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, 5 December 2019 commencing at 9:00am

	Apologies		9.00am
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 3 October 2019		
3.	Carried Forward / Action List Items		
4.	Clinical Team Co-ordinators (Presentation)	Pauline Clark	9.05-9.35am
5.	New Treatments and Technologies (Presentation)	Dr Sue Nightingale	9.35-10.05am
6.	Clinical Advisor Update (Oral) • Medical	Dr Sue Nightingale	10.05-10.20am
7.	2019 Winter Plan Outcomes	Pauline Clark	10.20-10.30am
MORNING TEA			**10.30-10.45am**
8.	Hospital Service Monitoring Report: Rural Health Services Mental Health Older Persons, Orthopaedics & Rehabilitation Hospital Laboratories Medical/Surgical & Women's & Children's Health ESPIs	 Win McDonald Toni Gutschlag Dan Coward Kirsten Beynon Pauline Clark	10.45-11.30am
9.	Resolution to Exclude the Public		11.30am
ESTIMATED FINISH TIME – PUBLIC MEETING			**11.30am**
	Information Items: Quality & Patient Safety Indicators – Level of Complaints 2019 Workplan		

NEXT MEETING: Thursday, 30 January 2020 at 9:00am (Tentative)

ATTENDANCE – 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
Wendy Dallas-Katoa
Jan Edwards
Dr Rochelle Phipps
Trevor Read
Dr John Wood (Ex-officio)
Ta Mark Solomon (Ex-officio)

Executive Support

David Meates – *Chief Executive*
Evon Currie – *General Manager, Community & Public Health*
Michael Frampton – *Chief People Officer*
Mary Gordon – *Executive Director of Nursing*
Carolyn Gullery – *Executive Director Planning, Funding & Decision Support*
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*
Kay Jenkins – *Executive Assistant, Governance Support*

COMMITTEE MEMBER ATTENDANCE SCHEDULE 2019 – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NAME	31/01/19	04/04/19	30/05/19	01/08/19	03/10/19	05/12/19
Andrew Dickerson (Chair)	√	√	√	√	√	
Jo Kane (Deputy Chair)	√	√	^	√	√	
Barry Bragg	#	√	#	#	#	
Sally Buck	√	√	√	√	#	
Dr Anna Crighton	√	√	~	√	√	
David Morrell	√	√	√	√	√	
Wendy Dallas-Katoa					* 21/11/19	
Jan Edwards	√	√	√	#	#	
Dr Rochelle Phipps	√	√	√	√	√	
Trevor Read	√	#	√	√	√	
Dr John Wood (ex-officio)	√	√	√	√	√	
Ta Mark Solomon (ex-officio)	#	√	#	#	#	

√ 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.
Jo Kane **Deputy Chair – HAC** 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.
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. **CRL Energy Limited** – 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** – 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. **Stevenson Group Limited** – Deputy Chairman Property interests in Auckland and mining interests on the West Coast. **Taurus Management Limited** – Director Property syndication company based in Christchurch
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. **The Art Registry Company Limited** - Shareholder **Theatre Royal Charitable Foundation** – Director
Wendy Dallas-Katoa Manawhenua	**Greater Healthy Christchurch** – Runanga Representative **IHI Research –** Social Change and Innovation Researcher **Manawhenua Ki Waitaha** – Chair, Representative of Onuku Runanga 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 and the CDHB.

	NZBA – Maori Advisory Group **Population Health Alliance SLA** – MKW Representative **RANZCOG** – Cultural Advisor, He Hono (Wahine Maori Collective of Obstetrics and Gynaecologists) **Te Kahui o Papaki ka Tai** – Mana Whenua Representative (Cultural Advisor) Maori Advisory Group to Pegasus Health/PHO **Victoria University** – Women's Health Representative
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 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 heritage 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.
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. **Governance Board (General Partnership Limited) Te Putahitanga o Te Waipounamu** – Chair Te Putahitanga o Te Waipounamu is a commissioning entity that works on behalf of the iwi in the South Island to support and enable whanau to create sustained social impact by developing and investing in ideas and initiatives to improve outcomes for Māori, underpinned by whānau-centred principles and strategies, these include emergency preparedness and disaster recovery. Te Pūtahitanga o Te Waipounamu also invests in Navigator roles to support and build whānau capability. **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. **Interim Te Ropu** – Member An Interim Ropu has been established to work in partnership with the Crown, Ministers, and the joint venture to help develop and shape initial work on a national strategy to prevent and reduce family violence, sexual violence and violence within whānau. The interim Te Rōpū has been appointed by the Minister of Māori Development and the Lead Minister in consultation with the Minister of Māori/Crown Relations. It comprises up to ten members who bring appropriate skills and expertise and who can reflect communities, rangatahi and whānau, urban

	and regional Māori and wāhine Māori. The group will help inform the terms of reference of the permanent Te Rōpū, with advice due by April 2019. **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 Corporation Limited** – 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. **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.

	Taranaki Capital Partners Limited – Director Not for profit company looking after share portfolios for Nga Rauru & Ngati Ruanui. **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 Ohu Kai Moana Portfolio Management Services Limited** – Director Sub-committee of Te Ohu Kai Moana **Te Ohu Kai Moana Trustee Limited** – Director & Trustee Charitable Trust of Te Ohu Kai Moana. **Te Putea Whakatupu Trustee Limited** – Shareholder Standalone Trust affiliated to Te Ohu Kai Moana. **Te Wai Maori Trustee Limited** – Shareholder Standalone Trust affiliated to Te Ohu Kai Moana. **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. **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 2019. **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 Arawhiti, Office for Maori Crown Relations **Member Chief Crown Negotiators Forum** Te Arawhiti, are responsible for monitoring and enhancing relations between Maori and the Crown, 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. **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.

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, 3 October 2019, commencing at 9.00am

PRESENT
Andrew Dickerson (Chair); Jo Kane (Deputy Chair); Dr Anna Crighton; David Morrell; Dr Rochelle Phipps; Trevor Read; and Dr John Wood.

APOLOGIES
Apologies for absence were received and accepted from Barry Bragg; Sally Buck; Jan Edwards; and Ta Mark Solomon.
An apology for lateness was received and accepted from Dr Rochelle Phipps (9.04am).

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

EXECUTIVE APOLOGIES
There were no Executive apologies.

IN ATTENDANCE

Item 4
Marie Lory, Perioperative Nurse Manager, Christchurch Campus
Christina Mason, Clinical Nurse Specialist
Kirsten Welsh, Clinical Nurse Specialist

Item 5
Berni Marra, Manager, Ashburton Health Services
Dr Scott Wilson, Rural Hospital Medical Specialist
Brenda Close, Director of Nursing, Ashburton and Rural

Item 7
Pauline Clark, General Manager, Medical/Surgical & Women's & Children's Health
Dan Coward, General Manager, Older Persons, Orthopaedics and Rehabilitation
Berni Marra, Manager, Ashburton Health Services
Win McDonald, Transition Programme Manager, Rural Health Services
Barbara Wilson, Acting Director, Quality & Operations, Specialist Mental Health Services (*SMHS*)

1. INTEREST REGISTER

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

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

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

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (12/19)
(Moved: Trevor Read/Seconded: Dr Anna Crighton – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 1 August 2019 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION ITEMS

The carried forward action item was noted.

4. PERIOPERATIVE NURSING (PRESENTATION)

Dr Rochelle Phipps joined the meeting at 9.04am.

The Committee received a presentation from Marie Lory, Perioperative Nurse Manager for Christchurch Campus. Christina Mason and Kirsten Welsh were also in attendance. The presentation provided an overview of the Perioperative Service for Christchurch Campus.

Members had the opportunity to ask questions and discussion took place on various issues, including:

- Staff morale and team building.
- Plans to bring surgery back in-house from the private sector once Hagley theatres opens.
- Sophistication of CDHB's instrument/equipment tracking systems.
- Owning instruments versus supply on consignment.

The Committee thanked the attendees for the informative presentation.

5. ASHBURTON RURAL HEALTH SERVICES (PRESENTATION)

The Committee received a presentation on Ashburton Rural Health Services from Berni Marra, Manager, Ashburton Health Services; Dr Scott Wilson, Rural Hospital Medical Specialist; and Brenda Close, Director of Nursing, Ashburton and Rural.

The Committee was also provided with a handout – "Ashburton Rural Health Services Division – Our Plan on a Page 2019-2020". Ms Marra noted that this provided a comprehensive picture of Ashburton's fit and contribution to CDHB's overall service delivery.

Members had the opportunity to ask questions and discussion took place on various issues, including:

- Refugee resettlement in 2020, quotas, and the condition of Ashburton's housing stock.
- Strong focus on integrated care strategies to reduce demand on acute care.
- General Practice services.

The Committee thanked the attendees for the presentation. The significant gains made by the Service were acknowledged, and the ongoing work for further improvements and gains in service delivery were positively supported.

6. CLINICAL ADVISOR UPDATE – NURSING (ORAL)

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

- Status of implementation for the Care Capacity Demand Management Programme.
- Trendcare implementation.
- Uptake for the Registered Nurse subscribing pathway.
- Nursing paperlite initiative.
- Discussions with the Midwifery Council and Ara School of Midwifery, which have resulted in a shortened pathway into midwifery for nursing graduates.

Discussion took place about incentivising nurses to work in specific areas (eg, rural, mental health). It was noted that this already occurs through a bond system, where there is the opportunity for a nurse's student loan to be wiped by working in a specific service for a specified period of time.

7. H&SS MONITORING REPORT

The Committee considered the Hospital and Specialist Services Monitoring Report for September 2019. The report was taken as read.

General Managers spoke to their areas as follows:

Rural Health Services – Berni Marra, Manager, Ashburton Health Services
Nothing further to add from the presentation earlier in the meeting.

Rural Health Services – Win McDonald, Transition Programme Manager

- Locums going to Chatham Islands are rural trained and have worked in rural environments. Having GPs who understand rural GP medicine is crucial.

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

- Unprecedented demand and record volumes continued across August and September. Primary Health colleagues are also reporting unprecedented demand.
- The impact on staff from the unrelenting demand and ongoing industrial action.
- Unrelenting presentations of family violence cases.
- Recent Medical Council visit as part of reaccreditation process as a medical training facility. Very complimentary about the RMO training programme.

ESPIs
Carolyn Gullery, Executive Director, Planning Funding & Decision Support, provided an update. Ongoing reporting issues were noted, along with a recovery plan that has been put forward. It was noted that financial penalties are no longer applicable.

The Committee acknowledged the success of the "Physiotherapists in the Emergency Department" initiative.

There was a query whether local prison populations were being screened for Hepatitis C. Ms Gullery advised that they are.

Specialist Mental Health Services (*SMHS*) – Barbara Wilson, Acting Director, Quality & Operations

- Currently recruiting for a number of mental health nurse vacancies.
- New facilities are on track and progressing well.

The Committee noted additions to the report, including new data sets and comparisons in performance against other DHBs. This information was well received.

There was discussion on Te Awakura readmission rates. Ms Wilson advised there were a number of contributing factors, including diagnosis, pressure on beds and length of stay, and the ability to move clients through the system.

Older Persons, Orthopaedics & Rehabilitation Service – Dan Coward, General Manager

- Focus remains on Enhanced Recovery After Surgery (*ERAS*), enabling people to recover faster from their surgery and return home earlier.
- Ongoing success with fall rates.
- Nurse Audit Data Insight Application (*NADIA*) pilot programme. A digital audit tool which has led to time savings, resulting in care time back to patients.

Resolution (13/19)
(Moved: Dr Rochelle Phipps/Seconded: David Morrell – carried)

"That the Committee:

i. notes the Hospital Advisory Committee Activity Report."

8. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (14/19)
(Moved: Trevor Read/Seconded: Jo Kane – 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 1 August 2019.	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(If required)*	Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)

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

INFORMATION ITEMS

- 2020 Tentative Meeting Schedule
- 2019 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 11.34am.

Approved and adopted as a true and correct record:

_____ _____

Andrew Dickerson
Chairperson

Date of approval

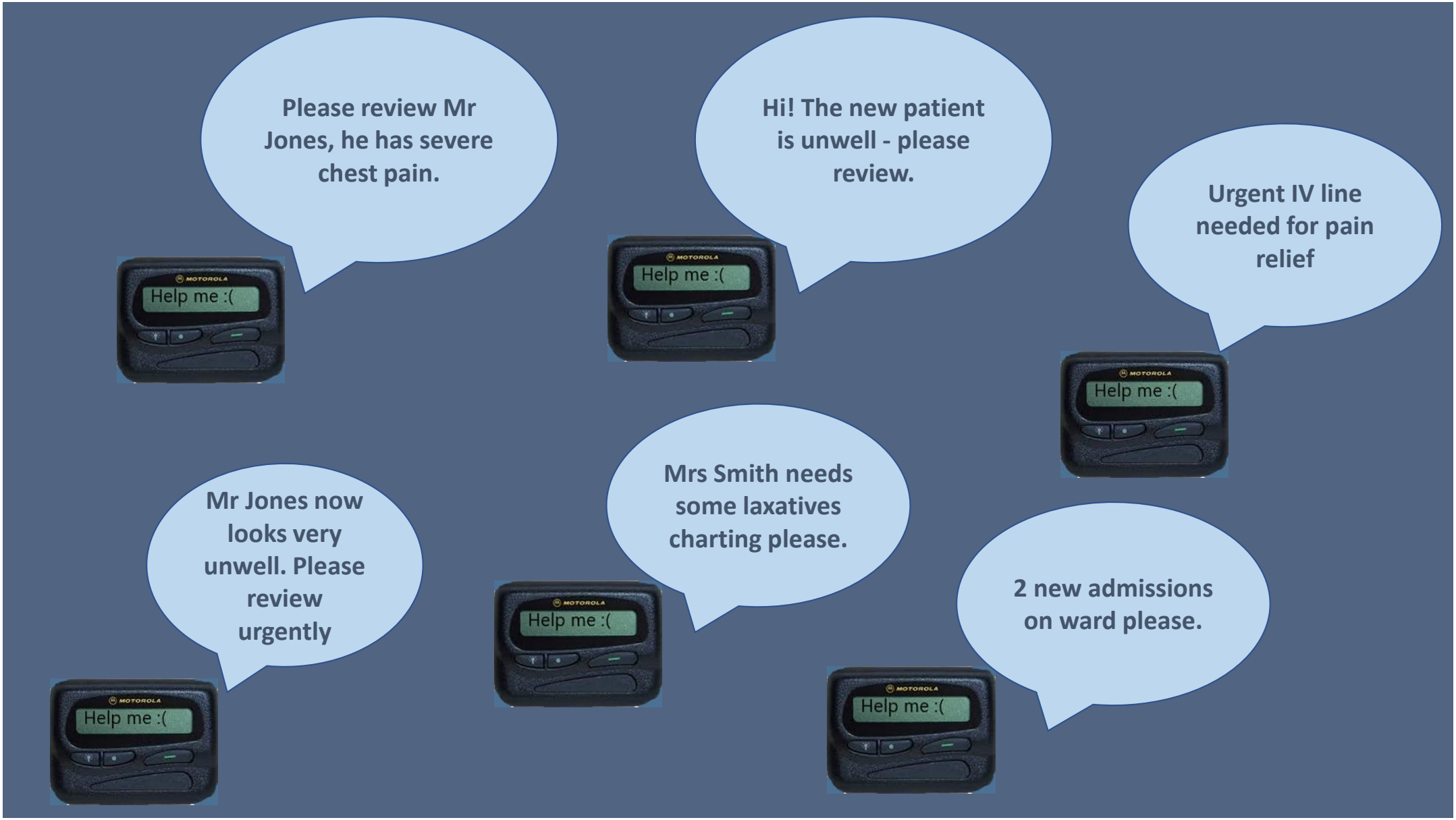
CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE
CARRIED FORWARD ITEMS AS AT 5 DECEMBER 2019

	DATE RAISED	ACTION	REFERRED TO	STATUS
1.	30 May 2019	New Treatments and Technologies Programme - Presentation	Dr Sue Nightingale	Today's agenda – Item 5.
2.	01 Oct 2019 (QFARC)	Strategic Paper on Maternity / NICU Services, following completion of national piece of work.	Carolyn Gullery	To be carried over to 2020 workplan.

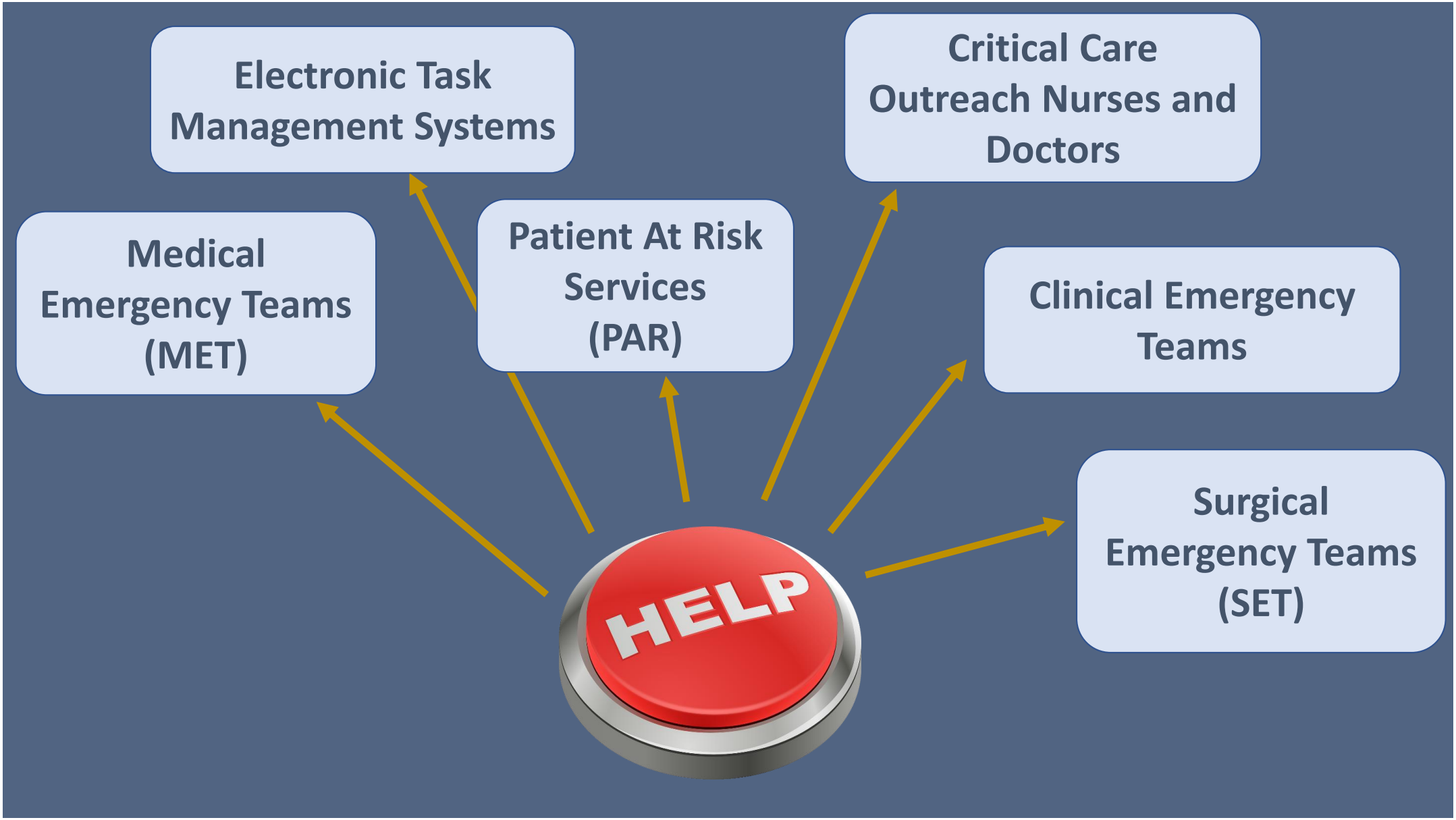
Teaming up in the afterhours

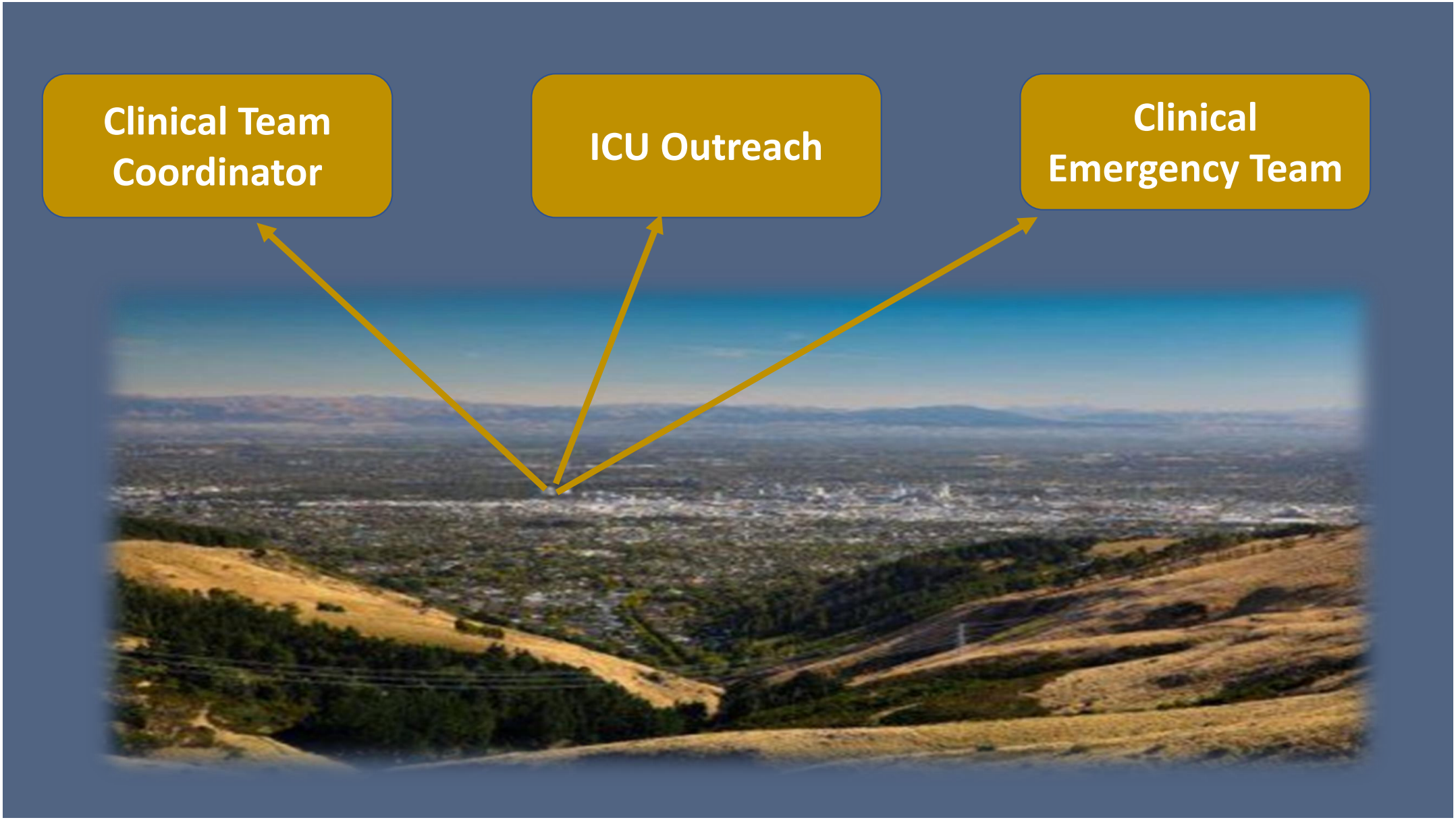

Please review Mr Jones, he has severe chest pain.
Help me :(
Hi! The new patient is unwell - please review.
Help me :(
Urgent IV line needed for pain relief
Help me :(
Mr Jones now looks very unwell. Please review urgently
Help me :(
Mrs Smith needs some laxatives charting please.
Help me :(
2 new admissions on ward please.
Help me :(

What are the afterhours?

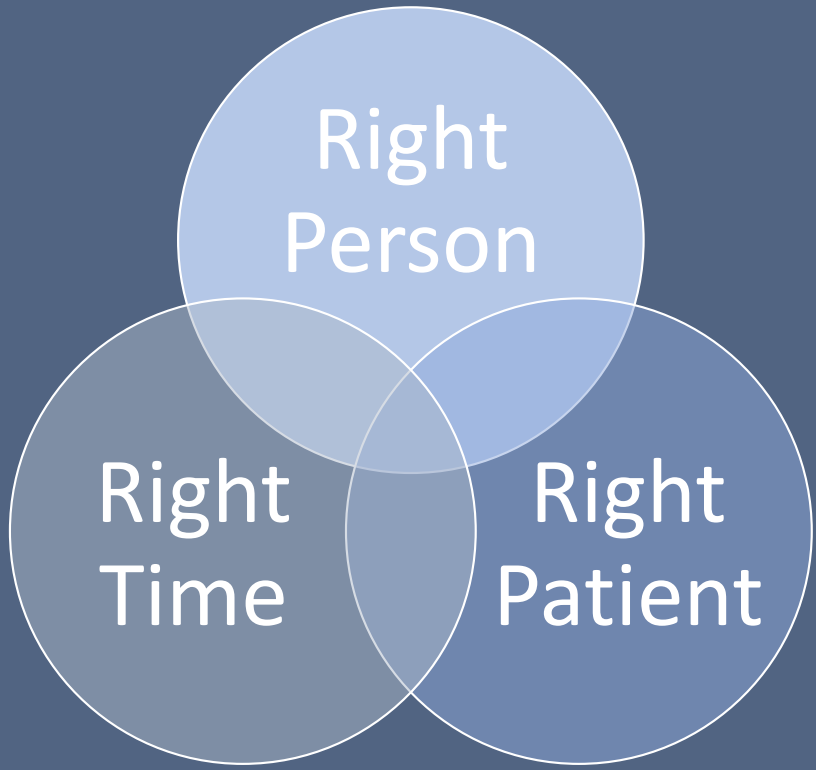
- Afternoons
- Nightshifts
- Weekends
- Public Holidays

Why have an afterhours team?...


Electronic Task Management Systems
Critical Care Outreach Nurses and Doctors
Medical Emergency Teams (MET)
Patient At Risk Services (PAR)
Clinical Emergency Teams
Surgical Emergency Teams (SET)
HELP


Clinical Team Coordinator
ICU Outreach
Clinical Emergency Team

The Clinical Team Coordinator role…



General Overview

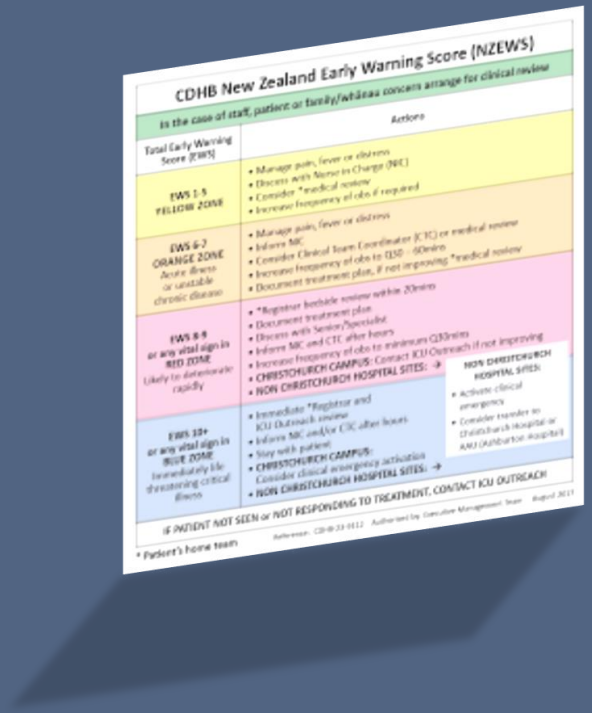
Clinical workload

Patient acuity

Point of Contact

Discussion → Triage → Escalation

Patients at Risk


CDHB New Zealand Early Warning Score (NZEWS)

In the case of staff, patient or family/whānau concern arrange for clinical review

Total Early Warning Score (EWS)	Actions
EWS 1-5 YELLOW ZONE	• Manage pain, fever or shiverss • Discuss with Nurse in Charge (NIC) • Consider *medical review • Increase frequency of obs if required
EWS 6-7 ORANGE ZONE Acute illness or unstable chronic disease	• Manage pain, fever or shiverss • Inform NIC • Consider Clinical Team Coordinator (CTC) or medical review • Increase frequency of obs to Q30 – 60mins • Document treatment plan, if not improving *medical review
EWS 8-9 or any vital sign in RED ZONE Likely to deteriorate rapidly	• *Registrar bedside review within 20mins • Document treatment plan • Discuss with Senior/Specialist • Inform NIC and CTC after hours • Increase frequency of obs to minimum Q30mins • CHRISTCHURCH CAMPUS: Contact ICU Outreach if not improving • CHRISTCHURCH HOSPITAL SITES: → • NON CHRISTCHURCH HOSPITAL SITES:
EWS 10+ or any vital sign in BLUE ZONE Immediately life threatening critical illness	• Immediate *Registrar and ICU Outreach review • Inform NIC and/or CTC after hours • Stay with patient • CHRISTCHURCH CAMPUS: Consider clinical emergency activation • NON CHRISTCHURCH HOSPITAL SITES: → • Activate clinical emergency • Consider transfer to Christchurch Hospital or AMU (Ashburton Hospital)

IF PATIENT NOT SEEN or NOT RESPONDING TO TREATMENT, CONTACT ICU OUTREACH

* Patient's home team

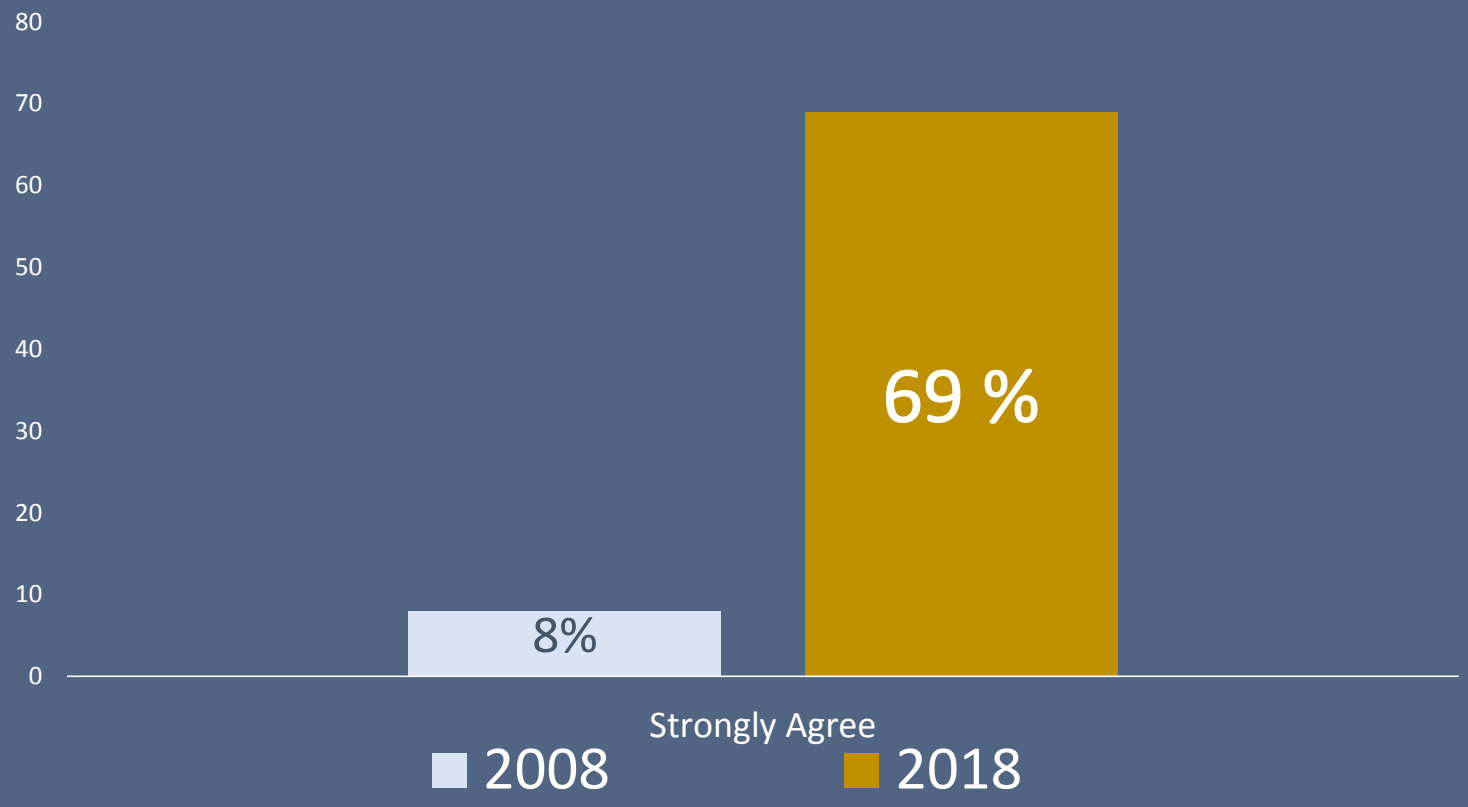
NZEWS Escalation

Clinical Emergencies

Shift Handover and Information Sharing


What do we actually do all shift?
26
Patient Reviews
14
Clinical Procedures
102
Incoming Pages
10km
Typical Distance covered each

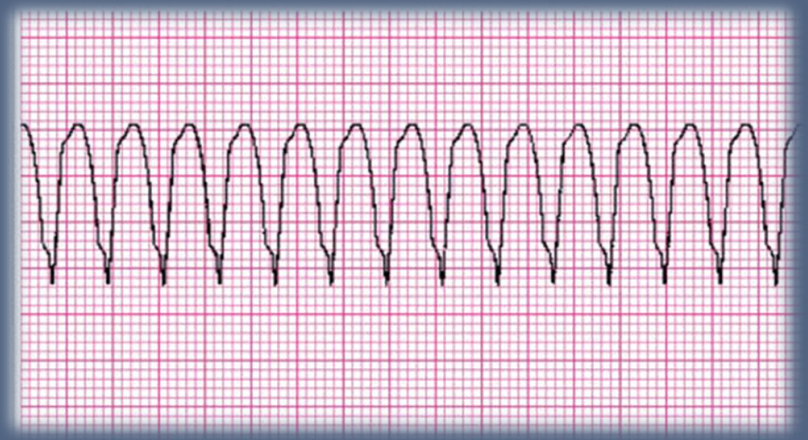
Improved patient care and safety?

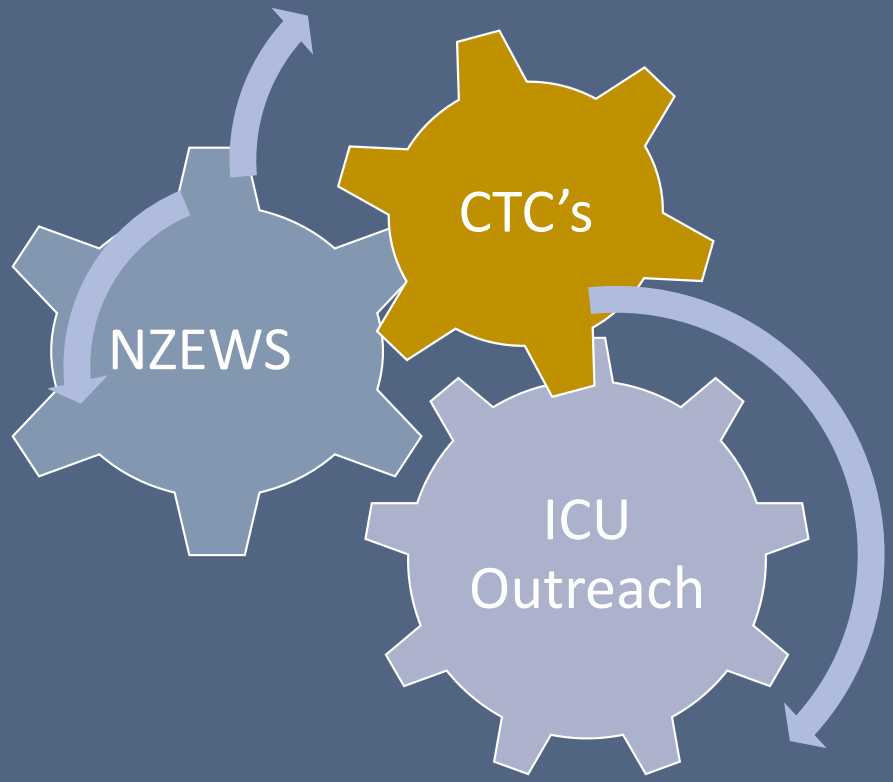



Workload
Senior Advice
Knowledge
Clinical Advice
Clinical Decision Making
Invaluable
Unwell Patients
Review
Asset
Approachable
Deteriorating Patients
Nursing
Experience
Communication
Concerns
Discuss Care
Role Guidance

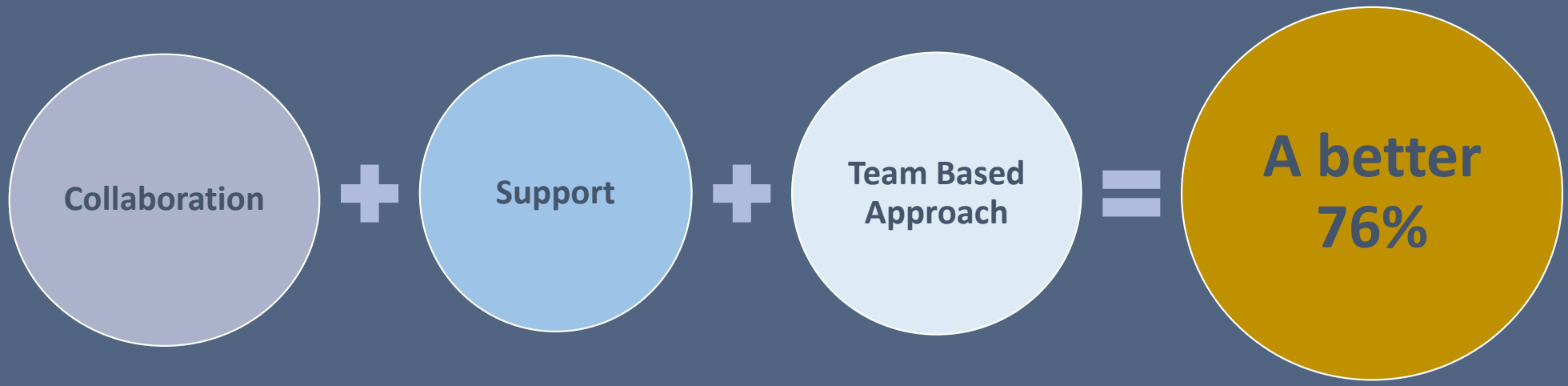
Any hard data?.....

Comparing 2004 – 2014 the risk of suffering an in hospital cardiac arrest had almost halved. Why??





So what does the afterhours look like now?



New Treatments and Technologies

Dr Mary Hunter - Clinical Director Special Projects
Natalie King - Programme Lead Treatments and Technologies
Dr Richard French - Clinical Director Service Improvement

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Business Need

The New Treatments and Technologies Programme was developed in response to a recurring demand from the Organisation for a clear rational process for adoption of new treatments and technologies, including purchase of new consumables

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Background

- 36,000 medical line items in Oracle
- Approx. 10% new added each year
- $140,000,000 Clinical Consumables PA
- $46,000,000 Clinical Capital Equipment
- New therapies and procedures additional
- Well developed procurement processes
- But what triggers the procurement?

Background

- Clinicians ask for new items
- Patients can benefit from new items
- We are compelled to get new items
- We employ people with new skills

Don't we have processes?

- Multiple business processes
- Variable understanding and adherence
- Critical evaluation often absent: (Health Technology Assessments)
- Rarely post-implementation review
- "*following the process will get you nowhere*"

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Aim

- Rigour
- Consistency
- Accountability

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Need

- Three level structure to cover scope of decision making required

SIC

Structure

Department

Department level

- Routine
- Narrow Scope in Usage
- Multidisciplinary
- Includes Clinical, Management and Technical Leads

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Divisional level

- Complex
- Multi-Departmental Usage Scope
- Divisional Clinical Leads, Finance, GM

SIC level

- Strategic
- High Unit Cost
- Strong political or public impact
- Regional or national impact

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Needs

- **Case to EMT for investment**
- Deliver a workflow to meet business needs
- Current paper based processes failing
- Required technology solution

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Functional Requirements

- Deliver a workflow
- Strong Pre and Post User Evaluation
- Visibility
- Archival
- Knowledge Base (HTA)
- SaaS
- Usable

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Requirements Matrix

	Microsoft Office	Microsoft Sharepoint	Jira	RTE	Survey Monkey	ECRI Suite
Deliver a workflow	-	✓✓	✓✓	✓	-	✓✓
Strong Pre and Post Evaluation	-	✓	✓	✓	✓	✓✓
Review	-	✓	✓	✓	✓	✓✓
Archival	✓	✓	✓	✓	✓	✓✓
Knowledge Base (HTA)	-	-	-		-	✓✓
SaaS	-	-	✓		✓	✓✓
Usable	✓	-	-		✓	✓✓

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The ECRI Institute

ECRI Institute
The Discipline of Science. The Integrity of Independence.

- Based in Pennsylvania, USA
- An independent nonprofit that researches the best approaches to improving patient care in the most cost effective manner.
- Uses **GRADE** (Grading of Recommendations, Assessment, Development and Evaluations) as the framework for grading the quality of evidence and making clinical recommendations .

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ECRI Institute overview

- Testing labs, medical research library, auditorium
- Offices also in London, UAE, and Kuala Lumpur

Full-time staff of 450 interdisciplinary staff includes:

- doctoral-level research scientists, methodologists and analysts
- clinicians (physicians, nurses, therapists
- master's-level medical librarians
- biomedical engineers
- patient safety experts

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The ECRI Suite for CDHB clinicians

ECRI has cloud based tools which inform decisions to introduce new treatments and technologies

- ValuVu: Workflow tool
- HTAIS: Health Technology Assessments (Library and Commissioned)
- SELECTplus: Procurement Information Tool

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What is ValuVu?

- **ValuVu** is a workflow tool
- Used to submit requests for departmental assessment of new consumables and procedure/treatment proposals.
- Provides structure to review requests, collate information and record decisions
- Supplies and Procurement involved with all requests
- Inform reports on requests and outcomes
- Enables virtual collaboration

ValuVu™

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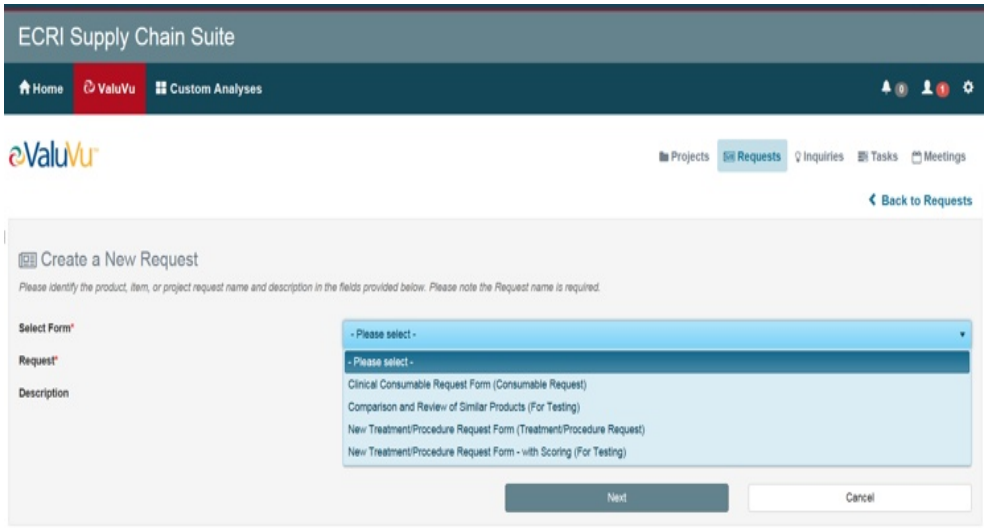
Project request forms on ValuVu



- New consumable request
- New Treatment/procedure request
- Rationalisation of consumable lines
- Changes to Medicine Treatments: Process for Change

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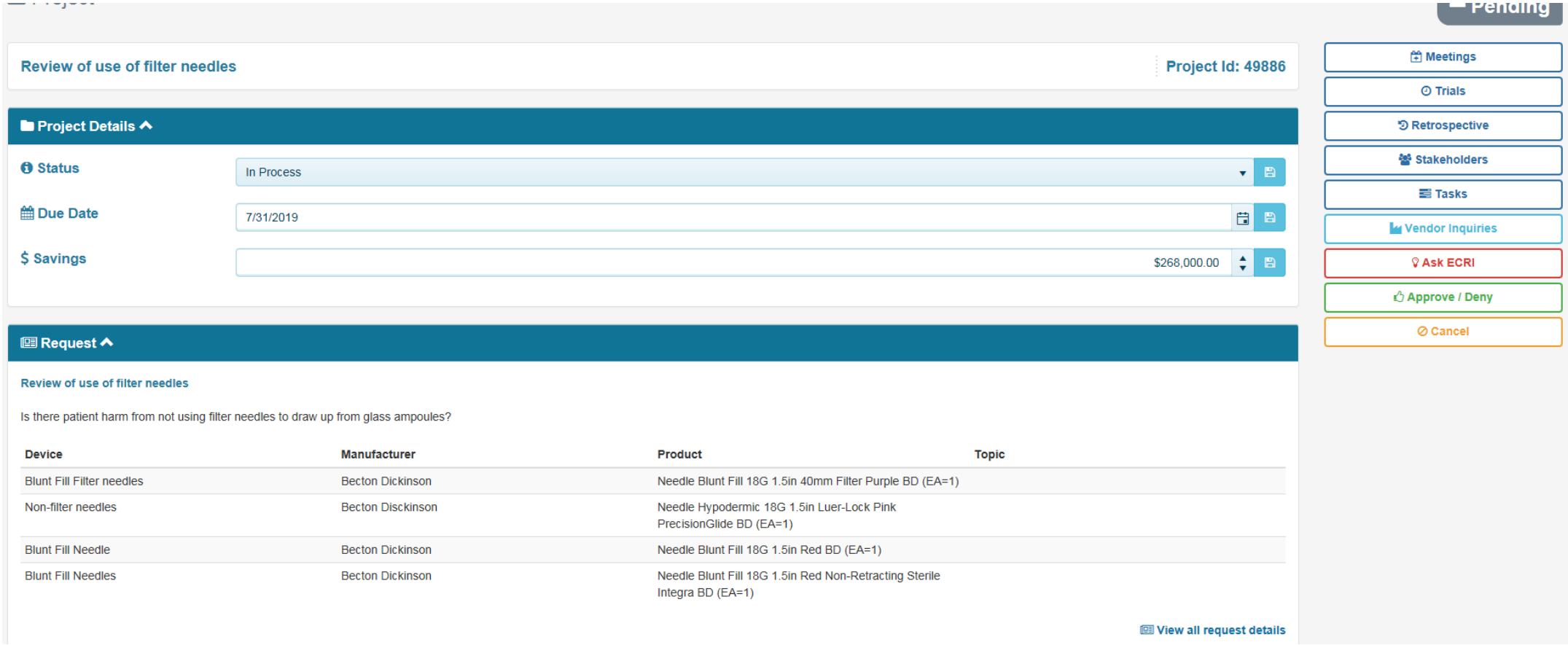
Example of what the form looks like



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An Organisation with a Memory

Documents and Links

Name	Link	Source	
Medicine Pots - Savings.msg		Project	
Alt supplier of Biodegradable medicine pots.msg		Project	
Reducing Waste at Te Whare Manaaki.docx		Project	
RE Catch up with Heather Gray re medicine pots.msg		Project	
Summary of meeting and action points.msg		Project	

1 2 5 items per page 1 - 5 of 7 items

Browse No file chosen. Upload

Allowed file types: *.tiff, .doc, .docx, .pdf, .xls, .xslx, .gif, .jpeg, .jpg, .png, .rtf, .txt, .ppt, .pptx, .msg* ***Max file size:*** *25MB*

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What is the HTAIS?

The **Health Technology Assessment Information Service (HTAIS)** provides evidence-based technology assessments on new, emerging and existing medical devices, drugs and procedures

There is a vast library of current assessments available and CDHB can request a limited number of additional ***Custom Product Briefs and Custom Rapid Reviews.***

CDHB Annual Subscription entitles us to commission 10 new HTAs

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MitraClip

MitraClip Clip Delivery System (Abbott Vascular) for Treating Functional Mitral Regurgitation

HEALTH TECHNOLOGY ASSESSMENT INFORMATION SERVICE™

PRODUCT BRIEF

The MitraClip® Clip Delivery System is an endovascular device intended to percutaneously treat symptomatic mitral regurgitation (MR) in patients at high risk of complications from open heart mitral valve repair. The system contains a steerable guide catheter, a clip delivery system, and a polyester-covered metal clip implant that holds together the mitral valve leaflets to restore more complete valve closure and reduce backward blood flow.

The Evidence Bar™: Evidence is somewhat favorable

Executive Summary

- **Conclusions:** Evidence from 2 meta-analyses and 2 RCTs suggests that MitraClip plus medical therapy is more effective than medical therapy alone for reducing cardiovascular risks in patients with functional mitral regurgitation (FMR). However, additional high-quality studies are warranted that compare MitraClip to other interventions, such as mitral valve repair/reconstruction, and to assess MitraClip's effectiveness over the longer term (≥5 year). 2 ongoing studies are likely to address evidence gaps.

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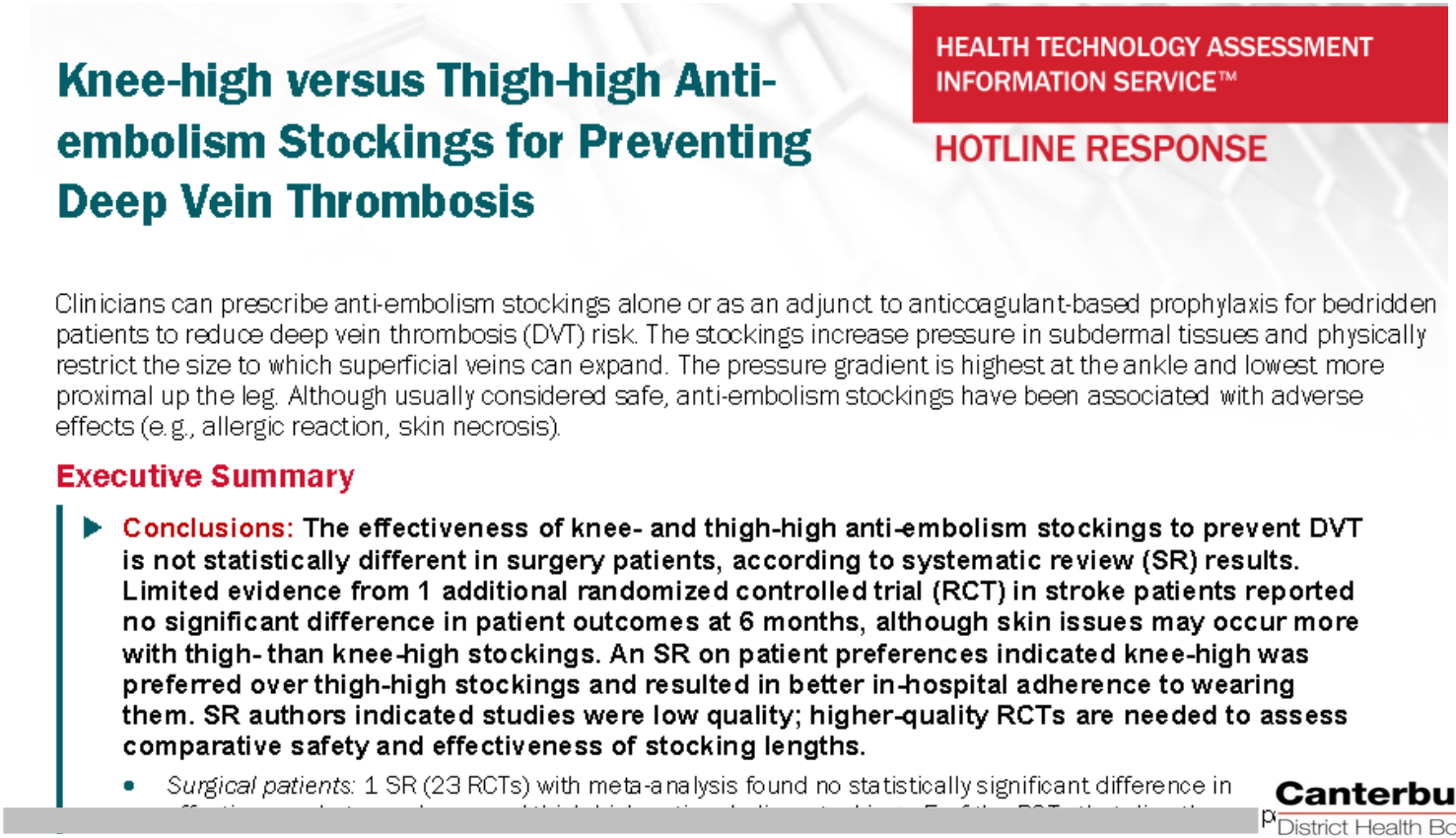
Knee-high versus Thigh-high Antiembolism Stockings for Preventing Deep Vein Thrombosis



Knee-high versus Thigh-high Anti-embolism Stockings for Preventing Deep Vein Thrombosis

HEALTH TECHNOLOGY ASSESSMENT INFORMATION SERVICE™

HOTLINE RESPONSE

Clinicians can prescribe anti-embolism stockings alone or as an adjunct to anticoagulant-based prophylaxis for bedridden patients to reduce deep vein thrombosis (DVT) risk. The stockings increase pressure in subdermal tissues and physically restrict the size to which superficial veins can expand. The pressure gradient is highest at the ankle and lowest more proximal up the leg. Although usually considered safe, anti-embolism stockings have been associated with adverse effects (e.g., allergic reaction, skin necrosis).

Executive Summary

- **Conclusions: The effectiveness of knee- and thigh-high anti-embolism stockings to prevent DVT is not statistically different in surgery patients, according to systematic review (SR) results. Limited evidence from 1 additional randomized controlled trial (RCT) in stroke patients reported no significant difference in patient outcomes at 6 months, although skin issues may occur more with thigh- than knee-high stockings. An SR on patient preferences indicated knee-high was preferred over thigh-high stockings and resulted in better in-hospital adherence to wearing them. SR authors indicated studies were low quality; higher-quality RCTs are needed to assess comparative safety and effectiveness of stocking lengths.**
  - *Surgical patients:* 1 SR (23 RCTs) with meta-analysis found no statistically significant difference in p

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Savings by moving to knee-high stockings

- The ECRI report concludes there is no difference in outcomes for Deep Vein thrombosis in surgical patients
- Knee-highs are preferred by patients

Knee-high stockings $4 each

Thigh-high stockings $11 each

Three departments alone - General Surgery

- DOSA

- Day Surgery

Are saving **$43,727** PA

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How are decisions made?

- Scoring system :
  - Quality of evidence
  - Predicted health improvements
  - Time to realization of financial benefits
- Departmental committee considers and votes
- Green light if falls within departmental financial delegations
- If in excess of departmental financial delegations – to Divisional or SIC level and used to inform business case

Treatments and Technologies Programme Scoring

Scoring tool for divisional assessment of requests for new treatments or procedures

Part 1 - Quality of Evidence:

Quality of evidence (for costs v. outcome)	A	B	C	D
Submission indicates that, for the diagnostic group in question, procedure costs will be reduced with either an improvement or no change in outcomes (cost neutrality point expected within first 12 months)	100	90	40	30
Submission indicates that, for the diagnostic group in question, procedure costs will be reduced with either an improvement or no change in outcomes (cost neutrality point expected within 1 - 2 years)	90	80	35	25
Submission indicates that, for the diagnostic group in question, procedure costs will be reduced with either an improvement or no change in outcomes (cost neutrality point expected within 2 - 5 years)	60	50	30	20
Submission indicates that, for the diagnostic group in question, procedure costs will remain neutral but outcomes will improve	60	50	30	20
Submission indicates that for the diagnostic group in question, procedure costs will be increased but patients will likely experience significantly improved overall survival rates	40	30	20	10
Submission indicates that, for the diagnostic group in question, procedure costs will be increased but patients will likely experience significantly reduced morbidity rates	20	15	10	5

GRADES OF RECOMMENDATION

A	At least one meta-analysis, systematic review, or RCT rated as 1 ++ and directly applicable to the target population OR A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+ directly applicable to the target population and demonstrating overall consistency of results.
B	A body of evidence including studies rated as 2++ directly applicable to the target population and demonstrating overall consistency of results OR Extrapolated evidence from studies rated as 1++ or 1+
C	A body of evidence including studies rated as 2+ directly applicable to the target population and demonstrating overall consistency of results OR Extrapolated evidence from studies rated as 2++
D	Evidence level 3 or 4 OR Extrapolated evidence from studies rated as 2+

LEVELS OF EVIDENCE underpinned by evidence from ECRI where available.

1++	High-quality meta-analyses, systematic reviews of RCTs or RCTs with a very low risk of bias
1+	Well-conducted meta-analyses, systematic reviews of RCTs or RCTs with a low risk of bias
1-	Meta-analyses, systematic reviews of RCTs or RCTs with a high risk of bias
2++	High-quality systematic reviews of case-control or cohort studies

Treatments and Technologies Programme Scoring

Scoring tool for divisional assessment of requests for new treatments or procedures

Part 2 – Alignment with CDHB priority areas:

In keeping with:

- CDHB Annual Plan 2018 – 2019 click here
- Canterbury System Level Measures Improvement Plan 2019/20 click here

Canterbury DHB has defined health outcomes based on priority needs for our population and aligned with the National Targets and Priorities. Any allocation of new funding or funding will be evidence based and directed to the priorities below. Each will require a consideration of cultural, gender and age issues:

No	Outcome
1	Better outcomes in population mental health, addiction services and mental health support in schools. Improved Maternal Mental health services both antenatal and postnatal.
2	Better outcomes in CVD, diabetes risk assessment, cancer services including support to quit smoking.
3	Better outcomes in child health; including oral health, immunization and obesity. Avoidable acute admissions for Pacific Children
4	Improved health and wellbeing of mothers and babies including vaccination and maternal mental health services.
5	Promote care and self-management of patients with long term conditions. Invest in service models to better enable and support our Pacific population. Deliver services in General practice rather than hospital settings.
6	Support for activities that continue to improve patient flow through hospitals and support the Electives targets.
7	Reduce inequalities and inequities in Maori health status by implementing Treaty of Waitangi responsibilities and preserving the rights to protection and to self-determination. Focus on factors which impinge on equity and patient experience within elective service streams. Reduced inequalities for Pacific people, people with disabilities, refugee communities, people living in poverty and gender dysphoria in line with national expectations;
8	Support for Healthy Aging including fall and fracture prevention services and identification of drivers for acute demand presentations.
9	Work towards achieving opportunities to reduce energy use, costs and emission.
10	Reduce duplication and waste and identify opportunities to enhance efficiency across the organisation

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What is **SELECTplus?**

SELECTplus provides information about equipment and consumables.

Advisory service which offers evidence-based comparative evaluations, price benchmarking data, and expertise to optimise equipment selection and procurement.

Product Comparison › Scanning Systems, Ultrasonic, Portable › Product Listing

PRODUCT LISTING - SCANNING SYSTEMS, ULTRASONIC, PORTABLE

RESET FILTERS:

SORTED BY: MANUFACTURER A-Z

FILTERED PRODUCTS: 4

SELECT ALL

MANUFACTURER

- ☐ Advanced Instrumentation... (2)
- ☐ Ambisea Technology Corp ... (7)
- ☐ Chison Medical Imaging C... (1)
- ☐ Clarius Mobile Health (2)
- ☐ Esaote SpA (3)
- ☑ FUJIFILM SonoSite Inc (4)
- ☐ Fukuda Denshi Co Ltd (1)
- ☐ GE Healthcare (15)
- ☐ Hitachi Ltd (2)
- ☐ Interson Corp Medical In... (2)

WHERE MARKETED

- ☐ USA (0)
- ☐ USA<1> (0)
- ☐ Worldwide (4)
- ☐ Worldwide<1> (0)

FDA CLEARANCE

- ☐ No (0)

SonoSite Edge II
MANUFACTURER : FUJIFILM SonoSite Inc
WHERE MARKETED : Worldwide
FDA CLEARANCE : Yes
LIST PRICE : $38,500

ADD TO COMPARE

SonoSite iViz
MANUFACTURER : FUJIFILM SonoSite Inc
WHERE MARKETED : Worldwide
FDA CLEARANCE : Yes
LIST PRICE : $12,695

ADD TO COMPARE

SonoSite M-Turbo
MANUFACTURER : FUJIFILM SonoSite Inc
WHERE MARKETED : Worldwide
FDA CLEARANCE : Yes
LIST PRICE : $24,995

ADD TO COMPARE

SonoSite SII
MANUFACTURER : FUJIFILM SonoSite Inc
WHERE MARKETED : Worldwide
FDA CLEARANCE : Yes
LIST PRICE : $22,995

ADD TO COMPARE

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	E	F	G	H
Manufacturer	**FUJIFILM SonoSite Inc** SonoSite Edge II	**FUJIFILM SonoSite Inc** SonoSite iViz	**FUJIFILM SonoSite Inc** SonoSite M-Turbo	**FUJIFILM SonoSite Inc** SonoSite SII
WHERE MARKETED	Worldwide	Worldwide	Worldwide	Worldwide
FDA CLEARANCE	Yes	Yes	Yes	Yes
CE MARK (MDD)	Yes	Yes	Yes	Yes
FORM FACTOR	Laptop	Handheld	Laptop	Tablet
DICOM 3.0 COMPLIANT	Yes	Yes	Yes	Yes
CLINICAL APPLICATIONS	Abdominal, arterial, breast, cardiology, lung, MSK, neonatal, nerve, OB/GYN, ophthalmic, orbital, small parts, spine, superficial, TCD, venous	Fetal, obstetric, abdominal, pediatric, cardiac (adult, pediatric)	Nerve, abdominal, OB/GYN, MSK, vascular, vein, cardiac, small parts, lung, ophthalmic, neonatal, superficial parts, transcranial Doppler, orbital, prostate, CIMT, breast	Abdominal, arterial, breast, cardiology, lung, MSK, neonatal, nerve, OB/GYN, ophthalmic, small parts, spine, superficial, venous
PROBE TYPES, MHz				
Flat linear array	L38xi (10-5), HFL38xi (13-6), HFL50x (15-6), L25x (13-6), HSL25x (13-6)	No	L38xi (10-5), L25x (13-6), L52x, HFL38x (13-6), HFL50x (15-6), SLAx (13-6)	L38xi (10-5), HFL38xi (13-6), HFL50x (15-6), L25x (13-6), HSL25x (13-6)
Convex array	rC60xi (5-2), C35x (8-3)	No	C60xi (5-2), C8x (8-5)	rC60xi (5-2), C35x (8-3)
Microconvex array	C11x (8-5)	C11x (8-5)	C11x (8-5)	C11x (8-5)
Phased / sector / vector array	rP19x (5-1), P10x (8-4), (10-5)	P21v (5-1)	P21x (5-1), P10x (8-4)	rP19x (5-1), P10x (8-4), (10-5)
Endovaginal	ICTx (8-5)	No	ICTx (8-5)	ICTx (8-5)
Endorectal	C8x (5-8)	No	C8x (5-8)	C8x (8-5)
TEE	TEExi (8-3)	No	TEExi (8-3)	No
CW	No	No	D2x	No
Dedicated 3-D/4-D	No	No	No	No
Others	No	No	No	No
SCAN MODES				
3-D (freehand)	No	No	No	No
3-D (automatic)	No	No	No	No
4-D (automatic)	No	No	No	No
Contrast harmonic imaging	No	No	Yes	No
Tissue harmonic imaging	Yes	Yes	Yes	Yes
M-mode	Yes	Yes	Yes	Yes
Doppler				

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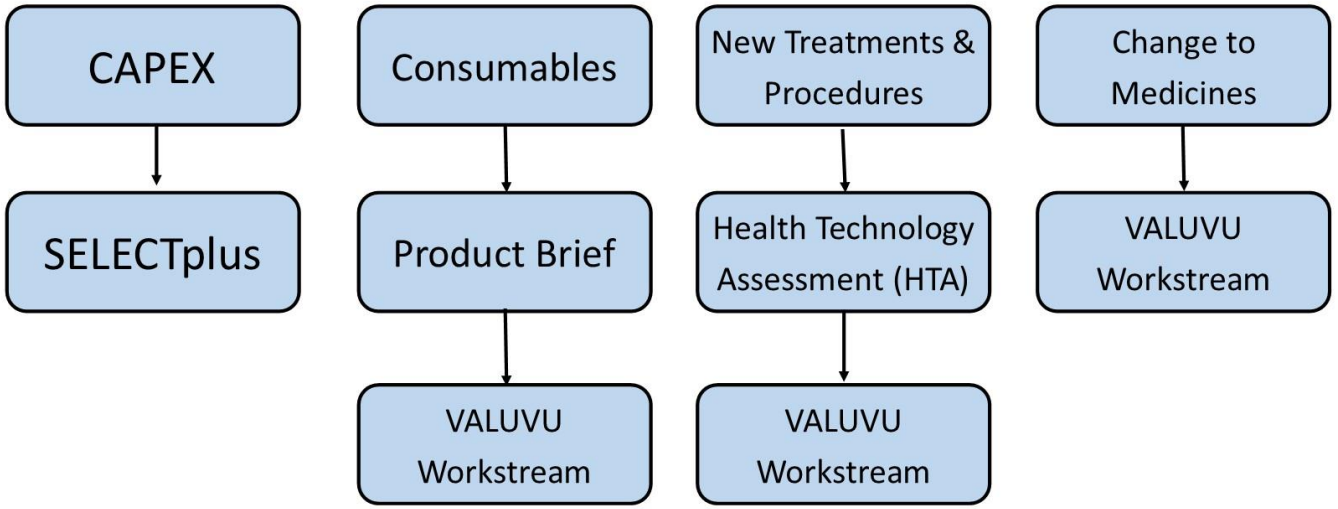
ECRI Summary

Cloud based tools which inform clinical decisions to introduce New Treatments and Technologies



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Where are we now?

- 61 projects on ECRI work streams
- We have commissioned and received 10 independent Heath Technology Assessments
- 522 Clinicians have signed up to ECRI
- For Operating Theatres at Christchurch Hospital, General Surgery and Ophthalmology the only way to request a new consumable is through ECRI.
- All drugs new to the organisation with financial or operational impact pass through ECRI workstreams

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Procurement Capability Index (PCI)

Our PCI is the highest in the country 5/5 and accounts for 5% of the DHB's Investor Confidence rating (ICR) pie.

ECRI was part of Supplies and Procurements' submission to our external auditors on the evidence base we use for new technologies selection. I.e. new product innovation and benchmarking.

Organisational Alignment

Alignment with DHB vision, culture and direction of travel

Such as:

Distributed Leadership

Earned Autonomy and ICR

People Strategy

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CANTERBURY DHB IS GOING GREEN!
30ml
20ml
10ml
Biodegradable paper medication pottles will gradually replace plastic ones over the coming weeks.

CLINICAL ADVISOR UPDATE – MEDICAL

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NOTES ONLY PAGE

2019 WINTER PLAN OUTCOMES

Canterbury District Health Board
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TO: **Chair and Members**
Hospital Advisory Committee

SOURCE: **Christchurch Hospital**

DATE: **5 December 2019**

Report Status – For:	Decision	Noting	☑	Information

1. ORIGIN OF THE REPORT

This report has been prepared to provide the Committee with information about the impact of the uplift in need for hospital services on Christchurch Hospital during winter 2019.

2. RECOMMENDATION

That the Committee:

i. notes the 2019 Winter Planning Update.

3. SUMMARY

Hospital and Specialist Services across the CDHB worked collaboratively under the clinical leadership of the Chief of Medicine, Dr David Smyth, and the Chief of Service, Dr Helen Skinner, supported by Operational General Managers Pauline Clark and Dan Coward.

The Winter Planning Update provided in May 2019 included some flow enablers which had not previously been undertaken, including:

- Emergency Department Front Of House Trial – with investment in additional Senior Medical and Nursing Staff at times where volumes were projected to be high.
- General Medicine – from a 12 Team Model to a 16 Team Model, enabling more timely review of an ever increasing and complex patient cohort.
- Burwood Campus - investment in an additional House Officer on weekends to support improved patient flow.

4. DISCUSSION

- Prior to winter 2019, we predicted that occupancy would exceed available beds. A series of actions and changes in our approach were put in place to ensure we could still manage to provide the care required by our population. This included building on the approaches previously taken with those initiatives noted above.

- As a system we worked to:

  - Achieve optimal patient flow.
  - Ensure the availability of an appropriate workforce.
  - Plan ahead and have contingencies thought through and primed to operationalise if necessary.
  - Maximise the use of Acute Demand Services.
  - Maximise the use of After Hours at 24 Hour Surgery, Riccarton Clinic and Moorhouse Medical.

- Maximise the use of the 24 Hour Observation Unit.
- Be creative and connected to manage our patients safely in the community.

- True to the forecasts the past winter proved to be the busiest we have ever experienced at Christchurch Hospital. Over the three months of winter there were around 800 more presentations to the Emergency Department than during any previous winter. This included provision of care for 100 more patients older than 75 years.

- There were 1,500 more acute admissions into the hospital than during winter last year – so from this perspective also, this was our busiest winter ever.

- Both generally and for people older than 75 years, the growth in admission volumes was higher than predicted by the established trend.

- A part of this winter's busyness was associated with a particularly heavy flu season. High numbers of patients with influenza like illness started presenting at the Emergency Department around a month earlier than expected. Between April and mid September 690 patients with influenza like illness presented at the Emergency Department – more than had in any year during at least the last ten years.

- During that same period, more than 870 people were admitted to hospital and were confirmed as having an influenza virus. At one point there were 70 people in hospital with the virus.

- Flow across the entire system proved to be an important aspect in surviving the winter. Twenty four (24) additional beds were opened at Burwood to facilitate flow of older people whose acute health needs had been met.

- Ongoing increases in demand for acute theatre have meant ongoing displacement of elective lists, in some areas reducing the elective surgery provided and in others driving increased outplacing costs.

- General Medicine has 135 allocated beds. During the 92 days of June, July and August there were no days where General Medical 10am Occupancy was less than 135, average was 195 and maximum was 232. This means that many patients were cared for in wards where the routines are optimised for other types of care; that clinicians are carrying out ward rounds in many different wards; and that the care processes are much less efficient and effective. During the height of winter, General Medicine patients were spread across 18 wards.

- This means that patients spend more time in hospital than would otherwise be required, compounding the number of people occupying beds. Despite previously being on a downward trend since 2016, the average length of stay for Acute Medical admissions has increased recently. In the last four months it has sat close to four days, around half a day longer than it was a year ago.

- This both contributes to and is contributable to General Medicine having many more patients in hospital at a time than allowed for by its footprint.

- While we have an aim of treating everyone and not running out of hospital beds, while not negatively impacting the health and wellbeing of those involved in delivering care, sick leave rates have increased by 11% in the last 12 months compared with the previous year.

5. CONCLUSION

The recognition across the system of the predicted high demand for health services this past winter and concern regarding the system's ability to continue to deliver, enabled us to make plans to provide the best care available as a system.

Demand for Hospital beds continues to outstrip supply. Sick leave rates amongst hospital staff are high. Clinical and Operational Teams are aware. Daily (at times down to hourly), execution of plans to promote flow and optimised staff placement have been and continue to be in place.

Report prepared by:	Pauline Clark, General Manager, Christchurch Campus
Report approved for release by:	Dr Greg Hamilton, Acting Executive Director, Planning Funding & Decision Support

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: **5 December 2019**

Report Status – For:	Decision	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Committee:

i. notes the Hospital Advisory Committee Activity Report.

3. APPENDICES

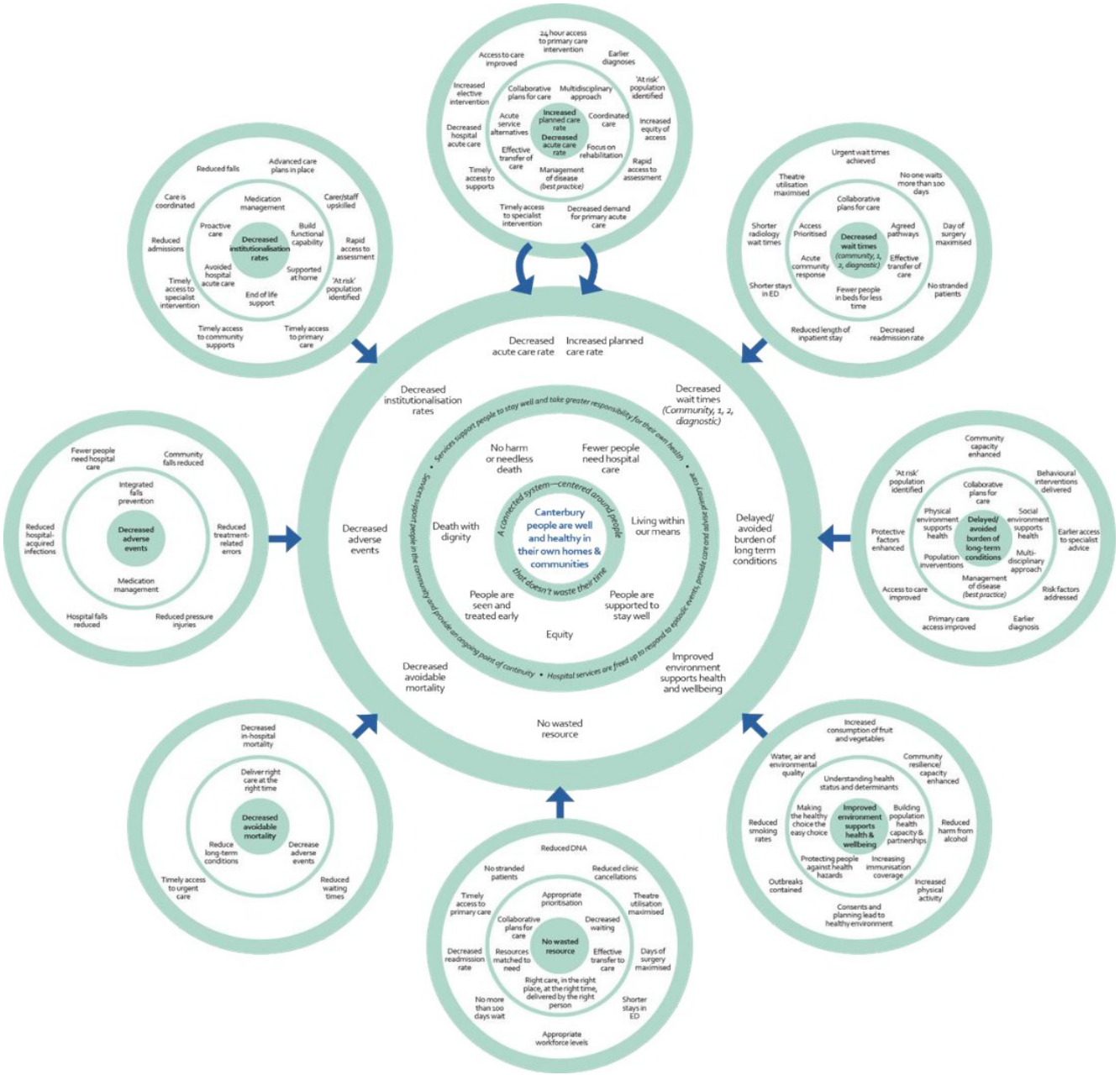
Appendix 1: Hospital Advisory Committee Activity Report –November 2019

Report prepared by: General Managers, Hospital and Specialist Services

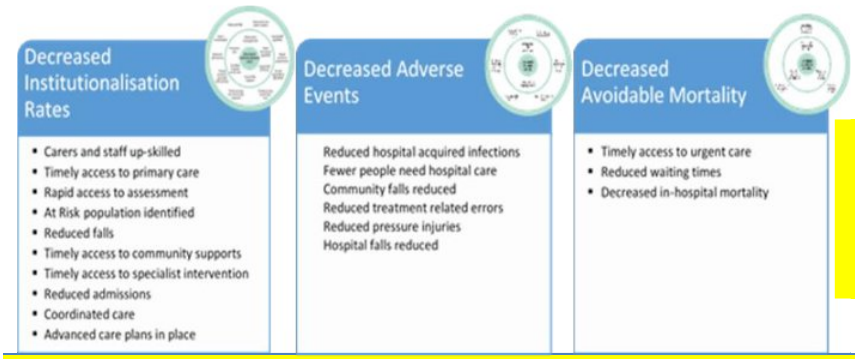
Report approved for release by: Justine White, Executive Director, Finance & Corporate Services

Hospital Advisory Committee

Activity Report



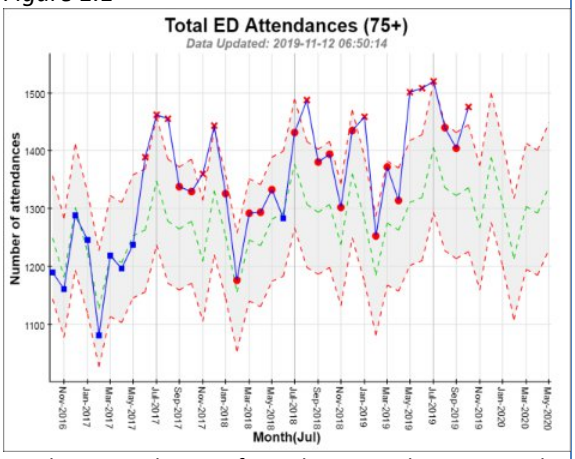
November 2019



Frail Older Persons' Pathway

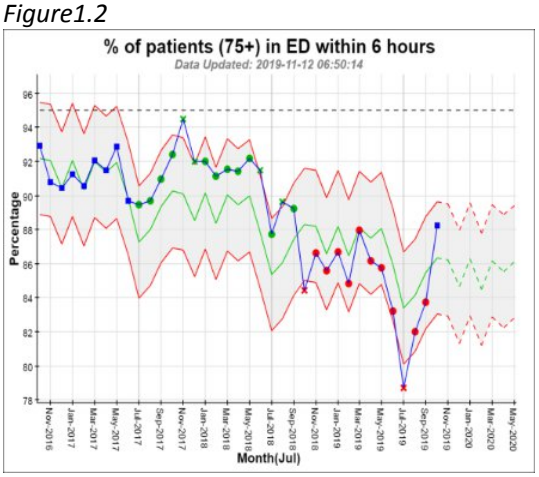
Outcome and Strategy Indicators

Figure 1.1



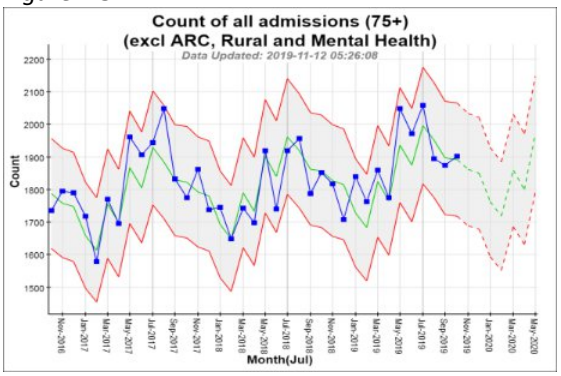
Total ED attendances of people over 75 has increased at a higher rate than the established trend. More patients were seen in the past six month period than in any other preceding.

Figure1.2



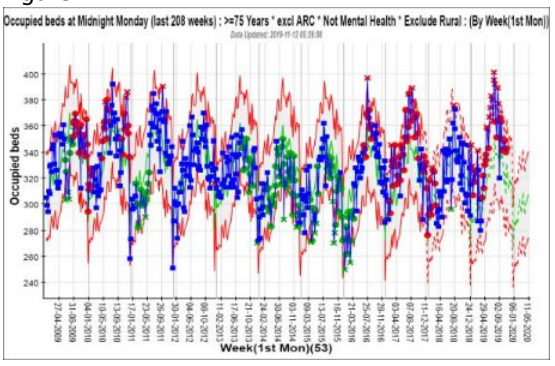
Analysis indicates there is a correlation between patients spending longer in the ED and hospital occupancy. Alongside this association, however, a significant shift does appear to have occurred around the time that transition between old and new information systems occurred. This may have been remedied, monitoring will continue.

Figure 1.3



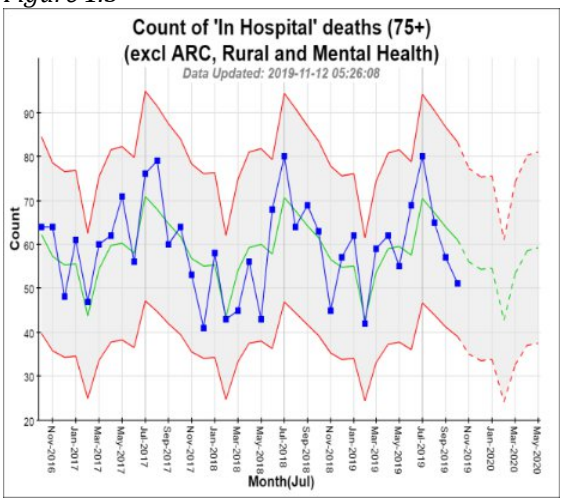
The count of all admissions for people 75 years and over continues to increase in line with the established trend.

Figure 1.4



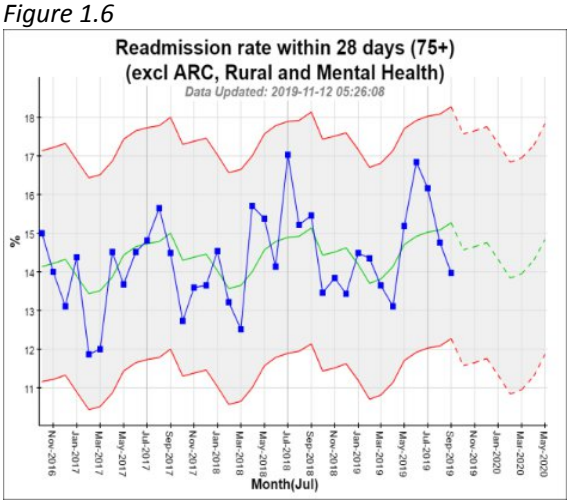
Apart from a period during March 2019, significantly more beds have been occupied by people >75 than projected during the first nine months of 2019. The winter peak occurred earlier than in 2018 with occupancy by this group of patients higher than it was during similar months the previous year. This increase has continued until the most recent measure early in November 2019.

Figure 1.5



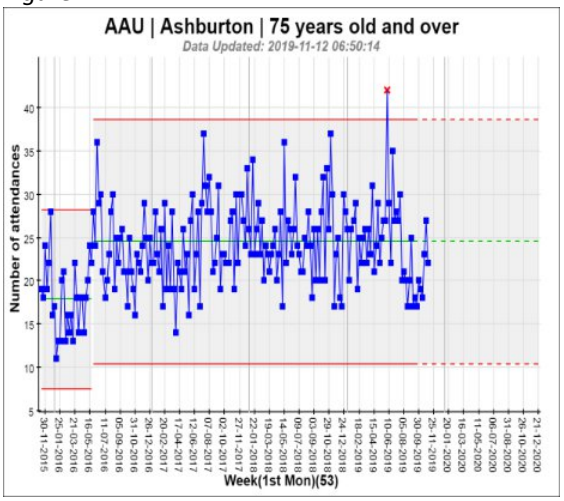
The number of in hospital deaths is within the expected range. Other analysis shows that the established trend of reducing rates of in hospital mortality continues.

Figure 1.6



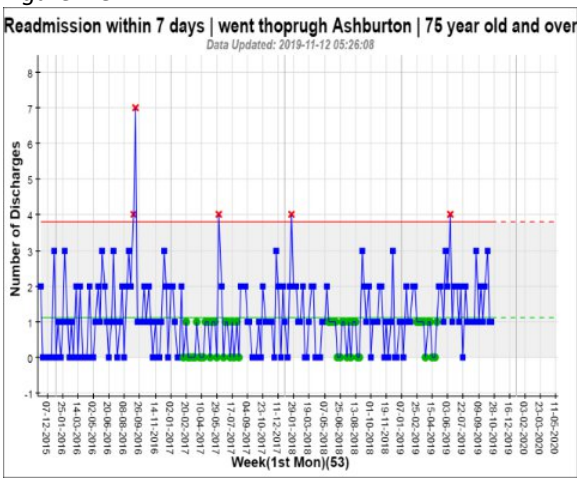
The readmission rate for people aged 75 years and over continues to be within the expected range, which shows a gradual ongoing increase.

Figure 1.7



Ashburton is experiencing an increase rate of presentations and admissions with the expected seasonal peak.

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

Continuing focus on reducing falls in medical wards.

- The number of falls in Canterbury District Health Board hospitals has reduced. However, the number and rate increased slightly over recent years at Christchurch Hospital. During 2018/19 there were around 76 falls per month or 9.2 per 1,000 admissions despite an ongoing focus at reducing the incidence of falls.
- It is thought that without this focus the number would have increased further as the hospital has become busier with complex patients over recent years. Along with this, our implementation of restorative care encourages patients to spend less time in bed.
- The number and rate of falls resulting in harm has reduced, indicating that some aspects of the risk assessment and management are working as designed.

- There are some good signs amongst the Health Quality and Safety Commission's process measures with more than 95% of patients receiving risk assessment within 24 hours. More than 90% of patients with a high-risk score have prevention strategies in place within 48 hours. Further work is occurring to develop a more customised set of prevention strategies for our patients and increasing involvement of the patient and family in managing the risk
- This will be enhanced by the proposed introduction of upgraded bedside boards.

Update on the new Maternity Assessment Unit

- An earlier report provided an update about the opening of a new Maternity Assessment Unit within Christchurch Hospital.
- During its first two months of its operation 470 women attended the unit. 114 of these (28%) were sent onto the Birthing Suite for further consultation and 19 directly to the Maternity Ward. Around half of the women directed to the Birthing Suite stayed there either for birthing or further investigation and treatment, the other half returned home following an obstetric review and plan.
- The remaining 337 women that attended the unit were able to return home directly.
- Average length of stay in the Unit was 1:44. In the old model it was regularly between four and six hours.
- All investigations carried out in the unit are led by midwives working at the top of their scope. This has provided a variety of practice to these staff. Those who have worked in this environment are reporting great job satisfaction.
- The FloView board in the Birthing Suite now only has women on it who really need to be there.
- This means that the women who require urgent care are triaged sooner in their journey and are receiving the care they require faster. The changes value women's time, reduce anxiety quickly, and have midwives working to top of scope boosting their job satisfaction.
- Lead Maternity Carers report that the new unit has made a difference and they value having direct access to an experienced midwife who can spend time reviewing clinical dilemmas which is building relationships with our community colleagues.
- Staffing requirements in the new unit have been reviewed and at this point three midwives per day are being assigned, a reduction from the four that we initially thought we might need.

Children's Outreach Nursing Service Nurse Prescribing

- A report from the Ministry of Health (MOH) 2016, noted a number of benefits of nurse prescribing, these included improved access to treatment, enhanced care, more effective use of medical staff time, strengthened inter-professional working practices and increased professional satisfaction for nurses.
- In early 2019 two very experienced Child Health Outreach Nurses working in the areas of Respiratory and Allergy and Eczema, were authorised by the Nursing Council to prescribe in their specialty scopes of practice.
- Nurse prescribing has improved the continuity of care for children and their whanau. This has resulted in caregivers making contact for early advice, with enables quicker treatment, reducing complications and hospital admissions or visits. Often the prescription is completed by the nurse as part of a home visit. Both nurses continue to work closely with senior doctors who are readily available for consultation and advice.
- Parents and caregivers are pleased with savings in both their time and money. Families no longer need to visit a doctor for a script. The nurses have also noted time savings, as they no longer spend time trying to find a doctor to write the prescription, and it frees-up doctor's time to do other activities.

- There are some limitations with the current authorised list of medications, as some of medications used by patients on a daily basis are not included on the current prescribing list. It is expected that over time the list will be altered to more fully reflect the breadth of the nurse specialty scope of practice.

Oxygen Prescribing

- Recent changes now allow oxygen to be prescribed on MedChart along with other medications.
- Oxygen is a drug with a therapeutic range, it is Canterbury District Health Board policy that oxygen should be prescribed. Being able to do so within MedChart makes it easier to do this and to keep patients safely within their target saturation range and ensure compliance.
- This will help us to avoid the risk highlighted by research that shows that liberal oxygen therapy is associated with increased inpatient mortality.
- The improved control provided will have benefits for patients as well as reducing the volume of oxygen used within our hospitals.

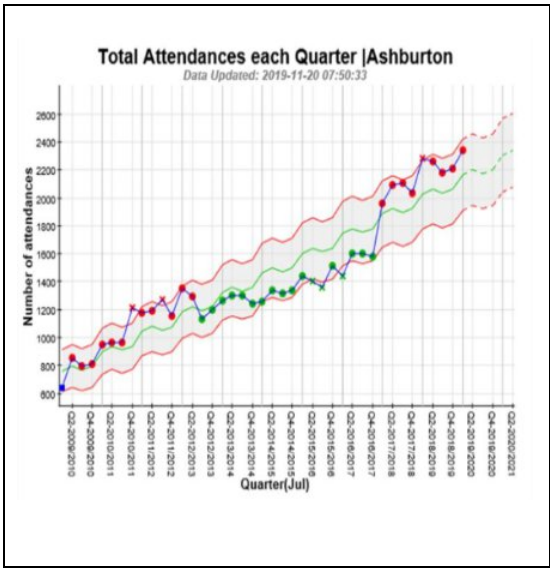
Study shows faster assessment of risk of heart attack is possible

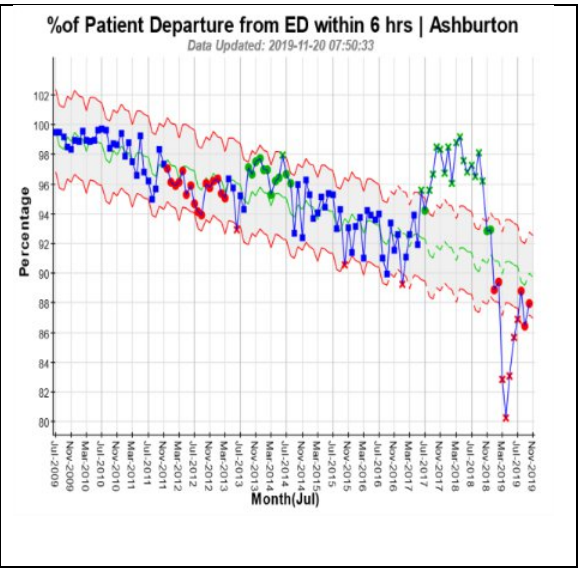
- About 50,000 people present at hospitals in New Zealand each year concerned they are having a heart attack. About 15 percent actually are. Admitting these patients when it's not necessary is inconvenient for the patient and their family and uses health resources that could be used elsewhere.
- Emergency Medicine Specialist and Director of Emergency Medicine Research at Christchurch Hospital Martin Than is lead author of research that shows that computer algorithms can help doctors better determine if a patient is having a heart attack.
- The new decision-aid combines a person's characteristics with the blood test results. The study found it gave doctors a more precise and individualised analysis of the probability that a patient was having a heart attack or not. It means that we can provide more accurate advice that is specific to the individual patient and can do it more quickly.

Update on progress with streamlined Vascular ward rounds

- A report on changes to the way that Vascular ward rounds are conducted was provided at this time last year. The model introduced was loosely based on the World Health Organisation Surgical Safety Checklist and 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.
- This way of working has now been in place for a year and has been audited twice. The second audit shows a further improvement in 19 of 21 of the clinical quality indicators surveyed and all subjective measures including significant improvements in observation chart review (20% to 75% to 81%), drug chart review (10% to 54% to 78.6%) and anticoagulation/antiplatelet treatment (32% to 61% to 58.1%).
- Overall, these findings are encouraging as they indicate that the introduction of a surgical ward round structure did not adversely affect ward round efficiency and contributes to provision of effective care for our patients, giving them the best chance of recovering quickly and without unintended harm.

Ashburton Health Services





- The above graphs demonstrate the presentations to the Acute Assessment Unit. Whilst the average number of presentations reports in mid-twenties, the variability in volume each day provides distinct challenges in providing a system response that optimises the resources available. The graph below demonstrates the trend in daily presentations to the unit, you will note we can drop to 14 presentations in one 24-hour period and peak at 40 within the same week. The graph represents presentations to the Acute Assessment unit in Ashburton only.

- We continue to encourage uptake of the Acute Demand packages of care and Acute Plans with our primary care partners through the Ashburton Service Level Alliance, committed to the principle that primary care presentations are best treated by primary care clinicians. With the increasing trend towards mid 30s in daily volume, we remain vigilant in exploring options to provide a sustainable model of medical care delivery. The current model provides one RMO on duty and one SMO on call for all acute and inpatient cover over the weekend period. The medical and nursing team are clear that patients presenting with primary care level health issues would be benefit more by treatment from a primary care provider than a hospital team and exploration on options to deliver this is in progress. The increased total volume provides an increased risk in wait time for persons over 75 presenting to the unit. The graph demonstrating our ability to provide a treat and discharge within the 6-hour period highlights

our current challenges. The significant drop in the March period relates to the introduction of EDaaG, however we have mitigated most of the data-based issues and this graph is representing a reasonably accurate picture of patient wait times and flow.

- One of strategies to provide an appropriate service response is the introduction of Advanced Nursing roles within Acute Assessment Unit (AAU). Work is in progress to introduce a range of standing orders that will enable the AAU nursing team to provide a treat and discharge service model. Whilst our intent is to maximise the work completed in other parts of the system, the AAU does not have the same staffing model as an Emergency Department(ED) and alignment to ED standing orders requires a level of detailed work to refine to a system more appropriate for a generalist setting. Whilst this requires substantive work initially, the long-term outcome will contribute to a more sustainable response to acute care demand for the Ashburton community.

Older Persons Health and Rehabilitation

To support the outcomes for frail older people, Older Persons Health and Rehabilitation have been focusing on the rethinking rehabilitation. We are seeing great outcomes with length of stay, meeting volume needs but importantly outcomes. Linked to this is what we are doing in the patient safety and quality space, culture change and ensuring we do no harm to the people we are entrusted with care.

Within the rethinking rehab workstream the following focus areas continue to support our outcomes:

- Goal setting – the workgroup are focusing on finalising the process for goal setting and standardising where we incorporate into the patients notes.
- Use of Volunteers – Ward B1 continues to trial the use of volunteers to have group sessions as part of rehabilitation activities within the ward and act as companions with patients with mild cognitive difficulties. As a result, we will roll out to Ward C2.
- Orientation to Burwood for patient expectations – the workgroup is proposing to replace the current pamphlets with flipcharts which will be more sustainable and provide visual aid to what activities and expectations towards rehabilitation while in Burwood.
- Ward D1 – is trialling no Interdisciplinary team meetings (IDT) on a Monday with more robust board rounds similar to the acute model. This has freed 24 hours of nursing and allied health time, which has gone back into patient activity and patient contact time. Another consequence of this is that they have reduced their Length of Stay (LOS) by another day.

The OPH&R Serious Event Review (SER) group have implemented their Medication Safety: wrong drug, wrong dose, wrong patient initiative to change how we think about, and talk about events. Managers follow-up with staff involved in SAC 3 and 4 errors supportively using a guiding investigation form that prompts the manager to ask questions leading up to the error, checks the wellbeing of the staff involved and provides an opportunity for the staff to offer solutions to improve how we work. The manager then meets with the SER group to have a conversation about what happened, identify opportunities to improve our systems, processes, environments, and ways of working. The process has now involved medical, nursing and allied health. The conversations between managers and the SER Group have been positive, supportive and honest. Interruptions while carrying out a process appears to be the major catalyst to non-adherence to policy and procedures at this early stage.

Reducing medication errors is focus and key a whole of strategy of providing a quality service that does no harm.

Approaching differently has seen the introduction of Pharmacy into Nursing Essentials Study Days (17 held this year). The outcomes we are seeing are the reduction in errors which is good for outcomes and reduces the impact on length of stay.

Pressure Injury:

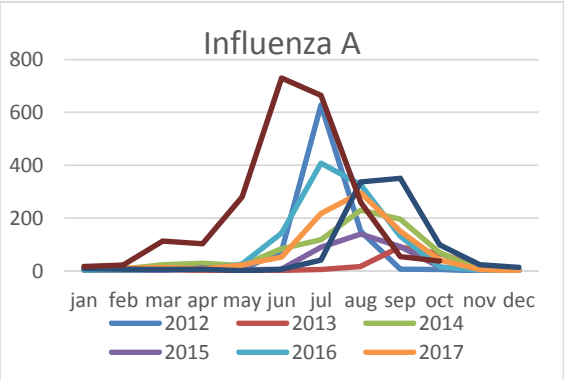
Purpose-T skin risk assessment tool was implemented on 15 July 2019 across Burwood Hospital inpatient wards. The implementation plan included intense nursing / allied health staff education sessions with ward 'champions' and Clinical Nurse Educators / Clinical Nurse Specialists continuing to train interdisciplinary staff.

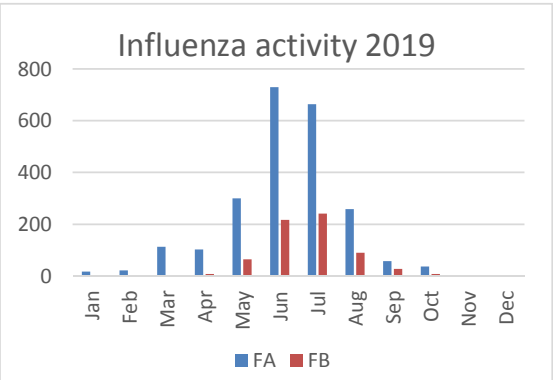
The working group have conducted monthly audits to assess the effectiveness of the implementation and to ascertain if the correct pathway and preventative strategies were followed on identifying a pressure injury using the new tool. From these results, the working group have made recommendations including further staff education as well as providing quick tips on the divisional monthly newsletter. Currently, the working group are finalising their project report with initial findings that the tool has been effective in staff identifying and documenting patients who have Stage I or II pressure injuries on admission to Burwood Hospital.

Laboratory Services

Impact of Influenza:

- **Respiratory virus testing**: The incidence of influenza and the number of influenza test requests has now plateaued with 37 cases of Flu A (down from 54 in September) and 8 cases of Flu B identified for the month of October. Respiratory requesting has however remained higher (possible due to elevated levels of Rhinovirus, Parainfluenza virus 3 and Human Metapneumovirus) than expected for this time of year and we will be continuing to work with the greater DHB circle to further look at demand management tools to identify any areas of inappropriate requesting.
- **Influenza in Canterbury:** Influenza A activity shows a clear plateau. H3N2 remains the predominant subtype. Influenza B activity has similarly dropped from 28 identified cases in September to 8 cases in October.





- RSV activity continues to fall with a further sharp decline to 23 identified cases, 58% positivity (down from 76 cases in September).

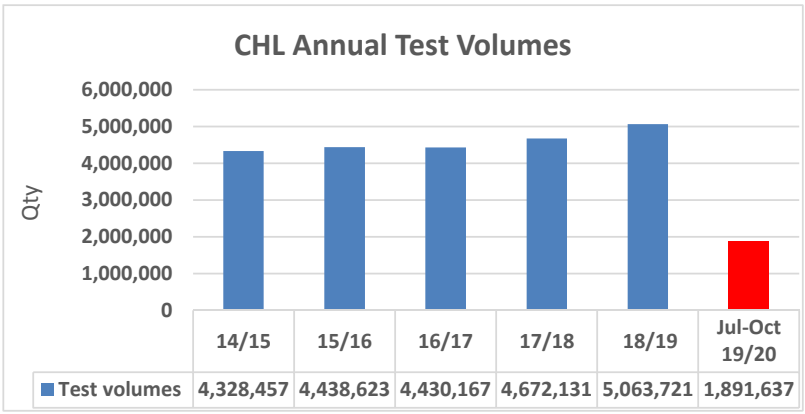
Measles in Canterbury:

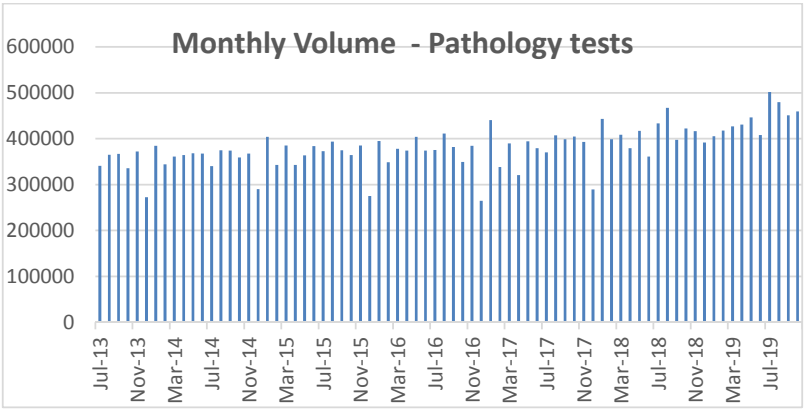
Measles activity has remained high for the month of October maintaining the pressure on the department and impacting on weekend service delivery with ongoing requirements for urgent identifications from a Public Health interest. This has been exacerbated due to significant case numbers referred from Southern DHB (Queenstown/Wanaka) and South Canterbury DHB. October data shows 280 individual measles PCR requests performed. The total number of confirmed measles cases for 2019, nationally, has now reached more than 1969 cases as of 31 October. The National Measles and Rubella Lab at CHL continues to work under pressure due to the significant National measles outbreak with unprecedented reporting requirements to the WHO.

Laboratory Activity Volumes:

October saw an overall 10% increase in testing volumes for same period in the previous year (18/19). CHL continues to identify opportunities to ensure test requests are clinically appropriate.

	Annual volumes					
F/Y	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**	**Jul-Oct 19/20**
Test volumes	4,328,457	4,438,623	4,430,167	4,672,131	5,063,721	1,891,637
Percent change		2.55%	-0.19%	5.46%	8.38%	





International Pathology Day:

A day to recognise the value and contribution of pathology to health systems was celebrated on Monday 11th November. CHL was able to recognise many recent successes with an article in the CEOs update for week commencing 11th November 2019.

Faster Cancer Treatment

Outcome and Strategy Indicators

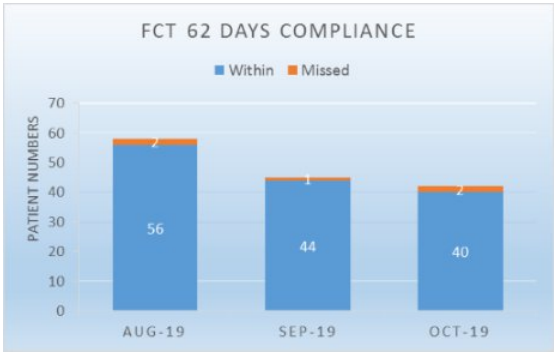
Key Outcomes - Faster Cancer Treatment Targets (FCT)

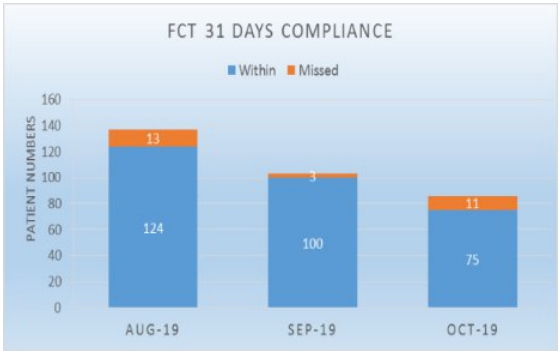
62 Day Target. In the three months of August, September and October 2019, of the 165 records submitted by Canterbury District Health Board 25 patients missed the 62 days target, 20 did so through patient choice or clinical reasons and are therefore excluded from consideration.
With 5 of the 145 included patients missing the 62 days target our compliance rate was 97%, meeting the 90% target.

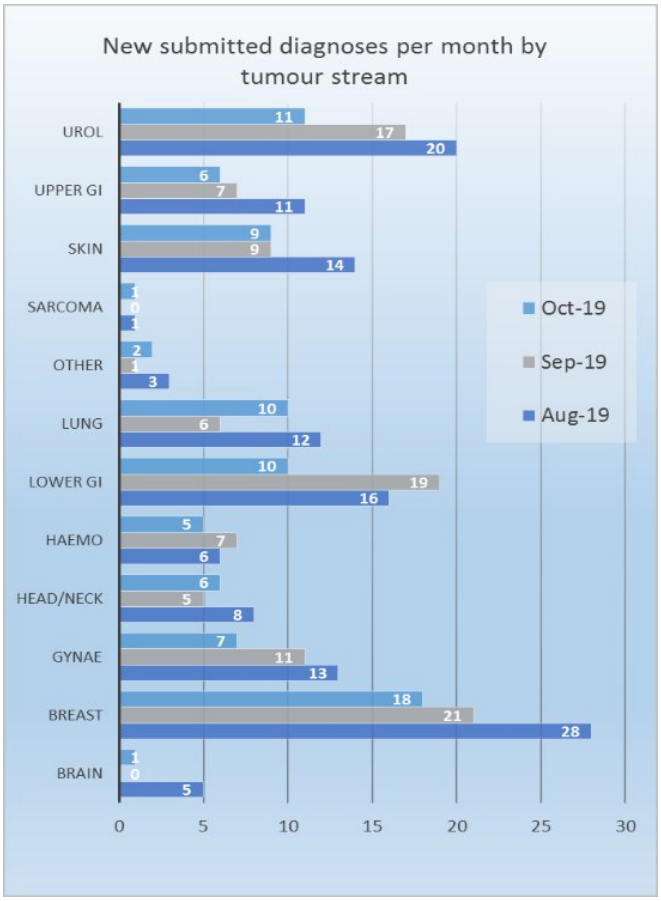
31 Day Performance Measure. Of 326 records towards the 31-day measure 299 (92%) eligible patients received their first treatment within 31 days from a decision to treat, meeting the 85% target.
Of the 27 patients who missed the 31 day target, 17 missed it by five days or less and 5 through patient choice or clinical considerations.

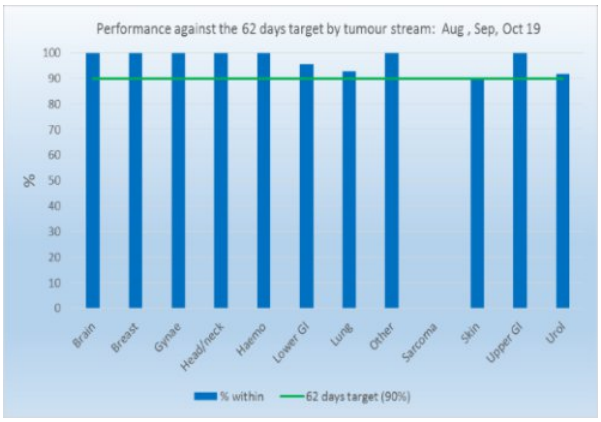
FCT performance in CDHB

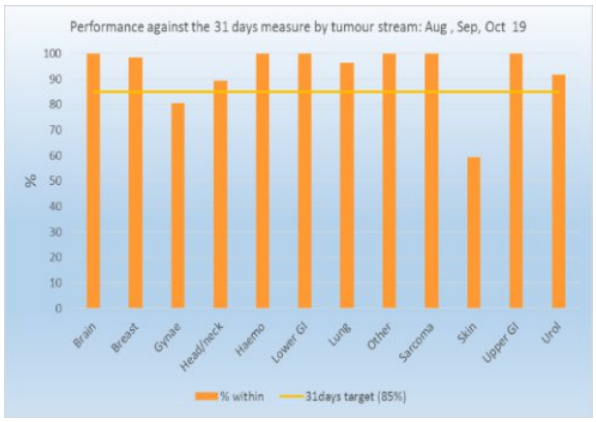
The dip in numbers in the last month of every report (October in this case) reflects the timing of when the report is compiled which is governed by the reporting requirements of the Ministry. A significant number of the patients who have a first treatment date in the period this report covers will be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

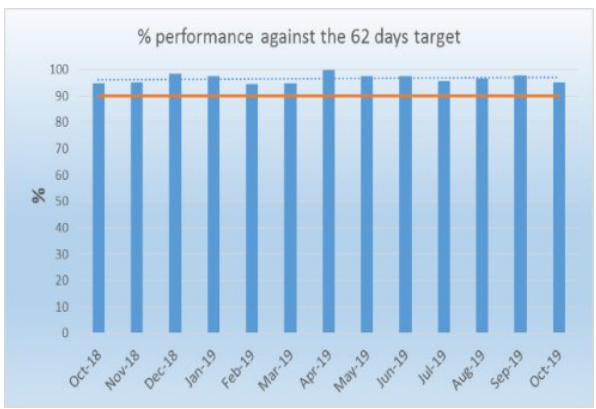


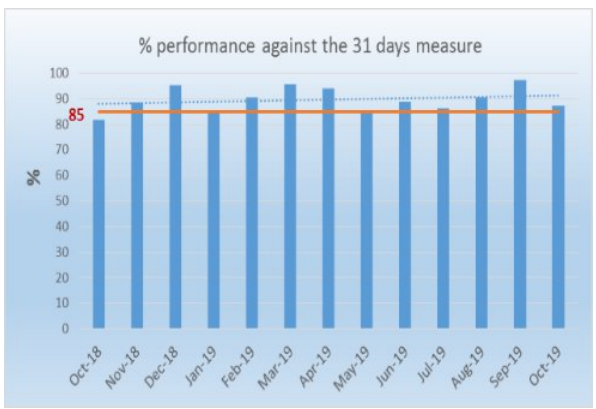



New submitted diagnoses per month by tumour stream
UROL
UPPER GI
SKIN
SARCOMA
OTHER
LUNG
LOWER GI
HAEMO
HEAD/NECK
GYNAE
BREAST
BRAIN
Oct-19
Sep-19
Aug-19
0
5
10
15
20
25
30


Performance against the 62 days target by tumour stream: Aug , Sep, Oct 19
%
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: Aug , Sep, Oct 19
%
Brain
Breast
Gynae
Head/neck
Haemo
Lower GI
Lung
Other
Sarcoma
Skin
Upper GI
Urol
% within
31days target (85%)


% performance against the 62 days target
%
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19


% performance against the 31 days measure
85
%
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19

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 used, 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:

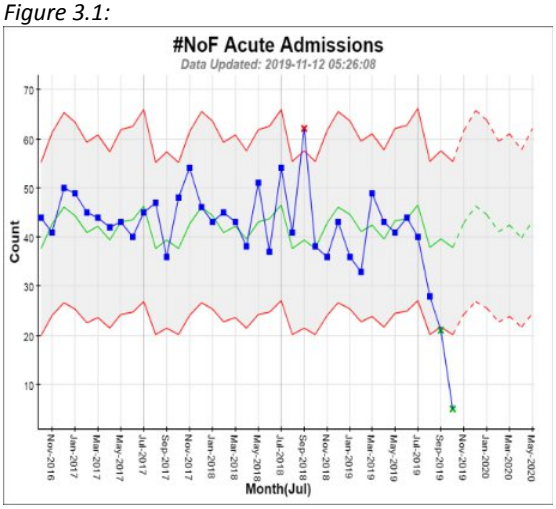
1. Patient choice: e.g. the patient requested treatment to start after a vacation or wanted more time to consider options
2. Clinical considerations: includes delays due to extra tests being required for a definitive diagnosis, or a patient has significant co-morbidities that delay the start of their cancer 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.

Enhanced Recovery After Surgery (ERAS)

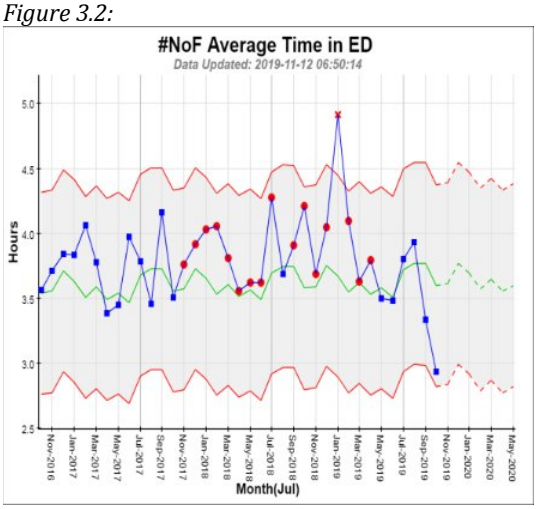
Outcome and Strategy Indicators – Fractured Neck of Femur (#NoF)

Figure 3.1:



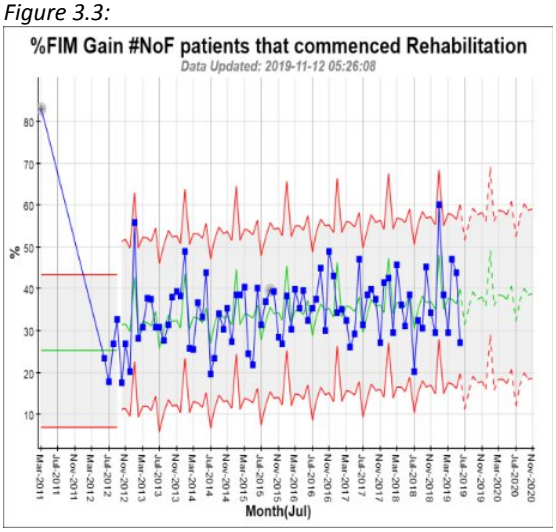
Coding delay has impacted on the latest data records for admissions.

Figure 3.2:



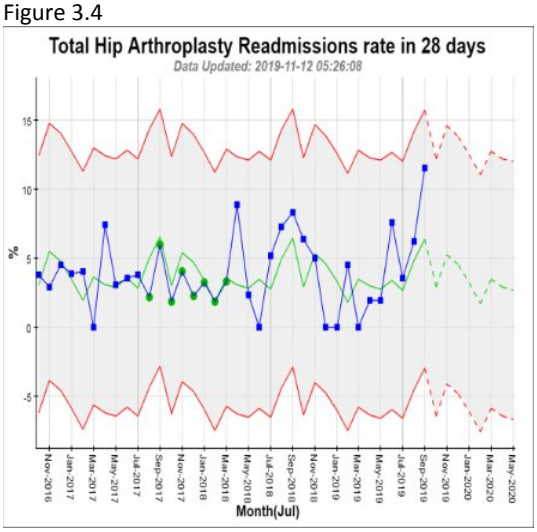
Patients with #NOF show a variable length of stay in ED.

Figure 3.3:



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

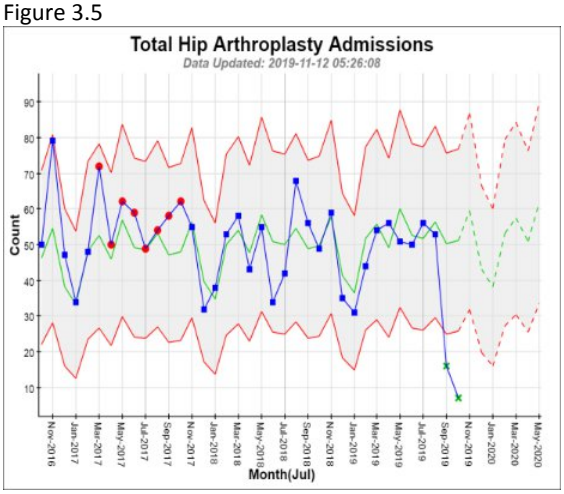
Figure 3.4



Readmissions continue to remain within expected mean values.

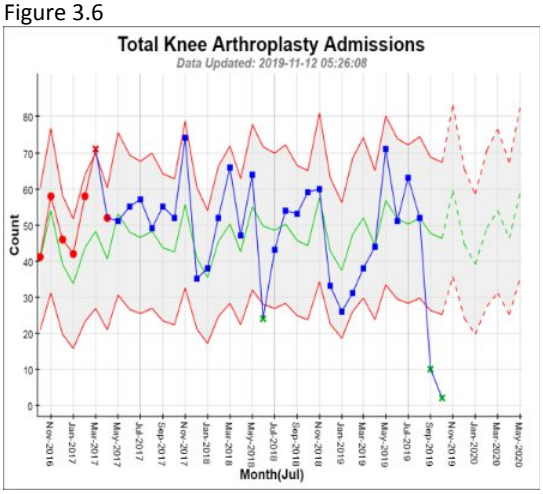
Outcome and Strategy Indicators – Elective Total Hip Replacement(THR) and Knee Replacement(TKR)

Figure 3.5



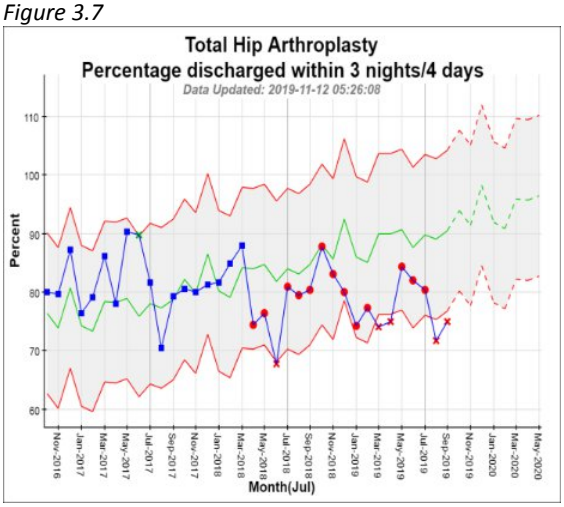
Coding delay impact on the latest data records.

Figure 3.6



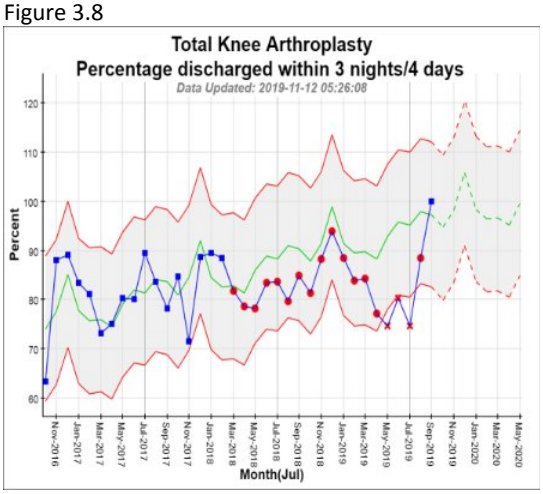
Coding delay impact on the latest data records.

Figure 3.7



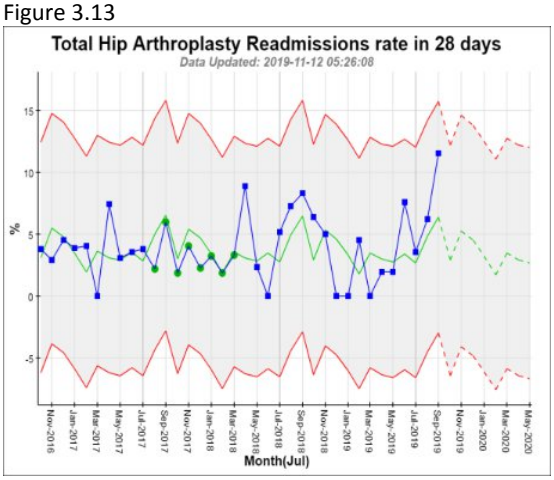
The percentage of patients remain close to expected range.

Figure 3.8



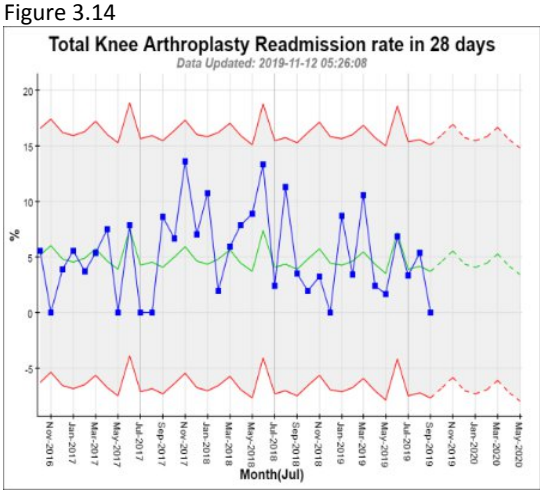
The percentage of patients clinically safe to be discharged is within expected range.

Figure 3.13



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

Figure 3.14



Readmission rates are maintaining within tolerances.

Achievements/Issues of Note

ERAS update

Supporting enhanced recovery of people following colorectal surgery

- Traditional length of stay for major colorectal surgery, including bowel resection procedures has been 12 to 14 days. An Enhanced Recovery After Surgery (ERAS) pathway was introduced in Christchurch Hospital over ten years ago with the aim of improving patients' recovery profile allowing earlier discharge. The pathway includes pre-operative education and early eating drinking and mobilising. Use of this pathway has been compromised due to the mix of acute and elective patients on the wards, changes in key staff members and overly complicated paperwork. Even so length of stay has reduced to 8-10 days.
- A reinvigorated approach to enhanced recovery has been implemented from the beginning of September 2019. Patients' expectations are addressed with early provision of a booklet and advice including advice about smoking cessation, exercise and diet prior to their operation, what they can expect during their time in hospital and how long this is likely to be. The pathway has been simplified with a more goal orientated approach particularly focusing on mobilisation - periods out of bed and walking several times every day - so that most patients will be ready for discharge after four and five days. Explanations are given to the patients about how recovery is improved with activity rather than traditional bed rest which is now thought to be detrimental much of the time.
- Further developments are anticipated with the pathway becoming electronic rather than paper based, this should facilitate capture of outcome measures and details of patients' progress, so problems can be identified and addressed in a timely way, a weakness in the current pathway. Most institutions with successful ERAS pathways have a dedicated ERAS nurse and physical separation of patients on the ERAS pathway. Neither of these conditions exist in the Christchurch hospital and to ensure the sustained success of the pathway these conditions will need to be met.

A new nutritional pathway to support recovery following hip fracture

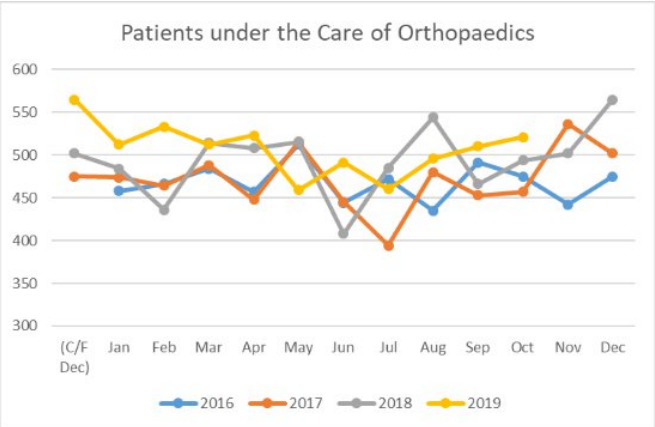
- Patients undergoing surgery due to a hip fracture are at risk of malnutrition due to anorexia and immobility that follows the trauma and surgery. It is known that oral intake in the postoperative phase is lower than needed, leading to deterioration of nutritional status.
- Malnutrition has been linked to longer hospital stays, poor wound healing, increased risk of pressure injuries all of which lead to recovery taking longer and a prolonged period of rehabilitation.
- Recent recommendations include that older patients with hip fracture should be offered oral nutritional supplements postoperatively in order to improve dietary intake and reduce risk of complications. The Canterbury Hospital Health Pathway for Fractured Neck of Femur has been updated to include and our dietary assistant has been leading the quality improvement process to implement this approach.
- In conjunction with Well Food a new diet code has been created on FloView that ensures that patients receive a high energy protein diet along with two oral nutrition supplement drinks (1.5kcal/ml) per day bringing our practice in line with the most up to date evidence-based practice for these patients.
- Catering assistants have participated in education sessions and staff on the orthopaedics wards have provided positive feedback following the first two weeks of this process.
- We expect these changes will have a positive impact on minimising the nutrient deficit and risk of malnutrition contributing to improved recovery for this group of people.

Orthopaedics

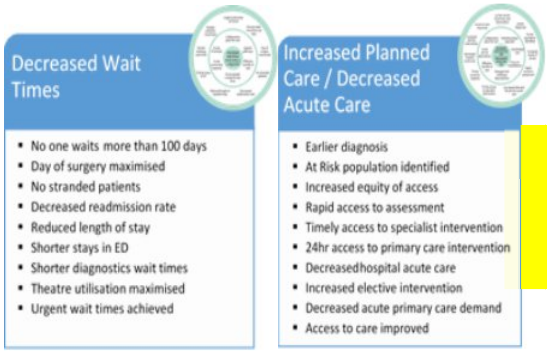
Orthopaedics has seen an increase of patients admitted to Christchurch Hospital over the past few months. This is up on that of the past 3 years. In October alone, there were 521 patients admitted to Christchurch Hospital under the care of Orthopaedics compared with October 2018 (494), October 2017 (457) and October 2016 (475).

Of these admissions there were 341 orthopaedic procedures completed in October 2019 compared with 298 in September 2019. To reduce the time spent waiting for surgery at Christchurch Campus, decisions to move some acute cases to Burwood occurred where clinically appropriate. There were 45 patients transferred to Burwood Hospital for surgery. Seven elective cases at Burwood were cancelled to accommodate acute cases.

Despite the larger volume, our average length of stay remains constant at 4.22 days in September and October. Our delays in access to theatre however was greater and can be linked to both the increased volumes admitted under Orthopaedics and the impact of MIT industrial action throughout October. This equates to 56% of patients who were ready for theatre receiving their surgery with less than one full days wait; a further 30% proceeded to theatre within 1-2 days of admission. However, October saw an increase in the number of patients (17 compared with 4 in September 2019) that waited in excess of 5 days for their surgery – mainly due to access to theatre resources, specialty surgeon availability, and the impact of MIT industrial action.



A review of some patients going through joint surgery is currently underway with a potential research piece in partnership with University of Otago and our Orthopaedic Department, supported by Anaesthesia to identify patients who could reduce length of stay to two nights and 3 days based on approach to surgery, peri operative activities and supports on discharge. We are at the early stages of engaging our clinical team and lining an approach to how we identify and manage and report this work. This is an extension of ERAS for joint surgery however builds on ongoing work of how we manage the growth of our planned care activity.

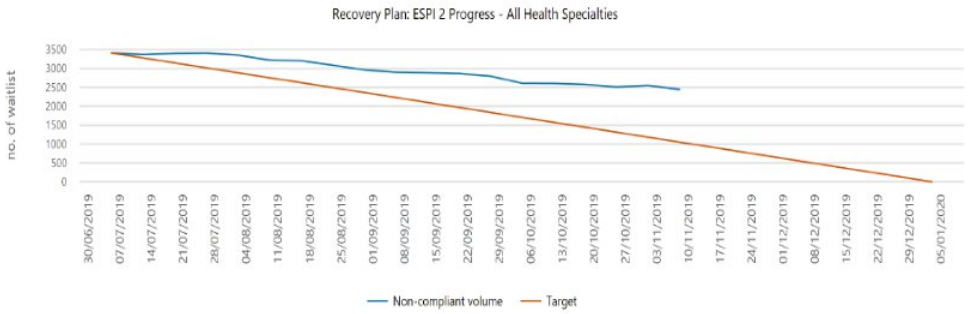


Elective Surgery Performance Indicators 100 Days

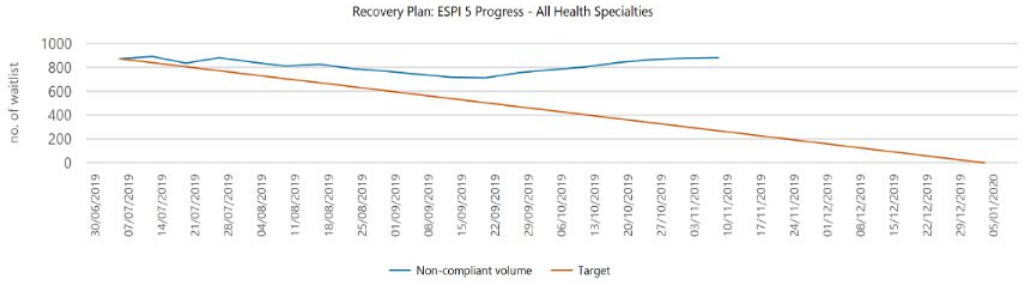
Achievements/Issues of Note

Elective Services Performance Indicators

- Services now have access to more targeted information that helps them to identify and correct data anomalies. For example we are able to identify waitlist entries for either a first specialist assessment or surgery that relate to patients who have been seen already and not removed from the wait list.
- Summary reports provided by the Ministry now reflect our internal reporting about the number of people waiting longer than target for their First Specialist Assessment, however Ministry reports about waiting time for surgery require further updating.
- Internal reports show 2,441 patients (23% of the total) waiting for First Specialist Appointment for longer than 120 days while 988 patients (18% of the total waitlist) have waited for surgery for longer than 120 days.
- A recovery plan has been agreed with the Ministry of Health that would see both of these measures in green or yellow status by the end of 2019. There is some confidence that this will be achieved for ESPI 2 (First Specialist Appointments) in many service areas. However, ongoing industrial action is affecting our ability to achieve the planned reduction in the number of people waiting longer than 120 days to receive the care we have undertaken to provide. Until the past four weeks the number of patients waiting for an appointment for longer than 120 days was reducing on a weekly basis. However, over the past four weeks progress has plateaued.



- The challenges in meeting our recovery plan for surgery waiting time are more troubling. As we make progress in reducing the number of patients waiting for their first appointment with a specialist it inevitably increases the number who are accepted for an elective surgical solution.



- The ongoing delays in the completion of Hagley Hospital are restricting our ability to provide elective surgery. While we can outsource a significant percentage of our elective surgeries to other providers there are many patients who are unsuitable for treatment anywhere other than in the public hospital where theatre time is at a premium.

Changes made to improve waiting times for Otorhinolaryngology specialist assessment

- For some time, the Otorhinolaryngology (colloquially known as Ear, Nose and Throat) service has had a very large waiting list for First Specialist Assessment appointments. Advice from lean coaches is that for the rate appointments are provided at the waitlist should not exceed 800 referrals. However, at its peak in March 2019 the waitlist held over 2,000 referrals.
- The waitlist has grown to this point over several years with capacity challenges, including parental leave, reducing the ability of the service to provide the amount of care it wishes to.
- Concerted work from the service had reduced the waitlist so that during July and August it contained between 1600 and 1700 entries.
- The service has made several changes to reduce our waiting list so that people are seen within 100 days of a referral being made. Referrals of some cohorts of patients with lower priority conditions, including children with mild to moderate obstructive sleep apnoea, are no longer being accepted.
- The introduction of e-triage has assisted the team to offer appointments only to people that require its service. It is now easy for the triaging clinician to write back to the referrer seeking more information whereas previously some patients would be seen because it was easier to assess them personally than seek information that would enable triage.
- Approval was given for the resources required to run a super clinic on a Saturday. 120 patients were seen with no “did not attends”.
- As at 8th November, the waitlist has been reduced to 1,439 referrals. Promising steps are being made towards attaining compliance with the ESPI2 target (120 days) and Canterbury District Health Board’s own objective that people will be seen at first specialist assessment within 100 days of an accepted referral being received.
- Once these targets are met it is envisaged that access will be restored for children with mild to moderate conditions.

Understanding barriers to health equity.

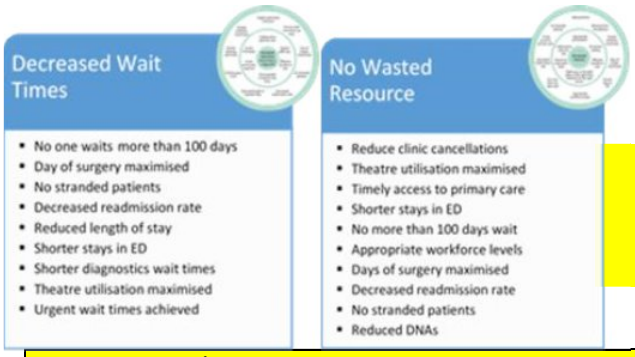
- Significant inequities in health outcomes for Māori are well documented. The most profound health disparities occur in cancer outcomes where Māori are 20% more likely to get cancer than non-Māori New Zealanders and are 80% more likely to die from it.
- While this inequality is widely recognised the Haematology Service has little information that demonstrates this or could be used directly to improve the situation.
- A registered Nurse, has been employed over a fixed term to monitor and evaluate service provision in Haematology through an equity lens, they have been working with colleagues within the service, Planning and Funding, Decision Support and the University of Otago to

create an improvement plan and research what barriers exist for Maori in presenting in a timely manner to the tertiary environment and our responsiveness as an organisation to the needs of Maori in an Inpatient environment.

- A statistical portrait based on patient flow dynamics for patients being treated for myeloma has been developed and early results show there are significant gaps in data collection and a need to access additional databases to enable progress to be made.
- Work continues in this area. As it develops it will hopefully identify and enable improvements within the pathway followed by patients with myeloma and will show us how to make similar improvements in other pathways for Maori with Cancer.
- This nurse-led initiative supported by the Haematology service was introduced in February 2018 to meet the needs of Maori in the Haematology environment to meet cultural competence for this patient cohort. This initiative marries nicely with the latest New Zealand Cancer Action Plan 2019 -2029 released by the MOH September 2019 and with evidence of outcomes in Feb 2020 we hope to ensure that this position will be endorsed as our normal way of working for all Maori patients on the Cancer continuum within Haematology and Oncology services.

Enhancing workforce cultural responsiveness in the Haematology Service.

- Recognising that poor health outcomes and lower rates of clinic attendance are related to patient and whānau impressions of cultural fit and safety and whether the patient and whānau involved in their care, the Haematology Service has developed a health assessment care plan that enables the patient and whānau to communicate their health needs and aspirations to the entire team involved in their care. The health frameworks of the Meihana Model and Advanced Care Plan, have provided the foundation of this health assessment.
- The health assessment is written in collaboration with the patient and whānau, describing their cultural and health aspirations. Each patient and whānau were advised of the aims of this initiative and their feedback has been invaluable in determining the content included moving forward.
- Future measurement strategies include a survey to identify patient satisfaction and conduct another workforce survey to evaluate perceived gains in cultural competency.
- Service databases will be accessed to measure changes in patient compliance, engagement and equity-focussed service delivery such as the equitable access to stem-cell transplants.
- The implementation of the Māori health assessment has shown improved patient outcomes by the recording and sharing of information such as; potential barriers to treatment compliance, spiritual links to land and how this relates to patient wellbeing, actions required to protect patient and whānau mana, and specific health education needs.
- Health professionals have reported increased knowledge, change of attitudes and improved skills when working with Māori.



Theatre Capacity and Theatre Utilisation

Achievements/Issues of Note

Planned Care Interventions

- Planned care targets have been agreed with the Ministry of Health and incorporate planned inpatient operations as well as range of procedures provided to hospital outpatients and patients in community settings.
- At 1 November 2019 we have provided 6,514 planned inpatient surgical discharges, 169 discharges less than the phased target of 6,683. The target for inpatient planned volumes is set at the same level as last year's target. There is confidence that in the absence of the extraordinary circumstances experienced in 2018/19 the end of year target will be met.
- Our overall target for minor procedures at this point of the year is 3,869 with a plan that 3,055 of these would be carried out in a hospital setting (either inpatient or outpatient). This is a new component in our planned procedure reporting and work practices to ensure all relevant data are counted against the target are being worked through.
- 2,808 minor procedures have been shown as provided in a hospital setting against the plan of 3,055.
- The final component added to this year's planned procedure target is the provision of publicly funded procedures in community settings. This is an area in which Canterbury has led the country. Provision of data from primary care to the Ministry of Health's National Minimum Dataset collection is being worked on so that these volumes can be counted.

Burwood Theatres

With the demand for acute orthopaedic surgery, a number of patients were transferred to Burwood for their surgery. There 45 cases in October alone that were transfer to Burwood. These made up of:

Lower limb	16
Upper Limb	14
Foot	3
Hands	6
Spines	4
Hip re-op	1
Hip re-op	1

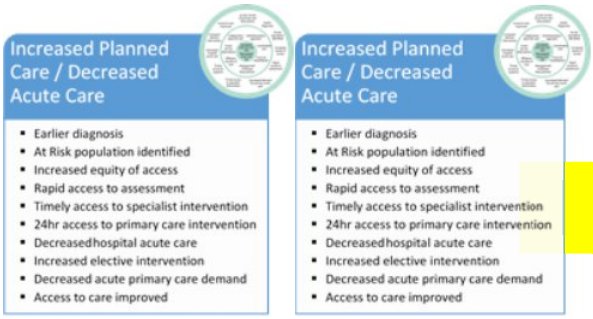
The impact was Burwood electives cancelled for acute resulted in 7 primary cancellations. These were elective cases postponed in October to assist with management of acute volumes: four of the seven cancellations were related to the MIT industrial action.

A further five cases were secondary postponements i.e. the flow on effect of the October cancellations requiring rescheduling of patients booked in November.

The ongoing focus on Burwood theatre utilisation for acute backfill lists resulted in:

- 20 Backfill lists offered – (96 hours)
    - 16 x 4-hour sessions (64 Hours)
    - 4 x All day lists (32 hours)
- 1 x All day session not used due to MIT strike (8 hours)
- 2 x 4 hours of all-day sessions (8hours) not used due to insufficient appropriate cases.
- 2 x 4-hour sessions not used due no appropriate cases (8 hours)

This results in a utilisation of 66% of sessions backfilled to support acute and or other cases when a surgeon went on leave.

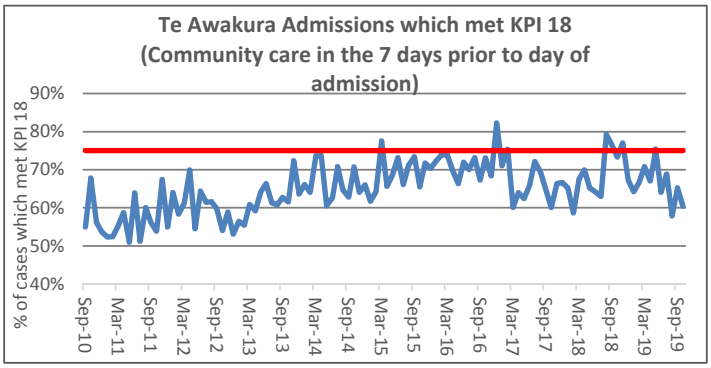


Mental Health Services

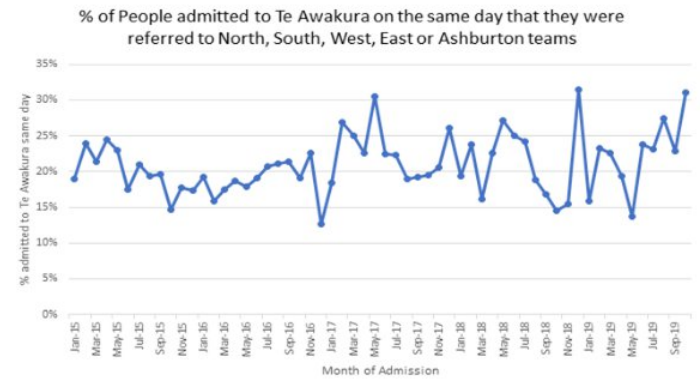
Cultural upskilling – Working with New Zealand Muslims

- Psychologists of Islamic faith recently provided a presentation on Working with New Zealand Muslims to staff from Canterbury DHB who were working at the Welfare Centre and supporting people affected by the 15 March mosque attacks.
- The presentation has been made into a video and is available for Canterbury DHB staff to view on the intranet.

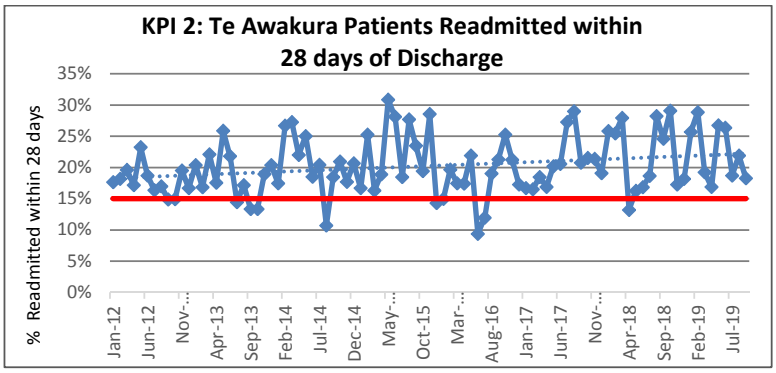
Adult Services



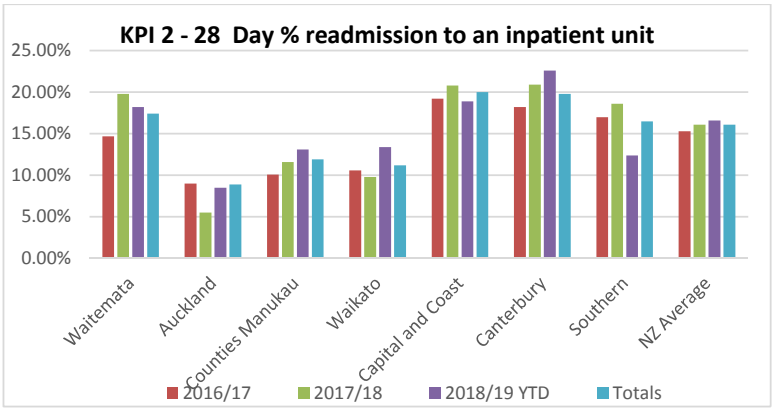
KPI 18 is an indicator of how engaged we are with consumers prior to admission to inpatient services. In August 2019, 57.8% of acute admissions to Te Awakura had a community contact in the seven days prior to the date of their admission. In September 2019, the figure was 65.2% and in October 2019, it was 60.4%. In most instances where KPI 18 was not met, the person was not currently under the care of Specialist Mental Health Services and was admitted on the same day of initial contact. We are seeing an increase in the number of people admitted on the same day which is likely to explain some of the downward trend in the KPI18.



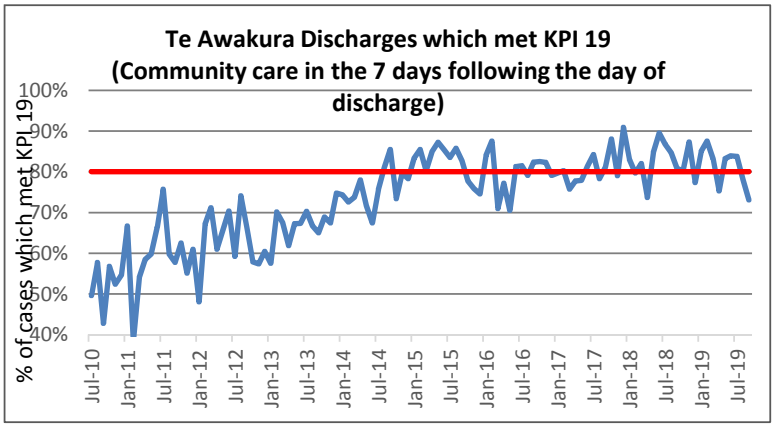
The graph below shows the **readmission rate within 28 days of discharge**. Of the 104 consumers discharged from Te Awakura in September 2019, 18.3% were readmitted within 28 days. Readmission rates are closely monitored.



The graph below shows the national comparison rates against DHBs with comparable populations.

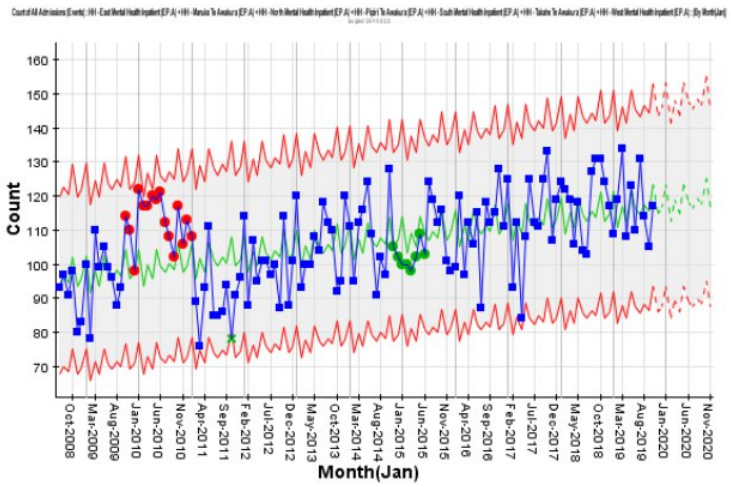


KPI 19 is a key suicide prevention activity and patient safety measure. In August 2019, 78.1% of consumers discharged from Te Awakura received a community care follow-up within seven days of discharge, and so met KPI 19. In September 2019, the figure was 73.1%. Individuals not followed up within 7 days and reasons for this are identified as part of our monitoring process. Often people have been difficult to engage in follow up, declined follow up, follow up has taken place just outside of the 7 day measure, or they have moved out of area.

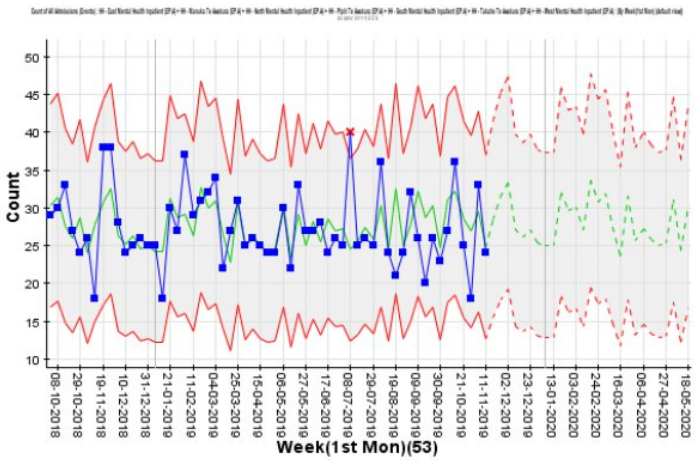


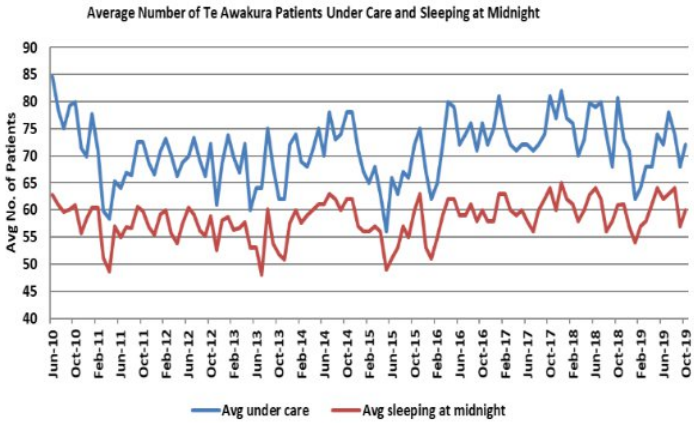
The number of adult admissions (to Te Awakura) as indicated in the graphs below shows an increasing trend but remains within the expected range.

Monthly Count of Adult Admissions (Te Awakura)



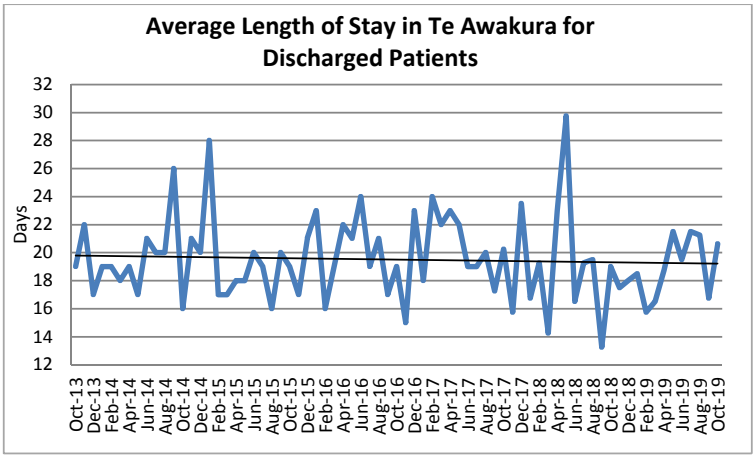
Weekly Count of Adult Admissions (Te Awakura)





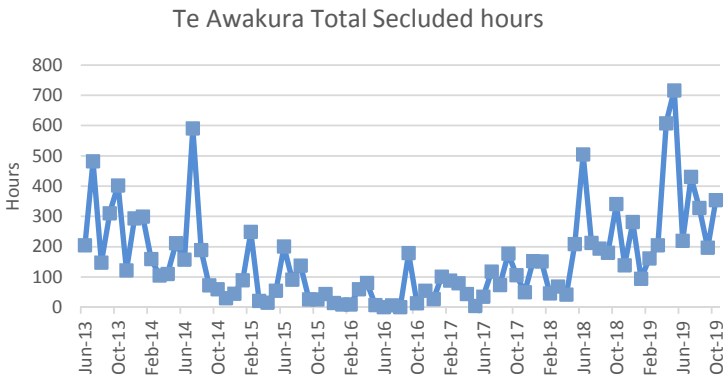
85% **occupancy** is optimal for mental health acute inpatient services. Occupancy in Te Awakura (the acute inpatient service) has regularly been above this figure. Occupancy was 88% in September 2019 and 94% in October 2019.

The average number of consumers under care in this 64-bed facility was 68 in September and 72 in October 2019. There were 9 sleepovers during September 2019 and 15 sleepovers during October 2019. Sleepovers are very undesirable and impact on our ability to offer a therapeutic inpatient experience.

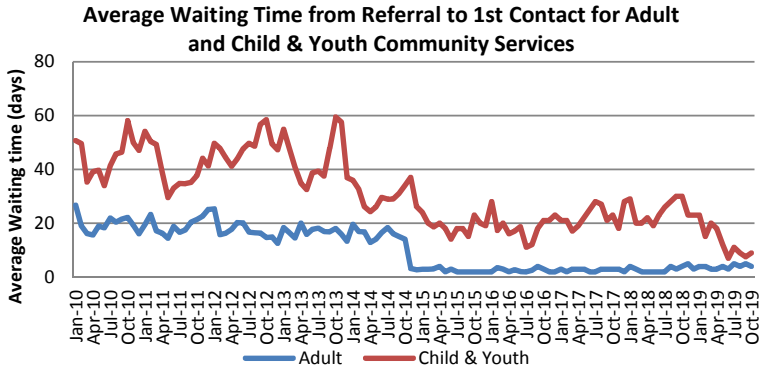


The average length of stay for consumers discharged from Te Awakura was 17 days for September 2019 and 21 days for October 2019. On the day of writing this report 39 of acute inpatient beds were occupied by people who have been in the service for 17 days or longer, 27 of those people had been in for longer than 30 days, 8 for longer than 60 days, 7 have been in for longer than 90 days and 2 people have been in the unit for more than a year

We are closely monitoring length of stay and developing an understanding of the complex reasons for delayed discharges, including issues that are impacting on consumer flow through mental health services. We have agreed an initiative with planning and funding to facilitate the move from long term inpatient stays to community packages of care which will commence in 2020.



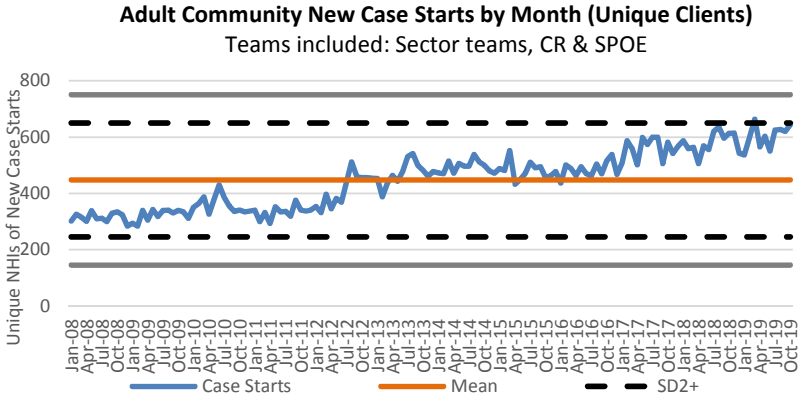
In September 2019, 9 consumers experienced **seclusion** for a total of 197.3 hours. In October 2019, 9 consumers experienced seclusion for a total of 353.7 hours. The recent increase is in the context of consumers presenting with drug related issues.



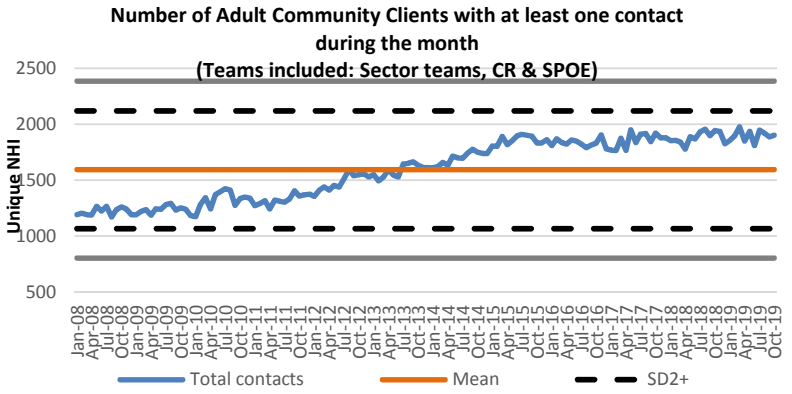
The graph above shows there has been an overall reduction in the time people spend waiting for services. Ministry of Health targets require 80% of people to be seen within 21 days and 95% of people to be seen within 56 days. The average waiting time for adults was 5 days for September 2019 and 4 days for October 2019. Our results for the Adult General Mental Health Service show 91.5% of people were seen within 21 days of referral in September 2019 and 98.4% were seen within 56 days of referral. In October 2019, these figures were 92.59% and 98.8% respectively.

For child and family services, the average waiting time to first contact was 8 days in September 2019 and 9 days in October 2019. Our results show 46.02% of people were seen within 21 days of referral in September 2019 and 74.43% were seen within 56 days of referral. In October 2019, these figures were 45.63% and 77.5% respectively.

These results are occurring in the context of significant increase in demand.



New cases were created for 620 individual adults (unique NHIs) in September 2019 and 643 in October 2019.



In September 2019 there was at least one contact recorded for 1884 unique adult community mental health consumers and 1899 in October 2019.

Supporting effective leadership

Model of care changes, increasing demand, resource pressures and the need for increased support for staff wellbeing has seen the introduction of Associate Charge Nurse Manager (ACNM) positions in the adult general service.

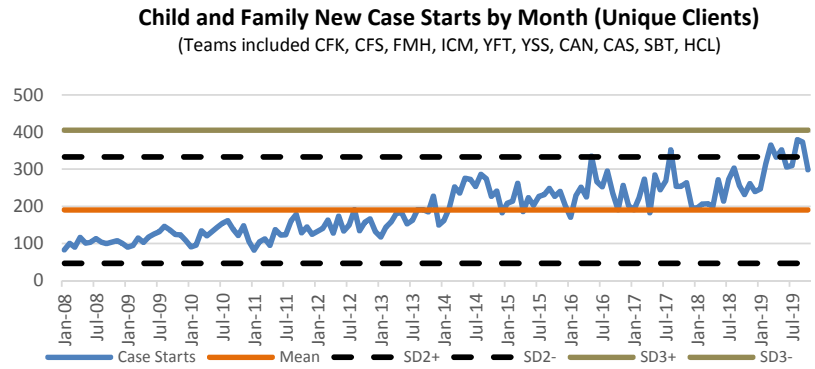
The roles were established in October of 2018, aimed at providing more consistent, sustained and coordinated leadership, at ward level throughout the day and evenings and weekends in the community services.

ACNMs work to promote a strong sense of teamwork, foster a team approach, and ensure safe, effective and consistent care is provided to our consumers, across the service continuum. In the community, the roles support the triage and prioritisation process and occasionally work on numbers to ensure timely care delivery for consumers. On the ward, they carry a small patient case load while maintaining a leadership focus.

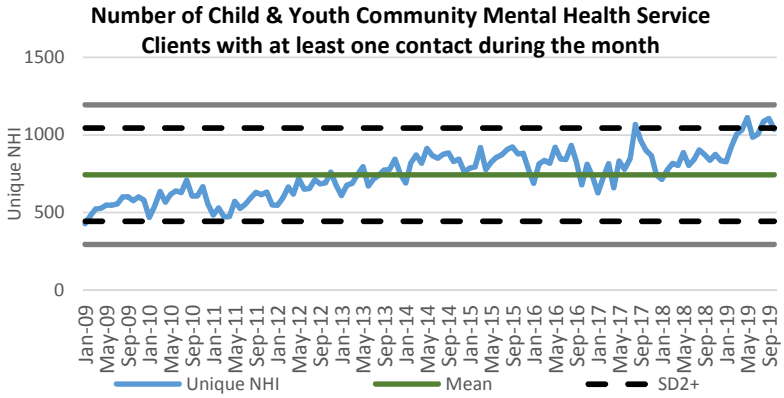
These new positions have been well received by staff. They have provided the opportunity to define and refine other clinical leadership positions and offer clarity around role responsibilities and accountabilities. Very positive feedback has been obtained on the impact these roles have had on the care provided to consumers and the promotion of safe and consistent practice.

Child and Youth

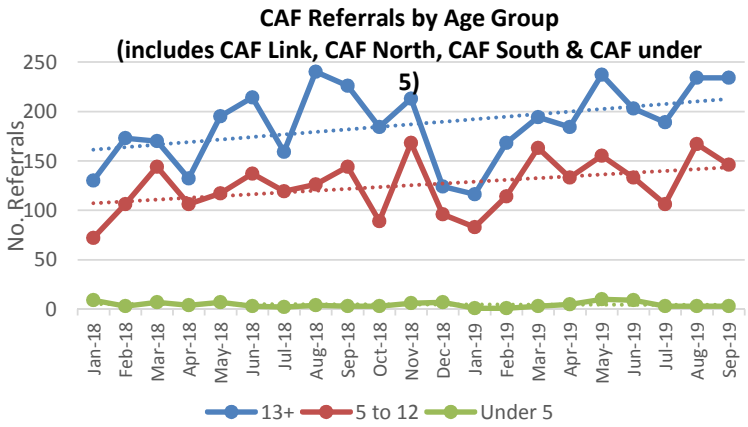
Child and Youth (CAF) continue to experience an increase in demand, as demonstrated by the graph below. As at October 2019 27.02% or 1354 consumers under SMHS care are aged under 18 years. New cases were created for 373 children and adolescents (unique NHIs) in September 2019 and 298 in October 2019.



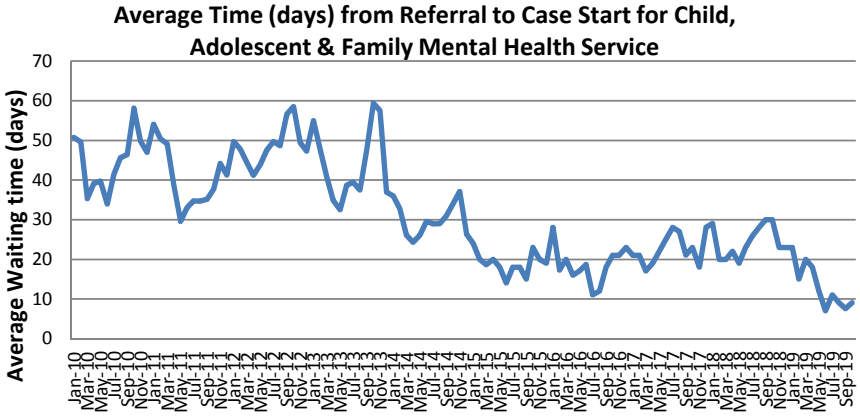
The number of unique clients with contacts below shows a similar pattern to new case starts graph, which further demonstrates the increase in demand for Child and Youth community Mental Health Service. There were 1105 unique patients with at least one contact during the month of September 2019 and in October 2019 there were 1035.



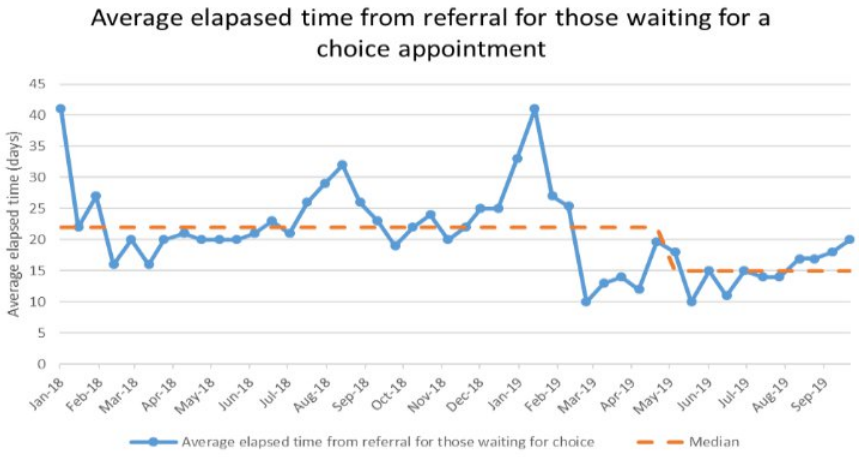
A review of referral sources demonstrates that most referrals to child and adolescent services comes from GPs, with a marked increase in referrals from the emergency department and from School Counsellors. Initiatives such as Mana Ake continue to identify unmet need and raise awareness of CAF services, while this is positive for our community it may be contributing to increasing demand for crisis services both within hours (provided by CAF) and after hours (Crisis Resolution/Emergency Department). The service is currently receiving an average of 75 referrals per week in October 2019.

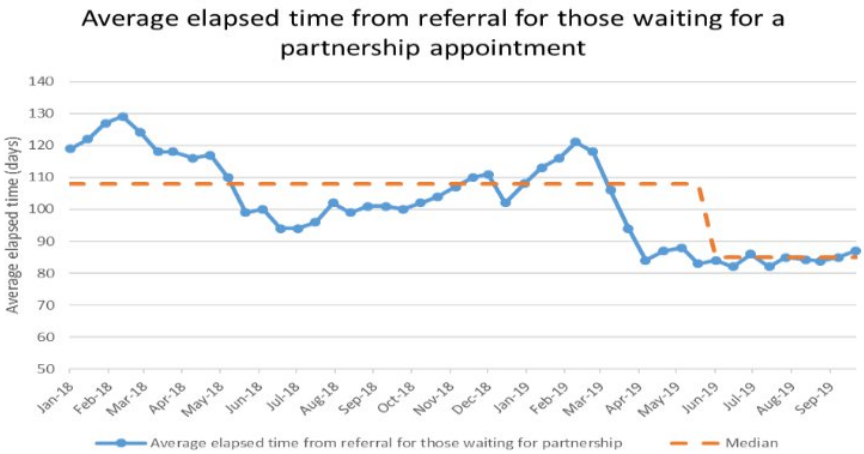


CAF continue to focus on managing wait-times in the context of increasing demand. we recognise the impact of delayed access to treatment for children, young people and their families and this is driver for continuous improvement. Initial contact (case starts) occurs as soon as possible, often by phone, to ensure urgent cases are identified and those not requiring SMHS services are redirected in a timely fashion.

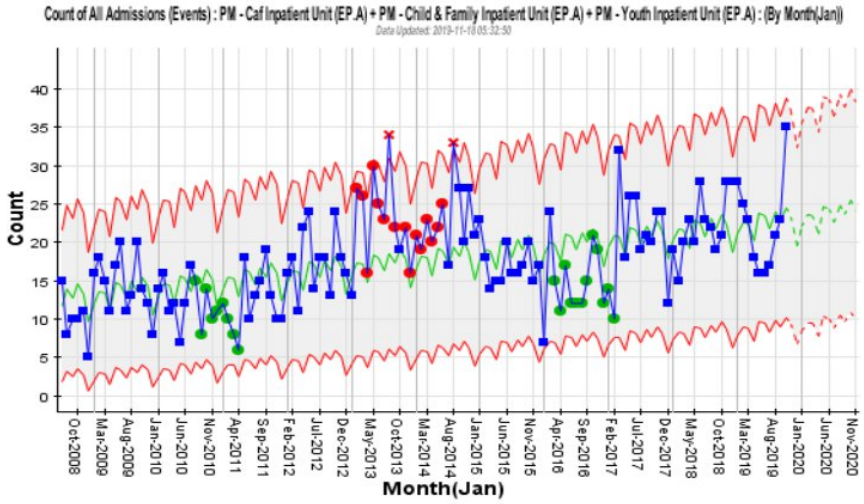


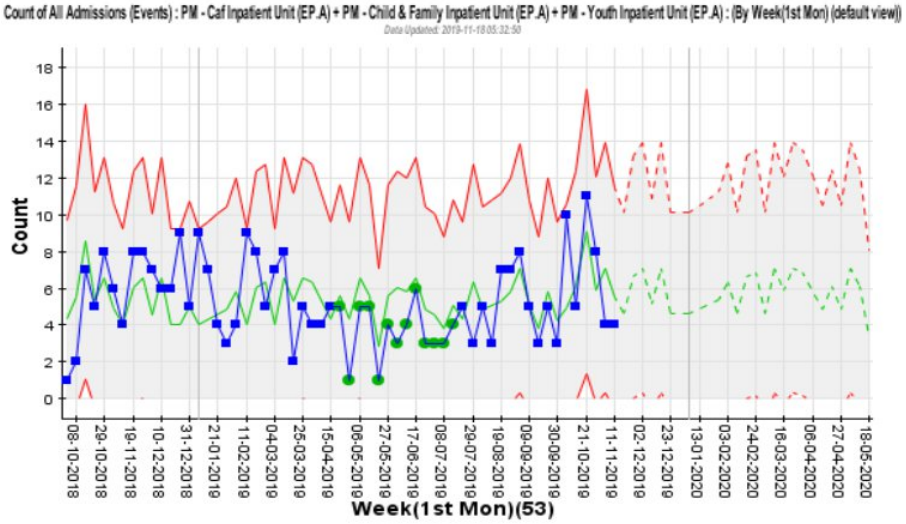
Those identified for treatment are then allocated a choice or partnership appointment. The number of children and adolescents waiting for choice and partnership appointments are increasing, resulting in an increase in average wait-times, although median wait-times which are more representative have shown improvement over the last 12 months.

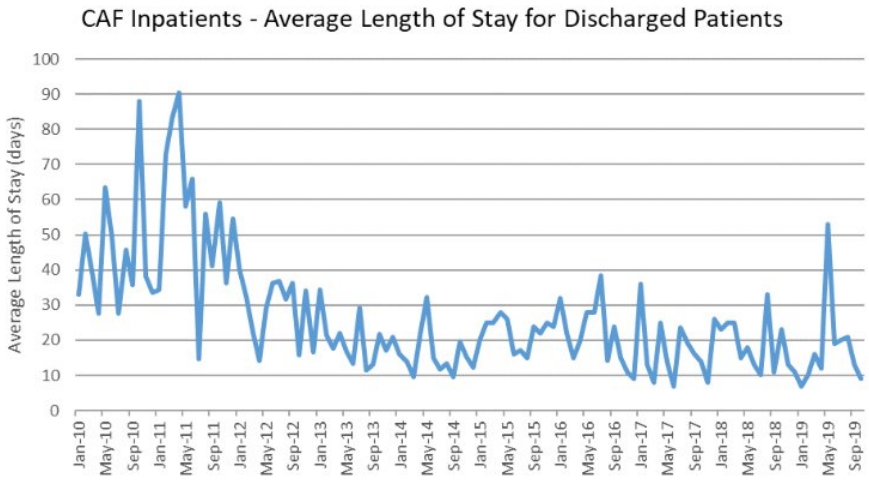




The graphs below show the number of admissions to the Child and Adolescent Unit and its predecessors. The first graph is a monthly view, and the second a weekly view.







The average length of stay for discharged patients was 13 days for September 2019 and 9 days for October 2019.

Rural Services

The adult rural mental health team has close working relationships with both rural PHOs Waitaha Primary Health and Pegasus. These services and relationships have evolved and strengthened since the Kaikoura earthquakes.

The rural mental health team provide clinical assessments, allied health treatment as well as case management. Clinics are held monthly in Kaikoura, Amuri, Hamner, Waikari, Amberley, Cheviot, Oxford, Rangiora, Darfield, Leeston and Akaroa and can include support to GPs. A rural GP voucher system is being launched, designed to address location and cost barriers in rural settings. The goal is to support people to access GP follow up following contact with Specialist Mental Health Services.

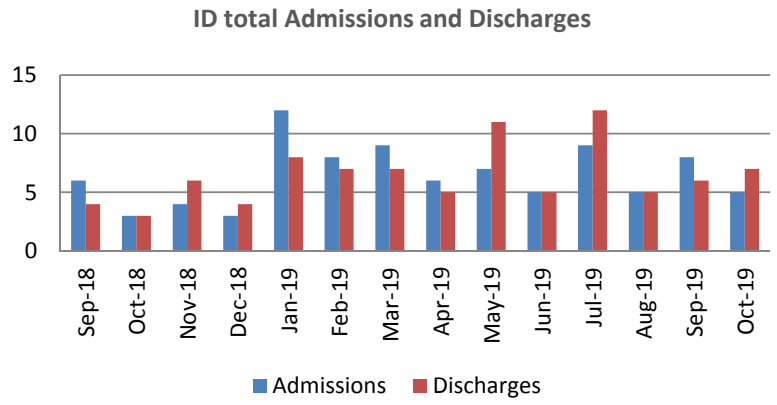
CAF services provide specialist mental health input almost daily to rural areas including Ashburton and Rolleston, Waimakariri and Hurunui. There is an acute response available to these areas as well as access to a range of services including individual and family appointments, groups, home visits, liaison and consultation with schools, GPs and NGOs. In Kaikoura, CAF provide minimum specialised CAF services and consultation to the one team community model. A clinician visits if a specialised assessment is required. The CAF specialist teams cover all of the Canterbury region including the School Based Team, the Children in Care team, the Under 5's team and the Youth Forensic Team.

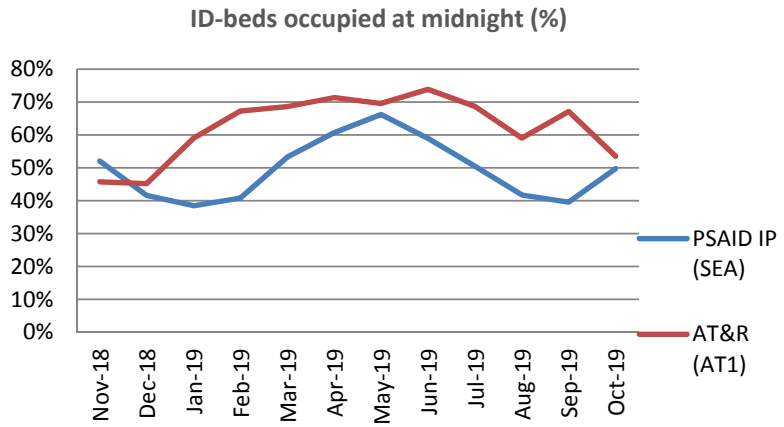
Intellectually Disabled Persons Health Service

The IDPH Service inpatient units comprise a secure unit, Assessment, Treatment and Rehabilitation (AT&R), currently operating as a 6 bed unit and a 15 bed dual disability unit, Psychiatric Service for Adults with Intellectual Disability (PSAID) within the Aroha Pai building, Hillmorton Hospital.

The Assessment, Treatment & Rehabilitation Unit is poorly configured to meet clinical and safety needs. Following a robust planning and approval process the building footprint will be extended to include four separate apartments for individuals who require this level of care environment. Building of these additions has commenced and is due to complete in late 2020.

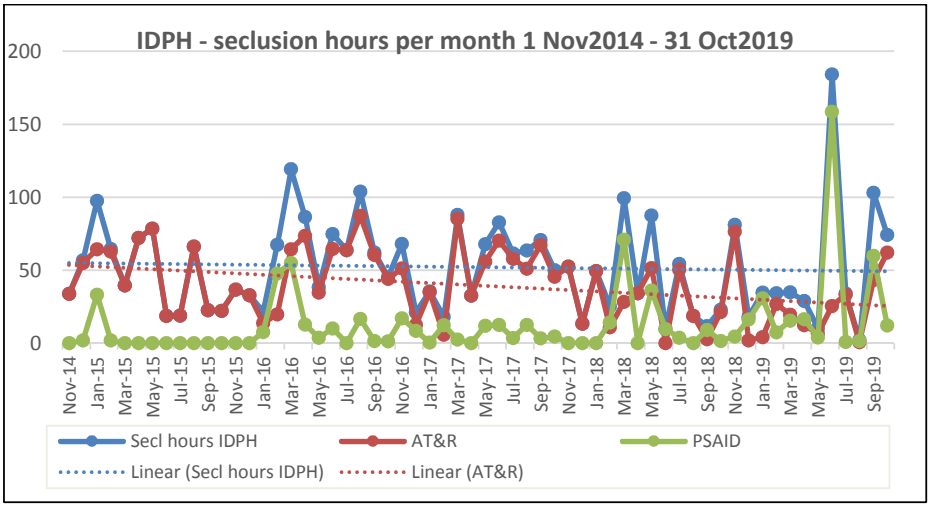
Interim internal modifications now include a second internal annex which is in use. The first internal annex area has resulted in a reduction in physical assaults and the requirement for seclusion for that person, and it is anticipated that the second area will result in a similar reduction of adverse events, this however has reduced the admitting capacity of the unit.

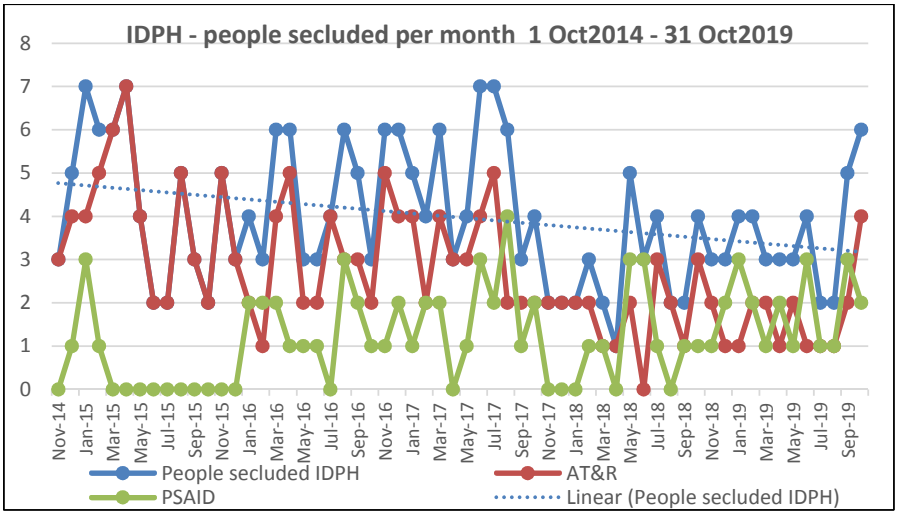


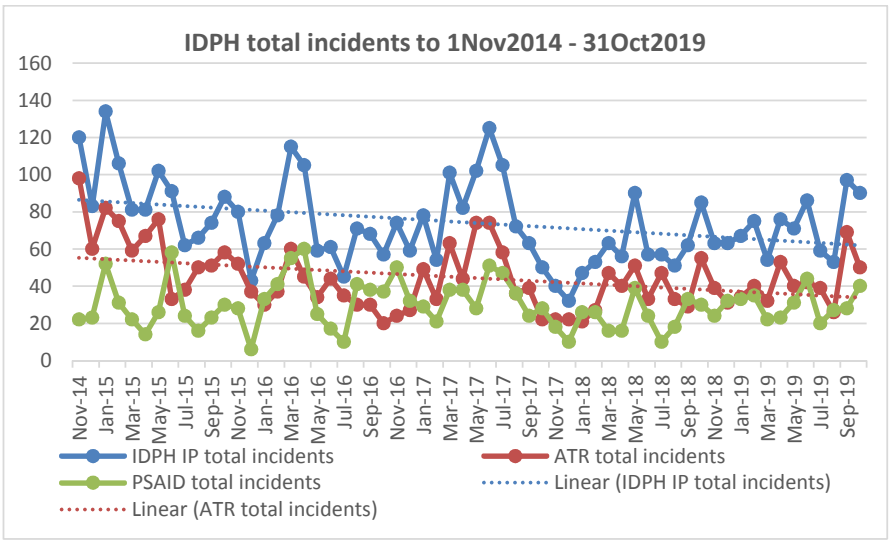


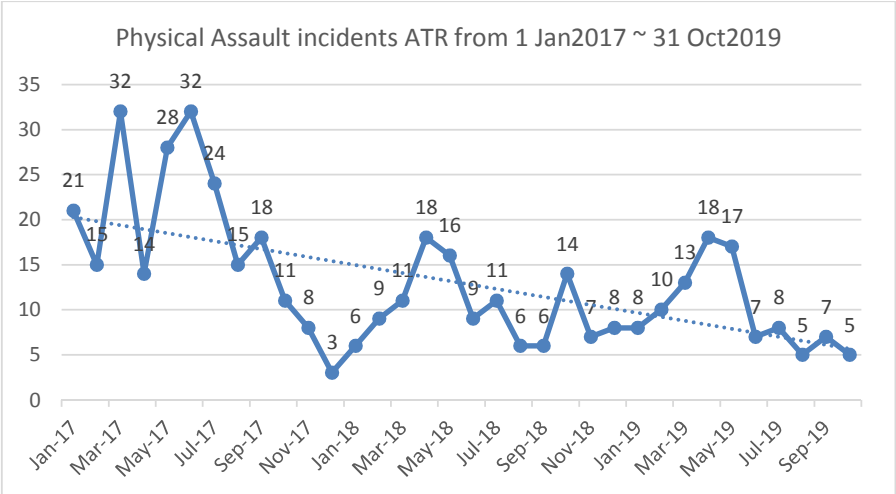
Occupancy in AT&R (AT1) was 67% for the month of September 2019 and 53% for October 2019. The figures for PSAID (SEA) were 50%% and 52% respectively.

In August the total seclusion used in IDPH was down to 2.2hrs. However, in September there was an increase of both PSAID, 58.8hrs and AT & R 43.2hrs. In October PSAID dropped considerable to 12.1hrs, however AT & R increased to 62hrs. The increase is attributable to the current consumer population who present with elevated levels of aggression and a high risk of harm to staff and others.




IDPH - people secluded per month 1 Oct2014 - 31 Oct2019
People secluded IDPH
AT&R
PSAID
Linear (People secluded IDPH)


IDPH total incidents to 1Nov2014 - 31Oct2019
IDPH IP total incidents
ATR total incidents
PSAID total incidents
Linear (IDPH IP total incidents)
Linear (ATR total incidents)


Physical Assault incidents ATR from 1 Jan2017 ~ 31 Oct2019

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 2019

MONTH $'000					YEAR TO DATE			
19/20 Actual $'000	19/20 Budget $'000	18/19 Actual $'000	19/20 vs 18/19 Variance $'000		19/20 Actual $'000	19/20 Budget $'000	18/19 Actual $'000	19/20 vs 18/19 Variance $'000
				Operating Revenue				
550	462	412	138	From Funder Arm	2,026	1,849	1,933	93
1,808	1,548	1,579	229	MOH Revenue	7,358	6,293	6,143	1,215
4,240	4,516	4,004	236	Patient Related Revenue	17,934	18,080	16,875	1,059
1,915	1,913	1,934	(19)	Other Revenue	7,389	7,443	6,390	999
8,513	8,439	7,929	584	**TOTAL OPERATING REVENUE**	34,707	33,665	31,341	3,366
				Operating Expenditure				
				Personnel Costs				
65,660	65,099	60,440	(5,220)	Personnel Costs - CDHB Staff	255,820	254,738	235,358	(20,462)
2,266	1,923	2,128	(138)	Personnel Costs - Bureau & Contractors	8,632	7,705	7,593	(1,039)
67,926	67,022	62,568	(5,358)	**Total Personnel Costs**	264,452	262,443	242,951	(21,501)
12,426	13,035	13,705	1,279	Treatment Related Costs	52,012	50,901	51,151	(861)
4,273	3,455	4,106	(167)	Non Treatment Related Costs	16,544	13,181	14,653	(1,891)
84,625	83,512	80,379	(4,246)	**TOTAL OPERATING EXPENDITURE**	333,008	326,525	308,755	(24,253)
(76,112)	**(75,073)**	**(72,450)**	**(3,662)**	**OPERATING RESULTS BEFORE INTEREST AND DEPRECIATION**	**(298,301)**	**(292,860)**	**(277,414)**	**(20,887)**
				Indirect Income				
(29)	1	-	(29)	Donations & Trust Funds	105	6	4	101
(29)	**1**	**-**	**(29)**	**TOTAL INDIRECT INCOME**	**105**	**6**	**4**	**101**
				Indirect Expenses				
2,558	2,968	2,134	(424)	Depreciation	10,220	11,604	8,409	(1,811)
-	(1)	7	7	Loss on Disposal of Assets	8	(3)	8	-
2,558	**2,967**	**2,141**	**(417)**	**TOTAL INDIRECT EXPENSES**	**10,228**	**11,601**	**8,416**	**(1,812)**
(78,699)	**(78,039)**	**(74,591)**	**(4,108)**	**TOTAL SURPLUS / (DEFICIT)**	**(308,424)**	**(304,455)**	**(285,826)**	**(22,598)**

Achievements/Issues of Note

Fine tuning our approach to high protein energy drinks

- Existing pathways enable nurses to identify patients requiring high protein and energy diets whose requirements are not complex enough to need direct input from a dietician and these patients are provided with a supplement drink alongside their meals.
- Our dietary assistant has been leading some quality improvement projects including one to examine the way we provide these supplements.
- Previously, the diet kitchen was making around 85 booster shakes each day using a supplement powder and sterile water. The cost of the powders was a significant part of the supplement budget, costing around $519/ week plus an hour's labour each day. Around 80% of these shakes were at least partially consumed, with 20% being returned and wasted.
- Dietitians taste tested a number of alternatives and compared the protein and energy provided by them. It was found that a readily available flavoured milk packaged in 250mL cartons tasted better, provided the same level of energy and 20% more protein than the existing product. Because it is packaged in a carton drinks that are not wanted by the patient are not handed to them by their catering assistant, reducing the amount of product that is wasted.
- As well as tasting better and providing the required nutritional value, the new product is 32% cheaper than the existing one.
- Following this analysis the off the shelf product has been introduced, replacing the previous approach.
- We are attaching stickers to the new product, encouraging patients to drink it.
- The lower price combined with reduced waste has been shown to decrease our costs during the first two months post implementation – with an estimate that savings will be more than $11,000 per year on product alone, in addition staff time is released by eliminating the need to make and dispense the drink into cups.

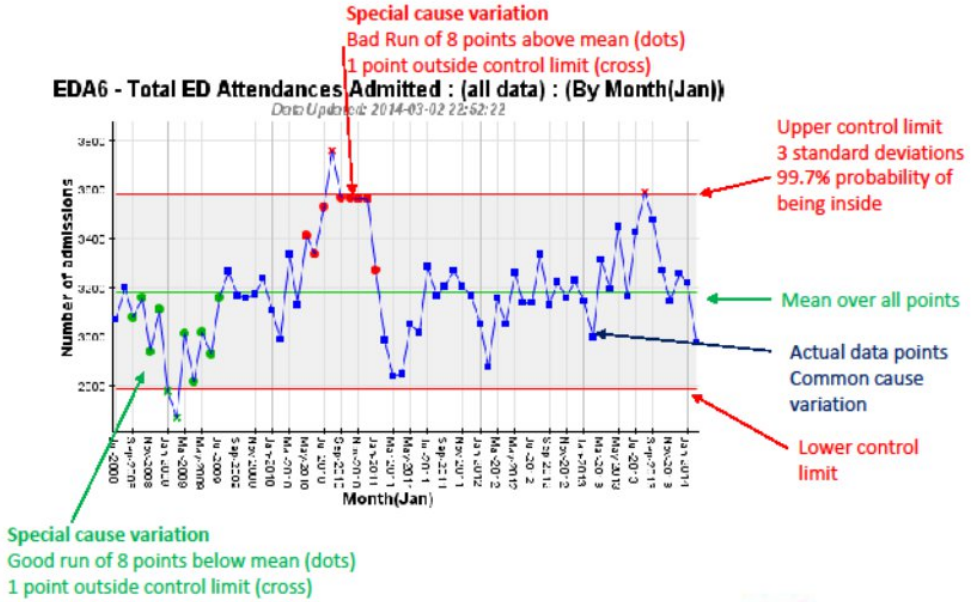
Outsourcing routine sterile hydration product compounding

- The Sterile Unit at Christchurch Hospital Pharmacy compounds sterile preparations including eye drops, hydration fluids, desensitisation regimes, intravitreal injections and trial drugs. The unit also dispenses parenteral nutrition and home intravenous antibiotic pumps which are made off site by Baxter Compounding.
- The capacity to compound materials is constrained by the size, equipment and staffing of the unit. It has been running at its capacity limit for some time.
- This had led to requests for new clinical trials drugs to be compounded being declined. Patients have been unable to benefit from entering some trials and departments were losing funding that accompanies participation.
- Some regularly used hydration fluids are made by adding sodium bicarbonate to a readily available bag of sodium chloride/glucose fluid – this requires compounding within a laminar flow cabinet to ensure sterility. Arrangements have been made with Baxter to provide us with the finished product, reducing the time for dispensing this product from 60-90 to 12-15 minutes per bag.
- While this costs $20 extra per bag it typically releases 10 – 15 hours per month which is used to carry out higher value work, enabling patients to benefit from entry into clinical trials and is remunerated by the sponsoring company. During 2018/19 the income associated with increased clinical trials work ($6,850) was approximately twice the cost of the additional Baxter compounding work ($3,460).

Lean process: Making processing of laparoscopic operating equipment more efficient

- Surgeons from General Surgery, Gynaecology, Paediatric Surgery and Urology use laparoscopic techniques in about 47 operations per week.
- Laparoscopic instruments are either packed and sterilised in standardised sets or individually. It was noted that as well as the standard set every operation required an individually packed grasping instrument was being opened. Alongside this a standardised "addon set" was opened for many operations, only one or two of the five instruments in this pack were regularly used.
- Having a standardised set, an addon set and universally opening an atraumatic grasper added to the complexity and time required to set up a theatre between cases.
- Use of only some instruments from the addon pack meant that the labour and consumables to clean, pack and sterilise the instruments in the pack was partially wasted. Instruments that had not been used were subject to needless wear and tear through the process of dismantling, cleaning and sterilising.
- We did not own enough atraumatic graspers to include one in each standard set, this resulted in Sterile Supply receiving numerous requests to fast-track the processing of these instruments which reduces the efficiency and productivity of its workflow.
- In order to improve this, a further eleven atraumatic graspers, costing $1,000 each, have been ordered and our standard sets are being restructured to include a grasper in each one. Rarely used instruments will no longer be packed in an addon set and will only be packed individually.
- Theatre setup will be simpler and slightly faster, instruments will receive less wear and tear and wasted cleaning and sterilising time has been eliminated. At least $2,000 in processing costs will be saved per week – covering the $11,000 investment inside six weeks.
- More than $85,000 will be saved in the first year.

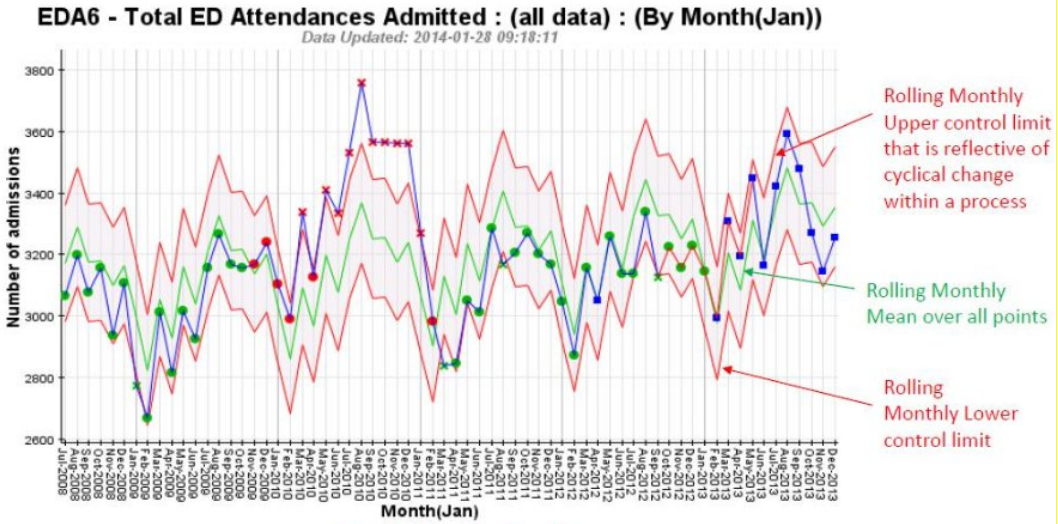
SPC: How to Interpret a Control Chart



sfn signals from noise

make it better

SPC: How to Interpret Cyclical and Trended Data



Criteria for a Cyclical Process:

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

sfn signals from noise

make it better

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

SOURCE: **Corporate Services**

DATE: **5 December 2019**

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 3 October 2019	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: **5 December 2019**

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 November 2018 to October 2019, as well as a 12 month overview of the complaints categories and compliance timeframes.

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 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. The Canterbury DHB Complaints Policy and associated documentation was reviewed and issued in January 2019.

Complaints data is reported as part of the Patient Experience and Harm Indicator Report and monitored by the Clinical Governance Group; Serious Incident Committee; the General Managers Group; and the Quality, Finance, Audit and Risk Committee (*QFARC*).

Process for inclusion of a commentary synopsis on trends and insights supporting the quantative complaint data reports has been set up going forward.

3. APPENDICES

Appendix 1:	CDHB Complaint Rate and Categories to October 2019

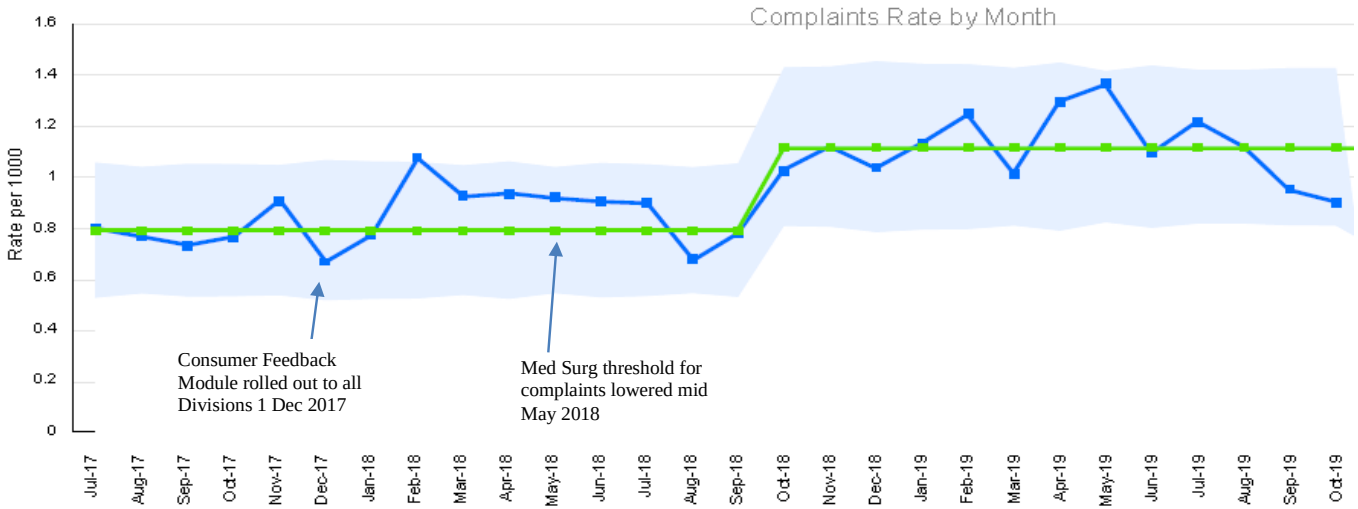
Report prepared by:	Irena de Rooy, Quality & Patient Safety Manager Susan Wood, Director, Quality & Patient Safety
Report approved for release by:	Mary Gordon, Executive Director of Nursing

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.

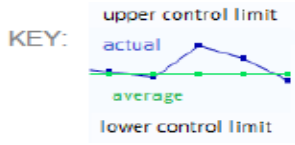
Outcome Indicator: **All Hospitals Complaints Rate**



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	2018/19	2017/18
Complaints															
Numerator	135	124	101	95									455	1,290	1,067
Denominator	110,883	110,935	105,957	105,266									433,041	1,227,274	1,256,975
Rate per 1000	1.22	1.12	0.95	0.90									1.05	1.05	0.85

Comments for six month reporting period of May to October 2019:

- Complaints reported continue to be predominantly related to care and treatment.
- The majority of complaints received generally relate to more than one category (topic). However, in October it was more commonly only one category.

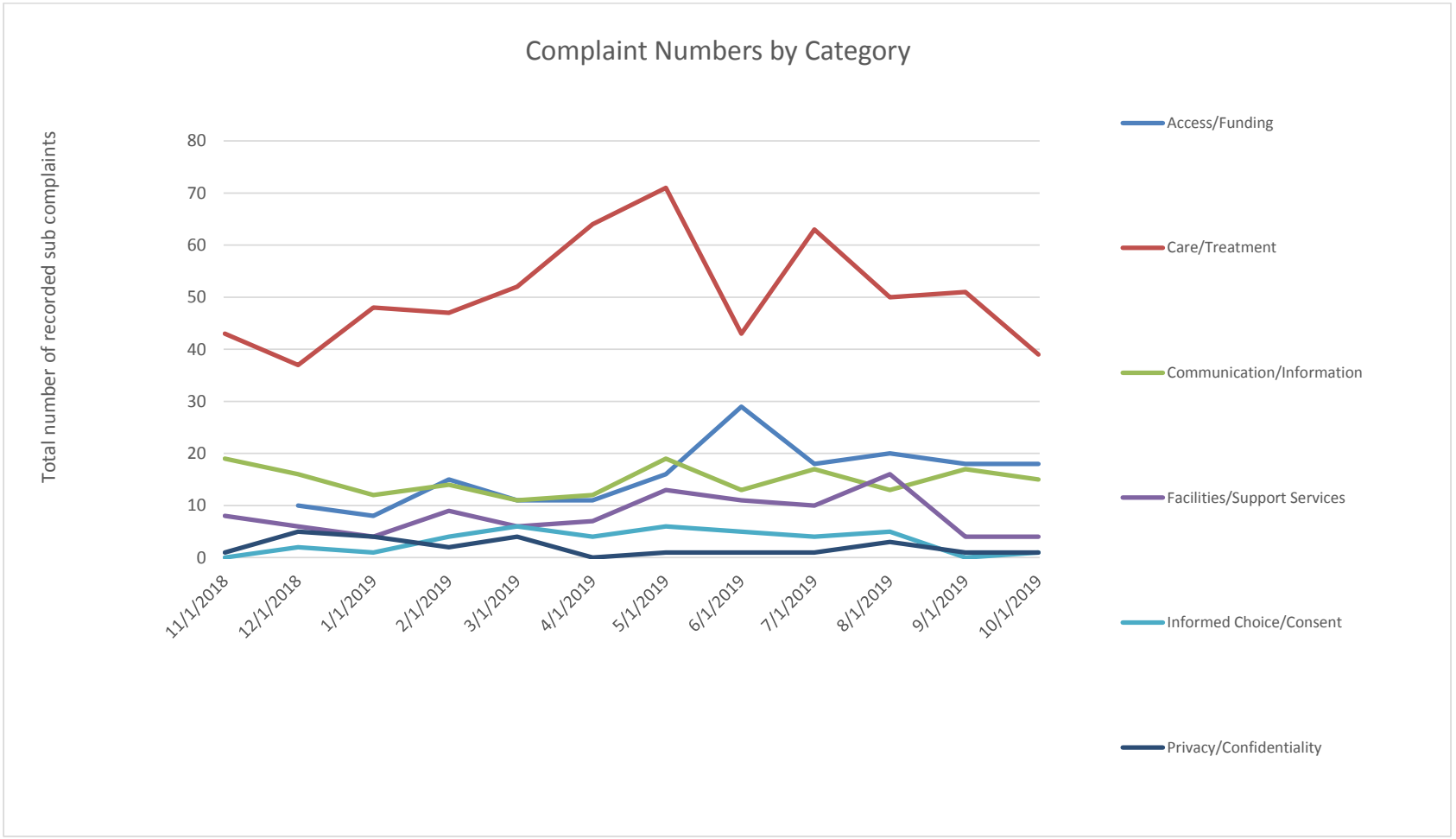
Year	Range of Total Complaints reported per month
15/16	50 to 72
16/17	36 to 98
17/18	63 to 107

Complaints by Category[1] from November 2018 to October 2019

CDHB													
Start Date: 1/11/2018	1/11/2018	1/12/2018	1/01/2019	1/02/2019	1/03/2019	1/04/2019	1/05/2019	1/06/2019	1/07/2019	1/08/2019	1/09/2019	1/10/2019	TOTAL
Total Complaint Forms	110	92	105	116	104	116	153	102	132	120	99	89	***1338***
Total Number of Categories per complainee													
1	20	23	18	19	14	20	19	18	21	35	27	30	***264***
2	37	25	25	27	30	24	40	25	30	32	21	27	***343***
3	27	26	28	19	18	23	29	20	22	23	27	16	***278***
4	12	8	14	15	14	17	19	15	20	9	7	8	***158***
>5	14	10	20	36	28	32	46	24	39	21	17	8	***295***
Access/Funding	10	8	15	11	11	16	29	18	20	18	18	18	***192***
Care/Treatment	43	37	48	47	52	64	71	43	63	50	51	39	***608***
Communication/Information	19	16	12	14	11	12	19	13	17	13	17	15	***178***
Facilities/Support Services	8	6	4	9	6	7	13	11	10	16	4	4	***98***
Informed Choice/Consent	0	2	1	4	6	4	6	5	4	5	0	1	***38***
Patient/Staff Relationships	29	18	21	29	14	13	14	11	17	15	8	11	***200***
Privacy/Confidentiality	1	5	4	2	4	0	1	1	1	3	1	1	***24***

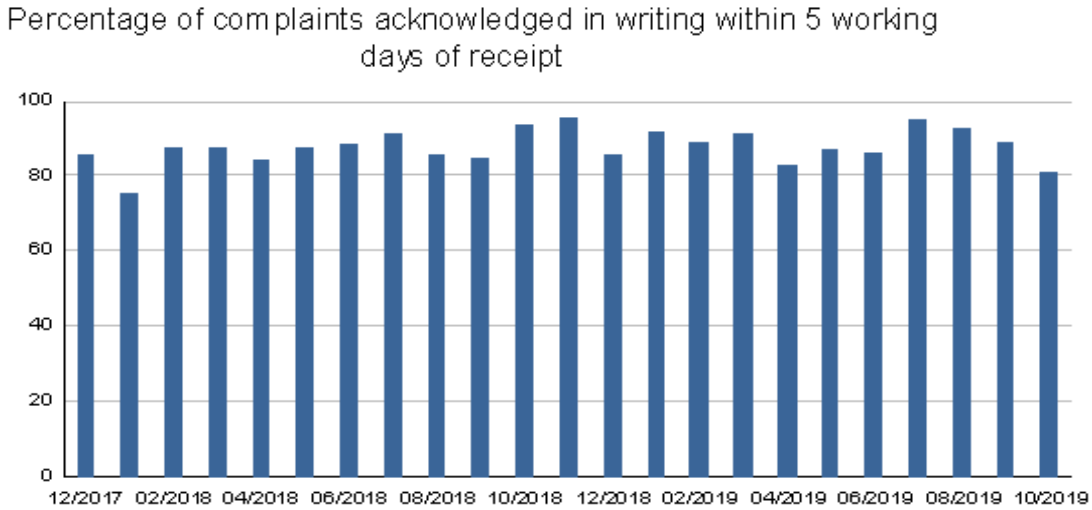
[1] The Breakdown of Complaints Categories data is refreshed monthly, reports are generated in the first week following the close of the month – hence the 'Total Complaints Forms' numbers may differ to the complaints numerator data as this is refreshed weekly.

Canterbury DHB Complaints Categories - November 2018 to October 2019



The consumer feedback module on Safety1st enables monitoring of the 5-day acknowledgement and 20-day response timeframes as per Complaints Policy.

5 day Response[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

Data for 2018/2019 year to date:

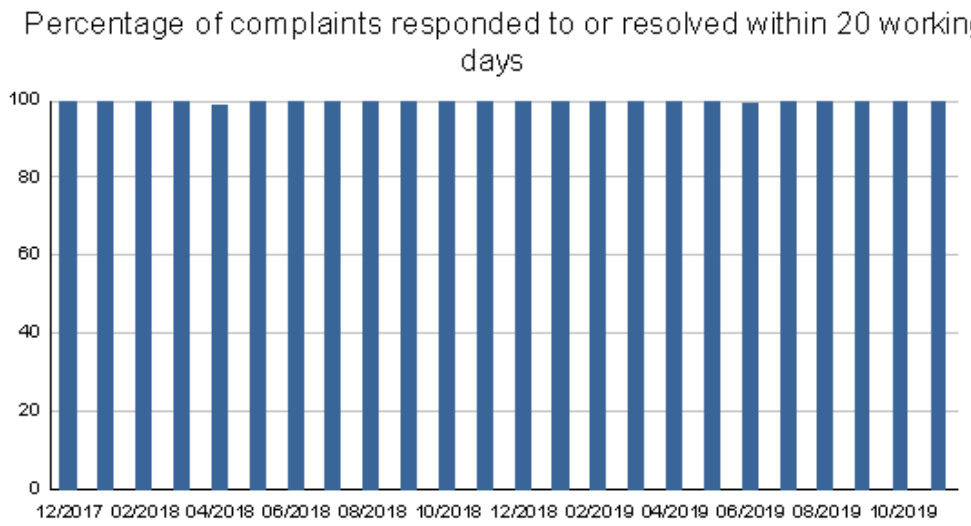
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	2018/19	2017/18
Percentage of complaints acknowledged in writing within 5 working days of receipt															
Numerator	125	111	88	75									399	1,107	545
Denominator	132	120	99	93									444	1,248	643
Percentage	95%	93%	89%	81%									90%	89%	85%

Comments for six month reporting period of May to October 2019:

- The percentage of complaints acknowledged in writing within 5 working days varies below the expected level of 100%. This is being investigated further with a view to improvement.

[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

Data for 2018/2019 year to date:

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	2018/19	2017/18
Percentage of complaints responded to or resolved within 20 working days															
Numerator	135	99	89	86									409	1,185	513
Denominator	135	99	89	86									409	1,186	514
Percentage	100%	100%	100%	100%									100%	100%	100%

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

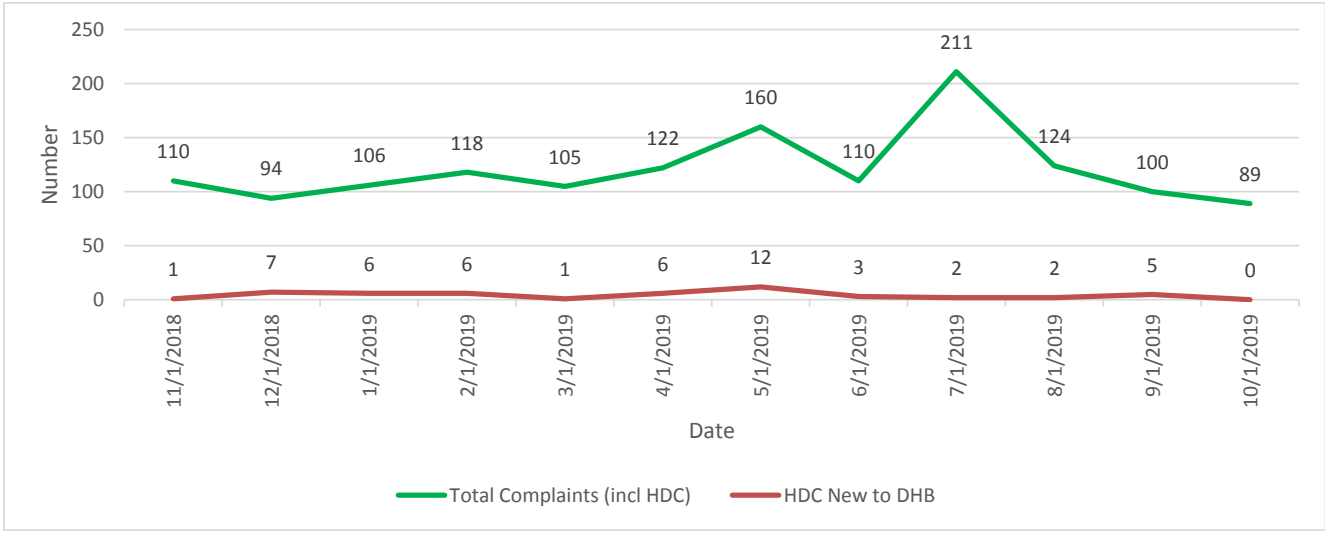
Comments for six month reporting period of May to October 2019:

- 100% of complaints were responded to or resolved within 20 working days.

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

Health and Disability Commissioner CDHB Complaints: Trend Reports - November 2018 to October 2019

Start Date: 1/11/2018	1/11/2018	1/12/2018	1/01/2019	1/02/2019	1/03/2019	1/04/2019	1/05/2019	1/06/2019	1/07/2019	1/08/2019	1/09/2019	1/10/2019	TOTAL
Total Complaint Forms	110	94	106	118	105	122	160	110	211	124	100	89	***1449***
HDC Complaint	**1**	**8**	**6**	**7**	**2**	**10**	**14**	**4**	**2**	**4**	**6**	**4**	***68***
Existing DHB Complaint	0	1	0	1	1	4	2	1	0	2	1	0	***13***
HDC New to DHB	1	7	6	6	1	6	12	3	2	2	5	0	***51***
HDC Request Type Other	**2**	**0**	**2**	**0**	**2**	**0**	**1**	**5**	**1**	**0**	**0**	**0**	***13***
DHB Information Request Only	1	0	1	0	2	0	1	4	1	0	0	0	***10***
Another Provider Information Request	1	0	1	0	0	0	0	1	0	0	0	0	***3***



Complaints to Health and Disability Commissioner involving District Health Boards

This report details the trends in complaints received by the HDC about DHBs between January and June 2019. The total number of complaints received about care provided by DHBs varies quarter to quarter.

Number of Complaints received in the last five years

	Jul - Dec 14	Jan - Jun 15	Jul - Dec 15	Jan - Jun 16	Jul - Dec 16	Jan - Jun 17	Jul - Dec 17	Jan - Jun 18	Jul - Dec 18	Average of last 4 6-month periods	Jan - Jun 19
Number of complaints	368	389	422	383	386	477	439	450	442	**452**	**427**

National Rate of complaints received in last five years by HDC[6]

	Jul–Dec 14	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17	Jan–Jun 18	Jul–Dec 18[2]	Average of last 4 6-month periods	Jan–Jun 19
Rate per 100,000 discharges	76.65	84.60	87.57	81.44	78.79	99.08	88.23	93.80	88.47	**92.40**	**88.02**

The rate of complaints remains similar to the previous six-month periods, with surgery being the most common service type complained about and misdiagnosis being the most common primary issue. There has been a slight increase in the number of complaints received by HDC about mental health services in the 2018/19 year, (20% to 23% of total in 2018/19). There are a number of factors that could be contributing to this small increase. These include a mental health workforce under significant pressure, and greater public awareness of mental health and addiction issues and service challenges — with significant attention generated by the Government's Inquiry into Mental Health and Addiction.

As can be seen in the table below, Canterbury DHB's complaint rate varies markedly over time. In the period Jan – Jun 2019, HDC received a total of 40[7] complaints about care provided by Canterbury District Health Board. CDHB Mental health services featured in 38.1% of complaints in Jan-Jun 2019.

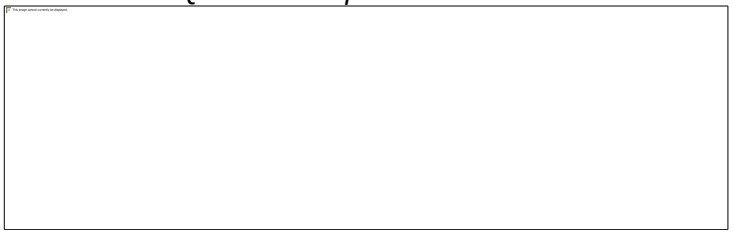
[6] Note: The HDC rates use a different denominator to the CDHB Complaints indicator.

[7] Provisional as of date of extraction (22 August 2019).

Number and rate of HDC complaints per total discharges[8] received in last five years for CDHB:

	Jul–Dec 14	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17	Jan–Jun 18	Jul–Dec 18[9]	Average of last 4 6-month periods	Jan–Jun 19
Complaints received	30	35	34	45	44	52	56	51	39	**50**	**40**
Rate per 100,000 discharges	53.46	63.91	59.64	81.95	76.99	91.79	95.29	90.33	67.21	**86.16**	**68.93**

Data for Last Quarter Compared to All



On review of all specific issues raised in complaints about Canterbury DHB, the most common issues were:

- Failure to communicate effectively with consumer (52.5%)
- Inadequate/inappropriate clinical treatment (35.0%)
- Disrespectful manner/attitude (22.5%)
- Inadequate/inappropriate examination/assessment (22.5%)
- Failure to communicate effectively with family (17.5%)

This is broadly similar to what was seen last period for Canterbury DHB.

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 & Allied Health	Clinical Advisor Update - Nursing	Clinical Advisor Update – Medical 2019 Winter Planning Update	Clinical Advisor Update - Allied Health (deferred) H&SS 18/19 Year Results	Clinical Advisor Update – Nursing	Clinical Advisor Update – Medical 2019 Winter Plan Outcomes
Presentations	Sleep Health Services in Canterbury	Burwood Campus Avoidable Admissions in General Surgery	Christchurch Campus – Children's Haematology & Oncology Centre (*CHOC*)	SMHS	Perioperative Nursing Ashburton Rural Health Services	New Treatments & Technologies Clinical Team Coordinators
Governance and Secretariat Issues						
Information Items	2019 Workplan	2019 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 2019 Workplan	2019 Workplan	2020 Tentative 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)