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, 30 May 2019 commencing at 9:00am

	Apologies		9.00am
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 4 April 2019		
3.	Carried Forward / Action List Items		
4.	Children's Haematology & Oncology Centre (*CHOC*) - Presentation	Pauline Clark	9.05-9.30am
5.	2019 Winter Planning Update	Pauline Clark	9.30-9.45am
6.	Hospital Service Monitoring Report: Medical/Surgical & Women's & Children's Health ESPIs Mental Health Older Persons, Orthopaedics & Rehabilitation Hospital Laboratories Rural Health Services	 Pauline Clark Pauline Clark Toni Gutschlag Dan Coward Kirsten Beynon Berni Marra Win McDonald	9.45-10.30am
7.	Clinical Advisor Update (Oral) • Medical	 Dr Sue Nightingale	10.30-10.40am
8.	Resolution to Exclude the Public		10.40am
ESTIMATED FINISH TIME – PUBLIC MEETING			**10.40am**
	Information Items: Quality & Patient Safety Indicators Level of Complaints 2019 Workplan		

NEXT MEETING: Thursday, 1 August 2019 at 9.00am

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
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	√	√				
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	**Canterbury West Coast Air Rescue Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air rescue and air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB. **CRL Energy Limited** – Managing Director CRL Energy Limited provides air quality testing and asbestos sampling and

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

	Heritage NZ – Subscribing Member Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the 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** – Board Member 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. **Liquid Media Operations Limited** – Shareholder Liquid Media is a start-up company which has a water/sewage treatment technology. **Maori Carbon Foundation Limited** – Chairman The Maori Carbon Foundation has been established to deliver environmental, social and economic benefits through the planting of permanent carbon forestry, to Maori and New Zealand landowners throughout the country. **Ngāti Ruanui Holdings** – Director Ngati Ruanui Holdings is the Investment and Economic Development Arm of Ngati Ruanui established to maximise profits in accordance with Te Runanga directions in Taranaki. **NZCF Carbon Planting Advisory Limited** – Director NZCF Carbon Planting Advisory Limited is a company that carries out the obligations in respect of planting and upskilling relating to the Maori Carbon Foundation Limited. **Oaro M Incorporation** – Member 'Oaro M' Incorporation was established in 1968. Over the past 46 years successive Boards have managed and maintained the whenua, located at 'Oaro M', Kaikōura, on behalf of its shareholders. Over time shareholders have requested the Board consider establishing an education grant in order to assist whānau with their educational aspirations. **Police Commissioners Māori Focus Forum** – Member The Commissioner of Police has a group of senior kaumatua and kuia who meet with him regularly to discuss issues of mutual interest and concern. Known as the Commissioner's Māori Focus Forum, the group helps guide policing strategy in regard to Māori and provides advice on issues of the moment. The Māori Focus Forum developed The Turning of the Tide with help from Police. The forum plays a governance role and helps oversee the strategy's implementation. **Pure Advantage** – Trustee Pure Advantage is comprised of business leaders who believe the private sector has an important role to play in creating a greener, wealthier New Zealand. It is a not-for-profit organisation that investigates and promotes opportunities for green growth. **QuakeCoRE** – Board Member QuakeCoRE is transforming the earthquake resilience of communities and

	societies through innovative world-class research, human capability development, and deep national and international collaborations. They are a Centre of Research Excellence (CoRE) funded by the New Zealand Tertiary Education Commission. **Rangitane Holdings Limited & Rangitane Investments Limited** - Chair/Director The Rangitāne Group has these two commercial entities which serve to develop the commercial potential of Rangitāne's settlement assets. A Board of Directors oversee the governance of the commercial entities, and are responsible for managing Crown lease properties and exploring commercial development opportunities to support the delivery of benefits to Rangitāne members. **SEED NZ Charitable Trust** – Chair and Trustee SEED is a company that works with community groups developing strategic plans. **Sustainable Seas NSC (National Science Challenge) Governance Board** – Member This is an independent Board that reports to the NIWA Board and operates under the Terms and Conditions specified in the Challenge Collaborative Agreement. The Board is responsible for appointing the Director, Science Leadership Team, Kāhui Māori, and Stakeholder Panel for projects within the Sustainable Seas NSC. The Board is also responsible for approving projects within the Research and Business Plan and for allocating funding. **Te Ohu Kai Moana** – Director Te Ohu Kai Moana is an organisation that works to advance Maori interests in the marine environment, including customary commercial fisheries, aquaculture and providing policy and fisheries management advice and recommendations to iwi and the wider Maori community. **Te Waka o Maui** – Independent Representative Te Waka o Maui is a Post Settlement Governance Entity. **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.
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. **Te Arawhiti, Office for Maori Crown Relations Governing Board, Ministry of Justice** – Ex-Officio Member Te Arawhiti, Ministry of Justice, are responsible for negotiating the settlement of historical Treaty of Waitangi claims, and the administration of the Marine and Coastal Area (Takutai Moana) Act 2011. They also advise and help claimant

	groups so they are ready to enter negotiations. **Chief Crown Treaty Negotiator for Ngai Tuhoe** Settlement negotiated. Deed signed and ratified. Legislation enacted. **Chief Crown Treaty Negotiator for Ngati Rangi** Settlement negotiated. Deed signed and ratified. Legislation awaiting enactment. **Chief Crown Treaty Negotiator, Tongariro National Park** Engagement with Iwi collective begins July 2018. **Chief Crown Treaty Negotiator for the Whanganui River** Settlement negotiated. Deed signed and ratified. Legislation enacted. **Chief Crown Negotiator & Advisor, Mt Egmont National Park Negotiations** High level agreement in principle reached. Aiming for deed of settlement end of 2018. **School of Social and Political Sciences, University of Canterbury** – Adjunct Professor Teach into graduate and post graduate programmes in political science, trade policy and diplomacy – pro bono appointment. **Te Urewera Governance Board** –Member The Te Urewera Act replaces the Te Urewera National Parks Act for the governance and management of Te Urewera. The purpose of the Act is to establish and preserve in perpetuity a legal identity and protected status for Te Urewera for its intrinsic worth, its distinctive natural and cultural values, the integrity of those values, and for its national importance. Inaugural term as a Crown appointment, re-appointed as a Ngai Tuhoe nominee. **University of Canterbury (*UC*) Council** – Council Member The University Council is responsible for the governance of UC and the appointment of the Vice-Chancellor. It sets UC's policies and approves degree, financial and capital matters, and monitors their implementation.

MINUTES – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE HOSPITAL ADVISORY COMMITTEE MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch,
on Thursday, 4 April 2019, commencing at 9.00am

PRESENT

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

APOLOGIES

An apology for absence was received and accepted from Trevor Read.

EXECUTIVE SUPPORT

David Meates (Chief Executive); Mary Gordon (Executive Director of Nursing); Jacqui Lunday-Johnstone (Executive Director of Allied Health, Scientific & Technical); Melissa Macfarlane (Team Lead, Planning & Performance); Kay Jenkins (Executive Assistant, Governance Support); and Anna Craw (Board Secretariat).

IN ATTENDANCE

Item 4

Helen Skinner, Chief of Service, Older Persons Health & Rehabilitation (OPH&R)
Sarah Hurring, Clinical Director, Older Persons Health Inpatient
Sally Nicholas, Operations Manager, OPH&R
Diana Gunn, Director of Nursing, OPH&R
Claire Pennington, Director of Allied Health, OPH&R
Jo Lilley, Quality Manager, OPH&R
Pip Hyde, Clinical Nurse Specialist, Older Persons Health

Item 5

Kathy Davenport, Service Manager General Surgery & Christchurch Outpatients

Item 6

Sally Nicholas, Operations Manager, OPH&R
Toni Gutschlag, General Manager, Specialist Mental Health Services
Kirsten Beynon, General Manager, Laboratories
Berni Marra, Manager, Ashburton Health Services
Win McDonald, Transition Programme Manager, Rural Health Services
Pauline Clark, General Manager, Medical/Surgical & Women's & Children's Health

Ta Mark Solomon opened the meeting with a karakia.

The Chair, Andrew Dickerson, acknowledged the horrific events of 15 March 2019. He advised that the Board, at its meeting on 21 March 2019, had acknowledged the outstanding response by our health system. Mr Dickerson further expressed his thanks to everyone involved.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register

- Ta Mark Solomon – addition – Governance Board (General Partnership Limited) Te Putahitanga o Te Waipounamu – Board Member
- Jo Kane – addition – Christchurch Resettlement Services

There were no other additions/alterations to the Interest Register.

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

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

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (04/19)
(Moved: Sally Buck/Seconded: Jan Edwards – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 31 January 2019 be approved and adopted as a true and correct record."

3. CARRIED FORWARD/ACTION ITEMS

The Committee noted the carried forward items.

4. BURWOOD CAMPUS (PRESENTATION)

Sally Nicholas, Operations Manager, Older Persons Health and Rehabilitation (*OPH&R*), introduced staff from Burwood Hospital who presented on OPH&R. Those in attendance and presenting were: Helen Skinner, Chief of Service, OPH&R; Sarah Hurring, Clinical Director, Older Persons Health Inpatient; Diana Gunn, Director of Nursing, OPH&R; Claire Pennington, Director of Allied Health, OPH&R; Jo Lilley, Quality Manager, OPH&R; and Pip Hyde, Clinical Nurse Specialist, Older Persons Health.

The presentation highlighted:

- The clinical nurse specialist liaison role within OPH&R
- Surgical Medicine – Older People Under Surgery (*OPUS*)
- Orthopaedic Medicine
- Fractured Neck of Femur (*NOF*) Pathway
- Quality Improvement
- Ongoing Plans
- Recent Presentations

It was noted that there is a lot of work being undertaken in the quality improvement space. Discussion took place around Serious Event Review (*SER*) processes.

The Chair thanked those in attendance for the informative presentation.

5. AVOIDABLE ADMISSIONS IN GENERAL SURGERY (PRESENTATION)

Kathy Davenport, Service Manager General Surgery & Christchurch Outpatients, presented on a new project which is in its infancy looking at reducing avoidable admissions in general surgery. The presentation outlined:

- Issues to be addressed and solved with regards to patient flow
- Project team meetings and discussions held to date
- Data analysis
- Decision by project group to focus initially on abscesses for maximum impact on patient flow
- Timelines going forward.

Discussion took place around General Surgery being a high performing department. Success of this initiative will further increase its already high performance rate.

Pauline Clark, General Manager, Medical/Surgical & Women's & Children's Health, noted that work being undertaken by General Surgery is proving inspirational to other services.

The Committee congratulated Ms Davenport on the new initiative.

6. H&SS MONITORING REPORT

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

General Managers spoke to their areas as follows:

Specialist Mental Health Services (*SMHS*) – Toni Gutschlag, General Manager

- SMHS is progressing in the right direction from a safety, wellbeing, and acute capacity crisis perspective.
- Have had 3rd visit from Worksafe. No issues or concerns have been raised. Worksafe have indicated they would like to schedule a 4th visit, potentially the last.
- SMHS has seen an increase in calls as a result of the mosque attacks on 15 March 2019.
- Intellectual Disability Service (*IDS*) – continues to be challenging. Facilities expansion is on track. Management of one individual continues to be a struggle. Currently five staff are off work on ACC as a result of workplace assaults.

  As a result of a letter of concern from senior clinicians last year, the MoH established working groups to look at the IDS service model and other issues. CDHB has been working closely with the MoH on a weekly basis regarding safety and sustainability issues, and a favourable response was anticipated in respect to additional funding. However, notification was received last week that this would not be the case, with the expectation that services continue to be provided within current funding.

  There is a $1M+ shortfall of funding for this service.

There was a query around the plan for ongoing wellbeing as a result of the mosque attacks. It was noted that a draft plan is due for completion later today. This piece of work is being led by CDHB, with other parties including Police, Ministry of Education, Christchurch City Council, Oranga Tamariki, St Johns, Ngai Tahu, and Ministry of Social Development. The draft plan will form the basis of a national plan. The importance of a joined up communications programme was stressed, to ensure that a cohesive Christchurch/Canterbury story is told. A copy of the draft plan will be circulated to Committee members when available.

There was discussion around money raised as a result of the mosque attacks and how this would be spent. It was noted that the Department of Internal Affairs is taking the lead on this.

There was a query around child mental health services following the mosque attacks. It was advised that additional work is already underway in this area. This is being led by Mana Ake.

Older Persons, Orthopaedics & Rehabilitation Service – Sally Nicholas, Operations Manager

- Took the report as read. Nothing further to add.

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

- Elizabeth Street Day Centre opened on Monday.
- Work continues on the Frail Older Persons Pathway.
- Work being undertaken in the acute care space.

Rural Health Services – Win McDonald, Transition Programme Manager

- Weekly / fortnightly meetings are occurring with General Practices.
- Increased acuity in comorbidities presenting in end of life patients. Not unexpected, but requiring flexing to meet demand.
- First workshop has been held in relation to the Oxford, Hurunui, Rangiora Observation Unit and what this may look like. Work is ongoing.

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

- Yesterday, site power blackout testing was undertaken on the Parkside Building, Riverside & Clinical Services Building, Oncology, and Food Services. This was part of a regular six monthly blackout screening programme. Initially, testing in Parkside West was unsuccessful, taking a couple of hours before a work around solution could be achieved. This directly impacted on theatre use, with the loss of surgical/theatre time during this period. It is expected to be a couple of months before permanent repairs can be made. This poses a heightened risk to the DHB. Weekly black out testing is being considered for Parkside West until the permanent solution is achieved. This incident further highlights the increasing fragility of the infrastructure environment.
- Easter / ANZAC period. Acute demand is expected to be large. Work is underway with primary health colleagues to ensure a joined up response.
- Notice of RMO strike action before Easter has been received. Whilst this excludes Canterbury RMOs, strike action will still impact Canterbury.

ESPIs

The Committee noted that in light of recent events, ESPIs have not been at the forefront. It was acknowledged that CDHB will have an ESPI issue for some time into the future.

Resolution (05/19)

(Moved: Ta Mark Solomon/Seconded: Sally Buck – carried)

"That the Committee:

i. notes the Hospital Advisory Committee Activity Report."

7. CLINICAL ADVISOR UPDATE – NURSING (ORAL)

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

- Nursing MECA settlement – meeting requirements for additional positions to be filled. Achieved by the end of February 2019.
- Increase in time taken to recruit for replacements positions – a particular issue for the Burwood Spinal Unit. Also evident within SMHS.
- Competency Assessment Program (*CAP*).
- Second registered nurse prescriber now in place in Paediatrics.
- Brenda Close, new Director of Nursing (*DON*) for Ashburton Health Services. Brings a wealth of experience in rural health, hospital facilities and access for indigenous people.
- Patient track developments.

8. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (06/19)
(Moved: Dr Rochelle Phipps/Seconded: David Morrell – carried)

"That the Committee:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of the minutes of the public excluded meeting of 31 January 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

- 2019 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 11.24am.

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 30 MAY 2019

DATE		ISSUE / ACTION	REFERRED TO	STATUS

There are no carried forward items at this time

Shared care is fair care:

Our national model for child cancer services delivers equitable and high quality care

Dr Amanda Lyver

Paediatric Oncologist

Chair, National Child Cancer Network

Kirsten Ballantine

Analyst, Coordinator New Zealand Children's Cancer Registry

National Child Cancer Network NZ
Linking Care / Sharing Knowledge / Advancing Best Practice

What is the NZCCR

- Registry development led by Paediatric Oncologists to meet their data needs, now and into the future

- To collect comprehensive data pertaining to childhood cancers and their treatment
- To support a wide range of child cancer research projects
- To provide timely information for national and local service delivery planning
- Uses the ICCC-3 (International Childhood Cancer Classification System, consistent with other children's cancer registries) and records non-malignant CNS tumours
- Is fully integrated with the Late Effects Assesssment Programme (LEAP) database used for planning and monitoring patients' long term follow up care

National Child Cancer Network NZ
Linking Care / Sharing Knowledge / Advancing Best Practice

Eligibility criteria

Included in our child cancer statistics (i.e. incidence and survival recording)

- children under the age of 15
- diagnosed in New Zealand
- with a cancer meeting ICCC criteria
- referred to a specialist paediatric oncology centre

National Child Cancer Network NZ
Linking Care / Sharing Knowledge / Advancing Best Practice

What do we hold

➢ **Demographic Information**

- Name, NHI (unique patient identifier), date of birth, gender, ethnicity, area of residence, name of parents, name of hospitals / doctors involved in the child's care

➢ **Disease-specific information**

- Date of diagnosis, type of cancer & location (by ICD-O-3), stage and risk information, laterality, basis of diagnosis, predisposing conditions and other relevant medical history

➢ **Initial treatment Information**

- Treatment protocol followed, date of start of treatment, clinical trial participation

➢ **Additional information (added at the end of treatment / entering LEAP programme)**

- Details of treatment dosages and start/end dates (chemotherapy, radiotherapy, surgery, transplant etc), disease and treatment-related effects, surveillance results, planned surveillance

➢ **Also…**

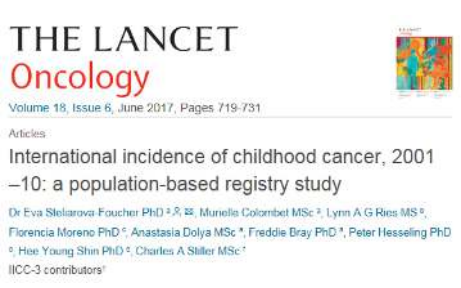
- Second malignancies, relapse, date and cause of death if applicable

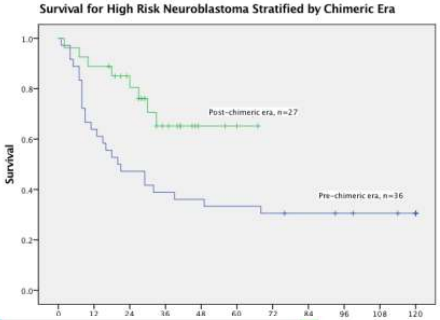
National Child Cancer Network NZ
Linking Care / Sharing Knowledge / Advancing Best Practice

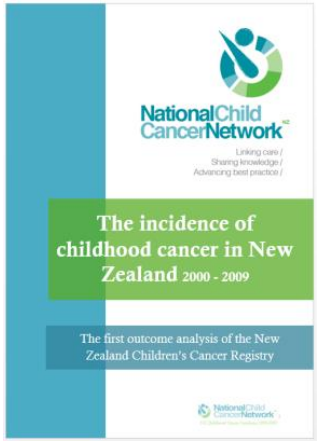
NZCCR Outputs

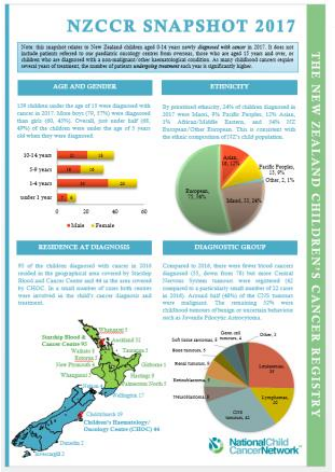
- Conference presentations
- Journal publications
- Collaborations with other registries
- Data to support NCCN advocacy
- Datasets for other researchers
- Updates to stakeholders
- Reports

(see www.childcancernetwork.org.nz
for further examples)



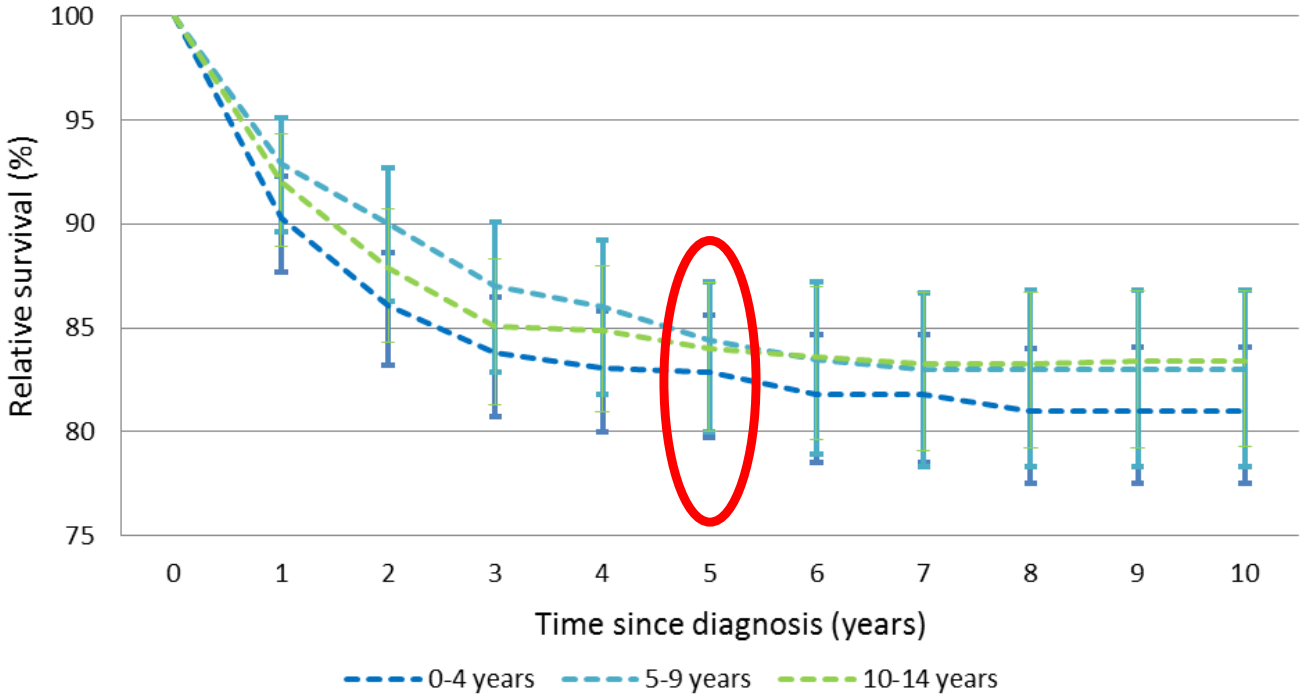






Five-year survival

1409 NZ children diagnosed with cancer from 2005-2014



New Zealand 2005-2014	84%
Australia 2004-2013	84%
Switzerland 2004-2013	88%
Canada 2004-2008	83%
Germany 2005-2014	85%
US 2007-2013	83%

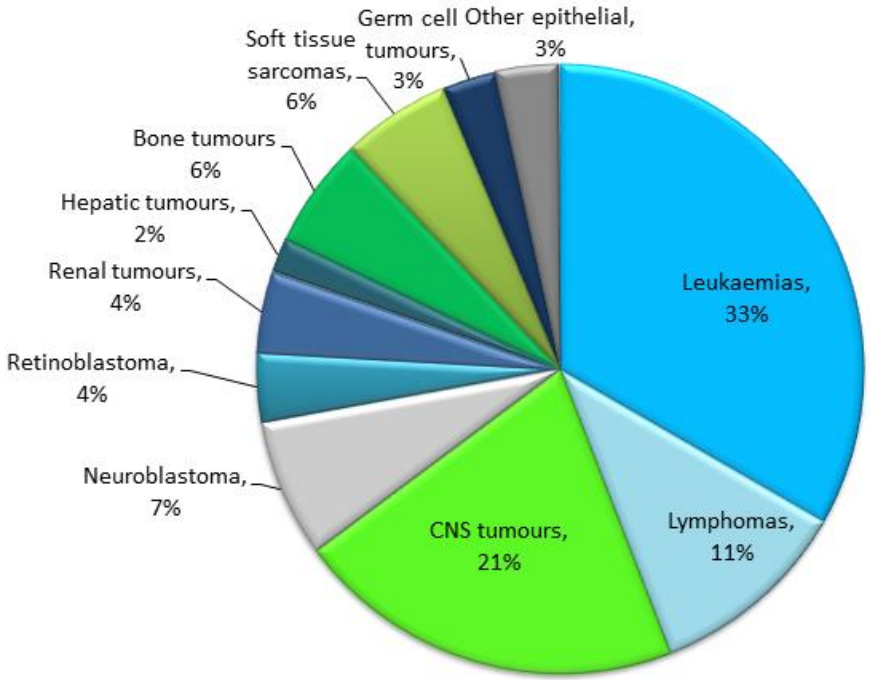
Ballantine, K. & the NZCCR Working Group (2017). *Child cancer survival in New Zealand 2005-2014: A report from the New Zealand Children's Cancer Registry*. Auckland: National Child Cancer Network.

National Child Cancer Network NZ
Linking Care / Sharing Knowledge / Advancing Best Practice

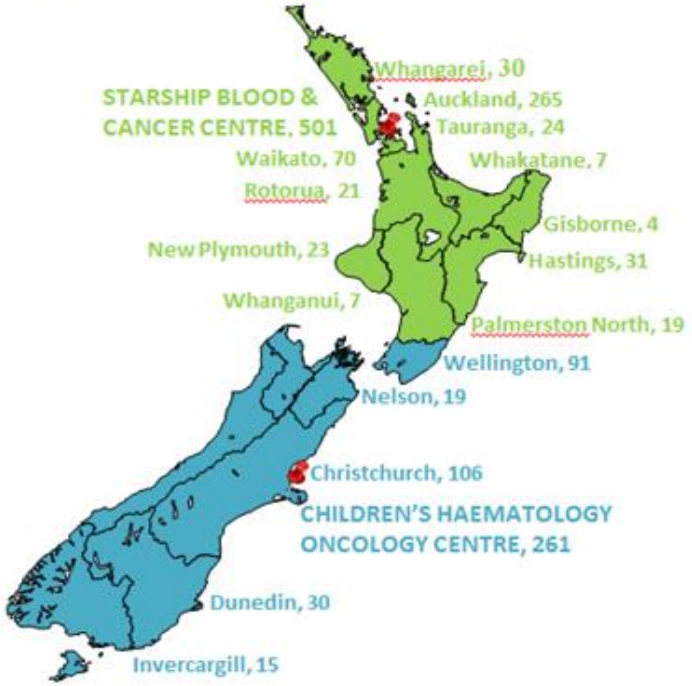
Latest analysis:

764 NZ children diagnosed with cancer from 2010-2014
(with follow-up to 31 December 2017)

NZ childhood cancer by diagnostic group



New childhood cancers diagnosed by shared care centre



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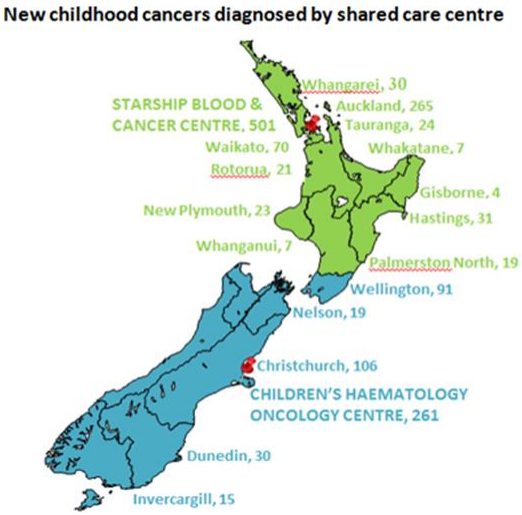
What is Shared Care?

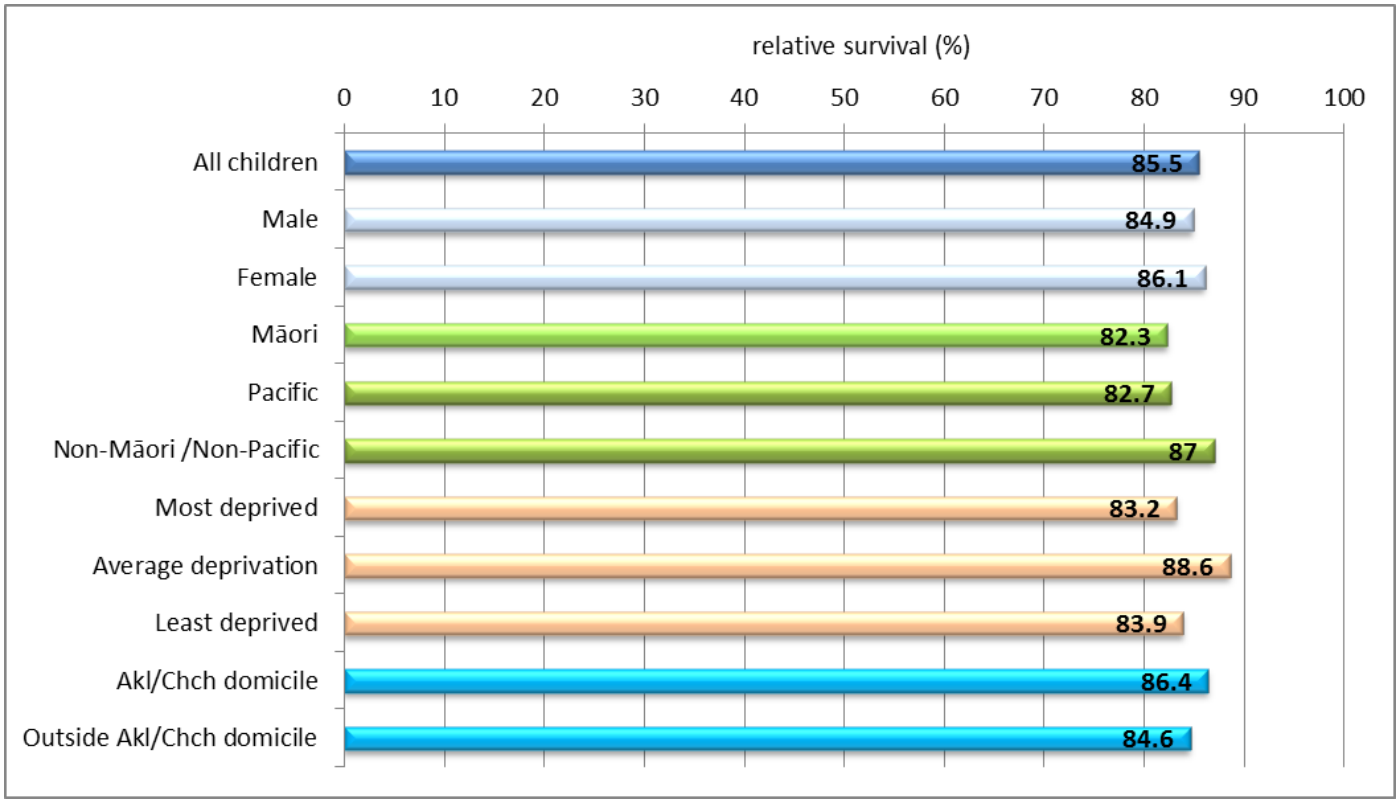
- Care provided with a DHB that is geographically remote from the lead paediatric oncology specialist site.
- The specialist oncology service is responsible for advising on and co-ordinating the initial diagnostic work-up, provision of intensive therapy and overall management of the child's care
- Components of the child's care can be provided closer to the child's home where there are appropriately trained staff and adequate facilities to ensure quality and safety



Latest analysis (ctd):

764 children diagnosed with cancer from 2010-2014
(with follow-up to 31 December 2017)

Three-year survival by demographic indicators



Sex

Ethnicity

Socioeconomic status

Domicile

NB: All 95% confidence intervals overlap

How has this been achieved?

- National Child Cancer Plan (Ministry of Health, 2010)
- National Child Cancer Network
  - Dedicated National Clinical Lead, Programme Manager and Data Manager
  - Financially supported by Ministry of Health
- Governance
  - Reference Group of sector representatives and Ministry of Health Cancer Team
- Established working groups dealing with specific issues
- Collaborative activity with NGOs
  - Aspects of service delivery and research driven and partially funded by NGOs
- Data capture by NZCCR cross referenced with NZCR, regularly reported and available for research activity

National Child Cancer Network NZ
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How has this been achieved? (ctd)

- Nationally consistent protocols and guidelines
  - Evidence-based patient care which minimises variability
- Trials-driven care
  - Rigorously audited COG membership
  - Formal affiliations with other international trials organisations
- Shared care model
  - Two specialist cancer centres and 14 shared care centres with agreed responsibilities and standards of delivery
    - Who does what, to whom, when and where, and who pays
  - Monitored on a three-year cycle which results in agreed service agreements between the partners

National Child Cancer Network NZ
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Summary

- Child cancer survival in NZ is comparable with our usual benchmark health systems
- There is no difference in survival for the usually accepted differentiators of ethnicity, urban/rural, socioeconomic status
- Child cancer offers a potential model for other specialty services

"Treatment as close to home as safely possible"

National Child Cancer Network NZ
Linking Care / Sharing Knowledge / Advancing Best Practice

2019 WINTER PLANNING UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

SOURCE: **Hospital and Specialist Services**

DATE: **30 May 2019**

Report Status – For:	Decision	Noting	☑	Information

1. ORIGIN OF THE REPORT

This report has been prepared to provide the Committee with an overview of 2019 Hospital and Specialist Services winter planning for the 2019 winter.

2. RECOMMENDATION

That the Committee:

i. notes the 2019 Winter Planning Update.

3. SUMMARY

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

Lessons learned from 2017 and 2018 have been embedded into 'business as usual' practice year round.

In 2019 key winter flow enablers which have not previously been undertaken include:

- Emergency Department Front Of House Trial – with investment in additional Senior Medical and Nursing Staff at times where volumes are 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

- Predicted demand during winter 2019 will exceed available beds.
- We will need to do all the positive things we have done in previous years, plus more.
- Flow is important. All/every decision made has to be coordinated across a Team, a Service, a Cluster and the System, with promotion of flow central to decision making.
- We enter winter with a community which has reduced resilience given recent and not so recent events. Hospital and Health System staff are part of the community and not immune from health and wellbeing challenges.
- Our focus remains on each Team delivering effective and timely care. This forms the foundation for collaborating with other Services. As well as partnering with Hospital and Specialist based Teams there is also strong engagement with Primary Health. This includes, for example, the Health Emergency Group (*HEG*) where pandemic planning across Primary Care, Community and Public Health and Emergency Management Teams is presented. A

sector pandemic influenza response framework, based on Ministry of Health (*MoH*) guidance is in draft.

- Availability of an appropriately skilled workforce is a key enabler of timely patient flow. Inputs into this include:
  - Appointments to winter flex roles for Nursing, Allied Health, Hospital Aides and Admin Support roles. Recruitment Specialists are partnering with Hiring Managers to achieve this.
  - Building capacity in Intensive Care and Progressive and High Dependency Care Units to enable the Christchurch Campus to flex during periods of peak demand. This includes working with other District Health Boards in the South Island to optimize options.
  - Continuing refinement of forecasting tools and visibility of dashboards in support of clinical and operational decision making that is best for patients and for staff.
- The aim is to ensure The Canterbury Health System is able to treat everyone, not run out of beds in Hospital and achieving this does not come at the cost of the health and wellbeing of those involved in delivering care.
- This winter at all times we will need 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.

5. CONCLUSION

There is recognition across the system of the predicted high demand for health services this winter and concern regarding the system's ability to continue to deliver.

There are days where demand for Hospital beds is forecast 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 are in place.

Reflection on performance feeds into regular short sessions aimed at achieving incremental performance gains, whilst keeping the patient and staff at the centre of all decision making.

Report prepared by:	Pauline Clark, General Manager, Christchurch Campus
Report approved for release by:	Carolyn Gullery, 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: **30 May 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

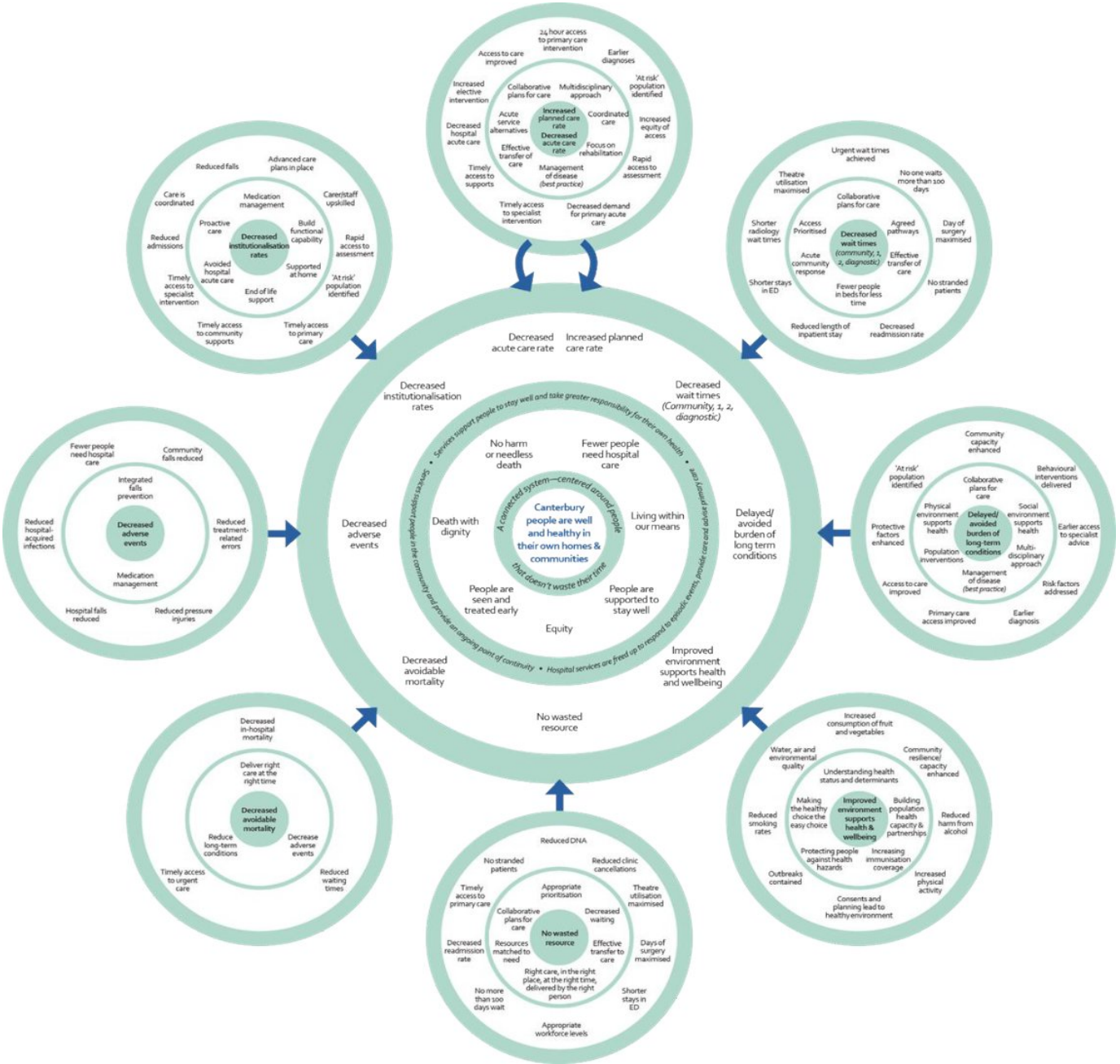
Appendix 1: Hospital Advisory Committee Activity Report – May 2019

Report prepared by: General Managers, Hospital and Specialist Services

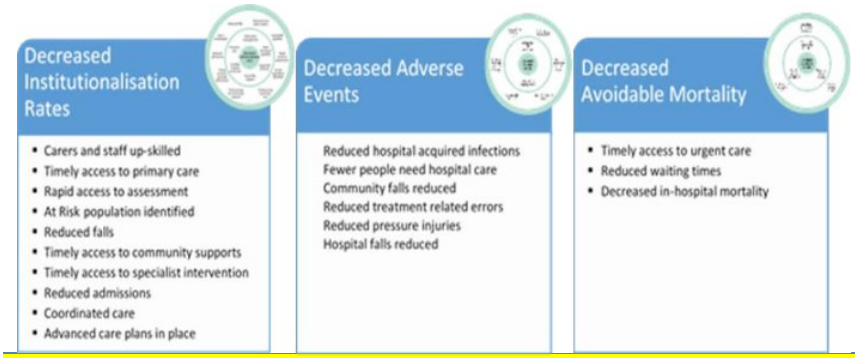
Report approved for release by: Justine White, Executive Director, Finance & Corporate Services

Hospital Advisory Committee

Activity Report



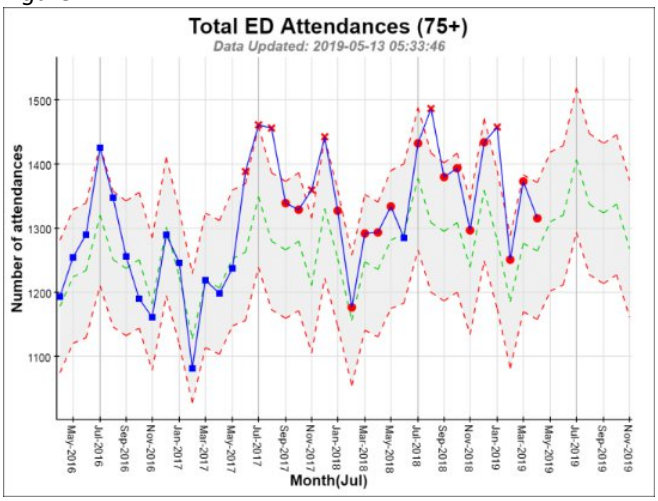
May 2019



Frail Older Persons' Pathway

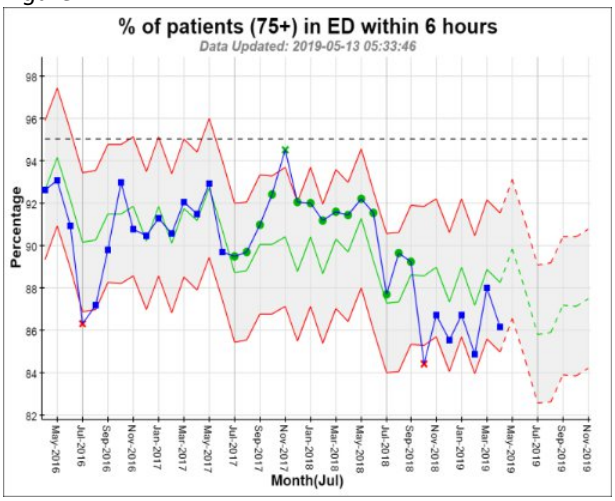
Outcome and Strategy Indicators

Figure 1.1



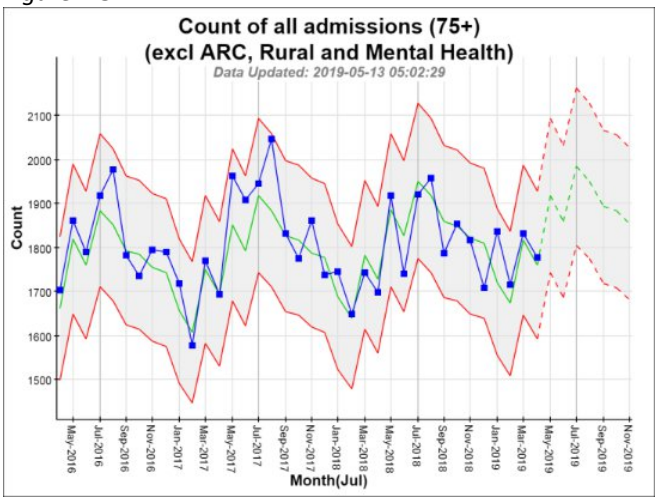
Total ED attendances of people over 75 has increased at a higher rate than the established trend.

Figure1.2



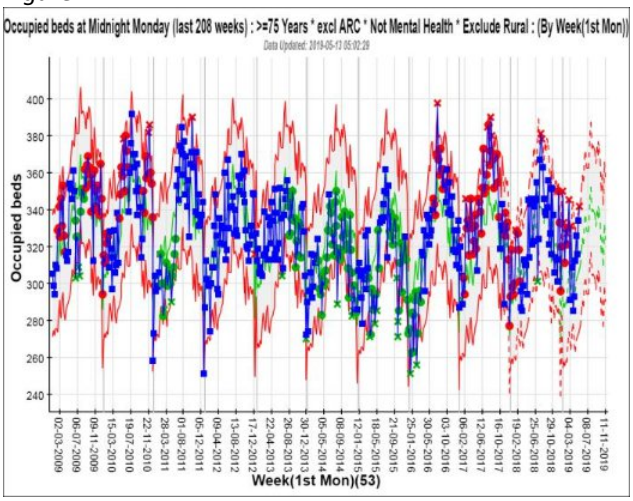
The apparent degradation in performance coincides with the transition from patient management system to another. While it does not appear that this relates to a real change in patient experience it is important that the data reported reflect what is really happening. Work is occurring to ascertain the cause and, if appropriate, remedy it.

Figure 1.3



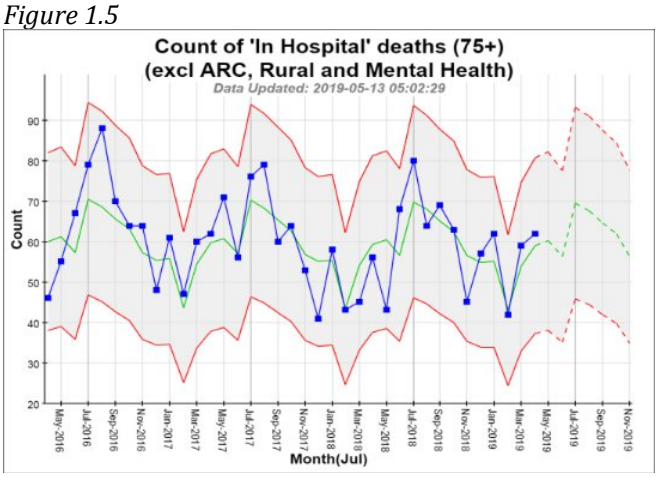
The count of all admissions for people 75 years and over continues to increase consistent with the established trend

Figure 1.4



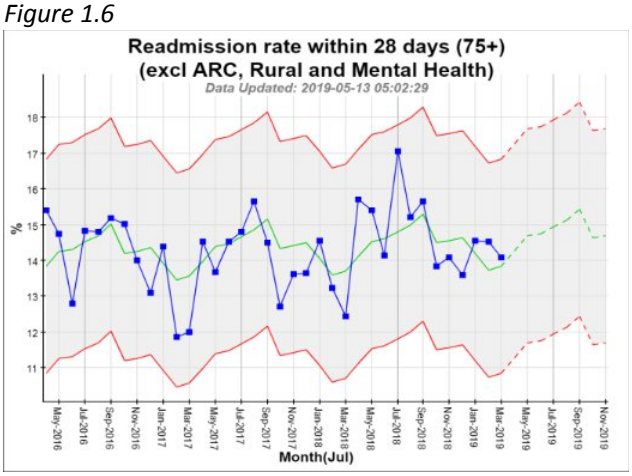
During the first three months of 2019 more beds were occupied that forecast. Since then occupied bed numbers have regularly been within the forecast range.

Figure 1.5



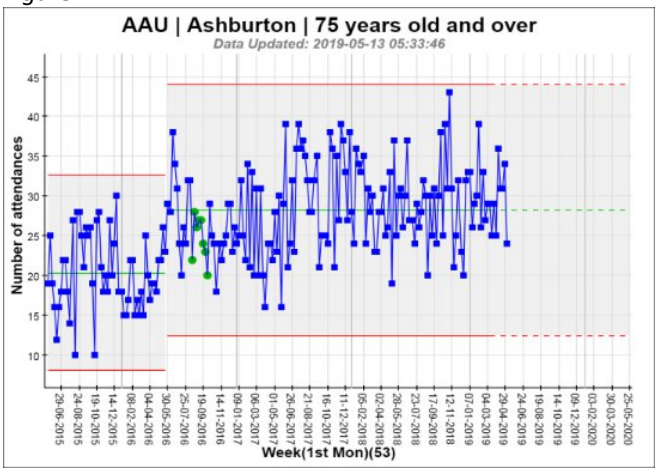
The number of in hospital deaths is within the expected range. The established trend of reducing rates of in hospital mortality continues.

Figure 1.6



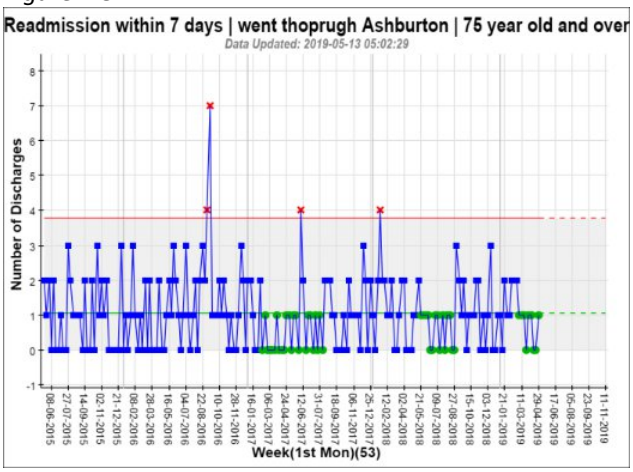
The readmission measure (balancing metric) for people aged 75 years and over continues to be within the expected range.

Figure 1.7



Ashburton Emergency Department attendances for this age group, whilst higher than previous years, is showing a more consistent level of presentations.

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

Christchurch Hospital Response to the Mosque attacks

The Christchurch Mosques attacks were one of the largest mass shootings in the world and because of the unique geographical circumstances Christchurch Hospital was the main centre for trauma care for the emergency response and the subsequent surgery. There is no precedent locally for managing 48 people with gun-shot wounds in one hospital and it is unusual even in overseas locales where the injured are usually spread over several large trauma centres. Fortunately for those who were brought into Christchurch Hospital, we could deliver the full suite of care from resuscitation to surgery and intensive care. The number of children injured placed particular pressure on the teams. Some key facts relating to this response are:

- Canterbury DHB had to refocus a busy hospital with existing physical constraints (Emergency Department, theatres, Intensive Care and ward beds) to meet the need of a mass casualty event of a scale and type not seen in New Zealand previously.
- Theatres ran continuously. Surgeons of almost all specialties, anaesthetists and theatre staff were called in and worked the Friday night, Saturday and Sunday.

- In addition staff from every area went above and beyond to ensure those providing direct care to patients were well supported. This includes our orderly, security, administrative, cleaning and WellFood staff, along with nursing and allied health teams.
- Twelve acute theatres operated all Friday night 15 March and throughout Saturday with seven acute theatres operating on Sunday.
- During and following the immediate response, planned surgery was deferred to enable timely management of acute work.
- As at 29 April, 83 theatre events have occurred. Patients from the mosque attack have spent a total of over 9,500 minutes in theatre. This is equivalent to more than six and a half continuous days.
- Our consumables and clinical supplies were been utilised at two to three times the usual rate and our warehouse staff were on deck all weekend to support the hospital teams.
- The Intensive Care Unit did not have sufficient capacity to take all of the patients needing its care. Some patients were moved to other wards and additional staff allocated to support.
- Canterbury had to transfer two stable existing patients for intensive care support at Capital and Coast DHB. A four-year old child was transferred to Starship after stabilisation. Subsequently her father was transferred to Auckland, after four operations, to be close to his daughter.
- Patients from other districts who would be likely to require intensive care were diverted away from Christchurch. This included diverting acute spinal work to Counties Manukau
- As at 29 April patients have spent 3,053 hours in the intensive care unit.
- Ward patients were moved and reallocated to allow cohorting of Mosque attack patients in key wards to minimise staff transit time.
- Maternity patients were recommended to go to primary birthing units wherever possible.
- Lock down of hospital facilities meant staff were unable to leave and patients unable to attend so Emergency Department patients were diverted to urgent care facilities, particularly the 24 Hour Surgery that was able to staff up and manage the additional load over the Friday and the weekend.
- Social work staff continue to play key roles, and a Social Worker was allocated to each patient as they arrived in our Emergency Department. Specialist Mental Health staff were deployed on Saturday to support the families and worked throughout the weekend.
- On discharge the patients are receiving a wraparound package of care for what is likely to be a long haul recovery or in a number of cases permanent disability. Family members are also requiring support.
- The decision was made to manage the 50 deceased at the Christchurch Hospital mortuary including providing Computerised Tomography scans of all deceased before the end of the weekend. This was undertaken to shorten the time to complete post mortems so families could have their loved ones back as quickly as possible.
- Before Monday, Mana Ake and the School based Mental Health Team had worked with Education to determine which schools would need the most intensive support and guidance for school staff on how to respond was on the Leading Lights website.

Our Staff: We have been providing comprehensive support to our people in the wake of the 15 March events.

Clot retrieval service continues to develop

Clot retrieval has dramatically changed the outlook for stroke patients with large clots. Without clot retrieval there is an 80-90% risk of death or disability. With clot retrieval treatment around 50% of treated patients are independent at three months. Some patients have been able to return home the next day, avoiding an extensive stay in the acute hospital and the requirement for ongoing rehabilitation or a lifetime of disability. Since the previous update, just over a year ago, the clot retrieval service has continued to develop.

Up until the past year clot retrieval was only available to people who had their strokes in either Christchurch, Auckland or Wellington. However during the past year advanced computerised tomography techniques have been introduced on the West Coast. This means that patients from the West Coast can now be considered for clot retrieval. So far three patients from the West Coast have received clot retrieval therapy in Christchurch following diagnosis on the West Coast. Other South Island District Health Boards continue to work to evaluate the opportunities for their populations which will be facilitated by the likely implementation of the South Island stroke telemedicine network.

In total 136 clot retrieval procedures have now been carried out. In 85% of these cases the clots have been successfully retrieved. While patients receiving this therapy would previously have been the group most severely affected 32% of patients have been able to be discharged home without the requirement for rehabilitation with 49% of patients going on to receive rehabilitation.

Within the next couple of months a fourth radiologist will join the roster, meaning the service will be provided 24 hours a day throughout the week, meaning that our therapeutic response will no longer differ depending on when a stroke occurs. The ongoing development of our capacity to provide this service means that 68 of these procedures were carried out in 2018 and 33 have been provided already in 2019.

Using data to change our systems – fine tuning the use of Early Warning Scores

Early Warning Scores amalgamate information from a range of observations carried out by health professionals to indicate that a patient's condition is deteriorating. Canterbury has had an Early Warning Score System in place for many years and previous reports have provided updates on the transition from our existing score to the National Early Warning Score as a part of the Health Quality and Safety Commission's deteriorating patient programme. This transition occurred in September 2017.

As a part of reviewing this implementation analysis of data was carried out to test whether responses within Canterbury District Health Board hospitals was reaching target. Discussion with health practitioners using the system quickly showed that red zone scores were occurring so often that teams did not have the capacity to respond to them. Analysis of the data associated with 4,500 patients over a six month period showed that while the number of red scores occurring had increased markedly there had not been an associated shift in mortality. 80 percent of these red scores were associated with a single measure trigger – rather than a combination of measures. In contrast the data clearly show that people with high aggregate scores, approximately 0.2% of those we record observations for, have a much worse outcome The single trigger responses are in place as a back-stop for health systems that are using paper based scoring, whereas within Canterbury an electronic system is in place and is reliably able to collect and calculate these scores. Having such a high number of red scores that are not associated with mortality risks "alarm fatigue" which leads to alarms being responded to slowly when they are actually important.

Having a system in place that allows analysis of a large amount of data, informing effective clinical governance has enabled us to work with Health Quality and Safety Commission to fine tune the way that Early Warning Scores are used, ensuring that the patients that need urgent attention to manage deterioration receive it.

The updated New Zealand Early Warning Score is being implemented in mid-May 2019 and will be monitored to ensure that we are not introducing harm. Future plans include using these data in other quality improvements programmes such as opioid safety and infection prevention and control.

Use of Personalised Care Plans by Allied Health on the Christchurch Campus.

Research has shown that shared care planning; involving the patients in their health journey, and use of joint goal setting improves health outcomes across a varieties of areas and conditions. It is also recognised that a single source of information reduces duplication, resource and confusion. Our services have been asking for a solution to support visibility of information at the point of 'transfer of care' between services. A collective project team has been developing the solution in partnership with the Canterbury Clinical Network and Orion Health to develop the Personalised Care Plan in Canterbury.

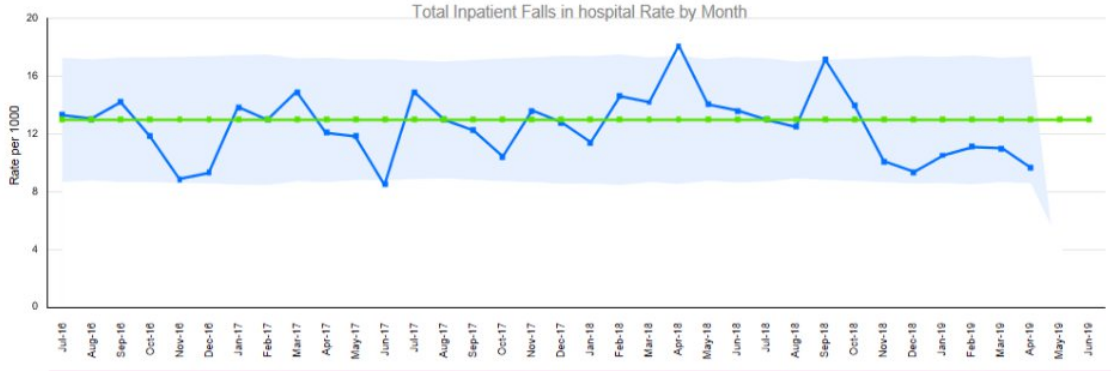
These are care plans that live in Health Connect South and are available throughout Canterbury and the majority of South Island. General Practice teams and District Health Board staff can see and use these for patients who require services that involve providers across different parts of the system. The Personalised Care Plan is a patient-centered plan which documents patient concerns, what they want to achieve with regard to their health or general wellbeing, and actions the patient and their care team are going to take to achieve these goals. The aim is to facilitate a collaborative partnership between the patient and their care teams; to coordinate rehabilitation around their needs and priorities, and to make the goals and activities visible to other clinical teams. We believe we can reduce the duplication and confusion of information, release clinical care time and provide a seamless transfer of consistent information with a single point of access.

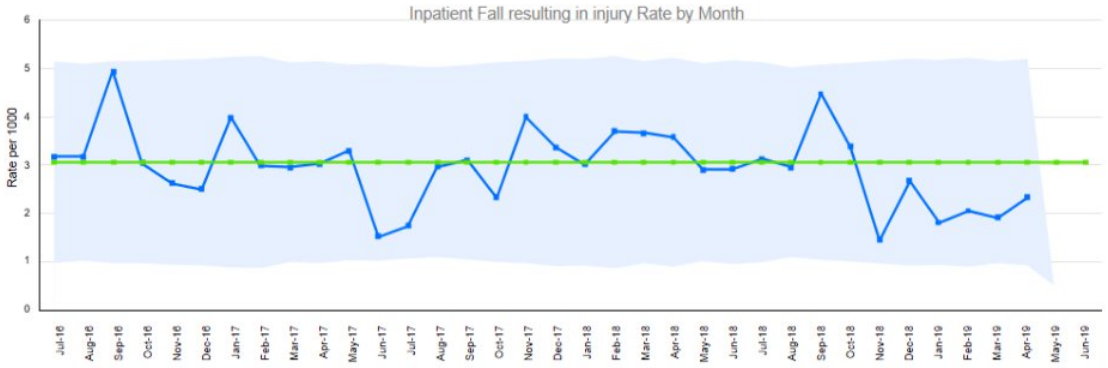
Currently the plan is in use by the Community Rehabilitation Enablement and Support Team General Practice and Allied Health. Over the coming months the use of the plan will be expanded to other services and teams across the health system. Burwood Allied Health teams commenced a graded implementation of use at the point of discharge from services from the beginning of March and Allied Health within the acute services, will begin to use the plan from 1st April.

To date 1,547 people in Canterbury have a Personalised Care Plan and we anticipate this number will increase as more services begin to use the plans. Baseline Measures have been taken and benefits for both staff and Patients will be assessed and improvements made.

Older Persons Health & Rehabilitation (OPH&R)

We are keeping a focus on our falls. The strategies as part of safe recovery programme have been focusing on what activity we can improve during night shift, such as the use of night lights in the patient bedrooms and ensuites. As well as how we work as a team on admission. New Admissions are (where possible), cohort in close proximity to the pod where the nurses will be stationed at night. Focus closer attention for the first few days. We ensure new arrivals go into a room which has sensors in use. We continue conversations about falls prevention in various clinical settings across the hospital. This includes conversations between, and within teams that include medical, nursing and allied health.

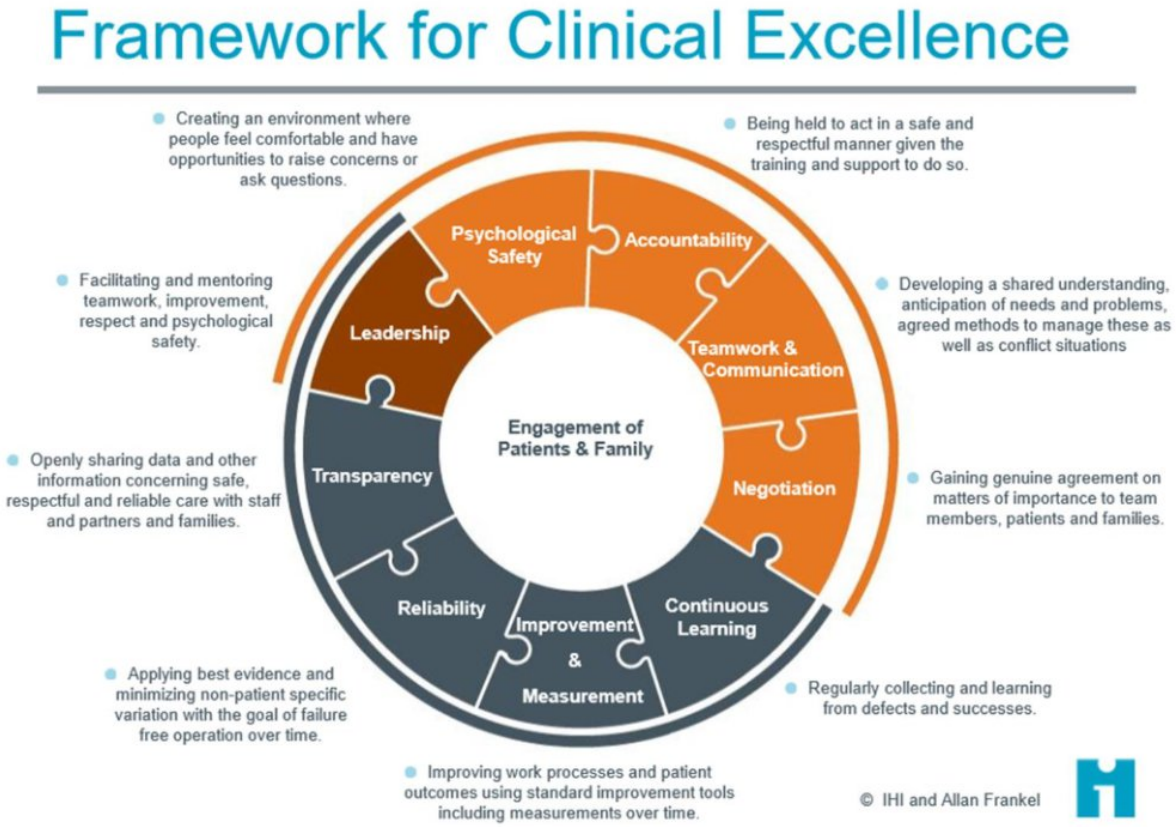




Intentional rounding education has been completed in all wards. All wards are now embedding this into their practice on all shifts and a focus currently surrounds continence. This is one of the causes for falls to occur when mobilising for toileting. To reduce this we are highlighting that intentional rounding includes toileting and holds an importance in the reduction of falls.

Medication errors is a current focus of the OPH&R Serious Event Review group and are finding ways to raise the profile of the importance of medication safety, particularly wrong drug; wrong dose and wrong patient. Working with the New Zealand Nursing Organisation (NZNO), the group aim to create a positive learning culture for the learnings behind the error within OPH&R. A focus on behaviour and culture across all levels of the division to manage and learn from of preventable errors.

In addition is the recent joining of Senior Pharmacist and Quality Facilitator in conjunction with existing Nurse Educator to the CDHB Fluid and Medication Manual Committee. We are using the framework for clinical excellence to support our change.



The first Burwood Hospital Transfusion Focus Group meeting was held in April 2019. This is a response from the Medical/Quality OPH&R partnership audit of appropriate prescribing and administration of blood over a 6 month period across the OPH wards.

The first meeting developed the Terms of Reference with the aim to meet quarterly for information sharing and updates around the management of the blood fridge, transfusion safety updates and New Zealand Blood Service requirements.

What this looks like in application, utilising a whole of system approach towards incident management where inter-organisational review will produce the greatest learnings with the greatest benefit to patients and safe practice, members of the group most appropriate will convene between times in needed to response to specific situations. The group will be a primary gateway to communication to the right people at the right time where required across the Burwood Campus. Within the group, the plan is to establish a professional network.

Reporting into the OPH&R Clinical Governance Group, the Transfusion Focus Group can also escalate to the CDHB Hospital Transfusion Committee (HTC) any findings outside divisional control and will inform the CDHB HTC where themes may emerge that may have potential implications outside of the division.

Membership includes:

- Charge Nurse Managers (CNM)s from the OPH wards that transfuse the least and the most
- Nurse Educator (NE) across OPH&R, NEs from Spinal and Orthopaedics
- Operating Theatre CNS and Anaesthetic Technician
- Quality Facilitator
- Quality OPH&R Manager (Chair)

- Orderly Manager
- New Zealand Blood Service Christchurch Blood Bank Team Leader
- Quality Associate
- Transfusion Nurse Specialist

These activities are key to ensuring the right clinical outcome for those in our care, which adds with our flow through reducing the incidents and subsequent readmission, bed days and length of stay impacts these quality indicators have on our frail elderly.

Ashburton Hospital

The weekly Older Persons Health (OPH) community interdisciplinary meeting continues to report positive outcomes as the expertise of specialist OPH, local gerontology nursing, district nursing, pharmacy and allied health workforce discuss care plans and next steps for older persons requiring complex care. Previous focus had been on patients waiting on discharge from the rehabilitation ward in Ashburton hospital, the team are building capacity and focus patients living in or returning to our community. Our next step is including practice nurse representation in the meetings and ensuring a personalised care plan in place.

Working with the Manawa team, the Director of Nursing is progressing a plan to host an intake for Gerontology Accelerated Programme in Ashburton. Provided in conjunction with a Post Graduate Certificate paper in Gerontology, this programme is focused on advancing gerontology clinical practice through clinical rotations over a 12 month period. Our intention is have this implemented out of Ashburton semester 1 2020. The intent is to build OPH specialisation across Ashburton, and will not be limited to the hospital but building capacity across the Ashburton health system.

Rural Health Academic Centre Ashburton (RHACA)

With the above information the question could be raised if we have the correct medical model of care, designed and implemented late in 2015. In partnership with RHACA, a review undertaken to explore the Ashburton medical model compared to the previous model that included specialist general surgeons, physicians, anaesthetists and the alignment of this model to the challenges faced in rural health delivery was presented. The success of the current model is highlighted in the summary of these findings as outlined below and we are mindful of maintaining this model as we progress the next steps.

Rural hospitals throughout New Zealand and internationally face difficult challenges related to workforce retention and recruitment, and relevant training for a generalist breadth of presentations alongside infrequent high acuity presentations to be managed with few staff.

In a large literature review, a rural generalist model was found to be most effective and suitable model for delivery of health services to rural Australia. Benefits of generalist model of care on health services includes; bridging primary care and tertiary care, being responsive to local context and leading in innovations such as videoconferencing, and enhanced inter professional education. Rural community hospitals have been shown to provide equivalently effective and efficient care, with improved patient experiences compared to larger hospitals.

The research sought to better understand and document the experience of Ashburton Hospital in strategically repositioning its medical model of care from a secondary specialist service-oriented hospital to a two tiered rural generalist training-oriented hospital (the only 2-tiered model in NZ) over the 10 years from 2008 to 2017, and to further identify key points of learning and challenges for rural hospitals facing similar challenges.

Summary key indicators comparing before and after transition included:

- Similar numbers of medical staff (15 vs 14) but fewer Senior Medical Officer full time equivalent (FTE) and more RMO FTEs.
- Loss of surgery, mainly day stay but infrequent acute or emergency operations
- Increased rehabilitation bed numbers (from 15 to 19)
- Total hospital annual admissions largely unchanged (3% down)
- Decreased length of stay for patients on acute ward from 4.5 to 3.1 days
- Dramatic increase in annual acute presentations (+147%), including Triage 1 and 2 cases (+188%)

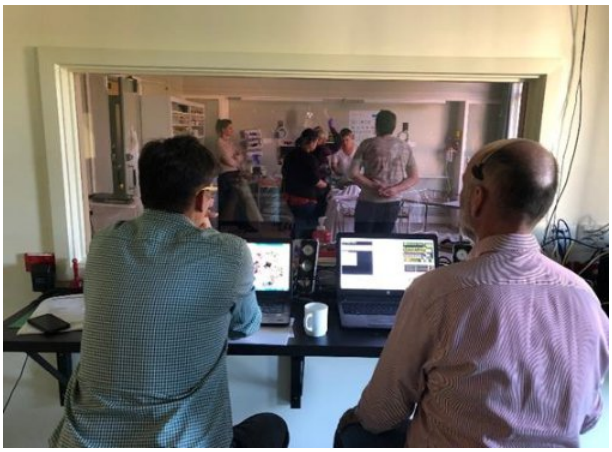
- Small increase in annual total transfers to Christchurch hospital (+12%).

These findings provide evidence that, notwithstanding the loss of local surgical services, the new model of care has been able to deal efficiently with a significantly increased load of acute presentations, without a large increase in transfers out, and maintaining a stable or decreased admission rate.

The recent facility changes in Ashburton have concluded with the RHACA moving into their 'final destination' in the previous Ward 6. Whilst some work is still required, the RHACA and maintenance and engineering team led an outstanding effort to have the unit fully set up with the appropriate simulation set up and debrief areas. This enabled us to deliver on site the first in **Trauma and Emergency in Rural Settings** programme (GEN 723) in partnership with Otago University. The broad aim of this paper is to equip rural practitioners with the knowledge, skills, and framework with which to manage emergency and trauma patients in a rural practice setting. Pre-requisites for the participation is the reliant heavily on participants' personal experience of managing rural cases to generate discussion, including work in a clinically relevant situation. This paper includes rural hospital simulations in the residential where we focus on advanced practical skills such as RSI, along with the teamwork necessary to make the right things happen in the resuscitation room. We are very proud in Ashburton to have been able to be the first site this course has been delivered in a rural setting.

17 participants from all over New Zealand and including 5 from the Cook Islands arrive in Ashburton for an immersion week of teaching and training. Both faculty and students reported the course as an outstanding success and the benefit of leaning in an environment that is realistic to the rural setting, as opposed to previous courses. Several of the participants have indicated a desire to work in the Ashburton Hospital and will be applying for RMO rotations as they arise later in the year.

The photo below includes Dr Steve Withington and Dr Samsa Kiuru observe the students respond to trauma situation and provide ongoing challenges for the team through the Laerdal simulation equipment. The rooms have been set up to enable full monitoring, with associated rooms for teaching and debrief, as indicated in second photo.



Emerging uses for hyperbaric therapy

While many people think of hyperbaric oxygen therapy as treating scuba divers with "the bends" or carbon monoxide poisoning, it is also a powerful and effective treatment for certain other diseases.

Central retinal artery occlusion is a rare, but emergent condition of the eye resulting in sudden, dramatic, and permanent vision loss. The retina has the highest of oxygen consumption of any organ in the body, therefore is very sensitive to ischemia. Without an active blood supply the eye would be permanently blind after about 90 minutes. This means that it is vital to identify patients with this condition and refer them to the Hyperbaric Medicine Unit as quickly as possible. Following work between the Eye Department, Emergency Department and Hyperbaric Medicine Unit at Christchurch Hospital these patients are seen within ten minutes of arrival in the emergency department

and are immediately referred to the Hyperbaric Medicine Unit. This close collaboration works to help minimise patient disability, and is vision saving.

Radiation cystitis is a disease in which one develops unhealthy, friable scar tissue in the bladder after having received radiation therapy for cancer (usually prostate cancer, but also rectal, vaginal, cervical, or endometrial cancers). Patients with radiation cystitis can have frequent bleeding in their urine, to the point that they become anaemic and require hospital admission, blood transfusions, and urinary catheters. Hyperbaric oxygen therapy has been well proved to heal this irradiated tissue and stop patient from further episodes of bleeding, therefore dramatically reducing the need for catheters, blood transfusions, and hospital admission.

New Home Dialysis Training Centre

The Home Dialysis Training Centre houses home haemodialysis and peritoneal dialysis training along with pre-dialysis education and dialysis services administration. Its work is key to supporting patients to independently perform their dialysis in their own homes, enabling them to work their dialysis into their own routine, and around their work hours, and lifestyle. This service has spent the past 12 years located on the third floor of the Diabetes building, which is scheduled for demolition later this month, and was the last to leave the building, having moved to its new location on Friday 3rd May.

The requirement for home dialysis services continues to grow, with 140 patients currently in Canterbury, West Coast and South Canterbury districts, and careful design has made the best use of the space available, ensuring that the centre has the capacity to provide its services for many years to come. The service was involved in the design of the new centre, spending many hours in the Design Lab mocking up rooms to make sure that the service fitted into the area in a workable way and would accommodate all the necessary equipment. The centre is close to the hospital which is important as the staff work with both community and hospital based patients. It has some dedicated off street parking and is entirely located on the ground floor, which is important as many patients experience mobility challenges.

The new centre provides a vast improvement on the old one and will ensure the service can be effectively provided now and into the future. It has more treatment rooms than the old one, an increase of four to 11 for haemodialysis and two peritoneal dialysis training rooms with the ability to flex this activity into the haemodialysis rooms depending on need. The staff station has also increased in size, enabling the team to work and learn together more effectively.

The Christchurch Kidney Society has offered to supply some artwork for the patient rooms and we look forward to making the unit inviting and welcoming to our patients.

Canterbury District Health Board Clinical Pharmacology supporting good medicine use nationally

Providing good information to people about how to take their medicines helps to ensure that they gain the most benefit from medicines prescribed for them. It also helps people to identify side effects and when to take action. Effective use of medicines by patients helps them to stay well in the community, supporting them to avoid unnecessary time in hospital.

The Canterbury District Health Board MyMedicines team produces patient information about medicines for CDHB and New Zealand and is now established as the national source of patient information about medicines and is distributed for free throughout New Zealand via the New Zealand Formulary.

- There were a total of 1,115,541 views of the information sheets from 22/12/2017 to 21/12/2018, compared to 381,790 views for the same time period the previous year.
- Thirty-three new sheets were requested and added to the database.
- Database integration into the New Zealand Formulary is almost complete with 98% of the original database now integrated.
- Methods of displaying side-effect frequencies in the sheets have been tested with consumers and integrating this information into the database will be a focus of 2019.

- A pilot of translating information into Te Reo Maori was completed for 10 sheets relevant to Maori health issues. This initiative has been endorsed by HQSC who have provided additional seed funding. Funding is now being sought for sustainable resourcing of Te Reo medicines information.
- Nationwide consumer testing project has continued with feedback surveys being conducted quarterly to ensure the information meets consumers' needs.

Development of Clinical Decision Support within MedChart

Canterbury District Health Board has largely transitioned from paper based to electronic systems for medicines use for inpatients within its hospitals. The Clinical Pharmacology Department has been heavily involved in MedChart configuration, clinical decision support, development and implementation.

Electronic systems offer many advantages over paper based systems, including that clinical decision support functions can be built into the system to help avoid patient harm. Clinical decision support functions can be categorised as rules that create alerts to guide clinical staff and pre-configured prescriptions to facilitate accurate and speedy prescribing. Most of the clinical decision functions in MedChart are locally developed to support CDHB clinicians. These are constructed to prevent patient harm (as opposed to errors per se) and minimising alert fatigue. This means that most alerts and functions are configured such they are useful most of the time to most clinicians).

MedChart data can be used to inform analysis, reporting and development of clinical decision support functions. International analysis shows that if appropriately focussed the resource required for this work can more than pay for itself. The Clinical Pharmacology Department is hopeful that in the future it will again have the resource to focus on use of this data and ongoing development of clinical decision support functions.

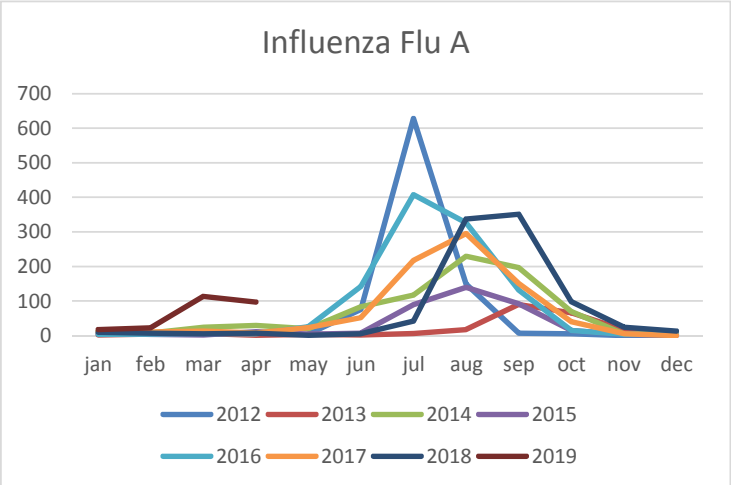
Canterbury Health Laboratory Services (CHLabs)

Winter planning

The testing strategy for winter activity using laboratory based rapid influenza testing is now in the final stages of planning. This will see rapid testing for FluA, FluB and RSV available for all Hospital and Emergency Department requests as well as community referred testing at CHLabs with reflex testing of a wider respiratory panel for "critical wards and cases". We will review benefits and impacts on patient management and flow post winter.

Influenza in Canterbury

Influenza A activity in Canterbury is still well above previous comparative years with an ongoing increase in workload for the Virology and Serology Lab, however whilst volumes are significantly up numbers appear to be steady over March/ April following an early spike in February/March. We have seen some small activity in Influenza B over the most recent week.



Measles in Canterbury

Measles numbers now sit at 39 confirmed cases in Canterbury with no significant increase since the last report. Notably we have now reached 30 days with no new confirmed cases locally and a drop in test requesting however

we are still seeing cases from other areas particularly Auckland and Northern regions. Globally measles still remains a problem and the ongoing risk of importation from travellers remains high.

Measles Vaccinations for Midwives

The current measles outbreak in Canterbury puts people not immune to this disease at risk. Non-immune health professionals are particularly at risk of catching the disease and passing it onto the people they are caring for. Measles during pregnancy increases the risk of miscarriage or premature birth.

A special vaccination event was recently hosted by the New Zealand College of Midwives to provide Mumps, Measles and Rubella vaccination to Midwives and Wellchild/Tamariki Ora Nurses who require vaccination because they were in the age group where they were unsure of their status and were concerned about their immunity. This is an example of the wider health system working together to ensure the good health of mothers and babies that depend on our care.

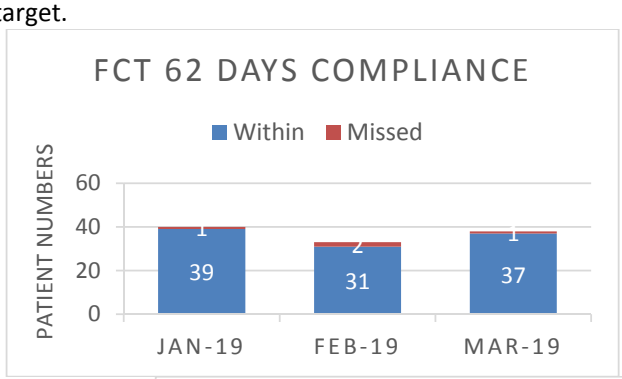
Outcome and Strategy Indicators

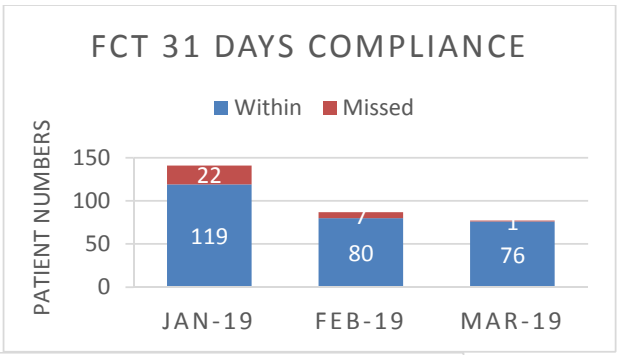
Key Outcomes - Faster Cancer Treatment Targets (FCT)

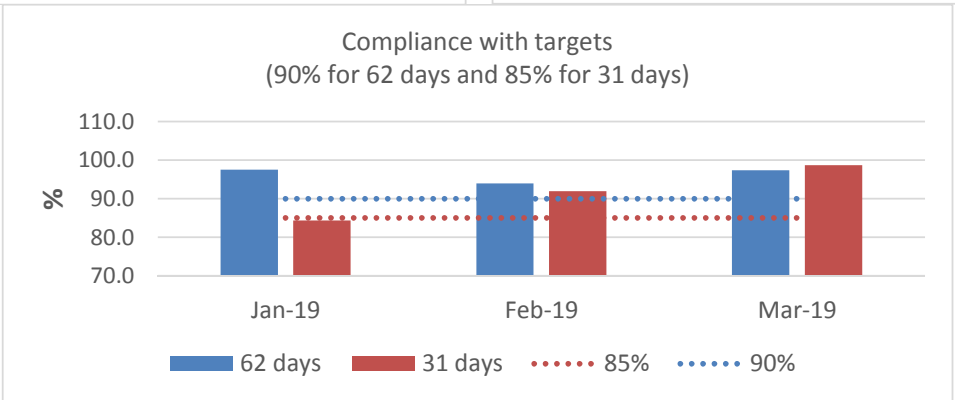
62 Day Target. For the three months of January, February and March 2019, Canterbury District Health Board submitted 125 records to the Ministry. Of the 18 who missed the 62 days target 14 did so through patient choice or clinical reasons and are therefore excluded by the Ministry of Health in compliance calculations. This leaves 111 patients eligible for inclusion in the target calculations.

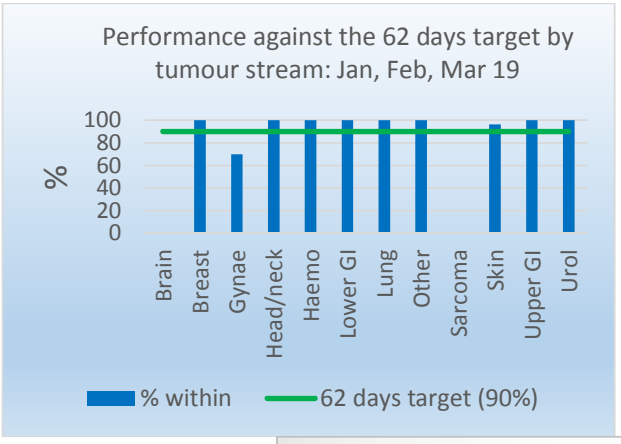
With 4 of the 111 patients missing the 62 days target through capacity issues our compliance rate was over 96% so once again the Canterbury District Health Board met the 90% target.

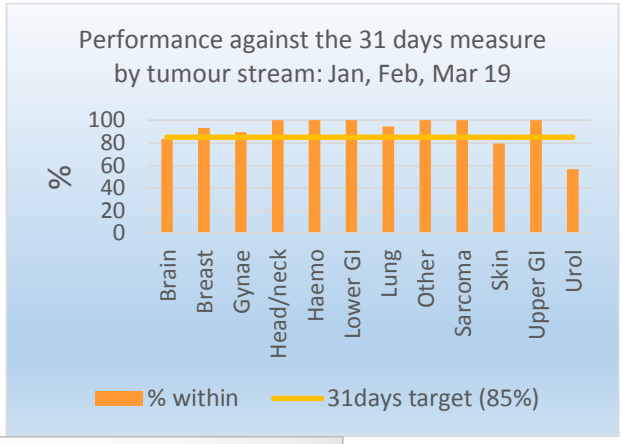
31 Day Performance Measure. Canterbury District Health Board submitted 305 records towards the 31 day measure in the same three month period. Unlike the 62 days target all patients who miss the 31 days target are included: there are no exceptions made for patient choice or clinical considerations but the threshold remains at 85% rather than 90% as is the case for the 62 days target. With 275 of the 305 (90.2%) eligible patients receiving their 1st treatment within 31 days from a decision to treat the Canterbury District Health Board continues to meet the 85% target.

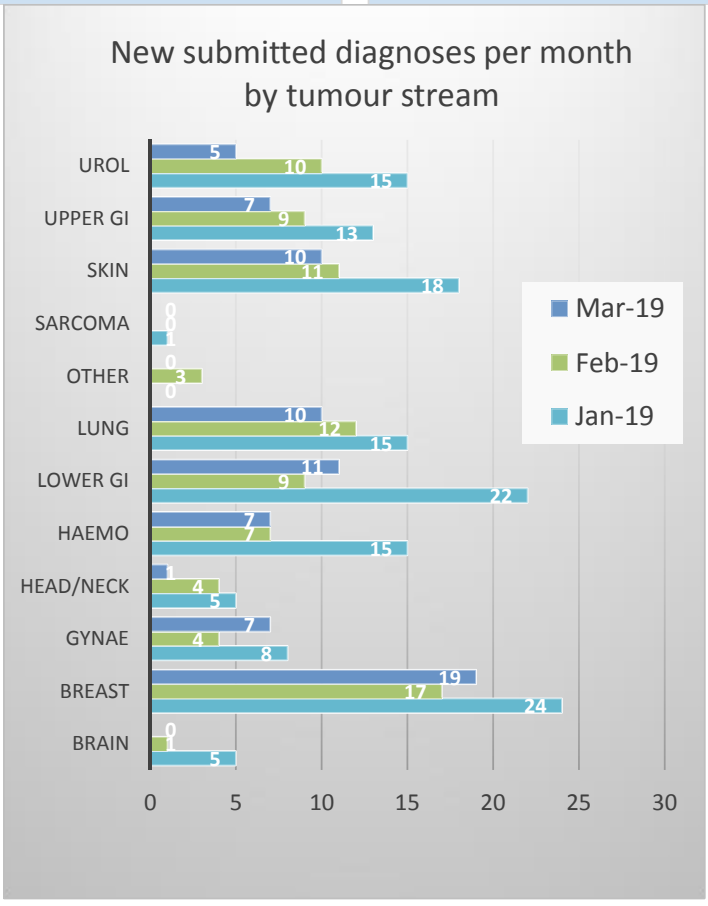










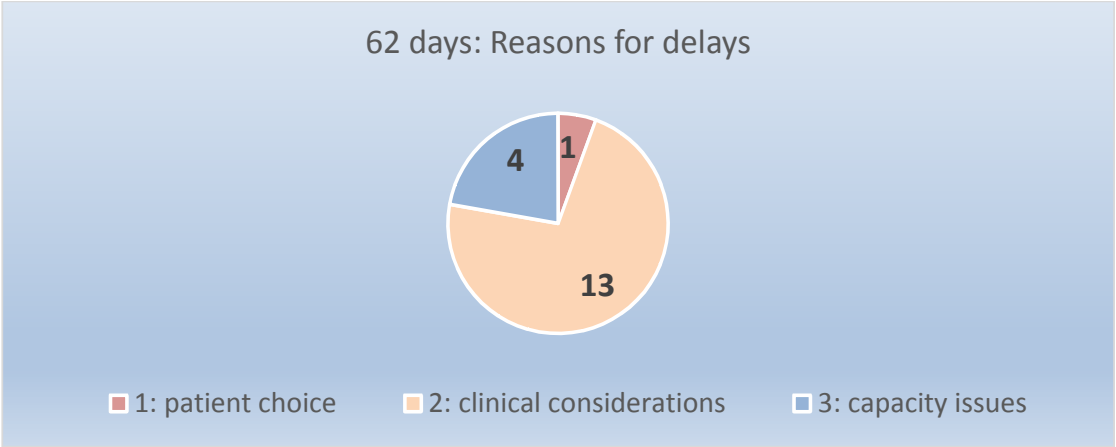


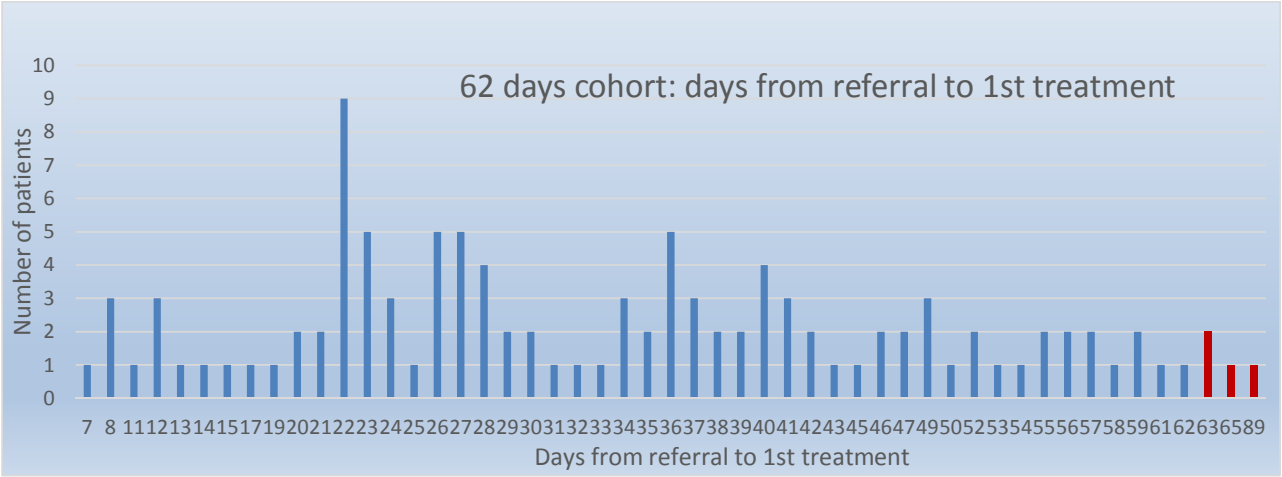
Patients whose treatment time misses the targets

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

The codes are:

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





Patients who missed the 62 days target but were non-compliant through choice or because of clinical considerations are not included so that the graph (above) aligns with MoH reporting requirements.

However every patient that does not meet the target is reviewed to see why. This is required in order to determine and assign a delay code, but where the delay seems unduly long then a more in-depth check is performed. These cases are usually discussed with the tumour stream Service Manager(s) to check whether any corrective action is required.

Training of vital new palliative medicine specialists

The Specialist Palliative Care Service in Canterbury is staffed by a broad interdisciplinary team. A critical component of that team is the five Senior Medical Officers. They provide clinical care to the most complex palliative patients and collegial support to clinicians throughout Canterbury and the West Coast. They are deployed across the acute hospital setting, the Hospice and the community (including aged residential care). They also provide palliative and end of life care education to a large range of healthcare professionals.

There is an international shortage of palliative medicine specialists and ensuring local training opportunities is a priority area for Health Workforce New Zealand. Over recent years the Canterbury District Health Board has had a steady stream of high quality palliative medicine registrars. There are currently five Advanced Trainees at various stages of training, with three of them undergoing dual training (one with Clinical Pharmacology, one General Medicine and Neurology - the latter trainee is doing a neurology fellowship in Melbourne at present. All current registrars have a clear expectation that they will work as specialists in New Zealand, and at least one is aiming to work in a rural centre. Training in the Canterbury District Health Board has an excellent reputation.

While the majority of palliative medicine Senior Medical Officers in New Zealand were trained overseas the local team of Senior Medical Officers are all New Zealand trained and received part or all of their training in Christchurch. This success over many years has been instrumental in the development of a very well integrated and respected service which provides the people of Canterbury with high quality care.

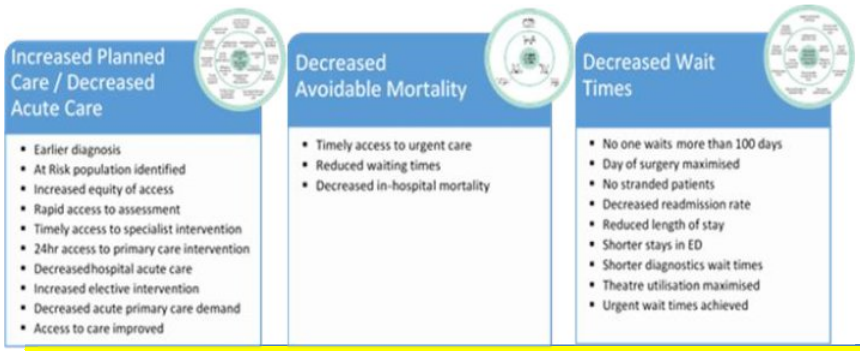
Te Ara Whakapiri: Care in the last days of life

Te Ara Whakapiri: Care in the Last Days of Life, was developed by the Ministry of Health in 2015 to raise the standard of end of life care in all healthcare settings across New Zealand. A Toolkit was released in April 2017 to assist with implementation. The Christchurch Hospital Palliative Care Service localised the Toolkit and progressively rolled out the programme in all clinical areas with the support of nursing and medical leadership. Full implementation was achieved by the end of 2017. Two audits were performed during 2018 showing very good uptake and further audits are scheduled. Alongside this, Nurse Maude has been responsible for implementation in the Hospice, the community and in Aged Residential Care.

The programme has been extremely well received and has rapidly become business as usual across the Christchurch Hospital and Burwood campuses. The programme includes a baseline assessment to ascertain the unique needs of each patient and whanau at the time they are identified to be in the dying phase. There are symptom management guidelines and treatment flowcharts to guide clinicians. One of the key components is a holistic observation chart which replaces the standard observation chart (now called Patientrack). This helps staff to identify all the elements that are required to ensure comprehensive care in a way that is visible to everyone in the care team. Checklists ensure that all aspects of care have been considered.

A refresh of the material, based on audit findings and the routine experience of staff, is scheduled for later this year. This will be facilitated by the South Island Alliance to ensure that all areas in the South Island are able to benefit from the enhancements made. It has been identified that there are parts of the programme that are not being used routinely or optimally and the reasons for this will need to be explored. It is expected that ongoing support and education will need to be provided.

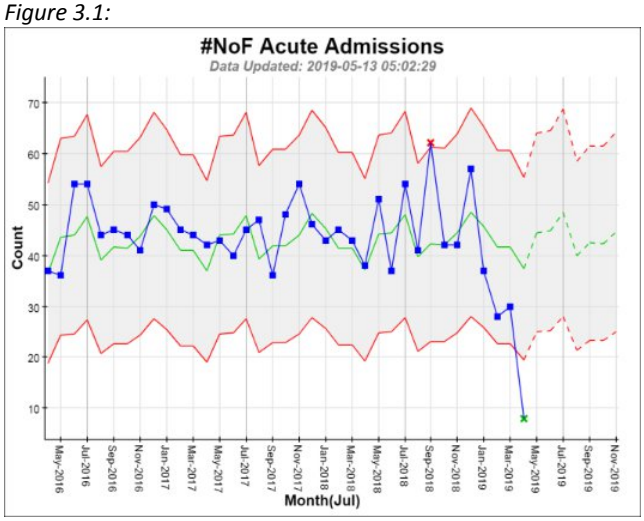
The Palliative Care Clinical Director is very proud of this work, noting that it has been very straightforward to implement as clinicians throughout the system have been extremely keen to make use of these resources.



Enhanced Recovery After Surgery (ERAS)

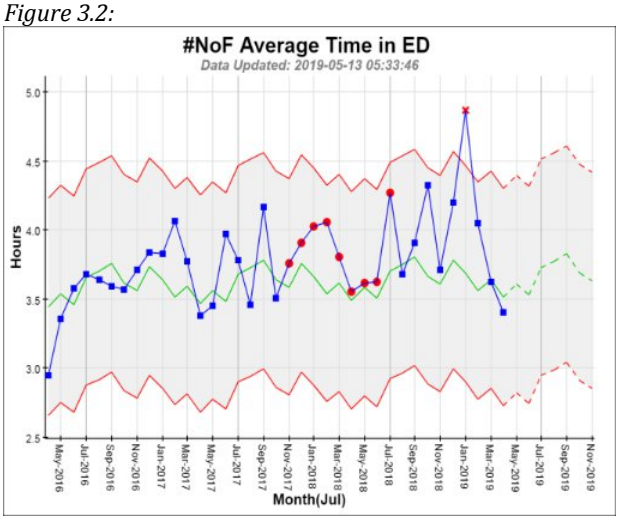
Outcome and Strategy Indicators – Fractured Neck of Femur (#NoF)

Figure 3.1:



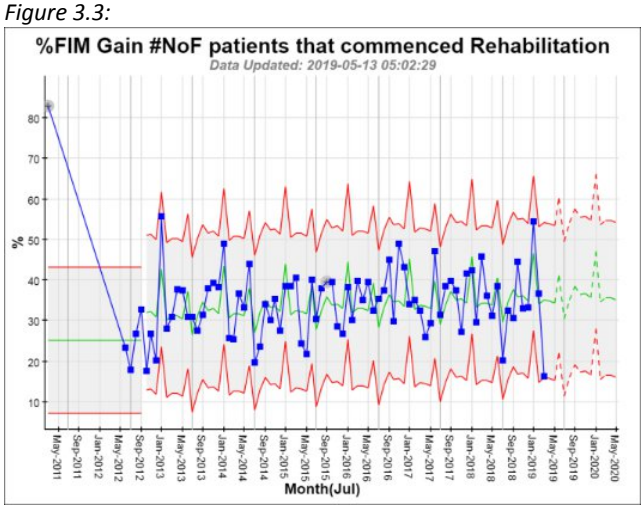
Coding delays impact on the latest data records for admissions. This is being addressed.

Figure 3.2:



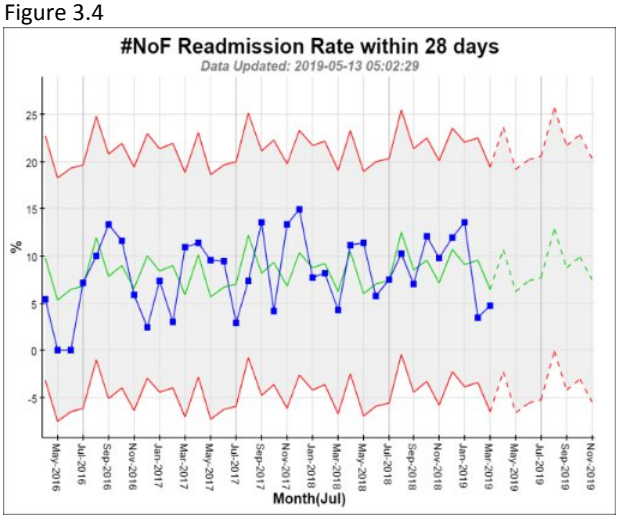
Patients with #NOF show a variable length of stay in ED.

Figure 3.3:



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

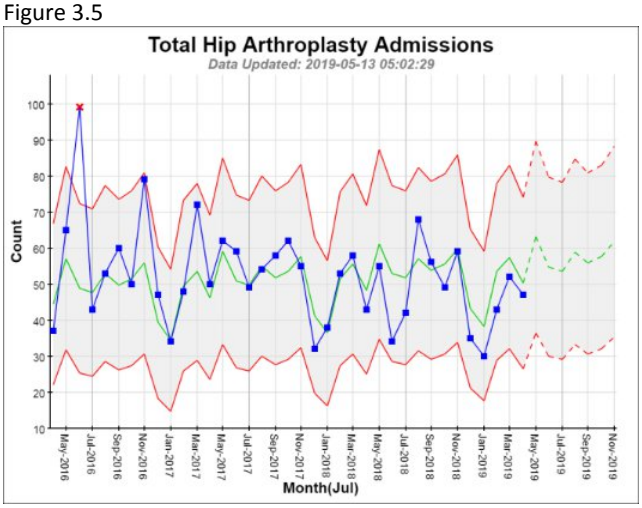
Figure 3.4



Readmissions continue to remain within expected mean values.

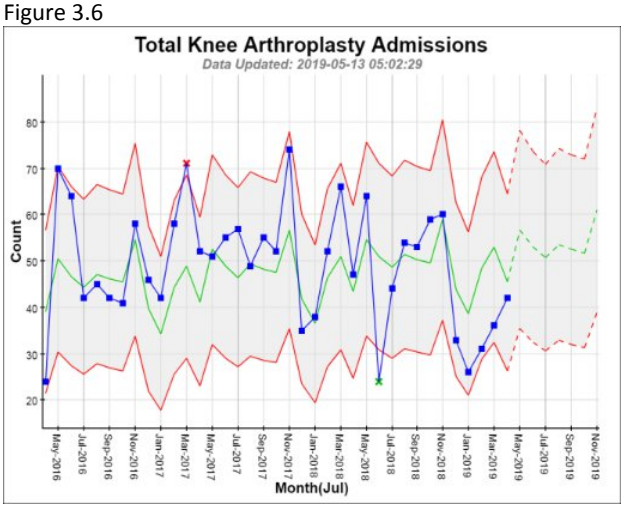
Outcome and Strategy Indicators – Elective Total Hip Replacement(THR) and Knee Replacement(TKR)

Figure 3.5



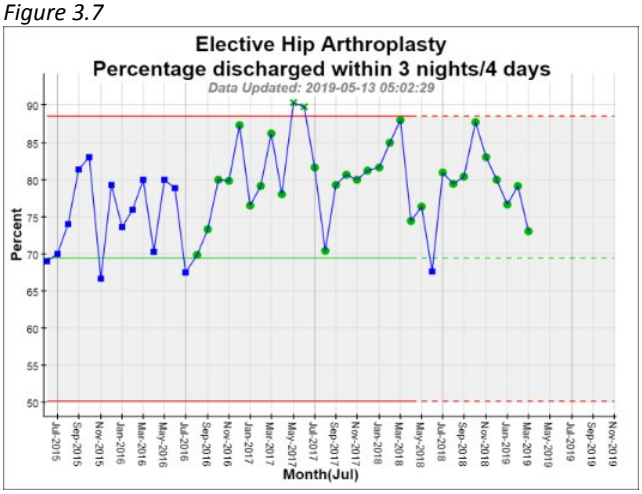
In recent months hip replacements have been tracking within or below projected levels.

Figure 3.6



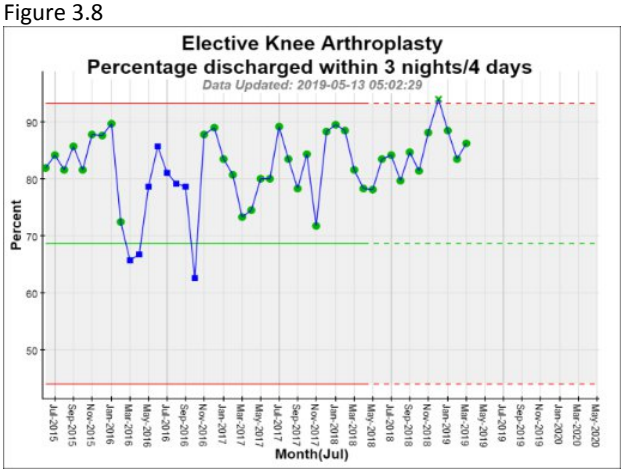
Knee replacement admissions over the previous twelve months have been tracking around the projected levels.

Figure 3.7



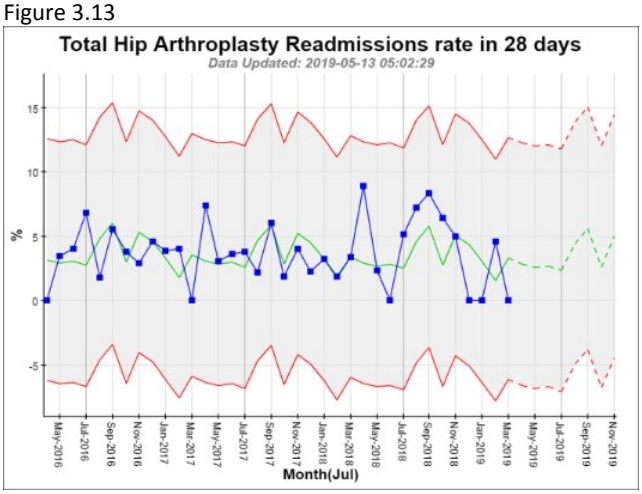
The proportion of patients clinically safe to be discharged within 3 nights/4 days is following established, increasing trend.

Figure 3.8



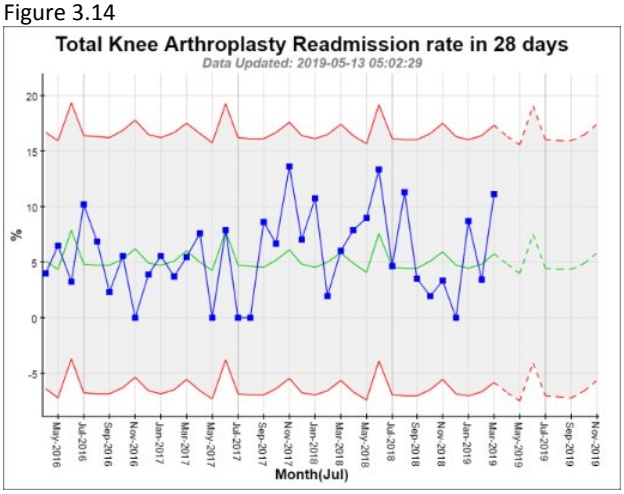
The proportion of patients clinically safe to be discharged within 3 nights/4 days is following established, increasing trend.

Figure 3.13



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

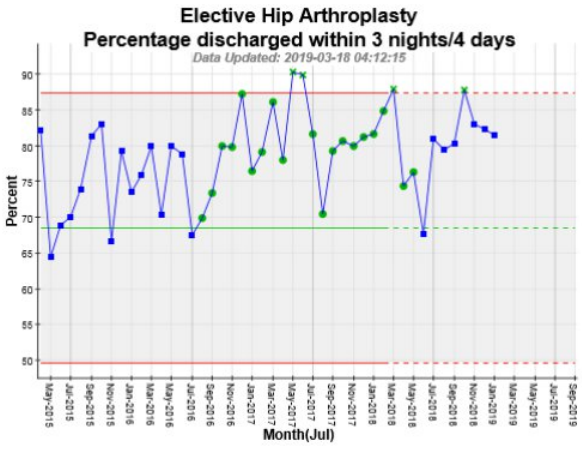
Figure 3.14

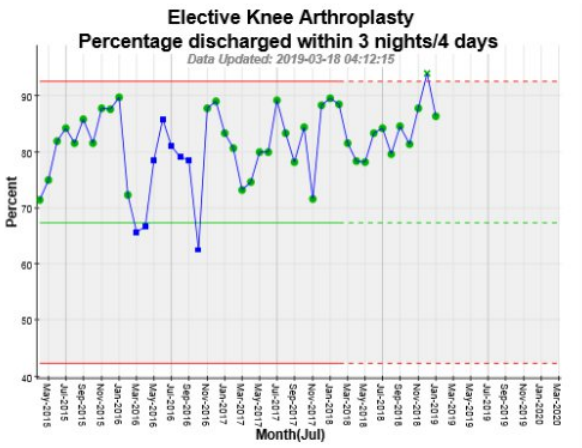


Readmission rates are maintaining within tolerances.

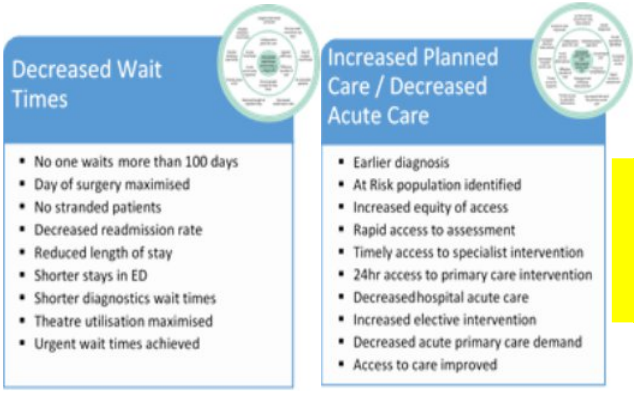
Achievements/Issues of Note

Enhanced Recovery After Surgery (ERAS) – Overall trend for both Elective Hips and Knees seeing improvement in the percentage of patients discharged within the target. Still some variation however variation on the positive line of improvement





Planning the rosters for the new acute theatres at Christchurch, Orthopaedics will increase acute theatre access to 3 dedicated theatres. This will in part support a timely access to theatre for fractured neck of femur patients. Current focus on being able to identify when patients are fit and ready for surgery and stable from a data interpretation is underway to see what balancing metric may exist to support clinical readiness wait time for access to theatre.



Elective Surgery Performance Indicators 100 Days

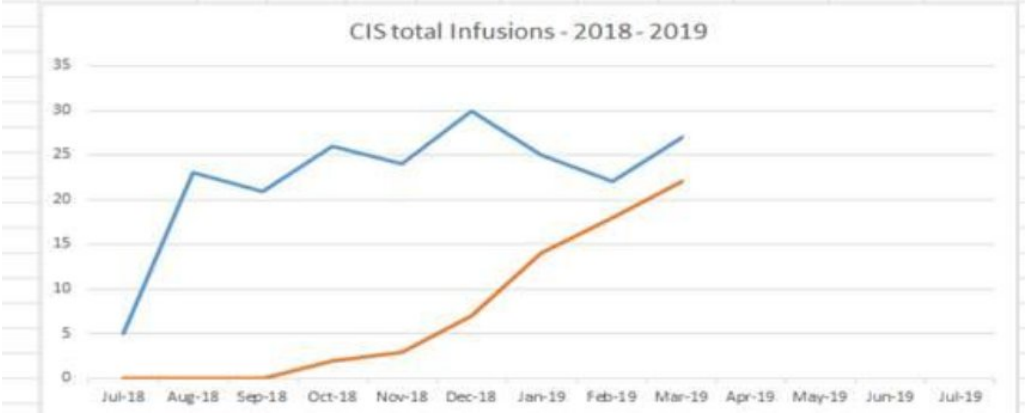
Achievements/Issues of Note

Provision of infusions in the community.

Previous reports have provided updates about the launch and expansion of the activity undertaken in community infusion centres.

The number of patients provided with care in these settings has continued to increase, providing their highest number of infusions in March 2019.

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Blood transfusions	5	23	21	26	24	30	25	22	27	
Intragam	0	0	0	2	3	7	14	18	22	
Total Infusions	5	23	21	28	27	37	39	40	49	



This not only provides care for people closer to home, meaning they can avoid a trip into a busy acute hospital but also frees up capacity in the hospital for care that can only be provided in that setting.

Planning is underway towards provision of bisphosphonate infusions, which help increase bone density for compromised oncology and haematology patients, in the community centres in the near future. This will release further space for work that can only occur within the hospital.

More assessments, shorter wait times and improving the sleep health of Cantabrians

World Sleep Day was recently celebrated across the globe. A study has shown that insufficient sleep costs the Australian economy up to $5.1 billion per year. Here in Canterbury, the DHB's Sleep Unit's work includes diagnosing and treating people with sleep disorders such as sleep apnoea.

Most sleep disorders are preventable or treatable, yet less than one-third of sufferers seek professional help.

Prior to 2007, the availability of specialised sleep services in Christchurch was extremely limited and increasing demand for sleep services meant long delays in sleep assessment and accessing continuous positive airway pressure technology. This led to the establishment of a community sleep assessment service carried out by trained general practitioners. The community assessment service has seen the number of people being assessed increase steadily and wait times decreasing year-to-year. In 2007 around 400 assessments were completed in Canterbury compared with 2000 assessments last year. The average wait time from referral to review has improved remarkably as well, particularly in the last three years with wait times decreasing from an average of 32 days in 2015 down to 15 days by the end of last year with treatment being provided to urgent and semi-urgent cases within the following two to four weeks..

The close integration between primary and secondary care clinicians and the Sleep Unit has seen more people with poor sleep health access the advice and treatment they need to improve their sleep health. This is a massive achievement and a credit to the effectiveness of the new assessment model and the hard work of our team of sleep specialists.

Diabetes team working with community providers to improve Māori and Pacifica experience of diabetes management.

Managers and clinicians from the Canterbury District Health Board Diabetes Service recently attended a workshop on long term conditions and diabetes that was run by the Ministry of Health

This included the opportunity to present on some work carried out in Canterbury in conjunction with Sports Canterbury on a community based Diabetes Be-Active programme that has been increasing lifestyle options for people with diabetes.

The event's major theme was showcasing initiatives aimed at reducing the equity gap, and fostering empowerment for Maori and Pacific groups through co-designing programs and supporting strategic approaches to workforce development. There is a growing appreciation and understanding of emerging models of care valued by consumers. This fits nicely with a shift in the diabetes nursing workforce with the appointment of a Maori Registered Nurse.

Our diabetes service is currently exploring new community based initiatives for diabetes education, from this we aim to work in partnership with local stakeholders and consumers piloting an education model acceptable for both Maori and Pacific people who are currently under-represented in classes. We aim to provide a specific education program for both Maori and Pacific by spring 2019.

There are several health apps for Maori and Pacific groups emerging, trialling these new tools, extending what technologies can offer our patients to improve self-management and health literacy independently is a further area for our diabetes service to extend into areas of routine practice options where appropriate. Having the team use, and share these apps will help us and our patients understanding the advantages and limitations of these approaches.

The aim of our collective partnership work with our Maori and Pacific colleagues, providers and consumers over coming months will align our aims and values in resourceful collaborative outcomes.

Clinical Nurse Specialist support for children with allergy and eczema

Eczema is a condition that affects around 20% of children, most of whom are able to be effectively managed in the community under the care of their General Practitioner. However some do require specialist care and some children with the most severe combinations of allergy and eczema require an extended period of wraparound care in order to ensure that the social and medical aspects of care are adequately assessed and managed. Children living in more deprived households tend to suffer from the most severe eczema and costs and ability to travel for treatment act as barriers to obtaining the required care. A small proportion of these children have previously been admitted to hospital for intensive treatment when care provided as outpatients or in the community has failed.

Until July 2017 children and their whānau were provided care for this condition by specialist paediatricians as outpatients. Due to challenges faced by whānau a high "did not attend rate" was experienced by these children. In order to address this a Clinical Nurse Specialist role has been put in place to care for children with moderate to severe eczema. She visits these children in their homes and other community venues. Over the past 18 months 190

children have been provided care by this nurse. Some patients only need to be seen once or twice and provided with information and evidence based education so that whānau can put in place a well-informed management plan that can be used at home and school. Some patients with especially challenging conditions have remained on the books for over a year to enable management to be optimised. The Nurse has now completed her prescribing training so will be able to prescribe a set range of drugs while still with the patient, rather than having arrange for a medical practitioner to carry out this task. This service has resulted in some heart-warming feedback from whānau as their children are able to attend school more regularly, wear normal clothes and sleep at night. This enables children to receive an education and parents to go to work.

Another aspect of the role involves development of material for HealthInfo and Community and Hospital HealthPathways and involvement in Plunket, public health, practice nurse and General practitioner education. This is enabling a consistent, well informed approach to the management of eczema throughout the health system, enabling the expertise gained by this nurse to be leveraged throughout the system.

Electronic referral system benefitting patients needing dermatology care

Referrals are being much more quickly assessed and more patients who need specialist care are being seen since the Christchurch/West Coast Dermatology Department began electronic triage in mid-2018.

This has proved to be an easy change, bringing greater efficiency and an ability to ensure the right patient is getting the right care at the right time. E-triage has proven to be much more resource-efficient both for the Dermatology department and primary care because it is now easier to deliver advice to referrers, and clinicians can see more patients who have a greater need for an in-clinic review. The Consultant Dermatologist reports enjoying being able to rapidly assess urgent referrals for rashes and skin lesions and provide timely practical feedback and support to GPs. Turn-around times for providing diagnostic help or management advice to general practice teams and their patients have significantly reduced, compared to paper referrals requiring dictation, typing, letter review, and then posting to the general practice.

The West Coast District Health Board Booking Co-ordinator notes that it makes the process much quicker that if the referrals come through by paper and the communication to the GPs is a lot clearer and goes to them directly.

Along with these advantages, e-triage has diminished the burden of paperwork, saved costs, and reduced the risk of mislaying documents. It also allows for improved communications about referrals between the clinicians within the service, such as between doctor and nurse-led services. It supports the service in ensuring that the patient is directed to the appropriately skilled health professional within the department. Digitising the process has ensured that the appropriate people can more readily see where referrals are at and what outcomes are.

Telehealth in Dermatology

Patients located remotely can now be assessed sooner and with less disruption, since the Dermatology Department's take up of Telehealth for patient consultations. It is also more convenient for patients than travelling to Christchurch. New patients can be seen in a tele clinic, without an extensive trip to Christchurch. This is also a substantial cost-savings, as it removes the need for patient travel and accommodation.

Gynae Outpatient Clinic Changes

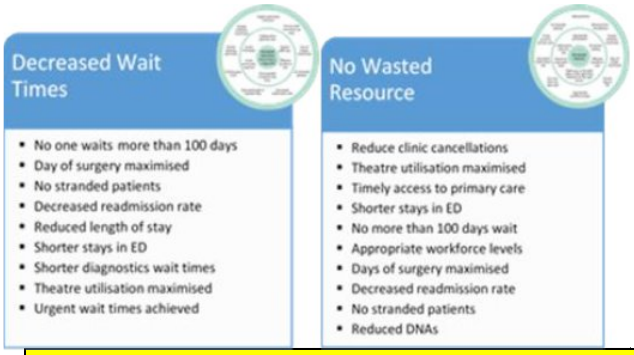
On 28 May 2018 there were Gynae Outpatient Clinic changes which meant that SMO and Registrar patient lists in Gynae Outpatient Clinics were combined. Prior to this there were separate lists for Senior Medical Officer and Registrar clinics. This fixed the patients to be seen by each clinician and was not sensitive to which patients were best seen by who on the day and often made for imbalanced load on different staff meaning some patients waited longer than desirable on the day. This change was designed to improve clinic flow, be women centred and provide improved opportunities for learning and engagement. The total number of patients seen each day has not changed.

These changes have been evaluated six months following implementation, the following has been noted by staff:

- Clinics seem to finish on time or even early
- It provides a better learning environment for resident medical officers and students. Patients come earlier and are able to be seen by a trainee intern or senior house officer first. In the old way of working this would have

required the Senior Medical Officer to wait for patients to be ready to be seen, creating a rush towards the end of the clinic.

- Patients seem to be waiting less and there has been a reduction in the number of complaints about waiting times.
- Patients can now be 'triaged' / allocated at the start of clinic to ensure they are seeing the most appropriate clinician.
- Some of the follow ups that were previously seen in Senior Medical Officer Clinics are most appropriately seen by a Registrar, for example follow up after Mirena insertion. This frees up capacity for Senior Medical Officers to care for patients that most require their services.
- A screen has been installed in the workroom allowing the team to see in 'real time' when patients have arrived, any late cancellations and patients who have not attended.



Theatre Capacity and Theatre Utilisation

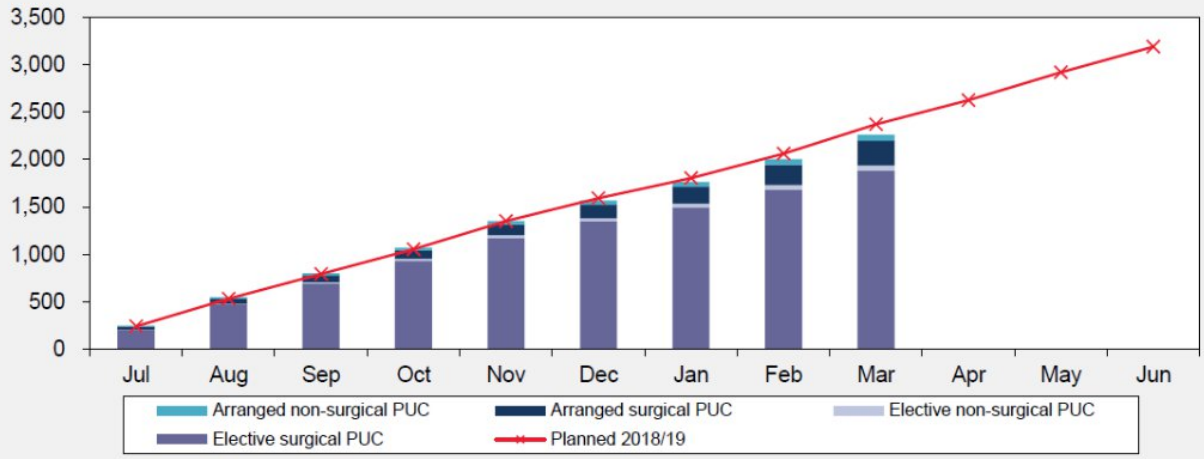
Achievements/Issues of Note

Elective Services Discharges

Elective Services Discharges

Elective Surgical Discharges ▼ **87.7%**

	2018						2019					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Planned	1,520	3,182	5,065	6,985	9,132	10,470	11,532	13,474	15,676	17,548	19,773	21,782
Actual	1,617	3,472	5,124	6,717	8,602	10,018	11,308	12,625	13,742			
Variance	97	290	59	-268	-530	-452	-224	-849	-1,934			
%Achievement	106%	109%	101%	96%	94%	96%	98%	94%	88%			



Reporting from the Ministry shows that Canterbury DHB met its elective discharges objectives at the end of the first quarter (until the end of September 2018), but indicates a significant under delivery by the end of March. Internal reporting shows that at the end of March 14,834 elective and arranged discharges have been completed. While data corrections will increase the count significantly industrial action by members of the Resident Doctor Association and the mass shooting incident of 15th March mean that we will not reach our target for elective services discharges this year.

Locally developed simulator training surgeons from around the world

From left, Paediatric Surgeons Spencer Beasley and Jon Wells using the baby chest simulator

Around one in 4,000 babies are born with oesophageal atresia, a congenital abnormality that means the baby is unable to swallow food.

The surgery required to fix this must be carried out within days of the baby's birth. It is common enough that all paediatric surgeons will come across it, but it is rare enough that it is difficult to train them in how to do the procedure competently when operating on actual babies with the abnormality. Traditionally the operation was performed with a thoracotomy, a cut in the baby's chest. More recently, in some centres, it's been performed as keyhole surgery, which is challenging in tiny infants and difficult to teach. Simulations for the surgery created overseas often involve practicing on animal tissue or live animals, are expensive and have procurement and ethical issues.

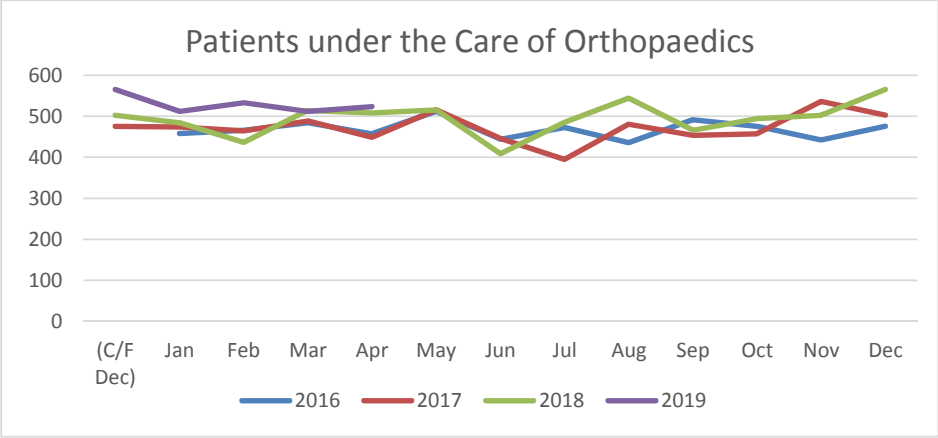
Two paediatric surgeons from Canterbury DHB have collaborated with the Canterbury DHB Medical Physics and Bioengineering department to create a lifelike replica of a ribcage, based on CT scans of a real baby. They also developed a synthetic skin and a replica of an oesophagus and windpipe with the most common form of oesophageal atresia. It contains layers of synthetic tissue that behave naturally and cause realistic problems for surgeons. The ribcage is reusable, and the internal organs are easily and cheaply replaced between simulations. The locally developed simulator will be used at the Neonatal Thoracoscopic Simulator course, being attended by around 400 participants on Thursday 14 March, which will teach participants advanced neonatal thoracoscopic skills.

Orthopaedics

- There were 523 patients admitted under Orthopaedic care in April 2019; higher volumes than April 2018 (515) and April 2017 (448)
- There were 330 acute procedures undertaken; decreased demand compared with March 2019 (354)
- The average wait for theatre in April was 0.88 days compared with 0.95 days in March 2019
- Transfers to Burwood for surgery 47/330
- 18 Burwood backfill sessions offered to Ortho Acutes giving an extra 80 hours of operating time over and above our Christchurch allocation
- We were unable to utilise 3.5 sessions (14 hours) of Burwood backfill sessions due to lack of appropriate cases to send or no surgeon available to operate.

Patients Admitted under Orthopaedics December – 523

>15 yrs = 462 <15 yrs = 61



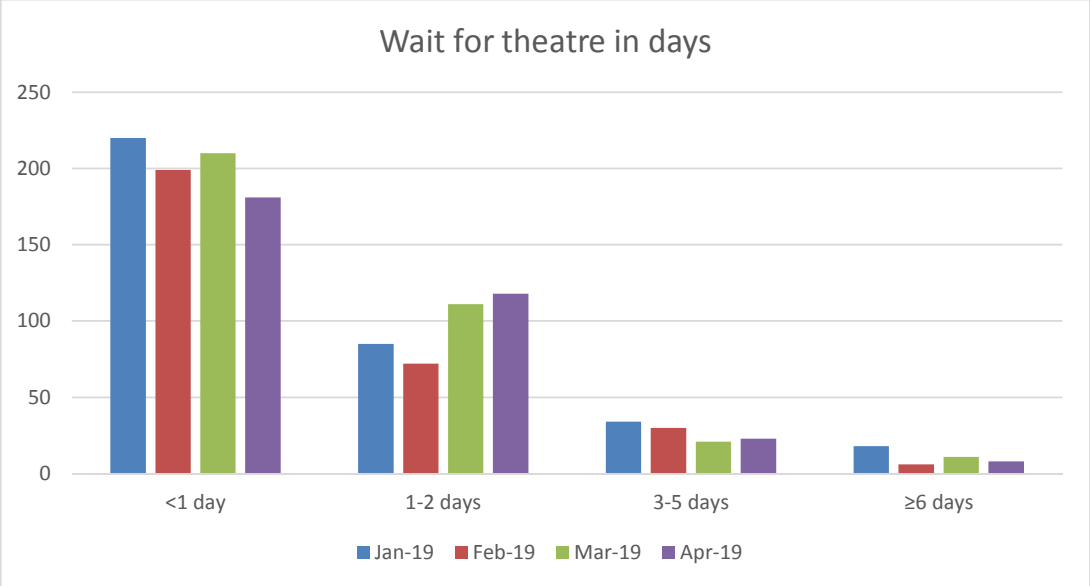
Average LOS: 3.58 days

>15yrs = 3.90 <15yrs = 1.46

Operative Management: 330

Average Wait for Theatre: 0.88 days

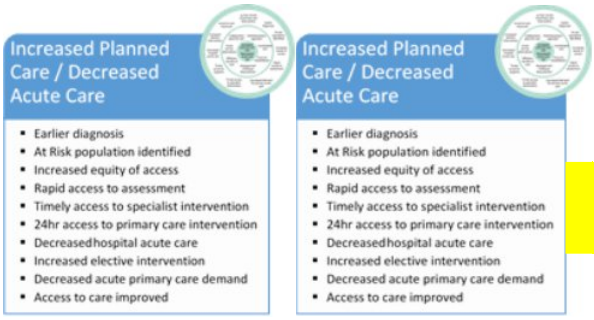
* Data calculated using "ready for surgery" date rather than admission date.



We have had 47 patients transferred to Burwood for surgery as per the table below:

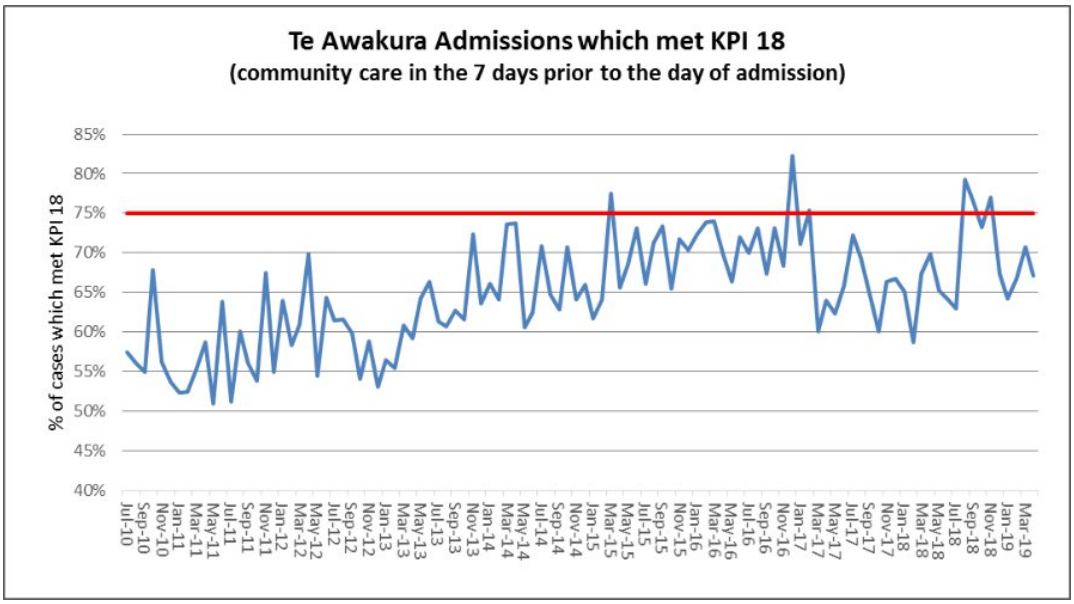
Lower limb	19
Upper Limb	11
Foot	0
Hands	7
Spines	1
NOF	2
Wash out	3
Tumour/Pathological	2
Hip revision	1

Of those 47 patients there were four elective cases that have been cancelled and two cases have been added to an elective list.

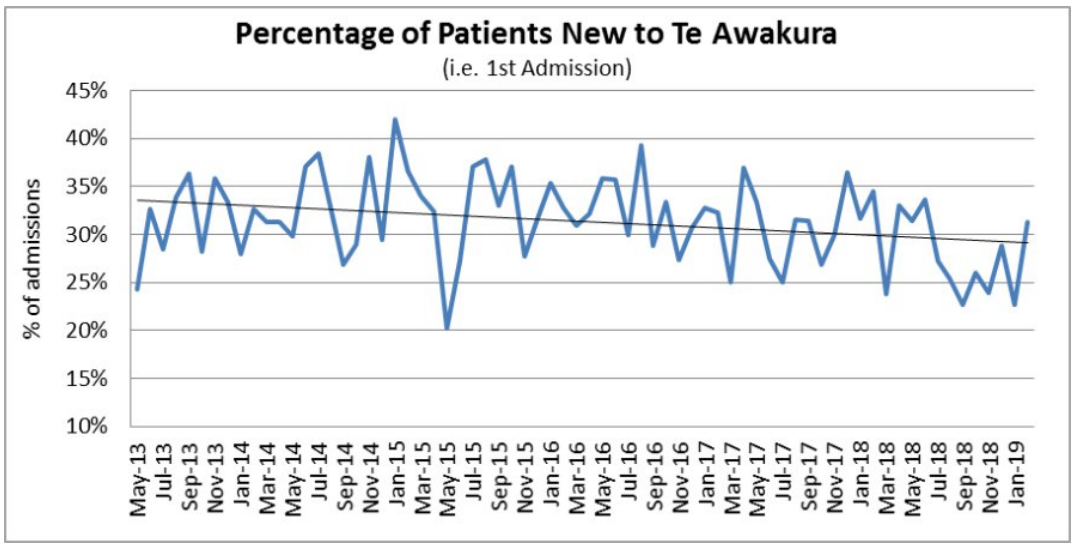


Mental Health Services

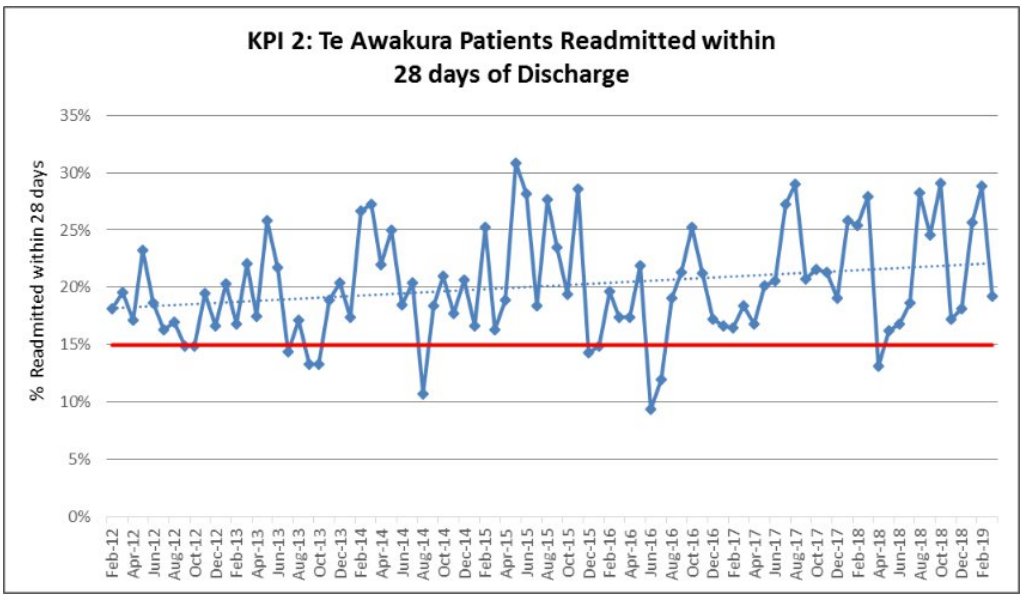
Adult Services



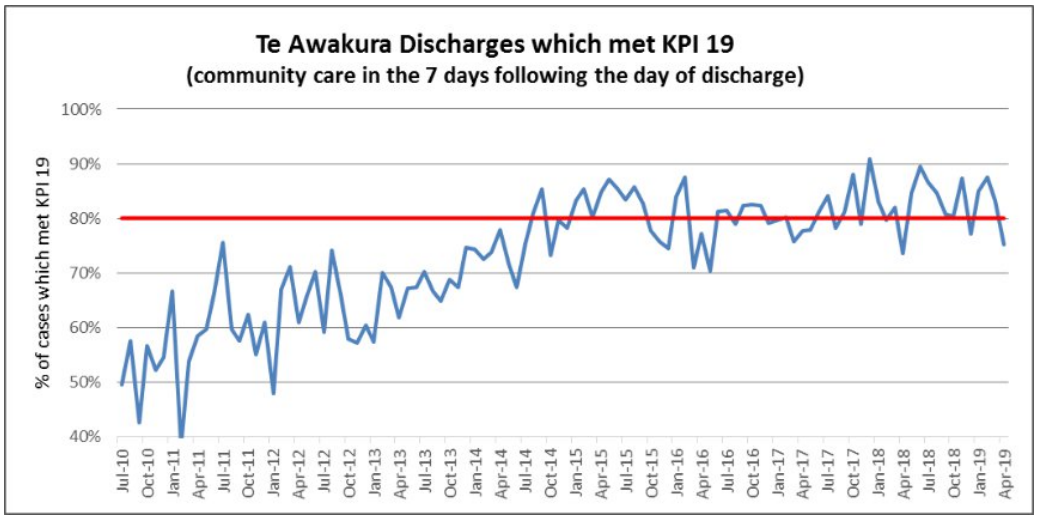
KPI 18 is an indicator of how well engaged we are with the consumers in our services. In March 2019, 70.8% of acute admissions to Te Awakura had a community contact in the seven days prior to the date of their admission. In April 2019, the figure was 67.0%.



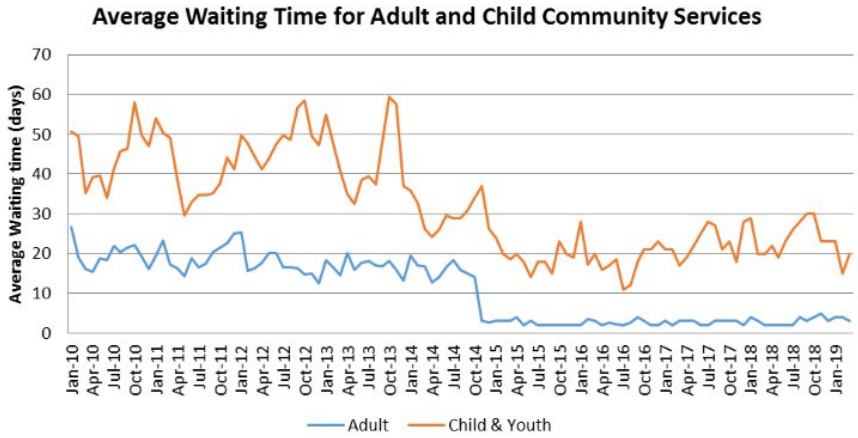
In April 2019, 27% of people admitted to Te Awakura were new (had not been admitted there previously), in March 2019, the figure was 32%.



The graph above shows the readmission rate within 28 days of discharge. Of the 125 Te Awakura consumers discharged in March 2019, 19.2% were readmitted within 28 days. Readmission rates are closely monitored.

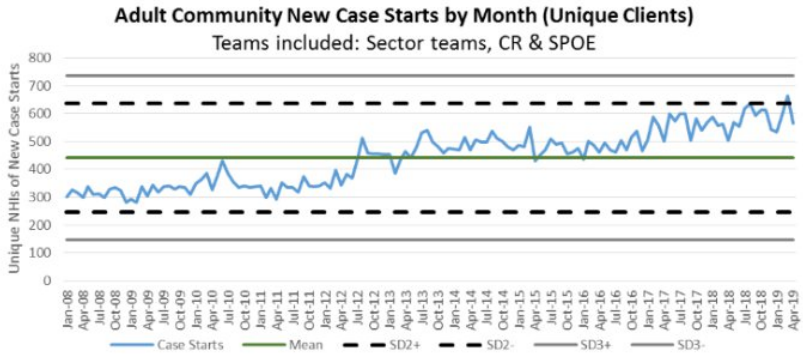


KPI 19 is a key suicide prevention activity and patient safety measure. In March 2019, 83.2% of consumers discharged from Te Awakura received a community care follow-up within seven days of discharge, and so met KPI 19. In April 2019, the figure was 75.3%.

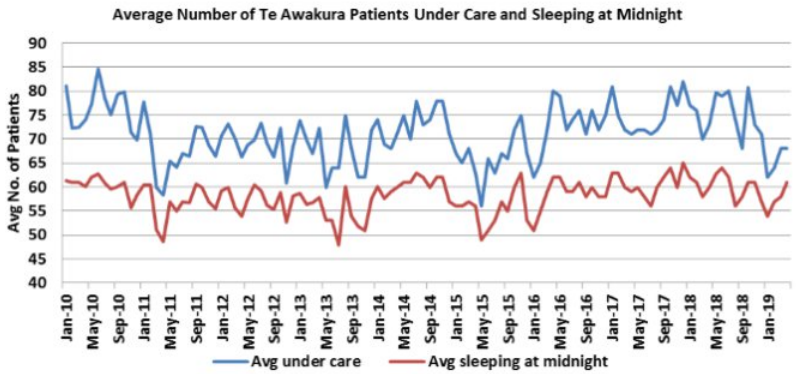


The graph above shows there has been an overall reduction in the time people spend waiting. Ministry of Health targets for these services require 80% of people to be seen within 21 days and 95% of people to be seen within 56 days. The average waiting time for adults was 3 days for both March 2019 and April 2019. Our results for the Adult General Mental Health Service show 94.2% of people were seen within 21 days of referral in March 2019 and 99.2% were seen within 56 days of referral. In April 2019, these figures were 94.8% and 99.4% respectively. These results are occurring in the context of significant increase in demand.

For child and family services, the average waiting time was 20 days in March 2019 and 18 days in April 2019. Reducing wait times has been a key focus for CAF services. Our results show 86.0% of people were seen within 21 days of referral in March 2019 and 89.7% were seen within 56 days of referral. In April 2019, these figures were 86.8% and 91.8% respectively.



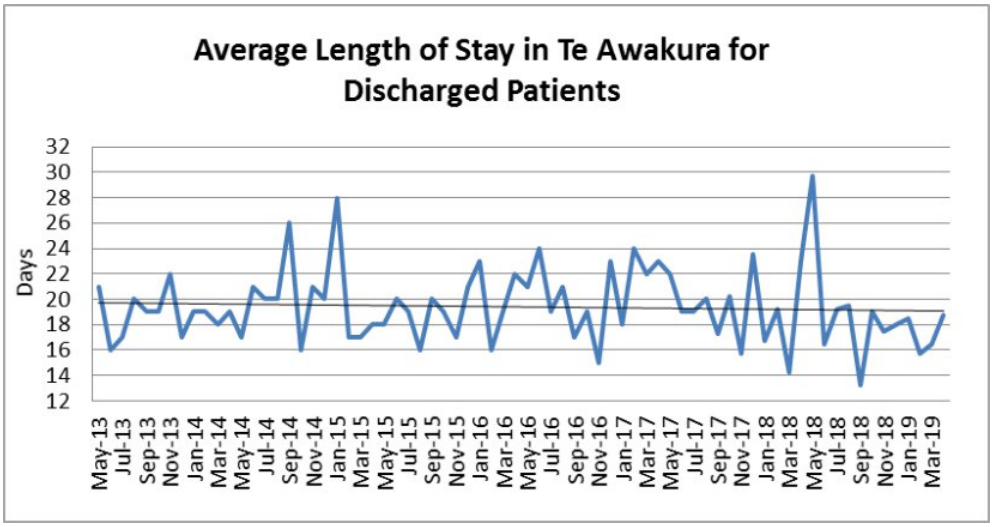
New cases were created for 663 individual adults (unique NHIs) in March 2019 and 565 in April 2019.



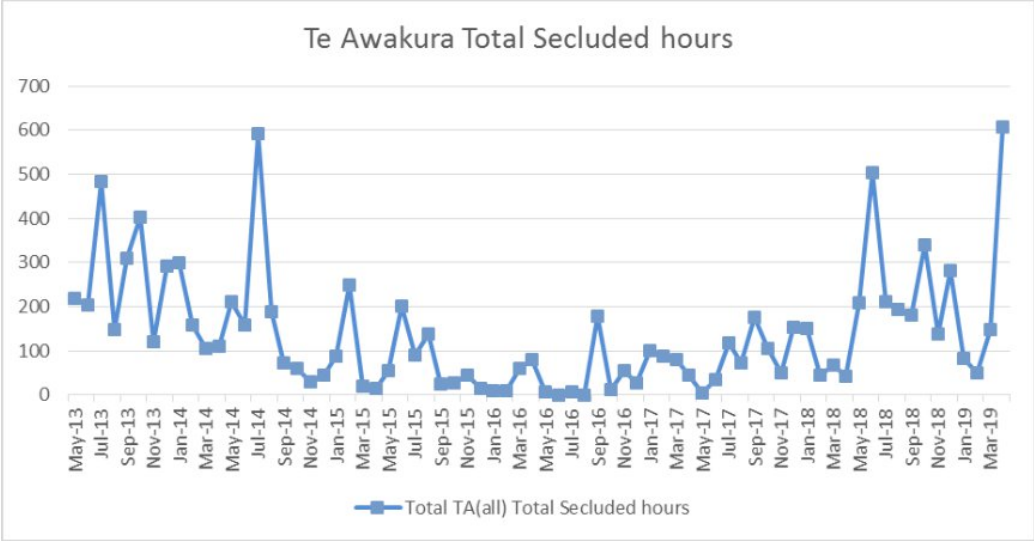
85% occupancy is optimal for mental health acute inpatient services.

Occupancy in Te Awakura (the acute inpatient service) has regularly been above this figure. Occupancy was 90% in March 2019 and 96% in April 2019.

The average number of consumers under care in this 64 bed facility was 68 in both March and April 2019. There were 20 sleepovers during March 2019 and 29 sleepovers during April 2019.

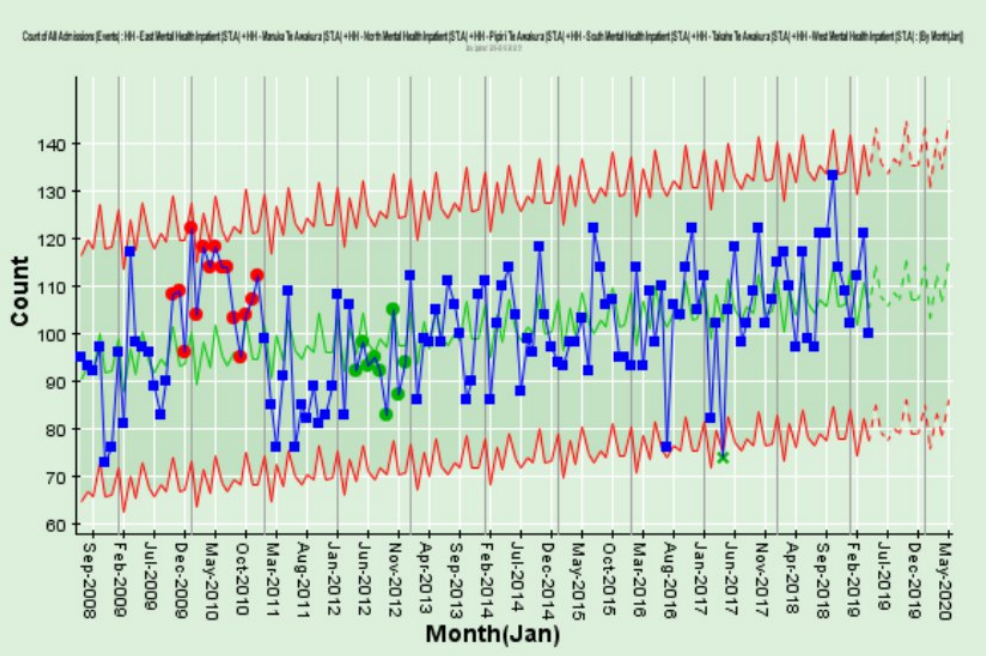


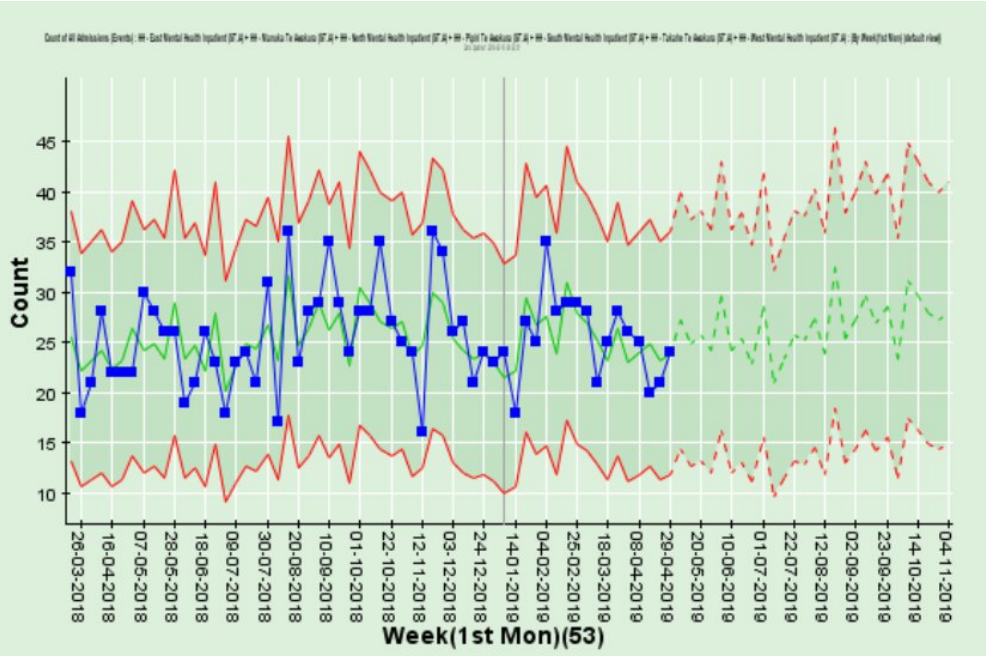
The average length of stay for consumers discharged from Te Awakura was 17 days for March 2019 and 19 days for April 2019. We are closely monitoring length of stay in terms of difficulties with accommodation supply in Christchurch.



Our focus on reduction of seclusion in Te Awakura continues. In March 2019, five consumers experienced seclusion for a total of 148.7 hours. In April 2019, six consumers experienced seclusion for a total of 607.0 hours. High occupancy and acuity with presentations that include alcohol and other drugs has impacted on the use of seclusion. The facility design limits our options for supporting people that are acutely distressed.

The next two graphs show a count of admissions to Te Awakura (the acute adult unit) – the first is a monthly view, and the second a weekly view. The number of adult admissions (to Te Awakura) shows an increasing trend but remains within the expected range.



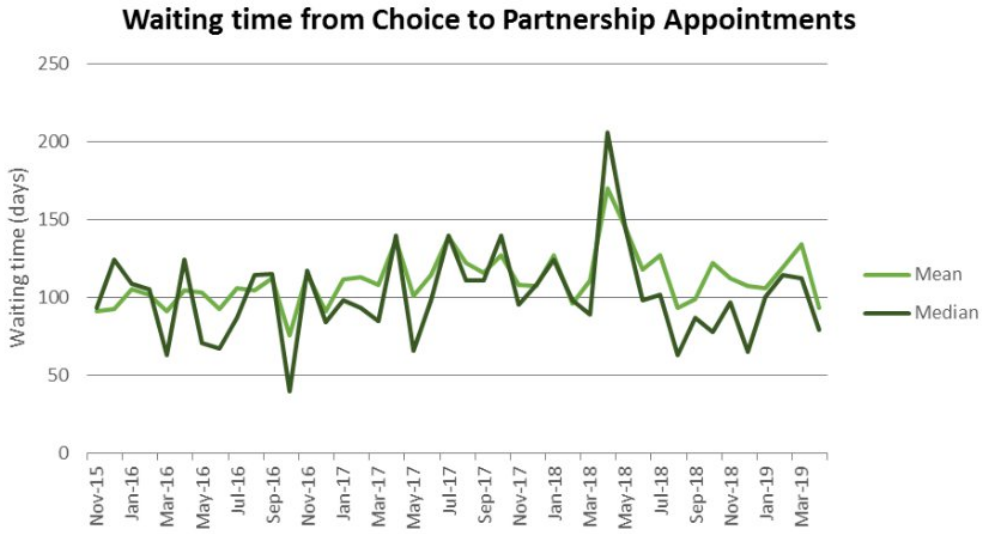


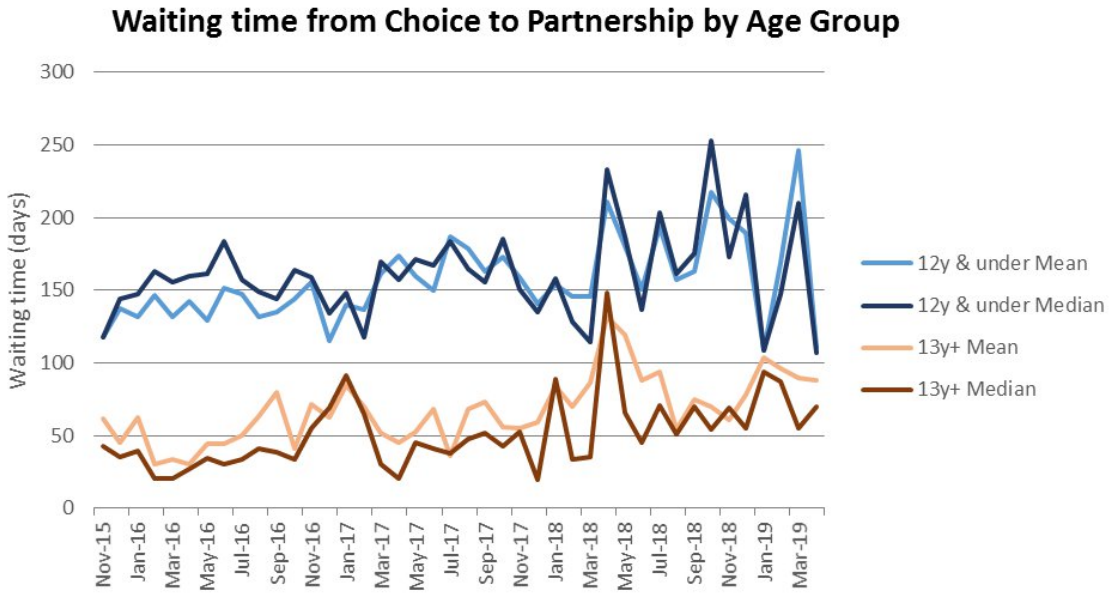
Child and Youth

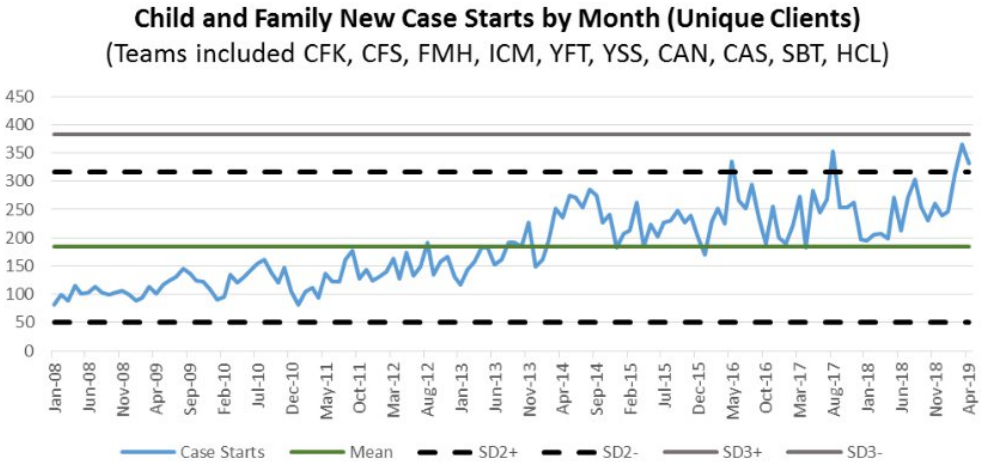
There has been a 98% increase in child and adolescent case starts in the past six financial years.

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

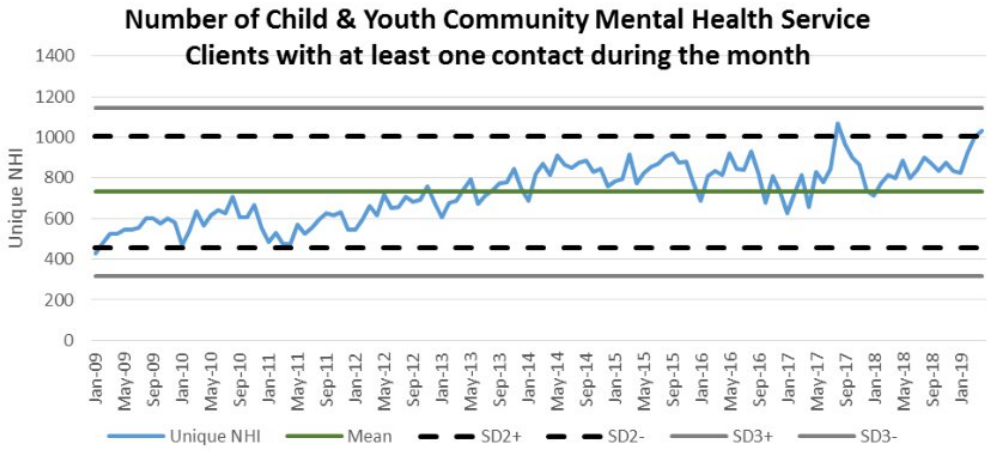
The graphs below show the waiting time between Choice (1st) and Partnership (2nd) appointments. Children and adolescents assessed as being of high priority go straight to a Partnership appointment, bypassing the Choice appointment process.



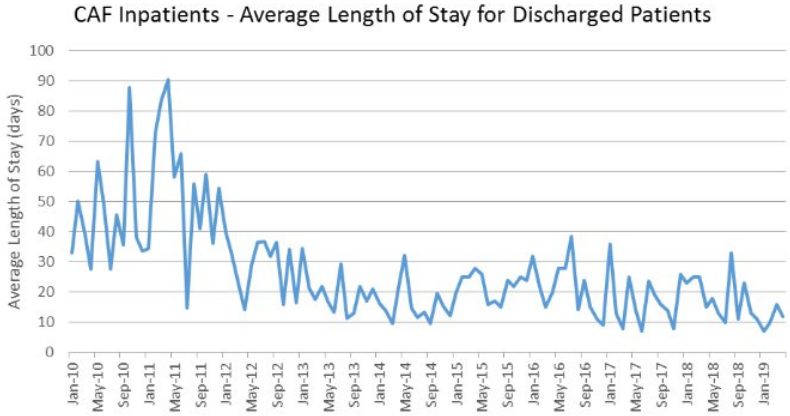




New cases were created for 365 children and adolescents (unique NHIs) in March 2019 and 332 in April 2019. CAF services are making good progress with implementation of a Direction of Change that supports more integrated services across the age ranges.

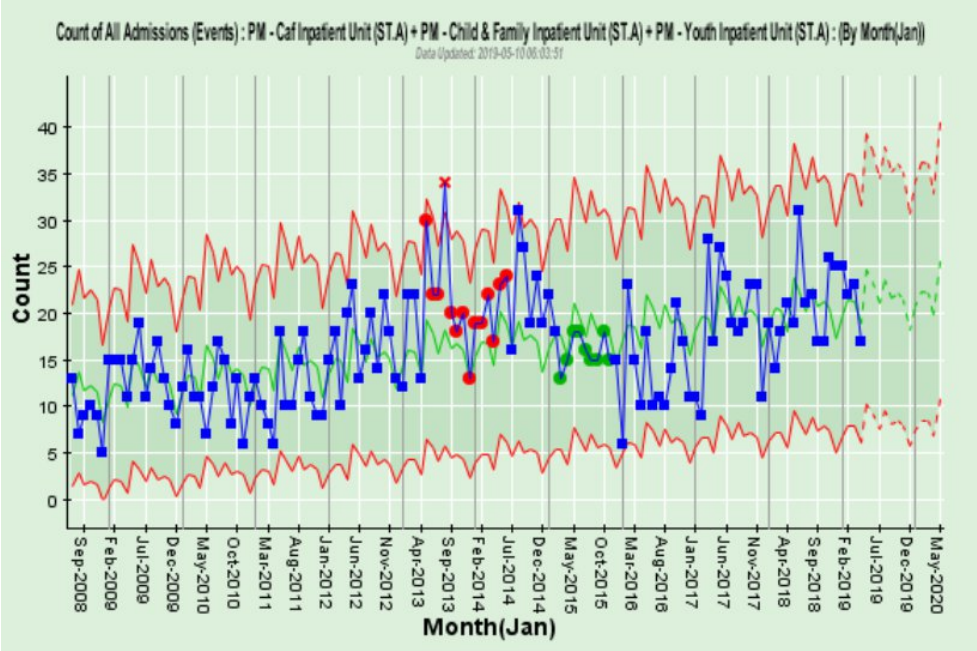


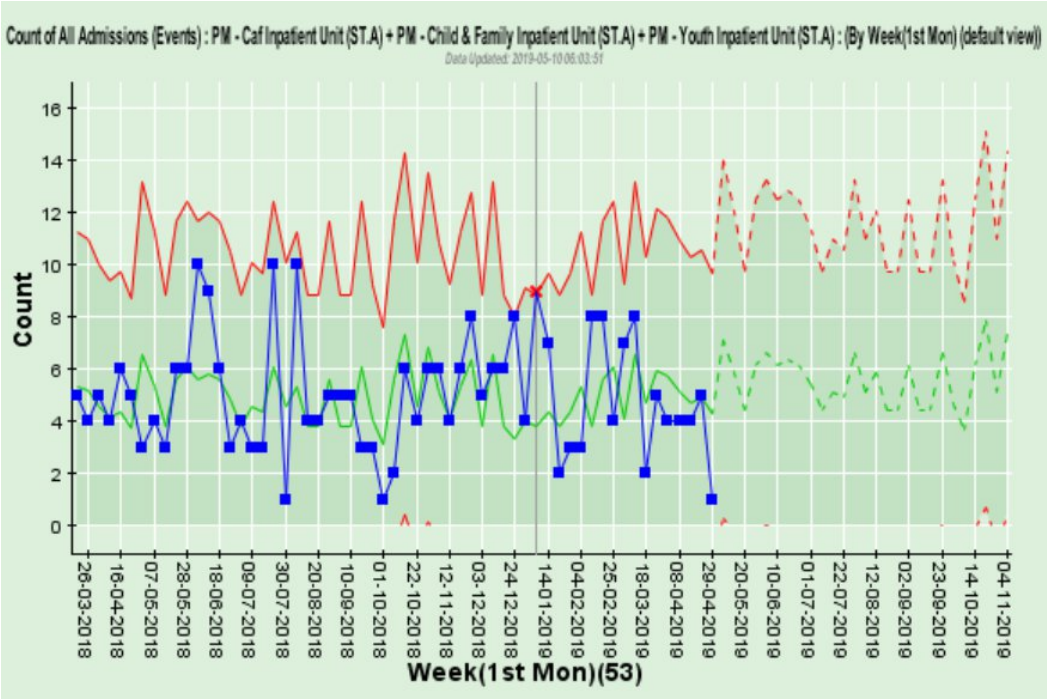
The number of unique clients with contacts above shows a similar pattern to new case starts graph, which demonstrates an increase in demand for Child and Youth community Mental Health Service. There were 1004 unique patients with at least one contact during the month of March 2019 and in April 2019 there were 1031.



The average length of stay for discharged patients was 16 days for March 2019 and 12 days for April 2019.

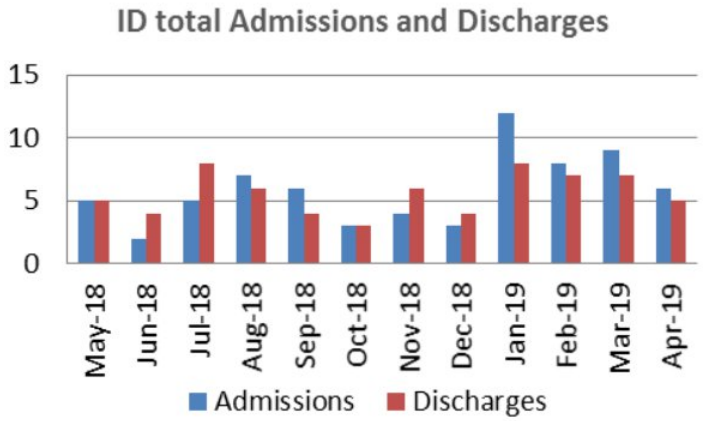
The graphs below show the number of admissions to the Child and Adolescent Unit and its predecessors. The first graph is a monthly view, and the second a weekly view.

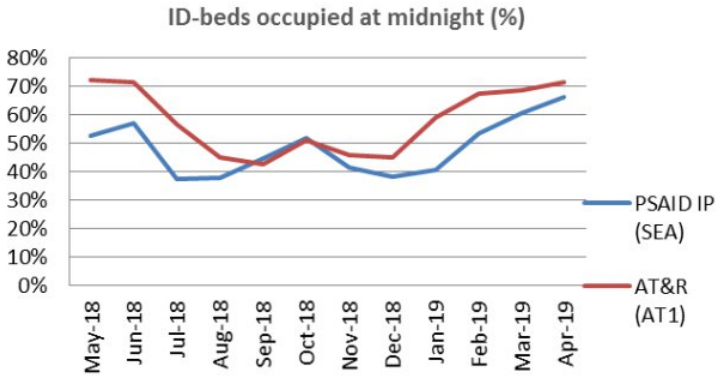




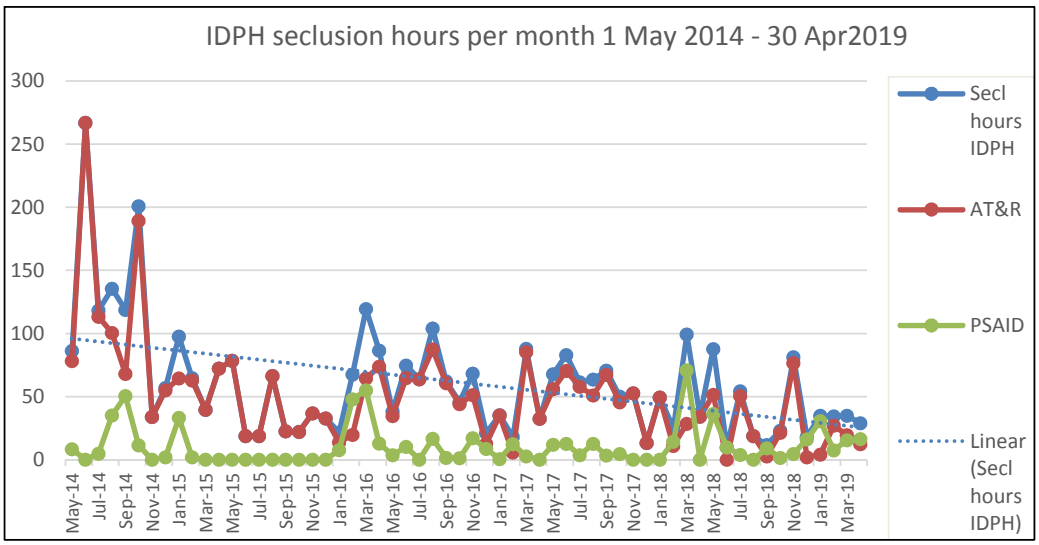
Intellectually Disabled Persons Health Service

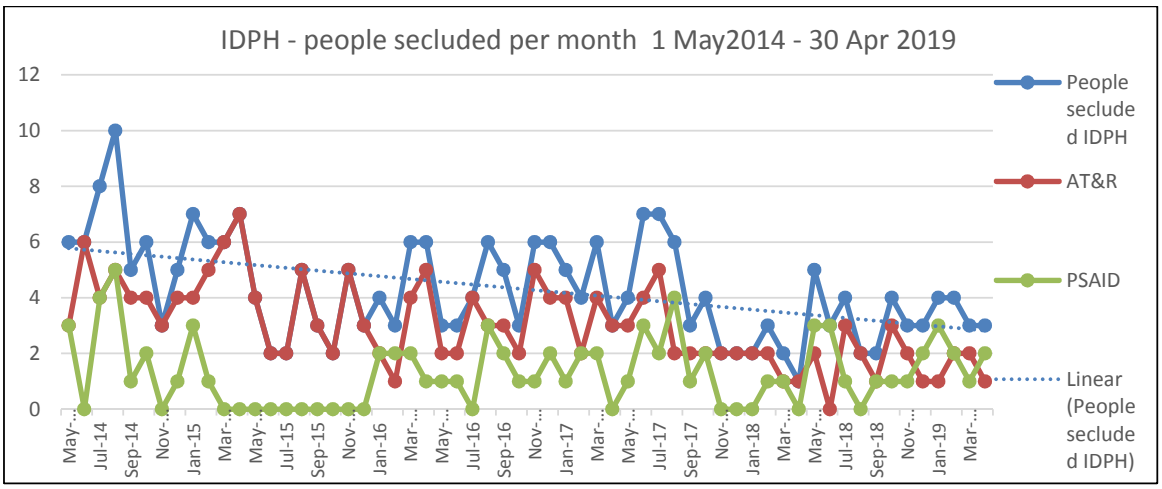
The IDPH Service inpatient units comprise a 8-10 bed secure unit, Assessment, Treatment and Rehabilitation (AT&R), and a 15 bed dual disability unit, Psychiatric Service for Adults with Intellectual Disability (PSAID) within the Aroha Pai Unit, Hillmorton Hospital.

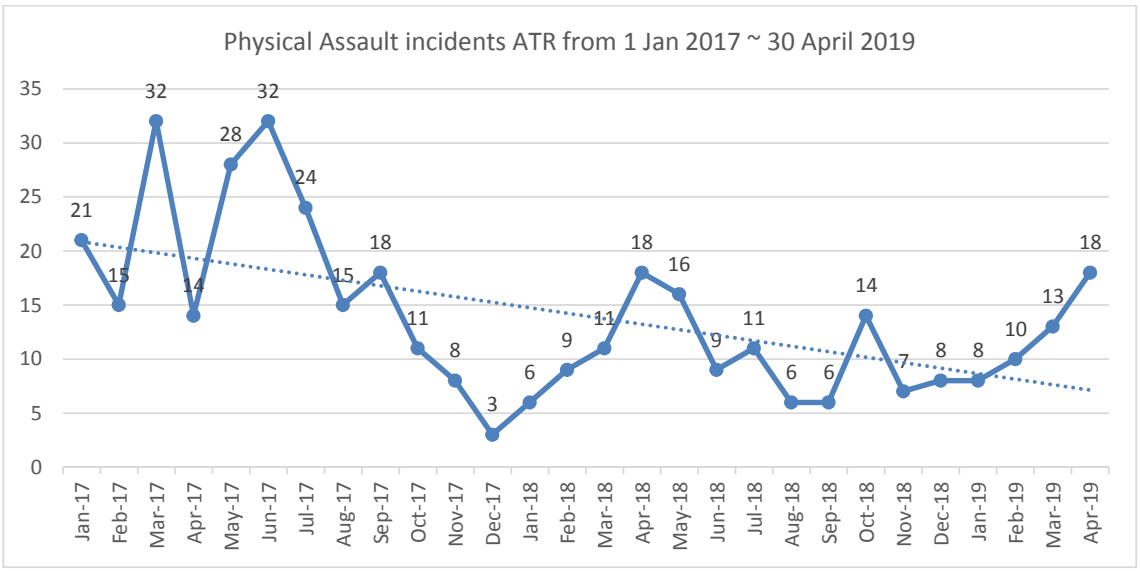


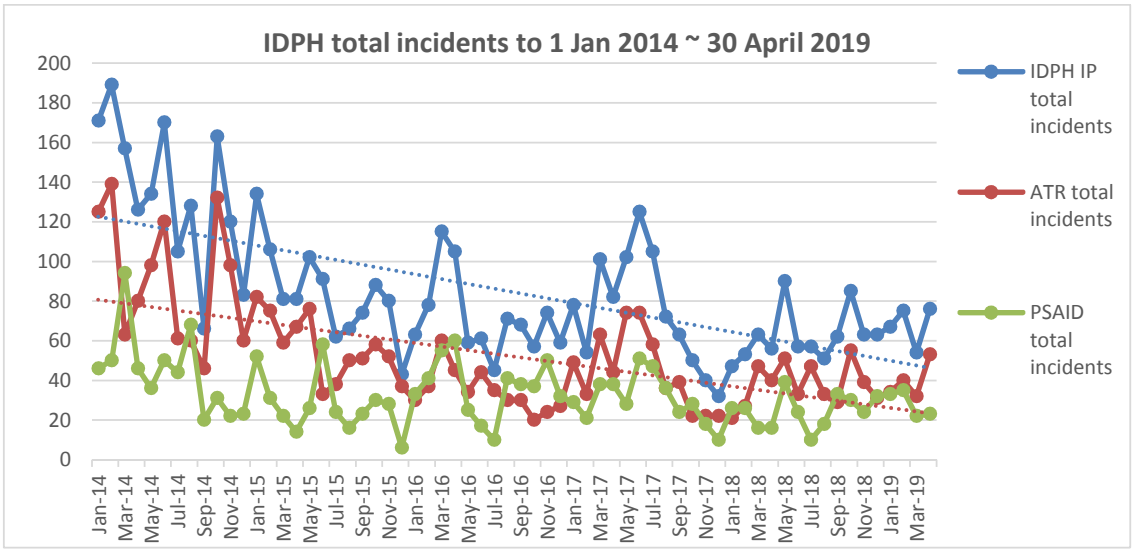


Occupancy in AT&R (AT1) was 69% for the month of March 2019 and 71% for April 2019. The figures for PSAID (SEA) were 61% and 66% respectively.




IDPH - people secluded per month 1 May2014 - 30 Apr 2019
People secluded IDPH
AT&R
PSAID
Linear (People secluded IDPH)


Physical Assault incidents ATR from 1 Jan 2017 ~ 30 April 2019


IDPH total incidents to 1 Jan 2014 ~ 30 April 2019
IDPH IP total incidents
ATR total incidents
PSAID total incidents

Improved Dental Care for clients of the Mental Health Service

People receiving treatment for mental health illness are, as a group, known to suffer from poorer dental health than the general population. This is associated with a range of factors including socioeconomic status, risk behaviours and the effect that some psychotropic medications have on reducing salivary flow.

A group of people from Specialist Mental Health Services, Hospital Dental, General Practice and Canterbury Initiative have worked together, in discussion with providers and consumers to develop some solutions for the barriers that prevent this group from accessing dental care. These include:

- Improving information provided to mental health clients by the Specialist Mental Health Service, Hospital Dental and General Practice. This will be supported by the establishment of a health promoter at the Hospital Dental Service to work with health providers, encouraging the use of HealthPathways and supporting consumers to access HealthInfo or hard copy information.
- Development of a dental surgery assistant role in the Hospital Dental Service with a focus on supporting mental health consumers, including reducing did not attend rates seen with this group.
- Working with the Equally Well programme to encourage discussion about dental health and provide a free pack including a toothbrush, paste and information, as a part of the Equally Well annual consultation.
- Provision of a free course of dental care to clients at Totara House, a specialist multidisciplinary service that provides care to young people following their first presentation of significant psychosis. This dental care will include examination, treatment, preventative care and education. Alongside this a pack will be provided containing a range of oral health care items.
- A range of new roles are being put in place to provide these improved services including a 0.5 FTE dentist, a dental surgery assistant, an oral health promoter and some administration capacity. Oral health care packs are being provided using outside sponsorship.

These developments are consistent with best practice for provision of care to mental health consumers and with the goals of “Equally Well”, which is a national initiative seeking to improve the physical health outcomes of mental health consumers. Getting this right will see mental health consumers being able to manage their own preventive oral care and access oral health services in a timely fashion when needed. A range of factors will be evaluated in order to help us fine tune our approach in this area.

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 10 Months Ended 30 April 2019

MONTH $'000						YEAR TO DATE				
18/19 Actual $'000	18/19 Budget $'000	17/18 Actual $'000	18/19 Variance $'000	18/19 vs 17/18 Variance $'000		18/19 Actual $'000	18/19 Budget $'000	17/18 Actual $'000	18/19 Variance $'000	18/19 vs 17/18 Variance $'000
					Operating Revenue					
481	398	647	83	(166)	From Funder Arm	4,796	3,997	5,900	799	(1,104)
1,469	1,618	1,506	(149)	(37)	MOH Revenue	15,193	15,952	15,232	(759)	(39)
4,686	4,681	4,259	5	427	Patient Related Revenue	42,099	46,213	41,344	(4,114)	755
1,540	1,629	1,226	(89)	314	Other Revenue	15,398	13,069	13,402	2,329	1,996
8,176	8,326	7,638	(150)	538	**TOTAL OPERATING REVENUE**	77,486	79,231	75,878	(1,745)	1,608
					Operating Expenditure					
					Personnel Costs					
65,232	60,940	58,733	(4,292)	(6,499)	Personnel Costs - CDHB Staff	609,325	588,018	553,230	(21,307)	(56,095)
2,006	2,064	1,749	58	(257)	Personnel Costs - Bureau & Contractors	18,940	19,637	18,306	697	(634)
67,238	63,004	60,482	(4,234)	(6,756)	**Total Personnel Costs**	628,265	607,655	571,536	(20,610)	(56,729)
13,185	13,094	11,639	(91)	(1,546)	Treatment Related Costs	126,346	130,240	117,369	3,894	(8,977)
3,964	3,923	3,568	(41)	(396)	Non Treatment Related Costs	35,897	34,380	36,227	(1,517)	330
84,387	80,021	75,689	(4,366)	(8,698)	**TOTAL OPERATING EXPENDITURE**	790,508	772,275	725,132	(18,233)	(65,376)
(76,211)	**(71,695)**	**(68,051)**	**(4,516)**	**(8,160)**	**OPERATING RESULTS BEFORE INTEREST AND DEPRECIATION**	**(713,022)**	**(693,044)**	**(649,254)**	**(19,978)**	**(63,768)**
					Indirect Income					
3	(46)	2	49	1	Donations & Trust Funds	10	(412)	45	422	(35)
-	-	-	-	-	Gain on Disposal of Assets	-	-	-	-	-
3	**(49)**	**2**	**52**	**1**	**TOTAL INDIRECT INCOME**	**10**	**(439)**	**45**	**449**	**(35)**
					Indirect Expenses					
1,915	2,385	2,147	470	232	Depreciation	17,795	21,526	21,544	3,731	3,749
-	-	19	-	19	Loss on Disposal of Assets	(6)	-	41	6	47
1,915	**2,369**	**2,166**	**454**	**251**	**TOTAL INDIRECT EXPENSES**	**17,789**	**21,483**	**21,585**	**3,694**	**3,796**
(78,123)	**(74,113)**	**(70,215)**	**(4,010)**	**(7,908)**	**TOTAL SURPLUS / (DEFICIT)**	**(730,801)**	**(714,966)**	**(670,794)**	**(15,835)**	**(60,007)**

Achievements/Issues of Note

Financial savings realised after audit of cytokeratin ImmunoHistoChemistry (IHC) in breast sentinel nodes

Over the past three months, an audit has been undertaken within the Anatomical Pathology department of CHL. The audit centred on cytokeratin IHC in breast sentinel nodes. Over the three month period there were exactly 50 cases, and in not one case did the IHC alter the stage or clinical management (Isolated tumour cells only found in nine cases). Any micro or macrometastases were already identified on the H+E (haematoxylin and eosin stain) stained sections.

As a result of this audit, a new protocol has been adopted, that cytokeratins will only be done on cases where:

- the tumour is a lobular carcinoma (harder to see on H+E)
- the patient has had neoadjuvant chemotherapy (any tumour, even ITC's (isolated tumour cells), is important)
- the Pathologist is unsure what they are seeing and wants confirmation

Of the 50 audit cases only nine (18%) would then have gone on to have IHC, so it is expected that in the future around 80% of cases will no longer need testing.

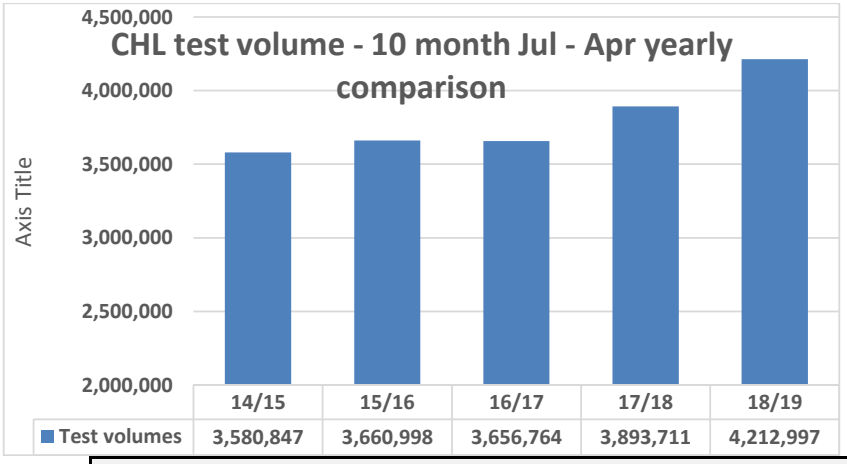
Reduction of overall spend and use of FTE in Haematology, and faster turnaround times achieved

Through an improvement in operational efficiencies, the tests/FTE has improved 17.7% when comparing May 18 – April 19 with May 17 – April 18. This means there has been a 13% decrease in costs compared to the year previous, or an 18% decrease in costs compared to the average across the last five years.

Over the same year, and also through operational efficiencies, the turnaround time for a Complete Blood Count test (CBC) has improved by 11.3 minutes, which is 18.4% quicker than it used to be provided during the previous year. A CBC is a blood test used to evaluate your overall health and detect a wide range of disorders, including anaemia, infection and leukaemia.

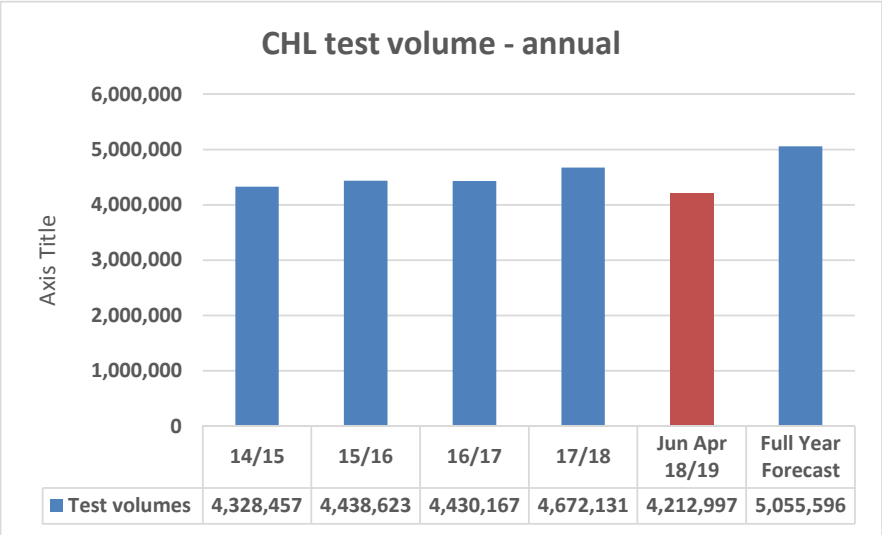
CHL volume activity reports

Activity year to date (10 months July-April) demonstrates growth in demand for laboratory services over previous years:



	Historical comparisons of 10 months (July-Apr) demand				
F/Y	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**
Test volumes	3,580,847	3,660,998	3,656,764	3,893,711	4,212,997
Percent change		2.24%	-0.12%	6.48%	8.20%

Extrapolated data, forecasting through to end of 18/19 indicates consistency with this growth in demand for services.



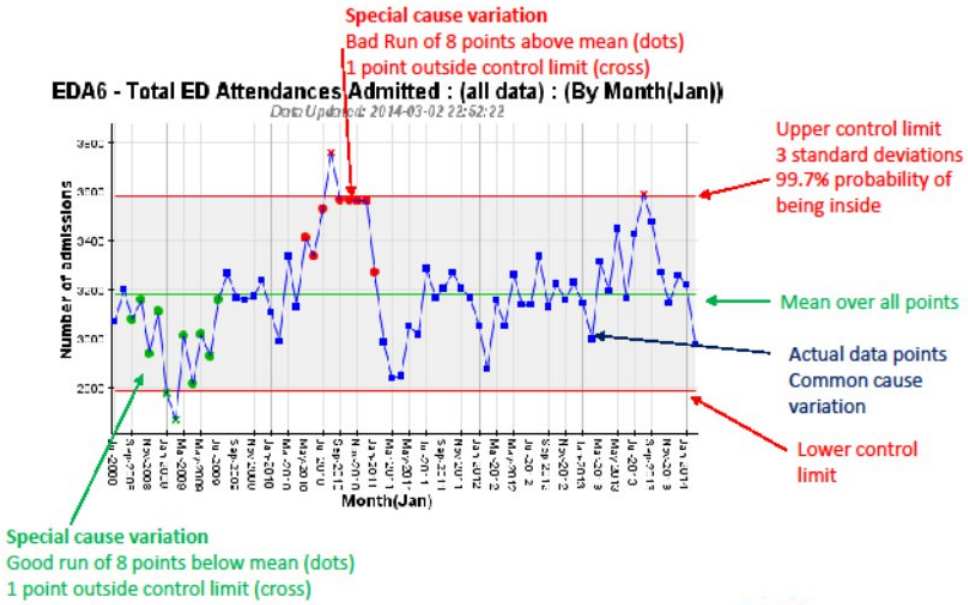
	12 months volumes					
F/Y	**14/15**	**15/16**	**16/17**	**17/18**	**Jun Apr 18/19**	**Full Year Forecast**
Test volumes	4,328,457	4,438,623	4,430,167	4,672,131	4,212,997	5,055,596
Percent change		2.55%	-0.19%	5.46%		8.21%

CHL continues to work with the regional alliance partner and internal referrers on ways to manage this growth and opportunities for any appropriate mitigations in service demand.

CHL Facilities

Activity is underway to repurpose the vacated space in the haematology and eye outpatient facility for a temporary relocation of laboratory support staff. The space in which CHL can occupy is limited due to a considerable portion of the mobile offices needing to be removed from site while the stairwell repairs are completed. This temporary relocation will help to generate some space within the laboratories to enable replacement of essential equipment and address some non-compliances in relation to the facilities. The programme of work to populate the vacated outpatient spaces has been delayed by the Outpatients building flood event. The vacated areas have required repopulation of outpatient services. This further delays the utilisation of these spaces by Labs which in turn prevents the scheduled sequence of changes to relieve pressure on space throughout the laboratory and the anatomical department in Otago School of Medicine.

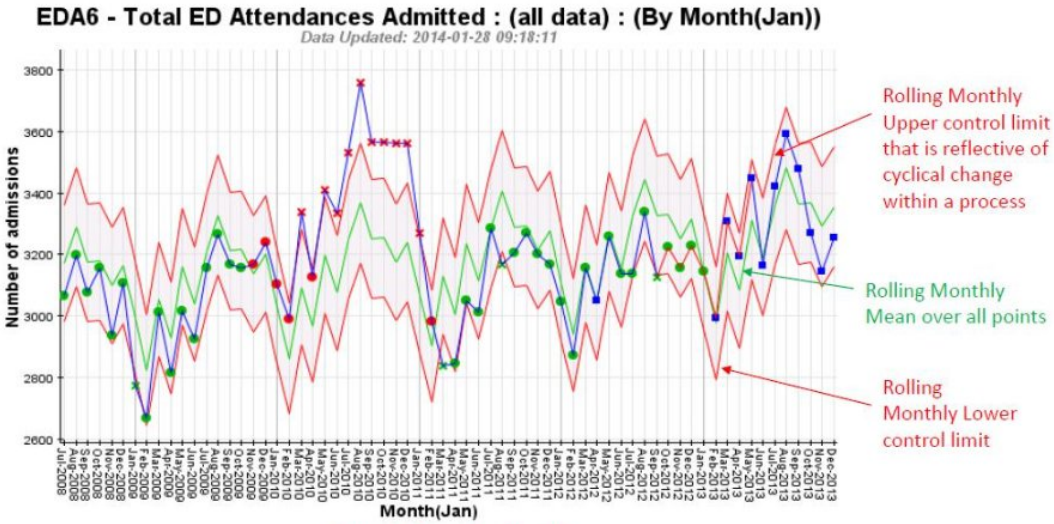
SPC: How to Interpret a Control Chart



sfn signals from noise

make it better

SPC: How to Interpret Cyclical and Trended Data



Criteria for a Cyclical Process:

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

sfn signals from noise

make it better

CLINICAL ADVISOR UPDATE – MEDICAL

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NOTES ONLY PAGE

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

SOURCE: **Corporate Services**

DATE: **30 May 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 4 April 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: **30 May 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 July 2016 to March 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 Harm and Patient Indicator Report and monitored by the Clinical Governance Group; Serious Incident Committee; the General Managers Group; and the Quality, Finance, Audit and Risk Committee.

3. APPENDICES

Appendix 1: CDHB Complaint Rate and Categories to March 2019

Report prepared by: Irena de Rooy, Quality & Patient Safety Manager

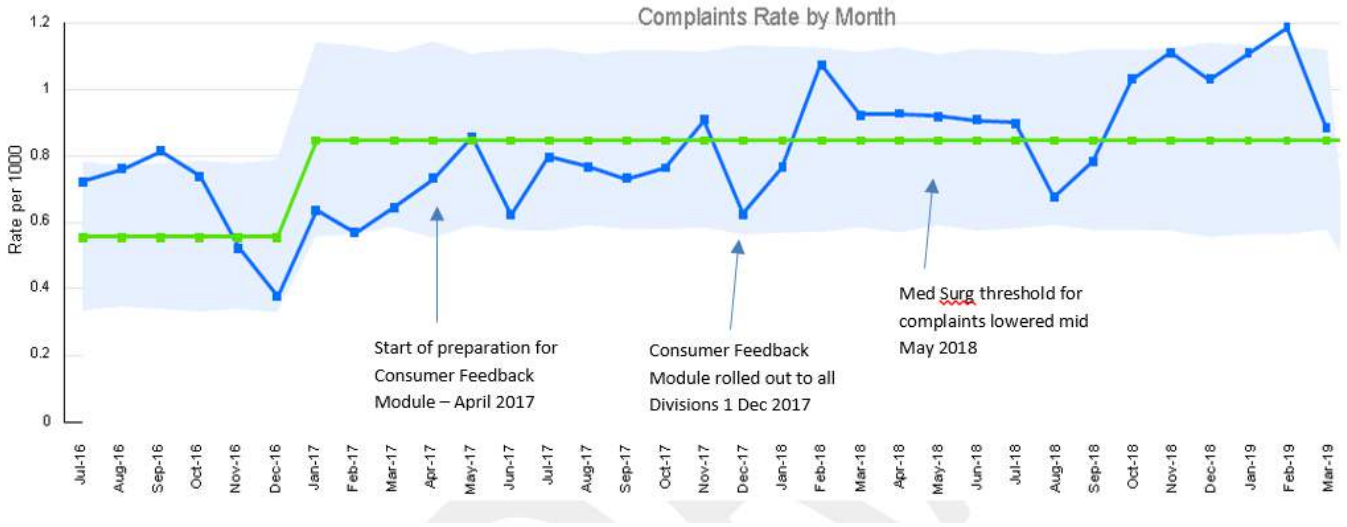
Report approved for release by: Mary Gordon, Executive Director of Nursing

APPENDIX 1

PATIENT EXPERIENCE: COMPLAINTS

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

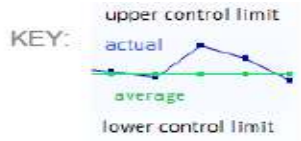
Outcome Indicator: **All Hospitals Complaints Rate**



Numerator: Total number of complaints received in the period.

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

Calculated as a rate per 1,000



Data for 2018/2019 year to date:

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	2017/18	2016/17
Complaints															
Numerator	96	79	81	107	113	92	105	113	92				878	1,061	816
Denominator	106,693	116,625	103,584	103,971	101,715	89,287	94,798	95,249	104,007				915,929	1,256,736	1,216,204
Rate per 1000	0.90	0.68	0.78	1.03	1.11	1.03	1.11	1.19	0.88				0.96	0.84	0.67

Please note *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.*

Comments

- Special cause variation: February 2019: data point falls outside the upper control limit. No clear trends were identified in the data; however a change in the way complaints were managed (mid 2018) in Med Surg has contributed to an increase in numbers for the Christchurch campus, previously a number of 'complaints' were managed as 'feedback' and not formally recorded as a complaint.

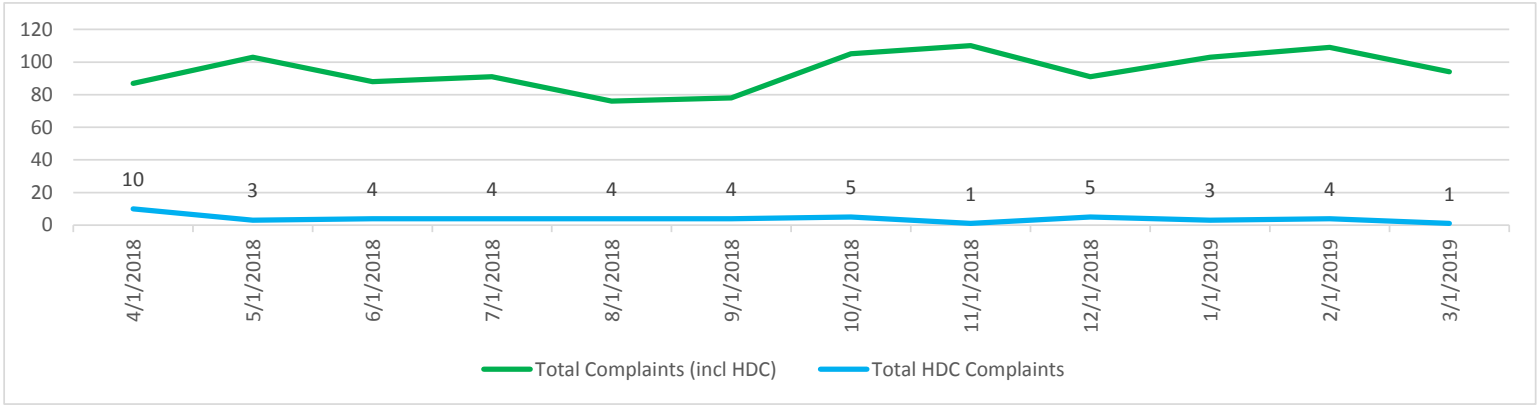
  February 2018; January and September 2017 - 9 consecutive points above the average required a step-change in the control limits. The increase was a result of the South Island Safety1st Consumer Feedback module roll out across the Canterbury DHB from 1 December 2017 when the definition of a complaint was revisited; all complaints are now recorded and counted (inclusive of the Health and Disability complaints).

- The rate for the 17/18 year was 0.85 (1,061 complaints) which is approximately 31% higher than the rate for the 16/17 year (rate 0.67, 816 complaints).

12 month breakdown of Complaints Categories from April 2018 to March 2019:

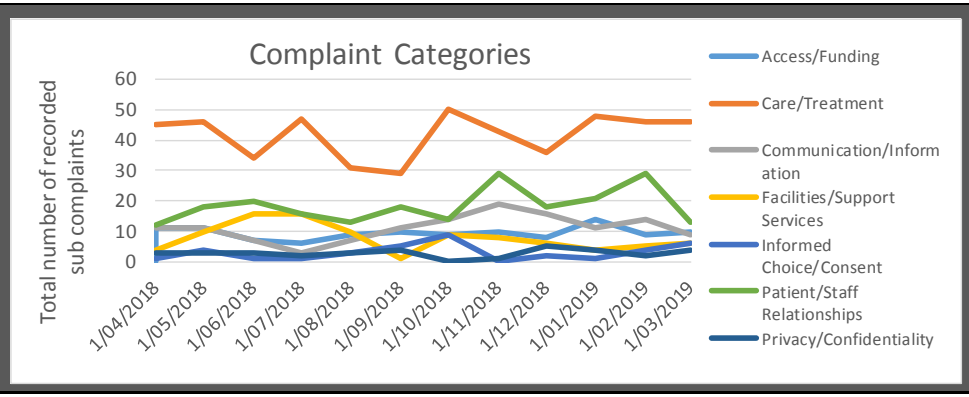
CDHB													
Start Date: 1/04/2018	1/04/2018	1/05/2018	1/06/2018	1/07/2018	1/08/2018	1/09/2018	1/10/2018	1/11/2018	1/12/2018	1/01/2019	1/02/2019	1/03/2019	TOTAL
Total Complaint Forms	87	103	88	91	76	78	105	110	91	103	109	94	***1135***
Total Number of Categories per complainee													
1	14	7	19	17	15	18	18	20	24	20	20	20	***212***
2	16	28	15	18	13	18	26	37	25	27	30	28	***281***
3	24	19	23	22	15	15	21	27	27	28	20	19	***260***
4	13	26	9	9	10	12	16	12	9	12	14	13	***155***
>5	20	23	22	25	23	15	24	14	6	16	25	14	***227***

CDHB HDC Complaint Trend Reports April 2018 to March 2019:



Complaints Categories trend graphs for April 2018 to March 2019

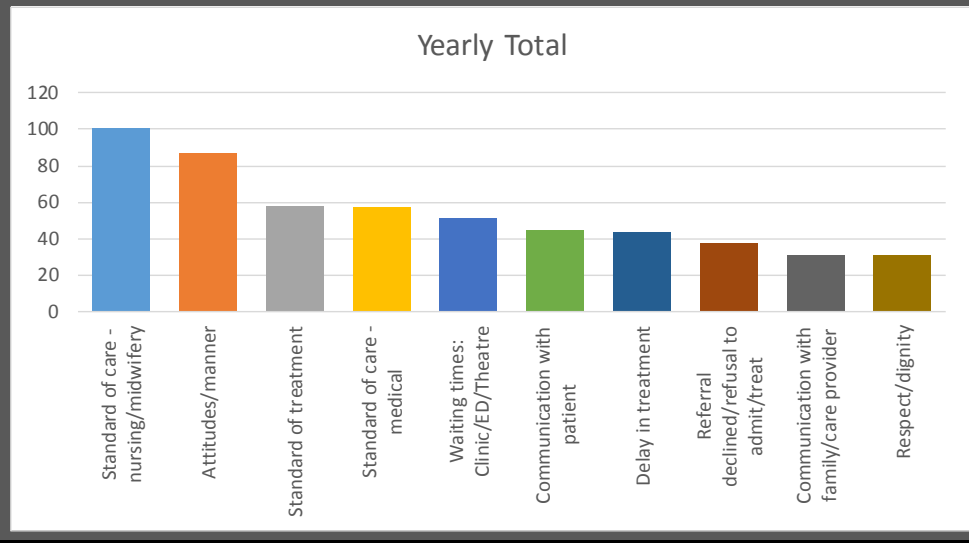
Yearly Grand Total by Cateogory		
TOP#		
1	Care/Treatment	501
2	Patient/Staff Relationships	221
3	Communication/Information	133
4	Access/Funding	114
5	Facilities/Support Services	95
6	Informed Choice/Consent	37
7	Privacy/Confidentiality	34



Complaint Forms count per form, each form can record multiple sub categories , sub-category count expectant to exceed count of complaint forms.

Top Ten Sub Categories Reported for the period - 01 Apr 2018 - 31 Mar 2019

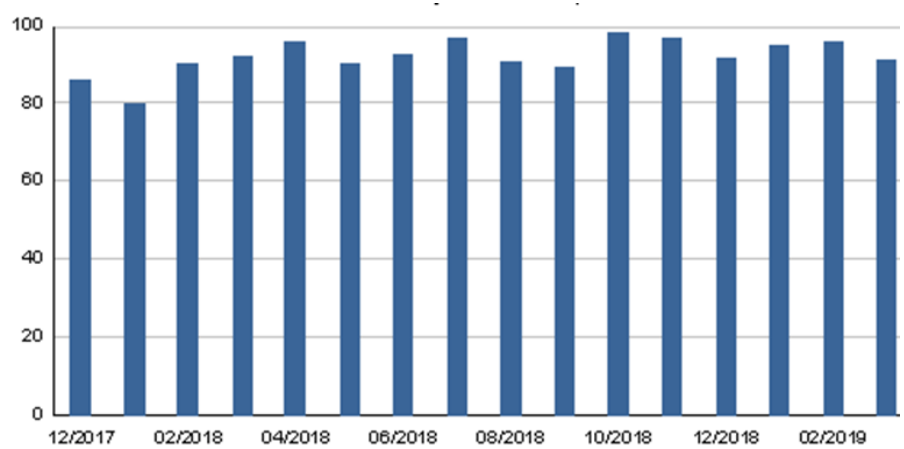
Top #	[Category] - Sub Category	Total
1	[Care/Treatment] Standard of care - nursing/midwifery	101
2	[Patient/Staff Relationships] Attitudes/manner	87
3	[Care/Treatment] Standard of treatment	58
4	[Care/Treatment] Standard of care - medical	57
5	[Care/Treatment] Waiting times: Clinic/ED/Theatre	51
6	[Communication/Information] Communication with patient	45
7	[Care/Treatment] Delay in treatment	43
8	[Access/Funding] Referral declined/refusal to admit/treat	37
9	[Communication/Information] Communication with family/care provider	31
10	[Patient/Staff Relationships] Respect/dignity	31



The implementation of the consumer feedback module on Safety1st has enabled monitoring of the 5 and 20 day compliance timeframes as per Complaints Policy.

5 day Compliance

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



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

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

Comment

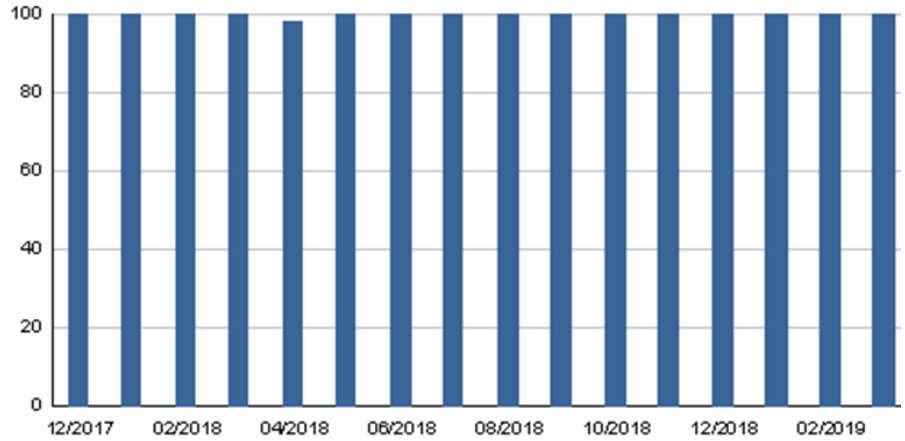
- 91% of complaints were acknowledged in writing within 5 working days of receipt for March 2019. The system issue creating the gap is currently being investigated.

Please note

HDC/Privacy Commissioner/Ombudsman/Minister of Health Complaints have different timeframes for responding and are excluded from this indicator.

20 day Compliance

Percentage of complaints responded to or resolved within 20 working days



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

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

Comment

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

Please note
HDC/Privacy Commissioner/Ombudsman/Minister of Health Complaints have different timeframes for responding and are excluded from this indicator

The percentage of complaints for the 5 day acknowledgment does not relate to the same complaint in the % 20 day responses.

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 (Becky Hickmott) & Allied Health (Jacqui Lunday-Johnstone)	Clinical Advisor Update –Nursing (Mary Gordon)	Clinical Advisor Update – Medical (Dr Sue Nightingale) 2019 Winter Planning Update	Clinical Advisor Update –Allied Health (Jacqui Lunday-Johnstone) H&SS 2016/17 Year Results	Clinical Advisor Update - Nursing (Mary Gordon)	Clinical Advisor Update – Medical (Dr Sue Nightingale) 2019 Winter Planning Review
Presentations	Sleep Health Services in Canterbury	Burwood Campus Avoidable Admissions in General Surgery	Christchurch Campus – Children's Haematology & Oncology Centre (*CHOC*)	SMHS	Christchurch Campus – ORL (ENT) TBC: Ashburton / Rural Health	TBC: Christchurch Campus – Dept. of Anaesthesia TBC: Labs
Governance and Secretariat Issues						2020 Workplan
Information Items	2019 Workplan	2019 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 2019 Workplan	2019 Workplan	2020 Meeting Schedule 2019 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 2019 Workplan
Public Excluded Items	CEO Update (as required)	CEO Update (as required)	CEO Update(as required)	CEO Update (as required)	CEO Update (as required)	CEO Update (as required)