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, 3 October 2019 commencing at 9:00am

	Apologies		9.00am
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 1 August 2019		
3.	Carried Forward / Action List Items		
4.	Perioperative Nursing (Presentation)	Marie Lory	9.05-9.35am
5.	Ashburton Rural Health Services (Presentation)	Berni Marra	9.35-10.05am
6.	Clinical Advisor Update (Oral) • Nursing	Mary Gordon	10.05-10.15am
7.	Hospital Service Monitoring Report: Rural Health Services Medical/Surgical & Women's & Children's Health ESPIs Mental Health Older Persons, Orthopaedics & Rehabilitation	 Berni Marra Win McDonald Pauline Clark Barbara Wilson Dan Coward	10.15-11.00am
8.	Resolution to Exclude the Public		11.00am
ESTIMATED FINISH TIME – PUBLIC MEETING			**11.00am**
	Information Items: 2020 Tentative Meeting Schedule 2019 Workplan		

NEXT MEETING: Thursday, 5 December 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	**Air Rescue Services Limited** - Director Subsidiary of the Canterbury West Coast Air Rescue Trust. Has gaming licenses with specified purpose of fundraising for air rescue services. **Canterbury West Coast Air Rescue Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air rescue and air ambulance services. Garden City Helicopters has a long-term

	air ambulance contract with the CDHB. **CRL Energy Limited** – Director CRL Energy Limited provides air quality testing and asbestos sampling and analysis services; methamphetamine contamination testing; dust; gas and noise workplace monitoring services in New Zealand. There is the potential for future work with the CDHB. **Farrell Construction Limited** - Chairman Farrell's Construction Limited is a commercial and light commercial construction company based in Christchurch. **New Zealand Flying Doctor Service Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB. **Ngai Tahu Farming** – Chairman Farming interests in North Canterbury and Queenstown Lakes District and Forestry interests in Canterbury, West Coast and Otago regions. **Stevenson Group Limited** – Deputy Chairman Property interests in Auckland and mining interests on the West Coast. **Taurus Management Limited** – Director Property syndication company based in Christchurch
Sally Buck Board Member	**Christchurch City Council (*CCC*)** – Community Board Member Chair of the Central/Linwood/Heathcote Community Board which has delegated responsibilities from the CCC. **Registered Resource Management Act Commissioner** From time to time, sit on Resource Management Act panels for the CCC. Specific interests will be declared at the time. **Rose Historic Chapel Trust** – Member Charitable voluntary body managing the operation of the Rose Historic Chapel, a CCC owned facility.
Dr Anna Crighton Board Member	**Christchurch Heritage Limited** - Chair - Governance of Christchurch Heritage **Christchurch Heritage Trust** – Chair - Governance of Christchurch Heritage **Heritage New Zealand –** Honorary Life Member CDHB owns buildings that may be considered to have historical significance. **The Art Registry Company Limited** - Shareholder **Theatre Royal Charitable Foundation** – Director
Jan Edwards	No conflicts at this time.
David Morrell Board Member	**British Honorary Consul** Interest relates to supporting British nationals and relatives who may be hospitalised arising from injury related accidents, or use other services of CDHB, including Mental Health Services. A conflict of interest may also arise from time to time in respect to Coroners' inquest hearings involving British nationals. In addition, the British Foreign and Commonwealth Office (*FCO*) may expect Honorary Consuls to become involved in trade initiatives from time to time.

	Canon Emeritus - Christchurch Cathedral The Cathedral congregation runs a food programme in association with CDHB staff. **Friends of the Chapel** - Member **Great Christchurch Buildings Trust** – Trustee The Trust seeks the restoration of key Christchurch heritage buildings, particularly Christchurch Cathedral, and is also involved in facilitating the building of social housing. **Heritage NZ –** Subscribing Member Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have heritage significance. **Hospital Lady Visitors Association** - Wife is a member of this, but no potential conflict of interest is expected. Should one arise it will be declared at the time. **Nurses Memorial Chapel Trust** – Member (CDHB Appointee) Trust responsible for Memorial Chapel on the Christchurch Hospital site. Note the chapel is now owned by the Christchurch City Council.
Dr Rochelle Phipps	**Accident Compensation Corporation** – Medical Advisor ACC is a Crown entity responsible for administering NZ's universal no-fault accidental injury scheme. As a Medical Advisor, I analyse and interpret medical information and make recommendations to improve rehabilitation outcomes for ACC customers. **OraTaiao: New Zealand Climate & Health Council** – Founding Executive Board Member (no longer on executive) The Council is a not-for-profit, politically non-partisan incorporated society and comprises health professionals in Aotearoa/New Zealand concerned with: • the negative impacts of climate change on health; • the health gains possible through strong, health-centred climate action; • highlighting the impacts of climate change on those who already experience disadvantage or ill health (equity impacts); and • reducing the health sector's contribution to climate change. **Royal New Zealand College of General Practitioners** – Christchurch Fellow and Former Board Member The RNZCGP is the professional body and postgraduate educational institute for general practitioners.
Trevor Read	**Lightfoot Solutions Ltd** – Global Director of Clinical Services Lightfoot Solutions has contracts with CDHB, and other health providers who have contracts with CDHB, to provide business intelligence tools and related consulting services. Should a conflict arise, this will be discussed at the time.
Ta Mark Solomon **Ex Officio – HAC** Deputy Chair CDHB	**Claims Resolution Consultation – Senior Maori Leaders Group** – Member This is an Advisory Board to MSD looking at the claims process of those held under State care. **Deep South NSC (National Science Challenge) Governance Board** – Member The objective of Deep South NSC is set by Cabinet, and is to understand the role of the Antarctic and Southern Ocean in determining our climate and our future

	environment. Building on this objective, the mission was developed to guide our vision, research priorities and activities. **Governance Board (General Partnership Limited) Te Putahitanga o Te Waipounamu** – Chair Te Putahitanga o Te Waipounamu is a commissioning entity that works on behalf of the iwi in the South Island to support and enable whanau to create sustained social impact by developing and investing in ideas and initiatives to improve outcomes for Māori, underpinned by whānau-centred principles and strategies, these include emergency preparedness and disaster recovery. Te Pūtahitanga o Te Waipounamu also invests in Navigator roles to support and build whānau capability. **Greater Christchurch Partnership Group** – Member This is a central partnership set up to coordinate our city's approach to key issues. It provides a strong, joined up way of working and ensures agencies are travelling in the same direction (so they do not duplicate or negate each other's work). **He Toki ki te Rika / ki te Mahi** – Patron He Toki ki te Rika is the next evolution of Māori Trade Training re-established after the earthquakes to ensure Maori people can play a distinguished role in the Canterbury rebuild. The scheme aims to grow the next generation of Māori leadership in trades by building Māori capability in the building and infrastructure industries in Canterbury. **Interim Te Ropu** – Member An Interim Ropu has been established to work in partnership with the Crown, Ministers, and the joint venture to help develop and shape initial work on a national strategy to prevent and reduce family violence, sexual violence and violence within whānau. The interim Te Rōpū has been appointed by the Minister of Māori Development and the Lead Minister in consultation with the Minister of Māori/Crown Relations. It comprises up to ten members who bring appropriate skills and expertise and who can reflect communities, rangatahi and whānau, urban and regional Māori and wāhine Māori. The group will help inform the terms of reference of the permanent Te Rōpū, with advice due by April 2019. **Maori Carbon Foundation Limited** – Chairman The Maori Carbon Foundation has been established to deliver environmental, social and economic benefits through the planting of permanent carbon forestry, to Maori and New Zealand landowners throughout the country. **Ngāti Ruanui Holdings Corporation Limited** – Director Ngati Ruanui Holdings is the Investment and Economic Development Arm of Ngati Ruanui established to maximise profits in accordance with Te Runanga directions in Taranaki. **NZCF Carbon Planting Advisory Limited** – Director NZCF Carbon Planting Advisory Limited is a company that carries out the obligations in respect of planting and upskilling relating to the Maori Carbon Foundation Limited. **Oaro M Incorporation** – Member 'Oaro M' Incorporation was established in 1968. Over the past 46 years successive Boards have managed and maintained the whenua, located at 'Oaro M', Kaikōura, on behalf of its shareholders. Over time shareholders have requested the Board consider establishing an education grant in order to assist whānau with their educational aspirations.

Police Commissioners Māori Focus Forum – Member
The Commissioner of Police has a group of senior kaumatua and kuia who meet with him regularly to discuss issues of mutual interest and concern. Known as the Commissioner's Māori Focus Forum, the group helps guide policing strategy in regard to Māori and provides advice on issues of the moment. The Māori Focus Forum developed The Turning of the Tide with help from Police. The forum plays a governance role and helps oversee the strategy's implementation.

Pure Advantage – Trustee
Pure Advantage is comprised of business leaders who believe the private sector has an important role to play in creating a greener, wealthier New Zealand. It is a not-for-profit organisation that investigates and promotes opportunities for green growth.

QuakeCoRE – Board Member
QuakeCoRE is transforming the earthquake resilience of communities and societies through innovative world-class research, human capability development, and deep national and international collaborations. They are a Centre of Research Excellence (CoRE) funded by the New Zealand Tertiary Education Commission.

Rangitane Holdings Limited & Rangitane Investments Limited - Chair
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.

Taranaki Capital Partners Limited – Director
Not for profit company looking after share portfolios for Nga Rauru & Ngati Ruanui.

Te Ohu Kai Moana – Director
Te Ohu Kai Moana is an organisation that works to advance Maori interests in the marine environment, including customary commercial fisheries, aquaculture and providing policy and fisheries management advice and recommendations to iwi and the wider Maori community.

Te Ohu Kai Moana Portfolio Management Services Limited – Director
Sub-committee of Te Ohu Kai Moana

Te Ohu Kai Moana Trustee Limited – Director & Trustee
Charitable Trust of Te Ohu Kai Moana.

	Te Putea Whakatupu Trustee Limited – Shareholder Standalone Trust affiliated to Te Ohu Kai Moana. **Te Wai Maori Trustee Limited** – Shareholder Standalone Trust affiliated to Te Ohu Kai Moana. **Te Waka o Maui** – Independent Representative Te Waka o Maui is a Post Settlement Governance Entity.
Dr John Wood **Ex Officio – HAC** Chair CDHB	**Advisory Board NZ/US Council** – Member The New Zealand United States Council was established in 2001. It is a non-partisan organisation, funded by business and the Government, and committed to fostering and developing a strong and mutually beneficial relationship between New Zealand and the United States. The Advisory Board supports the day to day work of the Council by providing strategic and operational advice to both the Executive Board and the Executive Director. **Chief Crown Treaty Negotiator for Ngai Tuhoe** Settlement negotiated. Deed signed and ratified. Legislation enacted. **Chief Crown Treaty Negotiator for Ngati Rangi** Settlement negotiated. Deed signed and ratified. Legislation awaiting enactment. **Chief Crown Treaty Negotiator, Tongariro National Park** Engagement with Iwi collective begins July 2018. **Chief Crown Treaty Negotiator for the Whanganui River** Settlement negotiated. Deed signed and ratified. Legislation enacted. **Chief Crown Negotiator & Advisor, Mt Egmont National Park Negotiations** High level agreement in principle reached. Aiming for deed of settlement end of 2019. **School of Social and Political Sciences, University of Canterbury** – Adjunct Professor Teach into graduate and post graduate programmes in political science, trade policy and diplomacy – pro bono appointment. **Te Arawhiti, Office for Maori Crown Relations** **Member Chief Crown Negotiators Forum** Te Arawhiti, are responsible for monitoring and enhancing relations between Maori and the Crown, negotiating the settlement of historical Treaty of Waitangi claims, and the administration of the Marine and Coastal Area (Takutai Moana) Act 2011. They also advise and help claimant groups so they are ready to enter negotiations. **Te Urewera Governance Board** –Member The Te Urewera Act replaces the Te Urewera National Parks Act for the governance and management of Te Urewera. The purpose of the Act is to establish and preserve in perpetuity a legal identity and protected status for Te Urewera for its intrinsic worth, its distinctive natural and cultural values, the integrity of those values, and for its national importance. Inaugural term as a Crown appointment, re-appointed as a Ngai Tuhoe nominee.

MINUTES – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

APOLOGIES
Apologies for absence were received and accepted from Barry Bragg; Jan Edwards; and Ta Mark Solomon.

EXECUTIVE SUPPORT
David Meates (Chief Executive); Mary Gordon (Executive Director of Nursing); Carolyn Gullery (Executive Director, Planning Funding & Decision Support); and Anna Craw (Board Secretariat).

EXECUTIVE APOLOGIES
Jacqui Lunday-Johnstone (Executive Director, Allied Health, Scientific & Technical); and Justine White (Executive Director, Finance & Corporate Services)

IN ATTENDANCE

Item 4
Toni Gutschlag, General Manager, Specialist Mental Health Services (*SMHS*)
Vicki Dent, Acting Quality Manager, SMHS
Peri Renison, Chief of Psychiatry, SMHS
Joan Taylor, Director of Nursing, SMHS
Barbara Wilson, Acting Director Quality & Operations, SMHS

Item 5
Kirsten Beynon, General Manager, Laboratories
Pauline Clark, General Manager, Medical/Surgical & Women's & Children's Health
Dan Coward, General Manager, Older Persons, Orthopaedics and Rehabilitation
Toni Gutschlag, General Manager, Specialist Mental Health Services
Berni Marra, Manager, Ashburton Health Services
Win McDonald, Transition Programme Manager, Rural Health Services

Item 6
David Green, Financial Controller

1. INTEREST REGISTER

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

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

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

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (09/19)
(Moved: Dr Rochelle Phipps/Seconded: Trevor Read – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 30 May 2019 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION ITEMS

The carried forward action item was noted.

4. SPECIALIST MENTAL HEALTH SERVICES (PRESENTATION)

The Committee received a presentation from Specialist Mental Health Services (SMHS). Those in attendance were Toni Gutschlag (General Manager); Vicki Dent (Acting Quality Manager); Peri Renison (Chief of Psychiatry); Joan Taylor (Director of Nursing); and Barbara Wilson (Acting Director Quality & Operations). The presentation provided an overview of the following:

- Demand. There have been measurable changes to service demand and utilisation in the period from January 2008 to June 2019.
- Workforce Development. Staff are the greatest asset and investment. Workforce development builds capability and confidence in practice.
- Quality Improvement. Two programmes underway are:
  - Zero Seclusion = Safer for All; and
  - Connecting Care Project.
- Facilities Summary
- SMHS Purpose & Strategy. Strategy work undertaken confirming core purpose and five strategic pillars.

Discussion took place on the following:

- Talking Therapies Programme - what it is, its importance in the SMHS space, and recognition of training.
- Where additional Mental Health funding could be used to be of greatest benefit to CDHB.
- Rural Child, Adolescent and Family (*CAF*) case starts - Kaikoura. The success of implementing wrap around services following the earthquake and learnings that have been taken from this.
- Rural CAF case starts - Ashburton. Issues currently faced and the joined up response from Health, Police, Education and Council.
- Including rate based measures in future analysis.

5. H&SS MONITORING REPORT

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

General Managers spoke to their areas as follows:

Laboratories – Kirsten Beynon, General Manager

- Focus has been on managing peaks, keeping work moving through, managing sick leave, and masterplanning.

There was discussion on Point of Care Testing, as well as the demand on laboratory services for rural work.

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

- AT&R Unit (the *Unit*). Following further staff assaults, SMHS is working closely with People and Capability, and the NZNO. There is now an agreed minimum staffing ratio of 2:1. In addition, a number of wellbeing measures are being implemented.

  Fast paced temporary works are underway to allow for better segregation of consumers in the short term.

  The Unit is currently closed to new admissions, with no physical capacity or staffing resource to provide care to additional consumers.

In response to a query on workforce development it was noted that the "Kirkpatrick Model" is an education evaluation methodology, used to assess whether training has resulted in changes in practice.

There was discussion around staff turnover rates, with it noted that most staff move around within the Service, so skills are not lost to SMHS.

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

- Highlighted the success of the "Rethinking Rehab" approach. This has resulted in:
  - an increased use of volunteers to support rehab activity within the ward environment;
  - the use of patient stories to create information videos provided to inpatients and their whanau to better support the inpatient journey and patient's transition back to the community; and
  - the development of Ward Action Plans.

The Committee extended its congratulations on the success of the "Rethinking Rehab" initiative to date.

There was discussion on Pressure Injuries and the introduction of the "Purpose T" skin risk assessment tool. This has led to a change in practice, with current focus on education and getting quality improvement embedded. Long term, it is expected a reduction in pressure injuries will be evidenced.

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

- Focus continues on building partnerships with other DHB campuses.
- Establishment of a clinical lead role for rehabilitation.

Rural Health Services – Win McDonald, Transition Programme Manager

- Akaroa. The medical centre has now shifted into the new facility.
- Kaikoura. Currently in the process of handover to a business as usual space/model.
- Chatham Islands.

There was discussion around challenges faced by the Chatham Islands. It was noted the Department of Internal Affairs has an investment strategy for the Chatham Islands.

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

- Record volumes across various services in July were highlighted, as well as for the calendar year to date.

- Christchurch Hospital continues on a regular basis to operate at levels of occupancy generally considered well above desirable levels for a tertiary hospital.
- Influenza rates are significantly higher this year, and have hit earlier than previously. To date 742 people have been hospitalised with influenza.
- A multi-agency, integrated response to family violence has been established.

There was a query around the drop in acute patients seen by Hospital Dental for the 18/19 year. It was noted that this was not due to a drop in demand, but rather a change in pathway. Increased distraction processes/systems have been implemented resulting in fewer patients required to be seen in the Hospital Dental setting.

Resolution (10/19)
(Moved: Sally Buck/Seconded: Trevor Read – carried)

"That the Committee:

i. notes the Hospital Advisory Committee Activity Report."

6. H&SS 2018/19 YEAR RESULTS (PRESENTATION)

David Green, Financial Controller, presented to the Committee providing an overview of:

- the provisional year end 2018/19 result;
- a series of one off items that impacted on the results;
- resource cost pressure increases with MECA settlements; and
- key areas of cost in the Provider arm which continue to be under pressure.

There was discussion around the one off items which impacted the result, noting that some are common to all DHBs, whilst others are unique to CDHB. There was a request that the variances to budget table be provided to the August Board meeting and also include any offsetting items (ie, revenue received over and above costs incurred or budgeted).

7. CLINICAL ADVISOR UPDATE – ALLIED HEALTH (ORAL)

This item was deferred.

8. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (11/19)
(Moved: David Morrell/Seconded: Sally Buck – 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 30 May 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 11.23am.

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 3 OCTOBER 2019

	DATE RAISED	ACTION	REFERRED TO	STATUS
1.	30 May 2019	New Treatments and Technologies Programme - Presentation	Dr Sue Nightingale	Scheduled for 5 December 2019 meeting.

Perioperative Nursing

Marie Lory

Perioperative Nurse Manager

Christchurch Campus

Perioperative Service Christchurch Campus

- Day Surgery Service (DSU)
- Day of Surgery Admission (DOSA)
- Operating Theatres
- Post Anaesthetic Care Unit (PACU)

Operating Theatre Locations

Current – 18 theatres

- 2 theatres level 3 CWH (Birthing Suite)
- 5 Theatres level 1 CWH
- 11 Theatres Parkside
- Burwood Procedure Unit (plastic local procedures)

February 2020 – 28 theatres (26 day 1)

- 2 theatres level 3 CWH (Birthing Suite)
- 5 Theatres level 1 CWH
- 9 Theatres Parkside
- Burwood Procedure Unit (plastic local procedures)
- 12 Theatres level Hagley

Operating Theatre Christchurch Campus

- Tertiary Referral Hospital

- Covers 13 Specialities
  - Nurses usually know 2 in depth
  - 1 common (acute ortho, general surgery, plastics and gynae
  - 1 specialised (vascular, ENT, Neuro, cardiothoracic, eyes, urology, peads and max fax)

- Can be common to have multi-speciality cases

Operating Theatre Christchurch Campus

- We have 176 full time equivalent (FTE) staff for nursing and 36 FTE Operating theatre Assistants (OTA) currently growing to cover the increase with Hagley coming on line
- Still need 26 more RNs and 21 OTAs
- We need to train all own staff
  - 10 week orientation package to get the basics
  - OTA – unregulated work force
- Committed to the Nurse Entry to Practice (NETP) programme for Nurses who have just graduated and are in their first year of practice

Operating Theatre Christchurch Campus

- 18 theatres Monday to Friday
  - 5 each day are Acute
  - 1 acute Caesarean Section theatre 24/7 (2 staff)

- 3 acute theatres each evening till 8pm then 2 theatres to 11pm
- 1 acute theatre overnight

- On call for cardiac (2), eyes (evening only) neuro and spines plus another pair of hands if you need to open another theatre

Senior Structure

- Perioperative Nurse Manager
- 3 Charge Nurses Managers – going to 4
    - Each has a portfolios with specialities and infection control or recruitment or health and safety
- 10 Clinical Nurse Specialists – going to 11
    - One stop shop for all surgeons for each speciality
- 1 Specialist Nurses – going to 4
    - Supports speciality work and CNS in larger specialities
    - Clinical role in working theatre
- 2 Nurse Educators
    - Generic education nursing and OTA

Main Roles

- Scrub Nurse
  - setting up the equipment/instruments, and making sure the field is sterile. Scrub nurses assist the surgical team by passing instruments during surgery and performing the surgical count.
- Circulating Nurse
  - Works outside the sterile field assisting all surgical staff. Provides equipment/instruments during the case, performs the surgical count, records case information and nursing care. Coordinates care.
- OTA cross between a hospital aid and orderly – undertake tasks to allow nurses to remain in theatre doing patient care

Example – Laparoscopic Cholecystectomy

Preference Cards

- Uses to record the information required to do a surgical case.
- Moving to a electronics system as need case information in any theatre 4000 cards between Christchurch and Burwood theatres
- 22 general surgeons with 662 cards

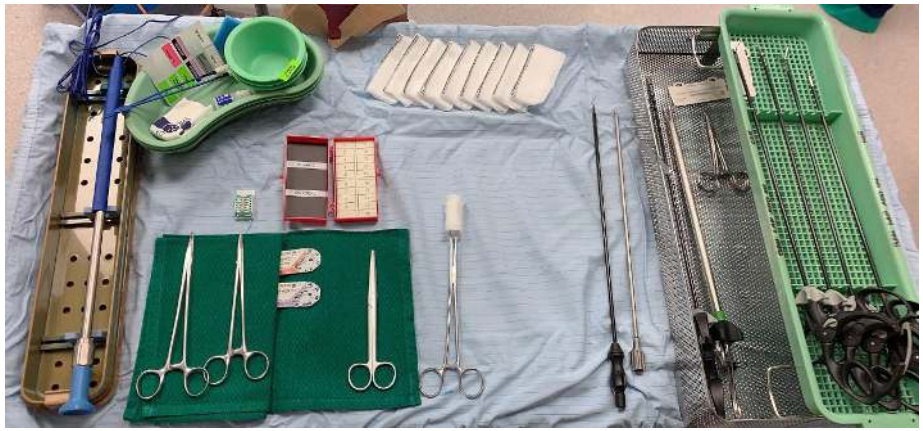
Linen /drapes

- Sterile reusable drapes – Compel
- Canterbury Laundry then packs sterilised

instruments

- All etching with a unique code and tracked to the patient. TDOC system
- Different types of tapes and tags depending on method of sterilisation
- 8 items for lap chole
- 2 sets with 44 instruments with 6 requiring assembly

Mayo and Scrub Trolley



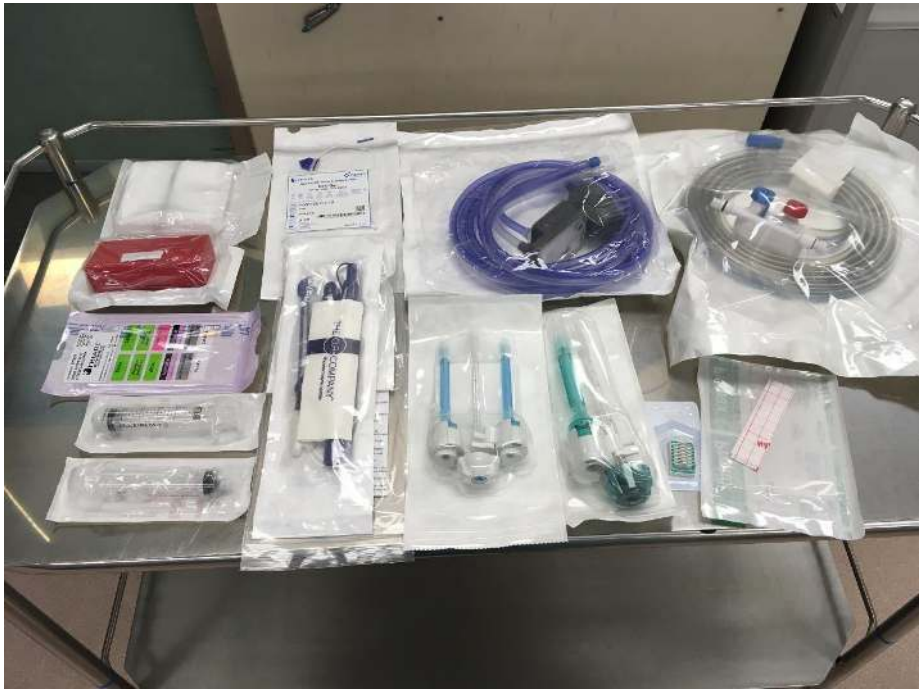
Pharmacy

- Medication safety module
- Decanted medication all labelled as it can all look like care fluid when it is not in it’s original container.
- Irrigation fluids

Sharps

- Sharp risk high in our environment
- Blade to start procedure
- Needles for local
- Sutures – needle with thread to sew close

Consumables



- Ordering min/max levels scanned
- Delivery time, minimum purchase time
- Generic stock and specialty stock

Ashburton Rural Health Services

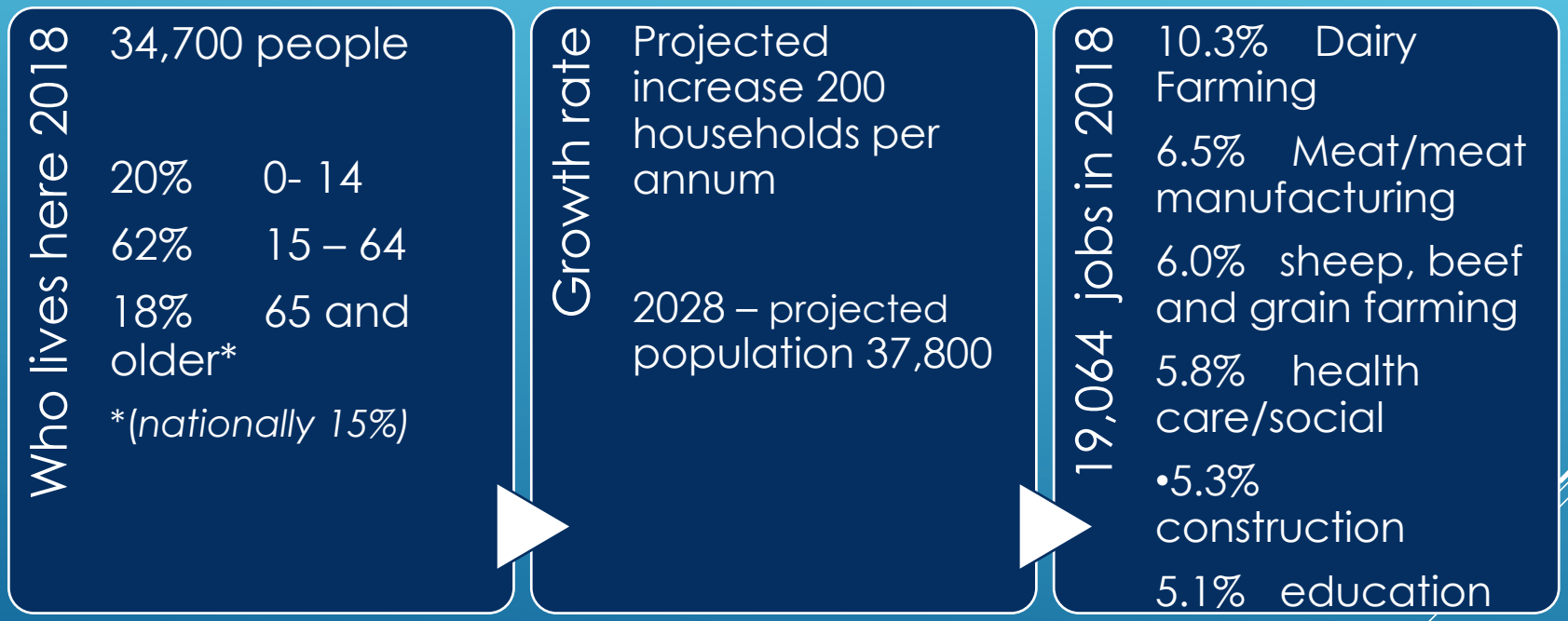
Hospital Advisory Committee - 3rd October 2019

An overview - Our plan on a page

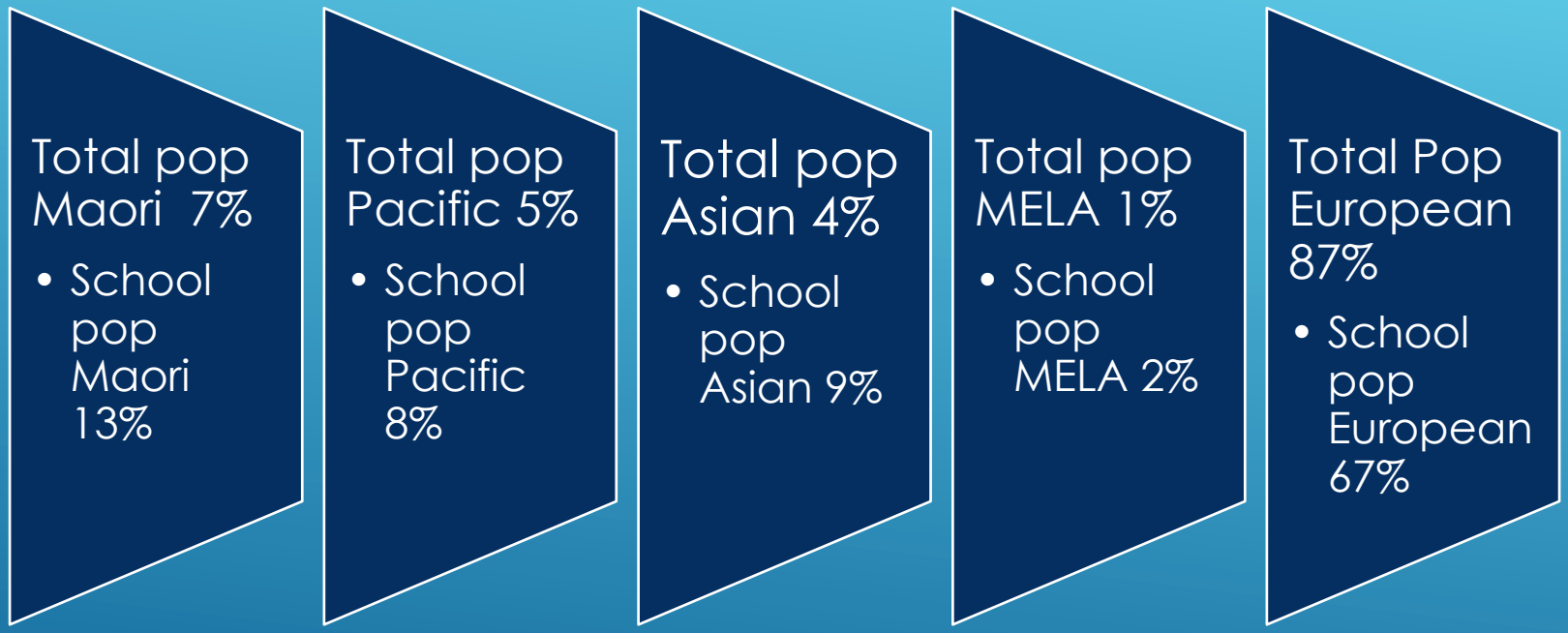
- Acute and Inpatient Care
- One Service – Multiple Sites, our partnership with specialist services
- A local lens delivering the maternity strategy
- Developing an integrated frail elderly pathway
- Co-ordination and care we provide in the community
- "Ashburton Inc" Our partnership with community
    - Rural Health Academic Centre

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

ASHBURTON - THE PLACE AND THE PEOPLE



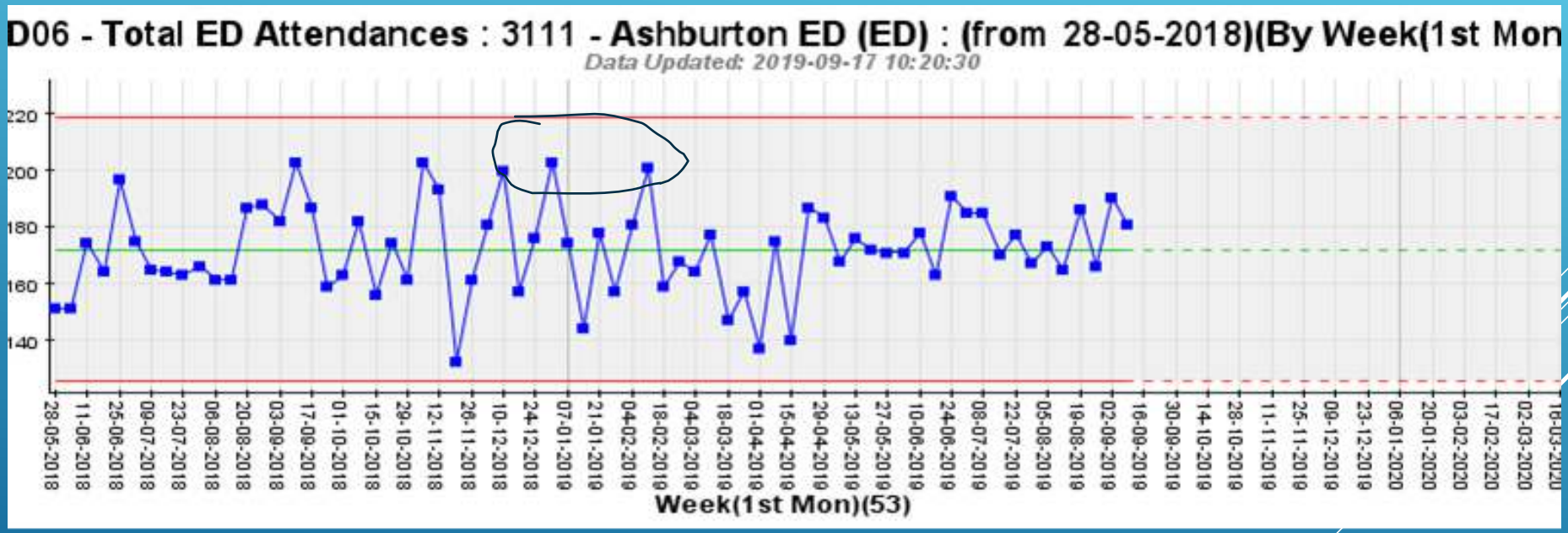
EMBRACING OUR DIVERSITY



Refugee resettlement in 2020

ACUTE AND INPATIENT CARE

9, 162 ED attendances in 2018 - those peaks are in summer



MANAGING DEMAND – WHAT CAN WE DO DIFFERENTLY

- Continue to working with general practice
  - **Acute episodic care** versus **longitudinal care**
- Explore opportunities for medical workforce - Urgent Care and ED registrars
- Nurse led discharge in AAU – what can we adapt from 24 Hour Med Centre
- Implementing nursing workforce that works across the wards/hospital as one team – flex with the flow
- Exploring the opportunities of expanding our volunteer workforce - youth volunteer
- Connecting people back to their primary care team

Regular team simulation training on site

Nurse Educator recently completed Boston training – team of qualified medical and nursing sim trainers

Paediatric Life Support (PLS) training – baby sim has arrived

National programmes held on site

- RiSC
- Emergency and Trauma
- More to come….

"The trauma burden in rural areas is at least as high, if not higher, than urban areas. Despite this, access to health services in rural areas is more limited." Dr Sampsa Kiuru, RiSC Programme

Inpatient Care

In a year - 3,919 stays for 2,496 people (12% of pop)

Higher rates of admission

- Diabetes
- COPD
- Cerebrovascular disease
- Fractured neck of femur (65 and older) 7/1000

- OPH team working closer with primary care, improving access to AT&R and NASC

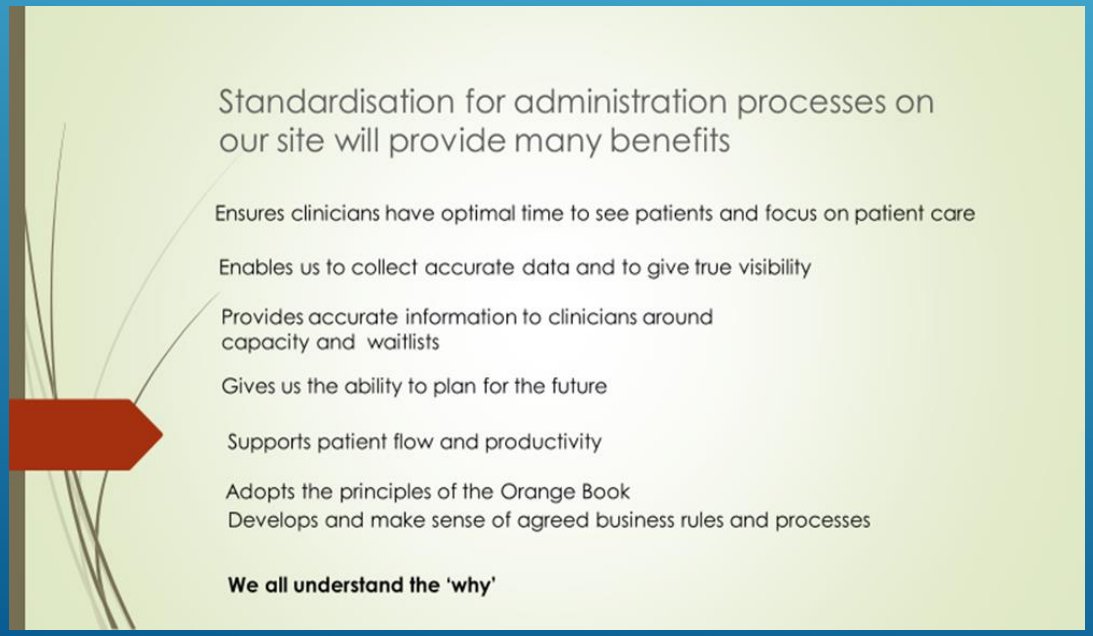
SAFE COMMUNITIES ASHBURTON DISTRICT

- Goal 4: Work collaboratively with agencies involved in falls prevention/education and safety in the home

- https://www.saferashburton.org.nz/wp-content/uploads/2019/06/Strategic-Plan.docx.pdf

One Service – Multiple Sites

- Outpatients, Day Procedures/Theatre, Chemotherapy/Medical Day Unit
  - Single waitlist - There are approximately 27,000 bookings made for the Ashburton facility per year
  - Partnership as a host site, achieve "the service" quality plan goals
  - Nursing staff – rotation through specialist service



Breast Surgeon
Cardiology
Child Development Service
Colorectal CNS
Colposcopy Nurse
CPAP Clinic
Diabetes
Diabetes Podiatry
Echocardiogram
ENT
Gastroenterologist
General Surgeon, Colorectal Surgeon, Surgeon Upper GI
Gerontology
Gynaecology
Nephrologist
Obstetrics
Oncology
Ophthalmologist
Paediatrics
Palliative Care
Older Persons Mental Health
Respiratory
Sexual Health Services
Urology

Ashburton "Inc"

On site – central CDHB service
- Stores /central supply
- RMO rostering/RDST
- Radiology
- Pharmacy
- Laboratory
- Wellfood
- Maintenance and engineering
- Adult Mental Health Services and CAFS
- Public Health – promotors and nurses
- Specialist service clinics

Expanding interest
- NGOs – ACADs etc
- Primary care
- Primary mental health - MBovis
- Safer Ashburton – Suicide Prevention Co-ordination

Opportunities for connection …

Collective planning
Impacts on service change – how we affect each other
Wellbeing and safety
Emergency response planning

We are one team

Presentation at Rural Hospital Summit on Ashburton Medical Model

Medical FTE change from **SMO 10 + MOSS 5 to SMO 6 + RMO 8**

- SMO team undertaking full breadth of rural hospital practice
- Training environment, full RMO roster including PGY 2 and rural registrars
- SMO teams and continuity of care for patients and RMO's
- Generalist mindset and strong RMO satisfaction
- However….increased workload challenges

South Island Rural Hospitals accredited for RHMS training:
- Ashburton, Grey Base, Queenstown, Dunstan, Oamaru
- Ashburton only facility with full team

Take home messages from conference

- Shortage of workforce across the country
- Connect with Australia – National Rural Health Commissioner
- Continue to grow the workforce by training in a rural environment – *if you train, you retain*

- *Proposal for a National Interprofessional School of Rural Health*

https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2018/vol-131-no-1485-9-november-2018/7741

2020 Ashburton

- *Rural Medical Immersion Programme (RMIP) Otago University*
- *Generalist Nursing pathway – we need to lead the way*

	2008	2017	change
Population Catchment	28,420	33,130	+4,710 (+16.6%)
Bed Days &Occupancy			
Acute Medical	4852; 63%	4839; 63%	-13
Rehabilitation	3041; 56%	5782; 83%	+2741 (+90%)
Length of Stay			
Total Average	2.0	3.1	+1.1 (+55%)
Acute Medical Ward	3.9	3.2	-0.7 (-18%)
Annual acute presentations:			
Total	3518**(2010)	7236	+3718 (+106%)
Triage 1+2	262**(2010)	659	+397 (+152%)
Acute admissions	2355	2278	-77 (-3%)
Transfers to Christchurch Hospital	404	454	50 (+12%)
In hospital deaths	55	69	+14 (+25%)

Rural Health Academic Centre Ashburton - Research underway

1. Audit of Oncology services in Ashburton
2. Audit of Shoulder Reduction methods in rural NZ hospitals
3. **Self Harm and Suicidality in rural youth**
4. Interprofessional education through RiSC
5. Procedural sedation and analgesia in Rural Hospitals of New Zealand: A hospital survey
6. Nurses experiences of RiSC - qualitative research project
7. Point prevalence study of antimicrobials
8. REGIONS Stroke Audit and Study
9. Experience of National Early Warning Score in Ashburton
10. **Qualitative Study into current trends in self harm among school aged youth: interview of community providers**
11. Rural Simulation Based Education: the Matthew Effect
12. **Rural Nursing Workforce Challenges in Ashburton**
13. **Ashburton Hospital Transition of Medical Model of Care over 10 yrs**
14. An accelerated chest pain pathway using point-of-care troponin in New Zealand rural and primary care populations
15. Ashburton Hospital model of rural workforce training
16. Levels of disability and relapse in Bangladeshi MB leprosy cases, 10 years after treatment with 6m MBMDT
17. How is postgraduate health education most effectively delivered in a rural or regional context?
18. Point of care ultrasound for FAST and AAA in rural New Zealand: quality and impact on patient care
19. Building collaborative research networks across rural and provincial Aotearoa
20. Rating Rural emergency team performance using the Team Emergency Assessment Measure (TEAM)

OPPORTUNITIES .....
HTTPS://ONEHEALTH.ORG.NZ

HUMAN HEALTH

ALTHOUGH MANY HUMAN INFECTIONS ARE ACQUIRED FROM OTHER HUMANS, MANY ARE ALSO THE RESULT OF HUMAN INTERACTIONS WITH THEIR ENVIRONMENT

CLINICAL ADVISOR UPDATE – NURSING

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NOTES ONLY PAGE

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: **3 October 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

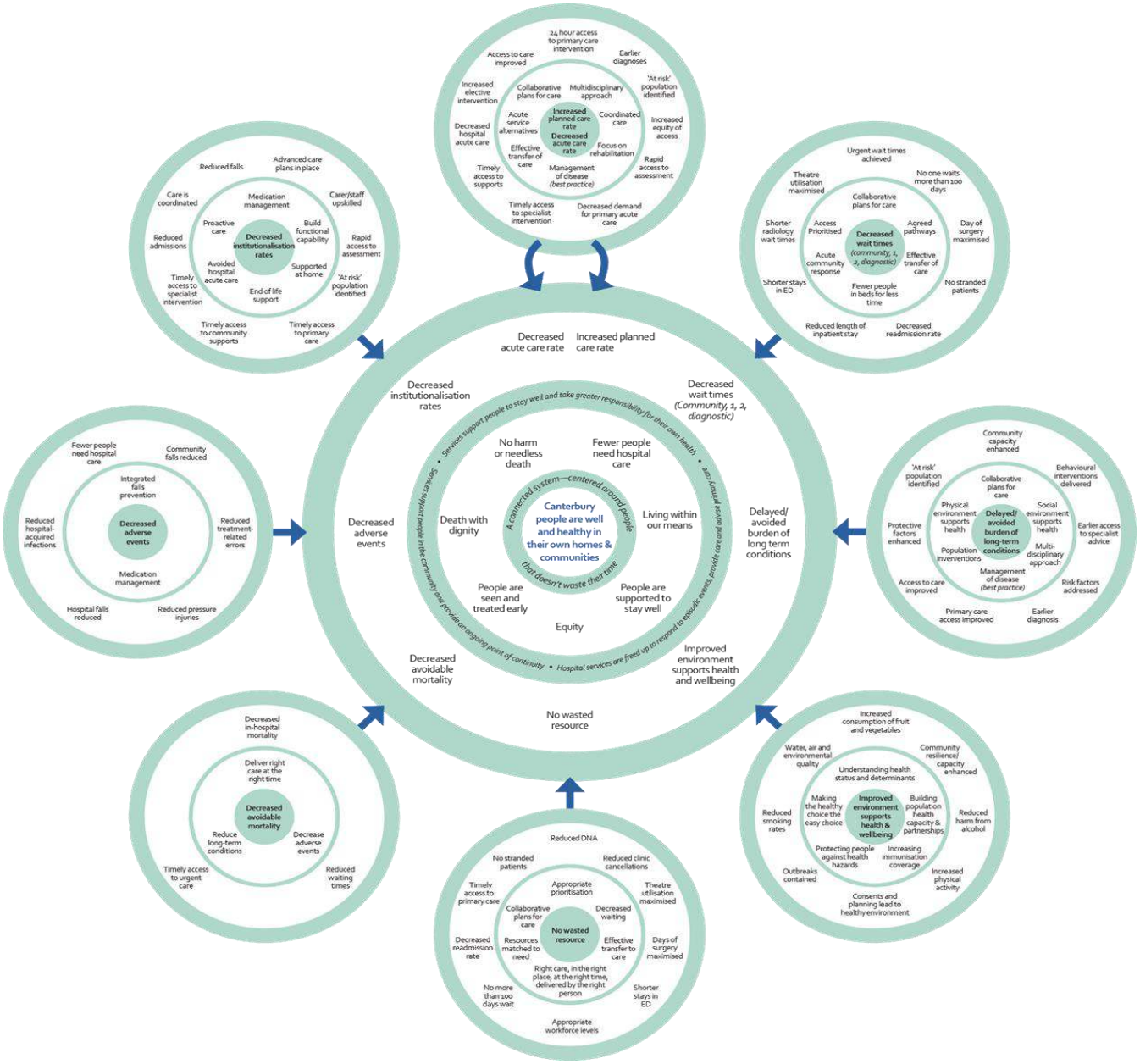
Appendix 1: Hospital Advisory Committee Activity Report – September 2019

Report prepared by: General Managers, Hospital and Specialist Services

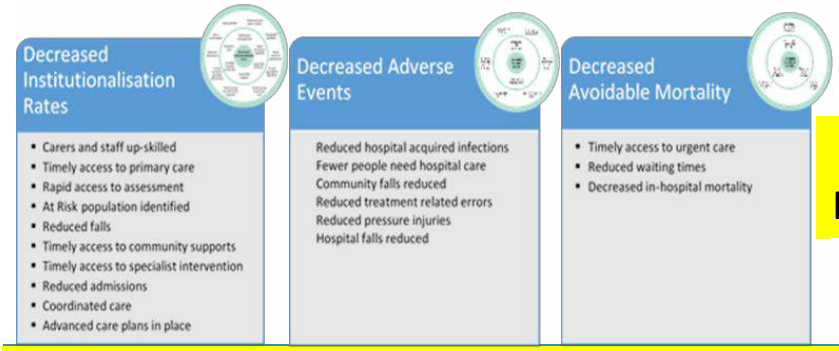
Report approved for release by: Justine White, GM, Finance and Corporate Services

Hospital Advisory Committee

Activity Report

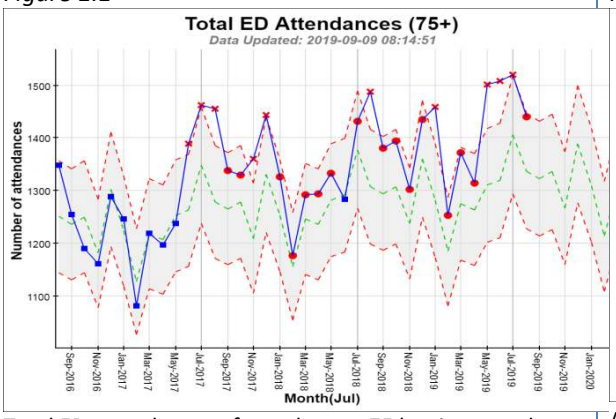


September 2019



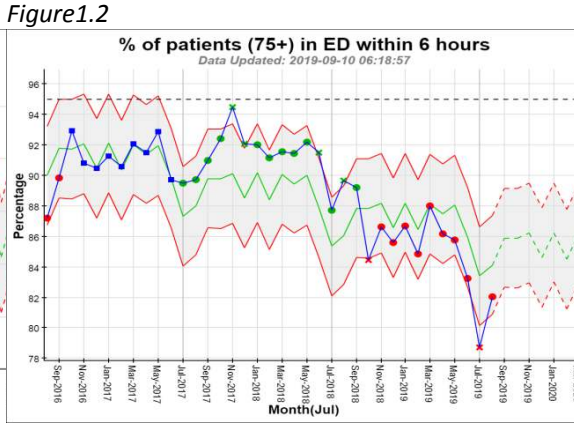
Outcome and Strategy Indicators

Figure 1.1



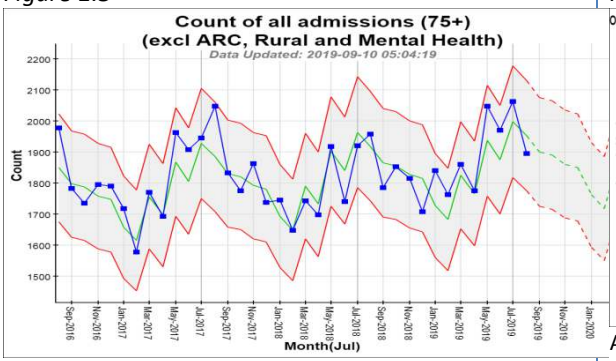
Total ED attendances of people over 75 has increased at a higher rate than the established trend.

Figure1.2



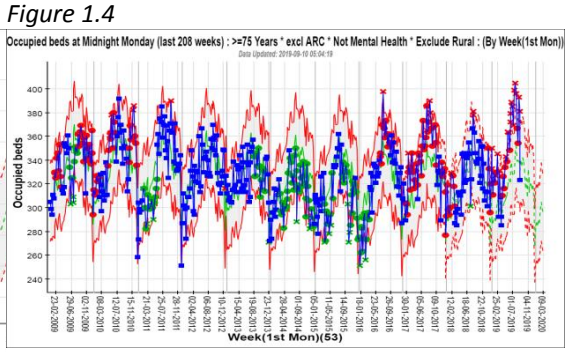
Analysis indicates there is a correlation between patients spending longer in the Emergency Department and hospital occupancy. Alongside this association, however, a significant shift does appear to have occurred around the time that transition between old and new information systems occurred. Evaluation of the way that information is managed between the two patient administration systems involved (EDaaG and SIPICS) is underway to determine if this is having an effect.

Figure 1.3



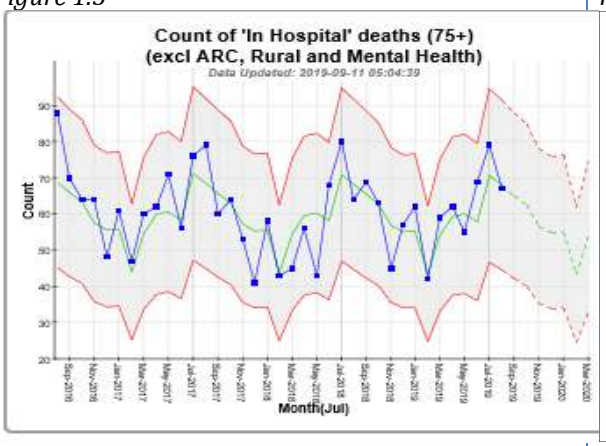
The count of all admissions for people 75 years and over continues to increase in line with the established trend

Figure 1.4



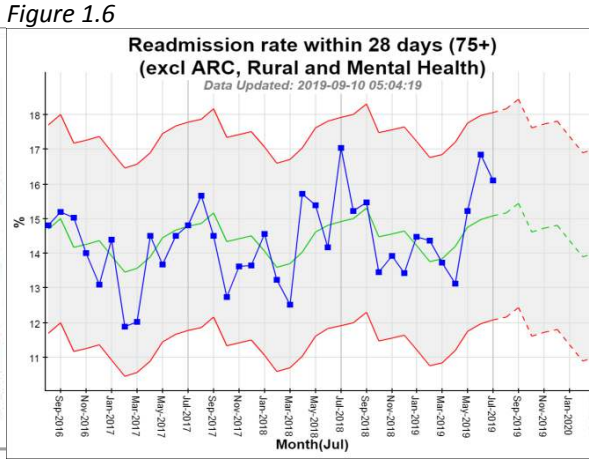
Apart from a period during March 2019, significantly more beds have been occupied by people >75 than projected during the first nine months of 2019. The winter peak occurred far earlier than in 2018 with occupancy by this group of patients higher than it was during similar months in the previous year.

Figure 1.5



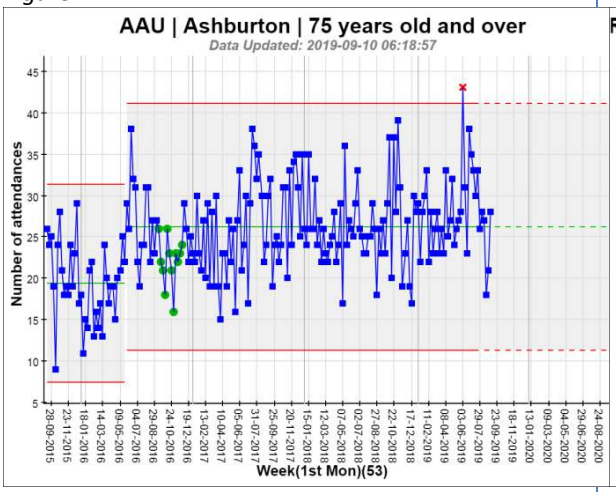
The number of in hospital deaths is within the expected range. Other analysis shows that the established trend of reducing rates of in hospital mortality continues.

Figure 1.6



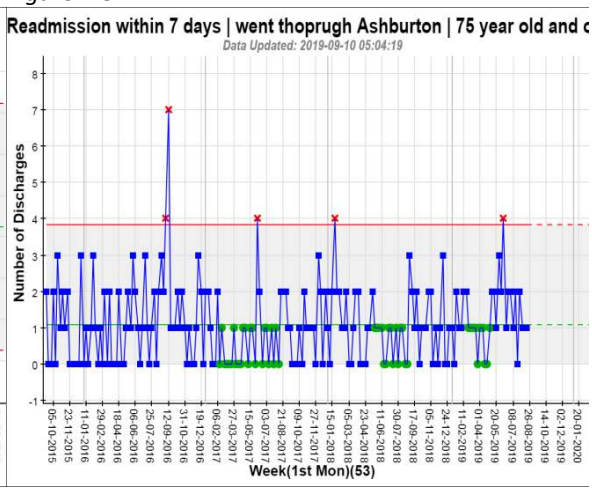
The readmission rate for people aged 75 years and over continues to be within the expected range, and shows an ongoing increase.

Figure 1.7



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

Figure 1.8

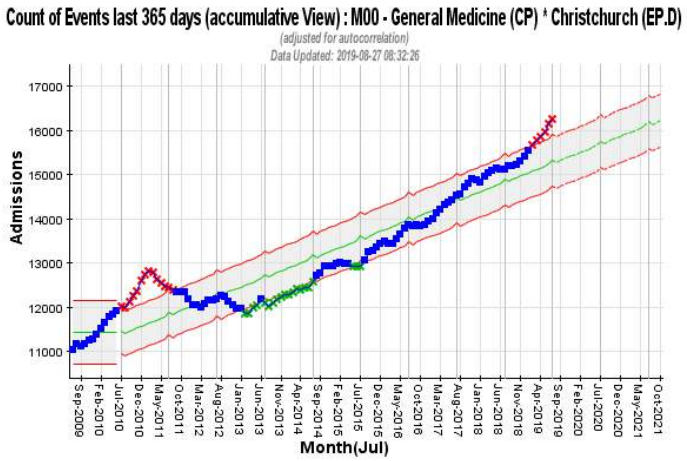


The readmission measure (balancing measure) for people aged 75 years and over continues to be within the expected range with no extreme decrease or increase indicated.

Achievements/Issues of Note

Ongoing increases in Christchurch Hospital Occupancy

- Occupancy in Medical/Surgical wards at Christchurch Hospital was at an all-time high between 1 July and 30 July 2019 with 93% occupancy of resourced beds. Occupancy was above 90% for 75% of the month. This was the busiest month ever recorded.
- One contributor to this is an ongoing increase in the number of people cared for by in General Medicine as shown in the graph below. Occupancy within General Medicine was measured at 94% for the month, the highest since July 2016.



- The impact of unrelenting demand on our people for healthcare has seen the concerning trend of high rates of sick leave continuing. We are putting additional emphasis on working with our people and our managers to turn this around.

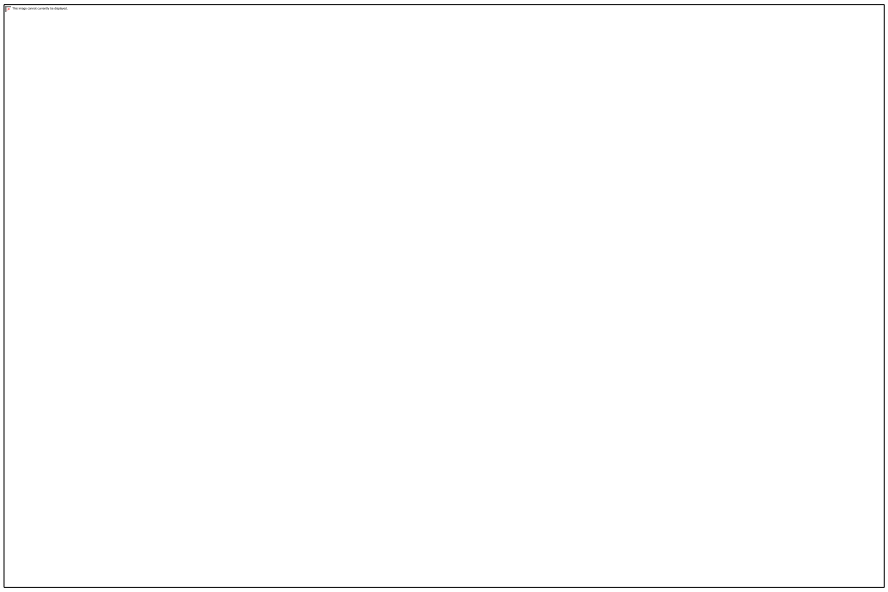
Providing faster care following heart attack

- There is clear evidence that the sooner patients experiencing a heart attack have their blocked vessels cleared by intervention in a Cardiac Catheter Laboratory the better their recovery is. The regularly used indicator of success is the proportion of patients who are in the Catheter Lab with a balloon inflated within 90 minutes of arrival in the Emergency Department.
- At the beginning of July 2018 a system, called Lifenet, was put in place which allows St John Ambulance to transmit electrocardiograms directly to staff in the Emergency Department and Cardiology.
- The team working on implementing this system included people from the Emergency Department, Cardiology and the Information Services Group. Along with this an 0800 number has been put in place for the Southern Region to act as a single point of contact for St. John staff from Nelson, Christchurch or Dunedin to call about patients having a heart attack.
- The implementation of these two changes has enabled us to quickly identify patients that need urgent intervention in the Cardiac Catheter Laboratory and mobilise the required staff.
- The proportion of patients with a ST elevation myocardial infarct whose Emergency Department (ED) to balloon time is less than 90 minutes has increased from 59% to 69% in the last 12 months (99/168 in 2017/18 and 132/192 in 2018/19).

Acute Stroke Imaging Service

- There has been a continual increase in demand for acute stroke services throughout the South Island. Under a Neurology and Radiology initiative, Telestroke has begun rolling out throughout regional Hospitals in the South Island. This allows CDHB Neurologists to provide advice to other DHBs on the immediate management of patients presenting with a stroke. If a patient is diagnosed with a major cerebral thrombus, thrombolysis and an endovascular clot retrieval procedure in Christchurch can be offered as a treatment option to these patients around the South Island.
- Radiology is a key aspect of the Telestroke service and the quick imaging and diagnosis of cerebral clots prior to subsequent clot retrieval procedures creates life changing positive outcomes to the South Island population.
- The imaging pathway model for the regional services is to ensure South Island coverage of Radiology acute stroke imaging, whilst covering locations of high priority and population of patients.
- The Christchurch Computed Tomography (CT) department has contributed to the rapid assessment and diagnosis of patients presenting to the hospital under the acute stroke pathway. The team has worked closely with Neurology senior medical officers and resident medical officers to reduce the

time between presentation in the emergency department to the computed tomography table to under 18 minutes.



Graph showing the increased volume of Computed Tomography perfusion scans performed in Christchurch.

- Work supporting the initiation of regional acute stroke imaging pathways includes:
    - Investigating which sites can perform CT perfusion imaging to identify salvageable brain tissue
    - Setting up the information technology connection from regional sites to the perfusion analysis desktop at Canterbury District Health Board
    - Developing regional acute stroke imaging pathway
    - Education for the regional ambulance service to quickly identify potential acute stroke patients and initiate the emergency pathway
    - Ensuring Computed Tomography Medical Imaging Technologists in regional sites are thoroughly trained to perform perfusion scans and understand perfusion maps
    - Ensuring sufficient cover and competency for the Interventional Radiology Clot Retrieval roster
- This range of activity is serving to support improved outcomes for people from around the South Island who experience strokes.

Emergency Department - Front of House Model

- Between June and October 2019, a new “Front of House” approach is being utilised on the busiest days of the week. A senior medical officer, nurse and a clinical nurse specialist work together to ensure front-loading of investigation and treatment of patients that are waiting to be seen. Patients have early decisions made about treatment required, and their likely need for admission. Some patients are treated and discharged home or referred for outpatient care. Others are referred immediately to an inpatient specialty or admitted directly into hospital. A smaller number are fed back into the emergency department for further ongoing care.
- From a patient and staff perspective, there has been excellent feedback. Patients are being seen earlier, and have investigations and treatment initiated. This is an effective use of their wait time.
- Results show that on the days the front of house model is working 70% of triage 3 and 4 patients receive medical officer review within 30 minutes compared with approximately 40% on other days.

An average of 27 patients are seen by this team each day with approximately two thirds (66%) being discharged immediately or referred to specialist teams without needing further care in the Emergency Department.

- The Front of House model has contributed significantly to a reduction in length of stay and inpatient admissions on the days that it is functioning.

Physiotherapists in the Emergency Department

- Patients experiencing musculoskeletal pain are one of the groups whose demand for Emergency Department services is increasing.
- The Primary Contact Physiotherapy role was introduced to Christchurch's Emergency Department in October 2018. This provides assessment of selected patients by physiotherapists directly from the waiting room. Physiotherapists in this role provide assessment and treatment including completion of standing orders for simple pain relief and referral for X-rays if deemed necessary.
- Between October 2018 and July 2019 the service has been run by four physiotherapists. It has provided service to 617 patients with 24% of these being primary contact patients.
- This new approach is an innovative service design and brings us in line with the way care is provided in Australia and Europe.
- We have seen a decrease in wait times for musculoskeletal presentations in the waiting room with an average wait time of 33 minutes for Physiotherapist assessment versus 60 minutes for medical staff. Length of ED stay is an average of 84 minutes versus approximately three hours for the average ED patient.
- 15% of patients with lower back pain seen by a physiotherapist were referred for x-ray compared with 61% of similar patients seen by medical practitioners. Only 6% of patients with lower back pain seen by the physiotherapist needed medical management. The remaining 94% were managed conservatively with mobility, exercise, analgesia and advice.
- The initiative has resulted in improved patient flow in ED and the releasing of medical staff time to focus sooner on those patients requiring medical staff input into their care.

Priority Placement Policy: Patients with Hypertriglyceridaemia Induced Pancreatitis

- Acute pancreatitis induced by high triglyceride levels is an acute life-threatening condition that requires specialised care to ensure the best possible outcome is experienced. Until recently there had not been a formal direction about where patients with this condition should be nursed. This has meant that sometimes patients have been nursed in areas unfamiliar with the needs of this group of patients, leading to delay in provision of plasmapheresis, inappropriate insulin infusion and notification to the relevant specialist care teams.
- Clinical Nurse Specialists from Lipid Disorders, General Surgery and Surgical Progressive Care Unit have developed a protocol covering the treatment of these patients that has now been published on Hospital Health Pathways.
- Patients are now immediately placed within areas with specialised nursing knowledge resulting in faster initiation of appropriate treatments and timely notification to the specialised teams involved in treatment of this patient group to ensure provision of additional support and advice.

Providing timely wound and drain reviews following discharge from General Surgery

- Reviews of drains and wounds are often required by patients after they have been discharged home from General Surgical wards. These reviews are generally required within a few days after discharge and do not occur within outpatient clinic bookings for consultant follow up.
- These were previously being undertaken in the treatment room on Ward 16 with patients given instructions to return to the ward on a specific date. Because this was not a specifically scheduled duty for medical staff competing demands (for example operating theatre commitments) mean that

patients were sometimes left waiting to be seen for more than an hour. Dressings were often completed by the Clinical Nurse Specialist(CNS) as specific nursing resource was not allocated to this duty.

- In order to resolve this the Hagley Outpatients Acting Charge Nurse Manager, Service Manager and Clinical Nurse Specialist from General Surgery have worked together to set up a wound review clinic in Hagley Outpatients. These clinics are bookable in the Patient Information Care System and appointments can be arranged around Consultant Outpatient clinic times to ensure medical team members are available to review. Staff training, and education has been provided to Hagley Outpatient staff to increase wound care and dressing application knowledge.
- Medical staff are now often available at the time of appointment, waiting times have been decreased for patients and all team members, including district nurses who are able to see upcoming wound clinic reviews in Health Connect South. Hagley outpatient nursing staff are available to assist with or complete dressings following review by the Clinical Nurse Specialist or medical team, thus reserving specialised resources for tasks that only they can perform.

Bereavement Project - After-death care

- Literature shows that providing timely and effective support to whānau at the time of the death of a loved one can reduce acute mental health presentations to the emergency department and that demonstration of compassion can mitigate any dissatisfaction of care provided.
- A bereavement working group, working with three pilot sites (Oncology Ward, Stroke/Medical Ward and Ashburton), and the Māori Health team has developed a range of cards to be sent to family members by a staff member known to the whānau a few days after the death of a patient. Information on normal grief and bereavement supports was provided as an insert. 45 cards were sent out and contact made successfully with 28 recipients to gauge their effect.
- Families have reported feeling touched and supported, noting that they felt really cared for. Some people found the grief insert useful, some kept it for others while some found it not relevant. Phone calls from the bereavement team were appreciated.

Maternity Assessment Unit

- Women with low-risk pregnancies often present at Christchurch Women's Hospital before their due date because they are concerned about some aspect of their pregnancy. This embeds the notion that hospital is the best place to be if you are approaching your due date. This may be true for women with complications or an unwell baby, but community-based options including home birth or birth in a community birthing unit will provide better outcomes and a more positive birthing experience for healthy women and babies. Attending hospital utilises specialist care capacity that are sometimes stretched and can compromise care that can be provided to those who really need it.
- A new Maternity Assessment Unit has been opened as a dedicated one-stop shop for women who have concerns during the second half of their pregnancy. Creation of this unit is part of the Canterbury Maternity Strategy that aims to ensure pregnant women receive the right care in the right place and at the right time. The model in place is midwife/Lead Maternity Carer led and involves an initial assessment, leading to a collaborative individualised care plan which may include being seen by an obstetrician or coming back for more monitoring. It is anticipated that many women will head back home with a plan for care in the community.

Further progress towards paperlite in General Surgery

- General Surgery wards are preparing to move into the new Hagley Hospital building – this work highlighted heavy reliance on keeping a stock of hard copy patient information pamphlets.
- Beginning in 2018 work began on decreasing the stock of pamphlets held on the wards and searching for a solution that would provide easy access to pamphlets that could then be printed on demand.
- As a result there is now a library of links to the patient information pamphlets on the General Surgery Nursing SharePoint page on the intranet. It is being well used by regular ward staff as well as by

visiting staff members. It saves nurses' time, releasing it for other tasks, and means that a physical stock of hard copy material does not need to be managed.

Family Escalation

- Patients and whānau often recognise subtle signs of patient deterioration even when vital signs are normal.
- As part of the national deteriorating patient programme led by the Health Quality and Safety Commission, a process known as Kōrero Mai (Talk to Me) has been piloted within Ward 22 (a children's ward) and the Paediatric Progressive Care and High Dependency Unit since February that empowers parents to raise concerns with a nurse, seeking a medical review. If they feel that a satisfactory response is not forthcoming can use an 0800 number which initiates a review via the Intensive Care outreach team for a second opinion.
- No 0800 calls have been received by the Intensive Care outreach team since going live. Over 43 parents/ whānau have been surveyed concerning their knowledge and perceptions of the system highlighting that the communication processes in place to notify them regarding the steps to escalate care were not working reliably. Parents and caregivers see the system as a positive step and are reassured by its presence. One family would have used the number if they had known about it.
- The pilot has now become business as usual for Ward 22 and the Paediatric Progressive Care and High Dependency Unit and will spread to the Children's Haematology/Oncology Unit in October. Over the coming months, parallel work will commence soon to explore the implementation of Kōrero Mai (Talk to Me) within adult in-patient services.

South Island Ketogenic Dietary Therapy Service

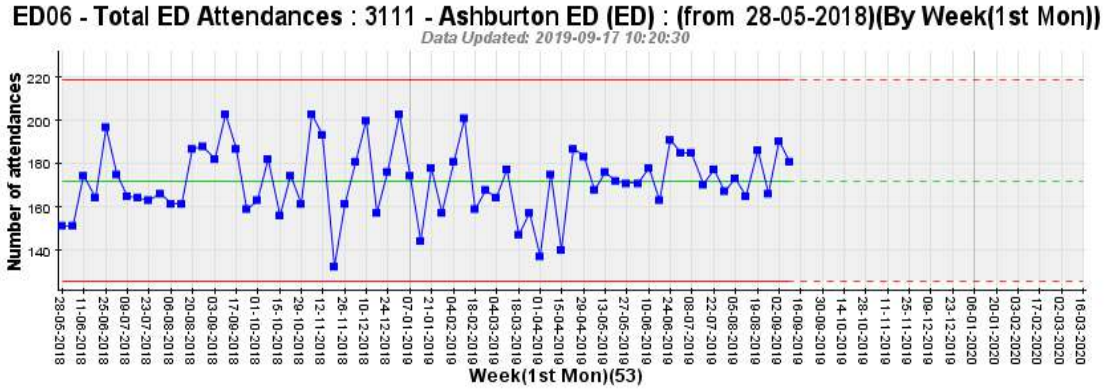
- Approximately 1% of children born each year, around 60 per year in New Zealand, will develop epilepsy. Around one third of cases will develop refractory epilepsy – meaning seizures are not well controlled by medicines. In these cases, seizures impact on the quality of life of the patient and their whānau and can create significant damage to the child's brain
- Many patients can experience a reduction in seizure activity through use of a ketogenic diet. 10 % will achieve total elimination of seizures, 30% reduction by >90% and 50-60% a 50-89% reduction. Similar to anti-epilepsy medication, after approximately 2 years patients are weaned off the therapy, and 80% retain the benefits gained during treatment.
- Canterbury DHB introduced a ketogenic therapy service for its paediatric population in 2016, and this has recently been extended to paediatric patients throughout the South Island and a regional pathway of care has been developed. This extended South Island service provides treatment for a further ten patients a year and is dietitian led by the Clinical Lead Ketogenic Dietitian. The other team members of the multidisciplinary team (Paediatric Neurologists, Pharmacist, Epilepsy Nurse, whānau members and ward staff). A model of care has been put in place that was developed in Canada that enables a ketogenic diet to be safely managed at distance using technology and a shared clinical record (Health Connect South).
- This development has enabled children and whānau from across the South Island to benefit from a significantly improved quality of life for patients and whanau by significantly reducing seizure activity. Patients receiving this therapy are now able to meet developmental milestones and progress well. Overnight stays in hospital are reduced by 86%.

Ashburton Health Services

- Work continues within the Ashburton Service Level Alliance (ASLA) to improve access to care for the total population, with a specific focus on our frail elderly and exploring discussions with our Maori, Pacific and migrant communities on challenges they are facing to access health care.
- Through this work we are pleased to report a reduced wait time for Needs Assessment and Co-ordination Services (NASC), with a wait time of two weeks reduced from an average of six weeks. We

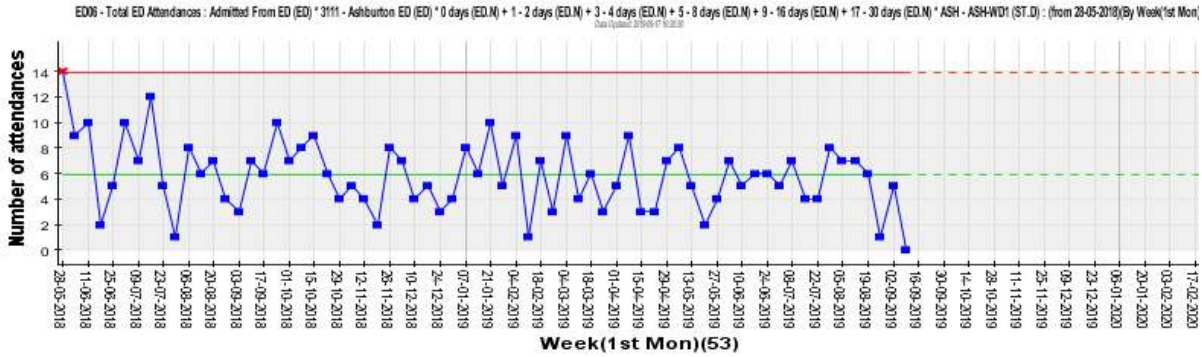
continue to review our opportunities to improve process in this area and identify succession planning that can a more integrated approach to service delivery.

- We are re-introducing regular meetings with hospital nursing leadership and local Aged Residential Care (ARC) nursing management to address communication and system issues to reduce admission to the hospital and improve discharge. The discussion links into the ASLA workgroup, where primary care is exploring options to manage acute primary care responses required by the local ARC facilities.
- At the hospital lens, we are monitoring the trends and information provided through SFN to inform quality improvement projects that can be introduced into the ASLA workgroup plan. Overall the presentations to the Acute Assessment Unit have plateaued as demonstrated in the table below. The Director of Nursing is leading the development and redistribution of work that could be provided through nurse led treatments to improve patient flow within the unit, with a particular focus on weekends.



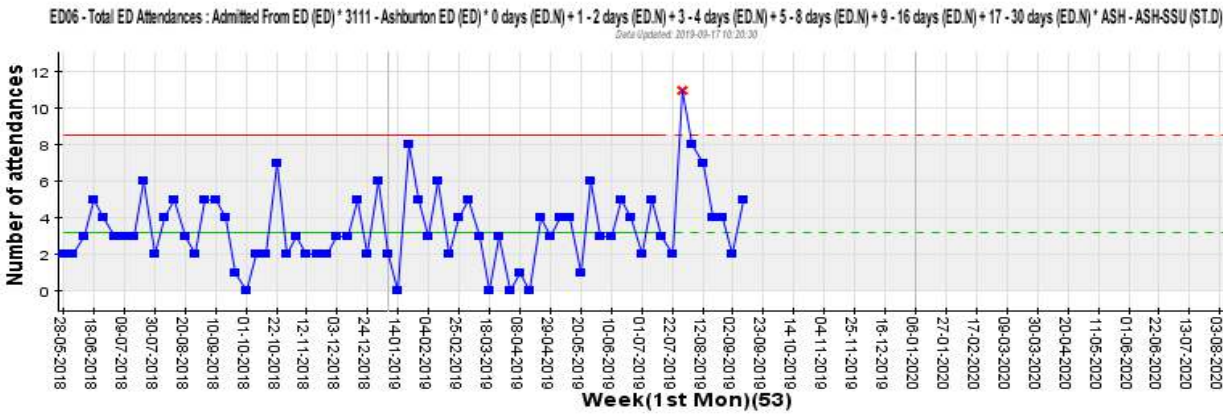
- In reviewing three months of presentations to the Acute Assessment Unit (AAU) 164 of the presentations were made up of **114 separate individuals, not enrolled in primary care**. This information and discussions to improve enrolment uptake are continuing within the ASLA workgroup.
- Alongside the presentation rate, we are reviewing the representation information and any correlation to recent discharges. The tables below identify information from the August discharges from the Short Stay Unit (SSU) Ward One (acute medical ward) that have returned to AAU within 30 days. Exploring re-presentation rates and rationale supports our intent to ensure patients are seen in the "right place" and are supported to stay well in their own homes. The recognition that the hospital provides acute episodic care is built on the partnership of primary care providing longitudinal care and ensuring patients reconnect with primary care as appropriate.
- The table reviewing representations from Ward 1 have maintained a consistent pattern with recent trend downwards, the average length of stay in this ward is 2.8 days.

Representation to ED within 30 days – WARD 1

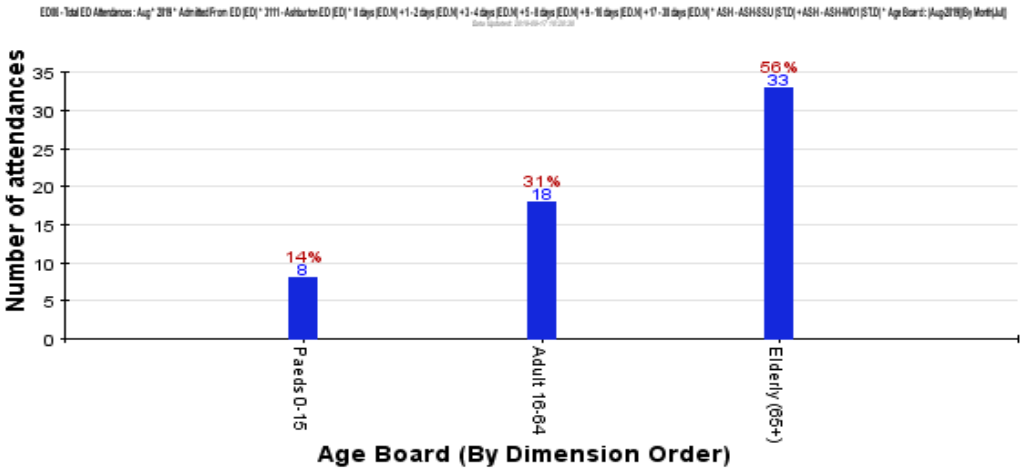


- However, when comparing with SSU, the unit within AAU where patients are assessed and treated and may then progress to discharge, transfer to Christchurch or admit to Ward is providing a distinct trend towards representation.

SSU representation within 30 days



- Month of August: presentations returning to ED within 30 days after Discharge WD1& SSU.



- The age distribution reflects the admission distribution to Ward 1, however this information has triggered a quality review to identify reason for presentation and corresponding access to primary care post discharge. We will continue to monitor this activity and introduce recommendations into the ASLA workgroup if appropriate.
- The rationale to explore this work in detail brings together our goals to reduce patient harm and best utilisation of resources across the system.

Older Persons Health

Reported Falls for Older Persons Health (OPH &R) inpatients have decreased by 13% year to date (14 reported incidents) from 105 2018/19 to 91 2019/20. The service has been working on a number of initiatives to decrease falls. Where possible new admissions are placed near the nurse's station in the Wards and patients pre-identified prior to transfer from Christchurch as a high falls risk are also placed into the sensor rooms. Intentional rounding to pro-actively engage with patients is imbedded in most wards with others refocusing on this as a priority. Two of the Inpatient Wards are also trialling a different type of sensor equipment which detects movement off the bed rather than once patients have stepped onto a sensor mat on the floor. The service has also put in place a new Inpatient Close observation form

and process to formalise the requests for close observation by a Hospital Aide. This process is to ensure that the reasons for the close observation is well documented and visible and reviewed on a regular basis. The Clinical Nurse Specialists and Educators review the patients and work with the nursing staff to manage the timeframes for the close observations and process to reduce or manage the risks. Alongside this the services is undertaking data collection and review to better understand the clinical reasons for the close observations and to further learn and support the improvement work with falls.

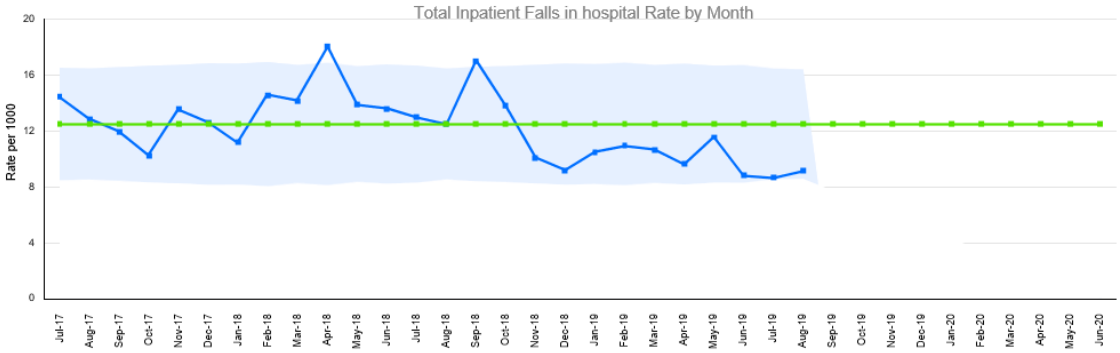
The services other main focus has been supporting patient flow across the system during the winter months. Inpatient occupancy has remained high and at full capacity. The Clinical Nurse Specialist Liaison role continues to support flow, reviewing and prioritising patients for transfer to Burwood from Christchurch Hospital and facilitating direct discharge home where appropriate. The average length of stay for Older Person Health has been maintained at similar levels to last year around 18 days despite transferring patients from Christchurch earlier. We have now moved onto one spreadsheet between admissions co-ordinator and the CNS Liaison which will support and allow for this.

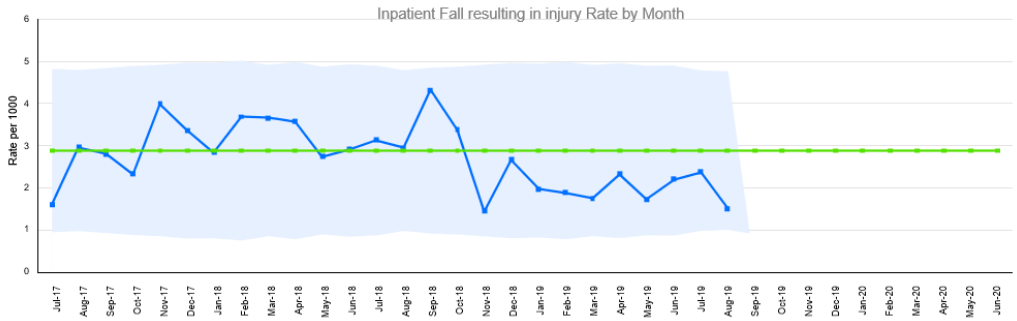
Falls Monitoring:

Since September 2018, the trend has remained below the average line.

Overall, falls accounted for 31% (143/454) of total OPH&R incidents reported for August 2019 compared to 39% (172/438) in August 2018. While this reduction and trend is reducing OPH&R continue to focus on further reductions. To achieve this, we continue with our Falls Prevention:

- Intentional Rounding initiative
- 'Post Fall Clinical Pathway' audit was completed by Department of Nursing in May 2019 and presented to OPH&R Falls Group and Nursing Governance Group. Results showed the form were generally well completed with the majority of criterions showing an improvement in compliance. Focus continues on staff education, specifically new staff and interdisciplinary team members.





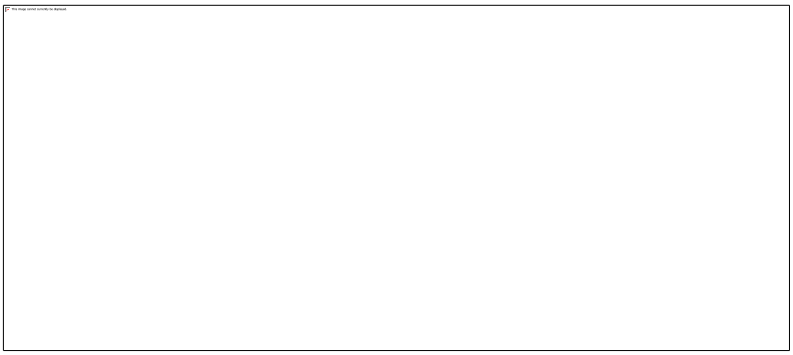
Communications Stream Working Group

Good progress is being made in establishing a 'Welcome to Burwood Hospital' flipchart that will be durable and provided in each patient room. It will replace the booklet of papers patients get on arrival, and provide information about why they are at Burwood, what they can expect from their stay, and what staff and rehab require from them. Also, information for visitors, use of room TV guidelines, how to keep themselves safe in hospital (falls prevention etc) and information about preparing to leave Burwood.
Will be a useful reference for families/carers also, plus a cost saving and improved environmentally sustainable option compared to what we have been doing :)

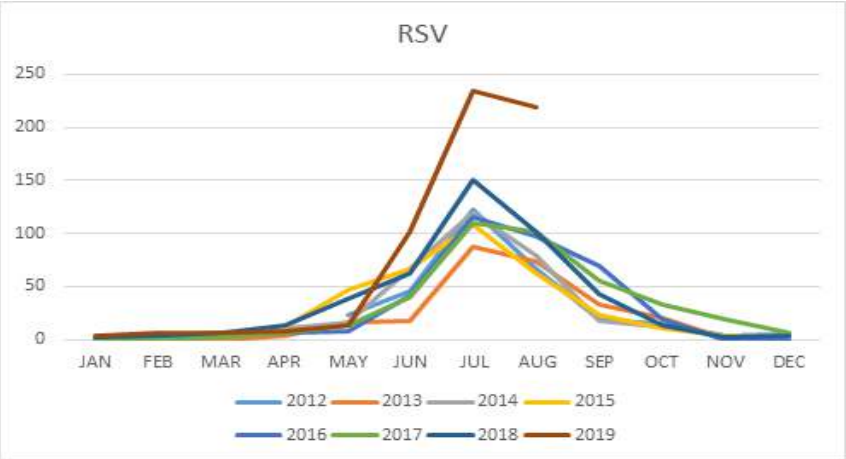
Laboratory Services

- **Respiratory virus testing**: As the incidence of influenza and the number of influenza test requests have further declined over the past 2 weeks with positivity rates fast approaching baseline levels we are advising that we will be stopping the availability of our rapid influenza A/B & RSV test as from Thursday 5th of September 2019. Respiratory virus testing from this point will revert to our routine Multiplex respiratory virus panel and will be available only after consultation with a microbiologist out of hours and over weekends. This will affect the turnaround time when specimens are received during the weekend or late in the day on Fridays. This change is particularly relevant to patients on the BMTU, NICU and CHOC wards.
- **Influenza in Canterbury:** Influenza A activity in Canterbury was characterised by an unusually early season this year (with a predominance of the H3N2 subtype) compared to a late influenza season seen last year (with a predominance of the H1N1pdm09 subtype). The numbers of positive influenza A samples peaked at the end of June/beginning of July and then started to decrease rapidly. A similar pattern with an unusual early start of the flu season and a drop in numbers at the end of June/beginning of July could also be seen in labs across Australia.

- Influenza B activity in July was approximately the same level as June and then dropped-off in August.



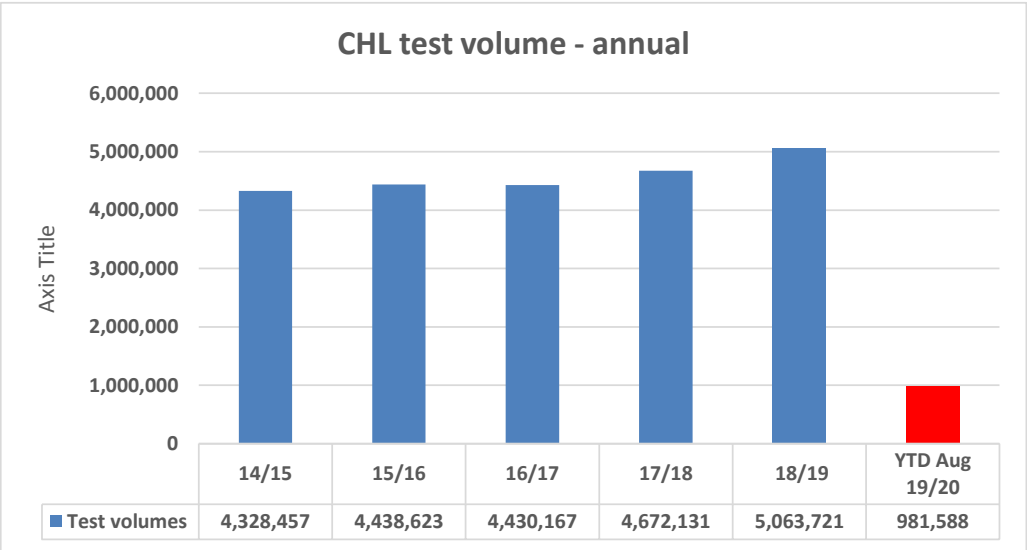
- RSV activity is still elevated. The higher total numbers seen this year could partially be attributed to the rapid FluA/B & RSV test that was offered 24/7 during the winter season.

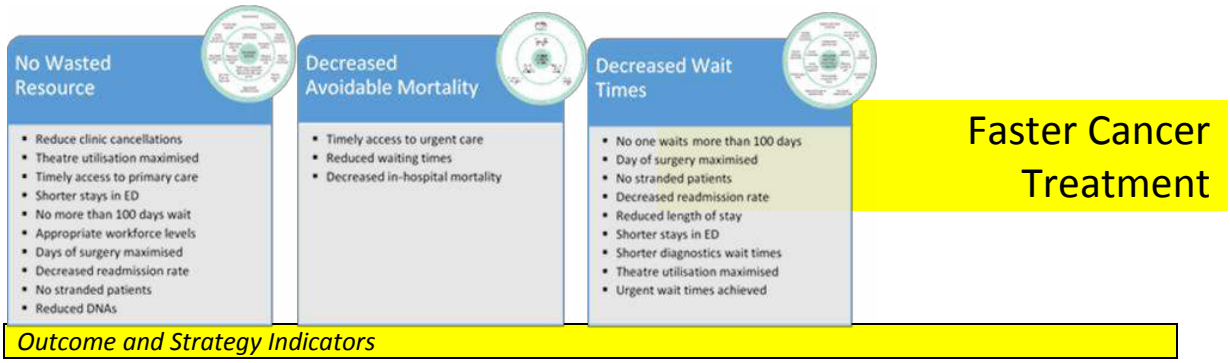


- **Measles in Canterbury:** After identifying 2 measles cases in Christchurch in July with epidemiological link to the Auckland outbreak, we haven't seen any additional measles case in Canterbury in August. However, several measles cases with epidemiological link to the Auckland outbreak have been reported in Queenstown since the 21st of August. The total number of confirmed measles cases for 2019 has reached more than 930 cases as of 30th of August. The National Measles and Rubella Lab at CHL had to respond to several requests from the Ministry of Health to provide measles data for their response to OIAs and WPQs.

Laboratory activity volumes:

	Annual volumes					
F/Y	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**	**YTD Aug 19/20**
Test volumes	4,328,457	4,438,623	4,430,167	4,672,131	5,063,721	981,588
Percent change		2.55%	-0.19%	5.46%	8.38%	





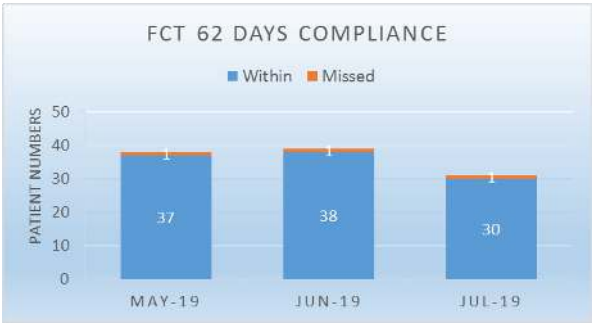
Outcome and Strategy Indicators

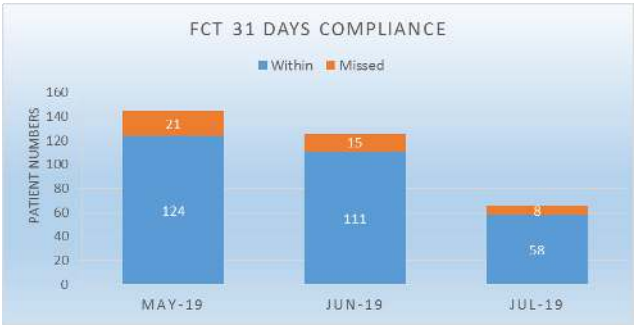
Key Outcomes - Faster Cancer Treatment Targets (FCT)

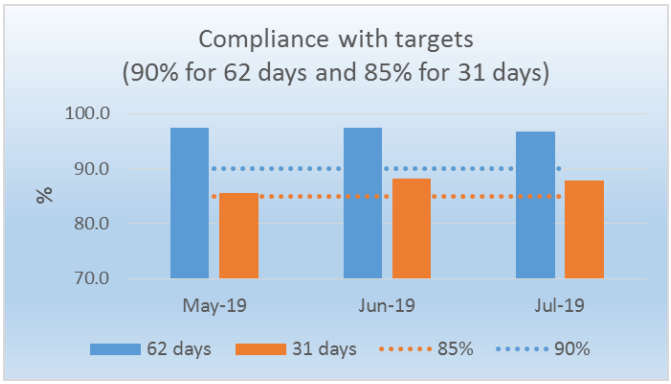
62 Day Target. For the three months of May, June and July 2019, Canterbury District Health Board submitted 122 records to the Ministry. Of the 17 who missed the 62 days target 14 did so through patient choice or clinical reasons and are therefore excluded by the Ministry of Health from compliance calculations. This leaves 108 patients eligible for inclusion in the target calculations.

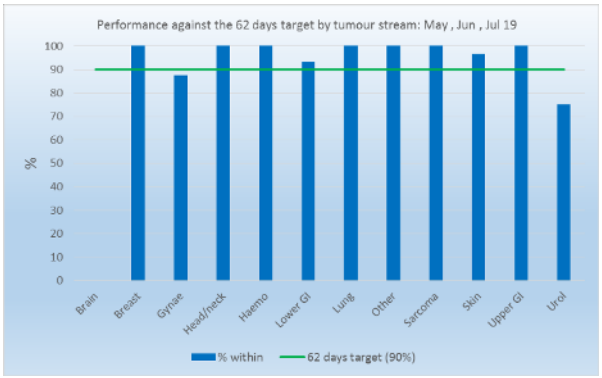
With 3 of the 108 patients missing the 62 days target through capacity issues our compliance rate was 97% so once again the Canterbury District Health Board met the 90% target.

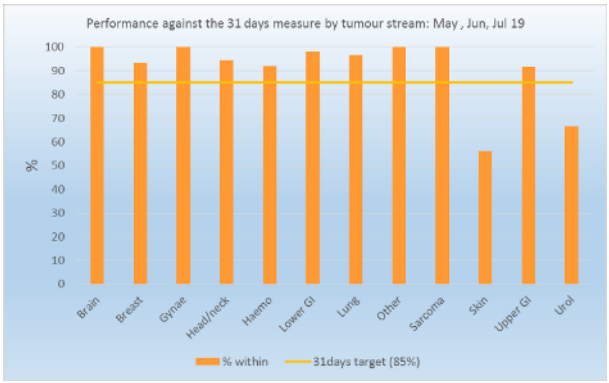
31 Day Performance Measure. Canterbury District Health Board submitted 337 records towards the 31 day measure in the same three month period. Unlike the 62 days target all patients who miss the 31 days target are included: there are no exceptions made for patient choice or clinical considerations but the threshold remains at 85% rather than 90%. With 293 of the 337 (87%) eligible patients receiving their first treatment within 31 days from a decision to treat the Canterbury District Health Board continues to meet the 85% target.

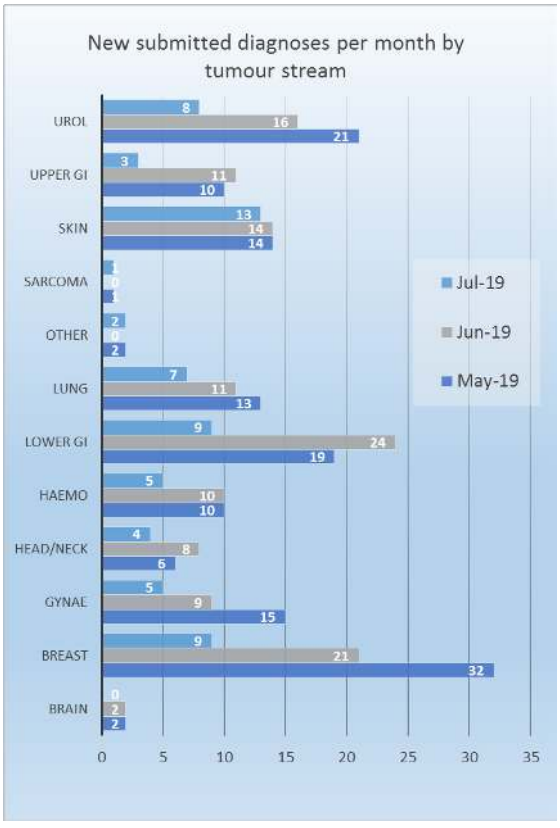





Compliance with targets
(90% for 62 days and 85% for 31 days)
100.0
90.0
80.0
70.0
%
May-19
Jun-19
Jul-19
62 days
31 days
85%
90%


Performance against the 62 days target by tumour stream: May , Jun , Jul 19
%
Brain
Breast
Gynae
Head/neck
Haemo
Lower GI
Lung
Other
Sarcoma
Skin
Upper GI
Urol
% within
62 days target (90%)


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

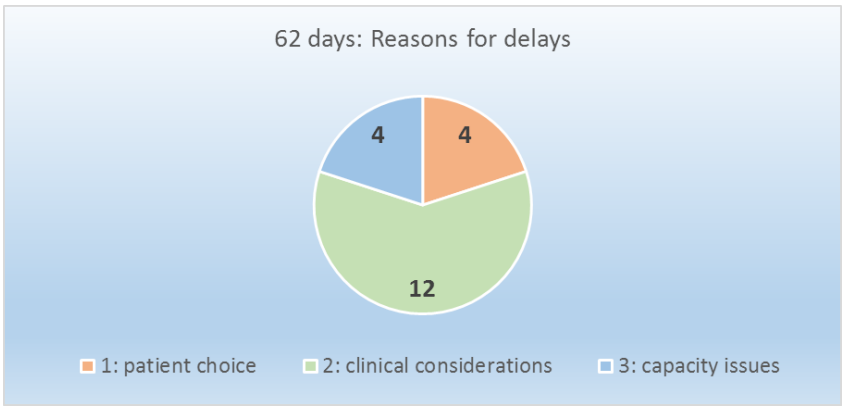

New submitted diagnoses per month by tumour stream
UROL
UPPER GI
SKIN
SARCOMA
OTHER
LUNG
LOWER GI
HAEMO
HEAD/NECK
GYNAE
BREAST
BRAIN
Jul-19
Jun-19
May-19
0
5
10
15
20
25
30
35

Patients whose treatment time misses the targets

The Ministry of Health requires District Health Boards to allocate a "delay code" to all patients who miss the 62 days target. There are three codes and only one can be used even when 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 Ministry of Health reporting requirements.

However every patient that does not meet the target is reviewed to see why. This is required 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.

Technologist Led Computed Tomography Colonography Service

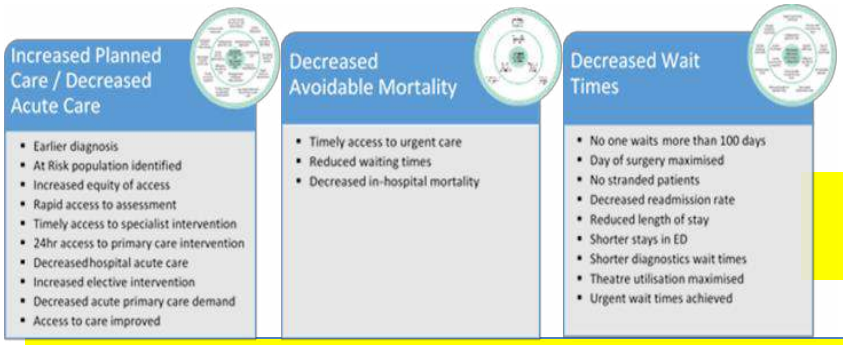
- Radiology has been providing a Computed Tomography Medical Imaging Technologist lead Computed Tomography Colonography service (CT).
- The technologists have been participating in a Radiology developed training program to become competent in performing colon insufflation and reviewing images to ensure optimal quality examinations are being performed.
- This supports Canterbury District Health Board's preparation towards entering the National Bowel Screening program by diverting demand for colonoscopy for other patient cohorts to Computed Tomography Colonography. Changing the workflow by increasing the tasks carried out by technologists has allowed continued provision of a high quality and efficient service to the community.
- Another benefit is to relieve Radiology Registrars from this duty which allows the registrars to concentrate on reporting and other specialised procedures.

Hepatitis C Treatment successful in Canterbury

- Hepatitis C is a viral disease that can result in the development of chronic liver disease and liver cancer.
- In July 2016 Pharmac provided access to a treatment that was able to cure around 50% of patients with Hepatitis C. In February 2019 further development occurred with access being provided to a treatment that can cure virtually all patients with Hepatitis C.
- Canterbury has led the country in uptake of all forms of treatment, being significantly ahead of the next highest district. 332 people in Canterbury have received treatment – 16% of the 2,054 patients nationally.
- Information about equity of uptake is available at a regional level. 20% of patients provided with curative treatment for Hepatitis C in the South Island are Māori.
- This high level of performance is due to alignment of a community clinic aligned with the needle exchange scheme, a programme coordinator and good integration between primary care, the specialist service and the community clinic.
- A subsidy scheme has been put in place to enable patients to receive their treatment via their general practice.
- This has enabled patients to be cured of a disease that could otherwise lead to lifelong liver disease associated with significant suffering, stigma and increased health system activity.
- Future work will focus on reaching those people who do not know that they have the disease so that it can effectively be wiped out in our population.

Improved support for multidisciplinary meetings

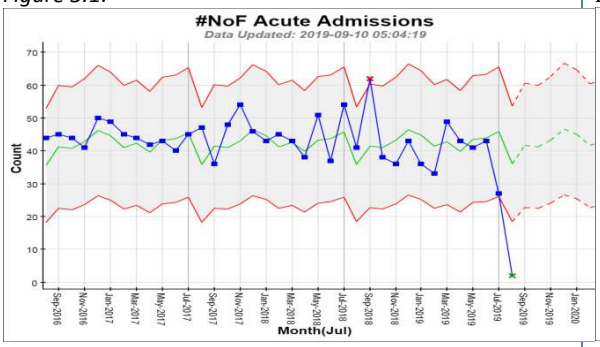
- Multidisciplinary care is key to providing best-practice treatment and care for patients with cancer. Multidisciplinary meetings have become an established part of the way these complex care journeys are coordinated, providing a forum where key items of clinical information are used to identify the best care plan for a patient. Specialists in cancer care attend these meetings and include surgeons, physicians, radiologists, pathologists, oncologists, cancer nurse specialists and cancer nurse coordinators as well as others in the multi-disciplinary team, using video conferencing as required.
- Approximately 65 multidisciplinary meetings are held monthly across the South Island covering 14 tumour streams.
- The Ministry of Health has encouraged providers to adopt a standard format and support framework for these meetings to ensure that all relevant information is covered reliably and efficiently for all patients. An electronic system to support these meetings created by the Southern District Health Board has been adopted as the standard approach throughout the South Island. This system provides a workflow to support the meeting, a standard view of information support discussion and a record of the treatment approach agreed at the meeting. A final summary is created prior to the end of the meeting and becomes a part of the medical record.
- Canterbury District Health Board has been progressively adopting this method. With the breast cancer module being adopted recently all tumour stream meetings in Canterbury now use this standard method.



Enhanced Recovery After Surgery (ERAS)

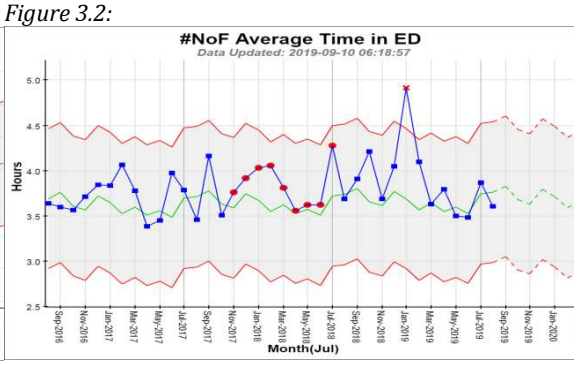
Outcome and Strategy Indicators – Fractured Neck of Femur (#NoF)

Figure 3.1:



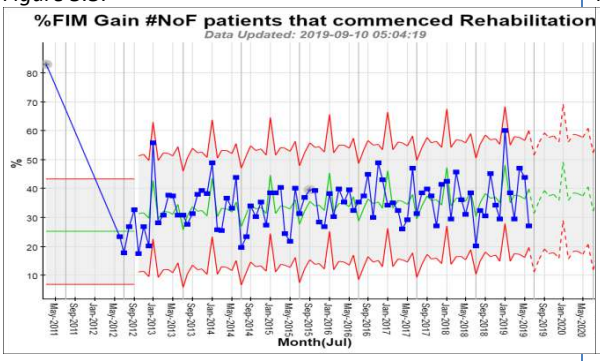
Coding delay impact on the latest data records for admissions.

Figure 3.2:



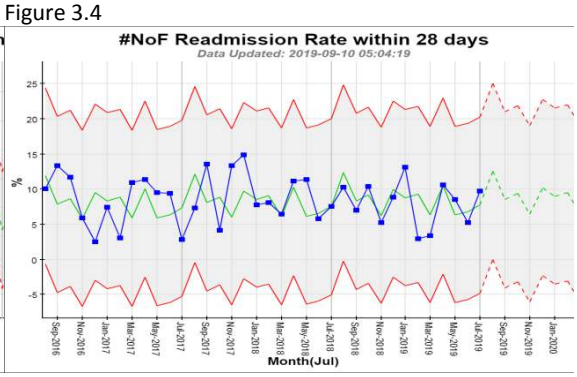
Patients with #NOF show a variable length of stay in ED.

Figure 3.3:



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

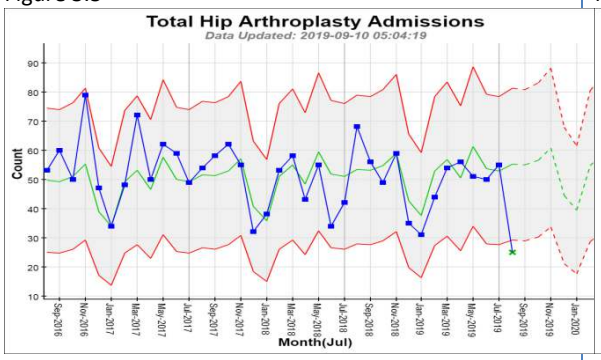
Figure 3.4



Readmissions continue to remain within expected mean values.

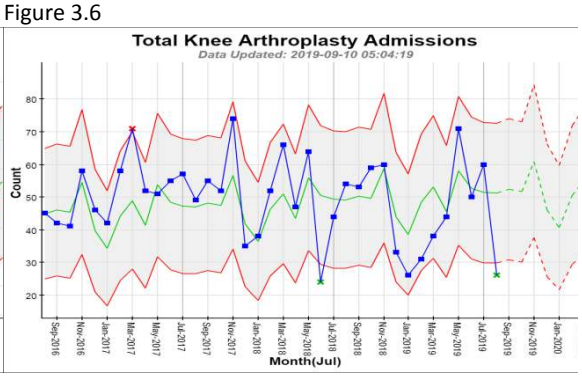
Outcome and Strategy Indicators – Elective Total Hip Replacement(THR) and Knee Replacement(TKR)

Figure 3.5



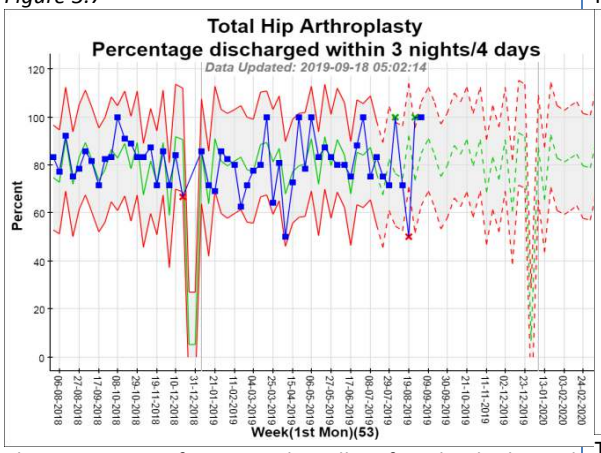
In recent months hip replacements have been tracking within or below projected levels.

Figure 3.6



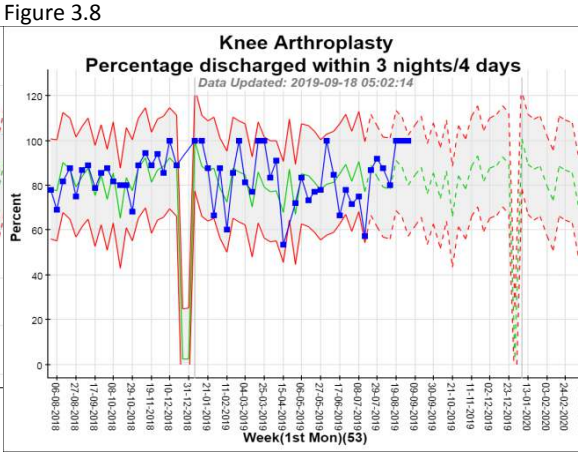
Knee replacement admissions over the previous twelve months have been tracking around the projected levels.

Figure 3.7



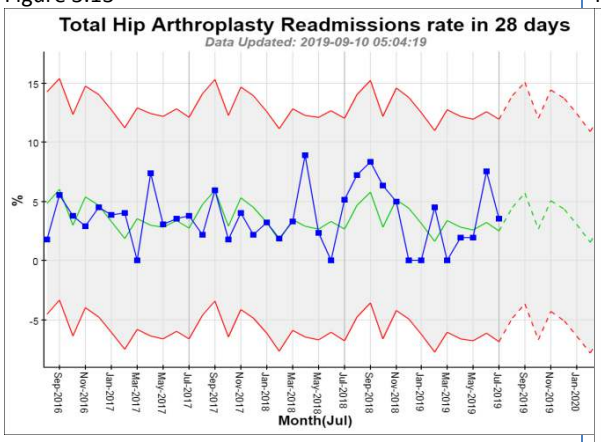
The percentage of patients clinically safe to be discharged within 3 nights/4 days is following established trend.

Figure 3.8



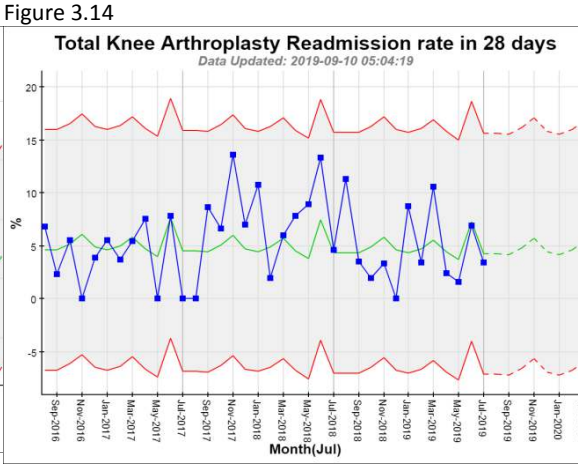
The percentage of patients clinically safe to be discharged within 3 nights/4 days is following established trend.

Figure 3.13



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

Figure 3.14



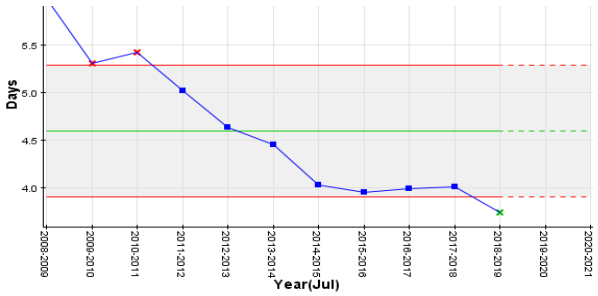
Readmission rates are maintaining within tolerances.

Achievements/Issues of Note

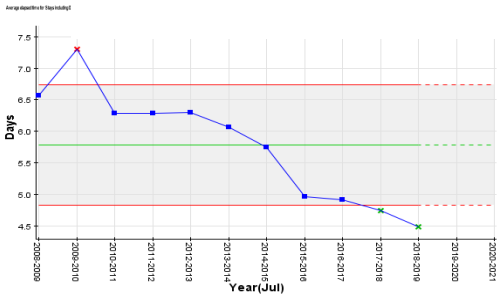
ERAS update

Enhanced Recovery After Surgery (ERAS) was introduced in September 2014. This was a Ministry of Health imitative introduced to enable people to recover faster from their surgery and return home earlier. At Burwood we have updated the pre-op education and patient information and focused on day of surgery mobilisation. We have also introduced a streamlined approach to administration of pain relief medication to support early rehabilitation. These initiatives have reduced the patient stay to 3 nights in most cases. Post-operative care also includes a post discharge follow up phone call to ensure that patients and their family feel support and we can address any issue or concerns in a timely manner.

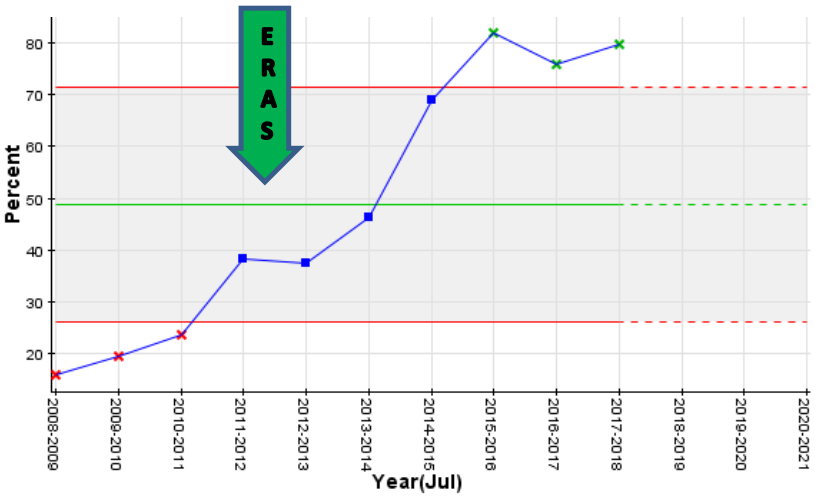
Mean LOS TKR



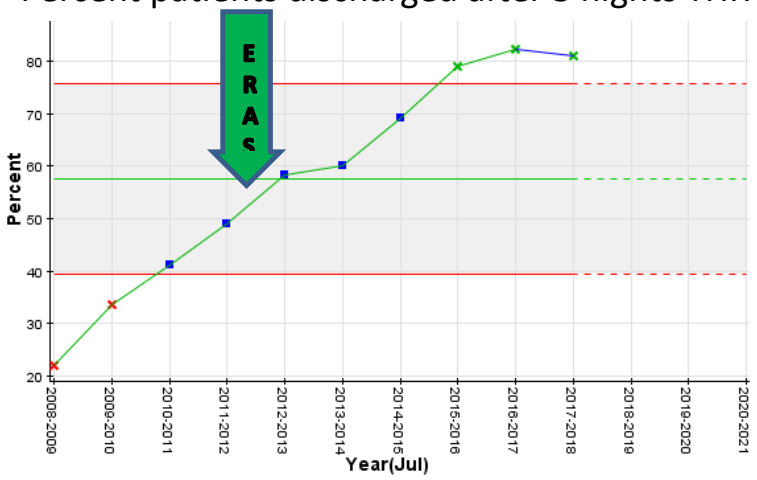
Mean LOS THR

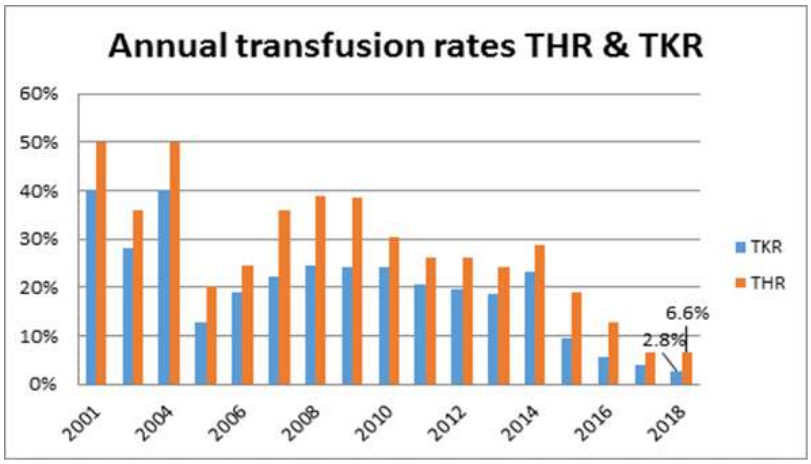


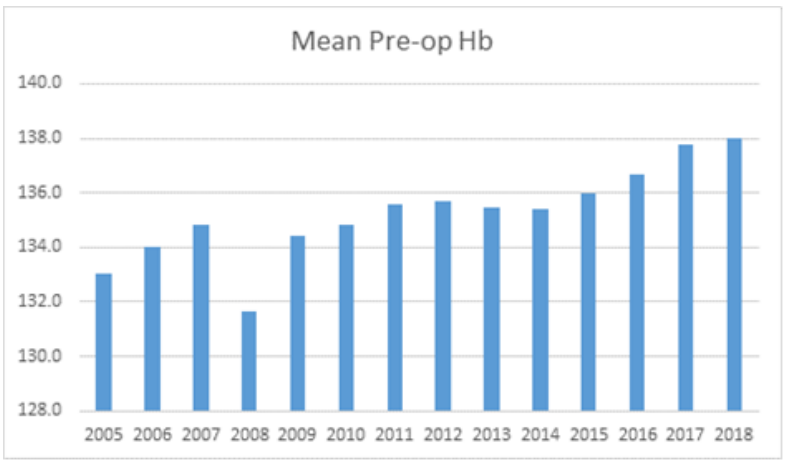
Percent patients discharged after 3 nights TKR

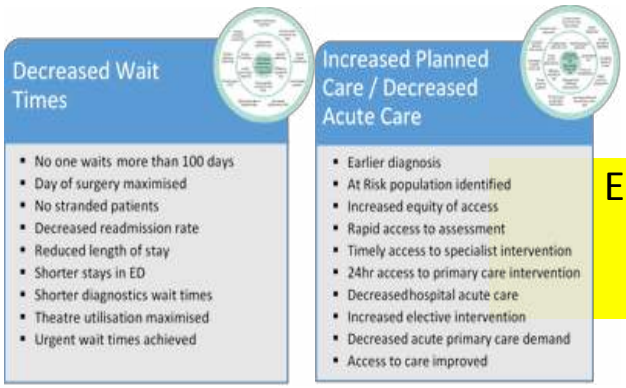


Percent patients discharged after 3 nights THR







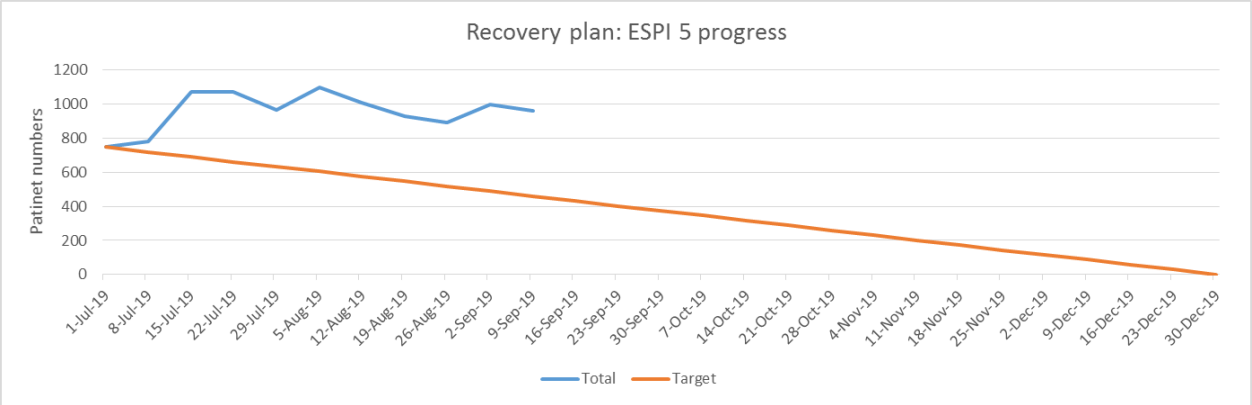


Elective Surgery Performance Indicators 100 Days

Achievements/Issues of Note

Elective Services Performance Indicators

- Over the past twelve months as changes in our systems and processes have been embedded and transferred data have been cleaned up it has been challenging to systematically provide updates to the Ministry of Health that allow assessment of Canterbury District Health Board's performance against waiting time targets.
- Over this time regular updates have not been provided in this report about performance in this area.
- Alongside the data issues experienced the events of March 15th along with a flood in the outpatient building and periods of industrial action have contributed to our inability to see all patients within our own target time of 100 days.
- We are now confident that internal reports are providing an accurate picture of performance, while summary reports provided by the Ministry continue to require further updating. Internal reports show 992 patients (around 18% of the total waitlist) have waited for Surgery for longer than 120 days with 2,890 patients (25% of the total) waiting for First Specialist Appointment for longer than 120 days.
- A recovery plan has been agreed with the Ministry of Health that will see both of these measures in green or yellow status by the end of 2019. Achievement against this plan in the past two months gives confidence that this will be achieved for ESPI 2 (First Specialist Appointments) and indicates reason for concern around ESPI 5 (surgery).



- As we make progress in reducing the number of patients waiting for their first appointment with a specialist it inevitably increases the number who are accepted for an elective surgical solution.
- The ongoing delays in the completion of Hagley Hospital are restricting our ability to provide elective surgery. While we can outsource a significant percentage of our elective surgeries to other providers there are many patients who are unsuitable for treatment anywhere other than in the public hospital where theatre time is at a premium.

Children's Outreach Nursing Service Weight Clinic

- During 2018 it was noted that the weight room in the Children's Outpatient Department was too small to accommodate a wheelchair and a hoist along with the chair scales. Parents were often taking their children to the paediatric wards at Christchurch Hospital, to Orthopaedic Outpatients at Burwood Hospital, to Montreal House or even to their local vet (not on Child Health advice) to be weighed to meet recommendations from paediatricians and dieticians.
- A solution was developed involving provision of a Children's Outreach Nursing Service weight clinic at Montreal House. It was held in the school holidays, initially in July 2018, to make it easier for children and their whānau to attend. This venue provides great parking and physical accessibility.
-
- The room used at Montreal house is large, enabling safe operation of the hoist, so as well as providing the other stated benefits to children and their whānau this environment enables weighing to occur while avoiding injury to children and staff.

New Phototherapy Machine Increases Treatment Capacity

- Ultraviolet B has been used for many years to treat skin conditions as it helps suppress the immune imbalance that drives inflammation.
- A new phototherapy machine has been installed in the Dermatology Department in Christchurch Outpatients which will allow more Ultraviolet light B treatment courses to be delivered to patients with skin conditions such as psoriasis, vitiligo, and other light responsive disease.
- Previously having only a single narrow-band UVB machine allowed for around 34 patients a week to be treated. However, with a second machine there is now capacity for treating around 54 patients a week, a 60% increase. Further increases are possible if matching nurse capacity is brought on board.
- This increase in machine capacity, along with an improved ability to quickly provide support to General Practitioners (due to the e-Referrals system, as previously reported) and hard work by the team are enabling the team to manage approximately 200 referrals to Dermatology per month with near to zero declines. This is a significant improvement on last year.

Reducing time spent waiting for appointments with the autism spectrum disorder coordinator

- Following diagnosis for autism spectrum disorder patients' whānau spend time with the Autism Spectrum Disorder Coordinator talking through what school and community support is required.
- Previously each of these consultations took up to two hours in the patient's home with follow up activities taking another hour. The waitlist for this service held over 70 patients – whānau were waiting up to nine months to be seen.
- Group sessions are now being run, each catering for five to ten whānau.
- This enables the coordinator to support several patients at a time and with whānau also providing support to one another.
- This solution has reduced the time required to complete each support plan by approx. 60 minutes and progress is being made towards shortening the waiting time for this service.

Introducing point of care testing for the human immunodeficiency virus

- A clinical nurse specialist from the Sexual Health Clinic has been providing an outreach clinic at Menfriends over the past twelve years. This supports a vulnerable group of men who are less likely to present at their general practice.
- Until recently testing for the Human Immunodeficiency Virus has only been possible by sending a blood sample to the laboratory.
- The Sexual Health Clinic and Canterbury Health Laboratories have worked collaboratively to trial point of care testing at the Menfriends clinic from early August 2019. .
- The trial will ensure that there is good alignment between the point of care method and traditional serology testing. Once this trial has been completed we are looking at adding syphilis into this testing platform. When successful this will enable us to cease conventional serology testing for this clinic.
- We will be one of the first District Health Boards in New Zealand to introduce this method.
- This will reduce the distress normally experienced while patients wait for one or two days for their test results, and diagnosis can be given by a CNS in a safe environment in real time. The provision of less invasive testing, using a finger prick, also reduces the distress experienced by some clients who refuse regular screening bloods due to needle phobia.

Changing the way that we work in the outpatients' building

During recent months changes have been introduced to the way that we work in the outpatients' building:

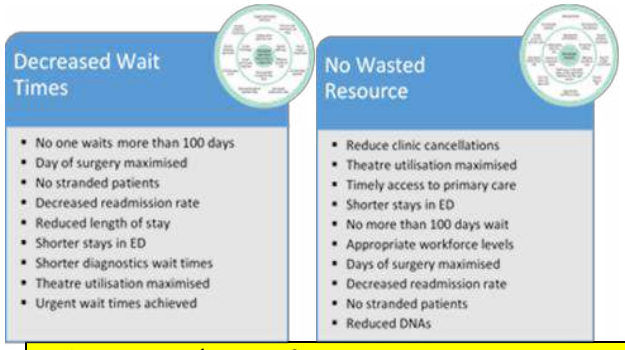
- Many patients require some nursing assessment or measures taken prior to the patient seeing a doctor. In many cases the measures required are limited to blood pressure and weight. These measures can be effectively carried out by hospital aides and do not need a Registered Nurse to carry them out. The hospital aide team underwent credentialing using the Calderdale Framework to enable them to be delegated these tasks. This releases Registered Nurses to carry out tasks that only they can provide, reducing the drivers that would otherwise see a demand to increase nurse capacity to support clinics.
- This means Registered Nurses can now provide a number of procedures in the clinic area including provision of iron infusions that otherwise would require capacity in the medical day unit. Similarly a wound clinic has been set up to enable patients who would normally return to inpatient areas to have wound reviews and drain removals.

Improving pre-operative assessment

- Our typical pathway for patients being provided with surgery involves an agreement between surgeon and patient, often at the first specialist appointment, that an operation is required and is being offered. General Surgery patients had typically received forms enabling triaging for pre-anaesthetic assessment and preparation along with their appointment for the First Specialist Appointment. This provided confusion about whether the patient was being offered surgery or not prior to the

appointment. Forms were sometimes lost or took a long time to be sent back, delaying decisions about further pre-anaesthetic assessment and preparation. This has led to delays in providing surgery and poor targeting of anaesthetist and nurse capacity for pre-anaesthetic assessment.

- A new model has been put in place for General Surgery patients that involves patients that would benefit from surgery being provided with some of the pre-operative assessment at the time of their First Specialist appointment. They are provided pre-anaesthesia assessment forms along with a clear message that this is a part of their assessment of suitability for an operation. Patients are asked to fill the forms return them before they leave clinic.
- Smoking cessation messages are also provided to these patients directly by the Surgeon. This direct messaging has been found to have a greater effect. It also allows sufficient time for them to manage their nicotine addiction prior to surgery which leads to better healing and recovery.
- These changes are early in their implementation and fine-tuning of the model is still occurring. Plans are in place to introduce these changes more widely.



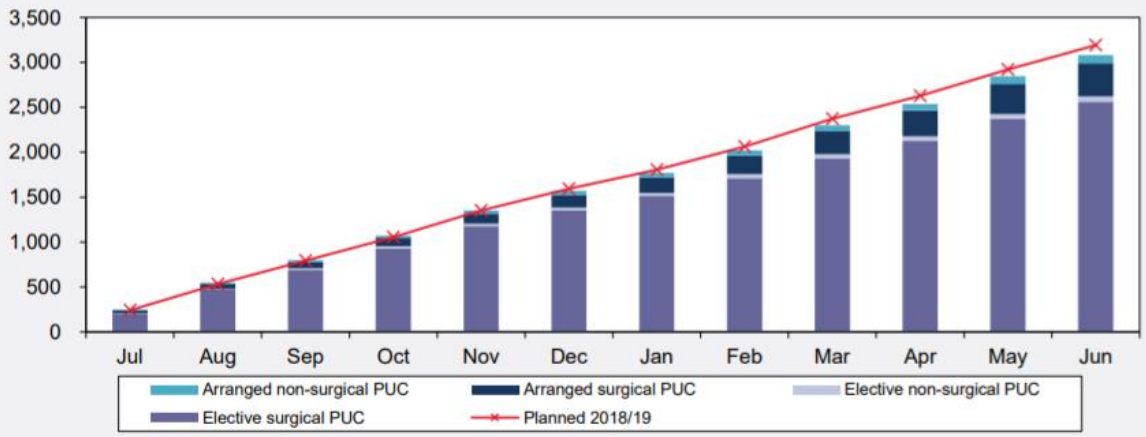
Theatre Capacity and Theatre Utilisation

Achievements/Issues of Note

Elective Services Discharges

Elective Surgical Discharges ▼ **97.6%**

	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	3,476	5,260	6,981	8,982	10,510	12,085	13,965	15,850	17,348	19,347	21,267
Variance	97	294	195	-4	-150	40	553	491	174	-200	-426	-515
%Achievement	106%	109%	104%	100%	98%	100%	105%	104%	101%	99%	98%	98%



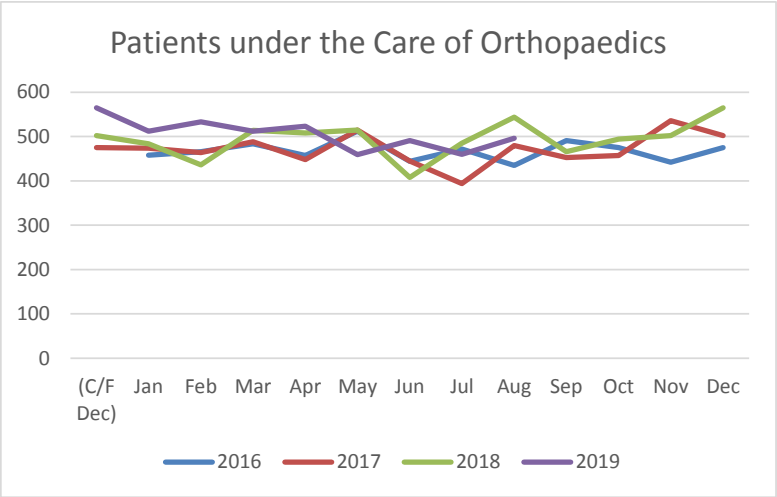
- Reporting from the Ministry of Health shows that Canterbury DHB met its elective discharges objectives at the end of the first quarter (until the end of September 2018), and performance continued to be close to target until the end of February 2019.
- There is significant under delivery between the end of March and May 2019. Fall off in performance was associated with no capacity being available in the ICU for elective surgical cases (Oct 2018) and the mass shooting of 15 March 2019.
- Under delivery in surgical procedures was off-set by wash up of ambulatory initiative volumes.

Orthopaedic Activity

There were 496 patients admitted under the care of Orthopaedics in August 2019, which was less than August 2018 where we saw a spike in admissions. We have seen continued flow of patients to Burwood. 45/302 patients were transferred for surgery to Burwood Hospital in a planned session. The average

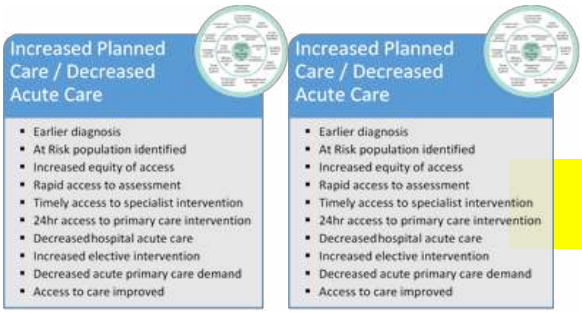
length of hospital stay remains relatively constant at 3.46 days however we continue to look at fit and ready for surgery as an indicator. The average wait for theatre was 0.79 days calculated on the "readiness for theatre" date. We know that 66% of patients who were ready for theatre received their surgery with less than one full days wait, while a further 26% proceeded to theatre within 1-2 days. By use of senior Registrars and fellows, we were able to utilise 72% of the allocated backfill lists at Burwood.

Our trends continue to sit within the norms expected:



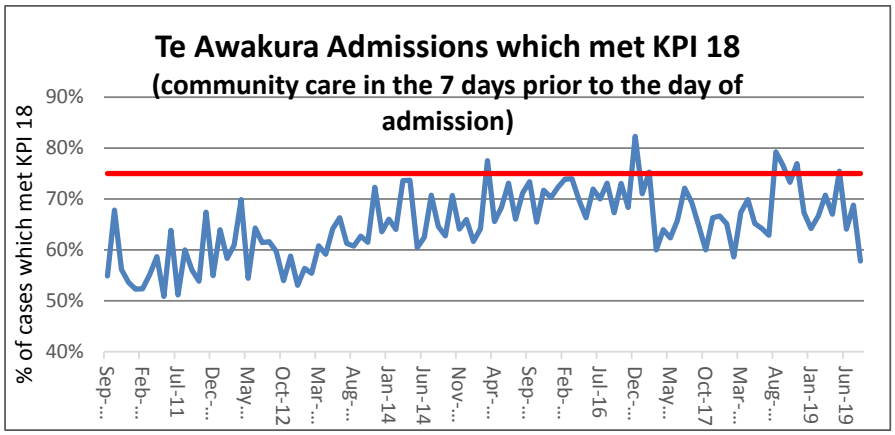
Of those transferred to Burwood for surgery (45) the ability to manage complex acutes, stay at Christchurch campus. We are focused on using our planned sessions and the outcome linked to our recovery plan only saw 2 elective cases cancelled.

Lower limb	13
Upper Limb	21
Foot	1
Hands	3
Knee re-op	1
Spines	3
NOF	1
Hip re-op	1
Removal FB	1



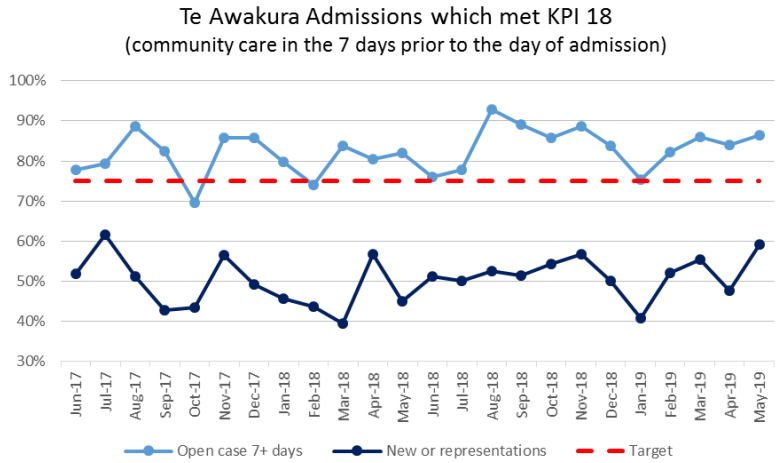
Mental Health Services

Adult Services

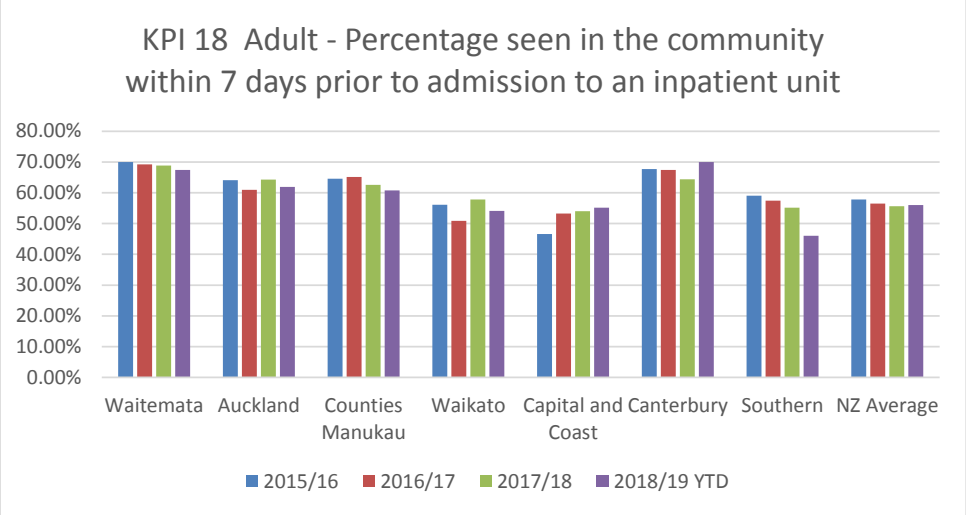


KPI 18 is an indicator of how engaged we are with consumers prior to admission to inpatient services. In July 2019, 68.8% of acute admissions to Te Awakura had a community contact in the seven days prior to the date of their admission. In August 2019, the figure was 57.8%.

A recent investigation into KPI 18 rates showed that in most instances where KPI 18 was not met, the person was not currently under the care of Specialist Mental Health Services. For people already under the care of Specialist Mental Health Services the target was achieved.

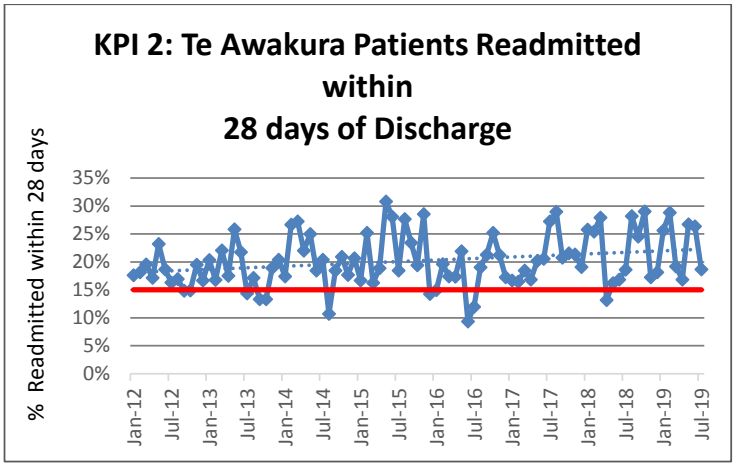


The graph below provides a comparison of our KPI 18 data against DHBs with comparable populations.

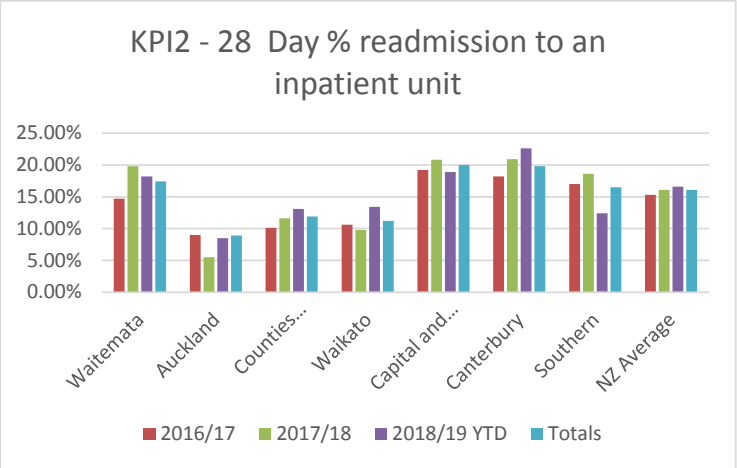


*Source: New Zealand Mental Health and Addictions KPI Programme

The graph below shows the **readmission rate within 28 days of discharge**. Of the 123 Te Awakura consumers discharged in July 2019, 18.7% were readmitted within 28 days. Readmission rates are closely monitored.

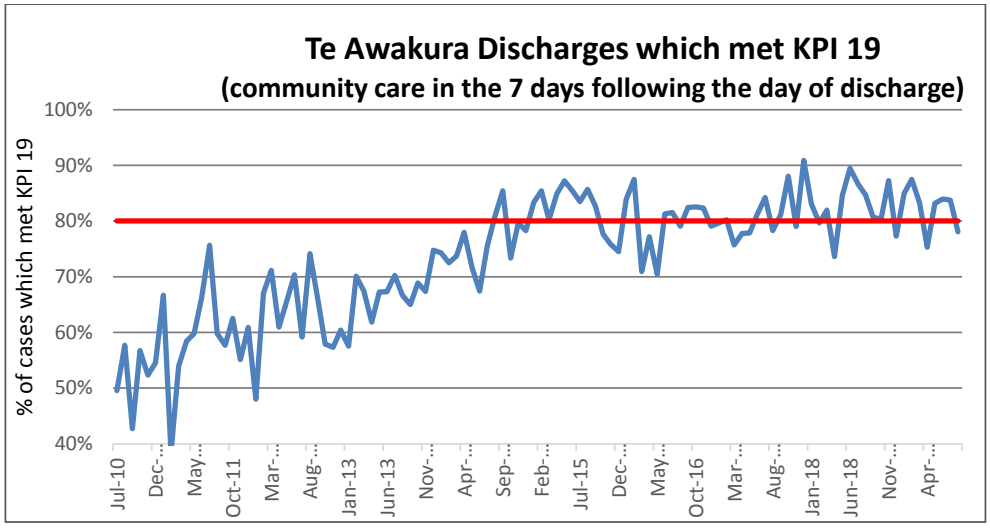


The graph below shows the national comparison readmission rates against DHBs with comparable populations.

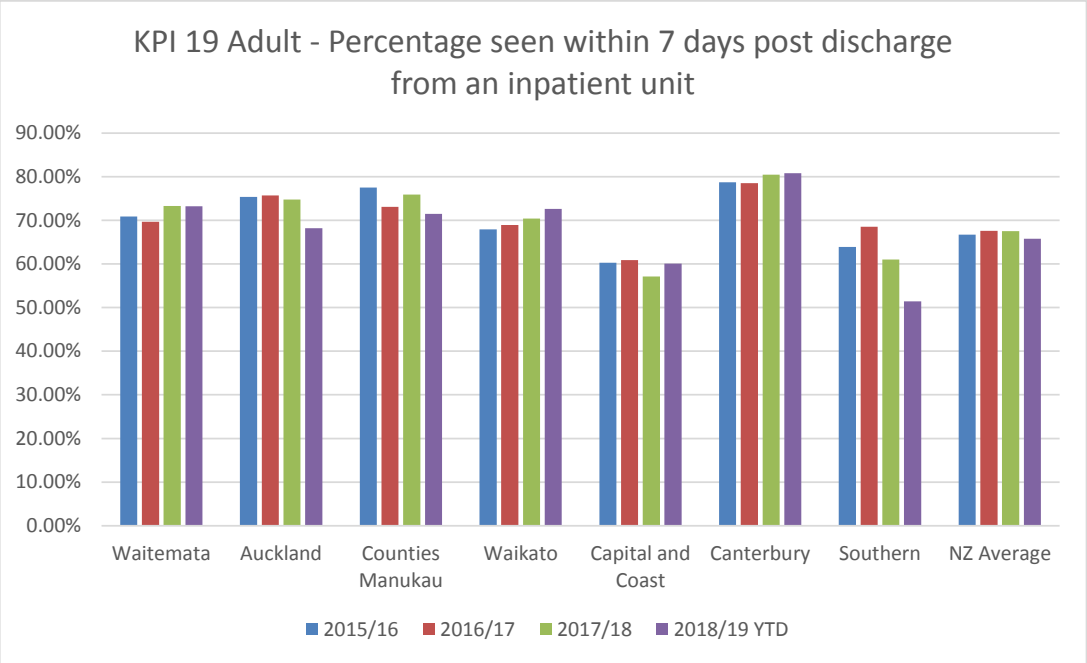


*Source: New Zealand Mental Health and Addictions KPI Programme

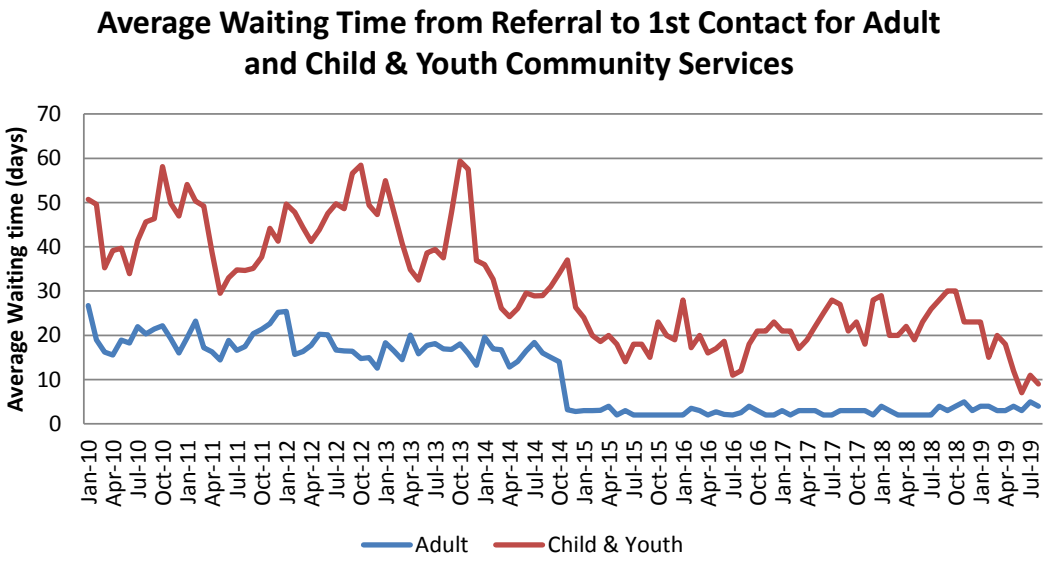
KPI 19 is a key suicide prevention activity and patient safety measure. In July 2019, 83.7% of consumers discharged from Te Awakura received a community care follow-up within seven days of discharge, and so met KPI 19. In August 2019, the figure was 78.1%.



The graph below shows the national comparison KPI 19 rates against DHBs with comparable populations.



*Source: New Zealand Mental Health and Addictions KPI Programme

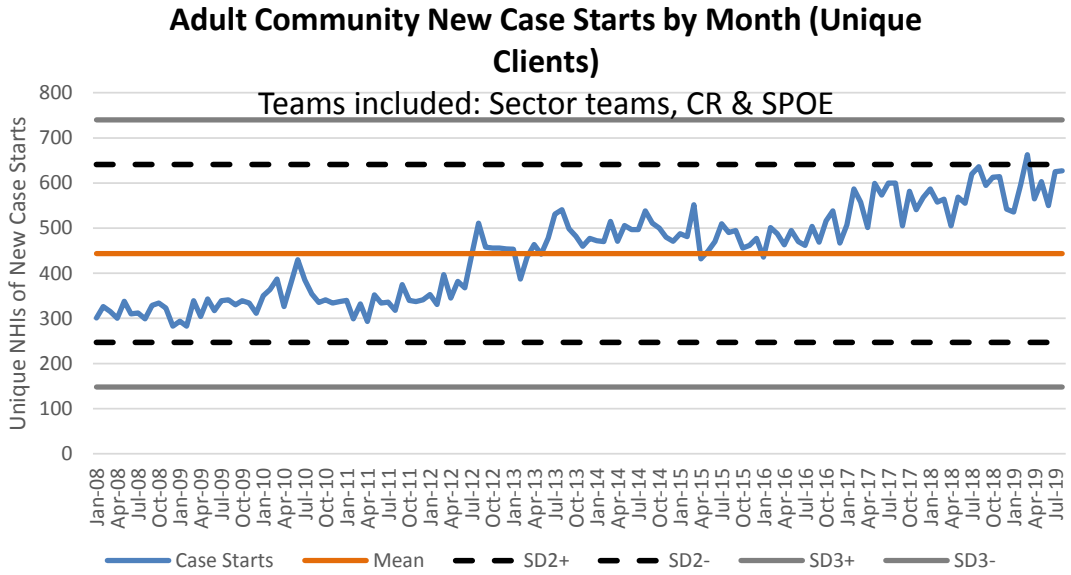


The graph above shows there has been an overall reduction in the time people spend waiting for services. Ministry of Health targets require 80% of people to be seen within 21 days and 95% of people to be seen within 56 days. The average waiting time for adults was 5 days for July 2019 and 4 days for August 2019. Our results for the Adult General Mental Health Service show 90.35% of people were seen within 21 days of referral in July 2019 and 98.9% were seen within 56 days of referral. In August 2019, these figures were 93.75% and 98.8% respectively.

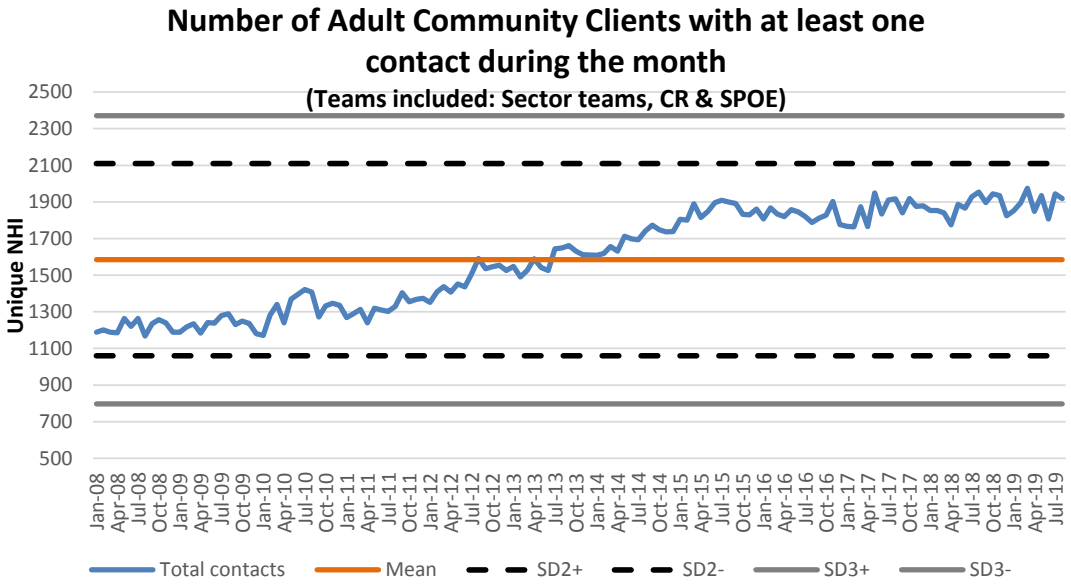
For child and family services, the average waiting time to first contact was 11 days in July 2019 and 9 days in August 2019. Our results show 51.1% of people were seen within 21 days of referral in July 2019 and

68.4% were seen within 56 days of referral. In August 2019, these figures were 65.9% and 82.6% respectively.

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



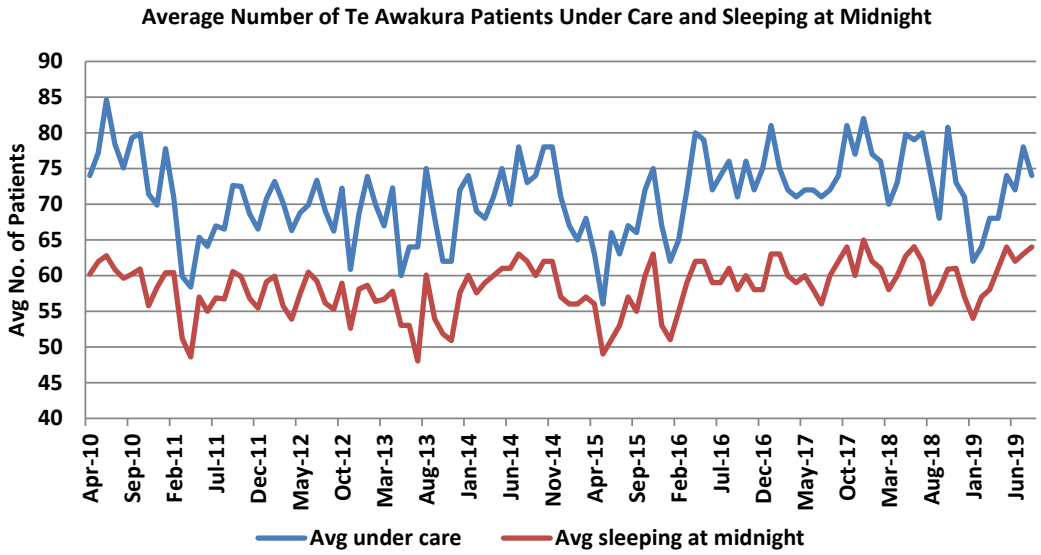
New cases were created for 625 individual adults (unique NHIs) in July 2019 and 627 in August 2019.

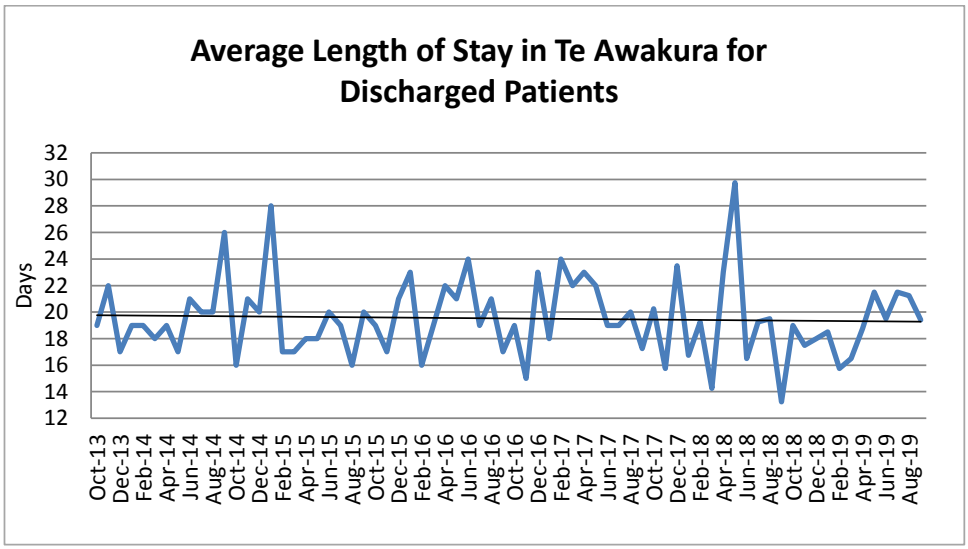


In July 2019 there was at least one contact recorded for 1945 unique adult community mental health consumers and 1918 in August 2019.

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 98% in July 2019 and 100% in August 2019.

The average number of consumers under care in this 64 bed facility was 78 in July and 74 in August 2019. There were 20 sleepovers during July 2019 and 7 sleepovers during August 2019.

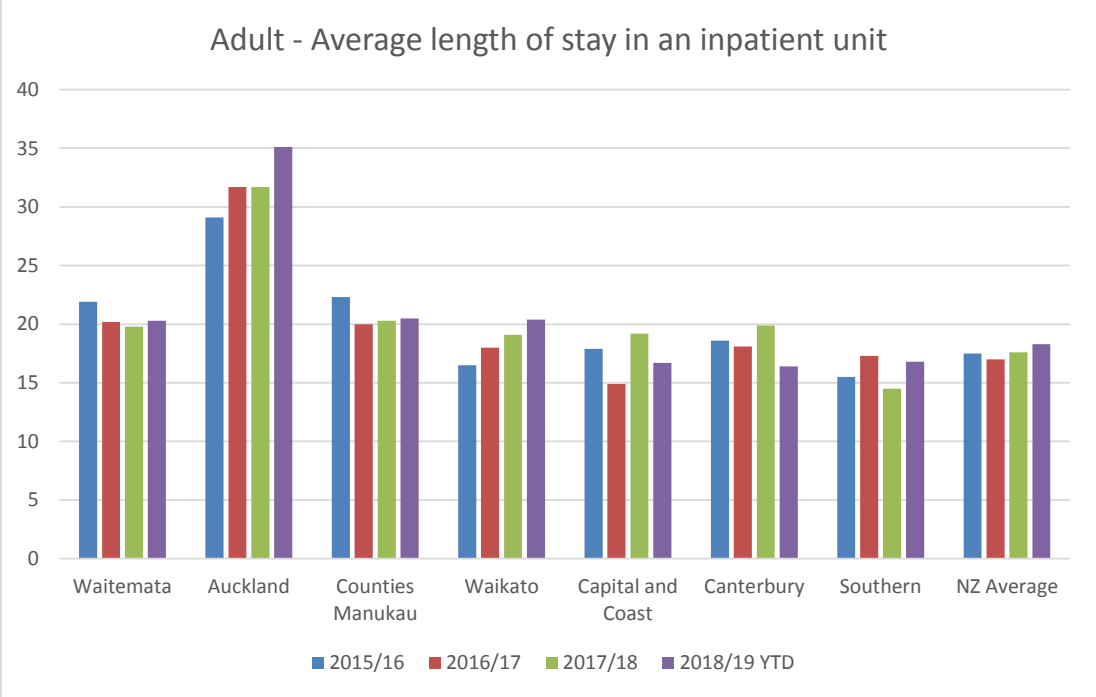




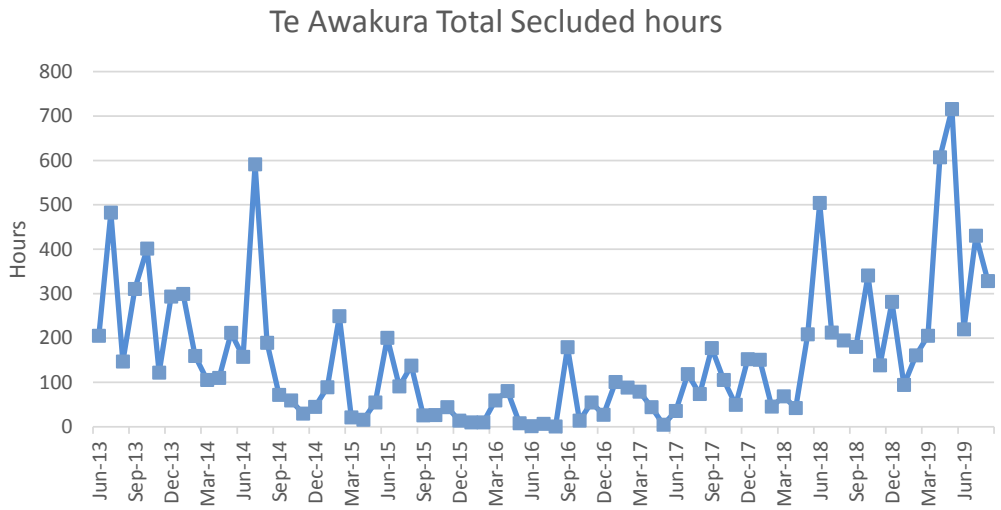
The average length of stay for consumers discharged from Te Awakura was 22 days for July 2019 and 21 days for August 2019. On the day of writing this report 37 of acute inpatient beds were occupied by people who have been in the service for 18 days or longer, 28 of those people had been in for longer than 30 days, 14 for longer than 60 days, 7 have been in for longer than 90 days and 2 people have been in the unit for more than a year

We are closely monitoring length of stay and developing an understanding of the complex reasons for delayed discharges, including issues that are impacting on consumer flow through mental health services

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

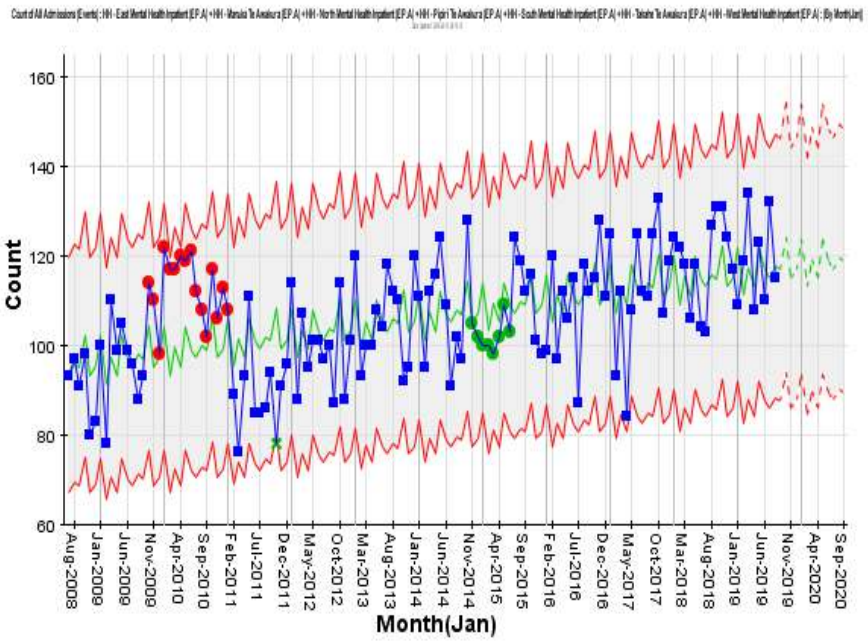


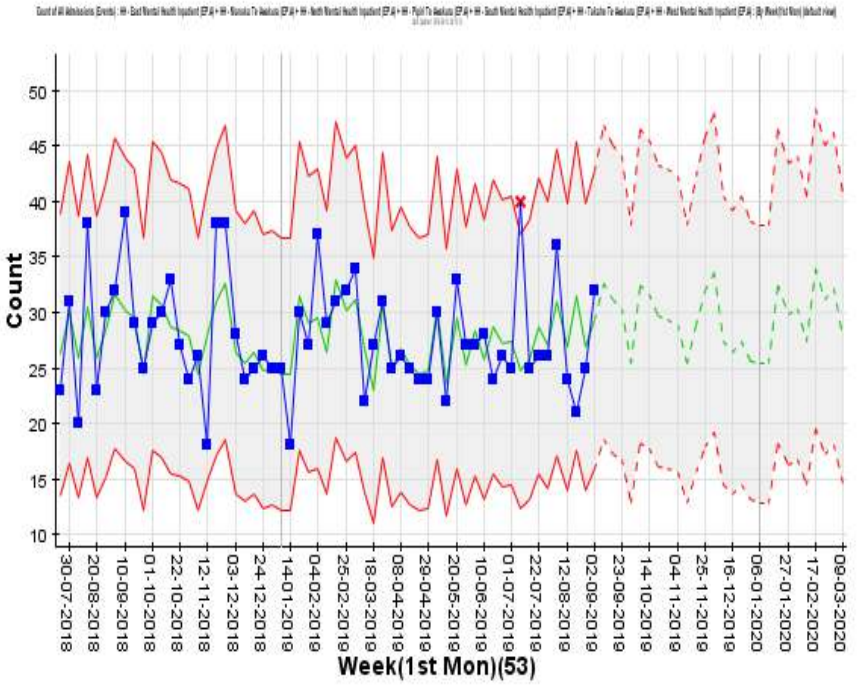
*Source: New Zealand Mental Health and Addictions KPI Programme



In July 2019, ten consumers experienced **seclusion** for a total of 430.6 hours. In August 2019, 14 consumers experienced seclusion for a total of 328.1 hours. The recent increase is in the context of consumers presenting with drug related issues, consumers accessing drugs whilst an inpatient and an individual with a complex physical condition resulting in impulsive, aggressive outbursts.

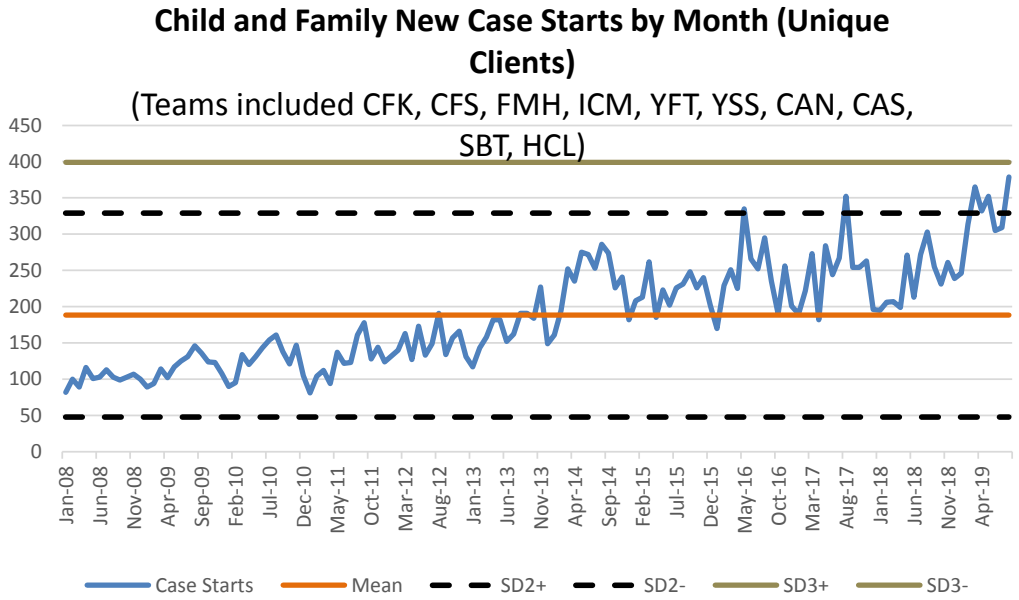
The next two graphs show a count of admissions to Te Awakura (the acute adult unit) – the first is a monthly view, and the second a weekly view. The number of adult admissions (to Te Awakura) shows an increasing trend but remains within the expected range.





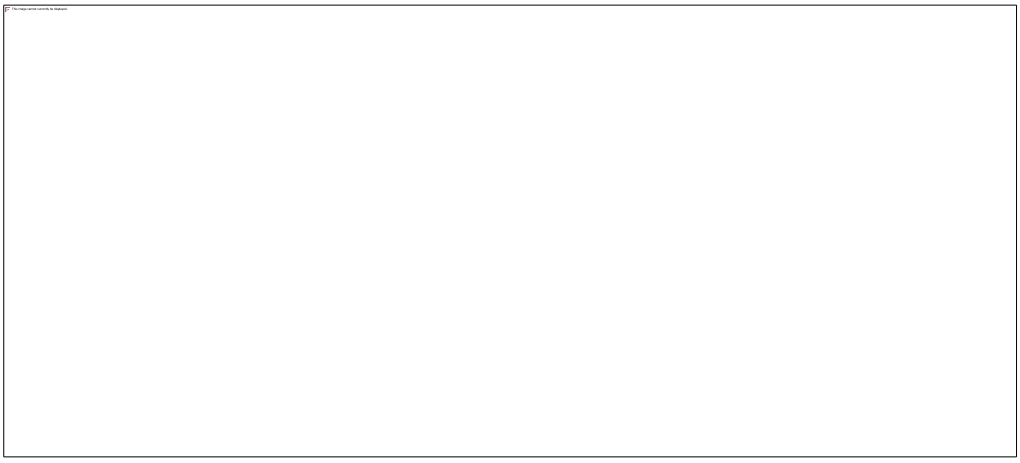
Child and Youth

CAF continue to experience an increase in demand, as demonstrated by the graph below. As at July 2019 26.5% or 1302 consumers under SMHS care are aged under 18 years. New cases were created for 329 children and adolescents (unique NHIs) in July 2019 and 379 in August 2019. This amounts to a 146% increase over 9 years.

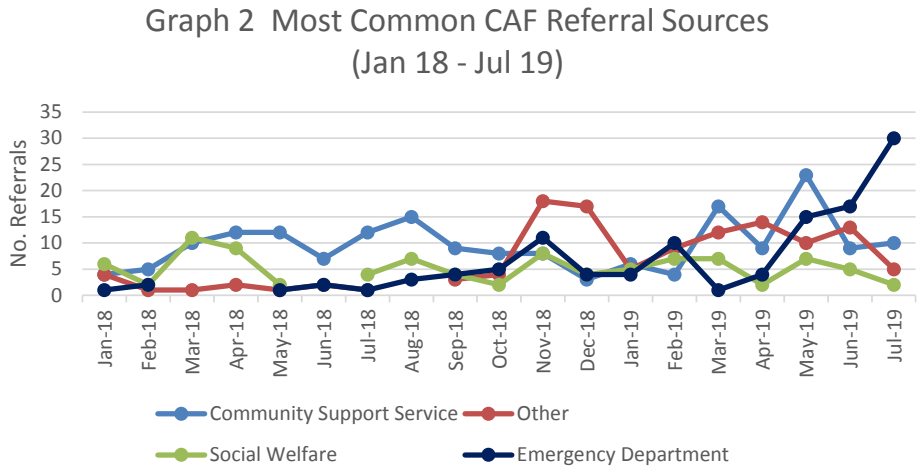


An analysis of the increasing number of referrals has been completed to enable us to understand trends and hopefully identify ways in which we can proactively target and address need.

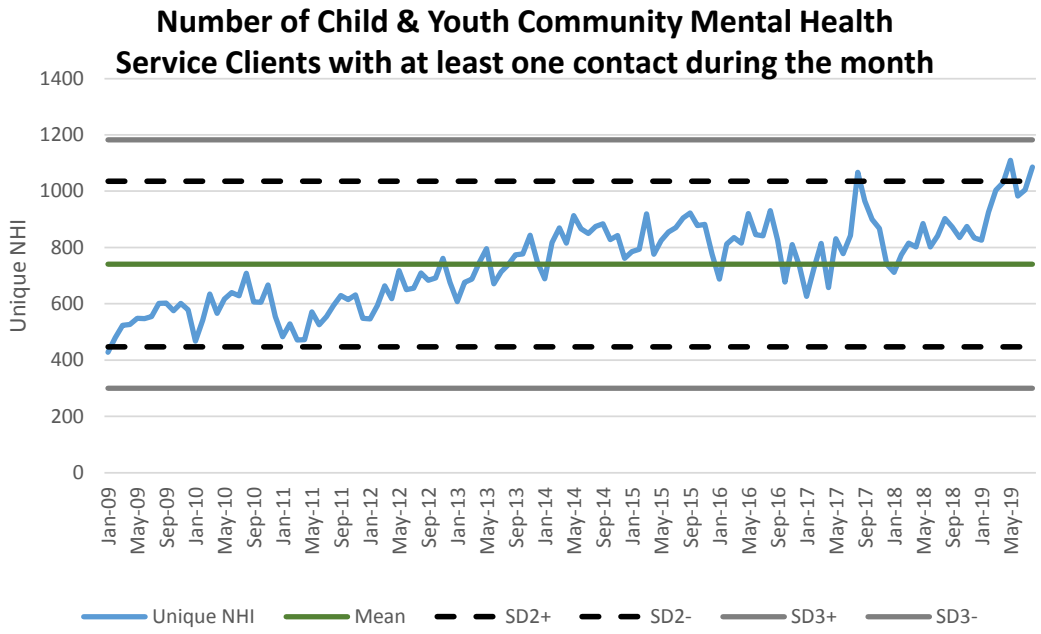
By age, 1.0% (13) are under 5, 34% (430) are aged 5 to 11, 60.5% (756) are aged 12 to 17 and 4.5% (57) are over 18.



A review of referral sources demonstrates that the majority of referrals to child and adolescent services comes from GPs, with a marked increase in referrals from the emergency department. The service is currently receiving an average of 84 referrals per week.

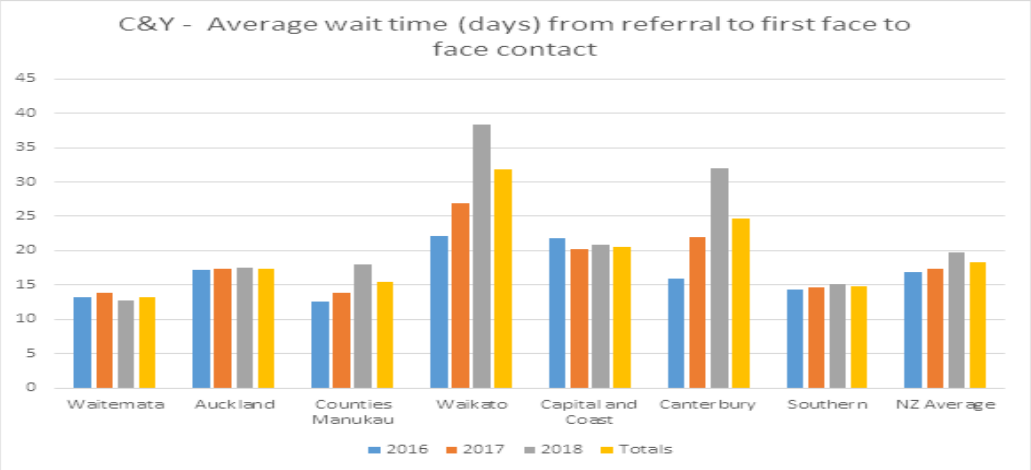


The number of unique clients with contacts below shows a similar pattern to new case starts graph, which further demonstrates the increase in demand for Child and Youth community Mental Health Service. There were 1035 unique patients with at least one contact during the month of July 2019 and in August 2019 there were 1086.

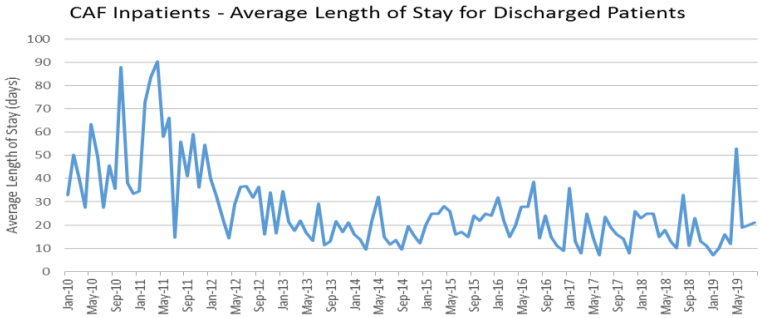


Despite an ongoing increase in referrals, CAF have worked hard to reduce the wait time from referral to treatment. The Service's Access team has been redesigned to improve waiting time and where appropriate to provide short term assessment and treatment to crisis presentations. Without these changes the increase in clinical activity would have resulted in longer waits for young people to be seen.

The graph below shows the national comparison average wait times against DHBs with comparable populations.

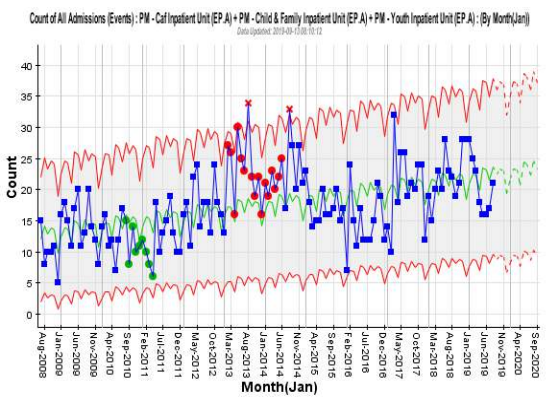


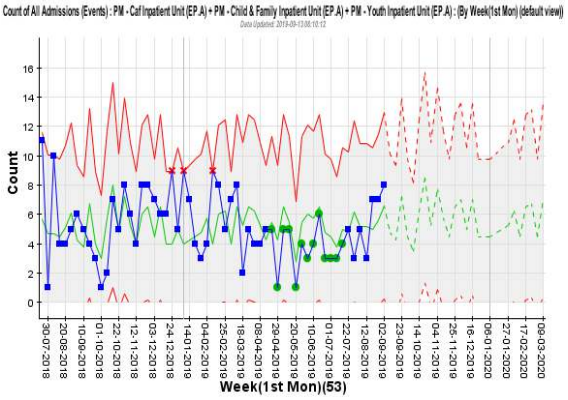
*Source: New Zealand Mental Health and Addictions KPI Programme



The average length of stay for discharged patients was 20 days for July 2019 and 21 days for August 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.



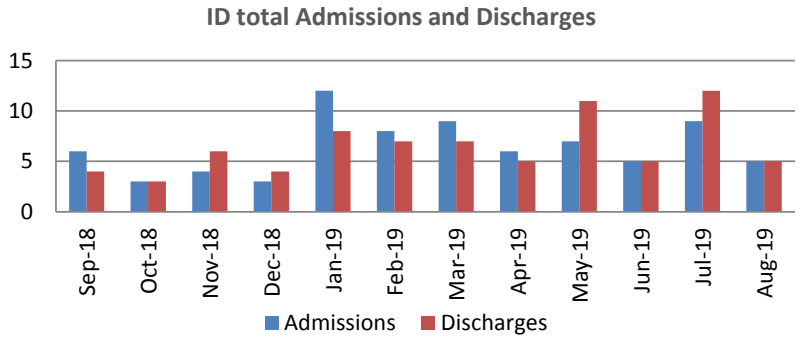


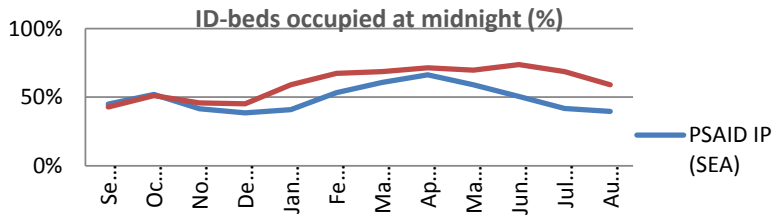
Intellectually Disabled Persons Health Service

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

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

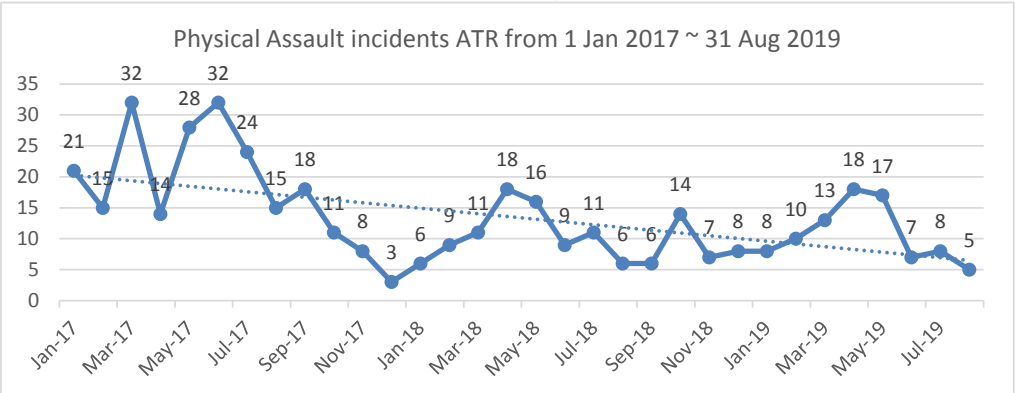
Interim internal modifications now includes a second internal annex which is in use. The first internal annex area has resulted in a reduction in physical assaults and the requirement for seclusion for that person, and it is anticipated that the second area will result in a similar reduction of adverse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

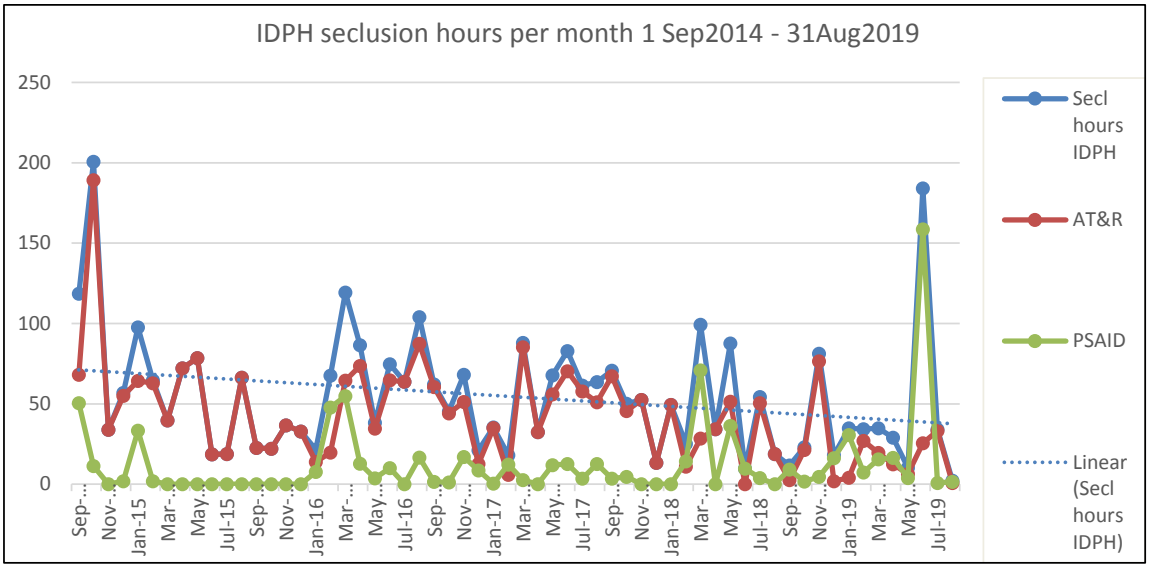


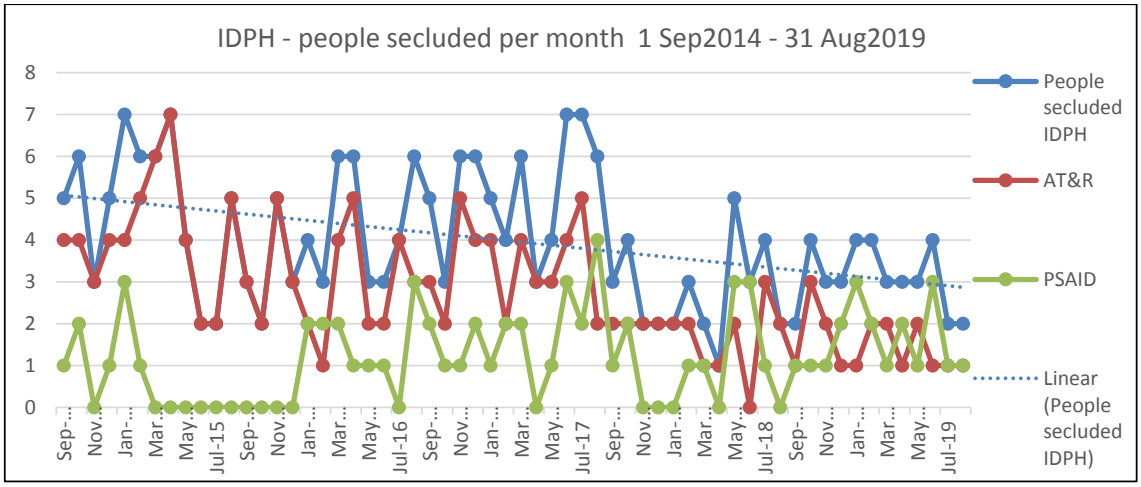


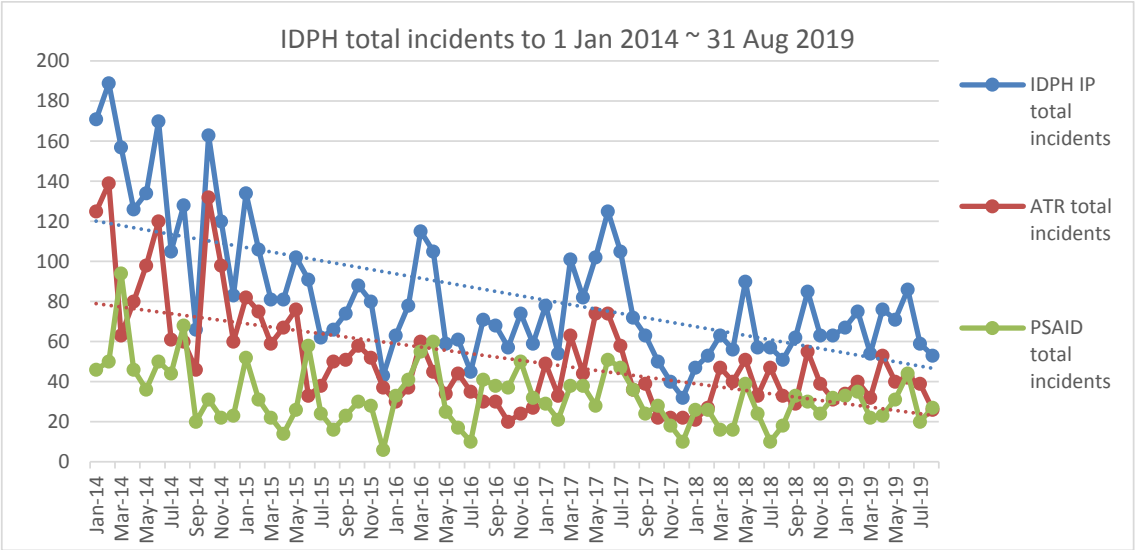
Occupancy in AT&R (AT1) was 69% for the month of July 2019 and 59% for August 2019. The figures for PSAID (SEA) were 42% and 40% respectively.

Since the uncharacteristically high level of seclusion in PSAID Inpatient service in June 2019, the total seclusion used in IDPH fell to a low 2.2 hours in August 2019.




IDPH seclusion hours per month 1 Sep2014 - 31Aug2019
250
200
150
100
50
0
Sep-...
Nov-...
Jan-15
Mar-...
May-...
Jul-15
Sep-...
Nov-...
Jan-16
Mar-...
May-...
Jul-16
Sep-...
Nov-...
Jan-17
Mar-...
May-...
Jul-17
Sep-...
Nov-...
Jan-18
Mar-...
May-...
Jul-18
Sep-...
Nov-...
Jan-19
Mar-...
May-...
Jul-19
Secl hours IDPH
AT&R
PSAID
Linear (Secl hours IDPH)


IDPH - people secluded per month 1 Sep2014 - 31 Aug2019
8
7
6
5
4
3
2
1
0
Sep-...
Nov-...
Jan-...
Mar-...
May-...
Jul-15
Sep-...
Nov-...
Jan-...
Mar-...
May-...
Jul-16
Sep-...
Nov-...
Jan-...
Mar-...
May-...
Jul-17
Sep-...
Nov-...
Jan-...
Mar-...
May-...
Jul-18
Sep-...
Nov-...
Jan-...
Mar-...
May-...
Jul-19
People secluded IDPH
AT&R
PSAID
Linear (People secluded IDPH)


IDPH total incidents to 1 Jan 2014 ~ 31 Aug 2019
200
180
160
140
120
100
80
60
40
20
0
Jan-14
Mar-14
May-14
Jul-14
Sep-14
Nov-14
Jan-15
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Jul-18
Sep-18
Nov-18
Jan-19
Mar-19
May-19
Jul-19
IDPH IP total incidents
ATR total incidents
PSAID total incidents

Living within our means

Living within our Means, including No Wasted Resource

Financial Performance

Canterbury District Health Board

Statement of Financial Performance

Hospital & Specialist Service Statement of Comprehensive Revenue and Expense
For the 2 Months Ended 31 August 2019

MONTH $'000					YEAR TO DATE			
19/20 Actual $'000	19/20 Budget $'000	18/19 Actual $'000	19/20 vs 18/19 Variance $'000		19/20 Actual $'000	19/20 Budget $'000	18/19 Actual $'000	19/20 vs 18/19 Variance $'000
				Operating Revenue				
498	463	483	15	From Funder Arm	1,027	930	920	107
1,687	1,548	1,619	68	MOH Revenue	3,876	3,095	3,084	792
4,591	4,717	3,990	601	Patient Related Revenue	9,156	9,442	8,794	362
1,728	1,647	1,778	(50)	Other Revenue	3,799	3,351	2,989	810
8,504	8,375	7,870	634	**TOTAL OPERATING REVENUE**	17,858	16,818	15,787	2,071
				Operating Expenditure				
				Personnel Costs				
63,621	63,665	59,617	(4,004)	Personnel Costs - CDHB Staff	127,460	125,837	116,551	(10,909)
2,345	1,875	1,935	(410)	Personnel Costs - Bureau & Contractors	4,653	3,754	3,632	(1,021)
65,966	65,540	61,552	(4,414)	**Total Personnel Costs**	132,113	129,591	120,183	(11,930)
11,914	12,686	13,237	1,323	Treatment Related Costs	25,912	25,170	24,642	(1,270)
4,116	3,097	3,631	(485)	Non Treatment Related Costs	8,218	5,964	6,818	(1,400)
81,996	81,323	78,420	(3,576)	**TOTAL OPERATING EXPENDITURE**	166,243	160,725	151,643	(14,600)
(73,492)	**(72,948)**	**(70,550)**	**(2,942)**	**OPERATING RESULTS BEFORE INTEREST AND DEPRECIATION**	**(148,385)**	**(143,907)**	**(135,856)**	**(12,529)**
				Indirect Income				
(1)	1	-	(1)	Donations & Trust Funds	(1)	4	3	(4)
(1)	**1**	**-**	**(1)**	**TOTAL INDIRECT INCOME**	**(1)**	**4**	**3**	**(4)**
				Indirect Expenses				
2,551	2,890	2,214	(337)	Depreciation	5,110	5,738	4,264	(846)
-	(1)	1	1	Loss on Disposal of Assets	5	(1)	1	(4)
2,551	**2,889**	**2,215**	**(336)**	**TOTAL INDIRECT EXPENSES**	**5,115**	**5,737**	**4,265**	**(850)**
(76,044)	**(75,836)**	**(72,765)**	**(3,279)**	**TOTAL SURPLUS / (DEFICIT)**	**(153,501)**	**(149,640)**	**(140,118)**	**(13,383)**

Achievements/Issues of Note

NADIA: Nurse Audit Data Insight Application - OPH&R

The releasing time to care module helped staff to recognise the time delays and insufficiency of paper auditing and manual reporting tools. From this an alternative digital way to complete and report auditing was conceptualised. This led to the development of a trial app and website that has recently been used to audit the patient bedside board completion

Developed for staff to have easy access and a streamlined process for auditing, result reporting, and overall data management. A digital platform developed to specifically meet the needs of auditors and allow development of action plans/ critical thinking to improve practice. The final stages of developing the official trial app are underway with the 12 week trial commencing mid-September.

Time savings Paper Bedside Board Audits

Current average time approx. 125 minutes per ward area (depending on size/skill mix of audit team)

*If audit team = 5 auditors then this would add on another 160 minutes **=** 285 minutes (Includes collation/review/debrief of audit results)

Bedside Boards Audits using Nadia

Current average 80 minutes per ward area. Plan - Use ward nurses who know their patients as the audit team and working alongside them will use approx. 5 – 10 minutes of their time and will add another 50 minutes = 130 minutes (Includes collation/review/debrief of audit results)

Total savings using Nadia = 155 minutes

Saving of time allows care back to patients. Increased focus will also be demonstrated through continuing to reduce falls, pressure injuries and medication errors. Quality linked to outcomes across OPH&R.

Auditing with NADIA: Cost savings per year if all audits digitised

CDHB Audits/Checklists	75	
		hh:mm
Total time Saved	2325000	38750:00
Applied to all audits/checklists	$ 1,356,250.00	

Nursing hours returned to providing care to patients and increasing patient contact time.

Audits included in NADIA trial:

Bedside Boards

IV Clinical Practice

Medication Administration Clinical Practice Audit

Medication Audit- Patient survey

NZ EWS

Patient engagement survey

Post-Fall clinical pathway form audit

Pressure Injury Sticker Audit

Purpose T Form Audit

Restorative Care Audit

Restraint and Seclusion Minimisation Audit

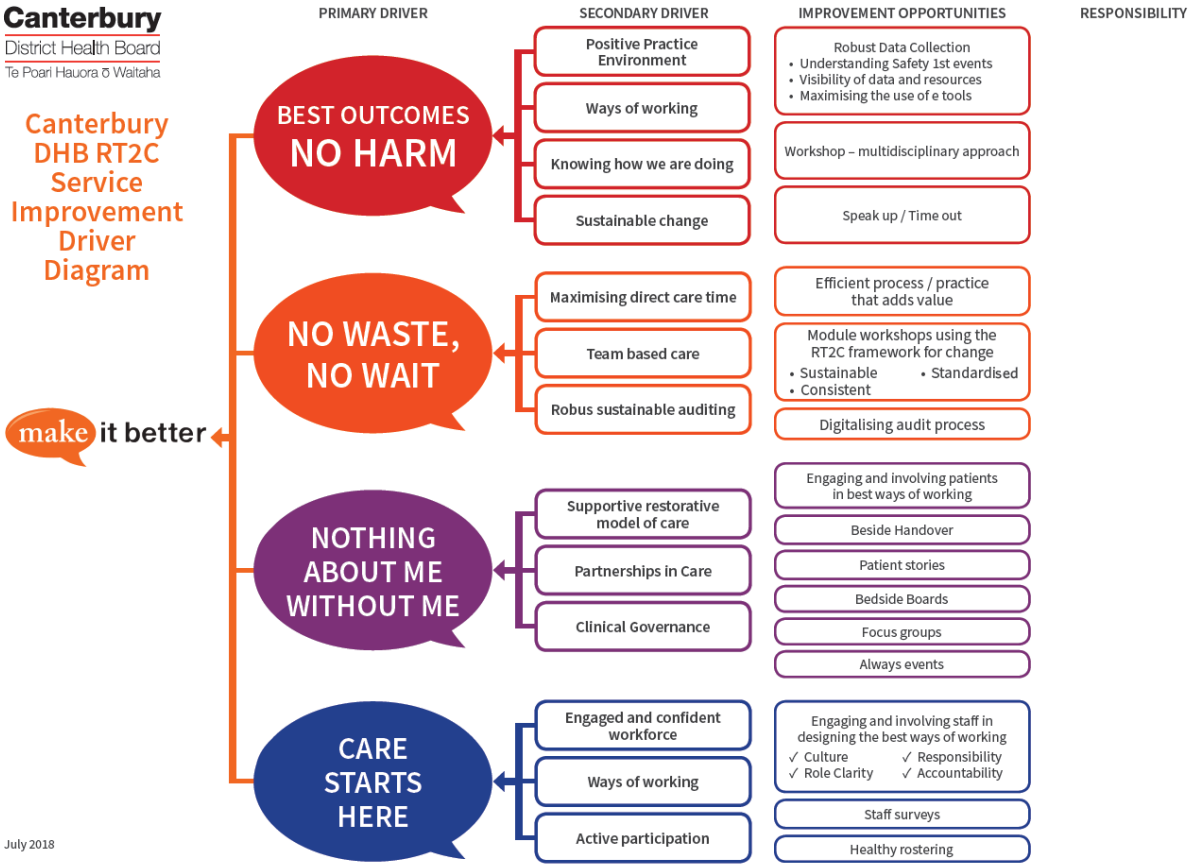
Resus Trolley Check List Audit

Shared Goals of Care Audit

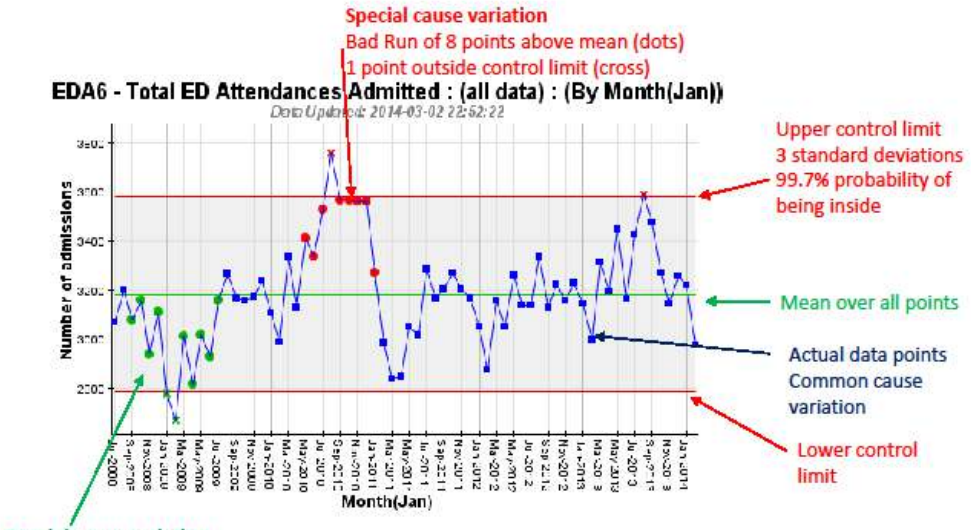
Staff Satisfaction Audit

Who will use it and how:

Each ward will be allocated an IPAD and a charger which will be situated in the CNM office. IV link staff/various senior staff and allocated staff members in each area will be loaded on to the application as users. Each staff member will be allocated a user passcode to access and use the IPAD app. Rollout is expected over the coming few weeks with the first set of monthly audits due end of September.



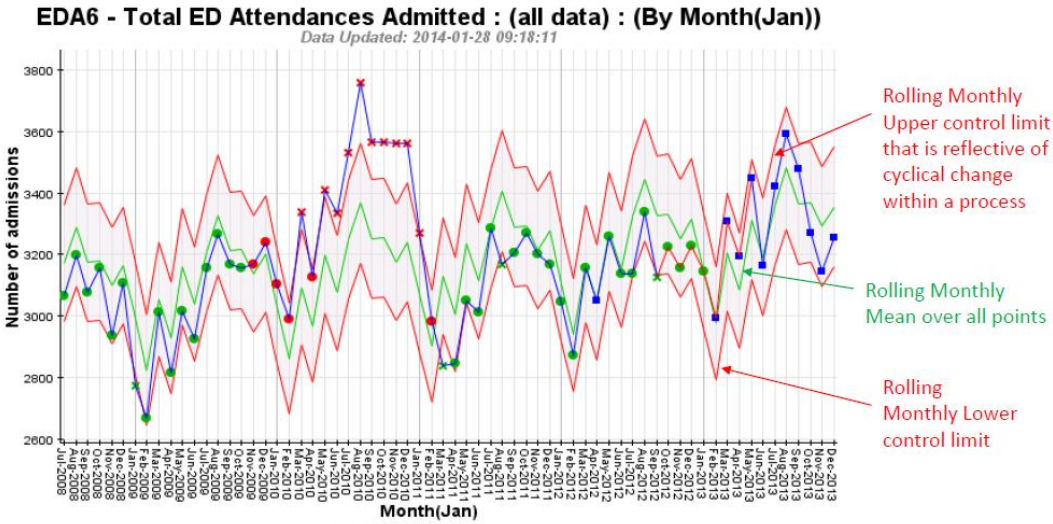
SPC: How to Interpret a Control Chart



sfn signals from noise

make it better

SPC: How to Interpret Cyclical and Trended Data



Criteria for a Cyclical Process:

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

sfn signals from noise

make it better

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

SOURCE: **Corporate Services**

DATE: **3 October 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 1 August 2019	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(if required)*	Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)

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

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

CANTERBURY DISTRICT HEALTH BOARD

Canterbury District Health Board
Te Poari Hauora ō Waitaha

EXCERPT FROM PUBLIC BOARD MEETING MINUTES
15 August 2019

Item 9
2020 Meeting Schedule

Resolution (XX/19)
(Moved: Dr Anna Crighton/seconded: Tracey Chambers – carried)

"That the Board:

i. confirms support for the proposed schedule of meetings for 2020 (Appendix 1);
ii. notes that in terms of the Canterbury DHB Standing Orders (Clause 1.6.1) a formal resolution will be required from the incoming Board in December 2020 to adopt a meeting schedule for 2020;
iii. notes that for planning purposes, the assumption has been made that the Community and Public Health Advisory Committee (*CPHAC*) and Disability Support Advisory Committee (*DSAC*) will continue as one committee (the Community & Public Health and Disability Support Advisory Committee (*CPH&DSAC*)) through 2020, however, should they revert back to two separate committees following review by the incoming Board, CPHAC and DSAC meetings will take place on the scheduled CPH&DSAC dates, with CPHAC meetings starting at 9:00am and DSAC meetings starting at 1.00pm; and
iv. reconfirms the delegation of authority to the Chief Executive, in consultation with the Chair of the Board and/or relevant Committee Chairperson, to alter the date, time or venue of a meeting, or cancel a meeting, should circumstances require this."

	S/S	Mon	Tues	Wed	Thu	Fri	S/S	Mon	Tues	Wed	Thu	Fri	S/S	Mon
January 2020				NEW YEARS DAY 1	PUBLIC HOLIDAY 2	3	4/5	6	7	8	9	10	11/12	13
February	1/2	3	4	5	WAITANGI DAY 6	7	8/9	10	11	12	13	14	15/16	17
March	1	2	QFARC 9AM 3	4	CPH&DSAC 9AM 5	6	7/8	9	10	11	12	13	14/15	16
April				1	HAC 9AM 2	3	4/5	6	7	8	9	GOOD FRIDAY 10	11/12	EASTER MONDAY 13
May						1	2/3	4	QFARC 9AM 5	6	CPH&DSAC 9AM 7	8	9/10	11
June		QUEEN'S BIRTHDAY 1	QFARC 9AM 2	3	HAC 9AM 4	5	6/7	8	9	10	11	12	13/14	15
July				1	CPH&DSAC 9AM 2	3	4/5	6	7	8	9	10	11/12	13
August	1/2	3	QFARC 9AM 4	5	HAC 9AM 6	7	8/9	10	11	12	13	14	15/16	17
September			QFARC 9AM 1	2	CPH&DSAC 9AM 3	4	5/6	7	8	9	10	11	12/13	14
October					HAC 9AM 1	2	3/4	5	6	7	8	9	10/11	12
November	1	2	QFARC 9AM 3	4	CPHAC/DSAC 9AM 5	6	7/8	9	10	11	12	CANTERBURY ANNIVERSARY DAY 13	14/15	16
December			QFARC 9AM 1	2	HAC 9AM 3	4	5/6	7	8	9	10	11	12/13	14

Tues	Wed
14	15
18	19
17	18
14	15
12	13
16	17
14	15
18	19
15	16
13	14
17	18
15	16

Thu	Fri	S/S	Mon	Tues	Wed	Thu	Fri	S/S	Mon	Tues	Wed	Thu	Fri	S/S
16	17	18/19	20	21	22	23	24	25/26	27	QFARC 9AM 28	29	HAC 9AM 30	31	
CDHB BOARD 9AM 20	21	22/23	24	25	26	27	28	29						
CDHB BOARD 9AM 19	20	21/22	23	24	25	26	27	28/29	30	QFARC 9AM 31				
CDHB BOARD 9AM 16	17	18/19	20	21	22	23	24	25/26	ANZAC DAY OBSERVED 27	28	29	30		
14	15	16/17	18	19	20	CDHB BOARD 9AM 21	22	23/24	25	26	27	28	29	30/31
CDHB BOARD 9AM 18	19	20/21	22	23	24	25	26	27/28	29	QFARC 9AM 30				
CDHB BOARD 9AM 16	17	18/19	20	21	22	23	24	25/26	27	28	29	30	31	
CDHB BOARD 9AM 20	21	22/23	24	25	26	27	28	29/30	31					
CDHB BOARD 9AM 17	18	19/20	21	22	23	24	25	26/27	28	QFARC 9AM 29	30			
CDHB BOARD 9AM 15	16	17/18	19	20	21	22	23	24/25	LABOUR DAY 26	27	28	29	30	31
CDHB BOARD 9AM 19	20	21/22	23	24	25	26	27	28/29	30					
CDHB BOARD 9AM 17	18	19/20	21	22	23	24	CHRISTMAS DAY 25	26/27	BOXING DAY OBSERVED 28	29	30	31		

January 2020
February
March
April
May
June
July
August
September
October
November
December

WORKPLAN FOR HAC 2019 *(WORKING DOCUMENT)*

9am start	31 Jan 19	04 Apr 19	30 May 19	1 Aug 19	3 Oct 19	5 Dec 19
Standing Items	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes
Standing Monitoring Reports	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report
Planned Items	Clinical Advisor Update – Nursing & Allied Health	Clinical Advisor Update - Nursing	Clinical Advisor Update – Medical 2019 Winter Planning Update	Clinical Advisor Update - Allied Health (deferred) H&SS 18/19 Year Results	Clinical Advisor Update – Nursing	Clinical Advisor Update – Medical 2019 Winter Planning Review
Presentations	Sleep Health Services in Canterbury	Burwood Campus Avoidable Admissions in General Surgery	Christchurch Campus – Children's Haematology & Oncology Centre (*CHOC*)	SMHS	Perioperative Nursing Ashburton Rural Health Services	New Treatments & Technologies Programme (NT&T) Christchurch Campus – Clinical Team Coordinators
Governance and Secretariat Issues						
Information Items	2019 Workplan	2019 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 2019 Workplan	2019 Workplan	2020 Tentative Meeting Schedule 2019 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 2019 Workplan
Public Excluded Items	CEO Update (as required)	CEO Update (as required)	CEO Update(as required)	CEO Update (as required)	CEO Update (as required)	CEO Update (as required)