessment, treatment and rehabilitation ward. Tabled below is the review of falls for the month of October, as we seek to find the key drivers for falls. The outcome and recommendation from this recent work is the notable gap in medication reviews for our residents. Work has been immediately put in place to support the pharmacy team undertake medication reviews for these residents, evidence from other areas in New Zealand has indicated this action can drop falls dramatically. The CDHB Falls Committee has an excellent programme of work for the inpatient setting, however we are exploring the opportunity to connect with our local Aged Residential Care Facilities (ARC) and implement a falls committee focused specifically in this environment. The shared learning of medication reviews or other work can be built into our Frail Elderly patient journey with primary care and pharmacy support.

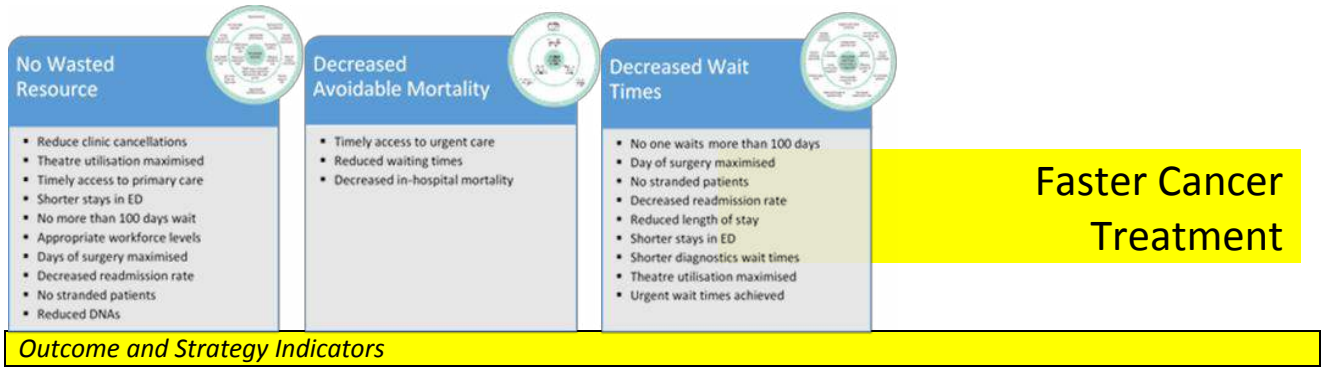
APPENDIX 1

Tuarangi Aged Residential Care Falls Rate – October 2018



- 20 out of 23 falls happened in the D6 wing. One SAC 2 Incident – Unwitnessed fall, assuming seizure factor as a reason for this fall. One resident who contributed five falls – several instances staff found him he himself lowering down and sitting on floor. Safety 1st for falls is being filled in on every occasion when staff found him on floor and recorded this as an unwitnessed fall.
- In addition to the discussions connected directly with the primary care teams via General Practitioner and PHO representation, the ALSA Operations Group are focused on implementing monthly practice managers meetings to support improved communication across the health provider community in Ashburton.
- The general practice representation of the Ashburton Service Level Alliance have also requested the establishment and implementation of a primary-secondary clinical governance group to explore system level improvements specifically between the hospital and primary care teams. The terms of reference and process are still to be worked through, primary care representation indicate a strong commitment to a vehicle such as this being the opportunity to address some of the current patient flow challenges. It was noted at the most recent meeting that the impending arrival of a new Director of Nursing for Ashburton and Rural would provide an ideal catalyst to explore how this opportunity could be bought to life.
- In addition to the current workgroup and localised representation committees discussing system level change, we have received ongoing feedback from primary care looking for a structured opportunity to discuss individual patient cases as an integrated system. The Senior Medical Officers (SMOs) working in Ashburton and primary care general practice representatives are progressing options to expand the hospital mortality and morbidity (M&M) committee to include primary care. Agreed shared learnings from these reviews would be provided to the local clinical governance group to progress any opportunity for system level change.

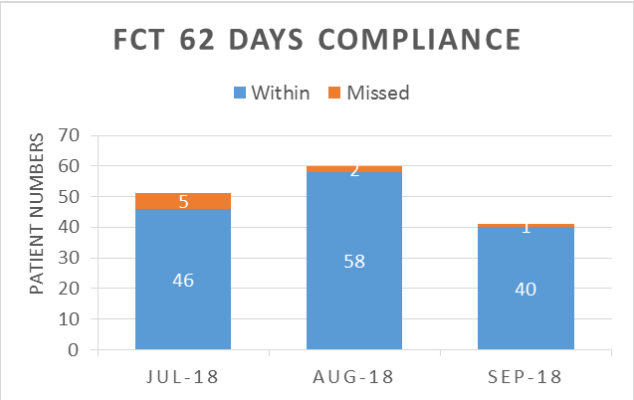
APPENDIX 1

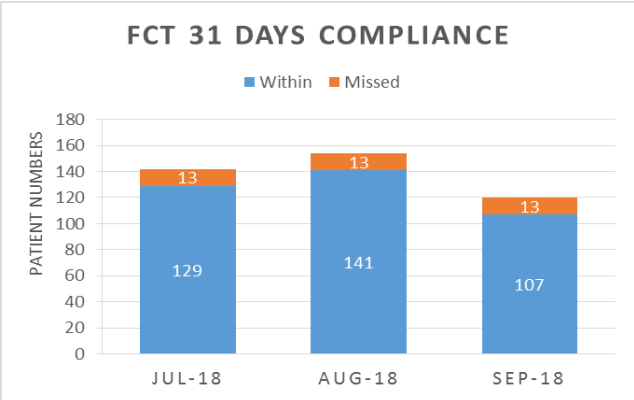


Key Outcomes - Faster Cancer Treatment Targets (FCT)

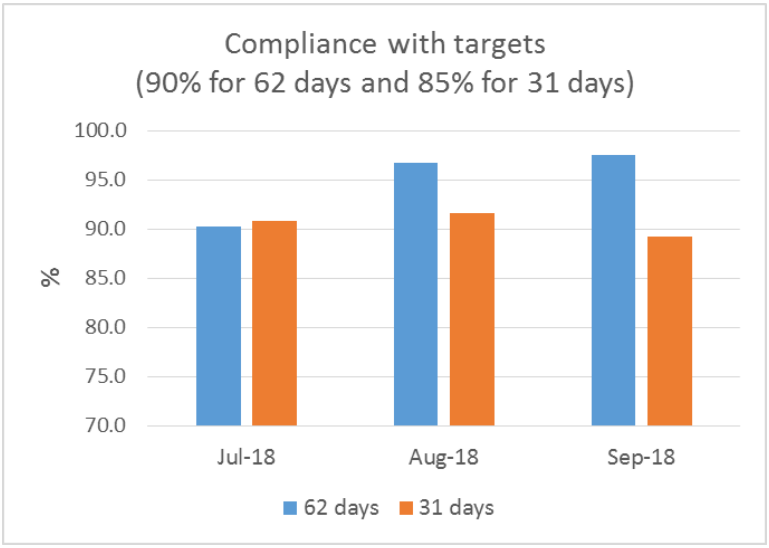
62 Day Target. For the three months of July, August and September 2018 Canterbury District Health Board (CDHB) submitted 176 records to the Ministry with 32 missing the 62 days target. Of these 24 missed the target through patient choice or clinical reasons meaning eight of the remaining 152 patients missed the target due to capacity or scheduling issues. CDHB once again met the target of having at least 90% of patients receive their first treatment within 62 days of referral with 94.7 % of eligible patients being treated within 62 days.

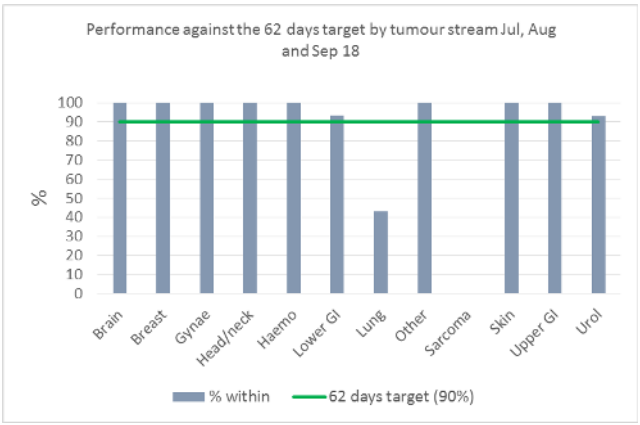
31 Day Performance Measure. CDHB submitted 416 records towards the 31 day measure in the same three-month period. Unlike the 62 days target all reasons for missing the target are included: there are no exceptions made for patient choice or clinical considerations but the threshold remains at 85%. 377 eligible patients (90.6%) received their first treatment within 31 days from a decision to treat, meeting the 85% target.

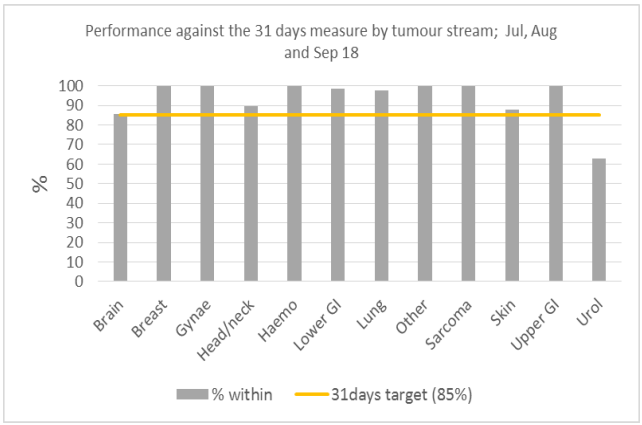


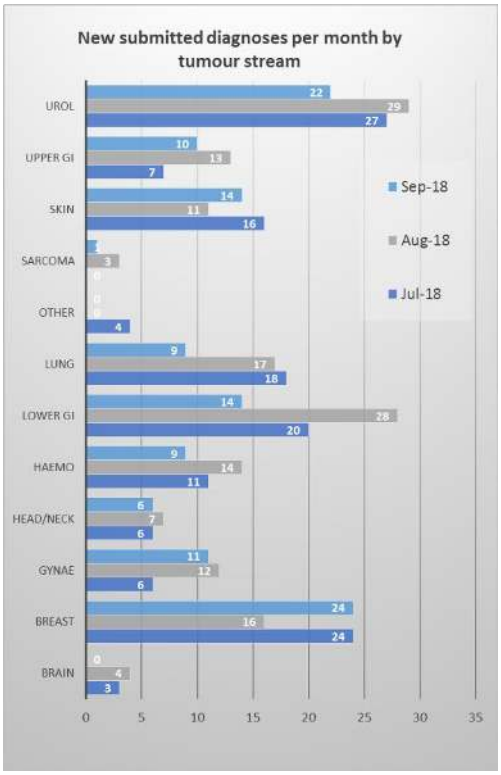


APPENDIX 1


Compliance with targets
(90% for 62 days and 85% for 31 days)
100.0
95.0
90.0
85.0
80.0
75.0
70.0
%
Jul-18
Aug-18
Sep-18
62 days
31 days


Performance against the 62 days target by tumour stream Jul, Aug and Sep 18
100
90
80
70
60
50
40
30
20
10
0
%
Brain
Breast
Gynae
Head/neck
Haemo
Lower GI
Lung
Other
Sarcoma
Skin
Upper GI
Urol
% within
62 days target (90%)


Performance against the 31 days measure by tumour stream; Jul, Aug and Sep 18
100
90
80
70
60
50
40
30
20
10
0
%
Brain
Breast
Gynae
Head/neck
Haemo
Lower GI
Lung
Other
Sarcoma
Skin
Upper GI
Urol
% within
31days target (85%)


New submitted diagnoses per month by tumour stream
UROL
22
29
27
UPPER GI
10
13
7
SKIN
14
11
16
SARCOMA
1
3
0
OTHER
0
0
4
LUNG
9
17
18
LOWER GI
14
28
20
HAEMO
9
14
11
HEAD/NECK
6
7
6
GYNAE
11
12
6
BREAST
24
16
24
BRAIN
0
4
3
Sep-18
Aug-18
Jul-18
0
5
10
15
20
25
30
35

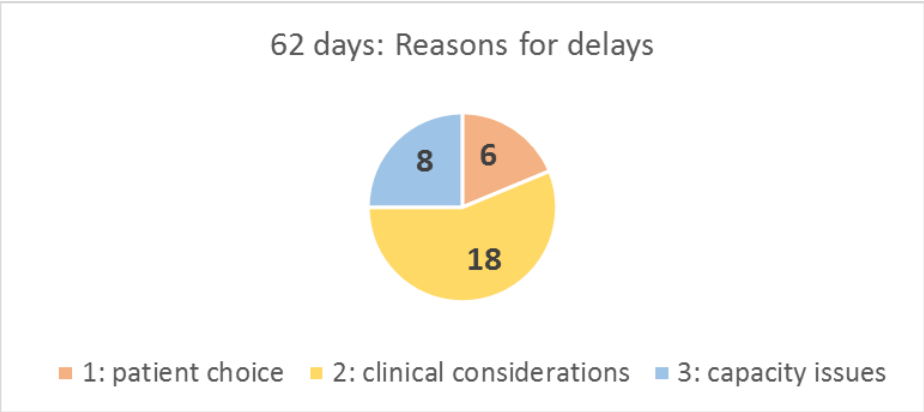
APPENDIX 1

Patients whose treatment time misses the targets

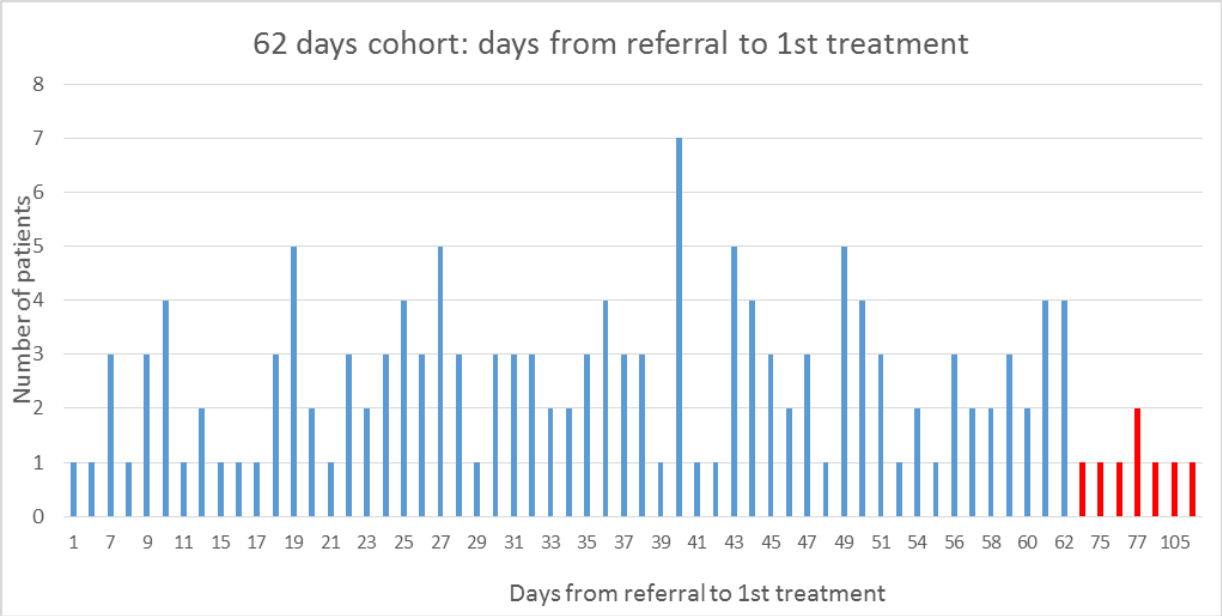
The Ministry of Health requires District Health Boards to allocate a "delay code" to all patients who miss the 62 days target. There are three codes and only one can be used even when delay is due to a combination of circumstances.In this circumstance the reason that caused the most delay is the one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

The codes are:

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



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



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

APPENDIX 1

Supporting physical exercise in patients being treated for cancer.

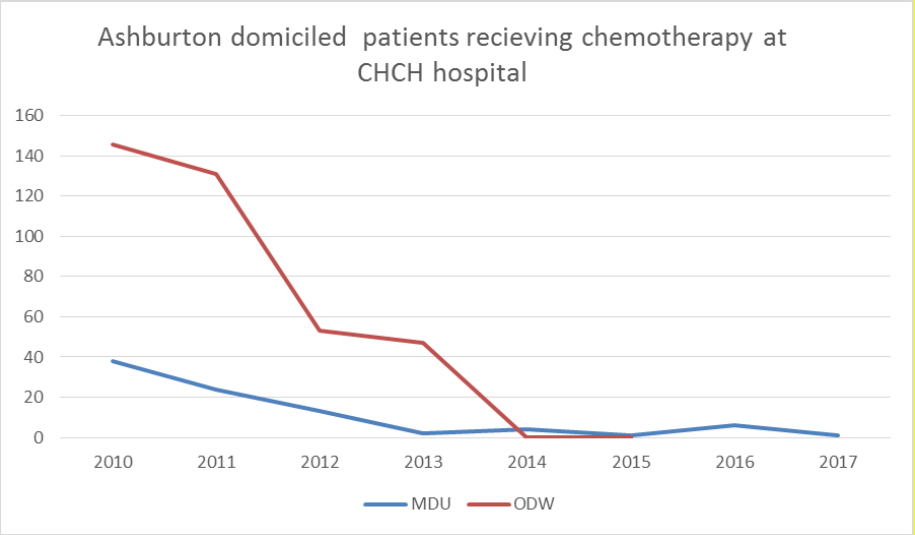
The benefits that most people can achieve from regular physical exercise are well recognised. Recent media articles have publicised the growing evidence supporting the value of supporting patients being treated for cancer to get involved in specific types of physical exercise.

A physiotherapist working within oncology will begin providing support to encourage physical activity early in the course of treatment of patients with breast cancer by providing a physiotherapist consultation at oncology clinic appointments. This will help patients to put changes in place to manage the significant reduction in function that typically occurs during this course of treatment. Alongside this, material about the value of exercise, and some useful approaches, has been added to the booklets provided to patients receiving chemotherapy and radiation therapy. A pathway and information sheets have been created for patients with haematological neoplasms. These changes will support an improved recovery and experience for specific groups of patients and help us to explore the best approach to support our patients being treated for cancer.

Ashburton Hospital Oncology Service Delivery

In September, the Clinical Nurse Specialist (CNS) and Medical Oncologist completed a service review and clinical audit of services provided through Ashburton Hospital. This report has highlighted opportunities for service in Ashburton to connect with the services in Christchurch further, building on the model currently delivered for Endoscopy where nursing staff regularly participate in service delivery and developments with their Tertiary Service colleagues.

The graph below shows a steady decline in Ashburton patients travelling to Christchurch for chemotherapy. The data source was provided by decision support reviewing appointments form the CONDW and CONMJ code.



Oncology Outpatient Clinics

This clinic occurs fortnightly provided by Oncologists and an Oncology CNS. A full day clinic with approximately 20 patients attending. Those involved in the triaging and allocation of patients try to ensure patients from Ashburton are referred to the Ashburton clinic. If oncology specialty care is required a shared care approach is often used between Ashburton and Christchurch clinics. Due to staff turnover it is important for us to ensure that those working in the oncology service in Christchurch continue to be made aware of the services that are able to be provided in Ashburton.

Some patient follow-up has also been provided via teleconference as routine follow-up or “one off”. This has been particularly useful for patients whose condition is not conducive to travel or when discussion is needed between patient and oncologist more urgently or between clinics.

APPENDIX 1

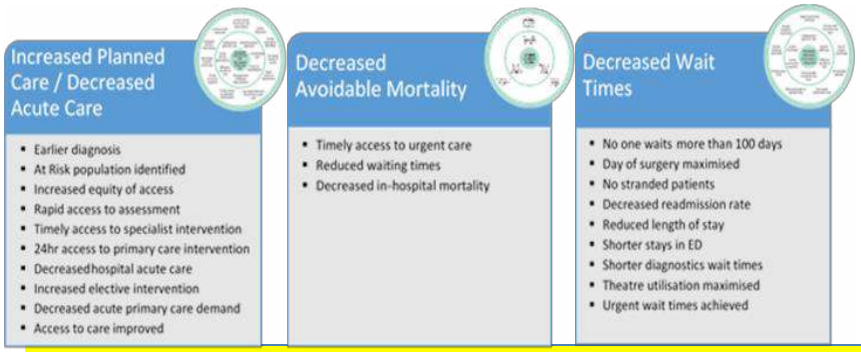
Chemotherapy Services

Ashburton Hospital is now able to offer a wide range of chemotherapy treatments. Treatments are given in a dedicated medical day stay (MDS) suite comprising of six chairs and two beds on Tuesday/Wednesday/Thursday 08.30-1700 each week. There are currently five registered nurses who are chemotherapy certified who also work in other areas of the hospital. These services are given in conjunction with other medical day stay procedures e.g. trial of voids, blood transfusions, bisphosphonate therapy, iron infusions and biotherapy for other disorders.

There are many strengths to the current service model and opportunities to explore further expansion. Patients continue to express a high level of satisfaction of care and remain grateful for the opportunity to have their care provided locally, i.e. chemotherapy, imaging, follow-up. The decrease in numbers of patients requiring care at Christchurch Hospital enables less disruption for patients, greater opportunities for whanau involvement and decreased costs associated with travel and time away from employment.

There are a number of detailed recommendations to investigate further, including how Ashburton Health Services can expand the nursing workforce delivering specialist services in the unit and work in partnership with primary care regarding the administration of other products ie bisphosphonates and iron infusions, thus releasing capacity in the hospital team. The general recommendation from this review is that with adequate resources patient's residing south of Rolleston and Darfield South could be offered the option of receiving treatment at Ashburton Hospital. Benefits of this would be parking and reduce numbers attending a stretched oncology day ward.

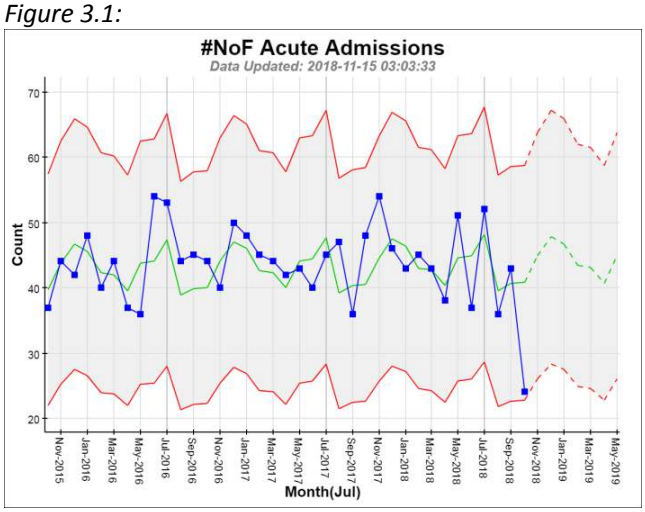
APPENDIX 1



Enhanced Recovery After Surgery (ERAS)

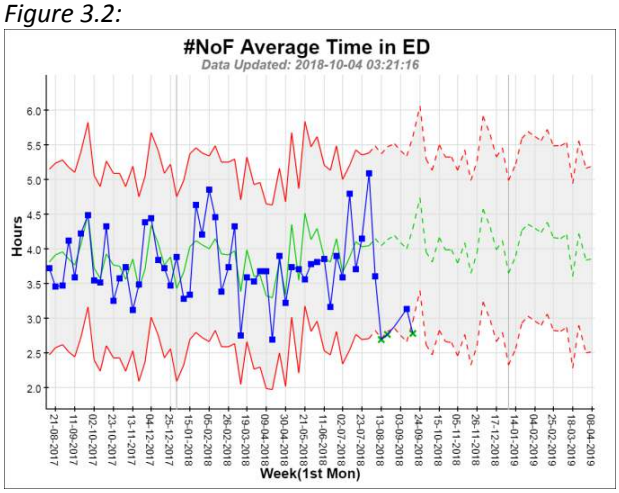
Outcome and Strategy Indicators – Fractured Neck of Femur (#NoF)

Figure 3.1:



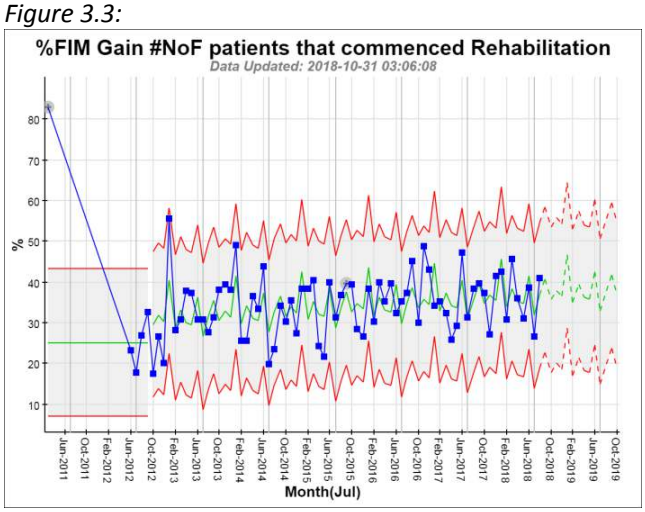
The number of #Nof admissions per month continues at the expected rate. The value indicated for the last month should be ignored as not all data are available yet.

Figure 3.2:



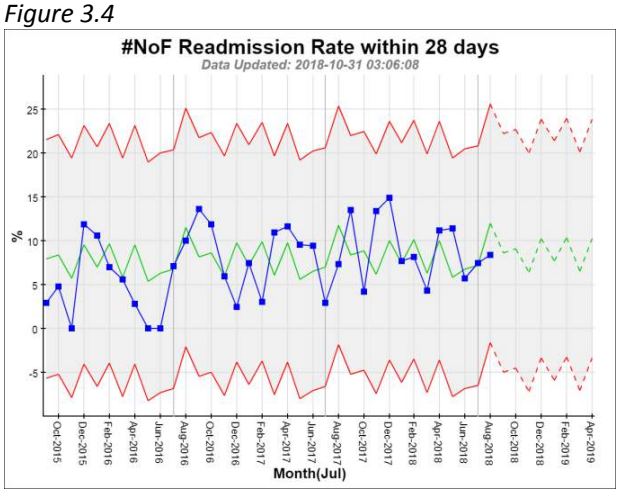
Patients with #NOF show a variable length of stay in ED. The red signals show that a statistically significant increase in the time spent in ED has occurred. The value indicated for the last month should be ignored as not all data are available yet.

Figure 3.3:



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

Figure 3.4

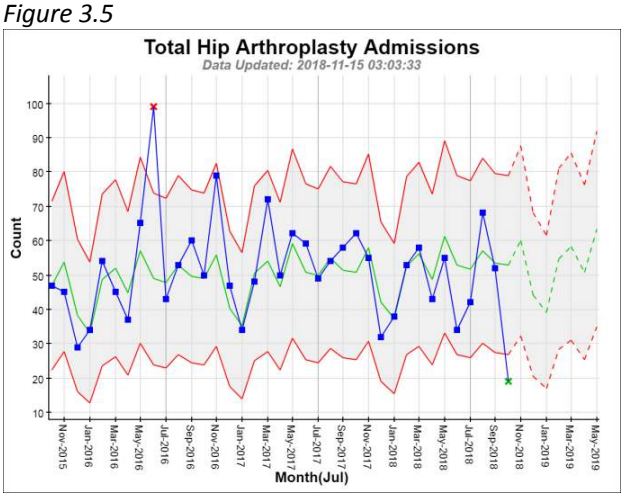


Readmissions remain within expected mean values.

APPENDIX 1

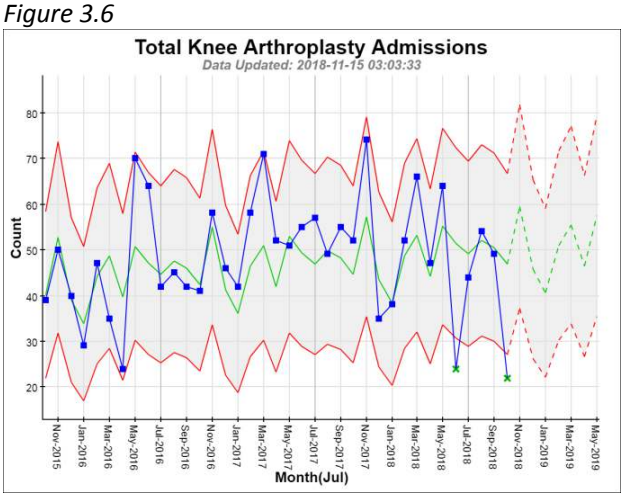
Outcome and Strategy Indicators – Elective Total Hip Replacement(THR) and Knee Replacement(TKR)

Figure 3.5



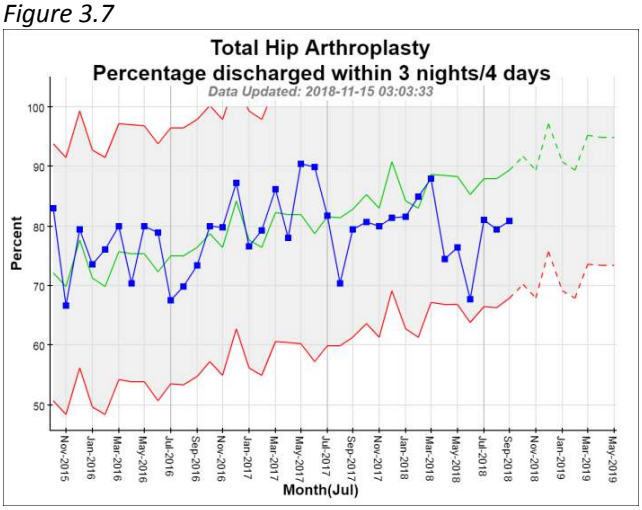
In recent months hip replacements have been tracking within projected levels.

Figure 3.6



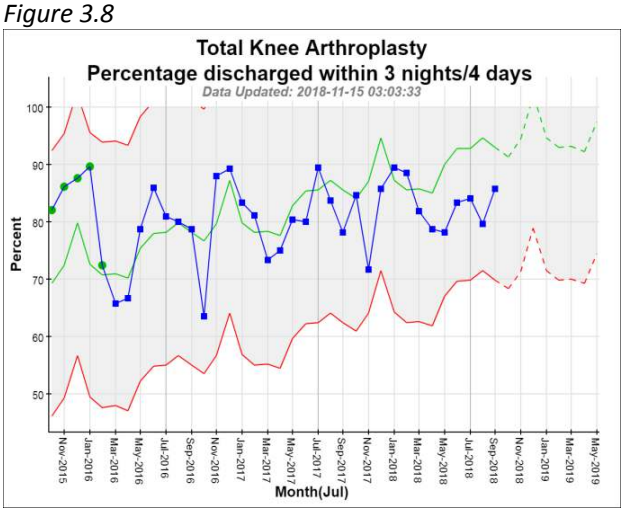
Knee replacement admissions over the previous twelve months have been at or above projected levels

Figure 3.7



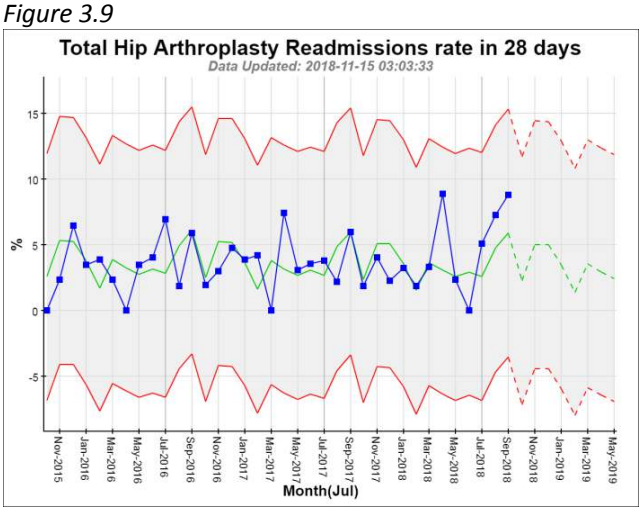
The proportion of patients clinically safe to be discharged within 3 nights/4 days is following established, increasing trend.

Figure 3.8



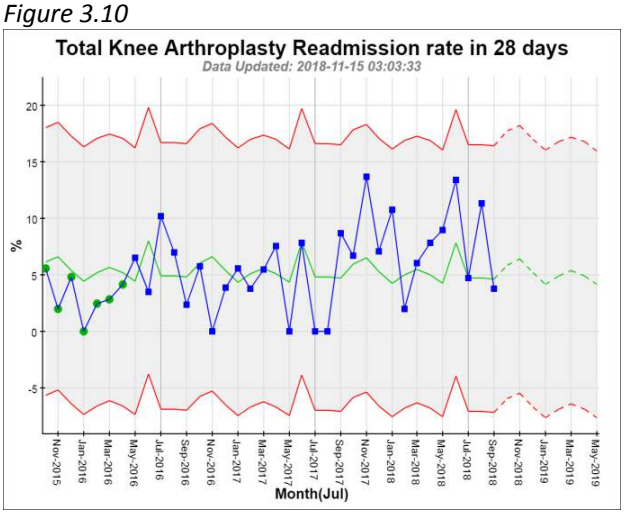
The proportion of patients clinically safe to be discharged within 3 nights/4 days is following established, increasing trend.

Figure 3.9



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

Figure 3.10



Readmission rates are maintaining within tolerances.

APPENDIX 1

Achievements/Issues of Note

Streamlining the Vascular Ward Round - A Time-Out Structure

Ward rounds are a platform for clinicians to gather information, sharing it with one another and the patient. The way that surgical ward rounds are conducted can impact patient outcomes as well as patient and staff satisfaction. Introduction of a formalised routine has been trialled recently for vascular ward rounds. The aim was to improve workflow, hand hygiene, and communication without increasing administrative time by providing defined ward round structure, improving the communication of patient status and the care plan to all multi-disciplinary team members as well as to ensure that management plans are understood at the bed space and that the patient has a voice.

The model developed is loosely based on the World Health Organisation Surgical Safety Checklist and has had input from nursing staff, consultants, Resident Medical Officer (RMOs), and Multidisciplinary Team (MDT) members were. It consists of a 'time-in' at the start of the ward round, 'pause' at each patient bedside, and a 'time-out' at the end of the ward round.

Use of the new routine was audited and fine-tuned and is currently in use in daily practice. This will continue based on the encouraging results of the audit. In particular the improvements in hand hygiene and staff satisfaction provide a strong argument for its continued utilisation. While very difficult to assess, it is hoped that this time-out structure will have an impact on length of stay, reduced investigations, reduced drug and management errors and patient complaints in the future.

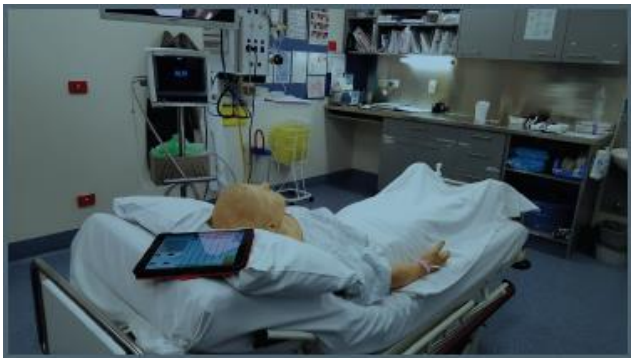
Bronchoscopy emergencies training

Bronchoscopy is an endoscopic technique used to visualise the inside of the airways. Procedural risks are small, but include major bleeding, pneumothorax and respiratory depression. There is evidence that simulation is an effective training method for emergency situations that may arise during bronchoscopy.

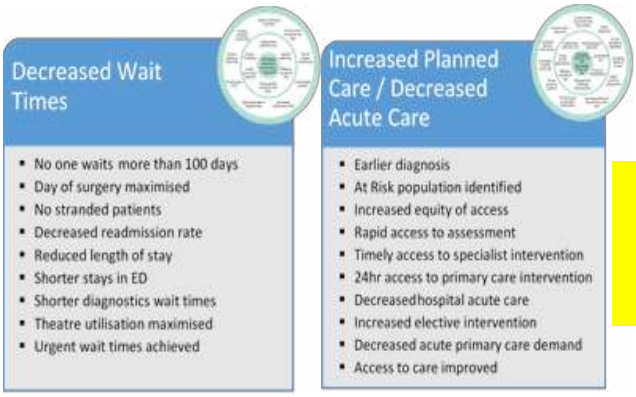
In Christchurch Hospital we had no routine training for emergency situations that may arise during bronchoscopy. This was identified by the as a significant clinical risk and there was broad support from within the department (medical and nursing) for training to occur.

Three clinical scenarios were created for each of hypoxia, bleeding and pneumothorax have been run. The majority of attendees felt that the simulation session was extremely valuable. A number of participants felt that taking part in the scenario was somewhat stressful and despite the majority of attendees indicating that they had the knowledge and skills to manage this type of patient, they felt the scenario had improved their clinical practice. This initiative is also felt to have enhanced collaboration between the departments.

A number of changes were made as a result of the simulation sessions, including standardising emergency equipment and purchasing a longer 'bronchial blocker' to assist with controlling major bleeding. The Respiratory Service and Endoscopy Department support continuing regular simulation sessions for the bronchoscopy team.



APPENDIX 1



Elective Surgery Performance Indicators 100 Days

Outcome and Strategy Indicators

Figure 4.1:

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

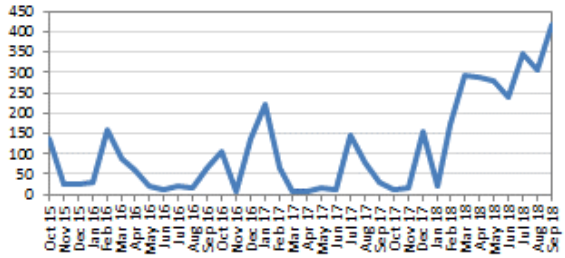


Figure 4.2:

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

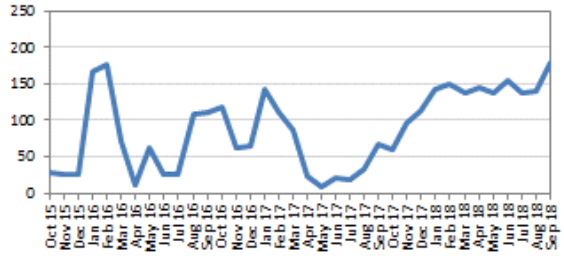


Figure 4.3:

ESPI 2 Result By Specialty - Surgical

Specialty	Number	%	Change
Cardiothoracic	0	0.0%	0
ENT	230	14.4%	92
General Surgery	4	0.5%	4
Gynaecology	1	0.2%	1
Neurosurgery	0	0.0%	0
Ophthalmology	35	4.6%	35
Orthopaedics	18	10.7%	9
Paediatric Surgery	0	0.0%	0
Plastics	0	0.0%	0
Urology	10	1.4%	4
Vascular	40	12.1%	25

ESPI 2 Result By Specialty - Medical

Specialty	Number	%	Change
Cardiology	0	0.0%	0
Dermatology	0	0.0%	0
Diabetes	1	0.8%	0
Endocrinology	5	2.0%	5
Endoscopy	0	0.0%	0
Gastroenterology	28	6.7%	-87
General Medicine	0	0.0%	0
Haematology	0	0.0%	0
Infectious Disease	0	0.0%	0
Neurology	0	0.0%	0
Oncology	0	0.0%	-1
Paediatric Medicin	44	9.7%	25
Pain	0	0.0%	0
Renal	0	0.0%	-1
Respiratory	0	0.0%	0
Rheumatology	0	0.0%	0

Figure 4.4

ESPI 5 Result By Specialty

Specialty	Number	%	Change
Cardiothoracic	2	5.4%	0
Dental	0	0.0%	0
ENT	6	1.6%	0
General Surgery	19	5.2%	9
Gynaecology	0	0.0%	-2
Neurosurgery	0	0.0%	0
Ophthalmology	17	4.3%	1
Orthopaedics	120	22.4%	42
Paediatric Surgery	0	0.0%	-1
Plastics	8	0.9%	-4
Urology	0	0.0%	-1
Vascular	5	14.3%	2
Cardiology	2	1.1%	-5

ESPI Results

Waiting > 120 Days

	Number	%	Status
ESPI 2 (FSA)	416	4.4%	
ESPI 5 (treatment)	179	4.6%	

APPENDIX 1

Achievements/Issues of Note

Elective Services Performance Indicator (ESPI) Target Outcomes

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

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

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

Diabetes Centre, Sport Canterbury and Linwood Medical Centre

Earlier reports on the work being done by the Diabetes Centre and Linwood Medical Centre to improve care being provided in the community to people with diabetes included information about work being done with Sport Canterbury to run a diabetes specific Be Active programme.

Sport Canterbury regularly runs Green Prescription lifestyle programs called Be-Active in several locations around Christchurch. The planned diabetes specific Be Active Programme started on 16th October in Linwood. This eight week programme is targeted at people with either pre-diabetes or type two diabetes. It is being run with input from the Diabetes centre dieticians and psychologist, alongside the Sport Canterbury educators and the Linwood Medical Centre practice nurse. The collaborative approach taken will enable Sport Canterbury, the practice nurse and the specialist team learn from one another, gain and share the most appropriate content best suited for an interactive lifestyle program. This also enables an increased focus on taking a wellness approach, gently introducing and raising psychological awareness for those living with diabetes along with their care providers.

Three base measures will be assessed pre and post program, these are: weight, HBa1C (a measure of longer term glucose control) and a wellness self-assessment.

The programme involves individual consultations with the Sport Canterbury team and a series of classes. Providing some of this activity at the patient's own general practice and including their practice nurse in the first of the classes ensures that patient's linkages with their general practice are reinforced and existing partnership between providers are strengthened. This keeps our patients at the centre point, with their health teams mobilising around the individual providing continuity of care.

The three teams of health professionals involved are committed to evaluating the benefits provided by this approach. Positive outcomes, and consumer satisfaction will support interest for further wider interest for a Diabetes Be Active program in Canterbury, extending readily accessible diabetes focused lifestyle programs close to home.

The locally operated Diabetes Society is keenly watching progress and contributing the consumer voice. This programme provides community based support so that patients stay well in their own homes, supports growing skills, knowledge and confidence in our community health partners enabling specialist diabetes practitioners to align specific high end care delivery. Right person, right time in the right place.

Developments in the treatment of obstructive sleep apnoea

Christchurch Hospital's Sleep Service Laboratory Manager recently attended the European Respiratory Society Conference, along with 22,000 other delegates. This is one of the two major annual global conferences focussed on respiratory medicine. Attendance at this year's conference has enabled us to keep up to date with key developments in areas which have a significant impact on the health of our population. One area of particular interest relates to phenotyping obstructive sleep apnoea cases in order to choose the most appropriate treatment.

Obstructive sleep apnoea (OSA) is a common treatable condition that is a major public health issue in New Zealand. Untreated OSA has a deleterious effect on quality of life and work-performance and is associated with increased morbidity and mortality and an increased risk of driving related accidents. The most common clinical treatment for OSA is with continuous positive airway pressure (CPAP). Each year 900 people are provided with a trial of CPAP in the CDHB catchment area. Around 70% of these patients gain significant benefit from this treatment and continue using it. However, 30% are unable to tolerate this therapy as their OSA may be more complex and not completely related to an anatomical constraint of the airway. One theme explored at the conference was precision medicine in OSA. The idea is that patients may have different pathophysiological reasons for developing OSA, therefore treatment options should be tailored to reflect each patient's physiology.

A team working in Australia has identified methods that enable the accurate phenotyping of OSA. The Christchurch Sleep Service will continue to monitor development of these methods closely, as these techniques could help identify patients where a trial of CPAP may not be appropriate first line therapy, and instead may be able to be directed towards other methods of treatment. This would free up more capacity to be used on those patients that would benefit from CPAP.

Improved collaborative care model for children with complex needs

An earlier update covered the initial development of a collaborative care approach by the children's outreach and Daystay nurses. This has now been adopted as the usual way of working in the Paediatric Outpatient Department, for children who have complex care requirements. Children with the most complex healthcare needs often need to visit many healthcare and educational professionals on a regular basis (during the trial period children needed to attend secondary or tertiary care more than 20 times each year, have more than three services involved in their care or require a solid organ transplant). This is disruptive for them and their whānau, making it difficult to develop a routine that supports their ongoing development and education.

Initially this approach involved developing an "ecomap" using the Whare Tapa Wha model of health to assess the whānau environment, strengths, stressors, sources of support and social, cultural and spiritual reality. The Outreach or Daystay nurse then worked together with the whānau, schools, health care professionals and other support agencies to "collate" their appointments and improve communication and documentation between services. This enables the whānau and the wider team to think together about solutions to the challenges being faced, thus minimising the number of appointments and disruptions to the whānau routine.

A whānau care plan is generated, providing an integrated snapshot of the decisions agreed at that meeting. This approach has made a huge improvement for patients and their whānau, illustrated by the comments below:

- "Now he is at school more and he can even play rugby, he couldn't before cos we were never there for practise."
- "OMG! Who knew we could come in for one day and everyone could come to us. Before we came in six times a month, now we come in for one day a month! L is not enjoying this as now he is at school every day to get his homework!"

This approach continues to develop. Over the past year the group of providers involved in this work has expanded, and has begun taking a collaborative approach, similar to that seen in Service Level Alliances, to design the way that we serve our patients. Primary care, schools, adult services, hospital and community allied health, nursing and senior medical officers from secondary care, Māori support worker, primary care workers, Youth Advisory and Child Health Advisory Council reps, have been involved. This allows a broad based approach with the entire team committed to thinking together about the way to best support our children and whānau. A structured approach is taken to make positive changes in areas that will make a difference for whanau. This year's focus has been on the way we support patients to shift from children's to adult services, which often involves a transition from Secondary to Primary based services. This is resulting in better communication between health providers and also between health providers, patients and whānau. General Practice will now be engaged throughout the transition process. The approach that has been developed sets people and providers up to have the best chance at successful transition.

A positive, unintended, consequence has been that key people across the system are now more familiar with one another which enables improved communication and troubleshooting between healthcare providers and schools.

The progress made over the past three years of this programme of work has been spectacular. The growing group of participants brings phenomenal knowledge and enthusiasm to the shared aim of improving our service for the children and whanau that we care for.

Community Infusion Centres releasing Medical Day Unit capacity

An update in mid-2018 provided information about the launch of a community based infusion service, carrying out tasks previously occurred in the Medical Day Unit at Christchurch Hospital. This has been required as demand for ambulatory treatment had increased to the point that the Medical Day Unit was unable to provide all services demanded of it. This unit has had no spare capacity during the past two years. Demand in this area will continue to increase, driven by improved clinical capability, a growing population and decisions made to fund drugs that require infusion services some of which are complex in nature.

Community based infusions are being provided from Helios Integrative Medical Centre in Opawa and the Linwood Medical Centre. The first group to benefit is a group of 15 people who require regular blood transfusions, and are otherwise medically stable. The process that clinicians use to obtain this care is now documented in Hospital Health Pathways and the Clinical Nurse Specialist in Haematology makes the necessary arrangements including arranging for the transfusion to be prescribed, seeking a scheduled time at the infusion centre and sending the appointment out. Acute transfusions continue to be provided at the Medical Day Unit as do General Practitioner requested transfusions. Work is occurring towards providing General Practitioner requested transfusions at the community infusion centres.

This change alone has released around 35 hours per month worth of capacity for other patients in the Medical Day Unit.

The next area of work under development sees the Medical Day Unit, Infusion Centres, Neurology and Immunology working together so that people receiving regular, usually monthly, infusion of Intragam P will receive this service at the Infusion Centres. The initial cohort of six patients will soon begin receiving their services in the infusion centre, releasing a total of around 24 hours a month for other services in the Medical Day Unit.

Our aims is to continue to develop this service for infusions that can safely be provided in the community, releasing time for the increases in demand faced by the Medical Day Unit.

Patients report appreciating the new service, finding that they receive the care they would have in the hospital but it is in a quiet environment with easy access to transport routes and easy parking.

The way we work in the new Outpatients' building

The Outpatients' building had been designed with a focus on having a "long life, loose fit" so that the range of health services provided from it can change over time without compromising those services.

Merely shifting into this space, continuing to do things the way that we always had would have squandered the opportunities provided by the building's design. Deliberate choices were made to agree changes that would impact on multiple services in order to deliver the right outcomes.

Care has been taken to ensure that teams are allocated space on the floors in a way that makes for the best clinical and operational workflows.

A collaborative approach has been taken, this was initiated through a series of five workshops at the design lab, followed by a series of working groups considering various aspects of the way that we work.

Principles were developed collaboratively by the Campus Outpatient and Ambulatory Services Team (COAST) that have subsequently directed plans about how we would work together. The principles developed were:

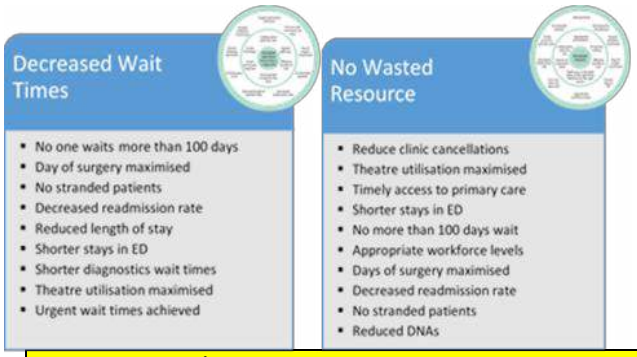
- Better together.
- Patient centred:
    - Solutions are focussed on what is best for patients.
    - Care is delivered by right person/right place/right time/, with the associated electronic activity achieved in real time.
- Right person, right task – doing the right thing, doing things right

- Consistency through standardisation:
    - Efficiency through process management, applying Lean principles and ensure the effective use of time, resources and people
    - Processes are safe and effective
    - Reduce waste.
- Optimal and maximised utilisation of our resources:
    - People – work within current FTE
    - Space
    - Equipment
- Open, transparent conversations (driven by the data).

An example of how these have directed the way that we work is that we no longer have any pure receptionist roles in the Outpatients' building. We now have a generic Administrator roles that encompass reception and booking duties. This approach highly values the customer service requirements inherent in all administrative tasks and enables provision of additional value at the front desk as every enquiry is addressed by somebody that can make bookings. This provides a productive, responsive environment that is patient centric

Lessons have been learned from this planning work that will inform our transition to Christchurch Hospital Hagley. Work continues to occur in specific areas that patient and clinician experience can be improved. The Pre-operative assessment project includes anaesthetists, surgeons, nursing and administrators redesigning the patient, clinical and administrative workflows in this area with a focus on valuing the patient's time and paperlite processes.

APPENDIX 1



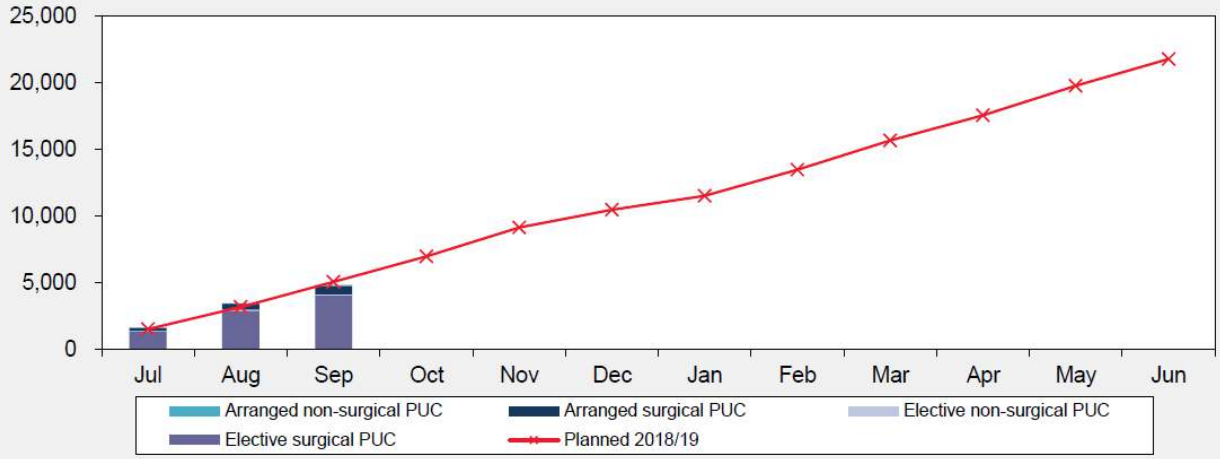
Theatre Capacity and Theatre Utilisation

Achievements/Issues of Note

Elective Services Discharges

Elective Surgical Discharges ▼ **95.5%**

	2018						2019					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Planned	1,520	3,182	5,065	6,985	9,132	10,470	11,532	13,474	15,676	17,548	19,773	21,782
Actual	1,616	3,463	4,837									
Variance	96	281	-228									
%Achievement	106%	109%	95%									



A phased plan for provision of the 21,782 elective surgical discharges to be delivered in 2018/19 has been agreed with the Ministry of Health. Increased volumes will generally be achieved through increases in outsourced and outplaced operating and are focussed on Ear, Nose and Throat and Plastic Surgery.

The increase in Ear, Nose and Throat outplaced theatre capacity is a part of its transition towards the capacity that will be available when the new theatre capacity within Christchurch Hospital Hagley opens.

NetworkZ Programme

Delivery of safe and effective care to surgical patients depends on effective teamwork and communication between the whole operating room team. Unintended patient harm is a substantial burden on global health. On many occasions failures in teamwork and communication are an important contributing factor. The underpinning mechanisms for effective teamwork are having a shared mental model of the patient condition, the goals of

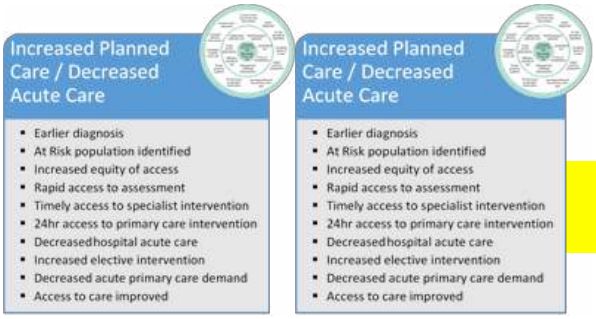
treatment, and the plans for care. Effective communication strategies underpin the development of a shared mental model and mutual trust and respect.

The Accident Compensation Corporation funds a simulation based multidisciplinary team training for operating room teams called NetworkZ, this programme is supported by the Health Quality and Safety Commission and delivered by the University of Auckland. NetworkZ comprises realistic simulated surgical cases presenting communication challenges to surgical teams, followed by a debrief to enable participants to reflect on the events, expose assumptions and communication issues, and identify good practice. The evidence to support teamwork training for healthcare teams is strong, but team training has not been systematically implemented at a national level. New Zealand stands to become a world leader in this field. We anticipate that this intervention will improve quality, safety, and efficiency of care for surgical patients throughout New Zealand.

NetworkZ has now been established at 10 District Health Boards across the country. The uptake and feedback to date has been excellent with regular sessions conducted not just at the main hospitals but also the satellite hospitals such as Blenheim and Thames.

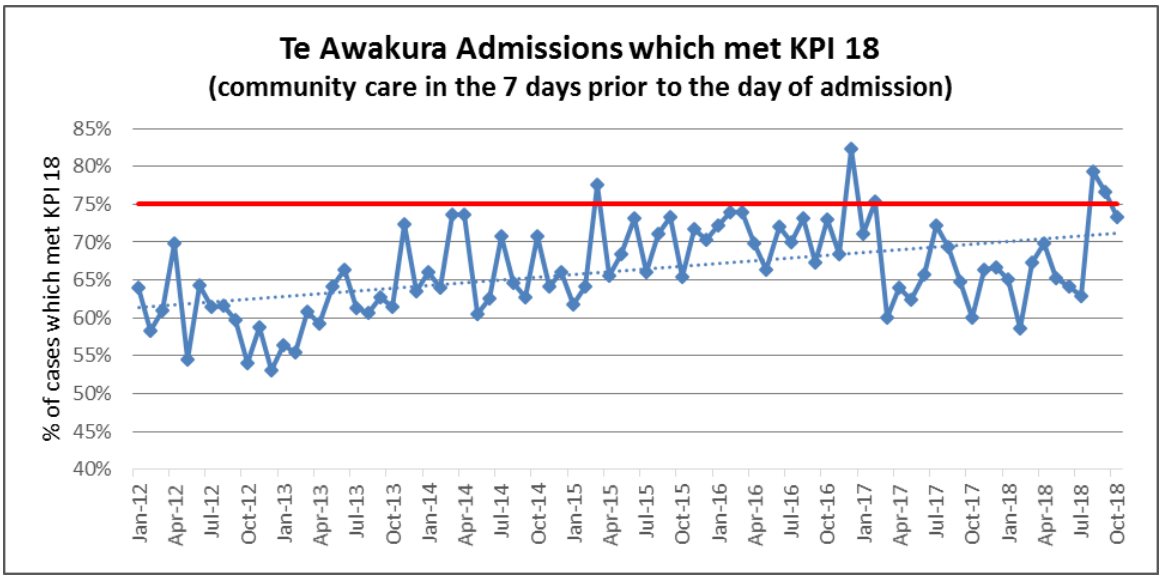
In 2020 CDHB will be a part of the fourth cohort to implement this programme along with Southern, Northland, Lakes and West Coast District Health Boards. Planning towards implementation will begin over the coming year.

APPENDIX 1

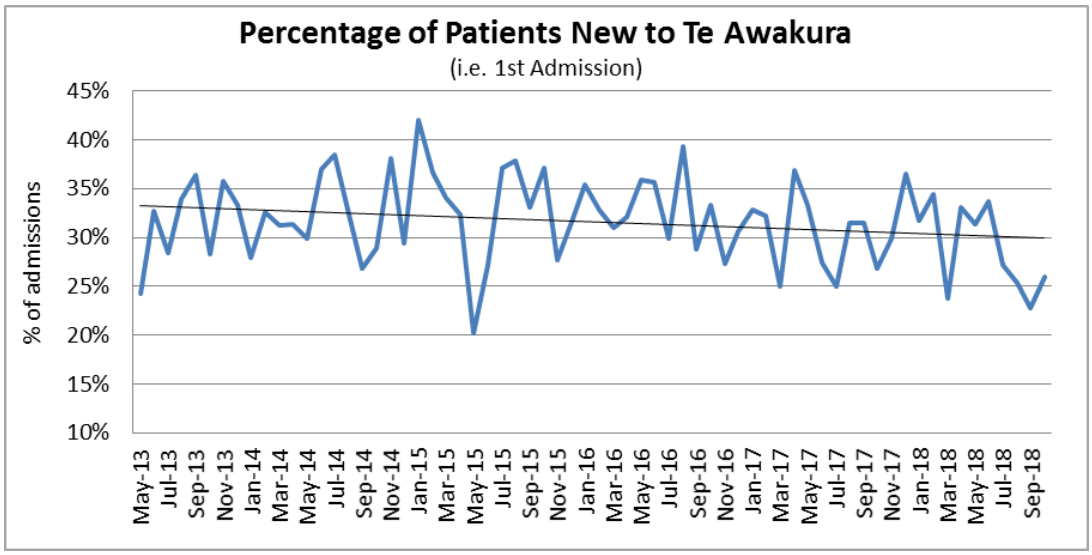


Mental Health Services

Adult Services

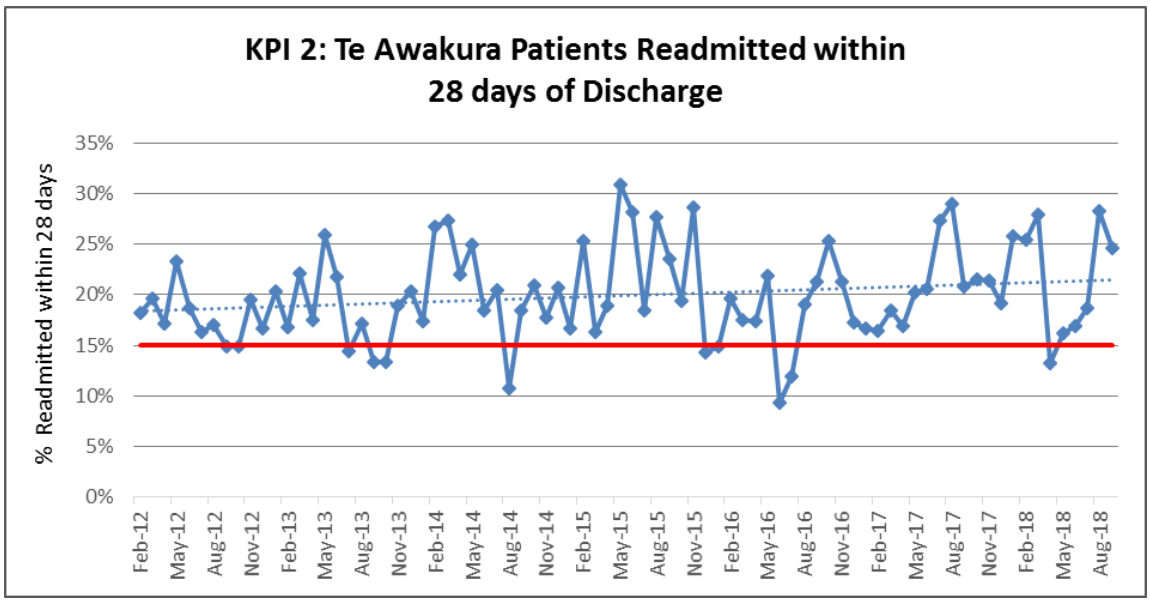


KPI 18 is an indicator of how well engaged we are with the consumers in our services. In September 2018, 76.6% of acute admissions to Te Awakura had a community contact in the seven days prior to the date of their admission. In October 2018, the figure was 73.3%.

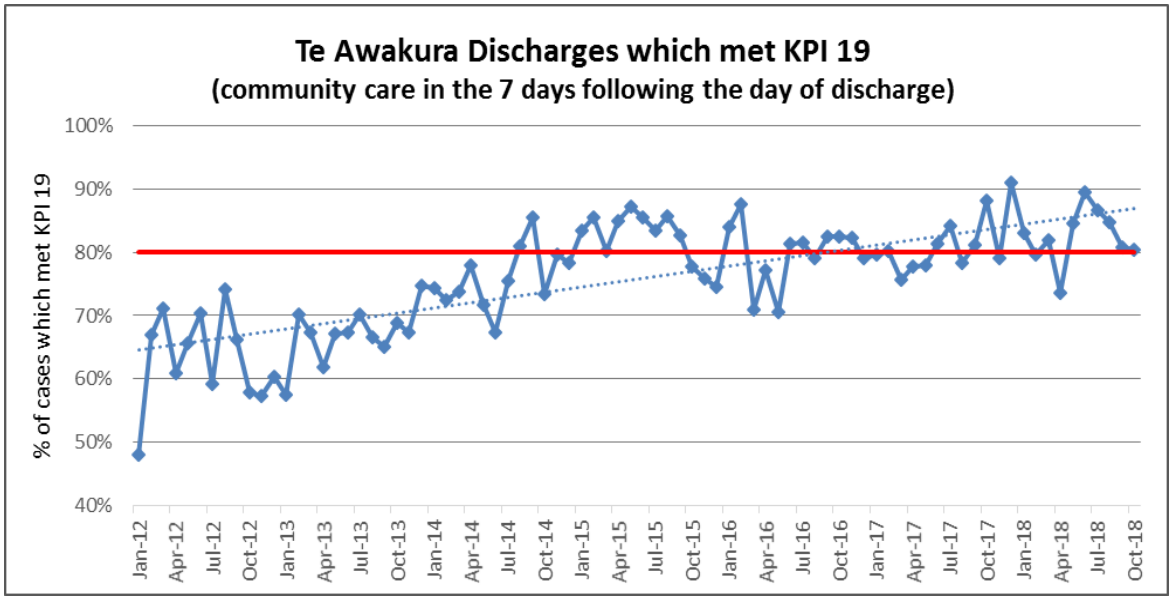


In September 2018, 23% of people admitted to Te Awakura were new (had not been admitted there previously), in October 2018, the figure was 26%.

APPENDIX 1

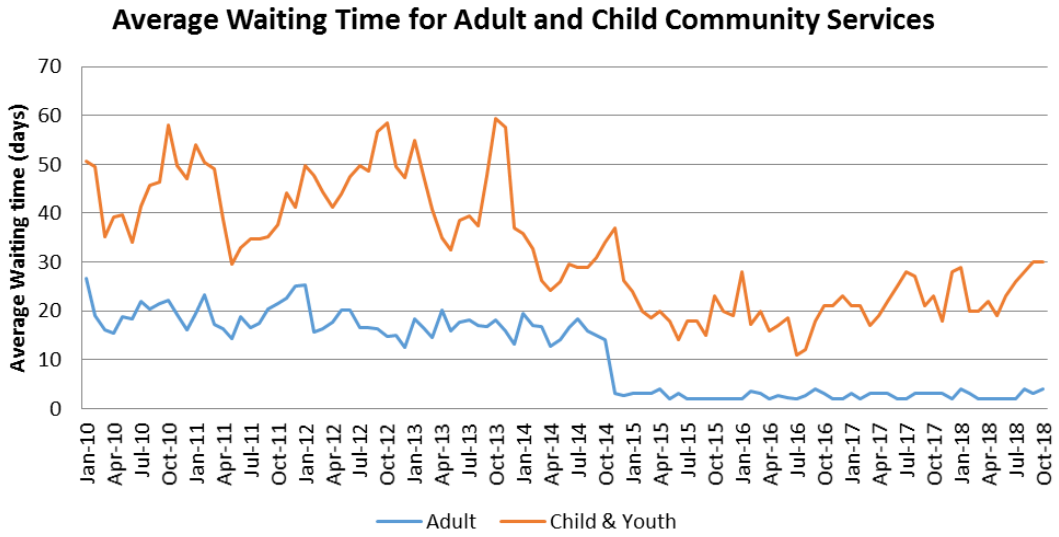


The graph above shows the readmission rate within 28 days of discharge. Of the 114 Te Awakura consumers discharged in September 2018, 24.6% were readmitted within 28 days. Readmission rates are closely monitored.



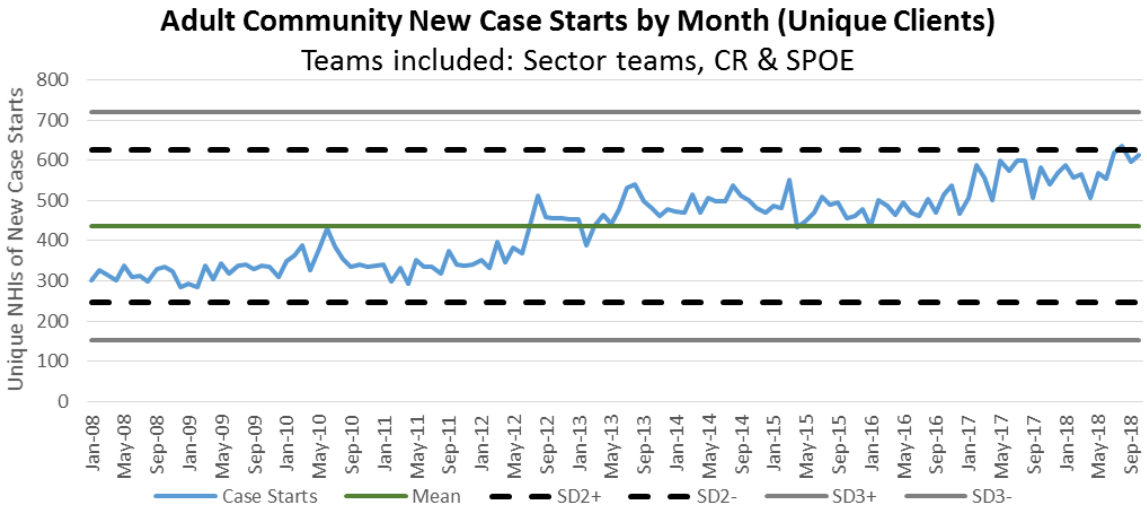
KPI 19 is a key suicide prevention activity and patient safety measure. In September 2018, 80.7% of consumers discharged from Te Awakura received a community care follow-up within seven days of discharge, and so met KPI 19. In October 2018, the figure was 80.3%.

APPENDIX 1



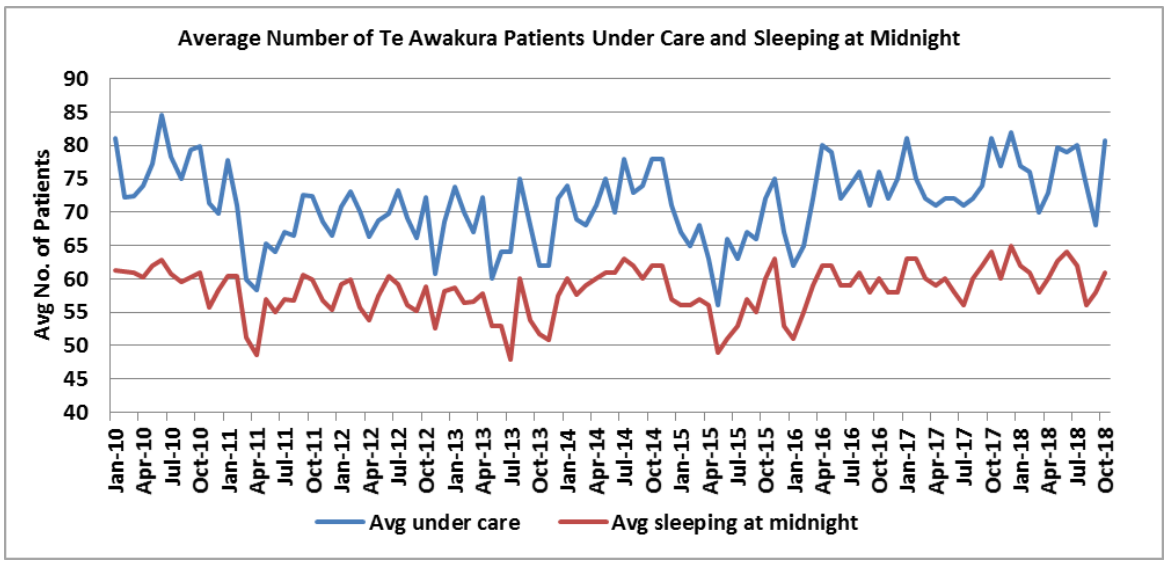
The graph above shows there has been an overall reduction in the time people spend waiting. Ministry of Health targets for these services require 80% of people to be seen within 21 days and 95% of people to be seen within 56 days. The average waiting time for adults was three days for September 2018 and four days for October 2018. Our results for the Adult General Mental Health Service show 94.5% of people were seen within 21 days of referral in September 2018 and 99.6% were seen within 56 days of referral. In October 2018, these figures were 93.1% and 98.7% respectively. These results are occurring in the context of significant increase in demand.

For child and family services, the average waiting time was 30 days for September 2018 and 30 days for October 2018. Reducing wait times has been a key focus for CAF services and activity has included seeing more people for a partnership appointment as the first contact. Whilst this has led to an increase in overall wait times, it is resulting in less people waiting for a partnership appointment and eliminating the two step process. Our results show 68.4% of people were seen within 21 days of referral in September 2018 and 81.0% were seen within 56 days of referral. In October 2018, these figures were 57.5% and 85.8% respectively.



New cases were created for 595 individual adults (unique NHIs) in September 2018 and 613 in October 2018. We are concerned about ongoing growth in demand for these services.

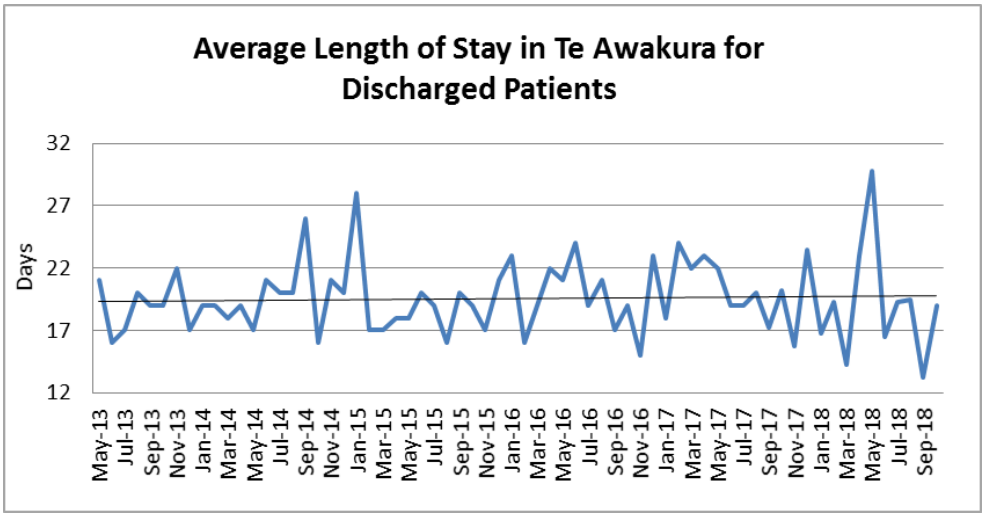
APPENDIX 1



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

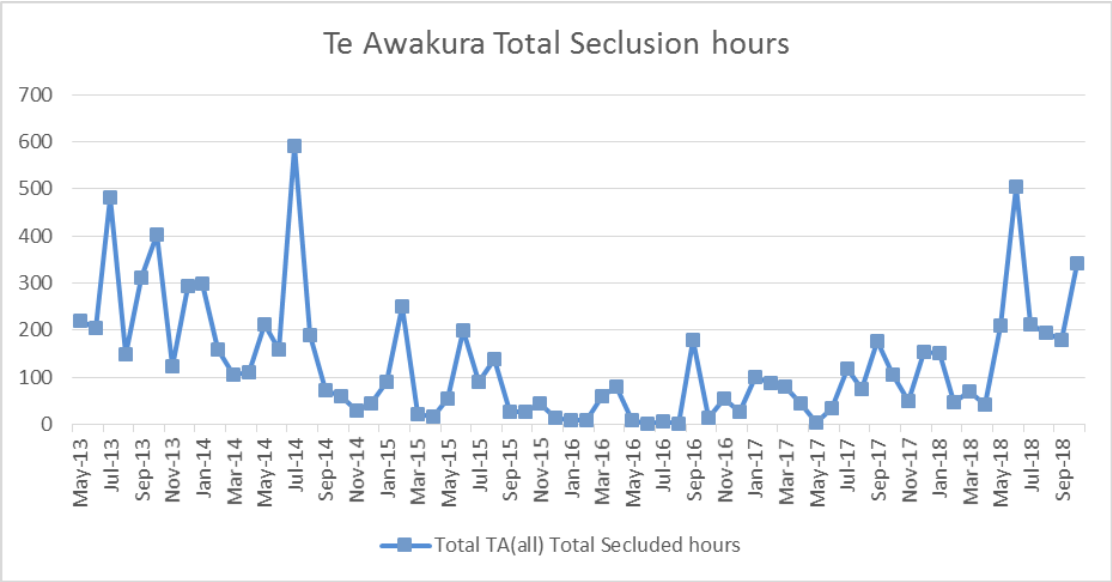
Occupancy in Te Awakura (the acute inpatient service) remains above this figure. Occupancy was 90% in September 2018 and 95% in October 2018.

The average number of consumers under care in this 64 bed facility was 68 in September 2018 and 81 in October 2018. There were 20 sleepovers during September 2018 and 64 sleepovers during October 2018.



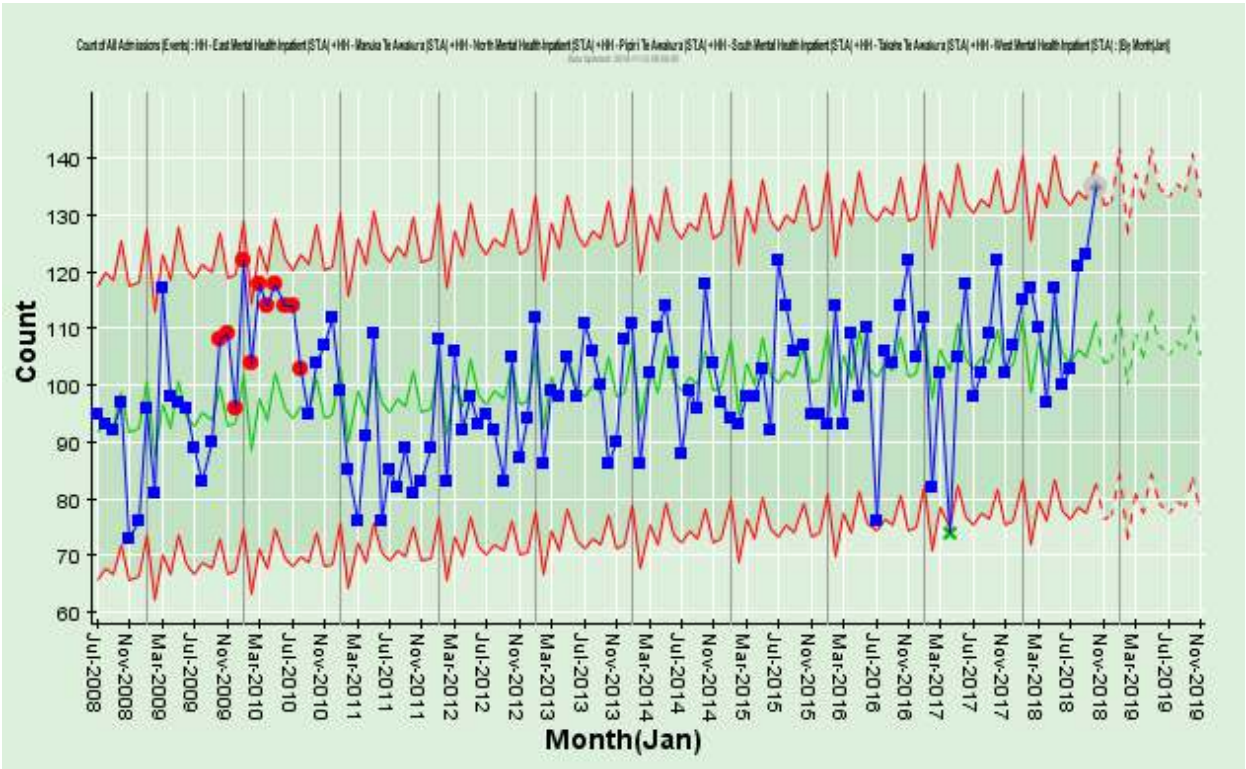
The average length of stay for consumers discharged from Te Awakura was 13 days for September 2018 and 19 days for October 2018. We are closely monitoring length of stay in terms of difficulties accessing suitable accommodation with intensive support. Approximately one-third of Te Awakura patients have been in service for longer than 30 days.

APPENDIX 1



Our focus on reduction of seclusion in Te Awakura continues. In September 2018, nine consumers experienced seclusion for a total of 180.1 hours. In October 2018, ten consumers experienced seclusion for a total of 341.0 hours. The recent increases have been a direct result of higher than usual number of acutely unwell consumers being admitted. In October, this was compounded by two of the four high care areas having limited capacity to manage acutely unwell people due to the high care needs of two people. The Te Awakura facility limits our ability to provide appropriate 'least restrictive' responses to people that are acutely distressed.

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



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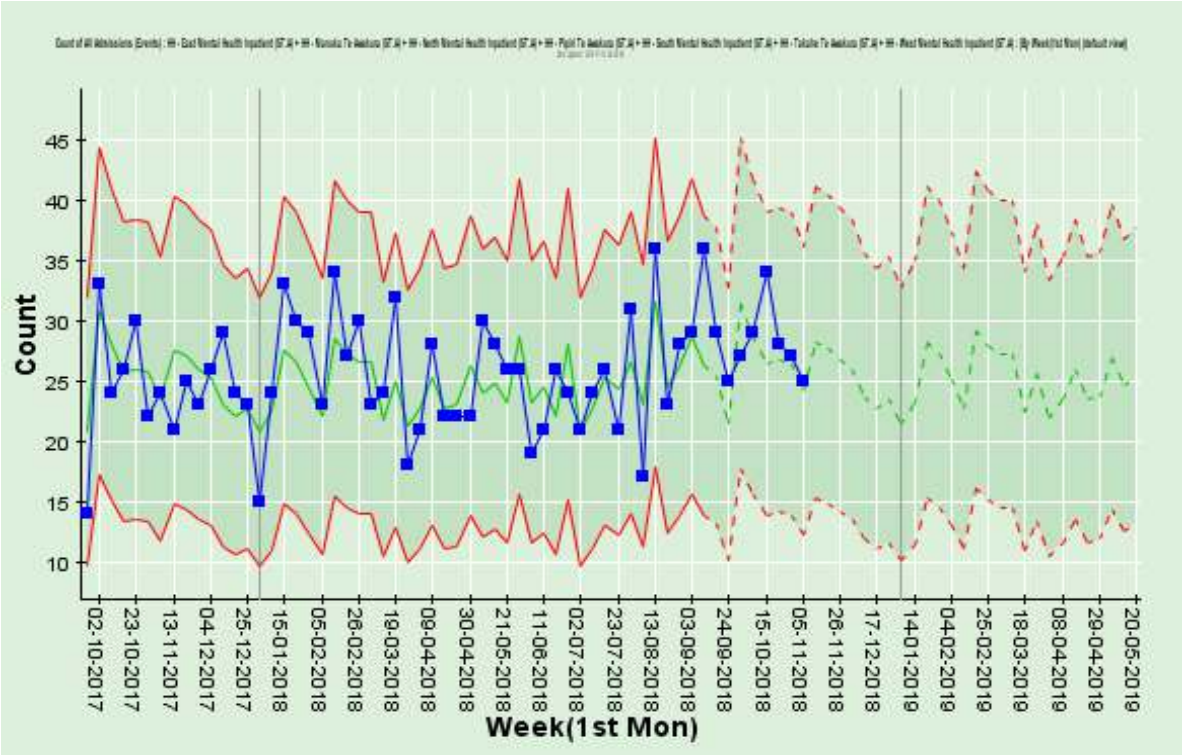
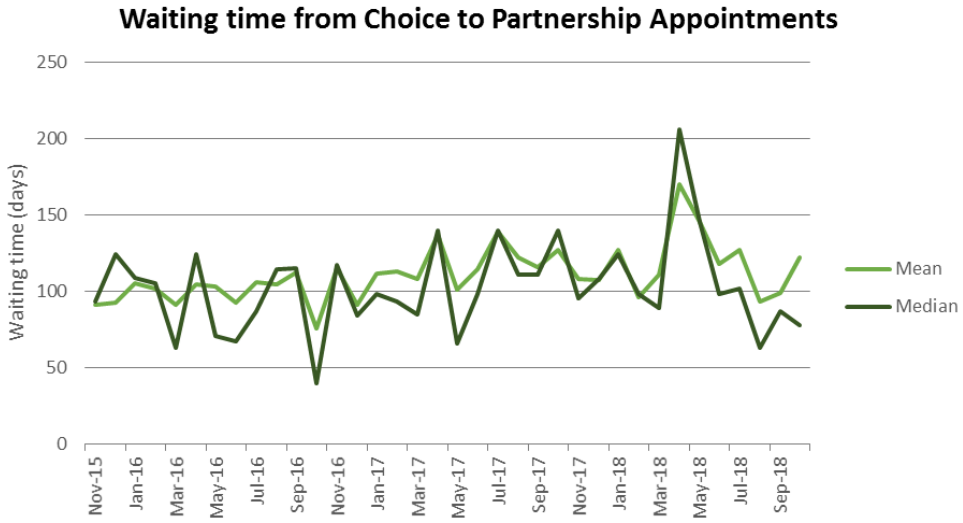


Child and Youth

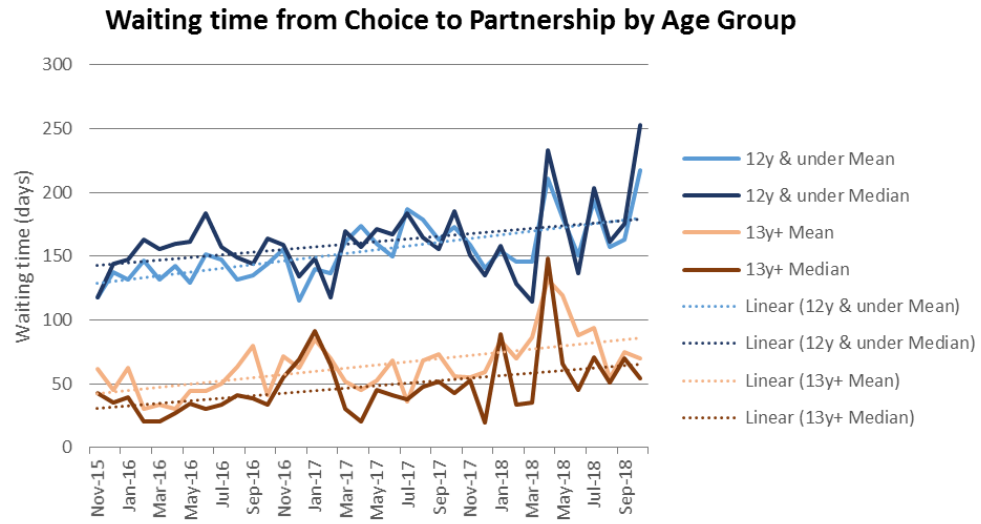
There has been a 100% increase in child and adolescent case starts in the past six financial years.

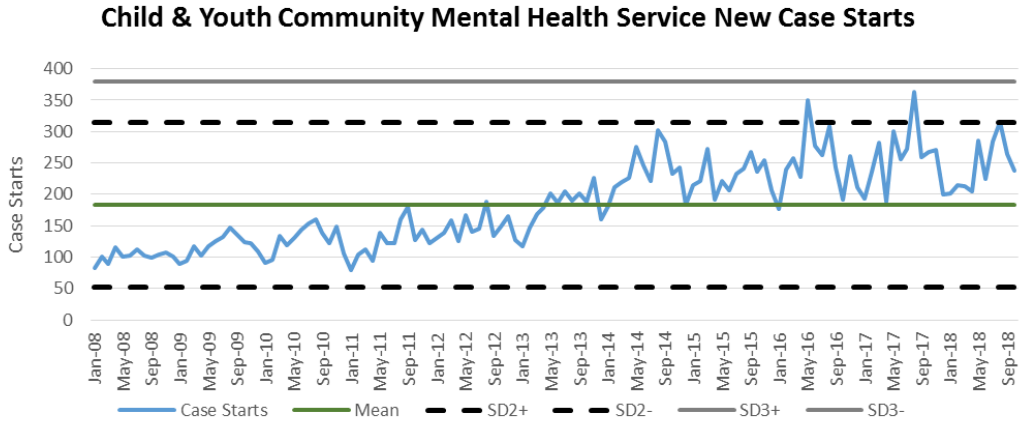
The focus on reducing wait times in the child and adolescent services is resulting in an internal wait of up to 20 weeks for some children and their families. Being seen early for the first contact is still important as it enables clinicians to make informed decisions about who is able to wait and who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

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

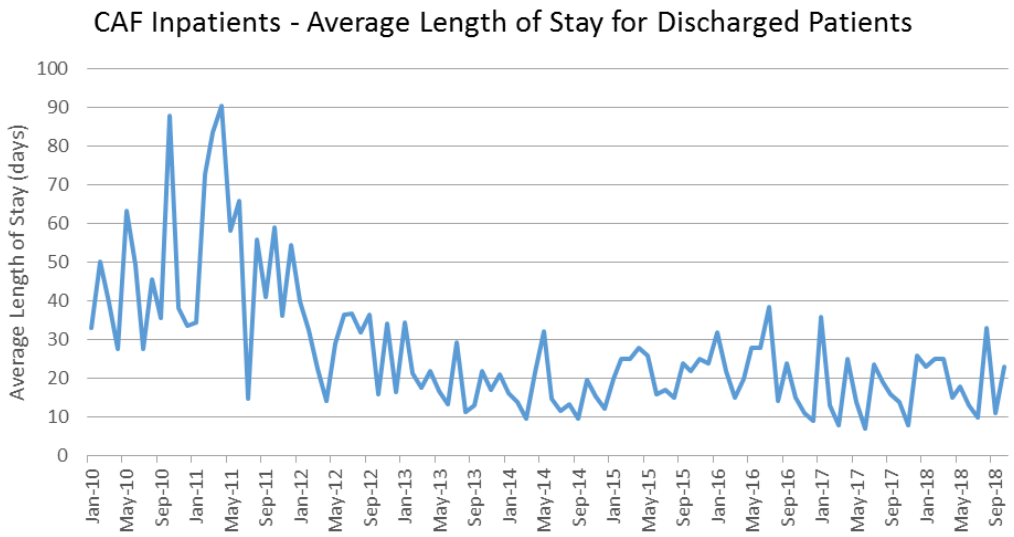


APPENDIX 1





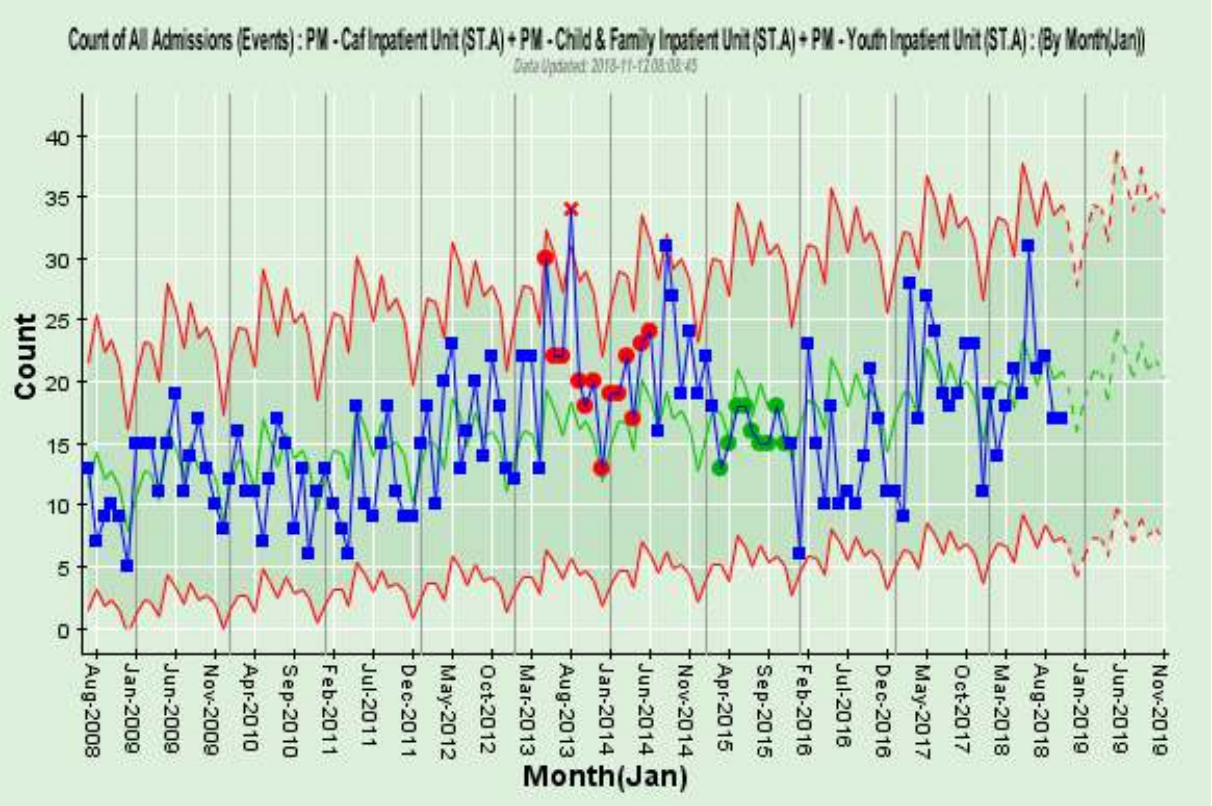
There were 264 new CAF case starts in September 2018 and 238 in October 2018. CAF services are making good progress with implementation of a Direction of Change that supports more integrated services across the age ranges.

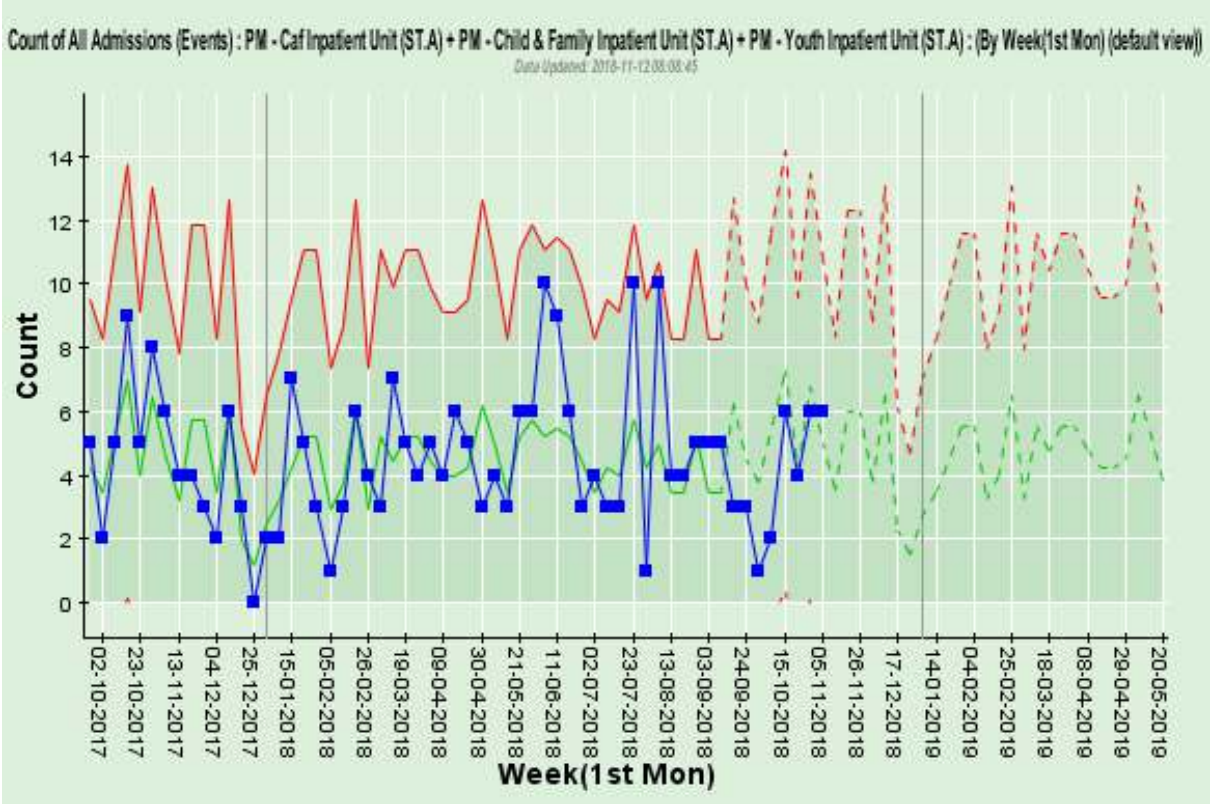


The average length of stay for discharged patients was 11 days for September 2018 and 23 days for October 2018.

APPENDIX 1

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





APPENDIX 1

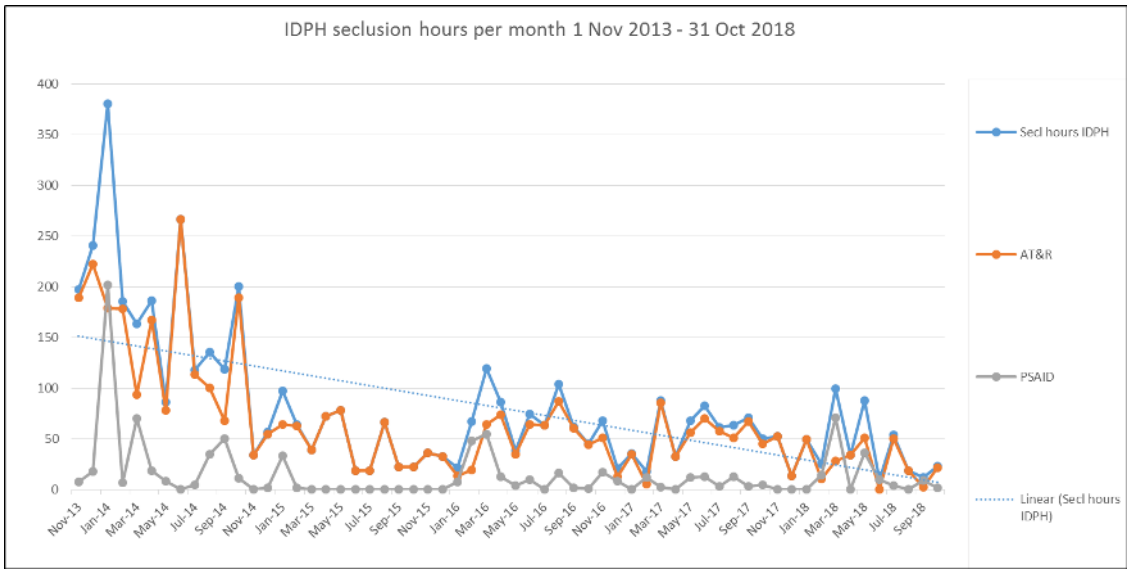
Intellectually Disabled Persons Health Service

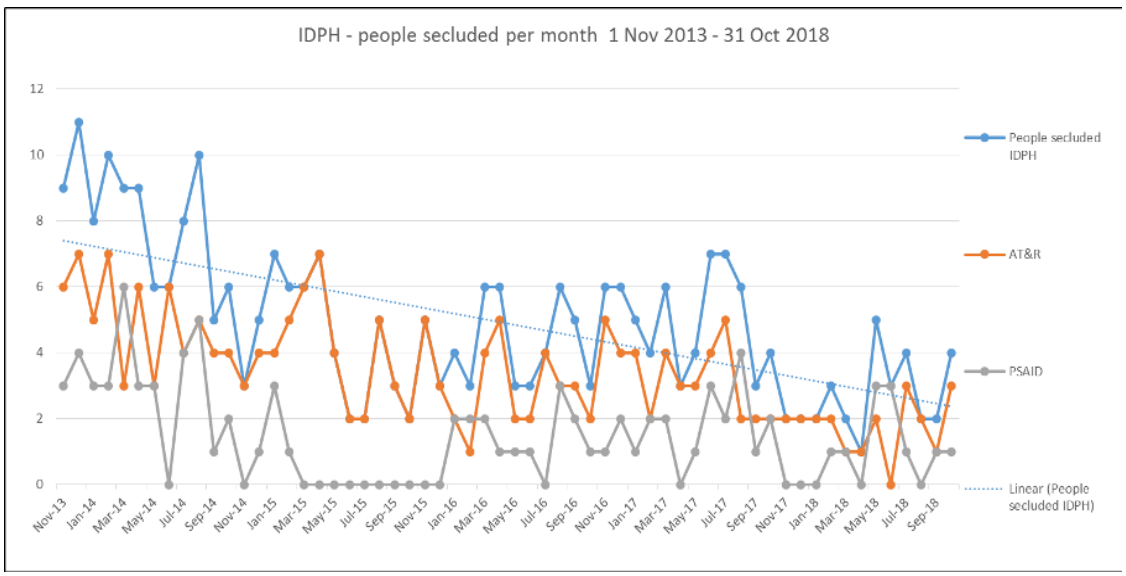
The IDPH Service inpatient units comprise a seven-ten bed secure unit, Assessment, Treatment and Rehabilitation (AT&R), and a 15 bed dual disability unit, Psychiatric Service for Adults with Intellectual Disability (PSAID) within the Aroha Pai Unit, Hillmorton Hospital.

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

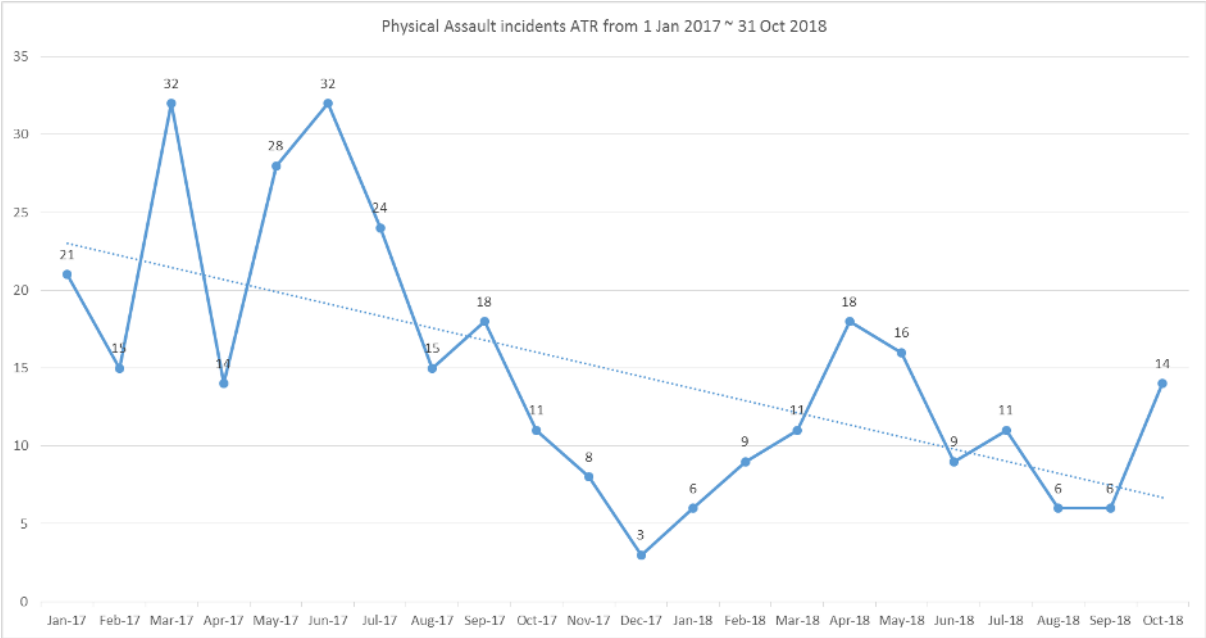
We work closely with the National Forensic Service (previously known as the National intellectually Disabled Care Agency or NIDCA) and Lifelinks Needs Assessment Service Coordination to seek solutions for placements. We provide both training for staff and carefully developed transition to discharge plans.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

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





APPENDIX 1


Physical Assault incidents ATR from 1 Jan 2017 ~ 31 Oct 2018
35
30
25
20
15
10
5
0
21
15
32
14
28
32
24
15
18
11
8
3
6
9
11
18
16
9
11
6
6
14
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
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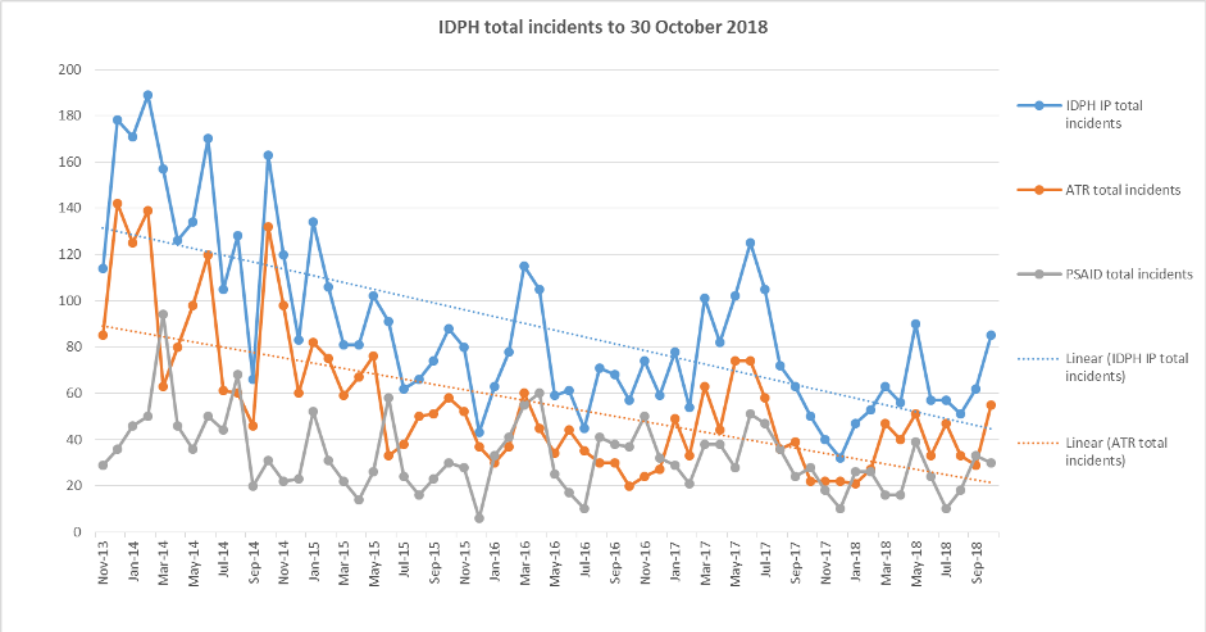
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18


IDPH total incidents to 30 October 2018
200
180
160
140
120
100
80
60
40
20
0
Nov-13
Jan-14
Mar-14
May-14
Jul-14
Sep-14
Nov-14
Jan-15
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Jul-18
Sep-18
IDPH IP total incidents
ATR total incidents
PSAID total incidents
Linear (IDPH IP total incidents)
Linear (ATR total incidents)

APPENDIX 1

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 4 Months Ended 31 October 2018

MONTH $'000						YEAR TO DATE				
18/19 Actual $'000	18/19 Budget $'000	17/18 Actual $'000	18/19 Variance $'000	18/19 vs 17/18 Variance $'000		18/19 Actual $'000	18/19 Budget $'000	17/18 Actual $'000	18/19 Variance $'000	18/19 vs 17/18 Variance $'000
					Operating Revenue					
412	403	559	9	(147)	From Funder Arm	1,933	1,605	2,455	328	(522)
1,579	1,553	1,531	26	48	MOH Revenue	6,143	6,207	6,106	(64)	37
4,004	4,168	3,879	(164)	125	Patient Related Revenue	16,875	16,699	17,003	176	(128)
1,934	1,388	1,459	546	475	Other Revenue	6,390	5,602	5,590	788	800
7,929	7,512	7,428	417	501	**TOTAL OPERATING REVENUE**	31,341	30,113	31,154	1,228	187
					Operating Expenditure					
					Personnel Costs					
60,440	61,131	55,066	691	(5,374)	Personnel Costs - CDHB Staff	235,358	236,648	214,961	1,290	(20,397)
2,128	1,672	1,803	(456)	(325)	Personnel Costs - Bureau & Contractors	7,593	6,726	8,033	(867)	440
62,568	62,803	56,869	235	(5,699)	**Total Personnel Costs**	242,951	243,374	222,994	423	(19,957)
13,705	11,981	11,836	(1,724)	(1,869)	Treatment Related Costs	51,151	47,994	47,083	(3,157)	(4,068)
4,106	3,423	3,895	(683)	(211)	Non Treatment Related Costs	14,653	13,964	15,518	(689)	865
80,379	78,207	72,600	(2,172)	(7,779)	**TOTAL OPERATING EXPENDITURE**	308,755	305,332	285,595	(3,423)	(23,160)
(72,450)	**(70,695)**	**(65,172)**	**(1,755)**	**(7,278)**	**OPERATING RESULTS BEFORE INTEREST AND DEPRECIATION**	**(277,414)**	**(275,219)**	**(254,441)**	**(2,195)**	**(22,973)**
					Indirect Income					
-	1	3	(1)	(3)	Donations & Trust Funds	4	5	5	(1)	(1)
-	-	-	-	-	Gain on Disposal of Assets	-	-	-	-	-
-	**1**	**3**	**(1)**	**(3)**	**TOTAL INDIRECT INCOME**	**4**	**5**	**5**	**(1)**	**(1)**
					Indirect Expenses					
2,134	2,160	2,144	26	10	Depreciation	8,409	7,844	8,602	(565)	193
7	-	-	(7)	(7)	Loss on Disposal of Assets	8	-	-	(8)	(8)
2,141	**2,160**	**2,144**	**19**	**3**	**TOTAL INDIRECT EXPENSES**	**8,416**	**7,844**	**8,602**	**(572)**	**186**
(74,591)	**(72,854)**	**(67,313)**	**(1,737)**	**(7,278)**	**TOTAL SURPLUS / (DEFICIT)**	**(285,826)**	**(283,058)**	**(263,038)**	**(2,768)**	**(22,788)**

APPENDIX 1

Summary of initiatives

Indication of Latest Efficiencies (including costs avoided)

		Core Financial Benefit			Ancillary Benefit	
		Budgetary Benefits			Non Budgetary Benefits	
Service	Name of initiative/project	Investment for project	$ savings	Financial year of savings	Costs avoided to date	Non-Financial Efficiency
Many	Paperlite processes – file storage project			$158,764		

Achievements/Issues of Note

Five years of information based improvements in dictation practice

This month marks the fifth anniversary of the first WinScribe report which was introduced to help us manage improvements in the dictation process and use of Winscribe licences. Since that time there have been remarkable individual and team improvements and widespread changes in performance that indicate the practices introduced over this time have helped us to work more efficiently.

Over a 60 month period there have been 1.5 million jobs dictated:

- Average length of dictation has stayed reasonably flat at around 2 minutes 35 seconds while transcription times have reduced by 7.5 minutes per job since September 2013, this is a reduction of 36%.
- Most jobs are being carried out in a timely manner. Around 82% of all dictation jobs have a transcription completion target of 5 days with this group now being completed in an average of less than 2.5 days.
- Total hours of dictation each month continue to increase, there are now around 500 more hours of dictation per month than in April 2014. The number of jobs completed each month continues to grow, even though there are several changes that have reduced the need for dictation in specific areas – such as the use of scOPe for operation notes. There are now routinely around 30,000 dictation jobs each month.
- Despite this the total number of hours spent transcribing these jobs has generally stayed flat. This is because the ratio between dictation and typing time has shown a 31% improvement since September 2013.
- Speech recognition has been helpful in Pathology in supporting the work flows. This area had over 2,100 jobs in August, all of them had a target of being completed in one day.

Paperlite processes are leading to reductions in file storage costs

The main focus of our paperlite approach is to ensure that information required to inform diagnosis and treatment of patients is readily available wherever it is required in the health system. Several services have focussed on effectively and safely running their clinics without the requirement to recall paper files by ensuring that the required clinical information is stored electronically. General Surgery and Gastroenterology are two services that have been successful in their attempts to avoid the requirement to recall paper files for their clinics. In addition both have also been successful at ensuring that as few paper forms are created as possible within their clinics.

These changes have had the desired advantage in that clinical information is now available via Health Connect South whenever a clinician requires it. It has also had advantages in the way that health system resources are used. Previous reports have highlighted the way that General Surgery has been able to re-allocate administrative resources to manage increased volumes of work in general Surgery and other Services as time handling files has been eliminated. In addition to this significant saving are being made in the cost associated with outsourced file storage.

In the twelve months to July 2016 file storage costs totalled $1,005,406. Two years later the cost was $814,838, a saving of $190,568 per year. The annual costs of recalling files, which is required both to access information and to file newly created paper records, has increased by $31,804 to $307,419 over the same period.

There are still many gains to be made that will reduce the cost of storage and recall of files. Discussions are ongoing with several services who run paperlite clinics but still create paper records that need filing. A major gain will be obtained once the process of gaining informed consent can be achieved electronically. Major gains will be made once Anaesthesia and Emergency Department are able to implement paperlite processes.

Paperlite – stocktake of forms used

Preparing for our shift to the new Outpatients' has been useful in helping us to think through the ways that we work. We have recognised that we did not know how big the challenge facing us is as we move towards paperlite ways of working carry and so a stocktake of the number of forms used in 16, mostly inpatient, areas of Christchurch Hospital has been carried out.

It identified that 735 distinct forms are used in these areas, that it is not always easy to find the right form for the task and that all wards have hard copy stockpiled for times when forms cannot be printed due to failure of electronic systems.

This work has given a clear measure of the work to be done as we move towards paperlite practices and will help us monitor progress. It has prompted a number of areas to cull obsolete forms. Plans are afoot to keep a single emergency supply of printed forms in the emergency linen room for when electronic copy is not available, reducing waste and making it easier to ensure that only up to date versions are available.

Combining delivery runs to make best use of resources

Effective operation of Christchurch Hospital requires that different types of supplies are delivered on a timely basis to all areas of the hospital. Over time several services have put in place routine delivery runs to ensure that mail, medicines, clinical records and sterilised equipment are delivered. People from these various units circulate around the hospital, criss-crossing each-others paths, each providing an effective service. There is a risk that if we continue to work in existing ways as the campus grows in both floor area and complexity that the total time required by these tasks will increase. When viewed collectively, and with the trend towards less mail and paperlite ways of working, it is clear that we can make more efficient use of these people's time, releasing some to enable other tasks to be performed.

A fresh approach, promoted by the Releasing Time To Care and an Xcelr8 project, has been put in place with the opening of Christchurch Hospital Outpatients' Building that combines these four delivery runs into one and standardises our approach. Mail, clinical records, pharmacy and sterile supplies will be delivered to the Outpatients' building as part of a single routine delivery run several times a day. While records and mail were previously dropped at several individual places within each department the process has been further streamlined by use of single drop off/pick up points for mail and records on each floor of the new building. These points are standardised, and swipe card secured.

Existing Orderly capacity will be used to carry out this task and Pharmacy Technician Sterile Supply and Mail Room capacity that was previously required to deliver to Outpatients' areas will be freed up to carry out other tasks, often those that only those teams can carry out.

Following a three month test period, during which lessons will be learned and processes improved, we will work within staff involved in these duties to consider rolling this approach out to areas within the Riverside and Parkside Buildings and then in Christchurch Hospital Hagley.

Optimising the way that Hospital Aides and Security staff are used

There are times during the hospital journey of some patients that a "Hospital Aide Special" duty is put in place, usually when patients are behaving in a way that risks their wellbeing, for example where a patient is at risk of falling and are unaware of the risk they create for themselves by attempting to leave their bed. Hospital Aides also provide rostered duties in wards, ensuring that the ward runs smoothly by managing supplies, preparing bed spaces for new patients and providing other care duties that do not require nurses.

The significant demands on the Christchurch Hospital pool of staff often means that there are insufficient Aides to cover all the special duties, meaning that Aides are regularly reassigned from other wards and duties to cover. This

impacts on the smooth running of these wards. There is a perception that Hospital Aide Special duties are sometimes used when a much less resource intense method could be appropriately used.

When reviewing this it quickly became clear that there was no consistent guidance about when Hospital Aide Specials or Security duties should be put in place, or how these duties should be carried out.

A series changes are being made to address this. The first involves defining an assessment form that provides clear guidance about the most appropriate response for each patient.

This form also provides guidance to the Hospital Aide or Security Officer about why they are stationed with this particular patient, clearly describing the support the patient requires and providing space for the Hospital Aide or Security observations so that we can improve the way that we care for these patients.

An education package has been created, tested and will shortly be deployed.

Streamlined Process for RMO Training Related Expenses

Previously all RMO training expenses were submitted on the same type of paperwork as other expenses. While authorisation was required by the Service Manager or relevant Clinical Director, amongst others, the signoff process was not clear or standardised. This meant that there was often duplication and inefficiency in our processes, there was not clear reconciliation of which expenses had already been paid and the process was open to being abused. Claims also often languished in a pile following rejection due to a lack of clarity about who had seen them and what the next appropriate action was.

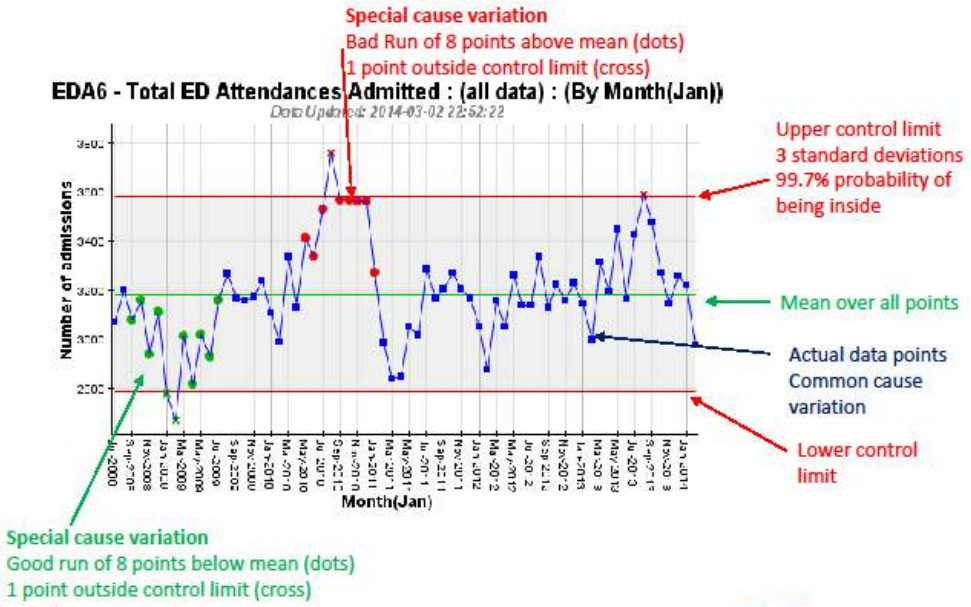
Training related expenses are increasing both in volume and value and was the group of expense claims that provided the most significant challenge. The forms and processes for claiming these expenses have been redesigned, ensuring that processes are now clear and easy to follow, potential for duplication of processes or inadvertent duplication of claims has been removed. Oversight has been improved by requiring all claims for training related expenses to be authorised by the training or educational supervisors. Educational supervisors signing off claims are also engaging in discussions regarding the appropriateness of claims before signing.

This has resulted in a much more timely and transparent process for RMOs and reduced the amount of claims that were being rejected by finance. It is also ensuring RMOs are having the appropriate discussions with supervisors before claiming the expense. Finally it has also allowed for greater visibility of claims and reduced the risks associated with this large cost.

The RDST is working with the MAX project team to integrate the RMO training related expenses into MAX, however the current double sign off process is proving challenging. The MAX team however has assisted with our employment related expense claims not only allowing RMOs to claim through MAX but also building in reminders for their Annual Practicing certificate expiry, a process that had previously been done manually by the RDST.

APPENDIX 1

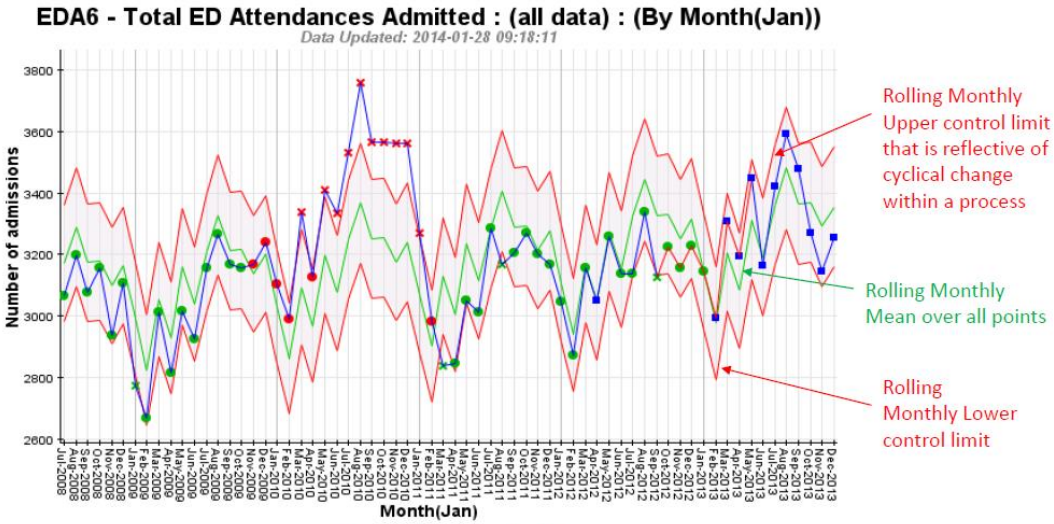
SPC: How to Interpret a Control Chart



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

PLANNING & FUNDING ELECTIVES PLAN – 2018/2019

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

SOURCE: **Planning & Funding**

DATE: **29 November 2018**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This Plan provides the Committee the operational context for the provision of outplaced, outsourced as well as internal provision and provision by other DHBs for elective services in the Canterbury DHB for the 2018/19 year.

2. RECOMMENDATION

That the Committee:

i. notes the Planning & Funding Electives Plan for 2018/19.

3. SUMMARY

This Plan intends to secure short to medium term sustainable solutions to meet current levels of demand for acute and planned surgical services, and to allow equity of patient access until the new Acute Services Building (*ASB*) opens, when major changes in the location and delivery of surgery services can be made.

4. APPENDICES

Appendix 1: Planning & Funding Electives Plan – 2018/19

Report prepared by: Ralph La Salle, Team Leader, Planning & Funding

Report approved for release by: Carolyn Gullery, Executive Director, Planning Funding & Decision Support

2018/19

P&F Electives Plan 2018/2019

CANTERBURY DHB

RALPH LA SALLE

Release Date: 27 Sep 2018

Contents

Release Date: 27 Sep 2018

1. Summary

This plan provides the operational context for the provision of outplaced and outsourced elective services in Canterbury DHB providing the direction for Elective Surgical Discharges achievement, timely access to elective surgery, perfroming our role as the largest tertiary hospital in the South island, preparing for Bowel Screening and providing equity of access to surgery within our resources.

Within this context, the core elements of the plan are:

- Elective Surgical Discharges Achievement
  - Provision of internal, outplace and outsource surgery;
- Timely access to surgery
  - Improve our level of ESPI achievement;
- Assist other DHBs meet their health target, ESPIs and Faster Cancer Treatment targets
  - Meet our IDF volume commitments;
- Prepare for Bowel Screening Rollout
  - Develop sustainable solution for gastro waitlist;
- Provide Equity of access to surgery within our resources
  - Invest in surgery areas where we deliver below national intervention rate
- Robust and timely data and management information

By integrating this approach utilising the whole system including internal and private provision, the plan is intended to secure short to medium term sustainable solutions to meet current and future levels of demand for acute and planned surgical services and to allow equity of patient access until the new Acute Services Building (ASB) opens when major changes in the location and delivery of surgery services can be made.

2. Introduction

This plan is intended to provide direction over the short term. For the next two years, the DHB will have reached its internal capacity to provide surgery within its own facilities due to a number of factors including population growth, aging population, new technologies, new treatments and faciltiy constraints. This plan will drive change: both in the way we deliver acute trauma and elective (planned) services as well as a change in the time that patients have to wait to access these services.

Aim – To develop a tactical operational plan for the next year and to undertake actions towards providing an interim solution for our facility constraints

Intervention rates and waiting times are key elements of improvement which need to be made to maintain and improve service provision.

Without undertaking this planning we run the risk of the following issues combining with population growth aggregating into service failure;

- The need to uplift elective surgical discharges by 452 specifically in 2018/19,
- The need to continue to increase the elective intervention rate by 550 discharges each year on average for each year after 2018/19,
- The projected increase in acute theatre need in 2018,

Release Date: 27 Sep 2018

- The projected increase in tertiary caseload year on year,
- The reliance of other South Island DHBs on our backstop capacity for their vulnerable services,
- The provision of a sustainable solution to the West Coast DHB through the Tranzalpine service,
- The support of current facilities projects here and at WCDHB including start-up timings,
- The support of new facilities programme of work, and
- The continued rebuild and refurbishment work that is on-going.

This plan proposes that this can be achieved through a combination of service improvement and intervention, strong demand management, an increase in elective capacity and pragmatic management. All work must be based firmly on a whole of systems approach.

3. Context

Demography

The Canterbury DHB has the largest total population aged over 65 of any DHB in the country, and will do so for at least the next 15 years. 15% of our population were aged over 65 in 2013, up from 13.4% in 2006 and increasing to 15.9% for 2018/19.

CDHB population estimates have grown to 567,870 for the 2018/19 year up by 9,040 from the previous year.

Other data include:
Male = 285,080
Female = 282,790

Maori = 51,840
Pacific = 14,010
Asian = 58,860

Over 65+ = 90,120

All numbers above influence electives delivery from various points;

- intervention rate - we have to do more to maintain equity with national intervention rates with incresed population
- co-morbidity – as people age the elective work we do get becomes more complicated and takes more time in theatre
- aging – more people are living longer requiring more treatment and more complex treatment
- new treatments – continued investment by the sector in new drugs and new therapies continues to drive demand and in some cases provide new levels of demand which the health system has not seen before
- ethnicity – our Maori population alone is larger than the total individual population in four other DHBs and the sum of the Maori, Pacific and Asian ethnicities in CDHB at 124,710 is larger than the total individual populations in 7 other DHBs

Demand

Achievement of national intervention rates for electives surgery is part of the information used to inform how CDHB prioritises allocation of resources within our system. 2016/17 was the first year that CDHB provided more surgical discharges overall than national intervention required. 2018/19 will see us needing to provide 452 additional surgical discharges. In addition, to create more acute theatre space, we will be relocating approximately 10 half day sessions out of Christchurch Hospital. There is no more capacity which can be accessed at CHCH hospital so any new discharges will have to be done by outplacing or outsourcing.

Activity/capacity gap

The current gap between the numbers of theatres we need to the number of physical theatres we have available to us in CDHB facilities is running between 7-8 theatres short. Further theatre capacity will not become available for us until the ASB facility is open in late 2019. For 2018/19, this gap implies that the any increase in discharges from last year's total will need to be done in either an outplaced or outsourced manner.

4. Operational Plan

At a high level, the basis of the electives plan is driven by the flow the system generates through its major constraint. For both the whole health system as well as each department, the major constraint is the availability and use of surgical theatres followed closely (and seasonally by bed capacity particularly in winter). With that in mind, the analysis below identifies the volumes needed to ensure volume of surgery is completed.

Canterbury Acute Volume Requirements

This operational plan is developed using the forecast volumes found in the rolling forecast model for Canterbury DHB.

Demand Assessment – Acute Surgical Discharge Volume					
	Actual	Actual	Actual	Actual	Forecast
	14/15	15/16	16/17	17/18	18/19
Previous Year – Acute - CDHB	17081	17592	18943	19442	20858
IDFs	963	1033	1186	1257	1225
Totals – Acute	18044	18625	20129	20699	22083

- Forecast based on detailed business case volumes for the period until 2018/19
- This equates to an increase of over 22% since 2014/15

Canterbury Acute Volume Capacity

The calculation for acute capacity is made through a series of high level calculations

- In 2014/15, acute capacity was based on three dedicated acute theatres 365 days, 24 hours per day and one dedicated theatre on weekdays (Monday through Friday) operating on a two half day sessions per day, 5 days per week.
- It was thought that between 2014/15 and 2019, no further acute theatre capacity would open; however, the increased population, the increase in directed services and destination policies and the complexities of those presentations required the staged opening of

Release Date: 27 Sep 2018

additional acute theatre capacity in the 2017/18 year with the potential for further acute need in 2018/19.

- The intention moving forward is not to substitute acute surgery for elective sessions if at all possible.

Canterbury Elective Volume Requirements

This electives plan is developed using the current 2017/18 health target volume increased by our share of elective uplift. These are consistently matched against those projections within current forecast models.

CDHB's Electives Surgical Discharges for the 2018/19 year total 21,782 which is an increase of 452 from the 2017/18 Health Target of 21,330. Included in the 21,782 are:

Elective Cases from a Surgical Discharge	18,931	These are normal planned cases
Arranged Cases from a Surgical Discharge	1,778	These are discharges where the plan for the case and the discharge occurs within 3-7 days
Elective Cases from a Medical Discharge	496	Occurs when a patient has a surgical admission but is discharged by a medical specialty
Arranged Cases from a Medical Discharge	225	Occurs when a patient has a surgical admission but is discharged by a medical specialty
Previous Additional General Surgery and Orthopaedic Discharges	120	MOH wishes to maintain the gen surg and orthopaedic discharges which were funded additionally in 2017/18
Bariatric Discharges	14	The bariatric initiative ended and these cases
Regional Discharges	218	This initiative continues – discharge number fell by 1 from previous year
Total Discharges	21,782	

The required uplift of discharges is 452 broken down as follows:

- 168 are base uplift
- 151 are funded uplift
- 120 are noted to maintain previous addl gen surg and ortho volumes
- 14 are noted to maintain previous bariatric surgery volumes
- (-1) is the reduction in regional volume

Given that bariatric, additional general surgery and orthopaedic volumes from previous year will remain, we need to distibute the balance (452-1-120-14=317). For 2018/19, we are investing in Plastics (159 discharges) and ORL (ENT) (160 discharges) to reduce the gap in intervention rates.

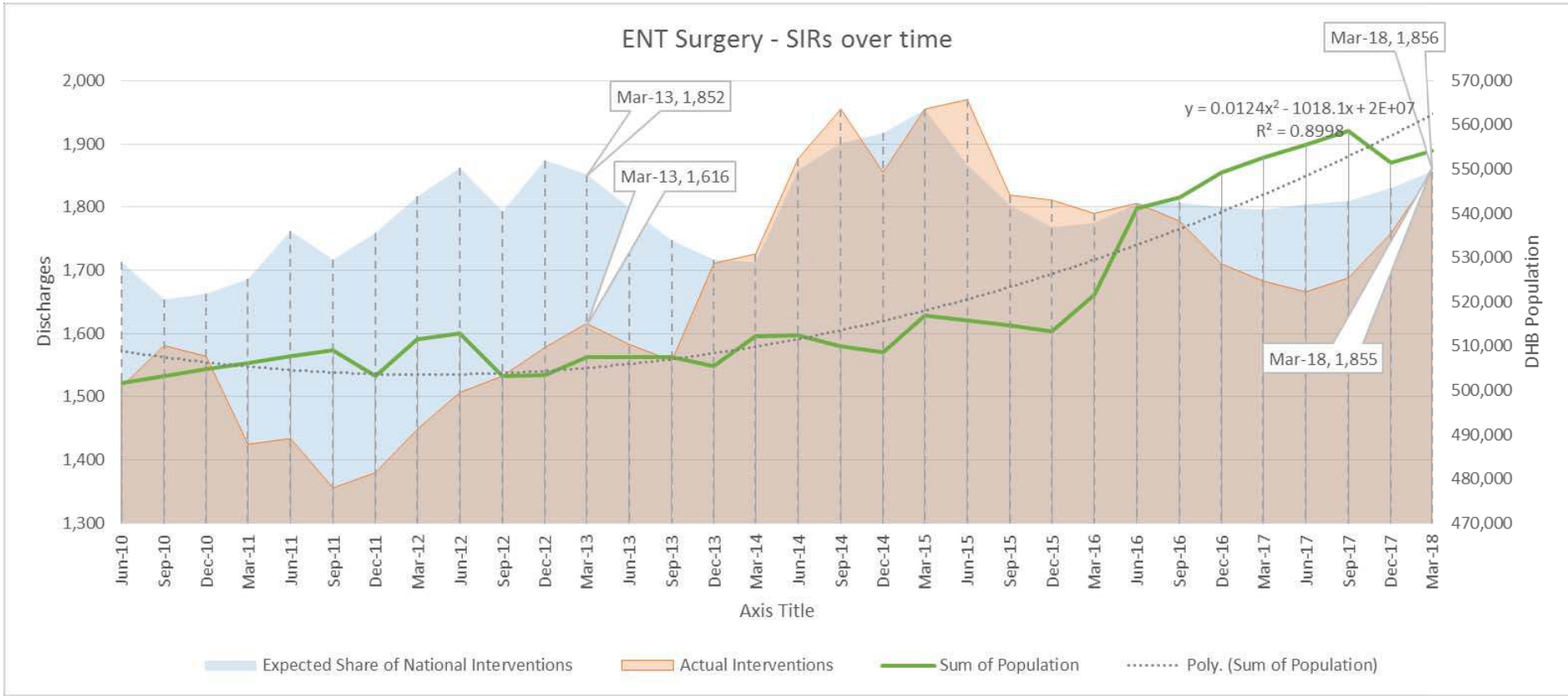
Release Date: 27 Sep 2018

Plastics Intervention Rates

Plastics standardised intervention rate (SIR) as of March 2018 is 78 discharges lower than expected. The increased investment of 159 discharges over the next year will provide the step change to move Plastics to meeting equity with national share.

6

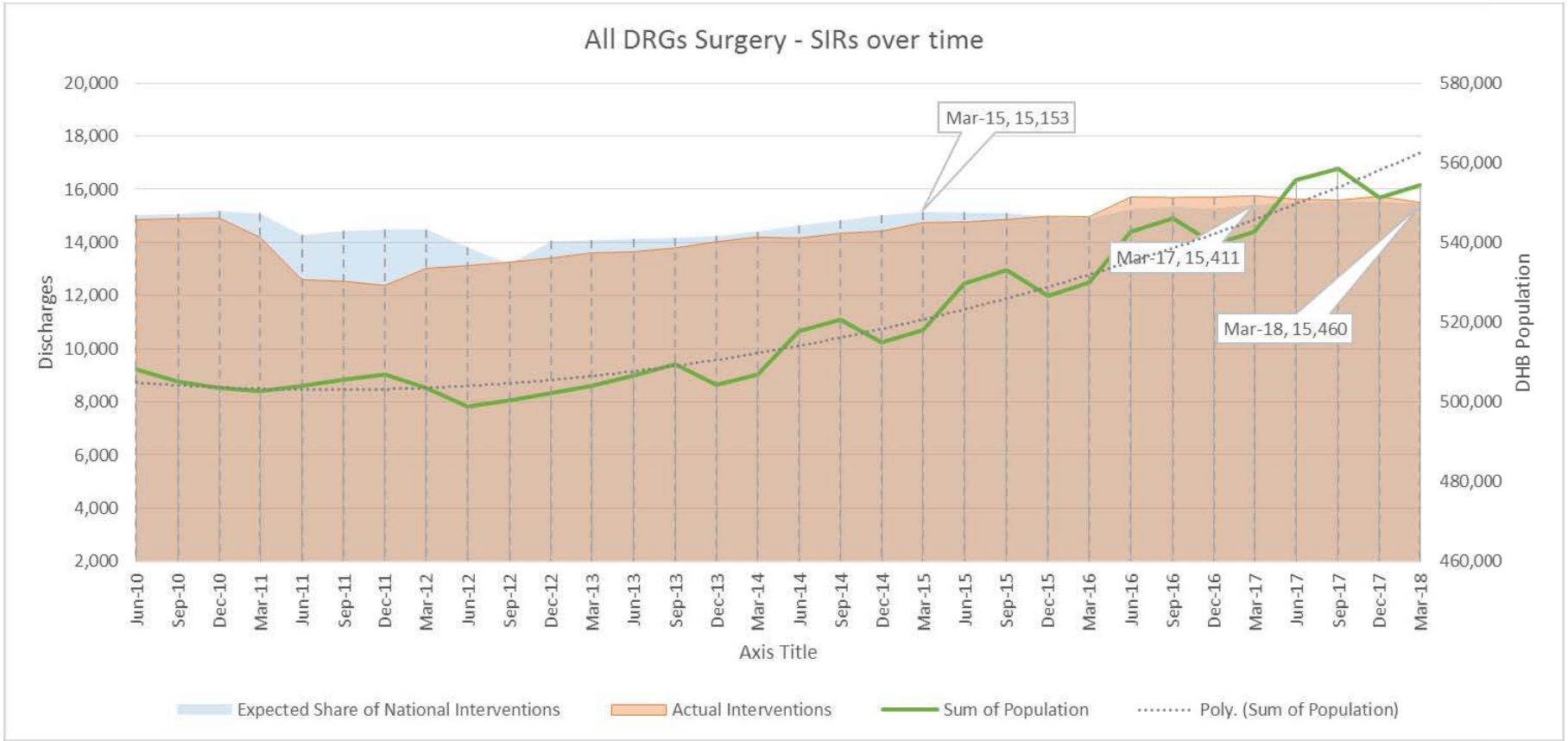
ORL (ENT) Intervention Rates



While ENT rates have shown recent improvement, they are highly volatile and take time and resource to gain back any lost ground. The investment in additional ENT discharges will provide a step change to move this service to a sustainable level of intervention for the population.

Other areas requiring investment in future years are dental, orthopaedics and ophthalmology.

All Surgery DRG Intervention Rates



Overall Canterbury continues to provide more surgical discharges for its population than the national intervention rates. Electives planning continues to reduce the individual gap areas as well as create the step changes necessary to have all departments and specialties providing at or above the national intervention rates

P&F Electives Plan: 2018-2019

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Why we are doing this	How we will do it	What success looks like
We want to achieve our Health Target to ensure equitable elective services to our population	Provide 21,782 elective surgical discharges using the whole health system including internal, outplaced and outsourced surgery	• Internal providers deliver their surgical volumes • Outplaced and outsourced volumes are delivered
We want to provide timely access to elective surgery	Increase our level of ESPI achievement	• Reduction of total wait list numbers to sustainable levels • Although we have a dispensation for 18/19, we will continue to try to meet or better ESPI wait time targets
We want to assist other DHBs meet their health target and ESPI requirements	Provide capacity in our system for other DHBs tertiary acute and elective cases	• We meet or exceed our IDF volume commitments with no detriment to our own population
We want to prepare CDHB for Bowel Screening roll out in 19/10	Work to achieve sustainable solution for gastro wait list	• Achievement of diagnostic colonoscopy targets
We want to provide equity of access to surgery within our resources	Invest in surgery areas where we are delivering below national intervention rates	• All services will provide standardized intervention rates at or above national rate

Enablers

- Technology and analytics to support high quality, timely care, access and use of resources
- Integrate SIPICs into 100 days program
- Further expand 100 days concept to Follow Up area

Release Date: 27 Sep 2018

5 Elective Volumes

Electives volume delivery for the 2018/19 year will combine discharges from internal CDHB provision (CHCH Hospital and Burwood), discharges done by other DHBs for CDHB and outplaced and outsourced private arrangements. A planned breakdown of volume by department in shown below.

Internal provision (including outplaced cases)

PUC	Description	To Be Done Internally	%
MS02016	Skin Lesion Removal	1900	12.2%
S00.01	General Surgery – Inpatient Services (DRGs)	1929	12.4%
S15.01	Cardiothoracic – Inpatient Services (DRGs)	178	1.1%
S25.01	Ear Nose and Throat – Inpatient Services (DRGs)	1727	11.1%
S30.01	Gynaecology – Inpatient Services (DRGs)	2164	13.9%
S35.01	Neurosurgery – Inpatient Services (DRGs)	252	1.6%
S40.01	Ophthalmology – Inpatient Services (DRGs)	1676	10.8%
S40007	Intraocular injections	322	2.1%
S45.01	Orthopaedics – Inpatient Services (DRGs)	1591	10.3%
S55.01	Paediatric Surgical Services (DRGs)*	490	3.2%
S60.01	Plastic & Burns – Inpatient Services (DRGs)	1661	10.7%
S70.01	Urology – Inpatient Services (DRGs)	1173	7.6%
S75.01	Vascular Surgery – Inpatient Services (DRGs)	454	2.9%
	Total	15517	100.0%

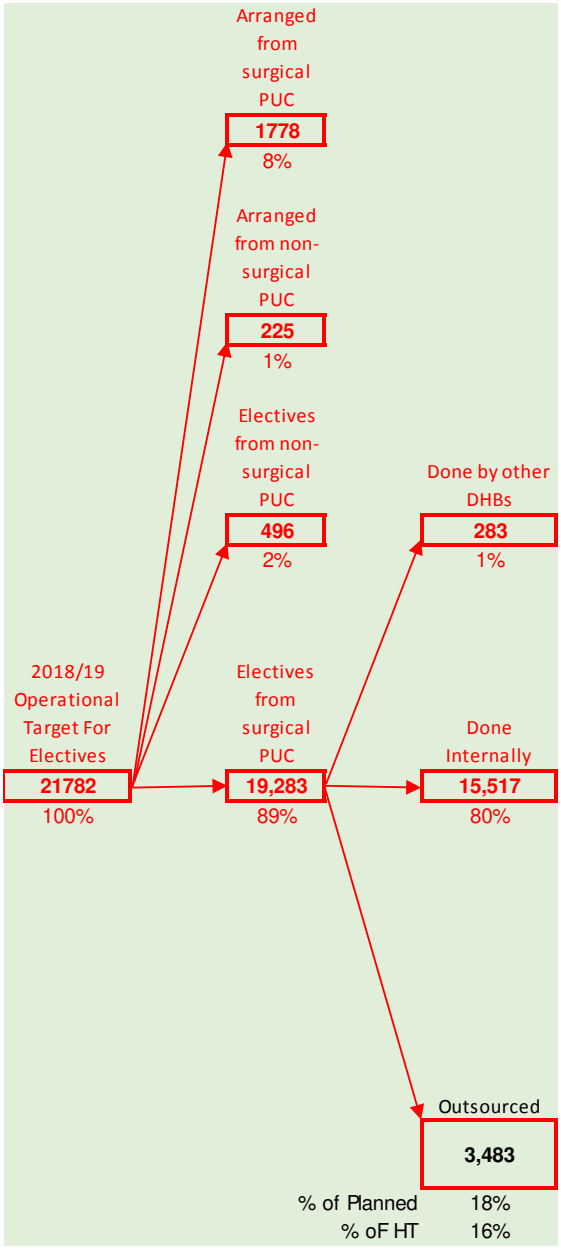
Done by other DHBs

PUC	Description	Discharges	%
S00.01	General Surgery – Inpatient Services (DRGs)	46	16.3%
S15.01	Cardiothoracic – Inpatient Services (DRGs)	2	0.7%
S25.01	Ear Nose and Throat – Inpatient Services (DRGs)	109	38.5%
S30.01	Gynaecology – Inpatient Services (DRGs)	25	8.8%
S35.01	Neurosurgery – Inpatient Services (DRGs)	14	4.9%
S40.01	Ophthalmology – Inpatient Services (DRGs)	8	2.8%
S45.01	Orthopaedics – Inpatient Services (DRGs)	42	14.8%
S55.01	Paediatric Surgical Specialties (DRGs)	2	0.7%
S60.01	Plastic & Burns – Inpatient Services (DRGs)	31	11.0%
S70.01	Urology – Inpatient Services (DRGs)	4	1.4%
S75.01	Vascular Surgery – Inpatient Services (DRGs)	0	0.0%
	Total	283	100.0%

Outsourced

PUC	Description	15/16 Outsourced Discharges	16/17 Outsourced Discharges	17/18 Outsourced Discharges	18/19 Outsourced Discharges	Total	%
S00.01	General Surgery – Inpatient Services (DRGs)	460	423	14	-1	896	25.7%
S15.01	Cardiothoracic – Inpatient Services (DRGs)	110	0	0	0	110	3.2%
S25.01	Ear Nose and Throat – Inpatient Services (DRGs)	100	0	152	160	412	11.8%
S30.01	Gynaecology – Inpatient Services (DRGs)	0	0	0	0	0	0.0%
S35.01	Neurosurgery – Inpatient Services (DRGs)	0	0	0	0	0	0.0%
S40.01	Ophthalmology – Inpatient Services (DRGs)	0	700	0	0	700	20.1%
S40007	Intraocular injections	0	0	0	0	0	0.0%
S45.01	Orthopaedics – Inpatient Services (DRGs)	0	0	0	0	0	0.0%
	Elective Joints (hips & knees)*	750	100	0	0	850	24.4%
	Elective - Other	0	0	36	0	36	1.0%
S55.01	Paediatric Surgical Services (DRGs)*	0	0	0	0	0	0.0%
S60.01	Plastic & Burns – Inpatient Services (DRGs)	100	0	100	159	359	10.3%
S70.01	Urology – Inpatient Services (DRGs)	0	0	0	0	0	0.0%
S75.01	Vascular Surgery – Inpatient Services (DRGs)	50	70	0	0	120	3.4%
	Total	1570	1293	302	318	3483	100.0%

Elective Surgical Discharge Make up



For 2018/19, 18% of what we do will be outsourced. In addition, we expect another 3,000 to 3,500 cases will be done in an outplaced arrangement. We expect about 30-35% of what surgery we provide will be done external to the DHB theatres.

Release Date: 27 Sep 2018

CLINICAL ADVISOR UPDATE – MEDICAL

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NOTES ONLY PAGE

WORKPLAN FOR HAC 2019 *(WORKING DOCUMENT)*

9am start	31 Jan 19	04 Apr 19	30 May 19	1 Aug 19	3 Oct 19	5 Dec 19
Standing Items	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes
Standing Monitoring Reports	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report
Planned Items	Clinical Advisor Update - Nursing (Mary Gordon) & Allied Health (Jacqui Lunday-Johnstone) Oxford Model of Care	Clinical Advisor Update –Medical (Dr Sue Nightingale) 2019 Winter Planning Update	Clinical Advisor Update - Nursing (Mary Gordon) & Allied Health (Jacqui Lunday-Johnstone)	Clinical Advisor Update –Medical (Dr Sue Nightingale) H&SS 2016/17 Year Results Labs Presentation	Clinical Advisor Update - Nursing (Mary Gordon) & Allied Health (Jacqui Lunday-Johnstone)	Clinical Advisor Update – Medical (Dr Sue Nightingale) 2019 Winter Planning Review
Presentations	Christchurch Campus – Respiratory (Sleep Service)	Burwood Campus	Christchurch Campus - Child Health TBC: SMHS	TBC: Labs	TBC: Ashburton / Rural Health Christchurch Campus – ORL (ENT)	
Governance and Secretariat Issues						2020 Workplan
Information Items	2019 Workplan	2019 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 2019 Workplan	2019 Workplan	2020 Meeting Schedule 2019 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 2019 Workplan
Public Excluded Items	CEO Update (as required)	CEO Update (as required)	CEO Update(as required)	CEO Update (as required)	CEO Update (as required)	CEO Update (as required)

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

SOURCE: **Corporate Services**

DATE: **29 November 2018**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Committee:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of the minutes of the public excluded meeting of 4 October 2018	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(If required)*	Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)

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

3. SUMMARY

The Act, Schedule 3, Clause 32 provides:

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

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

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

Clause 33 of the Act also further provides:

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

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

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

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

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

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

QUALITY AND PATIENT SAFETY INDICATORS – LEVEL OF COMPLAINTS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

SOURCE: **Quality and Patient Safety, Corporate Services**

DATE: **29 Nov 2018**

Report Status – For:	Decision ☐	Noting ☐	Information ☑

1. ORIGIN OF THE REPORT

The purpose of this report is to place before the Committee information on the number of external complaints received from patients of the Canterbury DHB. This is a regular six monthly information report on the Committee's work plan.

2. DISCUSSION

Attached (Appendix 1) is a report outlining the "All Hospitals Complaint Rate" expressed by rate of 1000 contacts for the period July 2016 to September 2018.

The report provides information on the number of complaints received in relation to the total number of: admissions; ED attendances (where the patient was not subsequently admitted); and outpatient attendances in the period at all Canterbury DHB hospitals. The total complaints rate data now includes complaints to the office of the Health and Disability Commissioner (*HDC*) about care provided by the Canterbury DHB.

Canterbury DHB has implemented the South Island Electronic Consumer Feedback Module in Safety 1st. From 1 December 2017, all hospital feedback data is entered into Safety 1st. This module includes compliments, complaints and suggestions, and has been in use in other DHBs since 2015. It provides more visibility of data, including HDC complaints, as well as easier analysis of trends to identify themes. Alongside this work the Canterbury DHB Complaints Policy and associated documentation is being reviewed.

Complaints data are reported as part of the Harm and Patient Indicator Report and monitored by the Clinical Board, the General Managers Group, and the Quality, Finance, Audit and Risk Committee.

3. APPENDICES

Appendix 1: All Hospitals Complaint Rate to September 2018

Report prepared by: Susan Wood, Director Quality & Patient Safety

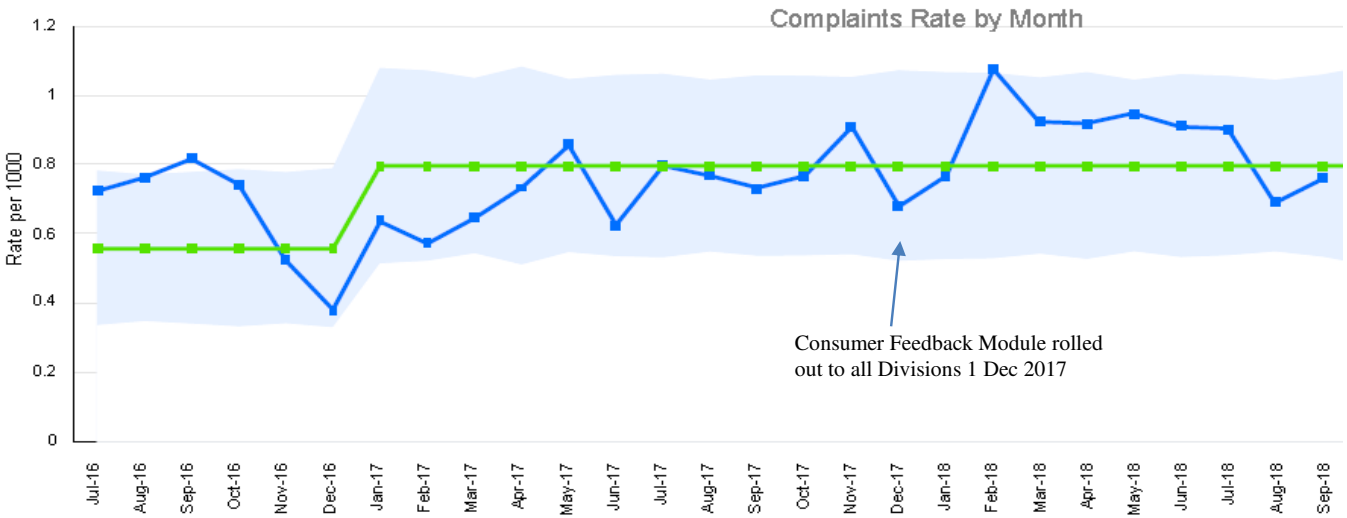
Report approved for release by: Mary Gordon, Executive Director of Nursing

APPENDIX 1

PATIENT EXPERIENCE: COMPLAINTS

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

Outcome Indicator: **All Hospitals Complaints Rate**



Numerator: Total number of complaints received in the period.

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

Calculated as a rate per 1,000

Data for 2018/2019 year to date:

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	2017/18	2016/17
Complaints															
Numerator	96	80	78										254	1,068	816
Denominator	106,253	115,947	102,863										325,063	1,254,162	1,213,399
Rate per 1000	0.90	0.69	0.76										0.78	0.85	0.67

Comments for September 2018 period:

- The CDHB Services complaint rate for the month of September 2018 was 0.76, 78 complaints were received. No special cause variation present.
- Special cause variation: In February 2018 the data point was outside the upper control limit. In September 2017 9 consecutive points were above the average between January and September, indicating an increase in the rate of complaints being received – this resulted in a step-change which re-calculated the control limits. The increase in rate is a result of the South Island Safety1st Consumer Feedback module roll out across the Canterbury DHB from 1 December 2017, all complaints are now counted in one dataset (inclusive of the Health and Disability complaints). The preparation for this work started in April 2017.
- The rate for the 17/18 year was 0.85 (1,068 complaints) which is approx. 31% higher than the rate for the 16/17 year (rate 0.67, 816 complaints).
- The majority of complaints received relate to a single category, the number of categories indicated per complainant ranges from 1 to more than 5.
- The top 3 categories in September were Care and Treatment (37), Patient/Staff Relationships (38) and Access/Funding (15). Care and Treatment and Patient/Staff Relationships are consistently the top 2 categories of complaints received.

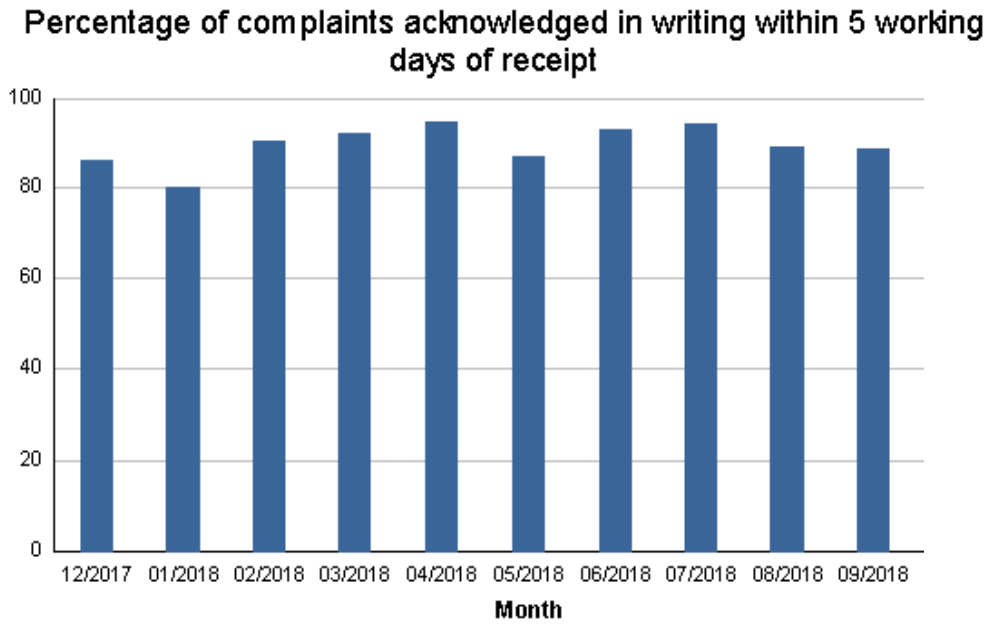
Breakdown of Complaints Categories[1] from December 2017 to September 2018

CDHB											
Start Date 1/12/2017	1/12/2017	1/01/2018	1/02/2018	1/03/2018	1/04/2018	1/05/2018	1/06/2018	1/07/2018	1/08/2018	1/09/2018	TOTAL
Total Complaint Forms	64	72	103	96	86	105	88	91	75	67	***847***
Total Number of Categories per complainee											
1	49	47	77	61	60	59	58	52	44	42	***549***
2	10	12	21	20	12	26	19	18	20	15	***173***
3	1	8	1	7	8	12	7	12	6	6	***68***
4	2	4	2	4	3	4	2	4	1	0	***26***
>5	2	1	2	4	3	4	2	5	4	4	***31***
Access/Funding	8	9	13	10	18	24	16	14	17	15	***144***
Care/Treatment	38	59	61	75	52	69	41	63	44	37	***539***
Communication/Information	15	17	25	32	29	27	23	21	29	11	***229***
Facilities/Support Services	12	8	8	12	7	13	19	23	10	5	***117***
Informed Choice/Consent	3	2	4	5	2	5	2	6	3	8	***40***
Patient/Staff Relationships	13	23	34	31	27	42	35	44	31	38	***318***
Privacy/Confidentiality	3	1	1	10	6	6	3	8	5	4	***47***

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

With the use of Safety1st we are now able to report on meeting our obligations to patients when they make a complaint. In September, 89% of complaints were acknowledged in writing within 5 working days of receipt.

5 day Compliance[2]



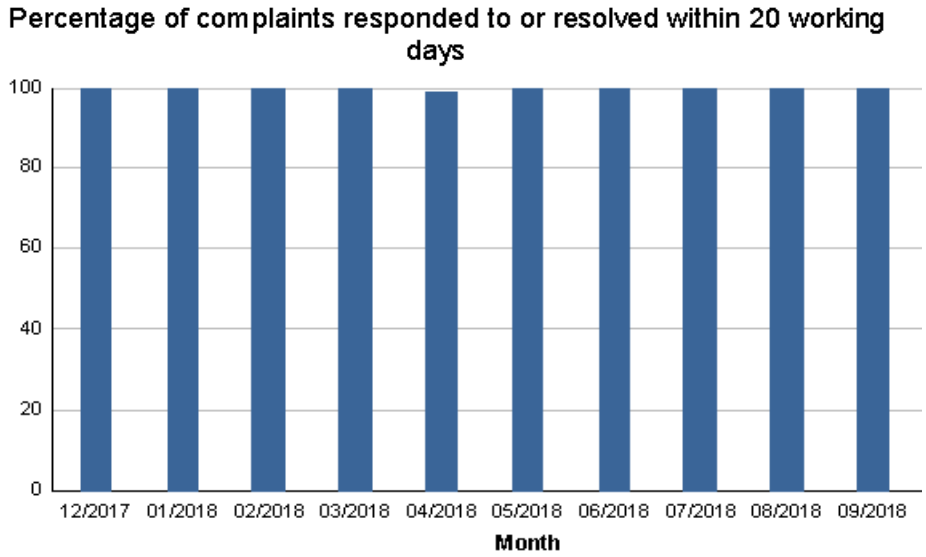
Numerator: Number of complaints acknowledged in writing within 5 working days, (excluding HDC/Privacy Commissioner/ Ombudsman/ Minister of Health Complaints)[3] within the period.

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

The issues creating the gap (<100%) are being reviewed by divisional Quality Teams.

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

20 day Compliance[4]



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

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

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

Complaints to HDC involving District Health Boards – Canterbury DHB Report for 1 January 2018 and 30 June 2018[6]

This report details the trends in complaints received by HDC about DHBs between 1 January and 30 June 2018. The total number of complaints received in Jan–Jun 2018 (452[7]) shows an increase of 7% over the average number of complaints received in the previous four periods.

Number of Complaints received in the last five years

	Jul–Dec 13	Jan–Jun 14	Jul–Dec 14	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17	Average of last 4 6-month periods	Jan–Jun 18
Number of complaints	330	330	368	389	422	383	386	477	439	**421**	**452**

The rate of complaints received during Jan–Jun 2018 (94.74) shows a 9% increase over the average rate of complaints received for the previous four periods.

National Rate of complaints received in last five years by HDC

	Jul–Dec 13	Jan–Jun 14	Jul–Dec 14	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17[3]	Average of last 4 6-month periods	Jan–Jun 18
Rate per 100,000 discharges	71.15	72.99	76.65	84.60	87.57	81.44	78.79	99.08	88.23	**86.89**	**94.74**

[6] Note: The HDC rates use a different denominator to the CDHB Complaints indicator.
[7] Data is provisional as of date of extraction (14 September 2018) and likely incomplete

The trends in complaints about DHBs in January to June 2018 have remained broadly consistent with previous periods. Surgery, mental health and general medicine have remained the most commonly complained about service types at DHBs, and misdiagnosis was again the most commonly complained about primary issue. However, complaints regarding an unexpected treatment outcome became more prominent in January to June 2018, with this issue increasing from being the primary issue in around 8% of DHB complaints in previous periods to 12% in January to June 2018. This issue often relates to post-surgical complications, and can sometimes reflect the quality of information provided to the consumer around the risks and possible complications of surgery.

In the period Jan–Jun 2018, HDC received a total of 51[8] complaints about care provided by Canterbury District Health Board. When DHBs were ranked according to their rate of complaints, Canterbury DHB was DHB 8, compared to DHB 12 in the previous six month period. As can be seen from the table below, Canterbury DHB's complaint rate for Jan–Jun 2018 was slightly lower than the national complaint rate for the same period. The rate for Jan–Jun 2018 (90.35) shows an increase of 4% over the average rate of complaints received for the previous four periods, but a decrease of 5% over the rate of complaints received in Jul-Dec 2017.

Number and rate of HDC complaints per total discharges[9] received in last five years for CDHB:

	Jul–Dec 13	Jan–Jun 14	Jul–Dec 14	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17[10]	Average of last 4 6-month periods	Jan–Jun 18
Complaints received	29	29	30	35	34	45	44	52	56	**49**	**51**
Rate per 100,000 discharges	51.95	53.83	53.46	63.91	59.64	81.95	76.99	91.79	95.29	**86.51**	**90.35**

Similar to national trends and what was seen last period at Canterbury DHB, surgery (39.2%) and mental health services (29.4%) were the most commonly complained about service types at Canterbury DHB. Canterbury DHB received a greater proportion of complaints regarding otolaryngology services (9.8%) in Jan-Jun 2018 than was seen nationally across all DHBs.

[8] Provisional as of date of extraction (14 August 2018).

The most common primary complaint issue categories for Canterbury DHB were care/treatment (49.0%) and access/funding (17.6%). Compared to what was seen last period for Canterbury DHB, complaints primarily concerning access/funding issues increased and complaints primarily concerning consent/information issues decreased in Jan-Jun 2018.

Similar to national trends and what was seen last period at Canterbury DHB, the most common specific primary issues were ‘unexpected treatment outcome (13.7%) and ‘missed/incorrect/delayed diagnosis’ (11.8%).

WORKPLAN FOR HAC 2018 *(WORKING DOCUMENT)*

9am start	1 Feb 18	29 Mar 18	31 May 18	2 Aug 18	4 Oct 18	29 Nov 18
Standing Items	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes
Standing Monitoring Reports	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report
Planned Items	Clinical Advisor Update – Nursing (Mary Gordon) & Allied Health (Stella Ward) Review of Winter Plan 2017 Medical & Radiation Oncology Presentation UK Visiting Geriatrician - Presentation	Clinical Advisor Update - Medical (Dr Sue Nightingale CMO) General Medicine Presentation	Clinical Advisor Update – Nursing (Mary Gordon) 2018 Winter Planning Update Older Persons Health and Rehabilitation Services Presentation	Clinical Advisor Update - Medical (Dr Sue Nightingale CMO) H&SS 2016/17 Year Results Rural Hospitals Presentation System Level Measures Framework Maternity Development Strategy Update	Clinical Advisor Update – Nursing (Mary Gordon) & Allied Health (Helen Little) Ashburton Health Services Presentation Ophthalmology Department	Clinical Advisor Update - Medical (Dr Sue Nightingale CMO) 2018 Winter Planning Review Planning & Funding Electives Plan 2018 /19
Governance and Secretariat Issues						2019 Workplan
Information Items	2018 Workplan	2018 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 2018 Workplan	2019 Meeting Schedule 2018 Workplan	2018 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 2018 Workplan
Public Excluded Items	CEO Update (as required)	CEO Update (as required)	CEO Update(as required)	CEO Update (as required)	CEO Update (as required)	CEO Update (as required)