AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora o Waitaha

HOSPITAL ADVISORY COMMITTEE MEETING
to be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
Thursday, 1 April 2021 commencing at 9:00am

Administration			
	Apologies		9.00am
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 28 January 2021		
3.	Carried Forward / Action List Items		
Presentations			
4.	Mental Health: The Acute Adult Pathway	Dr Greg Hamilton *General Manager* *Specialist Mental Health Service*	9.05-9.35am
Reports for Noting			
5.	Hospital Service Monitoring Report: • Medical/Surgical; Women's & Children's Health; & Orthopaedics ESPIs • Older Persons Health & Rehabilitation • Specialist Mental Health Service • Hospital Laboratories • Rural Health Services	Pauline Clark *General Manager, Medical/Surgical; Women's & Children's Health; & Orthopaedics* Dr Helen Skinner *General Manager & Chief of Service, Older Persons Health & Rehabilitation* Dr Greg Hamilton *General Manager, Specialist Mental Health Services* Kirsten Beynon *General Manager, Laboratories* Win McDonald *Transition Programme Manager Rural Health Services* Berni Marra *Manager, Ashburton Health Services*	9.35-10.20am
6.	Clinical Advisor Update (Oral) • Allied Health	Dr Jacqui Lunday-Johnstone *Executive Director of Allied Health, Scientific & Technical*	10.20-10.30am

7.	Resolution to Exclude the Public		10.30am
Estimated Finish Time			**10.30am**

NEXT MEETING: Thursday, 3 June 2021 at 9:00am

ATTENDANCE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE MEMBERS

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

Executive Support

(as required as per agenda)

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

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

COMMITTEE ATTENDANCE SCHEDULE 2020

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

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

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

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

MINUTES – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE HOSPITAL ADVISORY COMMITTEE MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
on Thursday, 28 January 2021, commencing at 9.00am

PRESENT
Andrew Dickerson (Chair), Jan Edwards; James Gough; Jo Kane (via Zoom); Naomi Marshall; Ingrid Taylor; and Sir John Hansen (Ex-Officio).

APOLOGIES
Apologies for absence were received and accepted from Barry Bragg; and Dr Rochelle Phipps.
An apology for early departure was received and accepted from James Gough (10.10am).

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

APOLOGIES
Kirsten Beynon (General Manager, Laboratories); Dr Richard French (Acting Chief Medical Officer); Berni Marra (Manager, Ashburton Health Services); and Win McDonald (Transition Programme Manager Rural Health Services).

IN ATTENDANCE

Full Meeting
Pauline Clark, General Manager, Medical/Surgical; Women's & Children's Health; & Orthopaedics
Dr Helen Skinner, General Manager & Chief of Service, Older Persons Health & Rehabilitation
Dr Greg Hamilton, General Manager, Specialist Mental Health Services

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
Naomi Marshall – Addition – NZ Nurses College, Aotearoa - Member

There were no other additions/alterations.

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

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

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (01/21)
(Moved: Ingrid Taylor/Seconded: Jan Edwards – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 3 December 2020 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION ITEMS

The carried forward action items were noted.

4. H&SS MONITORING REPORT

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

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

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

- Report focuses on SMHS Intellectual Disability Services to provide a greater depth of understanding. Services are provided to inpatients in two different units:
  - PSAID Unit. This falls under our population-based funding and is for those people with an intellectual disability and a mental health diagnosis.
  - Whaikaha (AT&R – Assessment, Treatment and Rehabilitation). This is funded by Ministry of Health Disability Support Services, with whom we have two contracts, and is for people who are under Court order under two different Acts. It is a secure unit. Generally, this cohort of people have relatively poor health, both physical and mental health. Some people have been there for a long period, with the longest standing consumer having been there since 2003. This is an institutional type approach for a group of people who are highly vulnerable.
- There are a lot of incidents, some of which are assaults – injury to staff and assaults between consumers.
- Staff are amazing in their commitment to this cohort of people. People who work here are values driven and come to work to make a difference for this vulnerable population, which includes taking on some of that risk we are trying to mitigate.
- Considerable frustration for AT&R with Disability Support Services in terms of how they fund that and the ability to provide a really good service.

Dr Hamilton thanked the Board for its investment. The four new pods on the new facility are hoped to be occupied by the end of March 2021. He noted that this will significantly change the living standards and lives of some of the more complex, long-term consumers.

Older Persons Health & Rehabilitation (*OPH&R*) Service – Dr Helen Skinner, General Manager & Chief of Service

- Pressure Injury Prevention Project update. The validated figures for the last four months of the 2020 year show 48 patients with pressure injuries versus 73 for the year prior, so a reduction of 25 in terms of pressure injuries. Staff are now very enthusiastic at looking at skin and ensuring they are picking up every possible blemish. There is still further work to be done to get down to the aim of 95% avoidable pressure injuries, knowing that 5% are unavoidable in terms of international best practice.
- Vestibular Screening Tool Pilot. There is evidence for using vestibular screening, which involves a series of four questions when patients come in to assess whether they have a risk of vestibular problems and what to do about it.. This is a piece of work the Allied Health Team is leading on and is being rolled out across the Older Persons Health & Rehabilitation Service, and will be rolled out into the community as well. ED is interested also. There is good evidence in terms of the validation of the tool in ED and the Acute setting, so is something that could be used across the DHB in terms or reducing the risk of falls and identifying what the risks are.
- ERAS. Highlighted OPH&R's 2020 results from the national hip fracture registry database.

There was discussion around needs assessments for patients, particularly at Burwood, for Aged Residential Care (*ARC*). Dr Skinner advised that times are monitored and data is kept to ensure there are no delays. In terms of initial assessments, there has been no delay. There has been some delay in terms of community re-assessments. Timeframes for assessment take anywhere between one to two working days.

Queried whether there was too much demand versus supply with regards to ARC, Dr Skinner advised we are running high occupancy levels in terms of dementia hospital elder care. This is the one area where we run high compared to the rest of the country in terms of the capacity we have.

There was discussion around the number of over 75s coming from rest homes and being admitted through ED, and what is or could be done to address this. Dr Skinner spoke of Advance Care Planning and Shared Goals of Care, as well as what can be done differently in the community. Becky Hickmott, Acting Executive Director of Nursing, noted that Ashburton has its own unique challenges in this space, part of which is the primary health sector understanding its role. She advised of a lot of changes and turnover in staff in Ashburton, and this impacting the flow through to ED. There is a significant piece of work underway to address this, but it is not quite at the implementation stage.

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

- Increase in acute presentations to Christchurch Hospital. It is not just ED experiencing this, but also the Acute Medical Assessment Unit, the "Bone Shop", the Surgical Assessment Unit, and the Children's Acute Assessment.
    - ED experienced a sharp uplift in presentations that occurred in late September, prior to the transition to Waipapa. Between January and the end of September 2020, there were an average 1,830 presentations to ED per week. Since then, this has risen to an average of 2,163 per week – an increase of 48 per day or 18%.
    - This cannot be explained by population pressures – the rate of ED attendances per 10,000 population increases sharply at the same time.
    - Within this we have seen an increase in self-referrals to the ED of around 2% - or 250 presentations per week.
    - Conversely, there has been a slight decrease in GP referrals. People are presenting directly, but their reasons for being there are in alignment with their health needs. Overall, people presenting need to be assessed in an ED environment, in a tertiary centre.
    - 24 hour medical centres, both Riccarton and Moorhouse, are also experiencing increased presentations, so not just the ED.
- Medical Oncology. As previously advised, additional project support has been invested in to assist with a revision to the model of care. This is in place and work is starting to pay dividends. Two new medical oncologists have been appointed and discussions continue around a third appointment.
- High neo-natal occupancy. This is a phenomenon being seen around New Zealand, possibly not helped by the MoH lead in the space, Andrew Simpson, having left his role. So again, work in the neo-natal cot space has stalled. CDHB's neo-natal service is designed to take 40 to 45. Currently it is sitting at 54. Another four are being cared for as part of the paediatric ward, which is putting additional pressure on paediatrics who are already experiencing demand issues. We also have some women and babies out in other parts of NZ. Very tight nationally when it comes to neo-natal beds/cots.
- Return of surgery and progress against plan. The opening of Waipapa provided a significant increase in acute theater capacity on the Christchurch Campus. Will be in a position to report on this in more detail at the Committee's next meeting.
- Have seen significant gains in terms of the pre-operative stay in inpatients.

- Planned on having outplaced surgery back by Christmas, with the exception of paediatric dental (which is planned for March due to availability of workforce and appropriate facilities). Outplacing has ceased.
- The plan around returning outsourced surgery is currently being tweaked to accommodate some unexpected sickness which will result in key people being away for a period of time.
- Recruitment of Anesthetic Technicians is an issue. Have two staff coming from the UK in the next quarter and the search continues.
- Been working very closely with Sterile Supply. They are a keen enabler.
- ESPIs. CDHB and MoH have agreed an ESPI improvement plan, which sees the DHB achieve compliance in ESPI 2 and 5 by 30 June 2021. A wobble was experienced in late December/early January, but are now on track to achieve this. Specific actions that services are undertaking to enable us to deliver include:
    - Orthopaedics have taken 64 long waiting elective/planned patients requiring hand surgery from the Plastic Service waitlist and put it into their own waitlist. They are able to do this without needing to use anesthesia and are utilising theatre space at Burwood for this.
    - Vascular Surgery have been able to utilise funding that the MoH provided for additional clinics. Have repatriated ambulatory treatment of varicose veins to the Outpatient Department.
    - Ear, Nose and Throat. Parental leave has affected capacity in the rhinology subspecialty, however, the full team is now back on board.
    - General Surgery: A number of SMO staff have recently returned from extended sick and annual leave, and a new fellow has started this week.
    - Some services are already green and will remain there.

Discussion took place around:

- Issues with neo-natal cot capacity, from both a regional and national perspective.
- Clinical safety in light of increased acute presentations.
- Fee structure for afterhours care.

The H&SS Monitoring report was noted.

5. CLINICAL ADVISOR UPDATE (ORAL)

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

- Acknowledged NICU's capacity issues, noting there have been a large number of extreme preterm, as well as preterm births with babies who have high need and long stay. The long stay has an ongoing impact. Many came spontaneously in labour or with membranes ruptured. Across the nation similar things are happening.
- Maternity is under pressure from a staffing point of view. From a safety angle, we are working to divert some of our nursing teams to help support.
- Christchurch and Burwood Hospitals were very full over the Christmas period. What would normally be a quieter period was not. Staff have been under significant pressure, but have done a stellar job.
- Recently visited the SMHS site at Hillmorton to see the built environment and the constraints impacting on patients and staff. Acknowledged the challenges that staff are working under. They are dealing with complex patients in very challenging conditions, yet the professionalism in care was clearly evident, with constant reassessing, triaging and attention to safety. Progress with new facilities cannot come quick enough for staff.
- Burwood has a key quality focus on medication administration at the moment. This involves a cross disciplinary approach.

- Looking across the board at how to mobilise and utilise nursing resources. A current focus is on outpatient services – how we use that workforce in a different way and also advancing working at top of scope.
- Trendcare implementation and CCDM is progressing well, in spite of some hiccups within the system. These have largely been rectified. ICU goes live with Trendcare mid-February and Surgery will be underway soon as well. CCDM teams have been described as "bull doggish" in their approach, which will continue to ensure accurate and reliable data.
- COVID readiness planning is well underway, working closely with Allied Health to ensure we are taking a cross disciplinary approach.
- MIQ nursing staff and the welfare teams have been under significant pressure during the holiday period, but have delivered a high standard of care and support. They perform a vital role in keeping NZ safe. Mindful that staff have times where they feel stigmatised in the community and their wider family are impacted on by the role that they hold.
- Commend primary health, who keep mobilising to support. Whole system approach is working well.
- In spite of the pressure on staff across the system, we continue to receive numerous letters and emails on the care provided and the willingness of nurses to go the extra mile.

6. SERVICES SUPPORTING OLDER PEOPLE LIVING IN RURAL COMMUNITIES

Ralph La Salle, Acting Executive Director, Planning Funding & Decision Support introduced the report, noting it was in response to a request from the Committee last year to better understand initiatives/services in place currently and those that are planned to support our rural older population to remain in their own homes/communities and into the future. Greta Bond, Service Development Manager, Older Persons Health (*OPH*); and Andrea Davidson, OPH Portfolio Manager, were in attendance.

The report was taken as read.

Discussion took place around the following:

- Strengths of the rural community, as well as challenges presented by distance.
- Ageing population – in terms of this community it is not only about the clients of the services, but also the people who are delivering the services. Rurally, we have an ageing workforce and in addition, particularly with nursing, a workforce where this is not their only job.
- The increase in demand for dementia care. Rurally this can be difficult to deliver, so new models of care are being looked at.
- Resources being deployed to rural areas and ensuring they are being utilised in the best possible way. Working with the community to make sure that services are developing to meet the current needs of people as opposed to the traditional way that services have always been delivered.
- Falls prevention referral programme and uptake in the rural community.
- The availability of consumables, particularly in terms of those which are meant to be provided on discharge from hospital, and the impact this has on providing nursing rurally.
- An electronic referral form is being implemented within secondary care, so someone referring for services in the community will be able to do this electronically. This will be a big benefit to providing rural services.

The Services Supporting Older People Living in Rural Communities report was noted.

7. 2021 WORKPLAN

The Committee received the 2021 Workplan, noting that this is a working document.

8. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (02/21)
(Moved: Naomi Marshall/Seconded: Jan Edwards – carried)

"That the Committee:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of the minutes of the public excluded meeting of 3 December 2020	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(if required)*	Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege.	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)

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

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 10.30am.

Approved and adopted as a true and correct record:

_____ _____

Andrew Dickerson
Chairperson

Date of approval

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

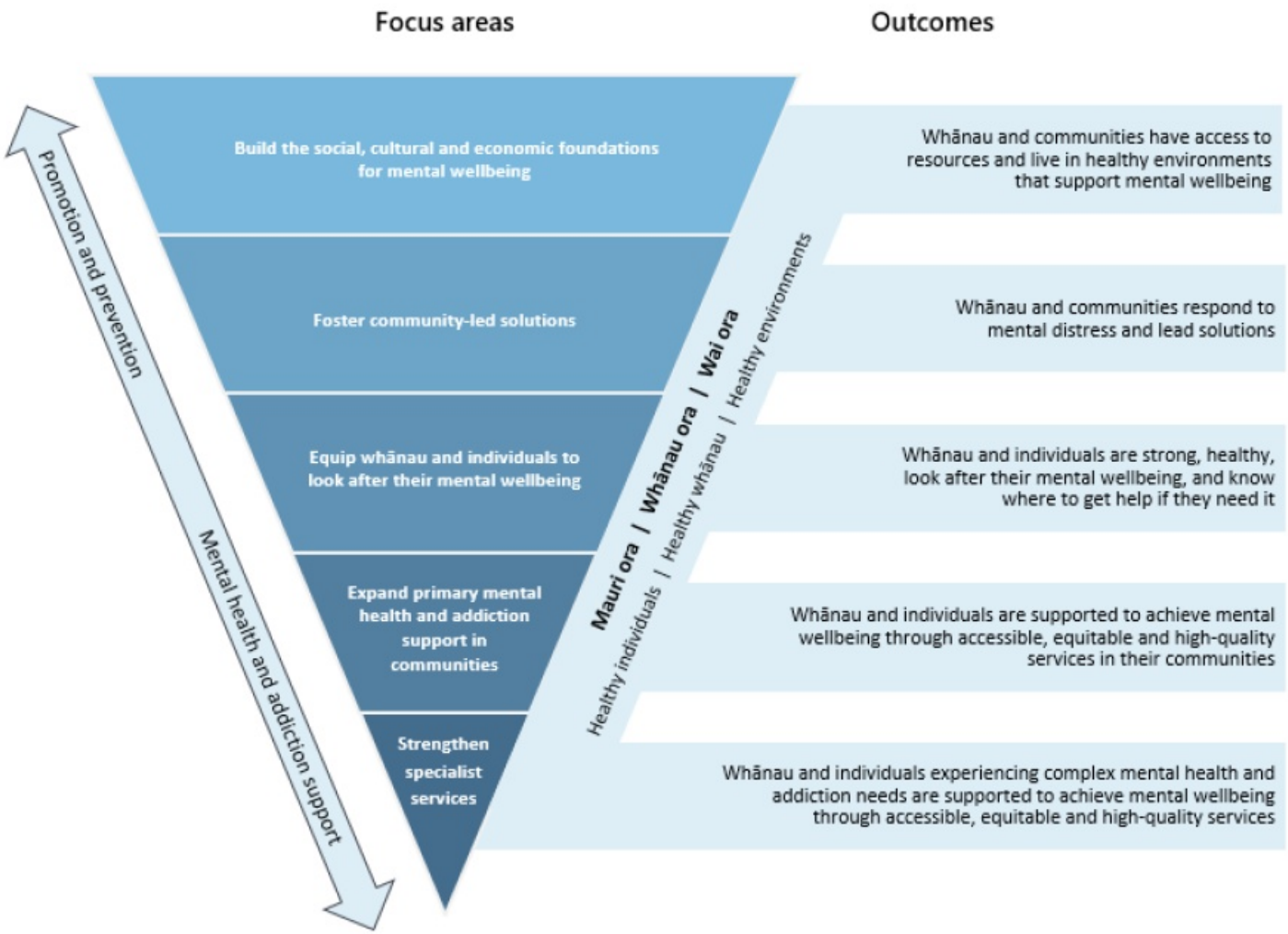
HOSPITAL ADVISORY COMMITTEE
CARRIED FORWARD ITEMS AS AT 1 APRIL 2021

DATE RAISED		ACTION	REFERRED TO	STATUS
1.	01 Oct 2020	H&SS Monitoring Report – development of "Living Within Our Means" section	Dr Peter Bramley / David Green	Under action.

Mental Health: The Acute Adult Pathway

Person centred response to people with acute mental health needs

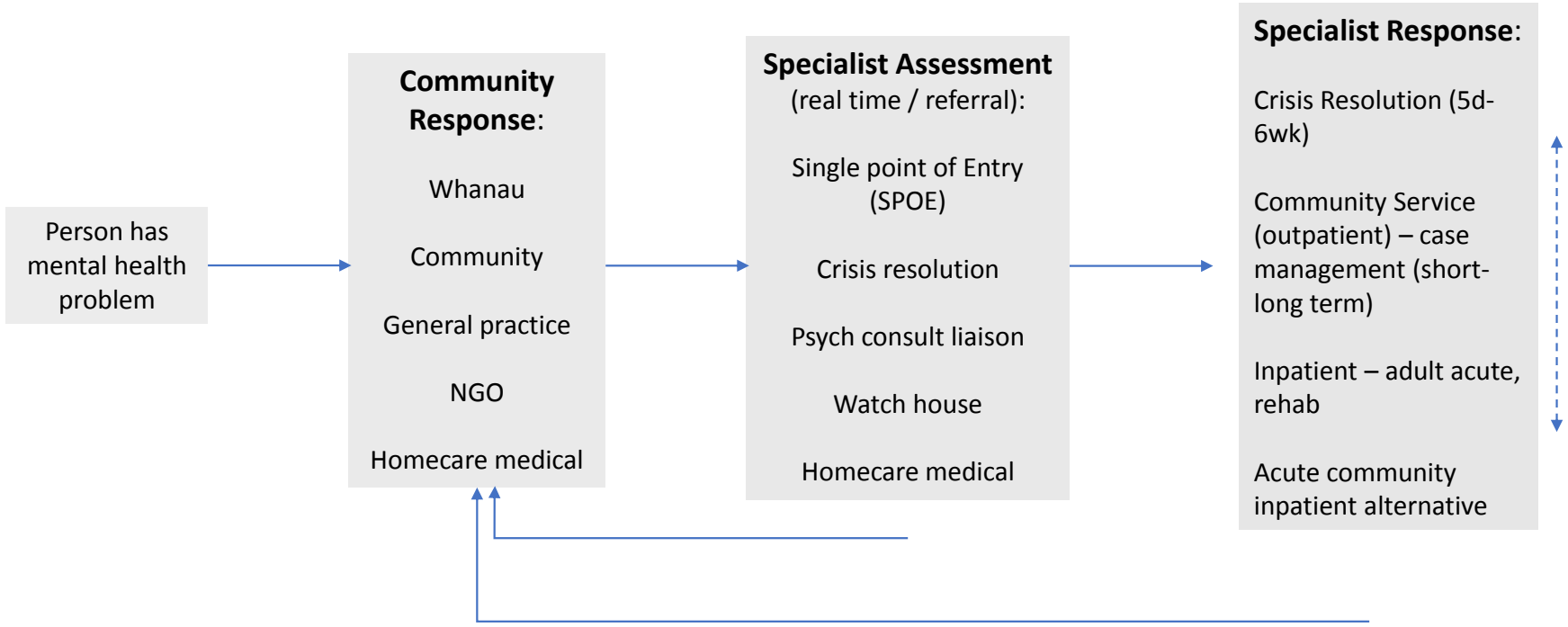
- Outline adult acute pathways
- Demonstrate the services available
- Understand how assessment (need) drives service responses
- Provide context of responses within an integrated system



Ministry of Health

- Mental Wellbeing Framework
- *Kia Kaha, Kia Māia, Kia Ora Aotearoa: COVID-19 Psychosocial and Mental Wellbeing Plan*

What happens when a person has a mental health problem?



Canterbury District Health Board, Specialist Mental Health Services

Nā ēnei tikanga ka ora hinengaro ai
Purpose & Strategy

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Core Purpose (Ngā Aratika)

To provide safe, compassionate & effective services that enable people with serious or acute mental disorders in their recovery.

Five Strategic Pillars (Ngā Pou Aronui)

Mana Tangata

A clearly defined focus on people with serious or acute mental disorders and who are unable to be treated elsewhere.

Pillar 1

Matatau

In-depth clinical/ specialist expertise in the assessment & treatment of people with serious or acute mental disorders.

Pillar 2

Mahi Tahi

A multi-disciplinary & integrated approach that places consumers & their families at the centre of all we do.

Pillar 3

Manaakitanga

A positive culture and environment that values our staff & embodies compassion, hope & wellbeing.

Pillar 4

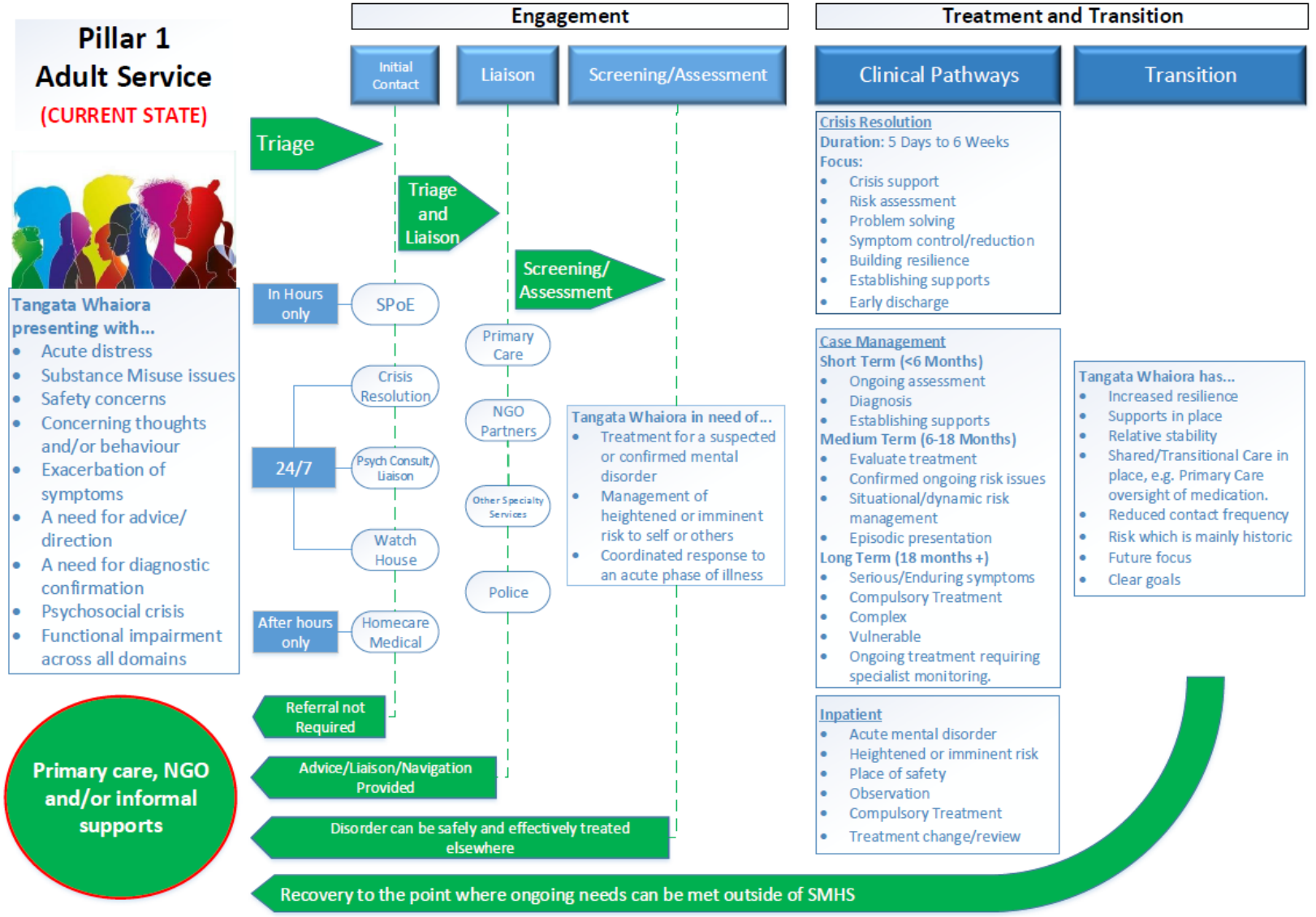
Whanaungatanga

Continuously building & sustaining our partnerships with the wider health system, other agencies & the community to support other professionals & help in the creation of a sustainable mental health system.

Pillar 5

From a **service provision perspective**

Specialist Mental Health Services



First steps

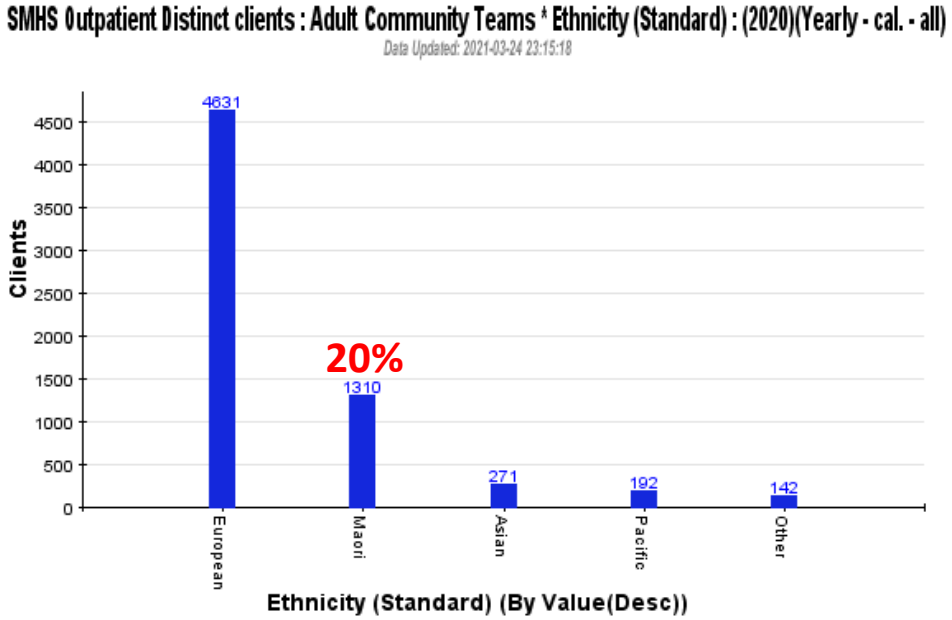
- When people are unwell and can't be managed in the community with natural supports, general practice and community resources…
  - Referral
  - Phone
  - Turn up
  - Identified by other services
- Triage – screening – assessment
- Liaison – problem solving – supports – case management – high risk: admission
- Return people home with right supports

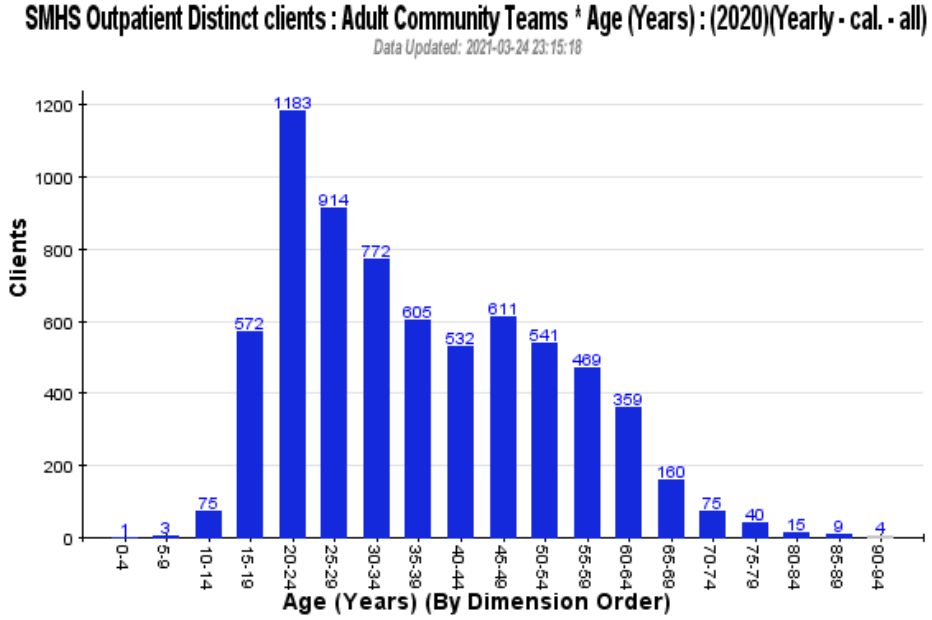
Adult community services

In 2020:

122,000 contacts

6,500 people





Community Service Contacts

- Multiple service responses
- Support people to live and succeed in the community

Service	2020
Ashburton (including crisis)	4967
Crisis Resolution	878
Adult (East, North, South, West)	90452
Hereford	7735
Psych Consult Liaison	4433
Rural	3129
Totara	5786
Watch house	2255
Clozapine clinic	102

Adult inpatient services

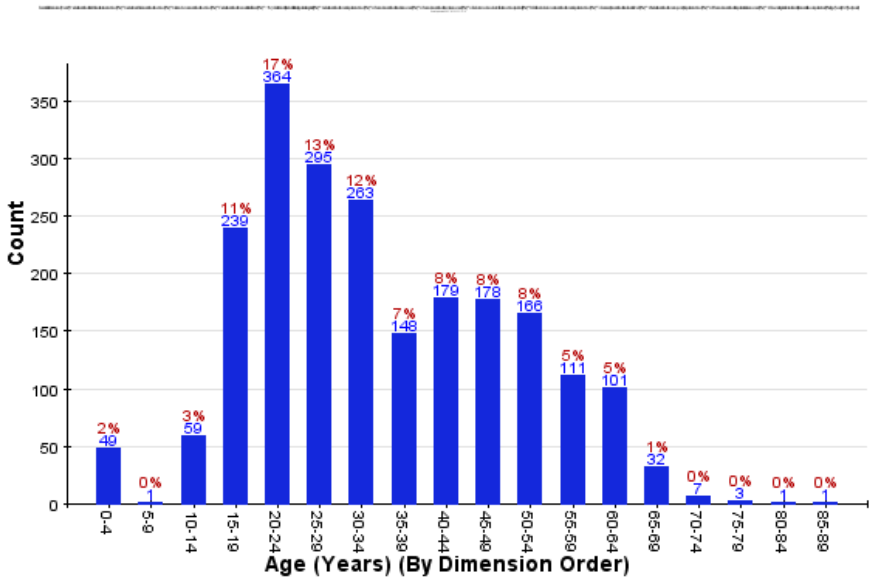
In 2020:

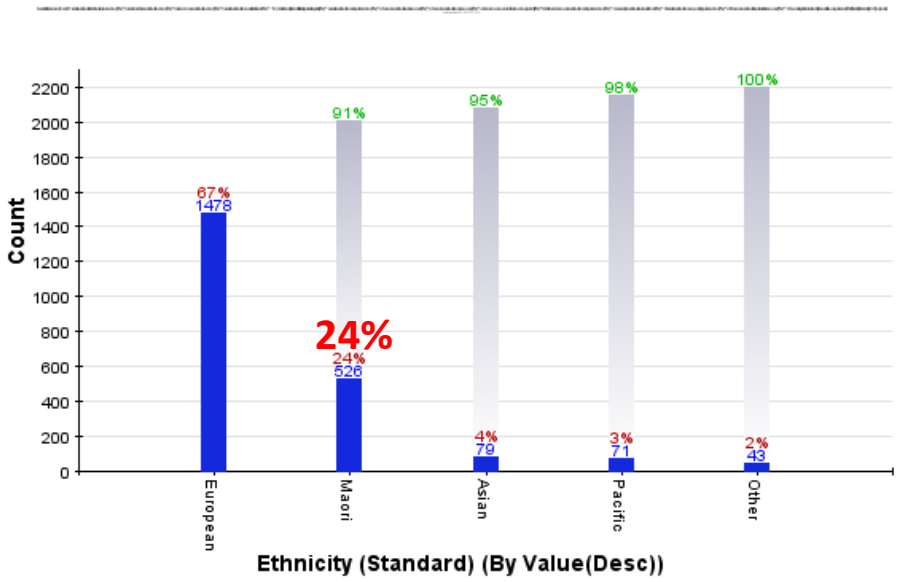
1,356 admissions

Seagar 38 admissions

Tupuna 13 admissions

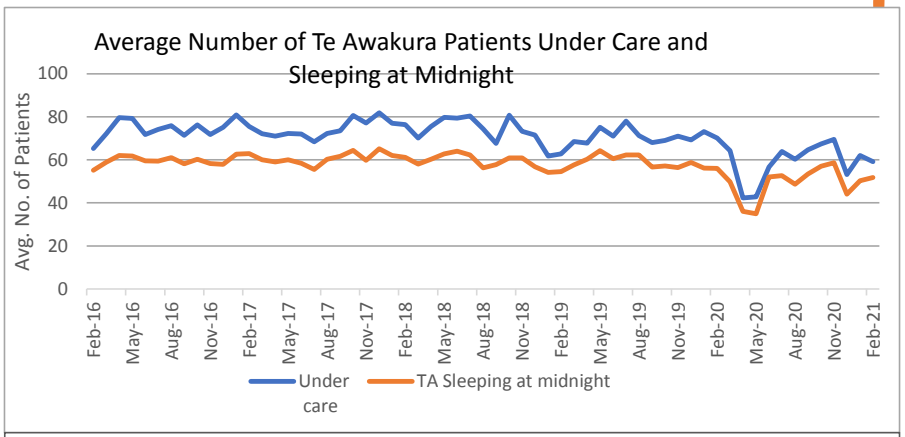
227 crisis admissions

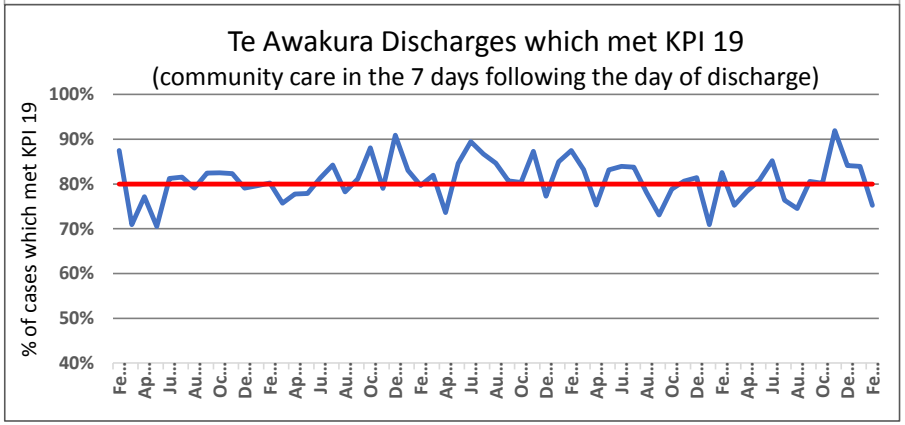


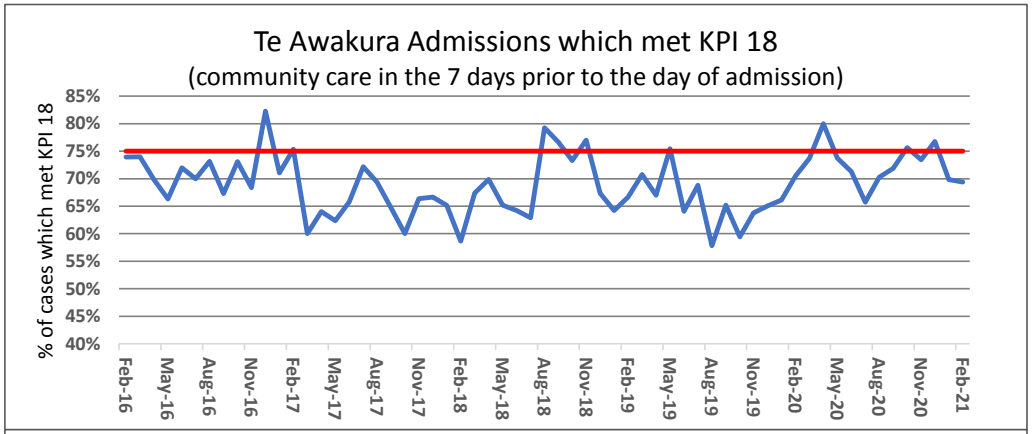


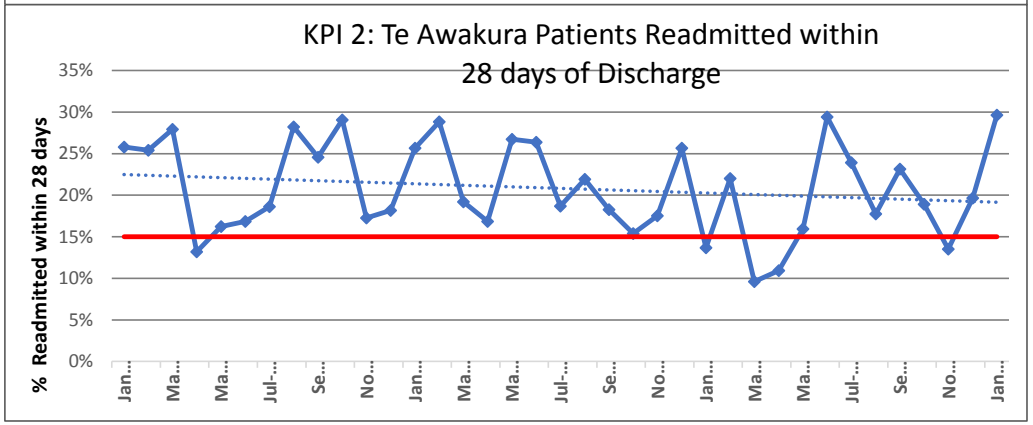
Key measures for inpatients

Good performance





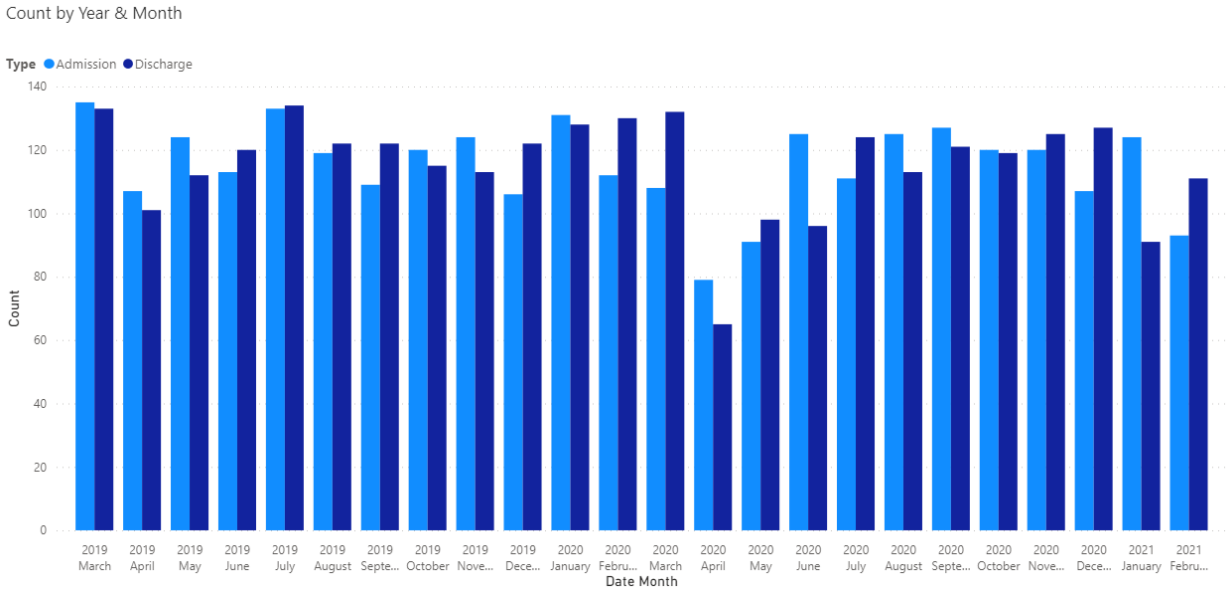




Impact of COVID-19

- Significant decrease in admissions – but no decrease in community contacts
- Innovative virtual services – not embedded
- Facilities – inability to house Covid-positive inpatients (recycled air)

Admissions and Discharges



Challenges

Community (outpatient)

- Volumes
- Complexity
- Communication and planning
- Housing and social supports

System responses, pathways and communication

Inpatient

- Environment – not fit for purpose
- Seagar – bed reduction
- Seclusion

Facility redevelopment and programme business case

H&SS MONITORING REPORT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

APPROVED BY: **Ralph La Salle, Acting Executive Director, Planning Funding & Decision Support**
David Green, Acting Executive Director, Finance & Corporate Services

DATE: **1 April 2021**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Committee:

i. notes the Hospital Advisory Committee Activity Report.

3. APPENDICES

Appendix 1: Hospital Advisory Committee Activity Report –March 2021

Hospital Advisory Committee

Hospital Activity Report

March 2021

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

Page 2 **Frail Older Persons' Pathway**

Authors: Helen Skinner General Manager & Chief of Service, OPH&R

Bernice Marra, Manager Ashburton health Services

Page 7 **Faster Cancer Treatment**

Author: Pauline Clark General Manager Christchurch Campus

Page 11 **Enhanced Recovery After Surgery**

Author: Helen Skinner General Manager & Chief of Service, OPH&R

Page 13 **Elective Surgery Performance Indicators**

Author: Pauline Clark General Manager Christchurch Campus

Page 16 **Theatre Capacity and Theatre Utilisation**

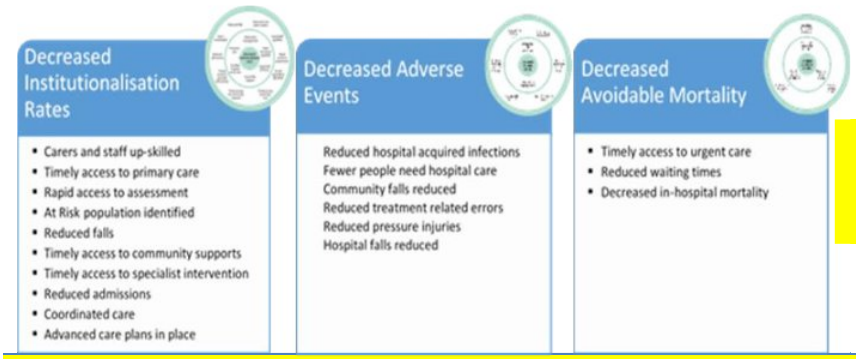
Author: Pauline Clark General Manager Christchurch Campus

Page18 **Mental Health Services**

Author: Greg Hamilton, General Manager Specialist Mental Health Services

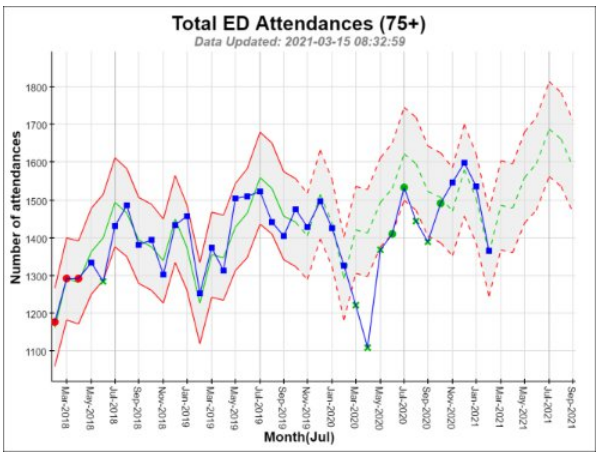
Page 23 **Living within Our Means**

Authors: David Green, Acting Executive Director Finance and Corporate Services and Pauline Clark General Manager Christchurch Campus



Outcome and Strategy Indicators

Figure 1.1



Covid 19 Alert Level restrictions led to a reduced number of ED attendances by people over 75 years in March and April 2020 with a subsequent return to forecast levels of attendances by that group.

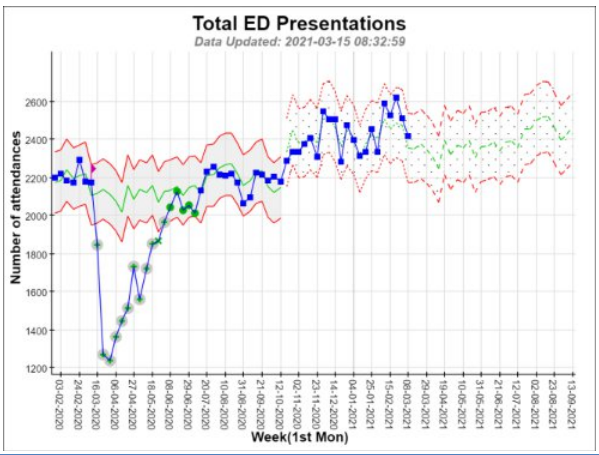
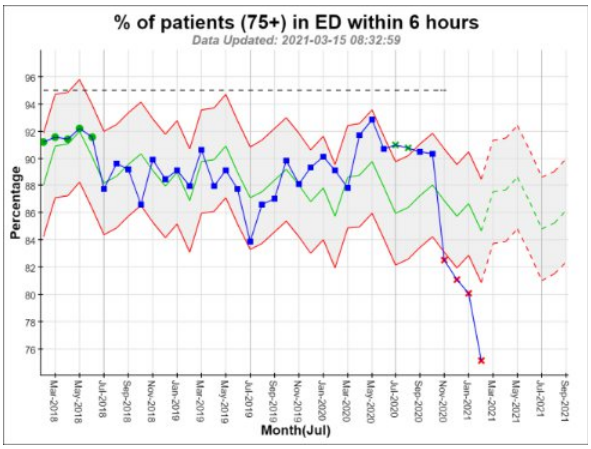


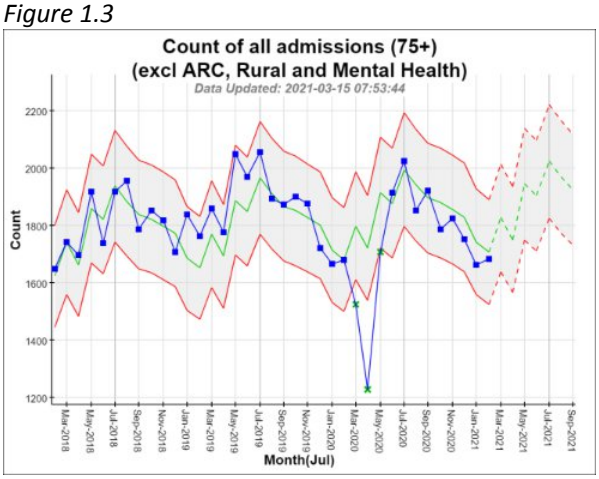
Figure1.2



Since mid-October total ED visits have increased by around 30 people a day, predominantly by those under 30 years old.
This mostly involves triage levels 4 and 5, and thus places demand within the ED as these patients are not generally admitted.

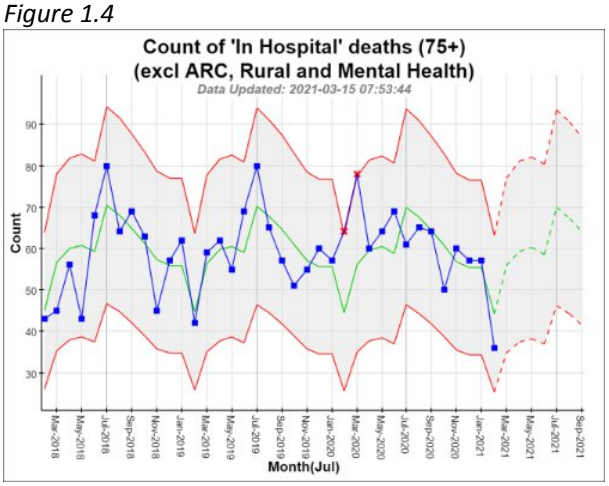
This, along with the team working in a new and larger unit, is providing challenges that contribute to patients spending a longer time in ED.
Planning and Funding, ED, the Communication team, Healthline and Urgent Care providers are working together to put in place plans to improve the system's ability to provide the care required by the population.
Key hospital services including General Medicine, Cardiology, Orthopaedics and General Surgery are also working with the Emergency Department to optimise timeliness of flow through the department for people requiring specialist service care.

Figure 1.3



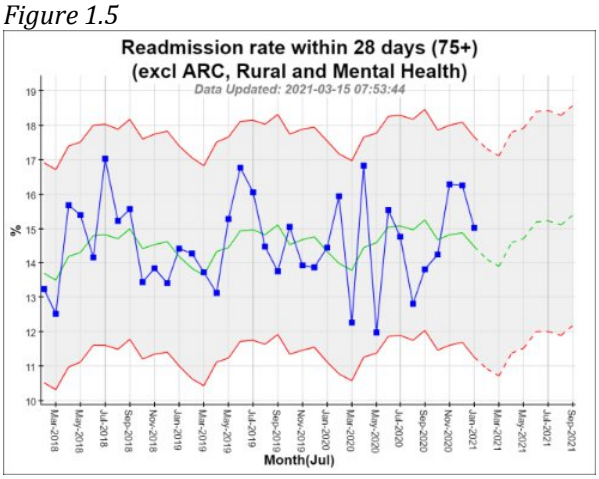
The number admitted has returned to the forecast range following the COVID lockdown period.

Figure 1.4



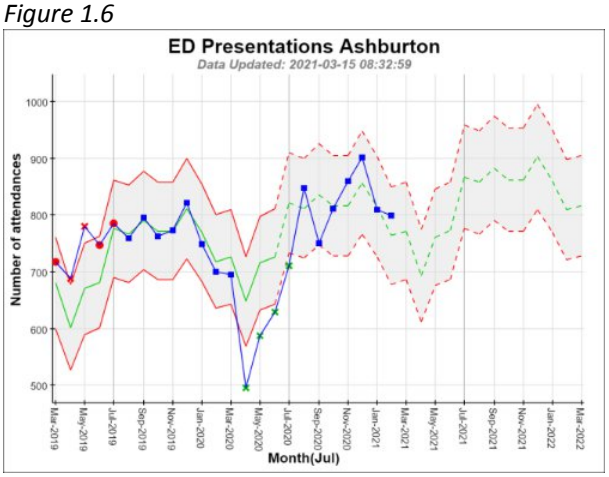
During the last nine months the number and rate of in hospital deaths against admissions has been within forecast range, which reflects an underlying reducing trend in the rate.

Figure 1.5



Readmissions remain within the expected range.

Figure 1.6



Ashburton rate of attendances,75+ age group, has been running in line with expected attendance means

Achievements/Issues of Note

Ashburton Health Services

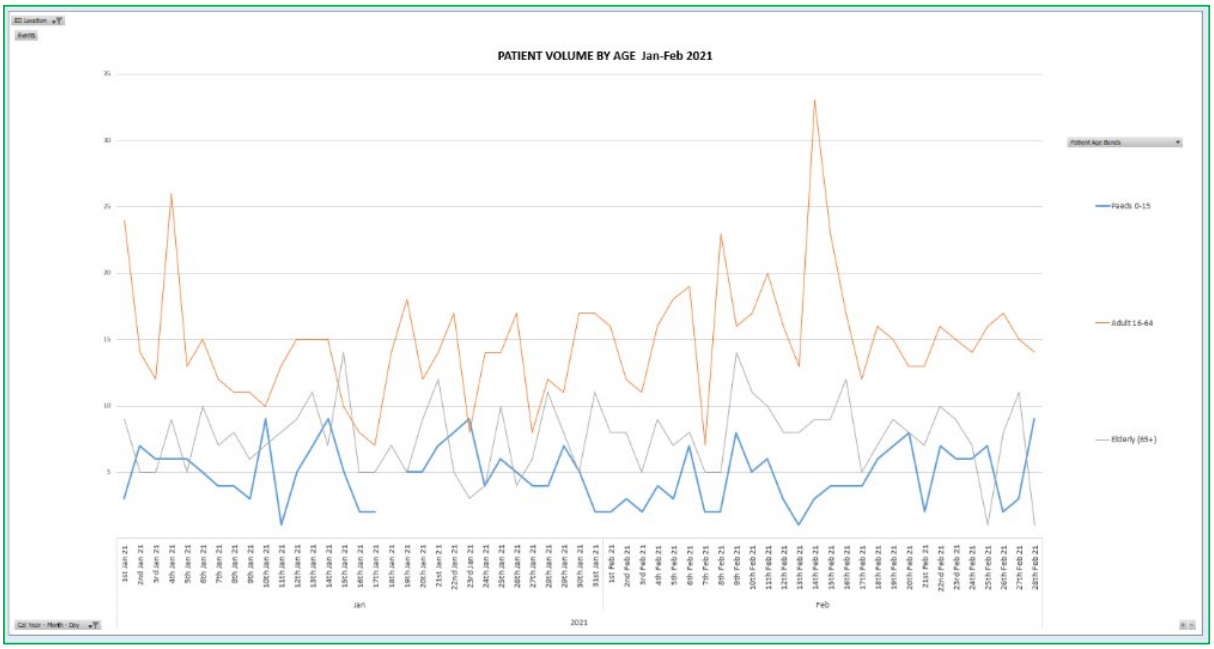
Noting Figure 1.1 and Figure 1.2 is an extract of total ED data reporting, we are mindful to provide clarity that this data set also includes presentations through Ashburton Acute Assessment Unit (AAU). The AAU data flow is rolled up and reported within the CDHB ED data extract set to the Ministry of Health**.** The commentary however relates the type of growth experienced in ED Christchurch.

Whilst AAU has experienced a growth in presentations, this is not consistent daily but described as clumpy, our admission rate of 30% remains constant and our presentation growth is in Triage 3. On average the occupancy of the wards remains high, but this is currently influenced by the increased pressure from non-weight bearing patients from across Canterbury. These patients are accepted into both wards and transferred once confirmation of bed availability. This process may take place over several days. A steady cohort of these patients require close observation, that is “one to one” cares, based on clinical assessment.

Without access to pool resources of HCA and nursing alongside the fact that our staff is predominantly part time workers, when we experience a spike in staff on leave via ACC injury it is a challenge to roster to any standard pattern. In the first two months of the year, this challenge has provided the team the environment of thinking outside the box and considering what is essential on the day.

AAU presentations

The graph below demonstrates the distribution of presentations to AAU across our three main cohorts. The core information in the graph below is the variability. Whilst we consistently look for trend data that can be interpreted to inform roster or resource distribution, the volume on any given day is not consistent enough to create a succinct pattern. This means our resourcing is consistent to the average, but must also respond to surge. In March we are commencing a weekend shift pattern of ED Registrars. We will regularly review the flow and test the impact this resource has on managing the consistently increased weekend surge on AAU. ED Registrars are required to complete a community run as part of their training, this provides the community run for this specialist service and a deployable resource for demand via the AAU.



Occupancy/inpatient trends

The following table reports the length of stay by clinical cohort. As a generalist service progressing towards a consolidation of wards (two physical wards will remain, but the objective is to operate as one "virtual ward") the length of stay is identified as a key monitor of integrated service delivery. Any variance on occupancy of same clinical cohort between wards will be closely monitored to identify interventions that can connect ensure there is consistency for the patient experience.

Integration influence

Alongside the review of acute flow and occupancy, the integration cluster incorporating NASC, district nursing and clinical nurse specialists have been detailing the flow of referral management and service response to primary care, with an intent to create a more proactive responsive community service.

The journey from health pathway information, ERMS referral management through to service response has identified a number of areas for improvement. We are working toward a target of 1% decline rate for referrals.

We are supporting the introduction of STRATA for inpatients led by Planning and Funding and are uplifting our information on patient care directly into the HealthOne platform. This will enable primary care to have a distinct patient "contact/response" record as opposed to searching through Health Connect South for the progress note.

Older Persons Health and Rehabilitation

Dementia-Friendly Hospital

Alzheimers NZ's Accreditation Committee has now completed its assessment of Burwood Hospital against their Dementia Friendly Recognition Programme standards and criteria. Based on this, Burwood Hospital has been recognised as NZ's first hospital to be '**Working to be Dementia Friendly**.'

To apply for this status, the division provided a comprehensive self-assessment and the feedback received stated that this told "*a story of an organisation committed to working to be dementia friendly, to seeking to understand the needs of people with dementia and to raising awareness and understanding across your staff and organisation*. *The Committee were very impressed with the work you have described and also noted the commitment you have shown in progressing work related to standards not required for this level of recognition*. *Our review of your self-assessment concluded that Burwood Hospital meets the requirements for **Working to be Dementia Friendly***."

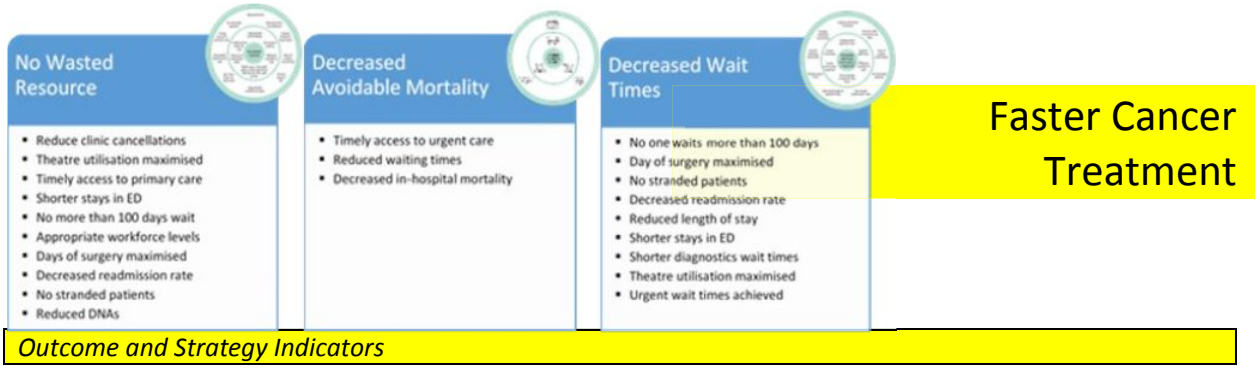
Burwood Hospital is now recognised as **Working to be Dementia Friendly** for two years from 10th March 2021. In acknowledgement of this achievement Alzheimer's NZ will visit the site to present a certificate and take the opportunity to publicly promote Burwood Hospital's achievement and the dementia friendly concept together.

As part of our journey towards being certified as being a 'dementia friendly' hospital OPH&R are promoting the online training available at: https://www.alzheimers.org.nz/get-involved/become-a-dementia-friend with the aim of engaging as many of our staff as possible from across all workforces to support dementia awareness, provide excellent services for people with dementia and become a recognised 'dementia friend.'

Safe medication administration

The OPH&R senior clinical leadership team have commenced an interdisciplinary working group looking at safe medication administration practice aimed at reducing medication errors within the division.

Initial work was focused around gaining a better understanding of current practice relating to administration of medication and the group are now seeking input from all nursing staff working in the hospital to better understand barriers to best practice and how the working environment can support safe medication administration. To ensure learnings across the DHB, this group is working alongside union partners and nursing leads across CDHB.



Outcome and Strategy Indicators

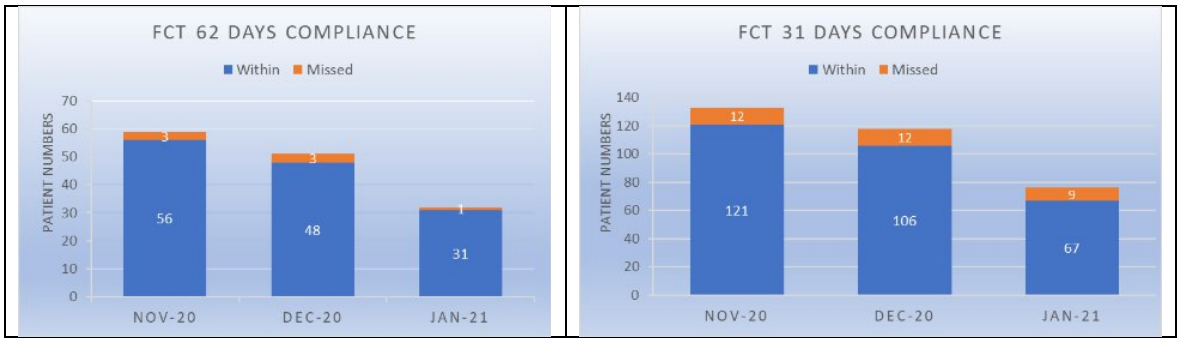
Key Outcomes - Faster Cancer Treatment Targets (FCT)

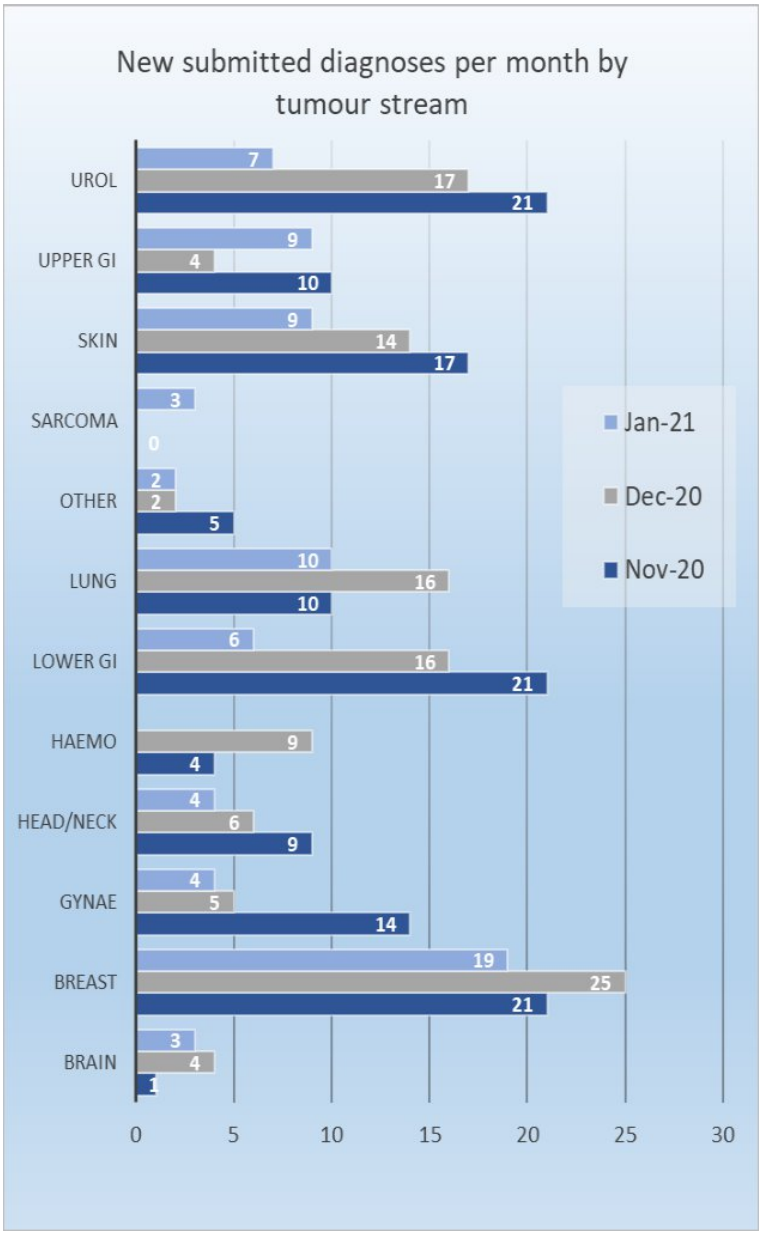
62 Day Target. In the three months to the end of January 2021 there were 167 records submitted by Canterbury District Health Board – slightly down just on the 172 submitted for the three months to the end of December. 32 patients missed the 62 days target, 25 did so through patient choice or clinical reasons and are therefore excluded from consideration. With 7 of the 142 patients missing the 62 days target through capacity issues our compliance rate was 95.1%, once again meeting the 90% target.

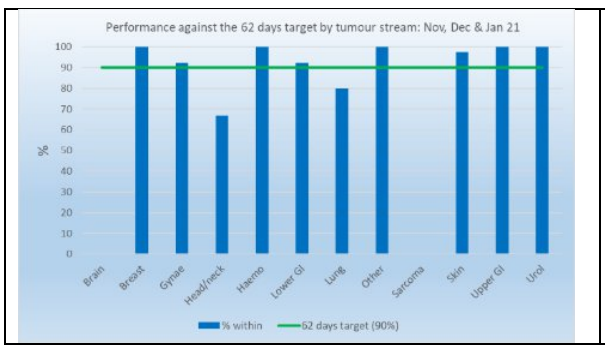
31 Day Performance Measure. Of 327 records submitted towards the 31-day measure 294 (89.9%) eligible patients received their first treatment within 31 days from a decision to treat, the CDHB continues to meet the 85% target. A total of 33 patients did not meet the 31 days target but it is worth noting that 11 missed it by 5 days or less and 7 through patient choice or clinical considerations.

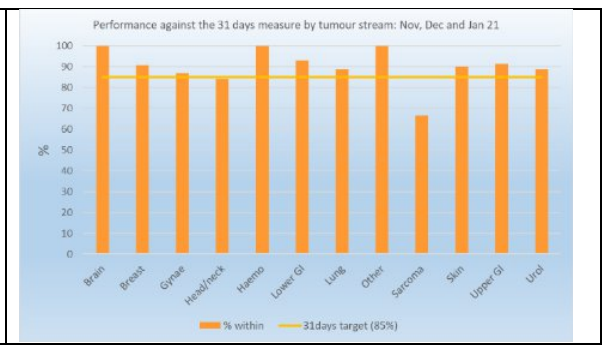
FCT performance in CDHB

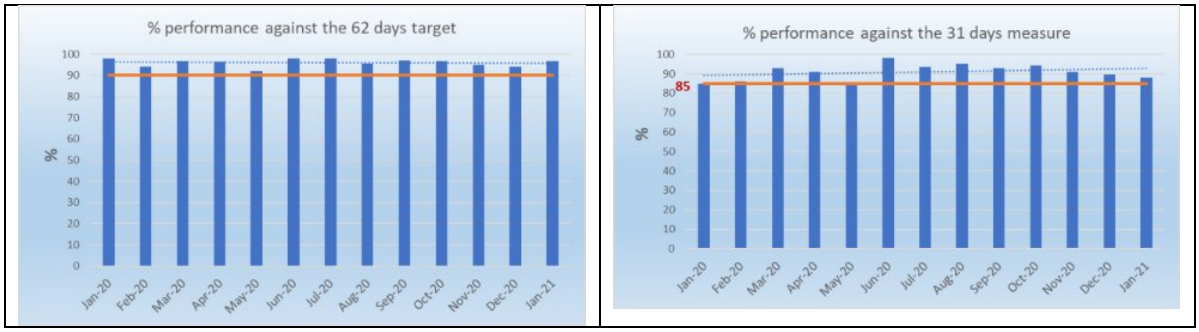
The dip in numbers in the last month of every report (January in this case) reflects the timing of when the report is compiled which is governed by the reporting requirements of the Ministry. A significant number of the patients who have a 1st treatment date in the period this report covers will be awaiting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




New submitted diagnoses per month by tumour stream
UROL
UPPER GI
SKIN
SARCOMA
OTHER
LUNG
LOWER GI
HAEMO
HEAD/NECK
GYNAE
BREAST
BRAIN
7
17
21
9
4
10
9
14
17
3
0
2
2
5
10
16
10
6
16
21
9
4
4
6
9
4
5
14
19
25
21
3
4
1
0
5
10
15
20
25
30
Jan-21
Dec-20
Nov-20


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


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



Patients who miss the targets

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

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

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

Achievements/Issues of Note

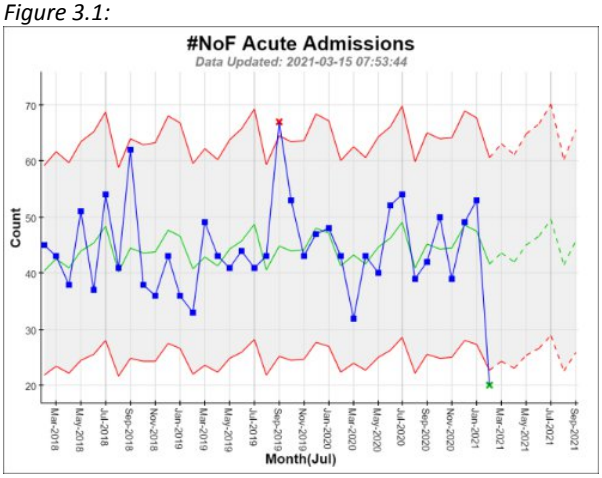
National Bowel Screening Update

- Although the National Bowel Screening programme had a relatively soft launch in Canterbury and is still in its early stages, participation is nearing 56% - close to the target of 60%.
- Equity for target groups is improving a weekly basis.
- As at the beginning of March 2021, 101 diagnostic procedures had been carried out as a result of positive screening tests leading to the diagnosis of eight cancers that would have otherwise not been identified until after they became symptomatic. This earlier diagnosis and treatment of bowel cancer will contribute to reducing the mortality associated with bowel cancer in Canterbury. It will also result in less complex surgery being required and reduce demand on other services including Oncology.

Enhanced Recovery After Surgery (ERAS)

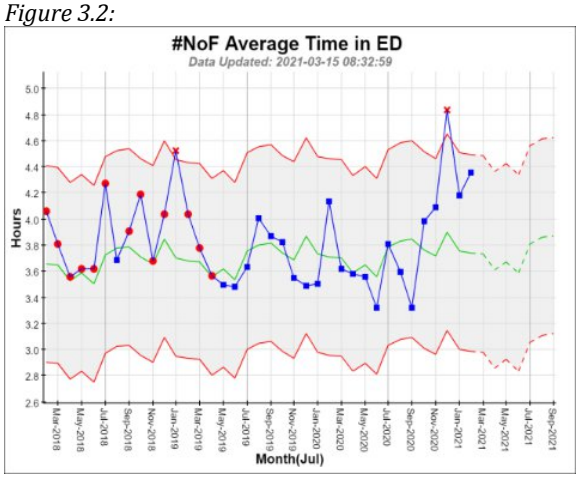
Outcome and Strategy Indicators – Fractured Neck of Femur (#NoF)

Figure 3.1:



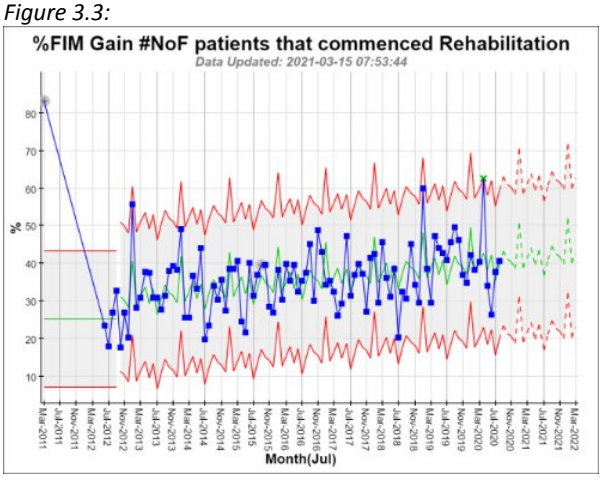
Admissions are generally following the expected mean count. Coding delay impacts the latest data point.

Figure 3.2:



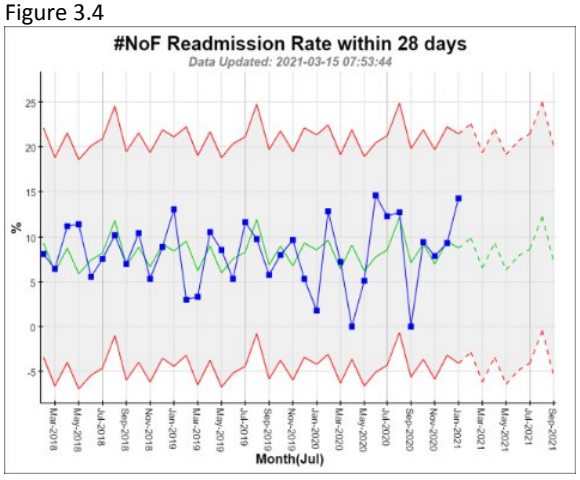
The time spent in the ED by people with a fractured neck of femur has increased. This is in line with the degradation in the proportion of people leaving ED within six hours of arrival that is commented on above. It is associated with a step change in the number of people attending ED that occurred in October 2020 and the shift to a new building. Review of work practices and resource levels against demand and the requirements of the environment is underway.

Figure 3.3:



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

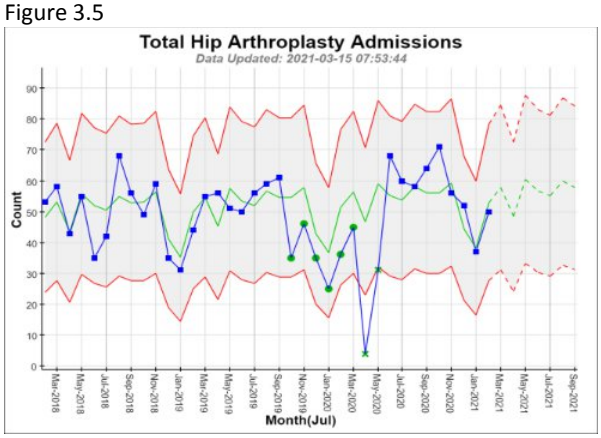
Figure 3.4



Readmissions continue to remain within expected mean values.

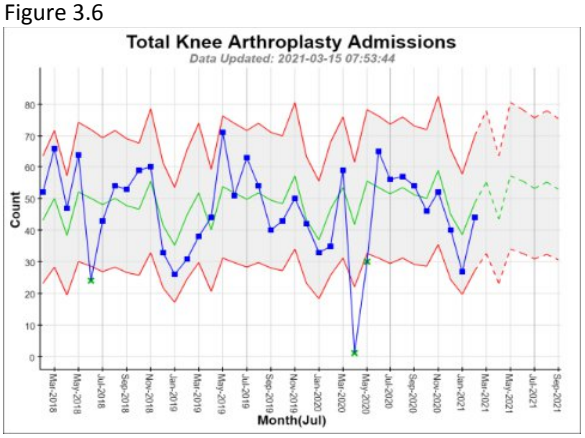
Outcome and Strategy Indicators – Elective Total Hip Replacement (THR) and Knee Replacement (TKR)

Figure 3.5



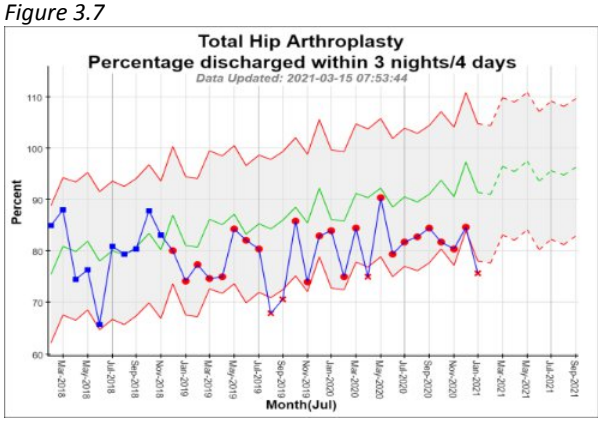
Admissions are trending within the expected range. April shows no record of planned admissions in line with NZ Covid 19 Alert Level 4 restrictions

Figure 3.6



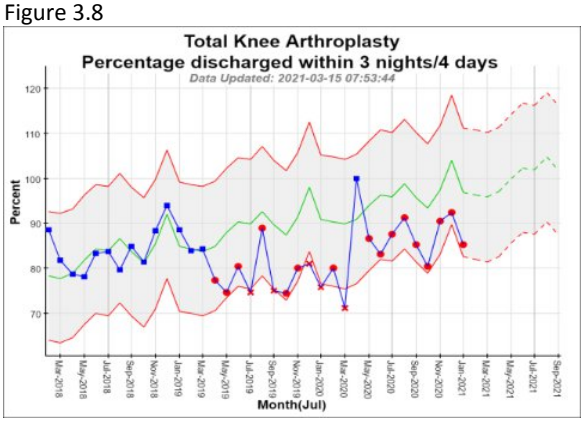
Admissions are trending within expected range. April shows no record of planned admissions in line with NZ Covid 19 Alert Level 4 restrictions

Figure 3.7



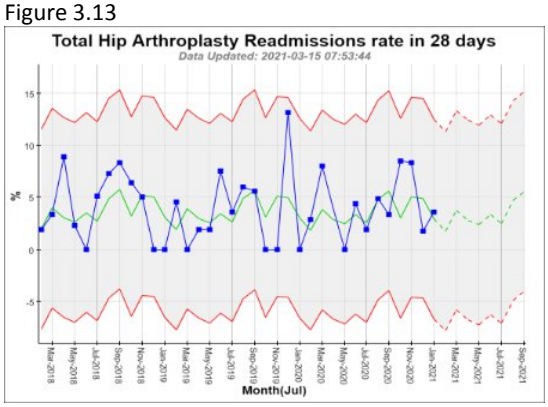
Data for the reporting period is not available – this is being followed up.

Figure 3.8



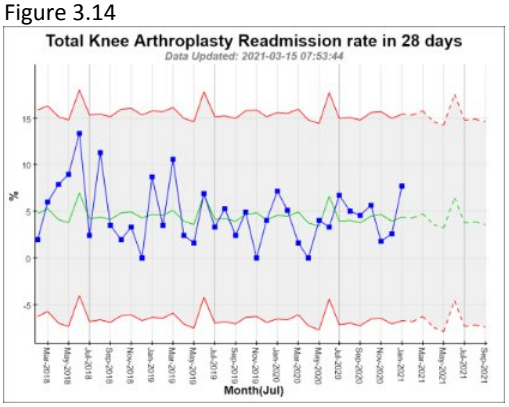
Data for the reporting period is not available – this is being followed up.

Figure 3.13



Readmission rates remain a low percentage

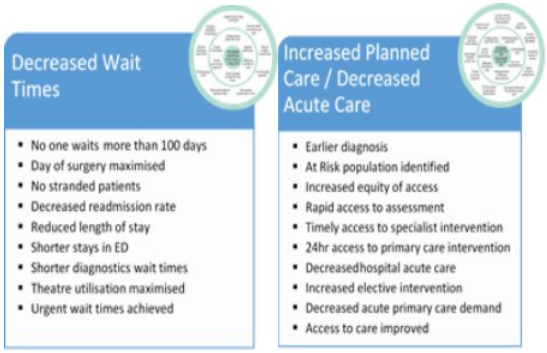
Figure 3.14



Readmission rates are maintaining within tolerances.

Achievements/Issues of Note

OPH&R continue to monitor performance for patients post fractured neck of femur using the NZ hip fracture registry. As detailed in the HAC report in January 2021, performance continues to be in line with expected standards.



Elective Surgery Performance Indicators 100 Days

Elective Services Performance Indicators

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

	Feb		Mar		Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan	
	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %
1. DHB services that appropriately acknowledge and process patient referrals within the required timeframe.	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %
2. Patients waiting longer than four months for their first specialist assessment (FSA).	1546	15.8%	1537	16.5%	1964	23.6%	2244	28.7%	2273	28.9%	1815	21.5%	1200	13.3%	908	9.3%	995	9.6%	1076	9.8%	1313	11.6%	1877	15.7%
3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT).	2	0.0%	0	0.0%	1	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
5. Patients given a commitment to treatment but not treated within four months.	731	16.8%	875	18.3%	1385	26.6%	1323	28.1%	1160	25.2%	1261	26.3%	895	18.7%	681	14.8%	715	15.3%	761	15.8%	970	19.3%	1282	23.6%
8. The proportion of patients treated who were prioritised using nationally recognised processes or tools.	0	100.0 %	3	99.8%	1	99.9%	0	100.0 %	1	99.9%	0	100.0 %	0	100.0 %	8	99.5%	1	99.9%	0	100.0 %	0	100.0 %	0	100.0 %

Summary of ESPI 2 Performance - From MoH Final Summary January 2021 (published on 3 March)

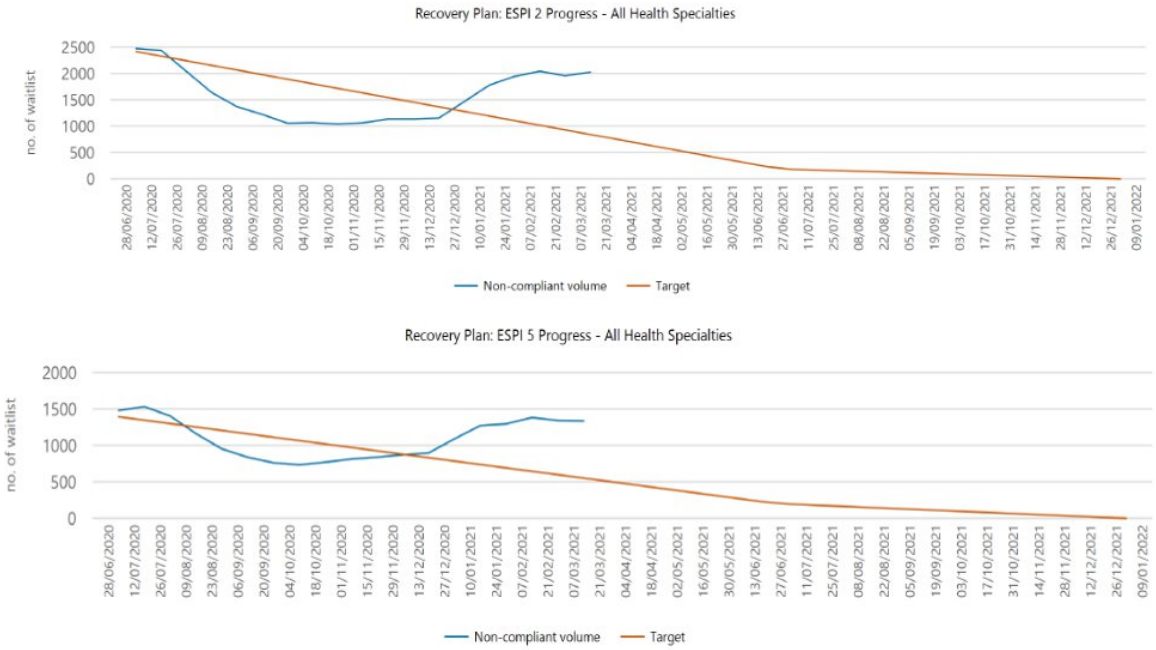
	Nov-20		Dec-20		Jan-21	
ESPI 2 (FSA)	Improvement required	Status%	Improvement required	Status%	Improvement required	Status%
Cardiothoracic Surgery	0	0.0%	0	0.0%	0	0.0%
Ear, Nose and Throat	65	6.4%	98	9.8%	120	11.6%
General Surgery	18	1.4%	43	3.7%	192	16.0%
Gynaecology	4	1.3%	4	1.2%	14	3.4%
Neurosurgery	1	0.7%	0	0.0%	3	1.9%
Ophthalmology	112	9.2%	160	11.6%	324	22.1%
Orthopaedics	83	8.7%	125	12.4%	171	16.4%
Paediatric Surgery	7	6.4%	6	5.3%	6	4.7%
Plastics	164	30.9%	191	37.5%	253	44.2%
Thoracic	0	0.0%	0	0.0%	0	0.0%
Urology	0	0.0%	2	30.0%	8	1.2%
Vascular	65	34.8%	81	37.0%	86	38.7%

Cardiology	17	4.2%	10	2.4%	31	6.7%
Dermatology	1	1.5%	1	1.5%	3	4.1%
Diabetes	13	7.6%	20	11.8%	37	21.3%
Endocrinology	9	3.4%	16	5.7%	27	8.9%
Endoscopy	292	21.0%	297	20.7%	298	20.7%
Gastroenterology	16	5.1%	21	7.4%	29	10.2%
General Medicine	4	2.9%	1	0.6%	2	1.0%
Haematology	0	0.0%	1	1.6%	1	1.4%
Infectious Diseases	1	10.0%	0	0.0%	0	0.0%
Neurology	13	3.7%	26	7.7%	53	13.9%
Oncology	8	2.9%	5	1.6%	17	5.3%
Paediatric Medicine	159	30.8%	178	31.8%	158	28.3%
Pain	0	0.0%	0	0.0%	14	45.2%
Renal Medicine	2	5.1%	0	0.0%	0	0.0%
Respiratory	22	7.3%	26	8.6%	25	7.7%
Rheumatology	0	0.0%	1	0.3%	5	1.5%
Total	1076	9.8%	1313	11.6%	1877	15.7%
ESPI 5 (Treatment)						
Cardiothoracic Surgery	0	0.0%	0	0.0%	0	0.0%
Dental	77	26.6%	79	31.6%	78	23.6%
Ear, Nose and Throat	145	21.8%	189	26.8%	249	33.8%
General Surgery	223	34.2%	254	33.4%	277	35.1%
Gynaecology	37	12.1%	32	10.5%	50	14.4%
Neurosurgery	0	0.0%	0	0.0%	0	0.0%
Ophthalmology	31	8.2%	33	8.2%	68	14.7%
Orthopaedics	60	9.7%	75	12.5%	111	18.8%
Paediatric Surgery	18	14.9%	25	22.3%	24	21.2%
Plastics	79	8.2%	169	16.3%	247	21.4%
Urology	5	1.5%	18	4.9%	42	10.8%
Vascular	5	6.5%	4	3.8%	12	11.0%
Cardiology	81	22.9%	92	28.4%	124	35.5%
Total	761	15.8%	970	19.3%	1282	23.6%

Note - ESPI 5 figures and ESPI2 figures are taken from the MoH ESPI Finals report for January 2021, published 3 March 2021.

The CDHB Improvement Action Plan 20/21 is in place and focusses on CDHB achieving ESPI/Planned Care compliance in the majority of services by the end of June. Prior to the Christmas holidays, CDHB was meeting the plan's overall target for the number of patients waiting for **First Specialist Assessment** however reduced capacity over the holiday period has been difficult to reverse. As at 12th March the overall target is no longer being met. 2,028 people have waited longer than 120 days for their appointment. Seven specialty areas have no patients waiting for **First Specialist Assessment** for longer than 120 days, seven are meeting their recovery plan target and 32 are not.

When considering patients **waiting times for admission and treatment** as at 12th March, CDHB is not meeting the plan's targets, 1338 people have waited longer than 120 days. Three specialty areas are meeting their recovery plan target and ten are not.



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

Maternity Assessment Unit

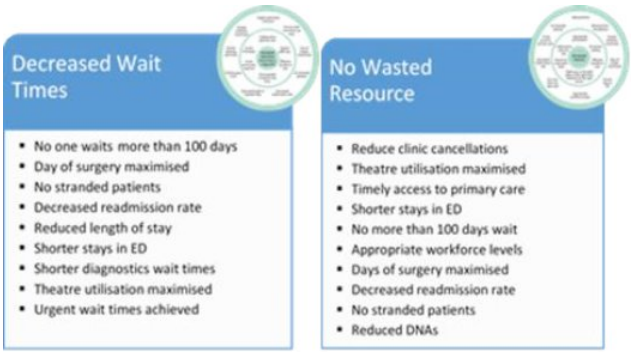
The Maternity Assessment unit that was introduced in 2019 as a part of the Canterbury Maternity Strategy continues to achieve its goal of ensuring that pregnant women receive the right care at the right time.

251 women presented at the unit in January and 249 in February with around one fifth of those going on to be transferred to the birthing suite for further treatment or consultation. The average length of stay, from the time of presentation to leaving the unit, is around two hours.

The unit continues to ensure that women are rapidly assessed, those that need complex care are transferred immediately and those that do not are able to quickly return home. It has reduced queues in the birthing suite and maternity unit and eliminated the long waiting times previously experienced in those settings.

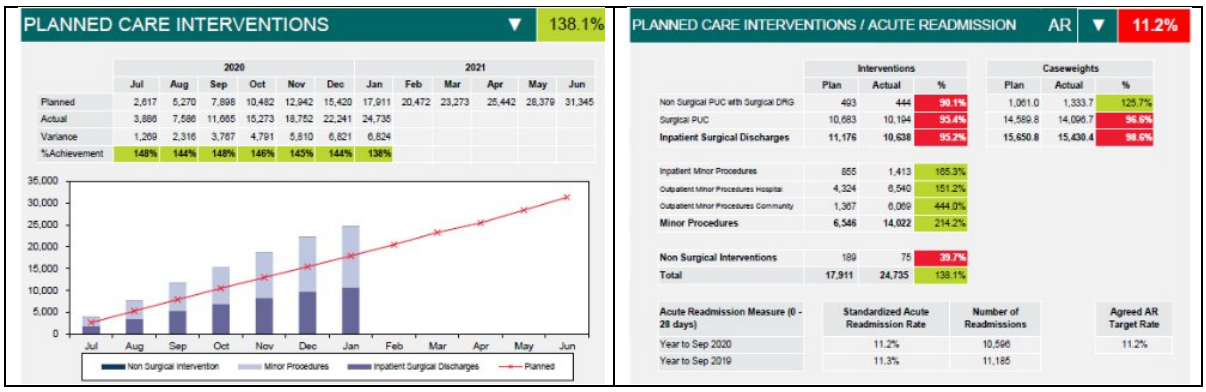
Telehealth Rheumatology care for Kaikoura

- Some patients requiring long term care from the Rheumatology service require regular, three or six monthly, follow up.
- A Rheumatology clinic was been put in place in Kaikoura that had grown to two days every three months, however this clinic had become over-subscribed.
- In order to address this, a telemedicine clinic has been put in place in Kaikoura that enables patients to receive on site care from a specifically trained registered nurse in Kaikoura while medical or CNS review is provided from Christchurch via telemedicine.
- The first telemedicine clinic will be provided in April and will enable on-site clinics in Kaikoura to be prioritised for those who most require face to face care while avoiding the need for stable patients requiring review to travel to Christchurch.



Theatre Capacity and Theatre Utilisation

- Planned care targets have been provided to the Ministry of Health. As per last year, they incorporate planned inpatient operations as well as range of procedures provided to hospital inpatients, outpatients and patients in community settings.
- As at year end our target is to deliver a total of 31,359 planned care interventions: made up of 19,614 surgical discharges, 11,409 minor procedures and 336 non-surgical interventions. This is 2% higher than the 2019/20 target of 30,675.
- Reporting from the Ministry of Health to the end of January shows that Canterbury District Health Board is exceeding its overall planned care targets by 38%, however, within this inpatient surgical discharges have fallen behind target.



- Internal reporting to the week ending 12 March shows that 29,126 planned care events have been provided – this is 7,911 ahead of the target of 21,215.
- Within this, 12,981 planned inpatient surgical discharges were provided – 59 below the phased target of 13,040. Planning and Funding, Operational and Production Planning teams are working together to forecast capacity over the remainder of the year as a part of planning to ensure that we successfully deliver against these targets.
- 16,071 Minor procedures have been provided 8,127 ahead of the target of 7,944. Inpatient, outpatient and community provision are all ahead of target.

Current theatre volumes

- Overall, when all operating by or on behalf of Canterbury DHB is considered (in house, outplaced and outsourced) fewer operations were provided in theatres in January 2021 than in January 2020 (2,019 compared with 2,350) and more in February 2021 than February 2020 (2,415 compared with 2,366) despite a significant reduction in the use of outplaced and outsourced surgery following transition to Waipapa. Further detail follows.
- Demand for arranged and acute surgery during January and February was 7% higher than in 2020 with 1,110 theatre events in January 2021 and 1,031 in February. Initial analysis indicates that patients spent less time waiting for surgery following acute and arranged admission due to the improved availability of acute surgical capacity – however there are some specific periods when waiting times for acute surgery

remains a challenge. As is our usual practice, analysis of demand will inform planning of theatre capacity required during future public holidays.

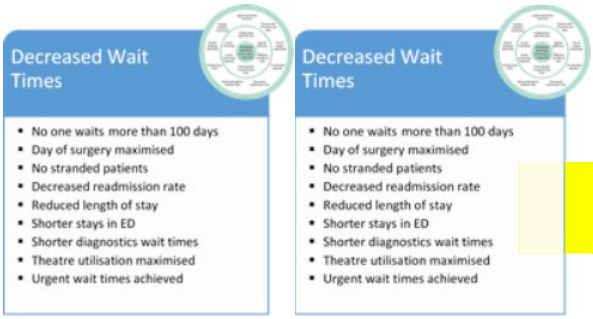
- The number of planned operations carried out at Burwood Hospital was 22% lower in January and 1% higher in February than the same months the previous year with 154 planned events in January 2021 and 258 in February.
- The number of outsourced and outplaced events has been reduced with increased in-house capacity enabling much of this work to be repatriated. The final tranche of outplaced surgery being repatriated occurred in the last week of February when dental operating returned to Christchurch campus. During January, 93 outplaced or outsourced theatre events were provided – 31% of January 2020, there were 163 such events in February – 41% of the previous February.
- More elective surgery was provided at Christchurch Hospital during both January and February than in those months in 2020 with 687 elective theatre events in January 2021 and 977 in February 2021 compared with 679 and 660 in 2020.

Waste minimisation grant application

Provision of cataract operating by the eye service has previously generated significant waste associated with the sterile packaging of surgical instruments. It is estimated that cataract operations would generate 624 bags of steripeel waste and 312 bags of blue paper wrap in a year.

The eye service has obtained a grant from the Christchurch City Council waste minimisation fund that has enabled it to purchase 13 stainless-steel cases and instrument sets enabling it to eliminate the requirement for disposable sterile packaging for its intraocular sets.

An earlier pilot proved that as well as achieving the goal of eliminating consumable packaging, but that it enables safe, efficient, management of fragile instruments. It is hoped that modelling this approach will encourage broader adoption across other high-volume areas of surgery.



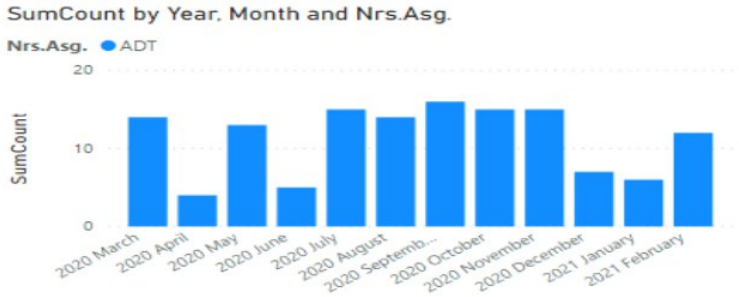
Mental Health Services

Recent reports from Specialist Mental Health Services to the Hospital Advisory Committee have focused on the adult, child and youth, forensic and intellectual disabilities. This report focuses on the specialist services.

The Anxiety Disorders Service

The Anxiety Disorders Service is a community-based team that provides treatment for people with moderate to severe anxiety disorders. This service supports adult community services for people who respond to a more tailored service response. The work includes a contribution to the broader mosque response.

New cases for the Anxiety Disorders Service



Average waiting time to first face to face contact for the Anxiety Disorders Service

Outpatient face-to-face contacts for the Anxiety Disorders Service

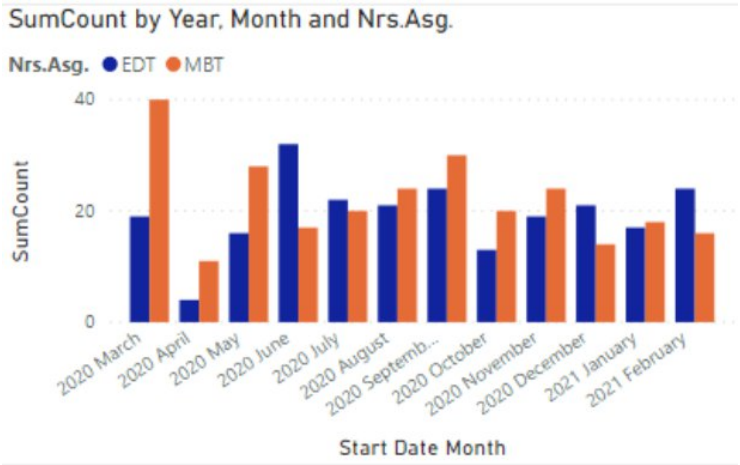
Note the impact of Covid 19; the decrease in face-to-face contacts was replaced by large increases in phone and audio-visual contacts.

Eating Disorders & Mothers & Babies

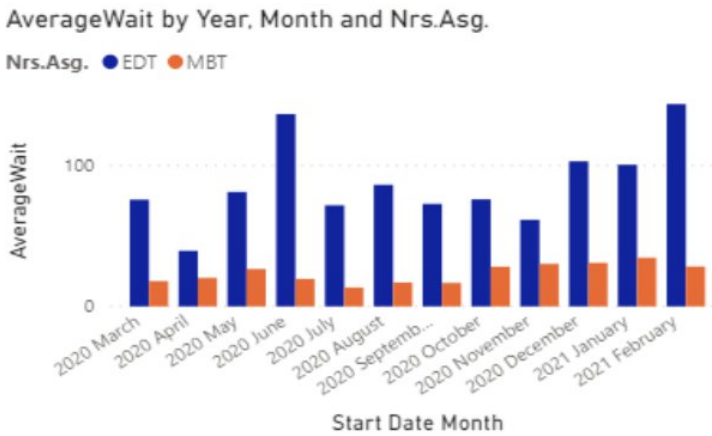
The South Island Eating Disorders Service (SIEDS) is the tertiary level provider of eating disorders treatment for the five DHBs in the South Island. It provides specialist inpatient beds for the South Island alongside specialist outpatient treatment, training, supervision and consultation. This service considers the needs of consumers and their family/whanau across the age span whilst working at each level of the health care sector, i.e., primary and secondary care.

The South Island Mothers & Babies Service provides a specialist perinatal mental health service for perinatal mental health care to the South Island, incorporating inpatient and outpatient care, education, training and consult liaison, for the treatment of mothers who are pregnant or have babies up to one year old. The service operates as a hub and spoke model, with the Mothers and Babies Service acting as a centre of expertise, providing treatment, supervision, clinical consultation and input into workforce development to allow care to be provided in other DHBs the South Island where possible. The goal is that every mother with severe mental health problems in the South Island has access to appropriate specialised care.

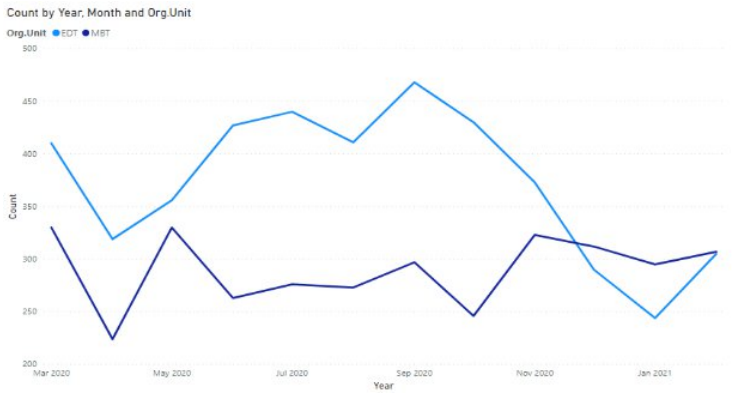
New outpatient cases for the outpatient Eating Disorders and Mothers & Babies teams



Average waiting time to first face to face contact for the outpatient Eating Disorders and Mothers & Babies teams

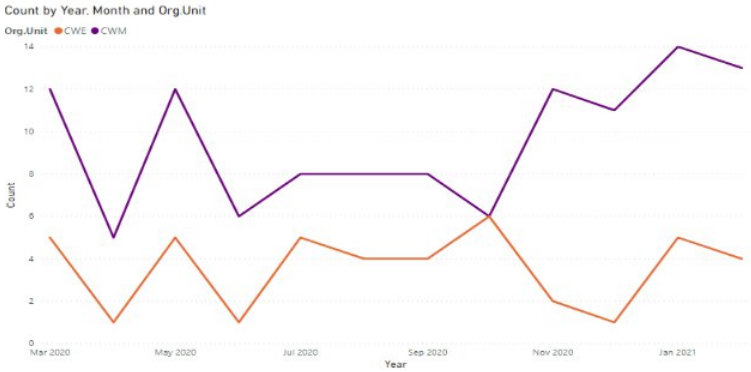


Outpatient contacts for the outpatient Eating Disorders and Mothers & Babies teams



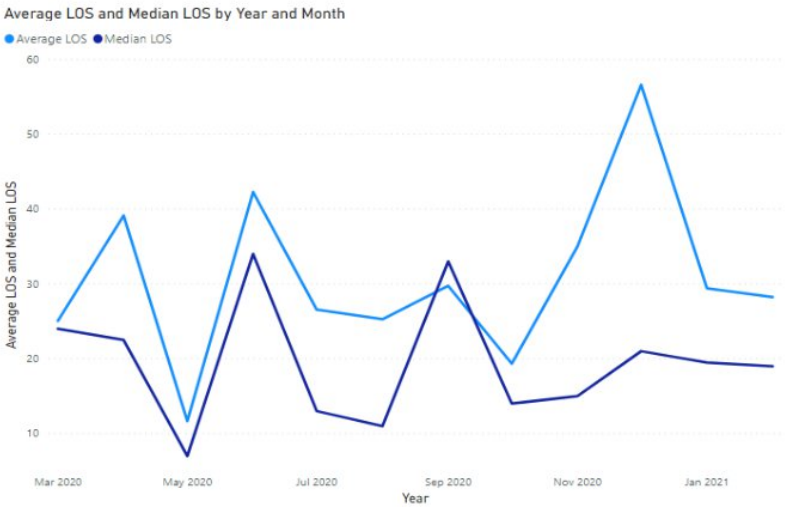
C Ward is the inpatient unit based at Princess Margaret Hospital which takes Eating Disorders and Mothers & Babies patients in need of an admission. C Ward has six beds for mothers, six beds for babies, and seven Eating Disorders beds which are used flexibly. Adolescents with eating disorders are usually admitted to C Ward, whereas children with eating disorders tend to be admitted to the 16 bed Child and Adolescent Unit.

Admissions to C Ward



Note: CWE = Eating Disorders, CWM=Mothers & Babies

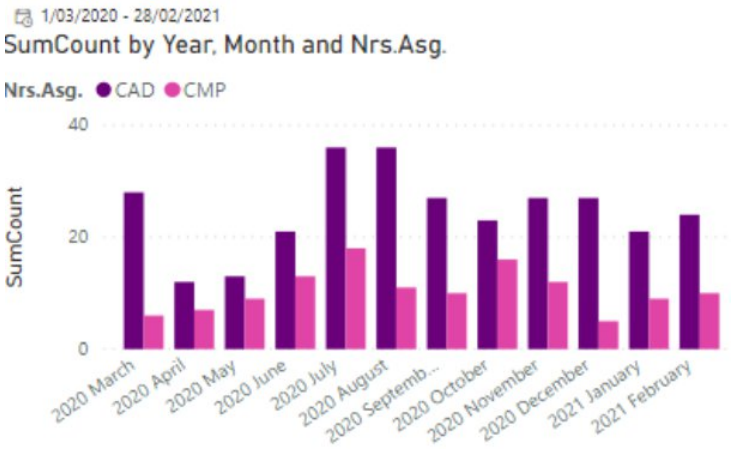
Length of stay for C Ward



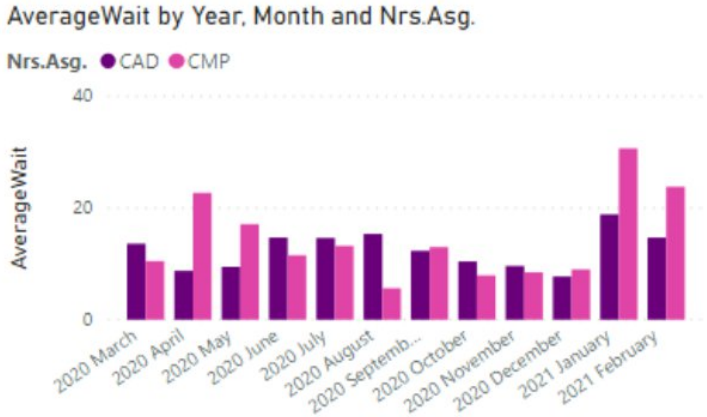
Addictions Services

In Canterbury, the co-ordination of addictions services is managed by the Christchurch Central Service (CCS), led by Odyssey House (a non-Government Organisation [NGO]) in partnership with other NGOs and Specialist Services. Two outpatient addictions services are provided by Specialist Mental Health Services; the Community Alcohol and Drug Service (CADS) and the Christchurch Opioid Recovery Service. CADS provides assessments and outpatient treatment for people that need assistance with co-existing moderate to severe alcohol or other drug dependence and mental illness. The Christchurch Opioid Recovery Service is a harm reduction programme that leads opioid substitution treatment (methadone or suboxone) for people who have opioid dependence. This service works in partnership with general practice and community pharmacy to provide community-based services for people who are stable.

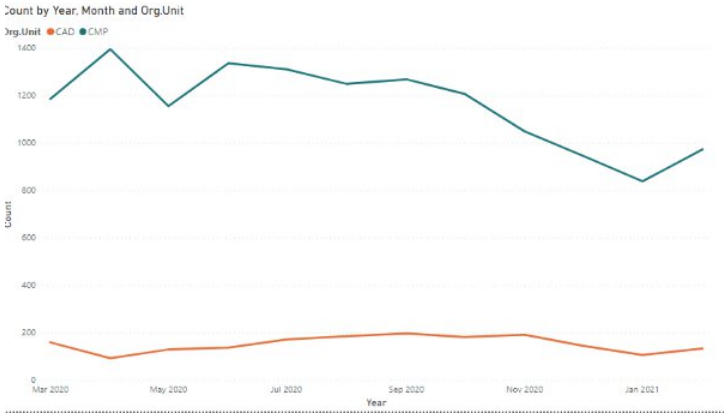
New outpatient cases for the Community Alcohol and Drug Service (CADS) and the Christchurch Opioid Recovery Service (CMP)



Average waiting time to first face to face contact for the Community Alcohol and Drug Service (CADS) and the Christchurch Opioid Recovery Service (CMP)

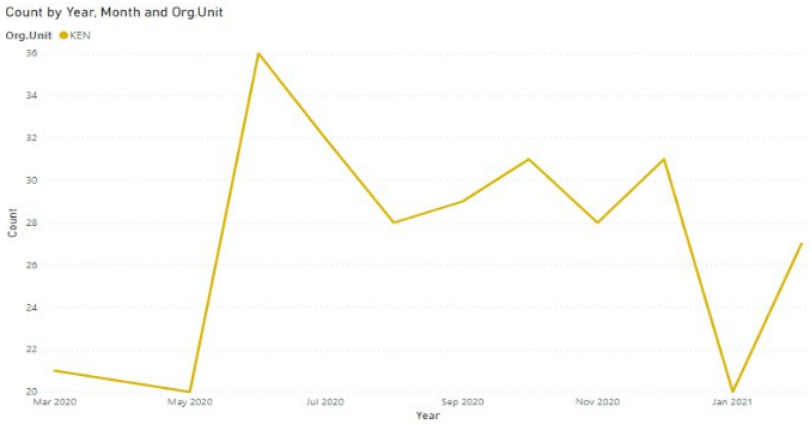


Outpatient contacts for the Community Alcohol and Drug Service (CADS) and the Christchurch Opioid Recovery Service (CMP)

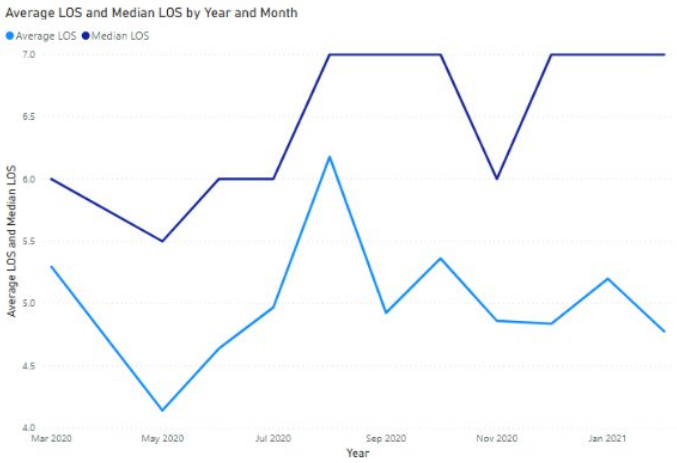


The Kennedy Detox Unit is based at Hillmorton Hospital. The Kennedy Detox Unit is a six-bed regional inpatient unit which provides specialist medical withdrawal management and stabilisation from alcohol and other drugs, for those with alcohol and/or other drug dependence. Patients usually commence NGO-run community-based addictions treatment programmes immediately upon discharge. People commencing on opioid substitution also typically spend a half day at the Kennedy Detox Unit for establishment, before moving onto treatment in the community.

Admissions to the Kennedy Detox Unit



Length of stay for the Kennedy Detox Unit



Living within our means

Canterbury District Health Board

Statement of Financial Performance

Hospital & Specialist Service Statement of Comprehensive Revenue and Expense For the 8 Months Ended 28 February 2021

MONTH $'000				YEAR TO DATE $'000		
20/21 Actual $'000	20/21 Budget $'000	20/21 Variance $'000		20/21 Actual $'000	20/21 Budget $'000	20/21 Variance $'000
			Operating Revenue			
302	266	36	From Funder Arm	2,177	2,120	57
1,689	1,538	151	MOH Revenue	13,019	12,595	424
4,700	4,435	265	Patient Related Revenue	37,520	35,154	2,366
2,644	1,704	940	Other Revenue	22,455	13,673	8,782
9,335	7,943	1,392	**TOTAL OPERATING REVENUE**	75,171	63,542	11,629
			Operating Expenditure			
			Personnel Costs			
65,445	64,473	(972)	Personnel Costs - CDHB Staff	542,868	547,445	4,577
1,833	1,948	115	Personnel Costs - Bureau & Contractors	16,553	15,838	(715)
67,278	66,421	(857)	**Total Personnel Costs**	559,421	563,283	3,862
12,286	13,988	1,702	Treatment Related Costs	108,045	111,060	3,015
3,746	4,037	291	Non Treatment Related Costs	32,182	32,262	80
83,310	84,446	1,136	**TOTAL OPERATING EXPENDITURE**	699,648	706,605	6,957
(73,975)	**(76,503)**	**2,528**	**OPERATING RESULTS BEFORE INTEREST AND DEPRECIATION**	**(624,477)**	**(643,063)**	**18,586**
			Indirect Income			
-	1	(1)	Donations & Trust Funds	98	10	88
-	**1**	**(1)**	**TOTAL INDIRECT INCOME**	**98**	**10**	**88**
			Indirect Expenses			
2,994	2,413	(581)	Depreciation	22,233	19,700	(2,533)
-	-	-	Net (Gain) Loss on Disposal of Fixed assets	(330)	-	330
2,994	**2,413**	**(581)**	**TOTAL INDIRECT EXPENSES**	**21,903**	**19,700**	**(2,203)**
(76,969)	**(78,915)**	**1,946**	**TOTAL SURPLUS / (DEFICIT)**	**(646,282)**	**(662,753)**	**16,471**

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

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

Waipapa Stock Levels

Transition to Waipapa has provide an opportunity to rationalise some of our approaches to ward supplies:

- The physical structure of Waipapa has enabled reduced stock holding. Store areas in Waipapa are shared between two wards – halving the value of stock on hand for those areas.
- All Waipapa areas have gone on to scanning ensuring stock is ordered and delivered when it is needed.
- The stock that was bought over from the wards was too much to hold in the shared rooms, this surplus is now being used as the first source of stock to top up ward store areas. Items not being used quickly enough to avoid expiry is being directed elsewhere.
- There is active communication between wards and coordinators about stock that is no longer required, or where minimum/maximum values can be reduced – further trimming the value of holdings.

Paediatric Medical Day Ward Trial of Play Therapy

The Paediatric Medical Day ward cares for 300-500 patients per month. Tamariki attending the day ward often have complex and long-term health issues and benefit from building trust with the day ward team who support them and their whānau over their ongoing psychosocial and medical needs.

Prior to Play Therapy being available on the Day Ward, sedation was being used to enable anxious children to undergo various procedures. The team was concerned about this and keen to provide a more tamariki/whānau friendly option in partnership with the whānau, to help increase coping skills.

An audit of this service for cost effectiveness and improving health literacy, coping skills and medication taking skills of the tamariki and their whānau to prevent inpatient admission. This has improved adherence to the medication and ongoing treatment plans, contributing to reduced admissions and timely discharge.

Savings of $47,000.00 have been identified over this 12-month period, via:

- decrease in sedations for procedures $17,800.00 saving
- Tamariki now able to swallow tablets avoiding infusions $10,296.00 saving
- Improved management of constipation avoiding admission for dis impaction $4,640.00 saving
- Improved management of constipation meaning one tamariki could be removed from the surgical waitlist $14,450.00 saving

Whānau satisfaction with the service is high.

Just in time supplies for whānau - Paediatric Outreach

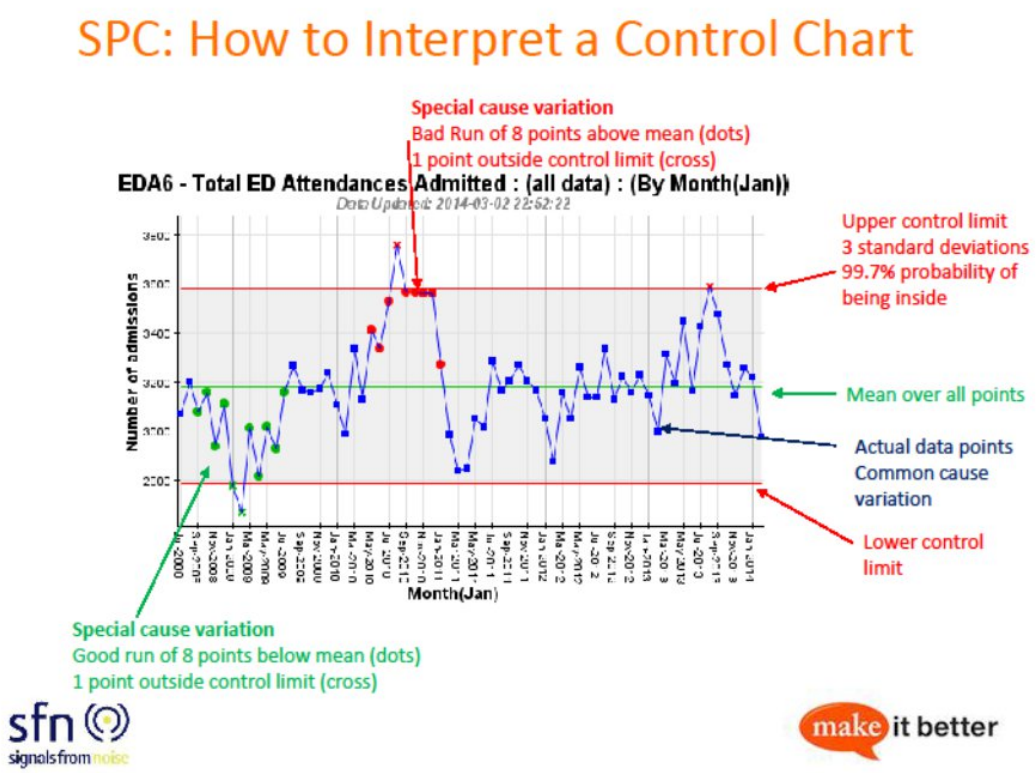
Several whānau receive ongoing supplies via the Paediatric Outreach Nurses which enable their tamariki to stay at home, attend school or early childhood education thus maintaining their wellbeing. The type of supplies involved includes those required to assist with breathing or feeding for tamariki that have difficulties with these most fundamental human functions.

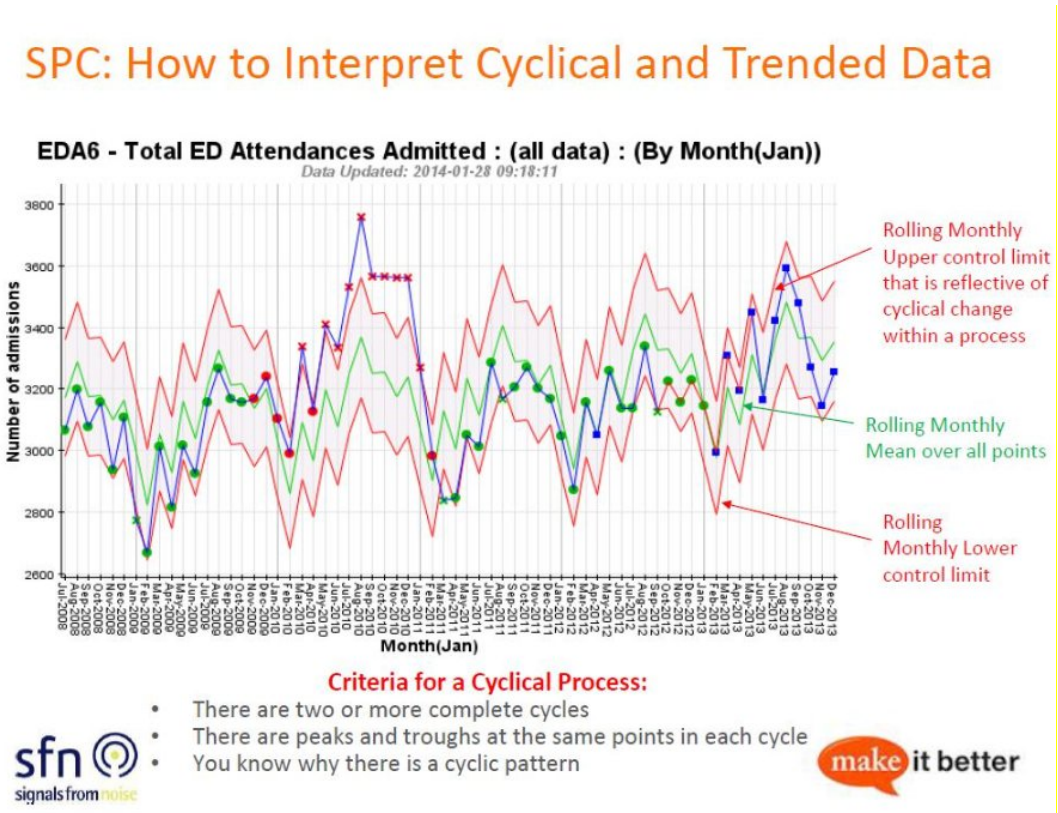
In the past supplies were packaged up on a two monthly basis and delivered to the patient's home. However changes in the whānau's requirements meant that that supplies were sometimes wasted.

The system has been changed. Whānau now phone the Paediatric Outpatient's aide, ordering their requirements from a template. The supplies are left at the orderly's lodge, meaning that a family member can retrieve it with no parking costs.

The small adjustments ensure that whānau feel more in control and order only what they can need – this has saved approx. $1,000 in the last month.

Achievements/Issues of Note





CLINICAL ADVISOR UPDATE – ALLIED HEALTH

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NOTES ONLY PAGE

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

DATE: **1 April 2021**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Committee:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of the minutes of the public excluded meeting of 28 January 2021	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(if required)*	Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege.	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)

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

3. SUMMARY

The Act, Schedule 3, Clause 32 provides:

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

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

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

Clause 33 of the Act also further provides:

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

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

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

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

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