HOSPITAL ADVISORY COMMITTEE MEETING

Thursday, 2 August 2018
9.00am

Board Room
Level 1
32 Oxford Terrace
Christchurch

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

AGENDA - PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE MEETING
To be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
32 Oxford Terrace, Christchurch
Thursday, 2 August 2018 commencing at 9.00am

ADMINISTRATION			**9.00am**
	Apologies		
1.	**Interest Register** *Update Committee Interest Register and Declaration of Interest on items to be covered during the meeting.*		
2.	**Confirmation of the Minutes of the Previous Committee Meeting** ▪ *31 May 2018*		
3.	**Carried Forward/Action List Items**		
MONITORING			**9.05am**
4.	**Update on Development of Maternity Strategy - Presentation**	Wayne Turp *Project Specialist, Planning & Funding* Norma Campbell *Director of Midwifery*	9.05-9.25am
5.	**H&SS 2017/18 Year Results – Presentation**	Justine White *Executive Director, Finance & Corporate Services*	9.25-9.40am
6.	**Hospital Service Monitoring Report** • *Hospital Laboratories* – Kirsten Beynon • *Older Persons, Orthopaedics & Rehabilitation* – Dan Coward • *Mental Health* – Toni Gutschlag • *Rural Health Services* – Berni Marra & Win McDonald • *Medical/Surgical* & *Women's & Children's Health* – Pauline Clark • *ESPIs* – Pauline Clark		9.40-10.30am
MORNING TEA			**10.30-10.45am**
7.	**System Level Measures Framework**	Linda Wensley *CCN Programme Manager*	10.45-11.05am
8.	**Rural Hospitals – Presentation**	Win McDonald *Transition Programme Manager*	11.05-11.30am
9.	**Clinical Advisor Update (Oral)** • Medical	Dr Sue Nightingale *Chief Medical Officer*	11.30-11.45am
10.	**Resolution to Exclude the Public**		11.45am
ESTIMATED FINISH TIME			**11.45am**

AGENDA - PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

INFORMATION ITEMS

- 2019 Meeting Schedule
- 2018 Workplan

NEXT MEETING: Thursday, 4 October 2018

ATTENDANCE LIST - PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE MEMBERS

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

Executive Support

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

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

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

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

	CRL Energy Limited provides air quality testing and asbestos sampling and analysis services; methamphetamine contamination testing; dust; gas and noise workplace monitoring services in New Zealand. There is the potential for future work with the CDHB. **Farrell Construction Limited** - Chairman Farrell's Construction Limited is a commercial and light commercial construction company based in Christchurch. **New Zealand Flying Doctor Service Trust** – Chairman The Trust has a services agreement with Garden City Helicopters for the provision of air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB. **Ngai Tahu Property Limited** – Chairman Potential for future property development work with the CDHB. Also, Ngai Tahu Property Limited manage first right of refusal applications from the CDHB on behalf of Te Runanga o Ngai Tahu.
Sally Buck Board Member	**Christchurch City Council (*CCC*)** – Community Board Member Chair of the Central/Linwood/Heathcote Community Board which has delegated responsibilities from the CCC. **Registered Resource Management Act Commissioner** From time to time, sit on Resource Management Act panels for the CCC. Specific interests will be declared at the time.
Dr Anna Crighton Board Member	**Christchurch Heritage Limited** - Chair - Governance of Christchurch Heritage **Christchurch Heritage Trust** – Chair - Governance of Christchurch Heritage **Heritage New Zealand –** Honorary Life Member CDHB owns buildings that may be considered to have historical significance.
Jan Edwards	**Integrated Family Health Service Programme, Canterbury Clinical Network** – Project Manager The programme supports primary care teams to develop integrated models of care that better support at risk individuals in their own communities. The programme is hosted by Pegasus Health (Charitable) Ltd and funded by CDHB. Should a conflict arise, this will be discussed at the time.
David Morrell Board Member	**British Honorary Consul** Interest relates to supporting British nationals and relatives who may be hospitalised arising from injury related accidents, or use other services of CDHB, including Mental Health Services. A conflict of interest may also arise from time to time in respect to Coroners' inquest hearings involving British nationals. In addition, the British Foreign and Commonwealth Office (*FCO*) may expect Honorary Consuls to become involved in trade initiatives from time to time. **Canon Emeritus - Christchurch Cathedral** The Cathedral congregation runs a food programme in association with CDHB staff. **Friends of the Chapel** - Member **Great Christchurch Buildings Trust** – Trustee The Trust seeks the restoration of key Christchurch heritage buildings, particularly

	Christchurch Cathedral, and is also involved in facilitating the building of social housing. **Heritage NZ –** Subscribing Member Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance. **Hospital Lady Visitors Association** - Wife is a member of this, but no potential conflict of interest is expected. Should one arise it will be declared at the time. **Nurses Memorial Chapel Trust** –Chair (CDHB Appointee) Trust responsible for Memorial Chapel on the Christchurch Hospital site. Note the chapel is now owned by the Christchurch City Council.
Dr Rochelle Phipps	**Accident Compensation Corporation** – Medical Advisor ACC is a Crown entity responsible for administering NZ's universal no-fault accidental injury scheme. As a Medical Advisor, I analyse and interpret medical information and make recommendations to improve rehabilitation outcomes for ACC customers. **OraTaiao: New Zealand Climate & Health Council** – Founding Executive Board Member (no longer on executive) The Council is a not-for-profit, politically non-partisan incorporated society and comprises health professionals in Aotearoa/New Zealand concerned with: • the negative impacts of climate change on health; • the health gains possible through strong, health-centred climate action; • highlighting the impacts of climate change on those who already experience disadvantage or ill health (equity impacts); and • reducing the health sector's contribution to climate change. **Royal New Zealand College of General Practitioners** – Christchurch Fellow and Former Board Member The RNZCGP is the professional body and postgraduate educational institute for general practitioners.
Trevor Read	**Lightfoot Solutions Ltd** – Global Director of Clinical Services Lightfoot Solutions has contracts with CDHB, and other health providers who have contracts with CDHB, to provide business intelligence tools and related consulting services. Should a conflict arise, this will be discussed at the time.
Ana Rolleston	**Christchurch PHO** – Board Member The Christchurch PHO is mostly funded by either the Ministry of Health and/or the CDHB. The Christchurch PHO supports General Practitioners delivering primary health care in Christchurch. **Manawhenua ki Waitaha** – Trustee Representative of Wairewa Rūnanga. Manawhenua ki Waitaha is a collective of health representatives of the seven Ngāi Tahu Papatipu Rūnanga that are in the CDHB area. There is a Memorandum of Understanding between Manawhenua ki Waitaha and CDHB. **Māori Women's Welfare League** – Member The Māori Women's Welfare League has contracts through the Ministry of Health for the delivery of health services for Māori.

	Te Kàhui o Papaki Kà Tai – Member A Canterbury-wide combined group of primary care organisations, clinicians, community organisations, Manawhenua, Maori community provider and District Health Board. The group is supported by Pegasus Health.
Ta Mark Solomon **Ex Officio – HAC** Deputy Chair CDHB	**Claims Resolution Consultation – Senior Maori Leaders Group** – Member This is an Advisory Board to MSD looking at the claims process of those held under State care. **Deep South NSC (National Science Challenge) Governance Board** – Member The objective of Deep South NSC is set by Cabinet, and is to understand the role of the Antarctic and Southern Ocean in determining our climate and our future environment. Building on this objective, the mission was developed to guide our vision, research priorities and activities. **Greater Christchurch Partnership Group** – Member This is a central partnership set up to coordinate our city's approach to key issues. It provides a strong, joined up way of working and ensures agencies are travelling in the same direction (so they do not duplicate or negate each other's work). **He Toki ki te Rika / ki te Mahi** – Patron He Toki ki te Rika is the next evolution of Māori Trade Training re-established after the earthquakes to ensure Maori people can play a distinguished role in the Canterbury rebuild. The scheme aims to grow the next generation of Māori leadership in trades by building Māori capability in the building and infrastructure industries in Canterbury. **Liquid Media Operations Limited** – Shareholder Liquid Media is a start-up company which has a water/sewage treatment technology. **Ngāti Ruanui Holdings** – Director Ngati Ruanui Holdings is the Investment and Economic Development Arm of Ngati Ruanui established to maximise profits in accordance with Te Runanga directions in Taranaki. **Oaro M Incorporation** – Member 'Oaro M' Incorporation was established in 1968. Over the past 46 years successive Boards have managed and maintained the whenua, located at 'Oaro M', Kaikōura, on behalf of its shareholders. Over time shareholders have requested the Board consider establishing an education grant in order to assist whānau with their educational aspirations. **Police Commissioners Māori Focus Forum** – Member The Commissioner of Police has a group of senior kaumatua and kuia who meet with him regularly to discuss issues of mutual interest and concern. Known as the Commissioner's Māori Focus Forum, the group helps guide policing strategy in regard to Māori and provides advice on issues of the moment. The Māori Focus Forum developed The Turning of the Tide with help from Police. The forum plays a governance role and helps oversee the strategy's implementation. **Pure Advantage** – Trustee Pure Advantage is comprised of business leaders who believe the private sector has an important role to play in creating a greener, wealthier New Zealand. It is a not-for-profit organisation that investigates and promotes opportunities for green

	growth. **QuakeCoRE** – Board Member QuakeCoRE is transforming the earthquake resilience of communities and societies through innovative world-class research, human capability development, and deep national and international collaborations. They are a Centre of Research Excellence (CoRE) funded by the New Zealand Tertiary Education Commission. **Rangitane Holdings Limited & Rangitane Investments Limited** - Chair/Director The Rangitāne Group has these two commercial entities which serve to develop the commercial potential of Rangitāne's settlement assets. A Board of Directors oversee the governance of the commercial entities, and are responsible for managing Crown lease properties and exploring commercial development opportunities to support the delivery of benefits to Rangitāne members. **SEED NZ Charitable Trust** – Chair and Trustee SEED is a company that works with community groups developing strategic plans. **Sustainable Seas NSC (National Science Challenge) Governance Board** – Member This is an independent Board that reports to the NIWA Board and operates under the Terms and Conditions specified in the Challenge Collaborative Agreement. The Board is responsible for appointing the Director, Science Leadership Team, Kāhui Māori, and Stakeholder Panel for projects within the Sustainable Seas NSC. The Board is also responsible for approving projects within the Research and Business Plan and for allocating funding. **Te Ohu Kai Moana** – Director Te Ohu Kai Moana is an organisation that works to advance Maori interests in the marine environment, including customary commercial fisheries, aquaculture and providing policy and fisheries management advice and recommendations to iwi and the wider Maori community. **Te Waka o Maui** – Independent Representative Te Waka o Maui is a Post Settlement Governance Entity.
Dr John Wood **Ex Officio – HAC** Chair CDHB	**Advisory Board NZ/US Council** – Member The New Zealand United States Council was established in 2001. It is a non-partisan organisation, funded by business and the Government, and committed to fostering and developing a strong and mutually beneficial relationship between New Zealand and the United States. The Advisory Board supports the day to day work of the Council by providing strategic and operational advice to both the Executive Board and the Executive Director. **Member of the Governing Board of the Office of Treaty Settlements, Ministry of Justice (as Chief Crown Treaty of Waitangi Negotiator)** – Ex-Officio Member The Office of Treaty Settlements, Ministry of Justice, are responsible for negotiating the settlement of historical Treaty of Waitangi claims, and the administration of the Marine and Coastal Area (Takutai Moana) Act 2011. They also advise and help claimant groups so they are ready to enter negotiations. **Chief Crown Treaty Negotiator for Ngai Tuhoe** Settlement negotiated. Deed signed and ratified. Legislation enacted.

Chief Crown Treaty Negotiator for Ngati Rangi
Settlement negotiated. Deed signed and ratified. Legislation awaiting enactment.

Chief Crown Treaty Negotiator, Tongariro National Park
Engagement with Iwi collective begins July 2018.

Chief Crown Treaty Negotiator for the Whanganui River
Settlement negotiated. Deed signed and ratified. Legislation enacted.

Chief Crown Negotiator & Advisor, Mt Egmont National Park Negotiations
High level agreement in principle reached. Aiming for deed of settlement end of 2018.

Governing Board, Economic Research Institute for ASEAN and East Asia (ERIA) – Member
ERIA is an international organisation that was established by an agreement of the leaders of 16 East Asia Summit member countries. Its main role is to conduct research and policy analysis to facilitate the ASEAN Economic Community building and to support wider regional community building. The governing board is the decision-making body of ERIA and consists of the Secretary General of ASEAN and representatives from each of the 16 member countries, all of whom have backgrounds in academia, business, and policymaking.

Kaikoura Business Recovery Grants Programme Independent Panel – Member
The Kaikoura Business Recovery Grants Programme was launched in May 2017 and is intended to support local businesses until State Highway One reopens by way of grants which can be applied for by eligible businesses. This programme is now closed.

School of Social and Political Sciences, University of Canterbury – Adjunct Professor
Teach into graduate and post graduate programmes in political science, trade policy and diplomacy – pro bono appointment.

Te Urewera Governance Board –Member
The Te Urewera Act replaces the Te Urewera National Parks Act for the governance and management of Te Urewera. The purpose of the Act is to establish and preserve in perpetuity a legal identity and protected status for Te Urewera for its intrinsic worth, its distinctive natural and cultural values, the integrity of those values, and for its national importance. Inaugural term as a Crown appointment, re-appointed as a Ngai Tuhoe nominee.

University of Canterbury (*UC*) – Chancellor
The University Council is responsible for the governance of UC and the appointment of the Vice-Chancellor. It sets UC's policies and approves degree, financial and capital matters, and monitors their implementation.

University of Canterbury Foundation – Ex-officio Trustee
The University of Canterbury Foundation, Te Tūāpapa Hononga o Te Whare Wānanga o Waitaha, is dedicated to ensuring that UC's tradition of excellence in higher education continues. From its earliest beginnings in 1873, philanthropic support and the generosity of donors and supporters has played a major part in making the university the respected institution it is today. The UC Foundation is

	dedicated to continuing that tradition. **Universities New Zealand** – Elected Chair, Chancellors' Group Universities New Zealand is the sector voice for all eight universities, representing their views nationally and internationally, championing the quality education they deliver, and the important contribution they make to New Zealand and New Zealanders.

MINUTES – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE HOSPITAL ADVISORY COMMITTEE MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch,
on Thursday, 31 May 2018, commencing at 9.00am

PRESENT
Andrew Dickerson (Chair); Jo Kane (Deputy Chair); Sally Buck; Dr Anna Crighton; Jan Edwards; Dr Rochelle Phipps; Trevor Read; and Ana Rolleston.

APOLOGIES
Apologies for absence were received and accepted from Barry Bragg; David Morrell; Ta Mark Solomon; and Dr John Wood.
Apologies for lateness were received and accepted from Ana Rolleston (9.45am).
An apology for early departure was received and accepted from Dr Anna Crighton (11.10am).

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

IN ATTENDANCE

Item 4
Dan Coward – General Manager, Older Persons, Orthopaedics & Rehabilitation
Linda Wood – Service Manager, Older Persons Health
Jane Clarke – Nursing Director, Older Persons Health
Helen Skinner – Chief of Service
Martin Lee – Clinical Director, Community Dental Service
Colin Pebbles – Clinical Director, Older Persons Mental Health
Janice Lavelle – Service Manager, Older Persons Mental Health and Community Teams

Item 5
Dan Coward
Toni Gutschlag – General Manager, Specialist Mental Health Services
Berni Marra – Manager, Ashburton Health Services
Win McDonald – Transition Programme Manager, Rural Health Services
Pauline Clark – General Manager, Christchurch Hospital

1. INTEREST REGISTER

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

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

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

There was a request that Committee members provide a brief description of the organisations listed on the Interest Register, in order to make it consistent with other Committees and the CDHB Board Interest Registers.

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (08/18)
(Moved: Trevor Read/Seconded: Sally Buck – carried)

"That the minutes of the meeting of the Hospital Advisory Committee held on 29 March 2018 be confirmed as a true and correct record."

3. CARRIED FORWARD/ACTION ITEMS

Item 2 Maternal Health Strategic Direction – there was discussion around why this has been pushed out for a further two months and whether this presents the organisation with any risks or problem areas. It was noted that co-design workshops are being held in early June and delivery of the strategy has been delayed until after that. The risks detailed at the time remain the same.

The Committee noted the carried forward items.

4. OLDER PERSONS HEALTH AND REHABILITATION SERVICES – PRESENTATION

Dan Coward, General Manager, Older Persons, Orthopaedics & Rehabilitation introduced Linda Wood, Service Manager, Older Persons Health; Jane Clarke, Nursing Director, Older Persons Health; Helen Skinner, Chief of Service; Martin Lee, Clinical Director, Community Dental Service; Colin Pebbles, Clinical Director, Older Persons Mental Health; and Janice Lavelle, Service Manager, Older Persons Mental Health and Community Teams, who presented to the Committee on Older Persons Health and Rehabilitation Services at Burwood Hospital.

The presentation provided an overview of the services, including:

- The range of specialities – Older Persons Health (*OPH*), Older Persons Mental Health (*OPMH*), Brain Injury Services (*BSU*), outpatients for many services including Christchurch Hospital; as well as community services covering dental, CREST and Stroke Rehabilitation Service.
- There are a number of stakeholders including the New Zealand Spinal Trust, The Champion Centre and Canterbury Orthopaedic Services.

<u>Spinal Unit – Dan Coward</u>

- The move into the new Spinal Unit at Burwood is underway, with spinal facilities decanting to the ward in June.
- There has been a reduction in traditional sports injuries presenting at the Spinal Unit.

<u>OPH – Linda Wood and Jane Clarke</u>

- OPH is over 65 years of age and over 50 years of age for Maori and Pacific Islanders.
- Smaller towns are becoming more sustainable, which means patients are able to return to their communities faster.
- 75% of patients in the service are from Christchurch Hospital, the remainder are from the wider community, including primary care.
- The service undertakes 2,000 admissions a year.
- 70% of patients return to where they came from on discharge; the remainder go to long-term hospital or rest home care.

- The mortality rate is 1.4% (200 deaths per year).
- The average age of patients is 83.
- Patients on the wards are encouraged to be self-managing (getting dressed in the morning, making their own breakfast etc).

There was a query around whether there is any correlation in advertising campaigns, such as stroke awareness, and functional improvement data. It was noted that Ms Clarke was not aware of any work being done to collect such data.

A query was raised whether Advance Care Planning has been introduced within the service. It was confirmed that it has.

There was discussion around the provision of seven day versus five day rehabilitation services. It was noted that rehabilitation continues through weekends, although not to the full extent as during the week. Mr Coward advised a range of initiatives are in place.

In response to a query from a member, Jane Clarke acknowledged that more work is required around falls prevention and that this remains a priority.

OPMH – Colin Pebbles and Janice Lavelle

- The service covers the area from Kaikoura to Arthurs Pass, Banks Peninsula and down to Rakaia.
- There are two Inpatient wards, an Outpatient Clinic, a Memory Assessment Clinic and a Day Clinic at Burwood Hospital, as well as consult/liaison services at Christchurch and Burwood Hospitals.
- The Interdisciplinary Community Team based at The Princess Margaret Hospital (*TPMH*) provides assessment, treatment and rehabilitation in the community and inpatient setting; is the acute emergency response service for over 65 year olds with mental health issues; and provides InterRAI assessments for the elderly.
- A highlight of the team's work has been the Walking in Others Shoes programme, which has recently been working with older people with Downs Syndrome, in conjunction with Hohepa Canterbury.
- There have been positive moves in dementia mapping.
- Repetitive Transcranial Magnetic Stimulation (*rTMS*) is an established new treatment for medication resistant depression, with other positive roles in aiding stroke rehabilitation/ predicting recovery. It is aimed to introduce this service at Burwood Hospital within the next 12 months, with involvement from the academic unit to evaluate local outcomes.

There was a query around what international data is available about rTMS and whether other DHBs are using it. It was noted that the treatment is FDA approved and can be effective when medication and ECT no longer work. At this time, no other DHB is using this treatment, however, other DHBs are looking at it.

In response to a question from a member, Ms Lavelle advised that a team is based in Rangiora, with 15/16 staff working from Rangiora at any one time.

Community Dental Service – Martin Lee

- Provide oral health services for children in Canterbury, South Canterbury and support the West Coast service.
- 89,000 children enrolled across 28 fixed and mobile clinics and 18 mobile clinics in schools.
- Improving access and availability of services through opening clinics in school holidays with volunteer staff, trialling call centre outbound calls in evenings, along with work underway with Unions to re-define hours of work in the MECA.

- A new clinical leadership structure has been established.
- The service is currently managing the effects of staffing shortages, early childhood caries and waiting times.

Ana Rolleston arrived at 9.45am.

Discussion took place on fluoridation of water, as well as the taxing of sugary drinks.

Mr Coward closed the presentation by acknowledging the team and their ability to work closely together. The Chair thanked Mr Coward and those in attendance for their presentation. It was noted that it is valuable to get feedback regarding facility improvements and how this can improve results for patients.

5. HOSPITAL AND SPECIALIST SERVICES (*H&SS*) MONITORING REPORT

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

General Managers spoke to their areas as follows:

Hospital Laboratories – Dan Coward (for Kirsten Beynon, General Manager)

- Facilities: Awaiting feedback from Capital Investment Committee, which met 17 May 2018.
- Facilities Short-Term: Working on plan for short-term fixes to show continued commitment to IANZ, dependant on outpatients move to new facilities.
- Winter Planning: Staffing plans in place ready to meet workload demands.
- SMO Workforce: Working on a range of contingencies for Anatomical Pathologist shortages to maintain service delivery for cancer reporting. Workload and demand still high, with pathologists working hard to keep up both the scientific and technical histology staff managing the same demands.

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

- There is work being done around falls prevention, with a change in language in terms of recovery programmes to motivate and mitigate risk from a personal perspective.
- Restraint Events in OPMH: OPMH has experienced a significant and ongoing trend in reduction of restraint events. This is an excellent outcome and reflects changes in model of care, environment and staff practice. The team is very proud of its achievements in this area.
- Winter planning is well underway, with a focus on coordinating and connecting services as well as providing strong leadership, working closely with acute demand, CCN and primary care.

There was a query around data on falls that lead to morbidity. It was noted that this can be provided to the Committee.

There was discussion around the ability of GPs to pick up non-acute patients if there is demand on the system in winter. It was noted that currently there is not much flexibility in the system but there is the ability to divert some cases that would normally present in the Emergency Department (*ED*) to extended hours clinics such as the 24 Hour Surgery, Moorhouse Avenue and the Riccarton Clinic. Planning and Funding are also working with pharmacies to come up with strategies to manage some cases.

It was queried whether the elective orthopaedic ward will stay at Burwood once spinal facilities move out. They will stay where they currently are, but there are repairs to be done in the unit.

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

- Te Awakura remains under pressure, but SMHS is committed to a programme of works agreed between NZNO, staff and managers. The environment itself is seen as the greatest challenge.
- There has been an increase in wait time to the Child and Family Service.
- Positive results are being seen through the ADHD pathway.
- Concerning trend of increased assaults in AT&R Unit. Work continues to support the team, including not accepting consumers from outside of Canterbury.
- Stu Bigwood has been seconded as a clinical member of the Facilities Leadership Team.
- Joan Taylor has been appointed as the Acting Director of Nursing.
- Sandy Clemett has been appointed as the Director of Allied Health.

There was a query around the KPI 18 data and whether a lack of follow-up in the community causes pressure in Te Awakura. It was noted while consumers have often been seen in the community, it can create pressure. The team is working to make improvements.

There was discussion around mental health in rural communities, particularly in areas affected by earthquakes and issues that may arise due to the Mycoplasma Bovis (*M. Bovis*) outbreak. It was noted that support is in place for rural communities, and preparations are underway for supporting people affected by M. Bovis. There was a request that David Meates contact the Mayors of Ashburton and Hurunui districts to discuss support being provided to rural communities.

There was discussion around the ongoing health and wellbeing of staff, and the importance of maintaining staff engagement over the coming years. It was noted that the impact on staff of working in poor facilities was becoming increasingly apparent, with it being equally apparent the resounding positive impact on staff at new facilities (eg, Ashburton, Burwood and Rangiora). It was noted that SMHS continues to take steps to ease pressures and is fortunate to have an exemplary team of staff, however, the toll on people has been and continues to be high.

The meeting adjourned for morning tea at 10.37am, reconvening at 10.54am.

Ashburton Health Services – Berni Marra, Manager Ashburton Health Services

- A frail elderly pathway workshop will be held in late June, with a good number of people indicating their attendance.
- There have been changes in staffing, which has provided a good opportunity to look at how the service operates.
- There is a positive operational group in the area, with many younger engaged GPs.
- Work is being done to ensure district nursing and primary care work together to tackle mental health issues and respond when required. This avoids patients going through the Acute Assessment Unit (*AAU*) or ED.

Rural Health Services - Win McDonald, Transition Programme Manager

- Two senior nurse positions in Kaikoura have been filled.
- It is anticipated that there will be an increase in registered nurses retiring in the next four years.
- The draft Hurunui Model of Care is scheduled to go to CPH&DSAC in July, and then onto the Board.

- The Chatham Islands stakeholder meeting is being held today. 40 different organisations are involved.
- The Oxford Model of Care is in draft form and will go out for public and health service consultation in the near future.

There was discussion around drug and alcohol issues in the Chatham Islands and how that compares with mainland Canterbury. It was noted that the issue is not as big as on the mainland, and community health providers are working with the Police and community networks to identify suppliers, with positive results. A campaign called "Stand Up" was recently launched.

There was a query around the retirement rates of registered nurses and what impact that will have. It was confirmed that there are strong numbers of graduate nurses coming through, with many completing their final placements in rural areas. Active planning to minimise the impact is underway.

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

- Traffic in Canterbury for Queen's Birthday weekend will be heavy, with several events occurring that will effect traffic flow. CDHB has made connections with Central Transport Control to minimise the effects on staff travelling to the hospital.
- Flu vaccination uptake for staff has been good.
- The Ministry of Health (*MoH*) accreditation survey visit will commence on 18 June.
- A changeover to the new Oracle finance/procurement system will occur on 1 July.
- Christchurch Campus is currently preparing for the SI PICS changeover.
- Planning can now get underway for the move into the Outpatients building, with the opening date confirmed.
- Work is continuing around re-presentation of cardio-thoracic patients in ED, with clinical nurse specialists working with their teams to increase confidence in clinical staff and consumers.
- Acknowledgement was made of Planning and Funding in their work sourcing over 50 filtration units for dialysis machines, after chlorination of the water supply.
- An acknowledgement was made of the clinical coding team and the work they do, with Ms Clark highlighting the clot retrieval service and how crucial coding is for this service.

Dr Anna Crighton retired from the meeting at 11.10am.

Acknowledgement was made by the Committee of the stroke pathway and the results this is achieving.

There was a query around whether CDHB will be moving to Snomed. It was confirmed that it is in use in ED.

An acknowledgement was made of the clot retrieval service. It was noted that it is the only service of its type in the South Island, which makes it a limited service as it uses a lot of resources and timing is crucial. There was discussion around whether there has been any research done on the efficacy of later clot removal. It was noted there has been some research. Other factors to consider are financial implications, as well as theatre/facility constraints.

It was acknowledged that without a lot of the improvements made in clinical services, such as clot retrieval, Enhanced Recovery After Surgery (*ERAS*) and FloView, the data would be very different. Committee members indicated they would like to thank and acknowledge the teams for their efforts. The Chair undertook to contact Dr John Fink, Clinical Director, to convey the Committee's appreciation.

ESPIs

- Still red, with Ms Clark indicating it is important to note the figure must be at zero to be anything other.
- Ms Clark is confident CDHB will make improvements in these figures.
- Financial dispensation has been given, due to theatre constraints and CDHB's moves through migration to SI PICS.

There was discussion around Faster Cancer Treatment and the data showing urology cancer waiting times exceeding targets. It was noted that this relates to one specific patient. The clinical team are aware and discussions have been held.

Resolution (09/18)
(Moved: Jan Edwards/Seconded: Sally Buck – carried)

"That the Committee:

i. notes the Hospital Advisory Committee Activity Report."

6. 2018 WINTER PLANNING UPDATE

The report was taken as read. There was no discussion.

Resolution (10/18)
(Moved: Trevor Read/Seconded: Ana Rolleston – carried)

"That the Committee:

i. notes the 2018 Winter Planning Update."

7. CLINICAL ADVISOR UPDATE

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

- There is a focus on migration of staff to the new Outpatients and Acute Services Building (*Christchurch Hospital Hagley*). This is a significant piece of work as there is an extra ward component and 10 new theatres, requiring high intensity nursing. There is significant lead-in time required to train nurses in theatre environments.
- Dedicated Education Units (*DEU*) have been commissioned to begin operating theatre nurse training.
- There has been an increase in nurse graduates, with 25 in February this year, 25 earmarked in September and a further 40-45 in February 2019.
- Technical commissioning work by bio-engineers and maintenance staff is ongoing. Teams are under pressure but positive.
- Wards in Christchurch Hospital Hagley will be up to 32 beds, larger than existing wards. This will mean a new nursing structure, with a floating registered nurse on each shift. The role is in place now, with positive feedback that the role helps around peak workload times.
- The HREF building is on schedule, with first staff moving in in July. The nurse workforce team, currently located at Corporate, will be amongst those moving, and will be co-located with nursing lecturers and clinical teams from Ara and University of Canterbury.
- Nurse Manager and Nurse Specialist roles have been made permanent in Kaikoura, with Ms Gordon acknowledging the work done by interim staff.

- Ms Gordon gave the opening address at the recent 40th Annual Enrolled Nursing Workforce Conference, and noted positive reinforcement of CDHB's nursing scope from the keynote speaker.
- Certification process scheduled for June will include a team of 25 being on site for a full week. 15 patient traces will be undertaken.

In response to a question from a member, Ms Gordon confirmed that the certification process would include ambulatory care.

There was a query around whether the new theatres will be vastly different. It was confirmed that the environment will be different to current arrangements, with a centralised system for decontamination and moveable racks for equipment. Existing staff will need to be trained and there have been mock environments set up at the Design Lab for this.

There was discussion around how many Enrolled Nurses there are in Canterbury. There are approximately 700 with current practicing certificates, with many specialising in mental health, primary community care, rehabilitation and aged residential care.

8. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (11/18)
(Moved: Sally Buck/Seconded: Jan Edwards – carried)

"That the Committee:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of the minutes of the public excluded meeting of 29 March 2018.	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(If required)*	Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)

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

INFORMATION ITEMS

- Quality & Patient Safety Indicators Level of Complaints
  An update on clinical governance was requested for a future meeting.
- 2018 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 11.44am.

Confirmed as a true and correct record.

_____ _____

Andrew Dickerson Date
Chairperson

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE
CARRIED FORWARD ITEMS AS AT 2 AUGUST 2018

DATE		ISSUE / ACTION	REFERRED TO	STATUS
1.	02 Aug 2016	AT&R Unit Update	Toni Gutschlag	Verbal Update.
2.	30 Nov 17	Progression of Maternal Health Strategic Direction	Carolyn Gullery	Today's Agenda – Item 4.
3.	29 Mar 18	Rural Hospitals presentation	Win McDonald	Today's Agenda – Item 8.
4.	29 Mar 18	Ashburton Health Services presentation	Berni Marra	Scheduled for 4 October 2018 meeting.
5.	19 Apr 18 (Board)	Ophthalmology Department - follow-up for glaucoma patients	Carolyn Gullery	Scheduled for 4 October 2018 meeting.
6.	29 May 18	Clinical governance update	Sue Nightingale	Today's Agenda – Item 9.
7.	29 May 18	Data on morbidity from falls	Dan Coward / Susan Wood	Today's Agenda – Item 6.

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: **2 August 2018**

Report Status – For:	Decision	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Committee:

i. notes the Hospital Advisory Committee Activity Report.

3. APPENDICES

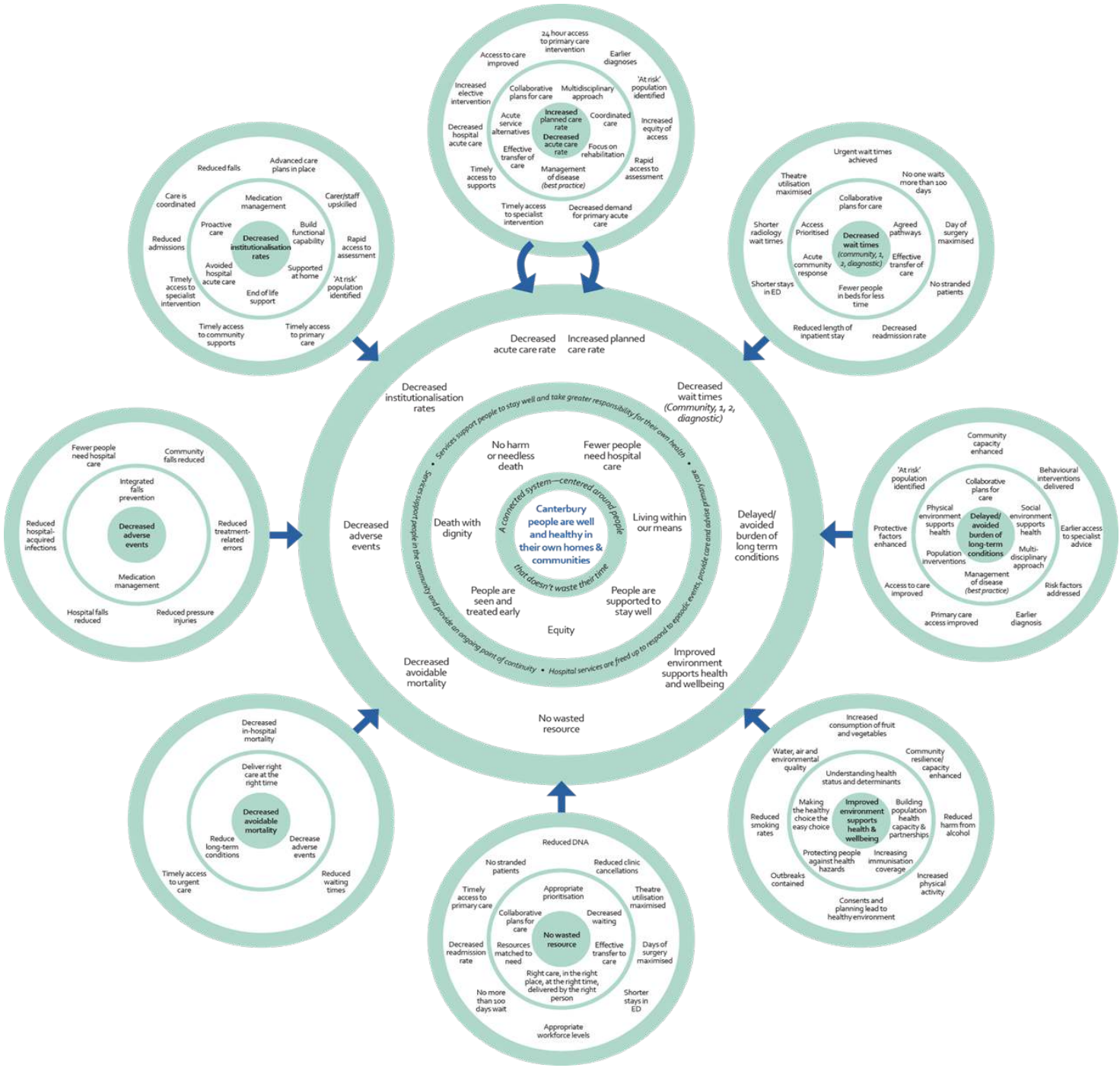
Appendix 1: Hospital Advisory Committee Activity Report – July 2018

Report prepared by: General Managers, Hospital and Specialist Services

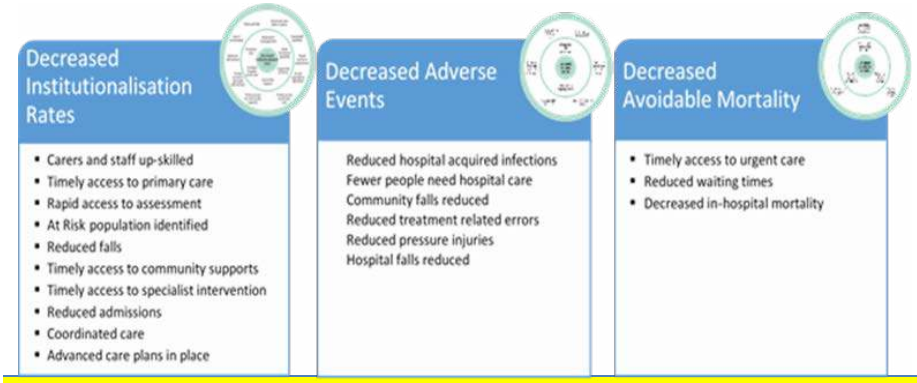
Report approved for release by: Justine White, Executive Director, Finance & Corporate Services

Hospital Advisory Committee

Activity Report



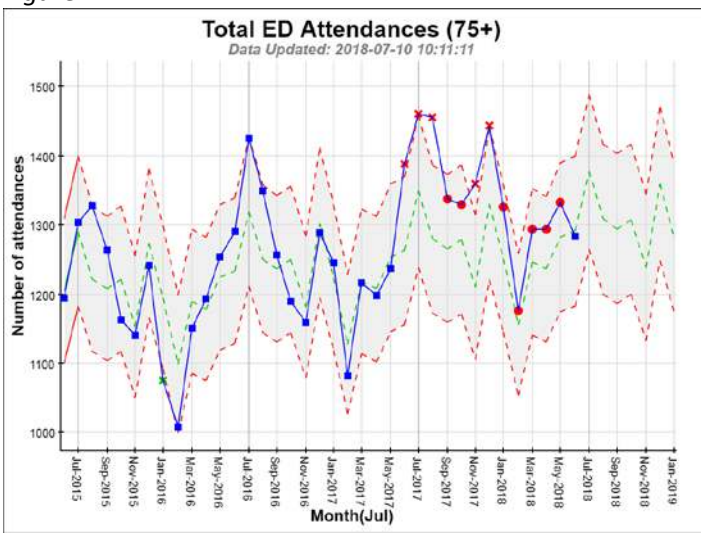
July 2018



Frail Older Persons' Pathway

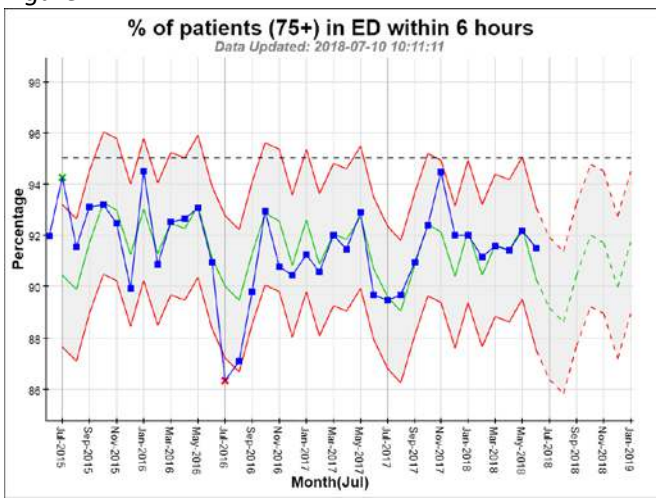
Outcome and Strategy Indicators

Figure 1.1



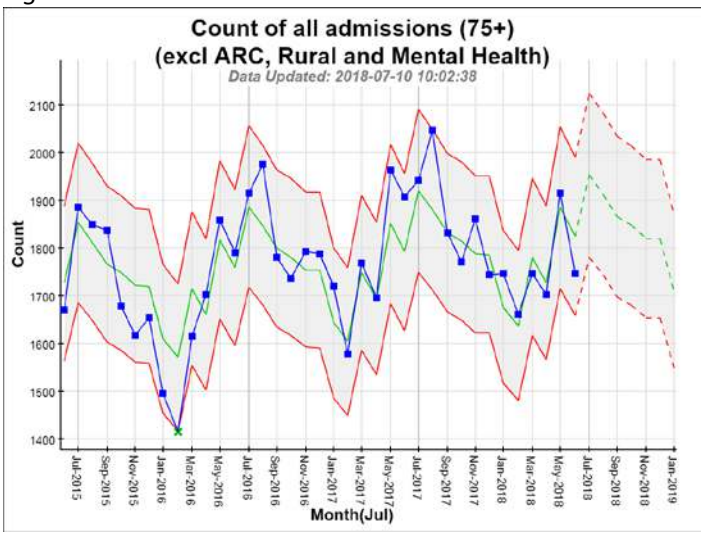
Total attendances of people over 75 has increased at a higher rate than the established trend. This increase is in line with that seen for the overall population

Figure1.2



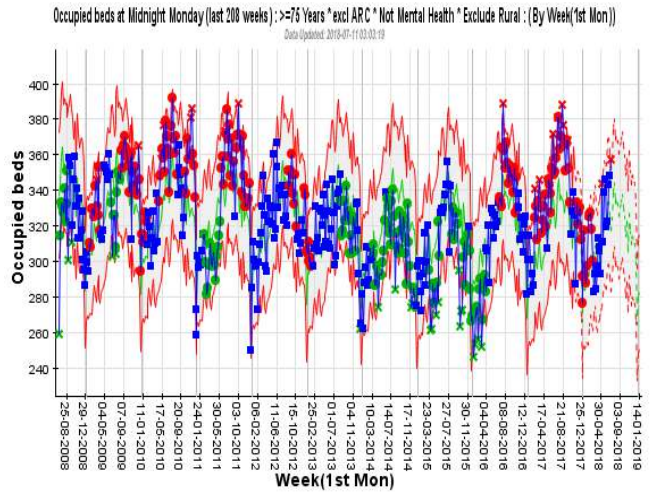
Patients 75+ leaving ED within the 6 hour target is tracking within the expected range.

Figure 1.3



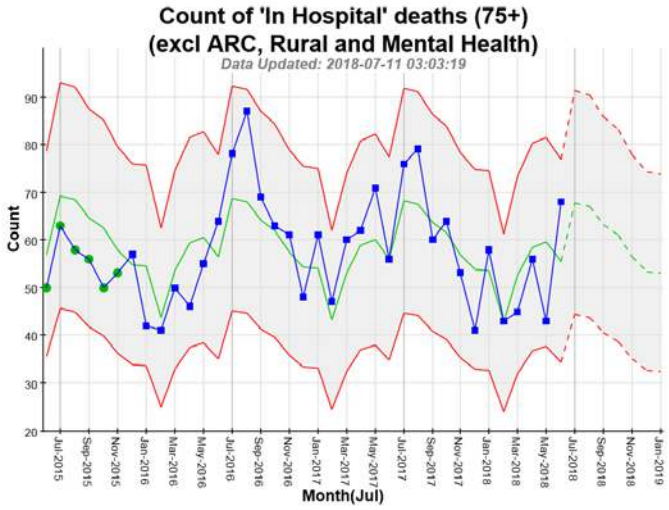
The count of all admissions for people 75 years and over continues to increase consistent with the established trend.

Figure 1.4



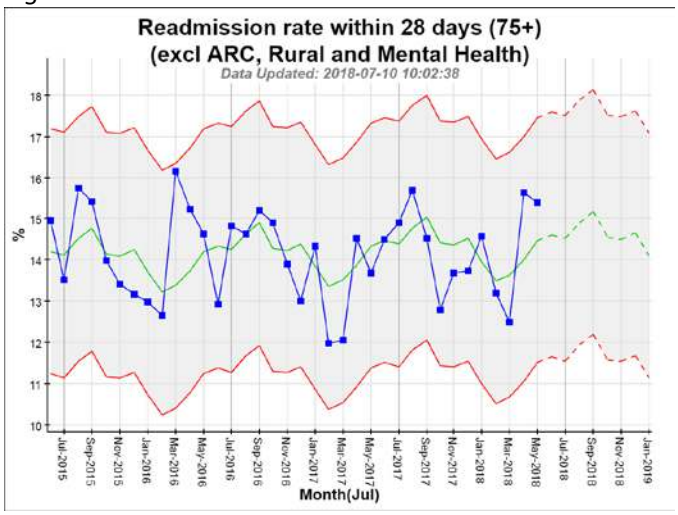
In winter 2017 Older Persons' Health increased the number of beds across the inpatient environment to support flow. Levels return to lower levels outside of this period. During winter 2018 an increase of 20 OPH beds is planned.

Figure 1.5



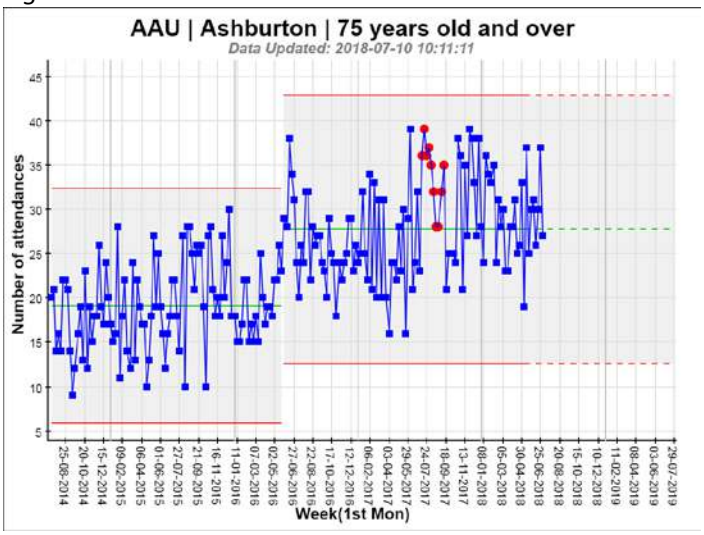
The number of in hospital deaths is within the expected range and continues the established trend of reducing rates of in hospital mortality.

Figure 1.6



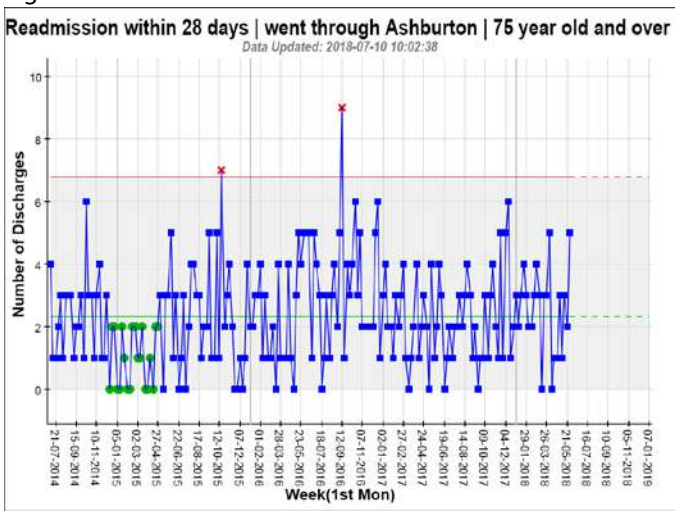
The readmission measure (balancing metric) for people aged 75 years and over continues to be within the expected range.

Figure 1.7



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

Figure 1.8



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

Achievements/Issues of Note

Winter Planning and patient flow

While ensuring appropriate patient flow is a year round focus in Canterbury's hospitals planning towards winter each year provides additional impetus in our efforts to plan our services so that all patients are provided with the support required to return to health both while in hospital and following their return home.

Earlier this year South Island DHB's, working through our South Island Alliance, agreed a series of principles that overarch our winter planning efforts. These have been detailed in this report in previous months and are not repeated in this update.

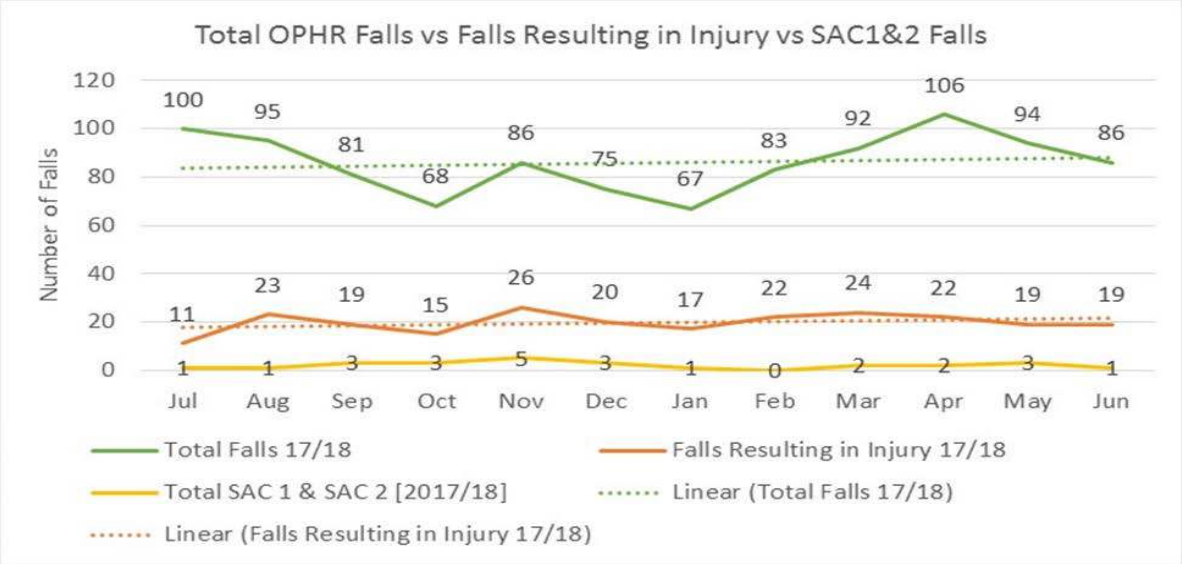
The stated focus on pandemic planning and patient flow has been recognised within Floview and the Hospital at a Glance dashboard. New icons have been generated within Floview to enable nursing teams to identify patients suffering from influenza or norovirus. This enables teams to be aware of the type of care required by these patients. As well as supporting us to provide care to the individual patients it assists us to manage patient movements at a hospital level to give us the best chance at ensuring viral diseases are not spread to patients that did not have them when they came under our care.

Older Persons Health & Rehabilitation (OPH&R) – Falls & Pressure Injuries

Overall, reporting of incidents has increased across OPH&R, as illustrated in the graphs below. Reporting limitations include: absence of bed days comparative to falls; complexity of the patient's condition/care requirements on admission; communication at handover upon transfer etc. These are also integral factors that impact upon the number of incidents pulled from Safety1st. In addition, the patient demographic within OPH&R has an increased risk of compromised skin integrity, deconditioning and mobility/balance/coordination challenges.

Year to Date (Jul-17 to June-18) comparison to same YTD period last year (Jul-16 to June-17):

- 1033 falls compared to 891 the previous year (increase of 16% (142))
- 25 SAC 1 or 2 fall events compared to 16 the previous year (increase of 56% (9))
- 10% (25/237) of falls resulting in injury were reported were SAC 2 events
- 23% (237/1033) of falls resulted in injury compared to 25% (226/891) the previous year
- 36% (373/1033) were repeat patient falls compared to 36% (321/891) the previous year
- Falls accounted for 40% (1033/2572) of total OPH&R incidents compared to 45% (891/1993) the previous year
- 59% (605) fall incidents occurred in the patient's bedroom and followed by 14% (148) in the bathroom. 5% (56) of fall locations were recorded as 'not stated'.



Falls prevention

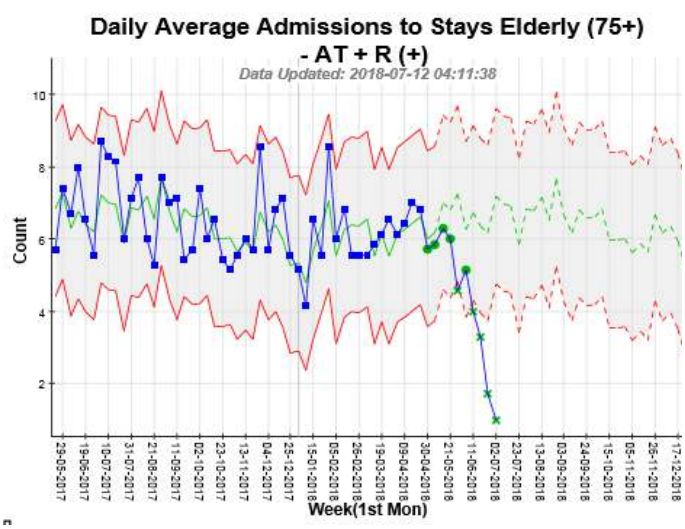
- Intentional rounding
- Falls strategy "Never Alone" looking at the first 48 hours of admission
- "Safe Recovery" programme based on recent Randomised Controlled Trial (RCT) evidence, a Safe Recovery Programme Educator position (Nursing, fixed-term position) has been advertised to resource the implementation of the programme
- A footwear policy that ensures the removal of socks as footwear on admission and includes footwear as part of the mobility assessment and how to access prescribed footwear as a falls prevention strategy

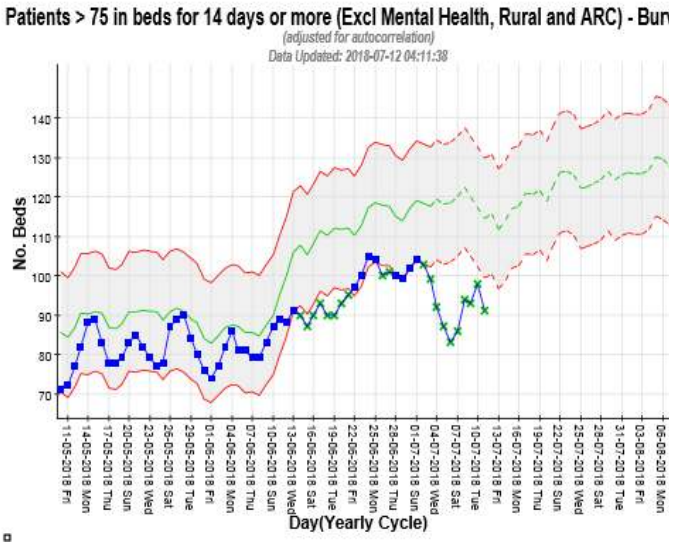
Pressure injuries

- A new system that alerts the CNS: Wound Care of all skin/tissue injuries raised in Safety1st for timely assessment and management
- Trial of the University of Leeds visual traffic light system for the assessment and management of pressure injuries with support of the CDHB Pressure Injury Group and led by OPH&R Clinical Governance: Prevention Strategies are being finalised prior to trialling in three wards.

These reports are seen and discussed by OPH&R Management and Leadership, Serious Event Review, Nursing Governance and Clinical Governance Groups. Our systems and processes are proactive with leadership and culture at the heart of achieving actions within timeframes.

Innovation and best practice is part of the OPH&R culture and is visible where the governance and leadership groups support the trialling of initiatives – actively keeping the patient's safety at the centre of all that we do.





Current trend shows over 75 population admission to stays has reduced in the last 5 months. This results in the reduced number of stays over 14 days.

Frail Older Persons Patient Journey – Ashburton.

A successful workshop was held in Ashburton on the 20th June exploring challenges and opportunities to improve the patient journey for older persons in Ashburton. Information was gathered on the current flow from presentation, admission and discharge back to the community. The participants included clinical representation from AAU, inpatient, specialist gerentology, NASC, community nursing, general practice, St John Ambulance, Aged residential care facilities and community NGOs including Presbytarian Services and Aged Concern and consumers.

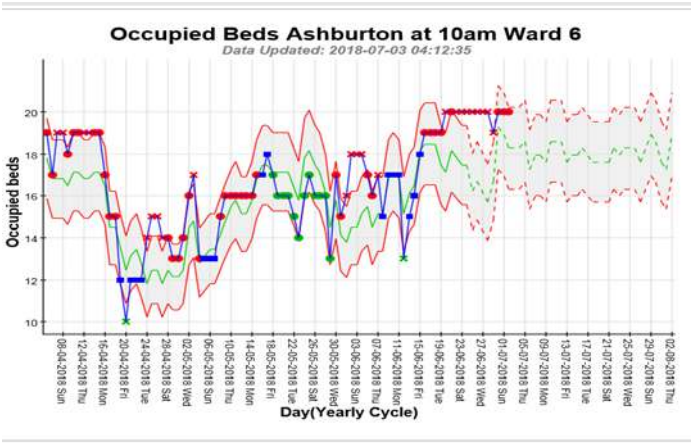
The informaton has been developed into a proposed work plan that will be presented to the Asbhurton Service Level Alliance (ASLA) on the 19th July. Work will be prioritised and actions progressed through the ASLA operations group.

The challenges highlighted were not unique to Ashburton, however it is anticipated that we will be able to bring together a mix of CDHB system wide approaches and local collaboration to effect change.

In observing the discussion it was interesting to note the variability of providers knowledge of the resources available and their potential constraints. This included mixed approaches from the general practices and their understanding of the local triage practice for older persons health referrals and balance between assessment and rehabilitation that can be progressed in the community by specialist services and that which will require a hospital admission. A distinct message was sent that general practice is seeking the ability to refer patients for full assessment, treatment and rehabilitation (AT&R) in an inpatient setting. Confusion or mixed messaging on the availability of this has in part been driven by the Ward 6 mixed occupancy of non-weight baring patients (NWB) and AT&R.

The physical occupancy of Ward 6 is identified in the graph below, what we are not able to demonstrate in this is the split between AT&R and NWB patients. A NWB patient is on average with us for six weeks, recently we have had a small number of these patients return to Ashburton for longer as their assessment at "Bone Shop" identifies they are not ready to move to full rehabilitation at Burwood. The narrative for the past quarter is our distribution of occupancy is 75% or more NWB patients and only a small number of beds available for Ashburton patients for

rehabilitation, eg in June of the 19 beds available, 15 were occupied with NWB patients and at one stage we were aware of 10 patients on the waitlist for a bed with us. During this we also have patients in Ward 1 identified as recovering from their acute medical requirements and we will looking to move these patients to Ward 6.



We are currently planning the final move for Ward 6 into the area upgraded in the facility developments completed in 2015/2016. The past six weeks we have progressed the bathroom improvements required to ensure this area is fit for purpose for this patient cohort.

In this ward move we will have the opportunity to refocus our planning for restorative care with our AT&R patients and define the commonalities of our NWB patients. Our intention is to rethink how we cohort these patients within the ward and in this cohort the workforce required to support their care needs. In simple terms the challenge in care delivery in Ward 6 is influenced by the significant number of patients reliant on manual hoisting, over lapped with the potential for an 'engager' to sit with the patient to reduce the risk of falls.

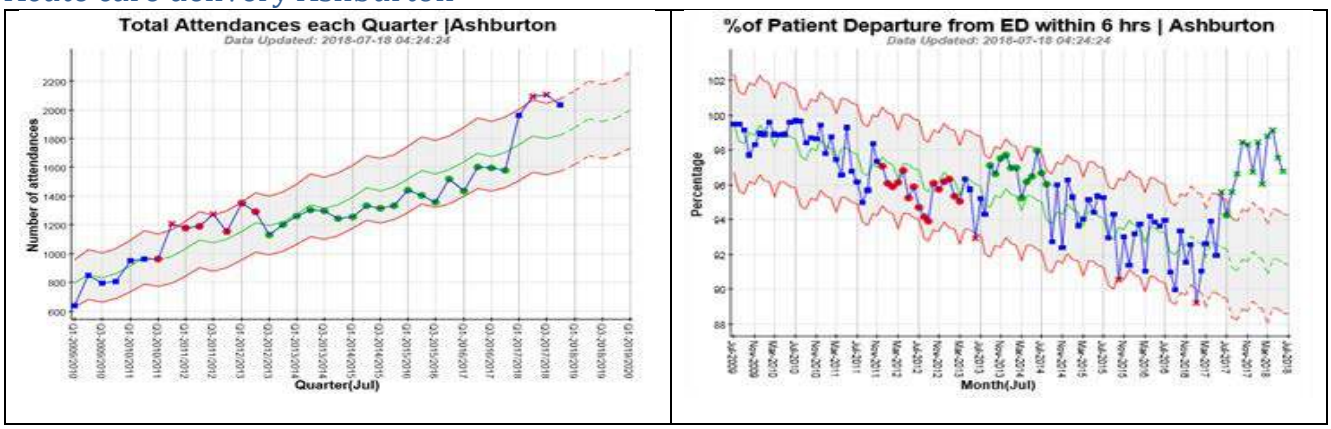
In the past two months we have been actively deploying our nursing and hospital aid across the hospital, moving away from our traditional model where workforce is rostered to each ward area exclusively. This opportunity has arisen as we cover vacancies that have arisen due to resignations and or sickness. The flex in applying this enables us to cohort our hospital aids to a work area in the morning and respond to the change in flow in the afternoon when we are discharging patients from the acute medical ward.

Ashburton Hospital has a very active volunteer community whom are active in the wards, particularly in Ward 6 during the week. We are exploring successful international models where this volunteer community has been trained to provide the 'engager role' to reduce the risk of patient falls in those identified as vulnerable. These roles do not mobilise patients but are trained to utilise the diversional therapy practice and seek appropriate clinical workforce when a patient does require mobilising.

A full breakdown of this work will be incorporated in the workplan with the ASLA.

An achievement to note in the care of older persons in Ashburton is the positive feedback received for Tuarangi during the recent certification audit. The auditors involved had previously assessed Tuarangi and were highly complementary of the progress in care plans and processes for our residents, describing these as some of the best they have seen. The team have worked consistently towards this goal and were grateful for the acknowledgement of their ongoing work and commitment.

Acute care delivery Ashburton



As demonstrated in the above graphs the flow into AAU remains consistent. To date we have not experienced any significant increase in presentations due to respiratory or seasonal demand. The ASLA operational group are overseeing the co-ordination of data reports for a number of local practices, outlining information on their patient flow through the unit. The objectives include the increased partnership between the hospital and primary care in providing acute care and identifying any trends or areas that we provide an alternate approach to acute care. It is also to "bust myths" that patients are repetitively presenting to the unit during hours and that this is due to cost only. The operational group are looking to take a proactive approach to the implementation of the acute plans. Building on this, during the recent industrial action we were able to work with St John ambulance to provide a voucher system that enable patient's access primary care if this was the agreed appropriate area for care provision. This is building on the Christchurch system that has been implemented for some time.

The Clinical Team Coordinator Role Improves Patient Safety After Hours.

The Clinical Team Coordinator role was permanently introduced to Christchurch Hospital in early 2008. This was the primary recommendation from a review of patient care in the after-hours period that showed that there were deficiencies in leadership, the way that the various teams work together and task distribution during this time that resulted in negative effects on staff (particularly resident medical officers) and patients.

In the ten years since the role was introduced, it has expanded from a roster of three senior nurses covering the medical wards on nightshifts, to 11 nurses covering both medical and surgical clusters in the afternoons, nightshifts and weekends. These after-hours periods cover 76% of the hospital's week. In this time, the hospital has changed and so have the responsibilities of this role. Earthquake repairs have seen wards and departments relocated and overhauled. The increased ability to manage patients in the community, through systems and supports such as the Acute Demand Management Service and Health Pathways, has meant the typical inpatient is now of higher acuity.

The current CTC role includes:

- facilitating daily handover meetings between the afternoon and night RMO shifts that provide a valuable overview of patient activity and acuity, as well as medical workloads across the whole hospital;
- coordinating duty house officer workloads by assessing and triaging tasks and requests from ward nursing staff;
- assessing patients as part of the New Zealand Early Warning Score escalation pathway;
- problem-solving clinical and logistical issues through good working relationships with ward nursing staff, Duty Nurse Managers, resident medical officers and Service Managers;
- supporting and mentoring ward nurses through Post Graduate studies;
- being members of the Clinical Emergency Team in the after-hours;
- contributing to many groups and committees within the hospital, including The Deteriorating Patient, Senior Nurse Review Steering Group, New Zealand Resuscitation Council, and Nursing Entry to Practice programme;
- performing clinical procedures traditionally provided by doctors, including IV cannulation, venepuncture, arterial blood gases, male urethral catheterisation and most recently, peripheral ultrasound guided cannulation.

The main aim of the Clinical Team Coordinator role is to ensure effective teamwork in the after-hours period so that staff, particularly junior resident medical officers, can work in an environment where they are supported, have manageable workloads and their activity is prioritised so they can be with the right patient at the right time to enable good clinical decision-making and high-quality patient care. The shift is typically spent circulating the wards and other clinical areas, interacting with patients and staff. Team members typically walk around 9km in a shift.

In a recent survey, respondents were asked what they found of most value from the role. Overwhelmingly both nurses and resident medical officers felt that being able to ask advice and having the support of a senior nurse in the after-hours was most valuable. When asked if they felt the role improved patient care and safety, 70% strongly agreed in 2018. When asked this same question in 2008, just 8% strongly agreed, suggesting that staff now place significant value in the role.

To date, the Clinical Team Coordinator role is unique to the Canterbury District Health Board within New Zealand and is one component that contributes to the relatively shorter length of stay experienced in Canterbury. No other district health boards have a position with this broad range of clinical and logistical scope. Having these roles in place is key to patient safety, and supports effective patient flow ensuring that patients are well enough to return home safely as soon as possible. The move to the new Christchurch Hospital Hagley has offered the opportunity to review and reflect on the role and how it may develop in the future.

Use of alternating air mattress in the community.

The Child Development Service works with children with disabilities throughout the district, providing support to the children and their families. When children's movement is diminished even sleeping a full night can create the risk of pressure sores developing. If this occurs infection can follow creating significant discomfort and pain, along with the potential for significant harm or even death.

One family cared for by the service has a 14 year old son with cerebral palsy. Throughout his life his mother has had to wake three times a night to turn him to avoid development of pressure sores. The service has been working with this family, trialling a range of approaches including positioning systems and various mattresses. The most recent successful approach involves use of an alternating air mattress. This is a mattress that uses changes in air pressure to avoid discomfort and the development of pressure areas. The mother reports in the first two weeks of the trial she has only woken to care for her son during the night three times in total.

This has ensured that this young man now sleeps comfortably most nights, provided a significant improvement in the mother's quality of life, while eliminating the risk of pressure sores developing that might lead to the requirement for hospital care and freeing up hospital beds for other patients who require hospital input.

Turning a hand hygiene negative into a positive – Christchurch Campus

Hand Hygiene is an important component in limiting the spread of infectious diseases in hospital. In contributing to patient safety it also contributes to preventing the requirement for avoidably long stays in hospital. In October 2017 the Christchurch Hospital Acute Medical Assessment Unit achieved 64% compliance with the 'five moments of hand hygiene', falling well below the target of 80%. The multidisciplinary team in the unit decided to do something about this. By March 2018, the unit's compliance rate had soared to over 80 percent, a huge leap and one that bodes well for the patients, staff and unit. Charge Nurse Manager Allison Partridge says it's been a combination of using tools that work for them and having people who are vigilant about hand hygiene and energised with the determination to do better. "The difference in improved compliance has come from making hand hygiene part of everyday clinical conversations and team updates. Auditors provided constructive feedback increasing awareness and driving improvement.

The Neonatal Unit has consistently been a high performer in this area. Compliance with the 'five moments for hand hygiene' has been above 80 percent since June 2014 and the unit continues to aim higher in order to protect the smallest patients in Canterbury District Health Board's care. In March 2016 its hand hygiene compliance reached 85 percent, hitting 90 percent in June 2017. It remains over 90 percent with the last audit period result of 92 percent.

Achieving high standards in this area has required the full support of the multi-disciplinary team in NICU. As far back as 2004 all staff were expected to complete hand hygiene education and post their certificates on the door of the Clinical Director. Since this time Infection Prevention and Control, Clinical Nurse Specialists, and NICU Gold Auditors

have worked together with staff from the unit's floor to develop and introduce solutions. Feedback is provided after each audit period via posters, emails and discussion at weekly forums.

Working in this complex area has required a re-framing of the way we think of the different zones around a patient. Equipment attached to the baby is identified as part of the baby, making hand hygiene practical and straightforward.

Other components of the winning formula adopted by this unit include: locally relevant posters, highlighting hand hygiene at weekly staff forums, discussing issues and solutions at core competency education sessions and providing new staff clear expectations for hand hygiene.

Team work and commitment to hand hygiene by NICU staff ensures the smallest patients are in clean hands, keeping them safe.

Using ePrescribing alerts to reduce opioid related harm.

The use of opioids for pain management is associated with constipation which causes discomfort for patients and when not managed properly can create significant harm. A local audit of patient coding shows that opioids are the most common cause of inpatient adverse drug reactions – with a rate of 3.9 per 1,000 admissions. Constipation accounts for nearly a quarter of these. While constipation caused by these drugs is manageable through the provision of laxatives alongside opioid drugs, the audit has shown that around two thirds of patients prescribed opioid drugs were also prescribed a laxative.

The implementation of ePrescribing has given us an opportunity to improve on this. Under the guidance of clinical leadership groups covering analgesic use and the use of the alert functions within ePrescribing, we have put in place a series of alerts in the electronic medication charts that alert prescribers that they have prescribed an opioid and there is no corresponding prescription for a laxative. This change has been associated with an improvement in the co-prescribing of laxatives, increasing it from 65% to 87%. A recent evaluation of coding data has shown a 17% reduction in the number of opioid associated adverse drug reactions and a 16% reduction in constipation in people prescribed opioids.

This has demonstrated the benefit provided by structured clinical stewardship over analgesic use and the sparing use of ePrescribing alerts. It has reduced the harm we create for patients and is expected to contribute to avoidance of extended stays in hospital.

Improved pathway for people with soft food impaction:

Around 60 people present to the Emergency Department each year with a soft food bolus impaction, a blockage of the oesophagus caused by compacted food, usually meat. This is a distressing situation that results in discomfort and an inability to swallow fluids, including saliva. Treatment involves endoscopic removal of the food, followed by examination of the oesophagus to determine the underlying cause for the obstruction. Until recently people presenting in this situation typically waited for three hours in the Emergency Department before being admitted to a ward and then directed to the endoscopy suite for treatment.

A new pathway has now been put in place where, instead of sending the patient on for full review in the Emergency Department, the triage nurse immediately refers patients with this condition to the gastroenterology registrar. They will then be sent directly to the endoscopy suite, and discharged home directly from there when appropriate.

This will reduce waiting time for the patient – reducing the discomfort experienced by the patient. It will also reduce the time spent in hospital and minimise the need for overnight stays by this group of people. It will also reduce the number of call outs required to carry out endoscopies outside of normal hours.

DRANZCOG Advanced Oral Examination Award - Dr Brendan Marshall.

The Canterbury District Health Board works in partnership with our colleagues at the West Coast District Health Board across many services. Obstetrics is one of the key services involved in this 'transalpine' approach to ensure provision of safe, sustainable services to women and their families on both sides of the Southern Alps. This includes regular visits to Christchurch Women's by staff from the West Coast, provision of leave cover on the West Coast by Christchurch based clinicians and a joint approach to clinical governance. While we are in a period where there is a

stable specialist obstetric workforce based on the West Coast previously we have experienced significant periods where we have been required to rely on a piecemeal approach, using short term locums to ensure a full roster.

Recently, both DHBs with support from HWNZ have looked at a unique approach that looks to train locally based doctors, providing them with advanced obstetric skills ultimately helping ensure more certainty of the service for West Coast women. This model has been available in Australia and we've recently demonstrated, that this approach to training can be replicated in New Zealand. Dr. Brendan Marshall, a general practitioner and rural hospital generalist working in Greymouth has recently completed an Advanced Diploma in Obstetrics (Adv. DRANZCOG). This enables Brendan to participate in providing obstetric support to women, including the provision of Caesarean section, assisted deliveries and other procedures that have previously only been provided by specialists. In order to complete this qualification Brendan has been seconded to Christchurch Women's Hospital for about the last six months, allowing Brendan to complete the practical components of the Advanced Diploma while simultaneously developing key relationships with the staff at CWH.

Both DHBs have been reassured that the training they are able to offer is of high calibre, as Brendan recently received word he had achieved the highest marks in Australasia in his Advanced Oral Examination, despite Christchurch being the first NZ centre to offer Adv. DRANZCOG training in over 20 years. He will travel to Adelaide to receive this award at the Fellowship Awards Ceremony in September.

This model has real potential to help us to sustainably develop a workforce that will provide for the needs of women on the West Coast (and indeed large parts of rural NZ) over the long term, ensuring that women can safely give birth closer to home, with the majority avoiding the need for a trip across the alps.

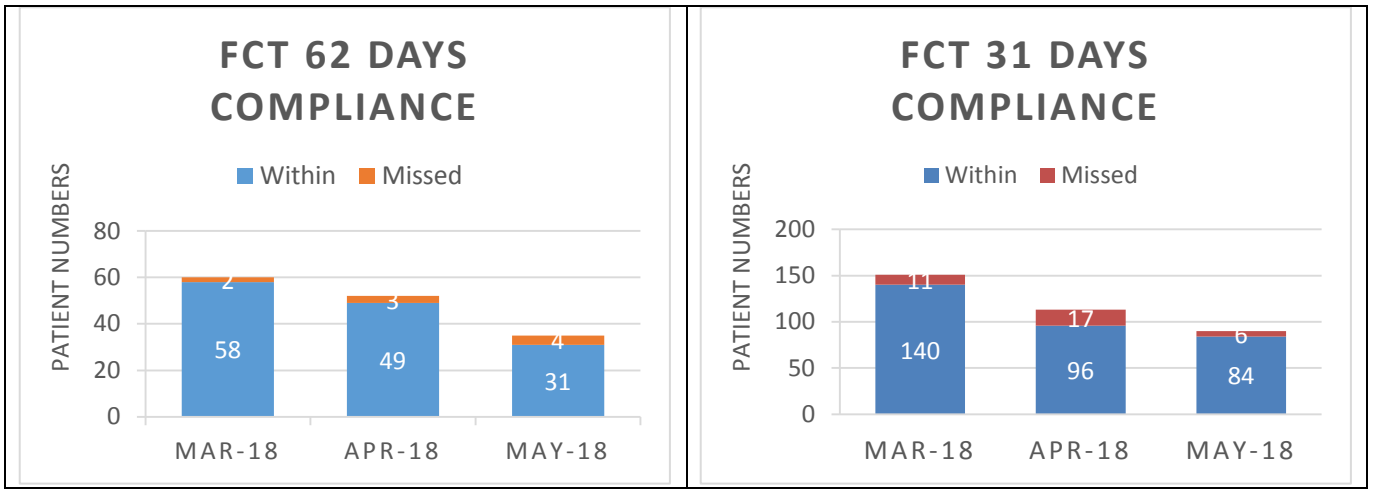
Faster Cancer Treatment

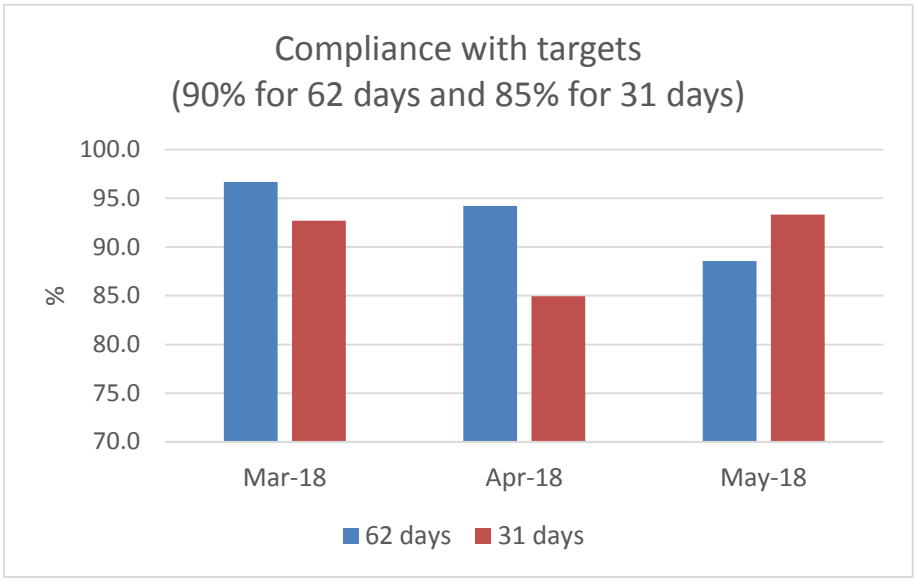
Outcome and Strategy Indicators

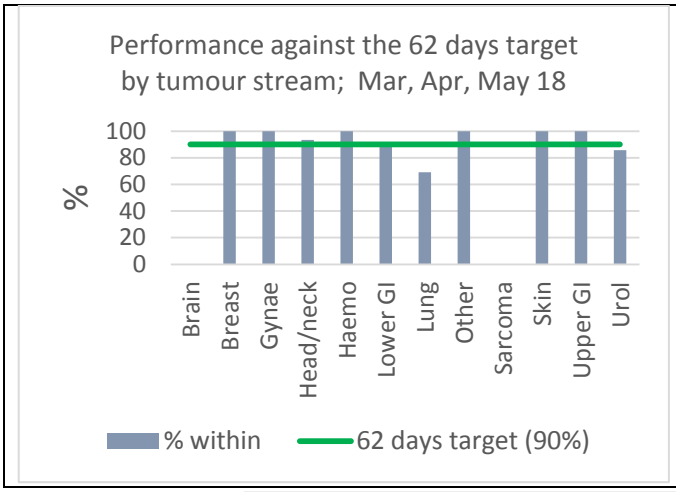
Key Outcomes - Faster Cancer Treatment Targets (FCT)

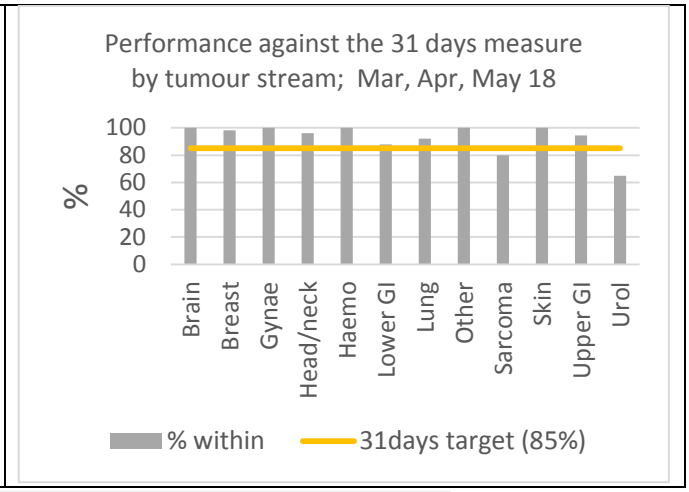
62 Day Target. For the months of March to May 2018 Canterbury District Health Board submitted 171 records to the Ministry of Health with 33 missing the 62 days target. Of these 24 missed the target through patient choice or clinical reasons leaving 47 patients eligible for inclusion in the target calculations. This means that 93% of eligible patients were treated within 62 days of receipt of referral, meeting the 90% target.

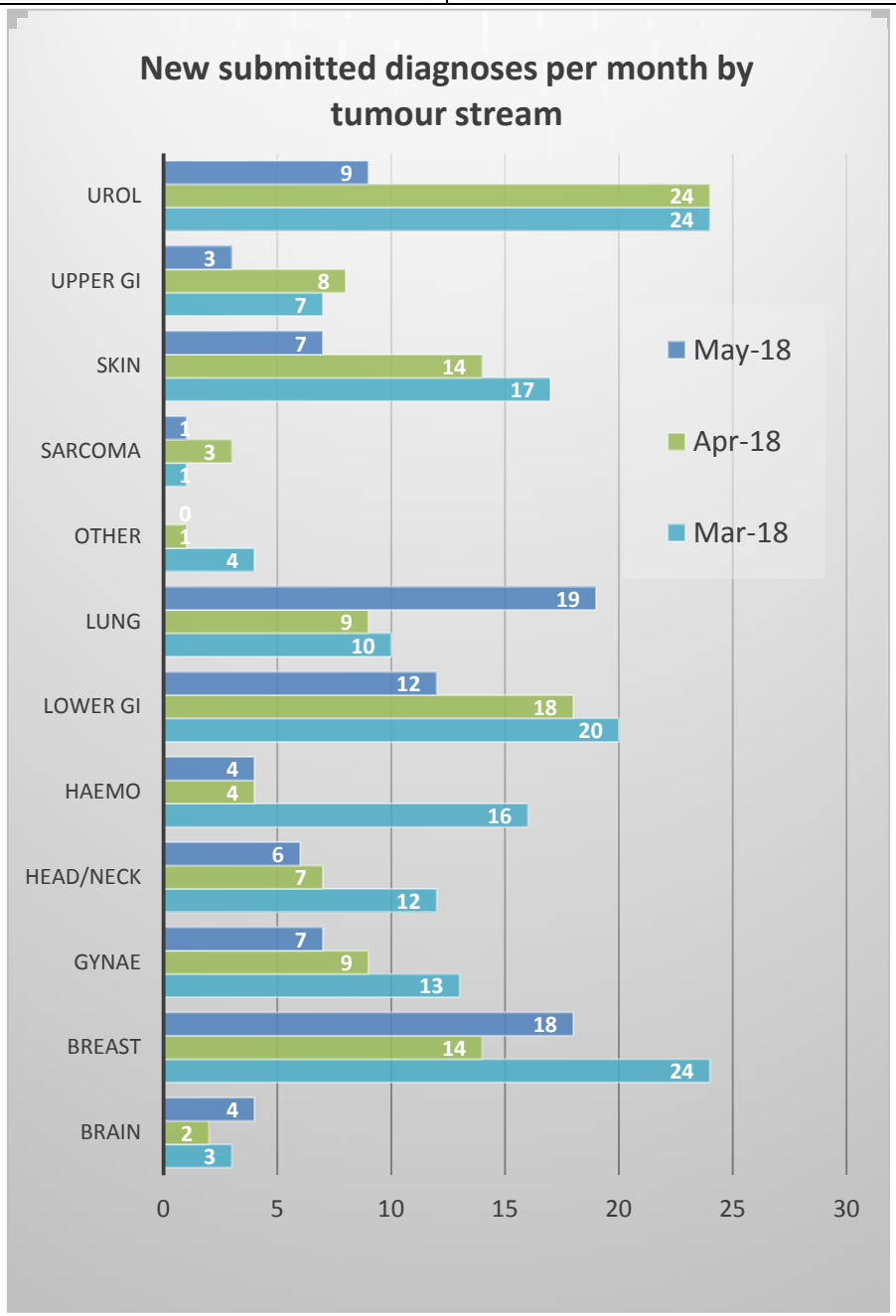
31 Day Performance Measure. Canterbury DHB submitted 354 records between March and May 2018. This figure includes patients also eligible for the 62 days target. In this period 90% of eligible patients received their treatment within 31 days of a decision to treat, meeting the 85% target.






Performance against the 62 days target by tumour stream; Mar, Apr, May 18
%
100
80
60
40
20
0
Brain
Breast
Gynae
Head/neck
Haemo
Lower GI
Lung
Other
Sarcoma
Skin
Upper GI
Urol
% within
62 days target (90%)

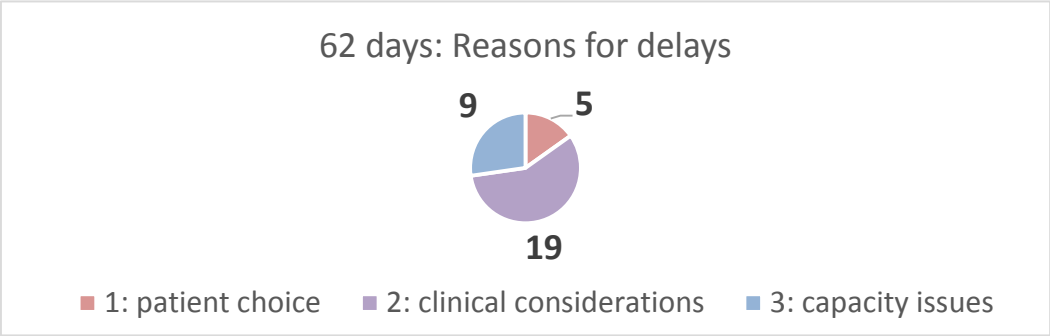

Performance against the 31 days measure by tumour stream; Mar, Apr, May 18
%
100
80
60
40
20
0
Brain
Breast
Gynae
Head/neck
Haemo
Lower GI
Lung
Other
Sarcoma
Skin
Upper GI
Urol
% within
31days target (85%)


New submitted diagnoses per month by tumour stream
UROL
9
24
24
UPPER GI
3
8
7
SKIN
7
14
17
SARCOMA
1
3
1
OTHER
0
1
4
LUNG
19
9
10
LOWER GI
12
18
20
HAEMO
4
4
16
HEAD/NECK
6
7
12
GYNAE
7
9
13
BREAST
18
14
24
BRAIN
4
2
3
May-18
Apr-18
Mar-18
0
5
10
15
20
25
30

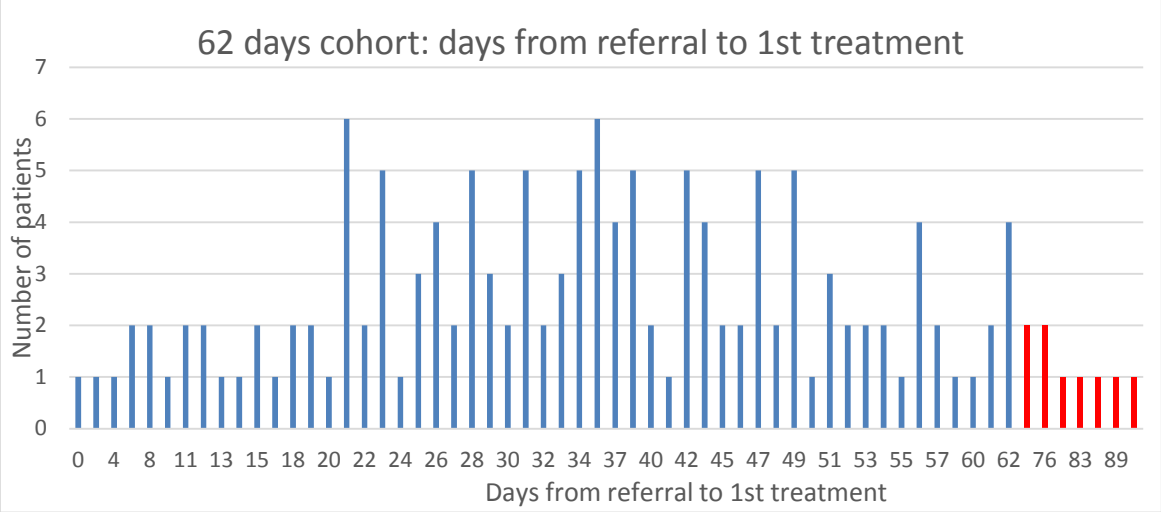
Patients who miss the targets

The Ministry of Health requires District Health Boards to allocate a "delay code" to all patients who miss the 62 days target. There are 3 codes and only one can be used even when delay is due to a combination of circumstances.In this circumstance the reason that caused the most delay is the one chosen.
The codes are:

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



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

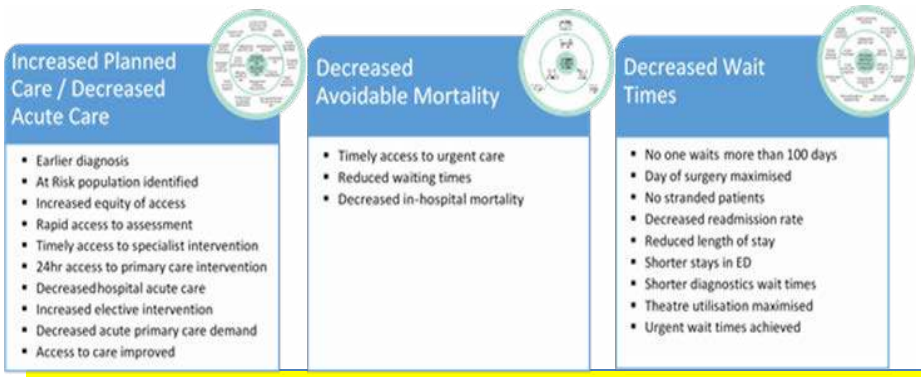


Each patient that does not meet the target is reviewed to see why. This will have happened in order to assign a delay code, but where the delay seems unduly long then a more in-depth check is performed. These cases are usually discussed with the Service Manager to see if any corrective action is required.

Head and Neck Cancer pathway

The project *'Valuing the patients time in complex cancer: Head and Neck'* is a joint project with NMDHB. The aim of the project is to review the patient pathway to identify and remove any barriers to timely treatment. The project also sought the views of patients and whanau to find out what they considered to be priorities.

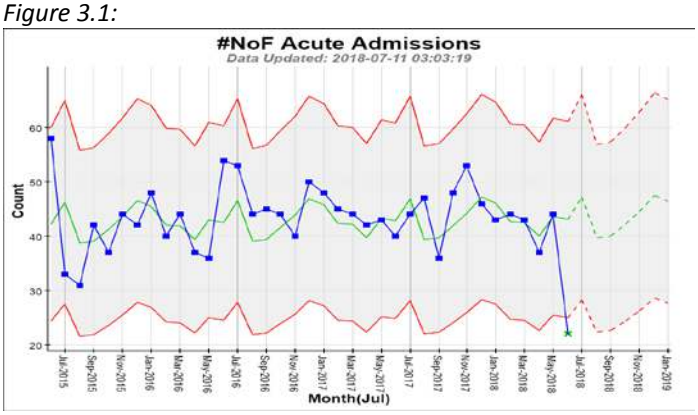
The project has finished and the final report (prepared and agreed by both DHBs) has been completed and is ready for review by the Southern Cancer Network. The report will focus on service improvements that have been implemented, or are due for implementation, based on the project's findings.



Enhanced Recovery After Surgery (ERAS)

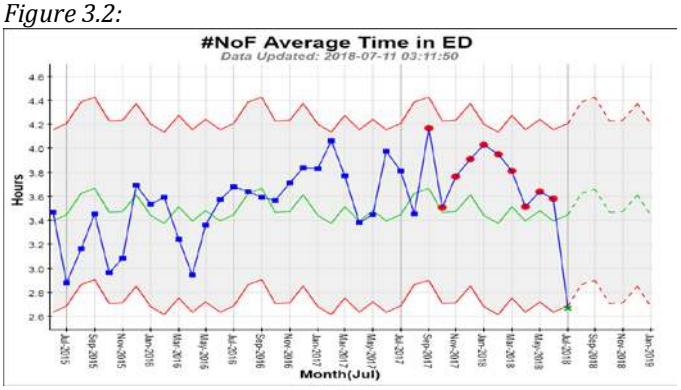
Outcome and Strategy Indicators – Fractured Neck of Femur (#NoF)

Figure 3.1:



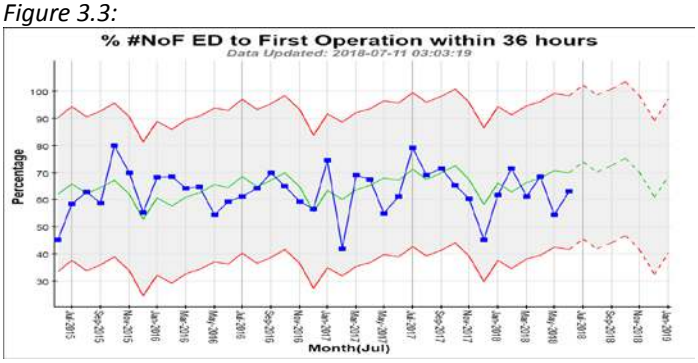
The number of #Nof admissions per month continues at the expected rate. The apparent reduction in June is expected to correct when all discharges are coded.

Figure 3.2:



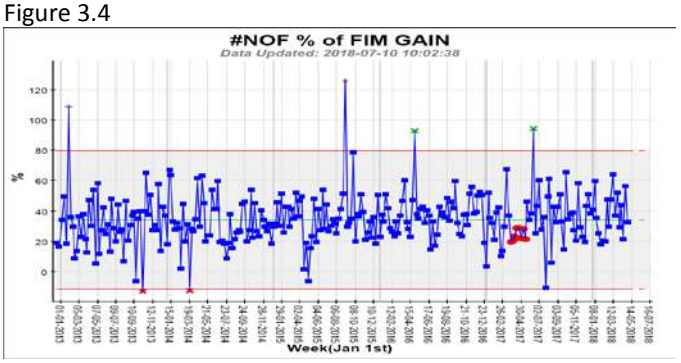
Patients with #NOF show a variable length of stay in ED. The red signals show that a statistically significant increase in the time spent in ED has occurred. The apparent reduction in June is expected to correct when all discharges are coded.

Figure 3.3:



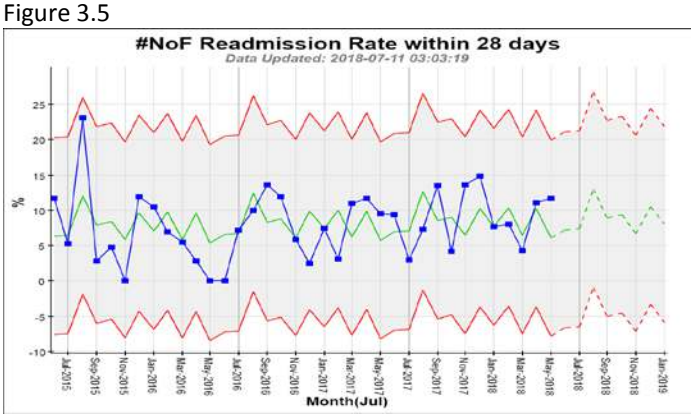
The target is set for patients to be operated on within 36 hours 'when clinically ready'. The proportion of people receiving treatment within 36 hours follows the existing trend of small, ongoing improvement.

Figure 3.4



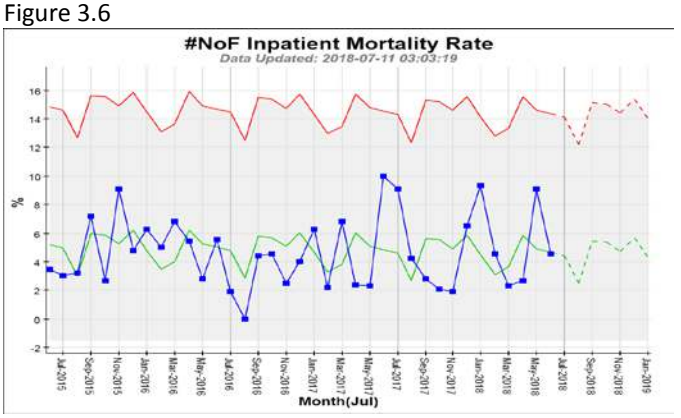
The Functional Independence Measure (FIM) is a basic indicator of severity of disability. The above graph shows the percentage gain for #NOF patients.

Figure 3.5



Readmissions continue to remain within expected mean values.

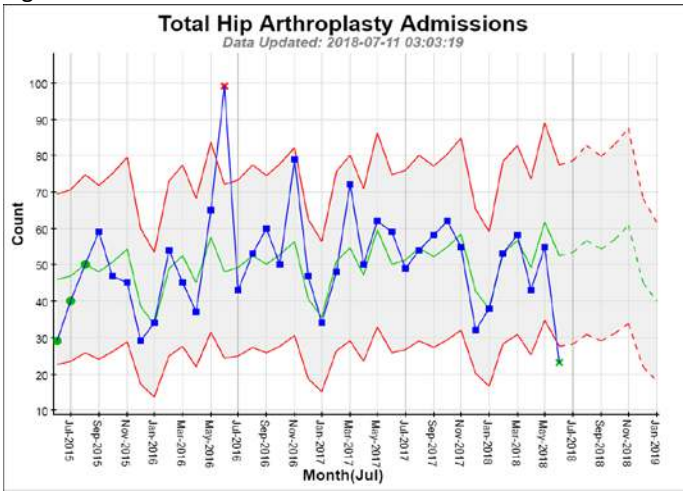
Figure 3.6



The mortality rate remains within the anticipated range.

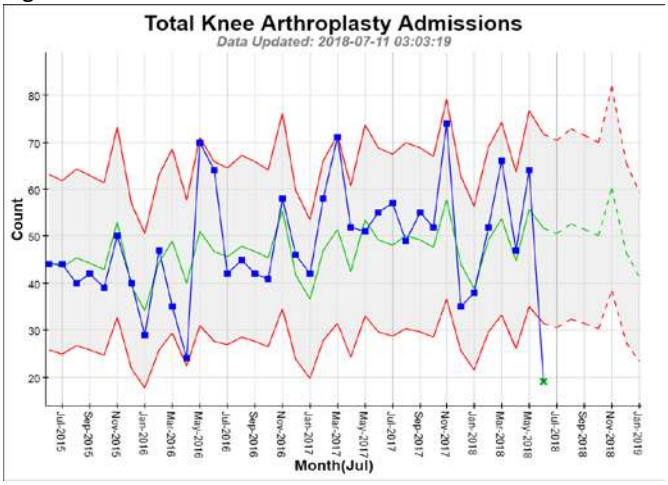
Outcome and Strategy Indicators – Elective Total Hip Replacement(THR) and Knee Replacement(TKR)

Figure 3.9



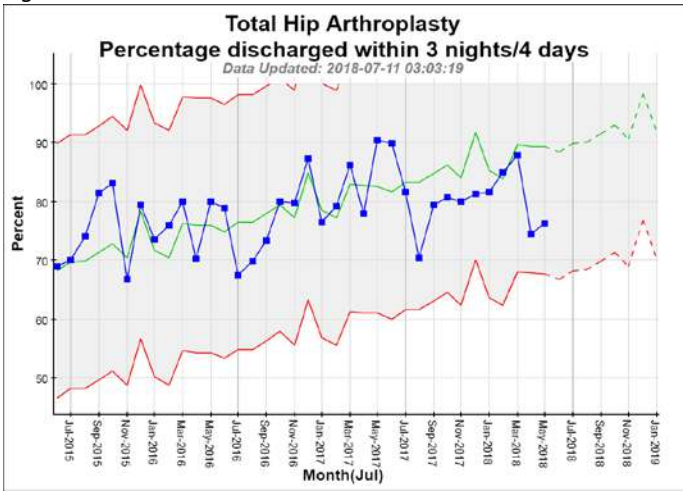
In recent months hip replacements have been tracking within projected levels. The apparent reduction in June is expected to correct when all discharges are coded.

Figure 3.10



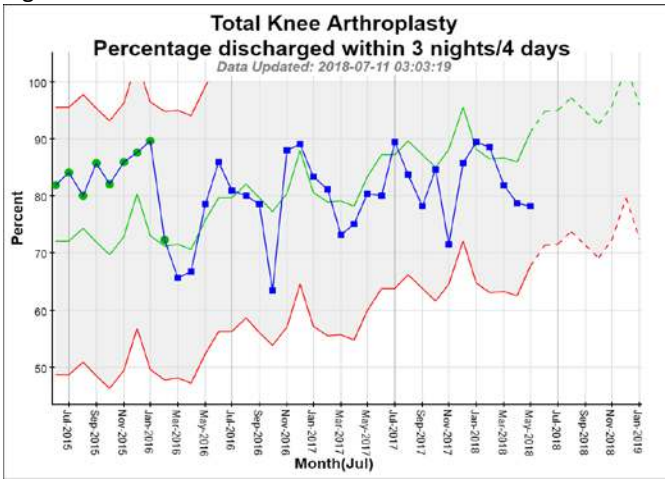
Knee replacement admissions over the previous twelve months have been at or above projected levels. The apparent reduction in June is expected to correct when all discharges are coded.

Figure 3.11



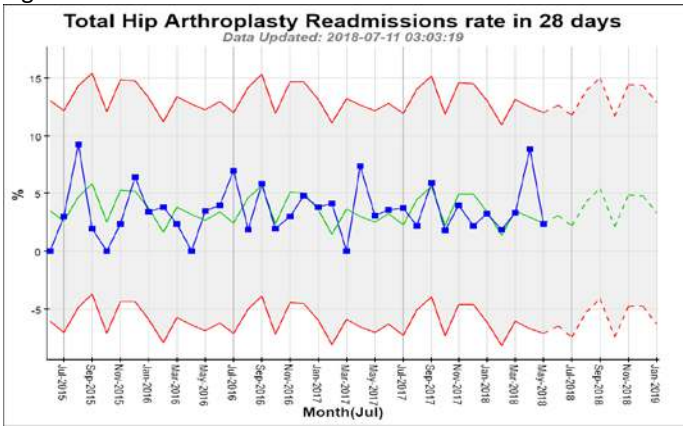
The proportion of patients clinically safe to be discharged within 3 nights/4 days is following established, increasing trend.

Figure 3.12



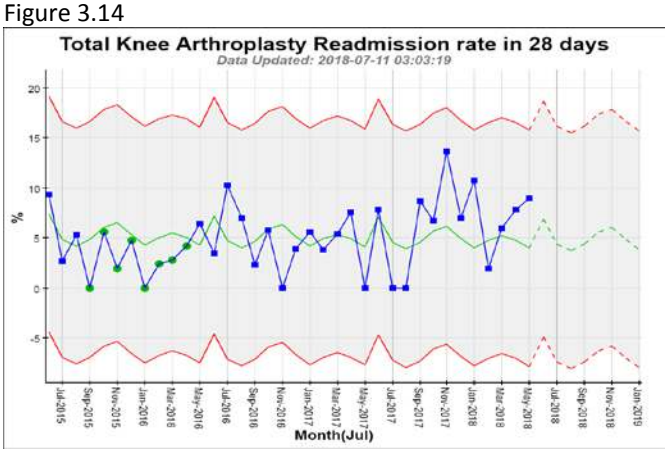
The proportion of patients clinically safe to be discharged within 3 nights/4 days is following established, increasing trend.

Figure 3.13



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

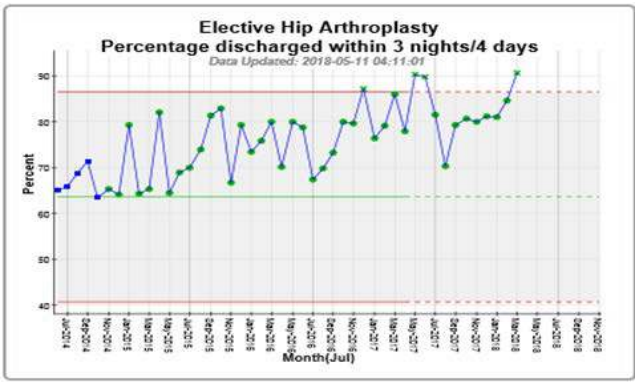
Figure 3.14

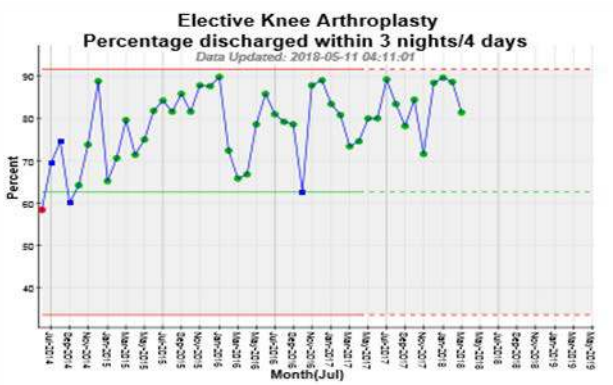


Readmission rates are maintaining within tolerances.

Achievements/Issues of Note

ERAS

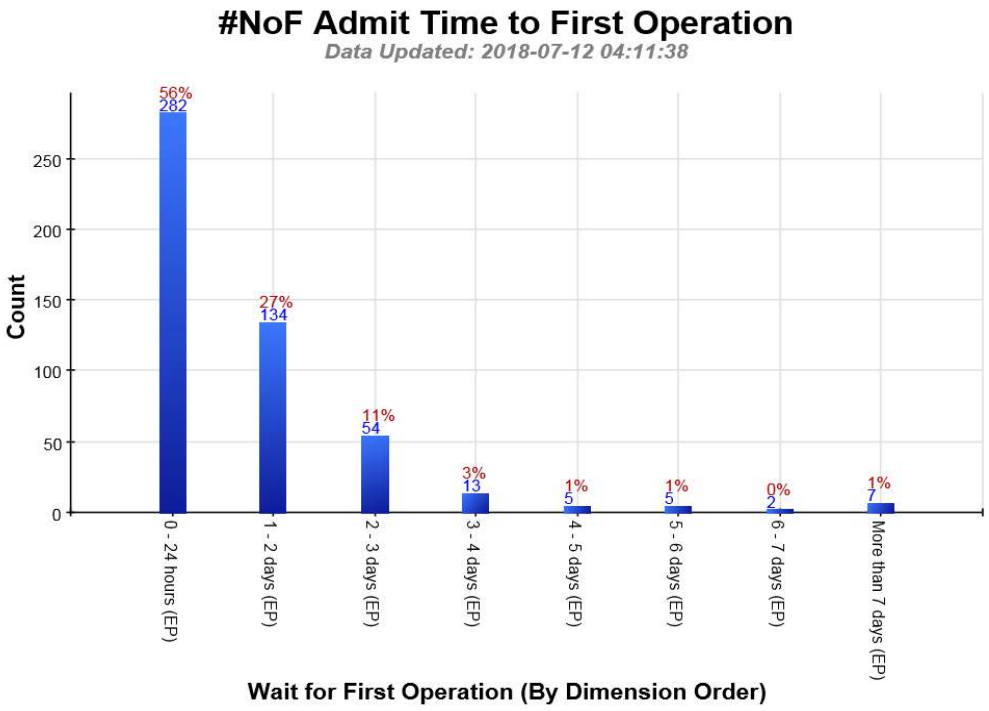


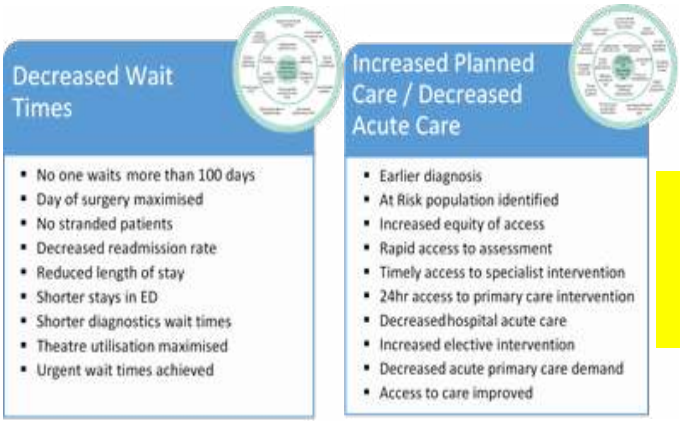


Electives – Overall for both elective hips and knee surgery the trend is seeing an improvement in the percentage of patients discharged within the target of 3 nights/4 days. While achieving a good consistency, we continue to audit outcomes as a balancing metric. Readmissions range has narrowed demonstrating further consistency in our approach.

Our joint surgery target was reached at the conclusion of May with lower numbers of joint surgery taking place during the month of June, the percentage drop of discharge within 3nights was influenced by the lower numbers reflecting several complex cases with multiple co-morbidities.

We have made changes to theatre access for orthopaedics which will make changes to fractured neck of femur (#NOF) surgery. An additional 10 sessions have been made over the 4 week schedule. The changes will support flow to theatre with additional capacity. The flow on effect will be a reduction in elective sessions converted at Burwood hospital to accommodate increased acute activity. During the 2017/2018 year over 350 acute cases were undertaken at Burwood.





Elective Surgery Performance Indicators 100 Days

Outcome and Strategy Indicators

Figure 4.1:

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

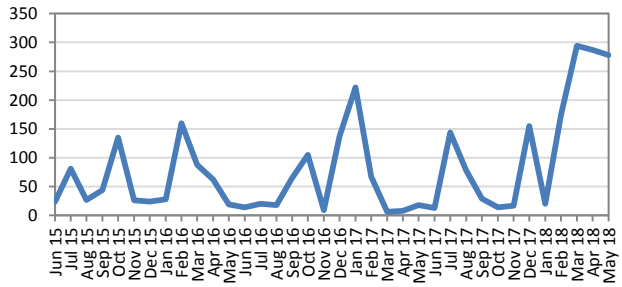


Figure 4.2:

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

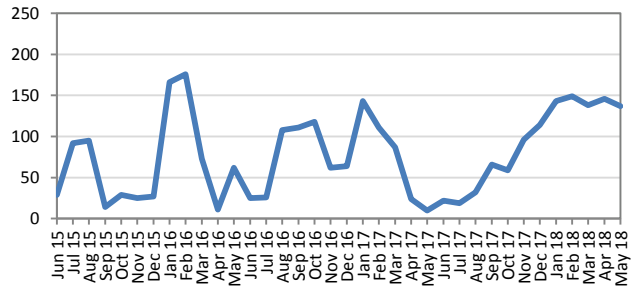


Figure 4.3:

ESPI 2 Result By Specialty – Surgical

Specialty	Number	%	Change
Cardiothoracic	0	0.0%	0
ENT	82	6.5%	-30
General Surgery	0	0.0%	0
Gynaecology	0	0.0%	0
Neurosurgery	0	0.0%	0
Ophthalmology	1	0.2%	-28
Orthopaedics	22	16.5%	9
Paediatric Surgery	0	0.0%	-4
Plastics	3	1.1%	2
Urology	8	1.1%	-16
Vascular	45	2.0%	-2

ESPI 2 Result By Specialty - Medical

Specialty	Number	%	Change
Cardiology	0	0.0%	0
Dermatology	0	0.0%	0
Diabetes	0	0.0%	0
Endocrinology	3	1.4%	3
Endoscopy	0	0.0%	0
Gastroenterology	109	18.8%	36
General Medicine	1	1.3%	1
Haematology	0	0.0%	0
Infectious Disease	0	0.0%	0
Neurology	0	0.0%	0
Oncology	0	0.0%	0
Paediatric Medicin	0	0.0%	0
Pain	0	0.0%	0
Renal	1	1.5%	1
Respiratory	0	0.0%	0
Rheumatology	0	0.0%	0

Figure 4.4

ESPI 5 Treatment by Specialty

Specialty	Number	%	Change
Cardiothoracic	0	0.0%	0
Dental	0	0.0%	0
ENT	6	1.3%	-2
General Surgery	6	1.4%	-5
Gynaecology	0	0.0%	-3
Neurosurgery	0	0.0%	0
Ophthalmology	0	0.0%	-3
Orthopaedics	108	24.3%	2
Paediatric Surgery	4	4.2%	0
Plastics	0	0.0%	-1
Urology	3	1.1%	-11
Vascular	6	11.1%	3
Cardiology	3	1.5%	3

ESPI Results

Waiting > 120 Days

	Number	%	Status
ESPI 2 (FSA)	278	3.2%	
ESPI 5 (treatment)	137	3.7%	

Achievements/Issues of Note

Elective Services Performance Indicator (ESPI) Target Outcomes

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

The same report shows that Canterbury District Health Board achieved a red result for elective services performance indicator five (covering waiting time for surgery) for the tenth month in a row. Data issues associated with the transition of data between patient management systems is one cause for this ongoing apparent failure to make target. The Ministry of Health has provided Canterbury District Health Board with dispensation for Elective Services Performance Indicator achievement between January 2018 and June 2019 to recognise the pressures associated with facility limitations and issues associated with data transition. These measures will continue to be published and Canterbury District Health Board remains committed to working towards its goal that patients will not wait longer than 100 days for elective services they have been offered.

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

Multiple teams working together to enable elective surgery.

Recently an eight year old boy with autism required an admission in order to have a gastrostomy tube inserted. Some children require gastronomy tubes to be inserted into their stomach through the abdomen to provide adequate nutrition. This young man becomes distressed when faced with unfamiliar situations and there was concern that this would prevent him from receiving the treatment he required.

Staff including the anaesthetist, Children's Outreach Nursing service, Ward 21 Play Specialist worked together to ensure that this young man was able to receive his surgery with minimal distress.

- The outreach nursing service provided education to the family about gastrostomy care and feeding regime prior to admission.
- The Play specialist worked with the school, providing photographs of equipment that may be used in the hospital so that the child could become familiar with them.
- Working with the family, the anaesthetist provided a pre-med prior to the patient entering the hospital, met the family at the entrance and assisted with the transfer to theatre.
- Clonidine was charted as part of post-op medication to help manage potential distress from being in hospital.
- Ward 21 assigned a single room that was as quiet as possible.
- The night before admission the family decorated the room with familiar things and the young man's mother and other family members were present post-op.
- The child was able to be discharged the day after surgery with the Outreach Nurse visiting him in his home on a daily basis.

Acknowledging the child's disability and working in a way that recognised his needs meant that the admission went smoothly and was reasonably stress free creating a positive experience for this eight year old. The treatment was provided in a timely manner due to the ability to do this.

Paediatric diabetes outreach sessions for newly diagnosed patients.

When children are first diagnosed as having diabetes the people that care for them are often uncertain about how best to support them to undertake their normal daily activities. The diabetes outreach team has been providing a range of opportunities for patients' families and school staff to be provided with information, and develop confidence in this situation.

Group sessions are run for parents three or four times a year. These sessions include an opportunity to refresh the information given to families at the time of diagnosis, provide information about pump use and updates on recent research findings. When a patient is newly diagnosed the team visits with school staff and parents to provide information about the needs of the child in that setting. Group sessions are also provided for teachers, teacher

aides and office first aid staff – two of these sessions have been provided this year. Alongside these group sessions, access is provided to excellent online resources and written material. Feedback provided by those attending the sessions has been overwhelmingly positive, noting that these sessions are a key part of the information and support provided.

Bringing the schools and whānau together soon after diagnosis demystifies the diagnosis for the teachers and allows discussion about what is required to enable children with diabetes to experience a normal, active childhood. This assists in ensuring that patients are supported to stay well in the community, avoiding the need for specialist intervention when things go wrong, freeing up time within the diabetes service to see other patients that can benefit from its attention.

Nurse clinics providing timely appointments for people with small aneurysms.

Aneurysms are a bulge in a blood vessel, caused by a weakness in the wall of the vessel. When aneurysms in a major artery are of a significant size there is a risk that they will rupture, leading to internal bleeding and death. However when they are small there is not significant risk of rupture and there is no benefit to be gained from immediate surgery. On this basis we do not offer these patients appointments with a surgeon, if we did it is likely that there would be a long waiting time for such appointments due to the number of people with higher priority conditions also needing those appointments. However without a way to be provided with information and reassurance many patients experience significant anxiety about their condition.

Since 2010 the vascular specialist nurses have been running small aneurysm clinics. These clinics enable patients to be seen in a timely manner, provided with a structured assessment and provision of information about aneurysms, the surveillance programme, open aneurysm repair and endovascular repair, risks of surgery, as well as the nature of follow-up care required following any surgery.

If, in the presence of a significantly sized aneurysm, a patient would be willing to receive surgery they are offered ongoing surveillance. Following this a plan is made with the patient and whānau covering the management of their aneurysm. If appropriate, smoking cessation is discussed as is the most appropriate medical treatment of their aneurysm. The patient leaves the appointment with reassurance and a clear, documented, plan that is sent to the patient and their GP. If the patient indicates that they would never wish to have surgery then surveillance is not required and the patient's notes are updated to show that in the case of an emergency presentation with a ruptured aneurysm the patient does not wish to receive high risk surgery. Around ten patients per month are seen at this clinic – a total of 860 people since its launch. This clinic offers significant benefit to the patients seen, ensuring that they are provided with reassurance, guidance on what future options are and a pathway to manage their condition appropriately over time. This approach ensures that patients that can benefit from the skills of our highly competent nurses while reserving surgeon appointments for patients that can only benefit from a surgeon's intervention.

Celo the safe-snapping app.

Snapchat or WhatsApp are used widely in the community to enable people to communicate. However while these applications allow encrypted image sharing, there are issues with using them in the health system. With these systems messages and images are stored on each phone and anyone who uses or steals the device can see them. This is not acceptable and so the benefits of these methods of communication have not been available to health professionals.

In response to this an app called Celo is being provided to Canterbury health professionals which lets medical staff confer or safely share a photo at the click of a button so that they can obtain a second opinion when they are in a hurry. Celo behaves more like a mobile banking app, where nothing is stored on the device and nobody can access information without the user's unique PIN code. All users on a Celo network are verified, so there is no chance of a user accidentally sending patient images to someone who doesn't work in healthcare.

Christchurch Hospital Paediatrician Dr John Garrett says the Celo app has been invaluable for his work. "I go to the Chatham Islands twice a year to see paediatric patients over there. One of my patients was also a patient in the plastic surgery service here." The patient's mother mentioned they were planning to fly to the Christchurch plastic surgery clinic for a follow-up appointment regarding a scar. The trip would have been a considerable inconvenience for the family involving three or four days of time off work and school. Along with that travel costs can also add up,

placing demand on an already stretched health budget. Using Celo, John was able to take a picture of the scar and send it straight to the plastic surgeon. Within five minutes she communicated that the scar looked fine and the patient was not required to travel to Christchurch. John has also found that the app is useful when he is on call. Registrars can share images with consultants instead of describing conditions on the phone enabling better decisions to be made for the patient. Celo is the preferred method of communication in the Paediatrics department and John is looking forward to it being more widely used in the hospital. Celo will also soon be used in the West Coast DHB, where clinicians regularly confer with Canterbury DHB staff. Plans are being developed to extend Celo's use to primary care, and also to enable the upload of images from Celo into Health Connect South so that they become a part of the patient's clinical record.

Celo has been developed in partnership with Canterbury DHB as part of the health board's focus on using technology to improve healthcare for patients and staff.

Maternity services – plenty of options

Maternity services are provided from a number of facilities throughout Canterbury. Our aim is to reserve use of the Christchurch Women's facility for births that may require support from services that are only available in that setting and that uncomplicated births will generally occur elsewhere, including in our primary maternity facilities.

A range of recent activity supports this strategy:

- Information is provided to women and midwives describing the facilities available at Ashburton, Darfield, Kaikoura, Lincoln, Rangiora and St George's Maternity facilities;
- This includes a recently produced video providing a virtual tour of the facilities available at Rangiora (http://cdhb.health.nz/Hospitals-Services/maternity-services/Maternity-Facilities/Pages/Maternity-Facilities-at-Rangiora-Hospital.aspx);
- A second birthing pool has been installed at Lincoln Maternity Hospital. This is being promoted to women who are wanting to use water when the pool is in use elsewhere.
- Education is provided by midwives for women with newly diagnosed gestational diabetes at our Burwood facility.
- When birthing services are provided at Christchurch Women's the option of relocating to a primary birthing facility for post-natal care is promoted.

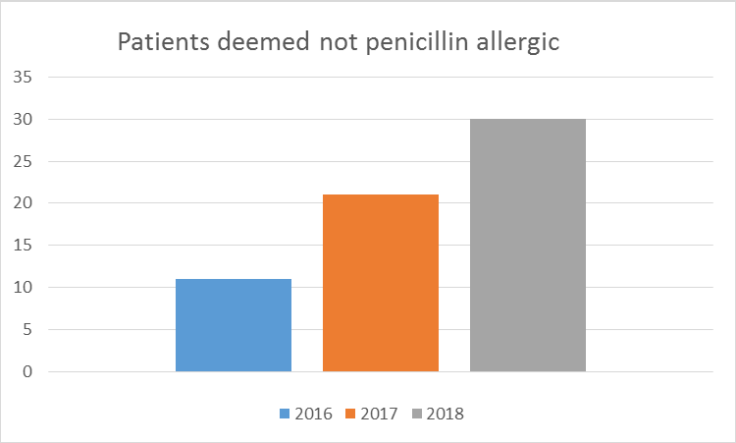
Changes in penicillin tolerance and allergy assessment.

Penicillin antibiotics are the most widely used antibiotics, however around 10% of the population is labelled as being allergic to these drugs. Doctors are reluctant to prescribe penicillin antibiotics to this group. The alternative antibiotic agents are often not as effective, cost more, and have more side effects such as gastroenteritis caused by Clostridium difficile. As a result this group can end up requiring more care to support their return to health which is disruptive for the patient and uses more health system resource.

However of those labelled as having penicillin allergy, around 95% do not have a previous history that is compatible with an allergy. Of the remaining 5%, 80% can tolerate a penicillin challenge. So, of 100 people labelled with penicillin allergy, 99 are likely to tolerate penicillin. The Immunology service at Christchurch hospital provides assessment for people who have been labelled as allergic to penicillin. Following referral from a general practitioner or hospital doctor a history of the person's reactions is discussed, followed by skin testing or laboratory testing, and ultimately a penicillin challenge.

When this service was initially offered it was provided from the Medical Day Unit. However, as we have developed our methods we have shifted the process entirely to the outpatient clinic, freeing space in the medical day unit for tasks that can only occur there.

Over the past three years more than 60 people have had their penicillin allergy status cleared, meaning that they are able to benefit from antibiotics in this group.

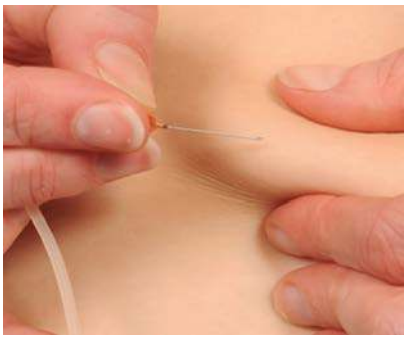


Developments in the future are likely to include simplification of our processes including moving directly to a penicillin challenge without the requirement for skin testing, a streamlined single appointment process for penicillin assessment and consideration of providing this work through a nurse specialist led clinic.

Transferring immunoglobulin treatment from hospital to home

Patients with antibody deficiency are susceptible to severe infections and require immunoglobulin replacement to stay healthy. For many people this means making a trip to hospital every three or four weeks for intravenous immunoglobulin therapy throughout their lives.

Provision of subcutaneous immunoglobulins has emerged as a simple way of receiving the treatment without requiring venous access. It is required on a weekly basis but with a small amount of training (two or three two hour sessions) and provision of the right equipment it can be self-administered at home. While it is required more frequently, the duration of each infusion is much shorter and the risk of significant reaction is much lower. Patients receive ongoing support through telephone and e-mail contact and technique is reviewed in nurse led clinics. Patients report that this option improves quality of life for them and their families and it is provided at a lower cost to both the hospital and patient. It frees up medical day unit capacity for other patient's whose therapy can only occur in that setting.



Since 2015, 11 of Canterbury's 26 patients requiring regular immunoglobulins have switched to sub-cutaneous infusion. Three out of Southern District Health Board's 14 patients and three patients from Nelson have also switched to this method.

Linwood Medical Centre and Diabetes Service working to develop new ways of working.

An update was provided in March describing a project being carried out in partnership between Linwood Medical Centre and the specialist diabetes service to improve the care for people with diabetes in the community. Two recent developments in this work include:

- The Linwood specialist diabetes clinic is working with Sports Canterbury to host a Diabetes Be Active programme pilot again. The original programme will be updated to provide key messages about diabetes self-management in a community setting. This material has previously been taught at specialist classes and it is exciting to see these being built into a community level program. Our aim is to achieve a sustainable diabetes specific programme via Green prescription (Sports Canterbury) with improved uptake within the

Linwood locality. This will enable other primary care practices to also refer their patients into the Diabetes Be Active program. This means that patients will benefit from insights and information that will help them to manage their condition in the community without the need to visit a hospital service.

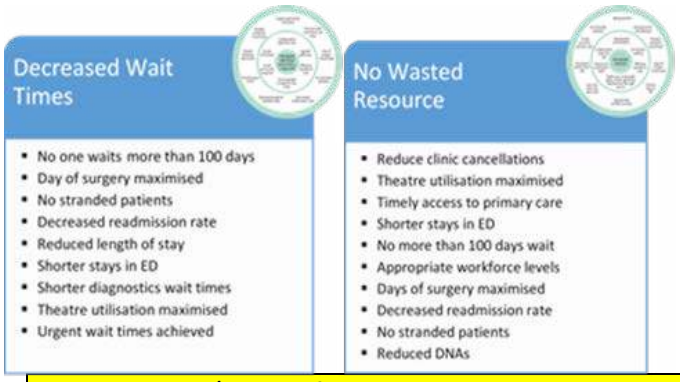
- Alongside this we continue to focus on improving the uptake of retinal screening amongst patients with diabetes who attend the Linwood Medical Centre. Early analysis of retinal screening results has resulted in an urgent referral back to the eye department, plus the need for many to be re-referred. The Ophthalmology department is now working closely with us and supportive of a coordinated approach to improving the 30% retinal screen rates for Linwood Medical Centre diabetes patients.

Community Infusion Service.

The Medical Day Unit at Christchurch Hospital provides a range of treatments to patients who have medical conditions or cancers. Patients attend the unit only for as long as is required for them to receive their treatment – this may be as short as one hour up to six hours. For most patients the treatment provided involves intravenous administration of drugs or blood products. This ambulatory model has become increasingly popular and this has resulted in an ongoing increase in demand for services from the Medical Day Unit and provides us with a risk that we will be unable to provide essential services in an appropriate setting.

Within the group of patients who receive treatment in this unit there are cohorts of patients whose treatment does not need to be in a secondary hospital setting. Clinicians have worked with Planning and Funding to define infusion services that can safely be carried out in the community and a provider has been identified to carry out this work.

From July this year lower complexity infusions are being provided from two medical practices in Christchurch. This provides a more convenient setting for many patients, avoiding a visit to Christchurch hospital and releases Medical Day Unit capacity to be used for other patients. The number of practices participating will increase over time as the service expands.

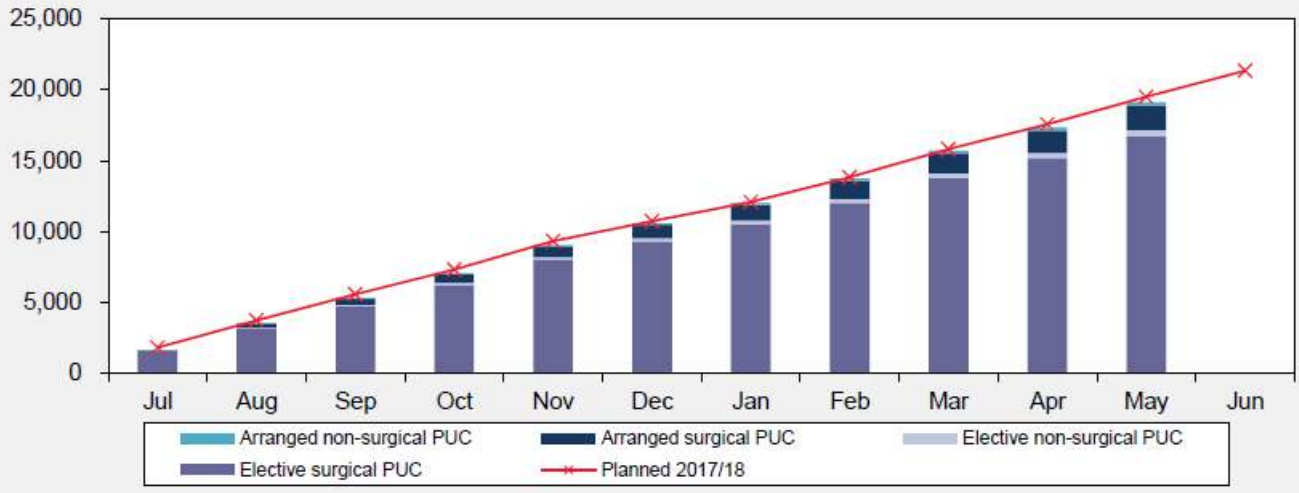


Theatre Capacity and Theatre Utilisation

Achievements/Issues of Note

Health Target ▼ 98.0%

	2017						2018					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Planned	1,824	3,742	5,574	7,330	9,335	10,737	12,073	13,827	15,808	17,556	19,489	21,330
Actual	1,624	3,539	5,311	7,044	9,054	10,591	12,015	13,742	15,704	17,325	19,108	
Variance	-200	-203	-263	-286	-281	-146	-58	-85	-104	-231	-381	
%Achievement	89%	95%	95%	96%	97%	99%	100%	99%	99%	99%	98%	



Ministry of Health reporting shows that following May 2018 Canterbury District Health Board was running 381 discharges (round 2%) behind its Elective Health Target. Internal reporting, which is more up-to-date, shows that at the end of June we have provided more elective and arranged discharges than planned.

Within this, it is clear that in-house delivery is above planned levels and outsourced discharges are running shy of target. Catching up on delayed data entry along with some corrections being put in place will increase the outsourced count. We will meet the Elective Health Target at the end of June. Note however that there is a mismatch between target and delivery in the various sub-categories (i.e. arranged versus elective and between specialties). For example, we have provided 310 more arranged discharges than planned. This represents good practice, as it ensures that patients receive surgery soon after an acute event, without having to be waitlisted. Canterbury District Health Board is working through these mismatches with the Ministry of Health.

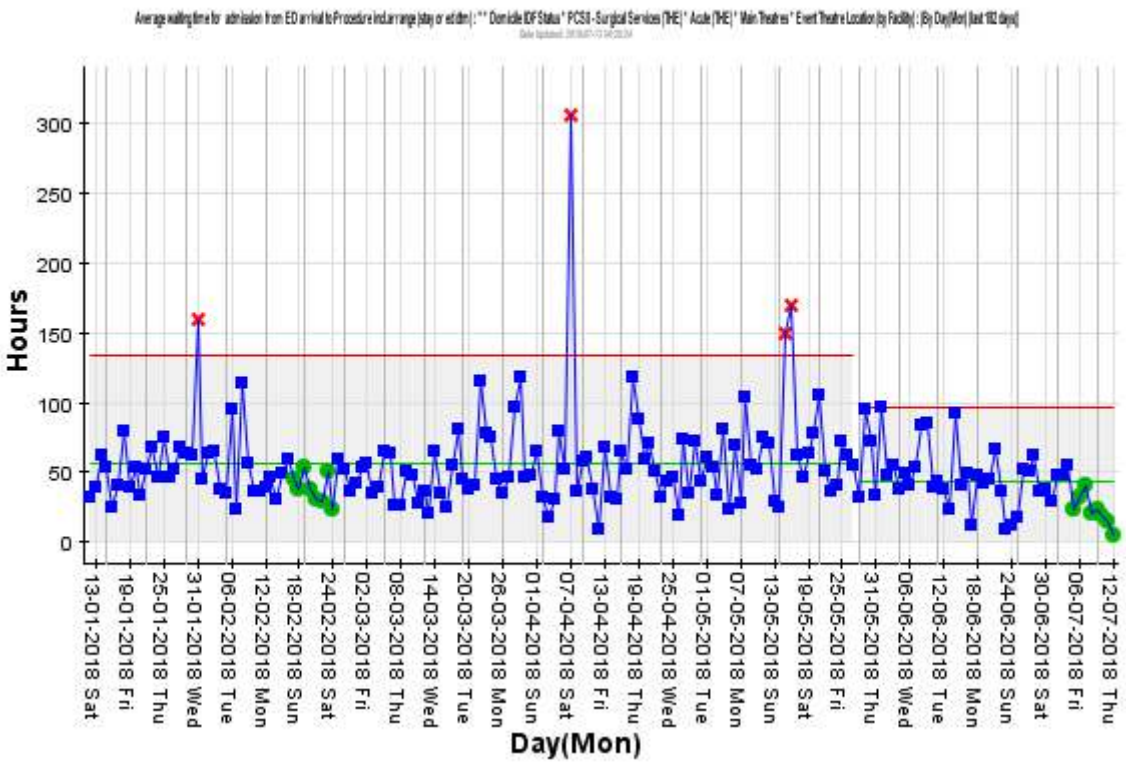
Achieving this outcome has required a deliberate effort from all services involved. For example, General Surgery has been constantly monitoring how many elective discharges it has been providing throughout the year, and regularly fine tuning the way it is working to ensure that in-house and outplaced delivery was higher than its target. This has been achieved by holding extra hernia and gallbladder clinics and backfilling as many theatre sessions as physically possible.

Timely acute surgery

In the last iteration of this report an update was provided indicating that more capacity for acute surgery was being developed by increasing the outplacing of elective surgery.

Early indications are that this is proving effective and providing a much closer match between incoming acute surgery and the capacity available for it to occur each week.

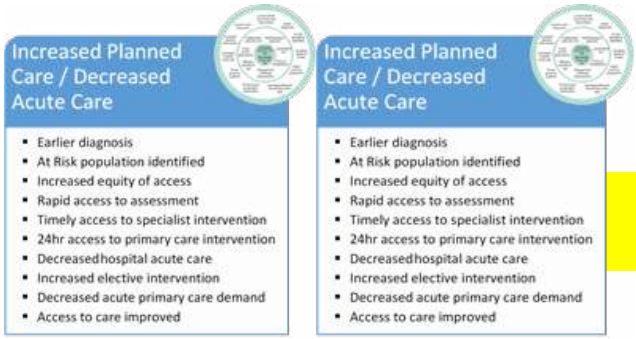
The average time that patients spend waiting for their first operation is showing much less day-to-day variation and has reduced.



The number of patients waiting for acute surgery for more than two days was lower in June than it had been since September 2017. This measure will be monitored to assess whether this is a significant and sustainable change.

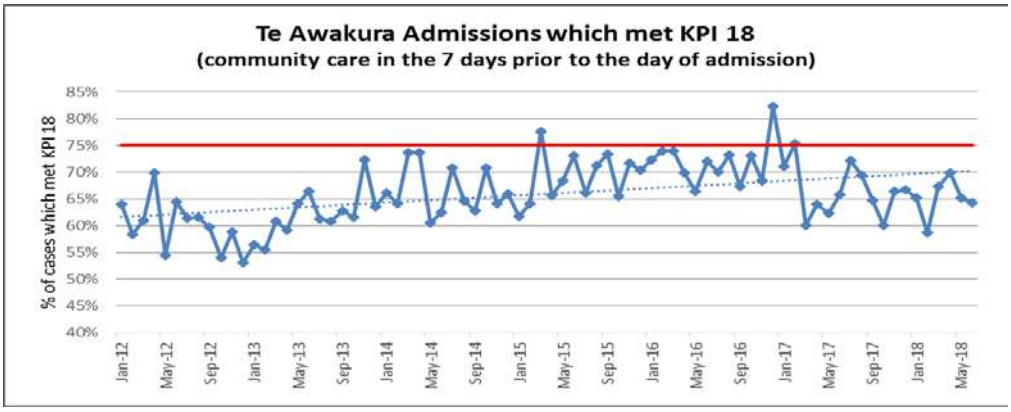
The opening of Christchurch Hospital Hagley in 2019 will provide a significant increase in theatre capacity on the Christchurch Hospital campus, from 18 physical theatres to 28. This increase will enable us to repatriate all outplaced surgery and the majority of outsourced surgery. There is a particular focus on increasing scheduled acute operating capacity. This will enable us to much better manage the time that patients spend waiting between acute admission and their first operation. It will also enable us to eliminate the need to send patients to Burwood for operations for acute and arranged surgery, freeing up capacity at Burwood for elective operating.

This increased acute theatre capacity during week days will enable us to reduce the growth in late and weekend theatre capacity. It will support a reduction in length of stay for acute surgical patients due to a reduction in the time spent waiting in hospital for surgery along with reducing deconditioning that occurs while patients wait for surgery. Supporting reduction in length of stay is essential to ensure that we remain within available bed capacity.

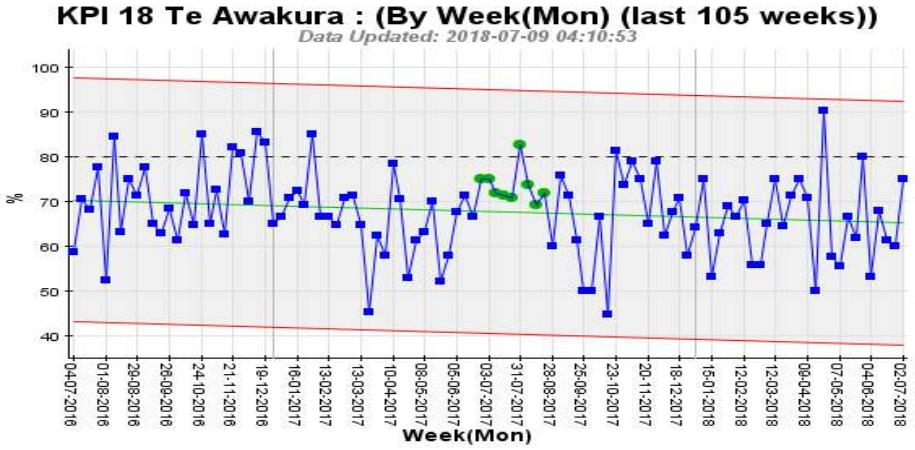


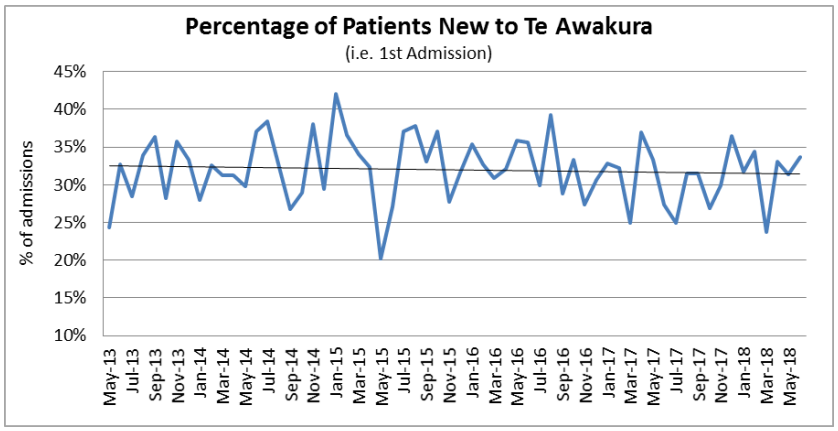
Adult Services

KPI 18 is an indicator of how well engaged we are with the consumers in our services. In May 2018, 65.2% of acute admissions to Te Awakura had a community contact in the seven days prior to the date of their admission. In June 2018 the figure was 64.2%.

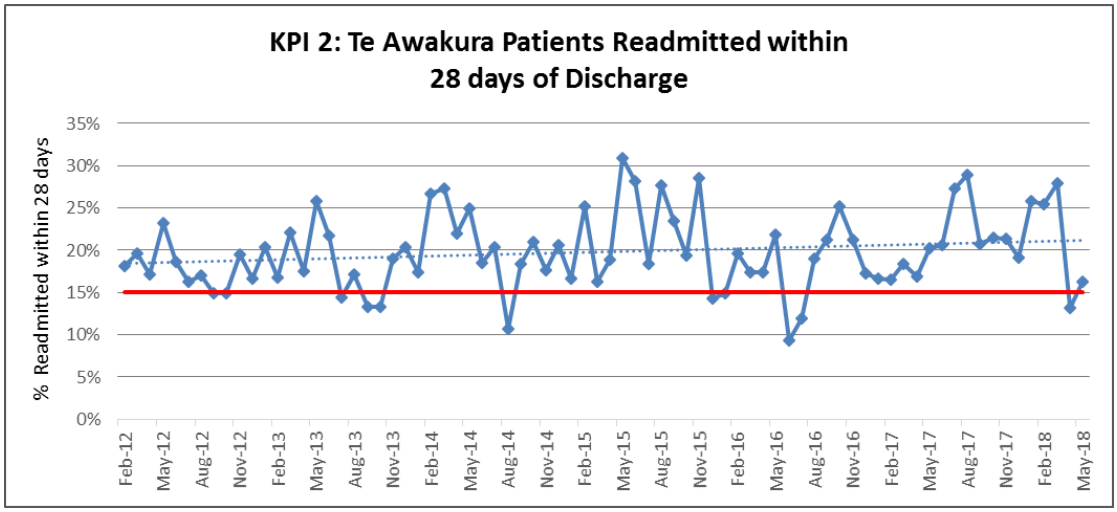


The graph below shows a weekly view of KPI18:

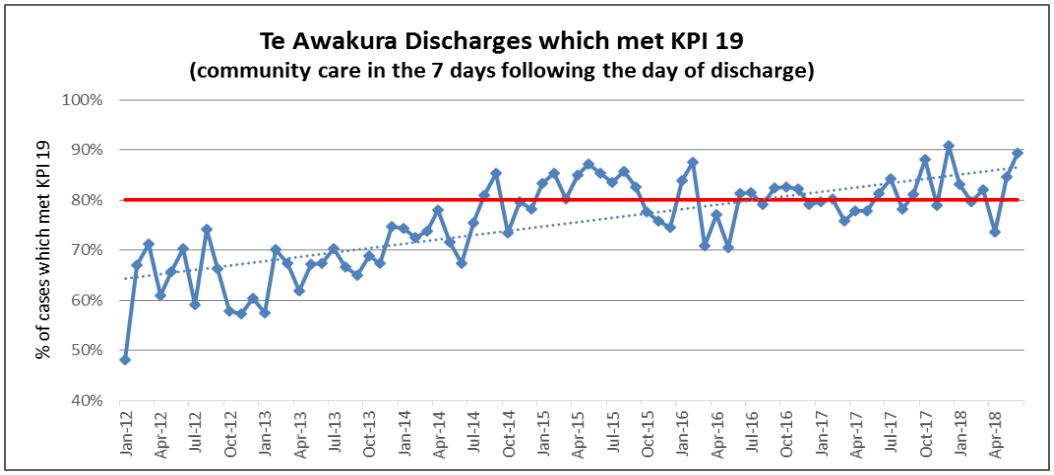




In June 2018, 34% of people admitted to Te Awakura were new (had not been admitted there previously).

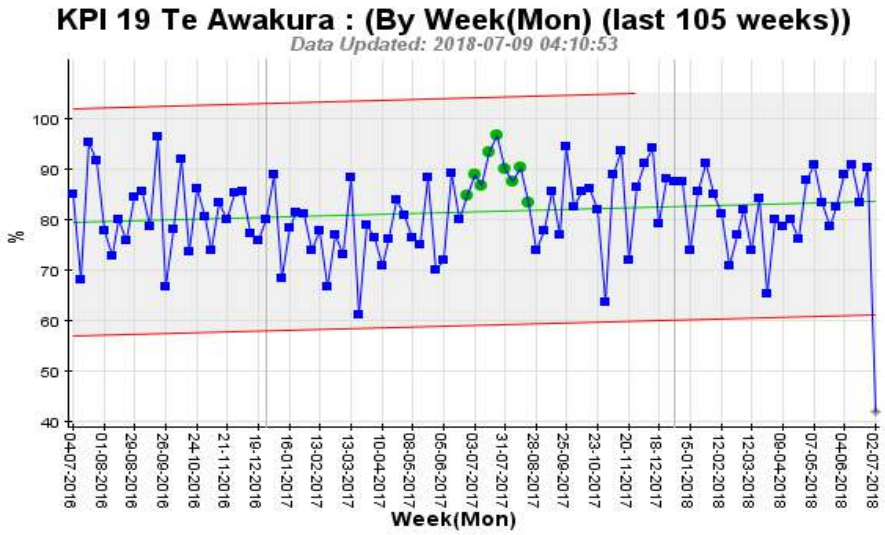


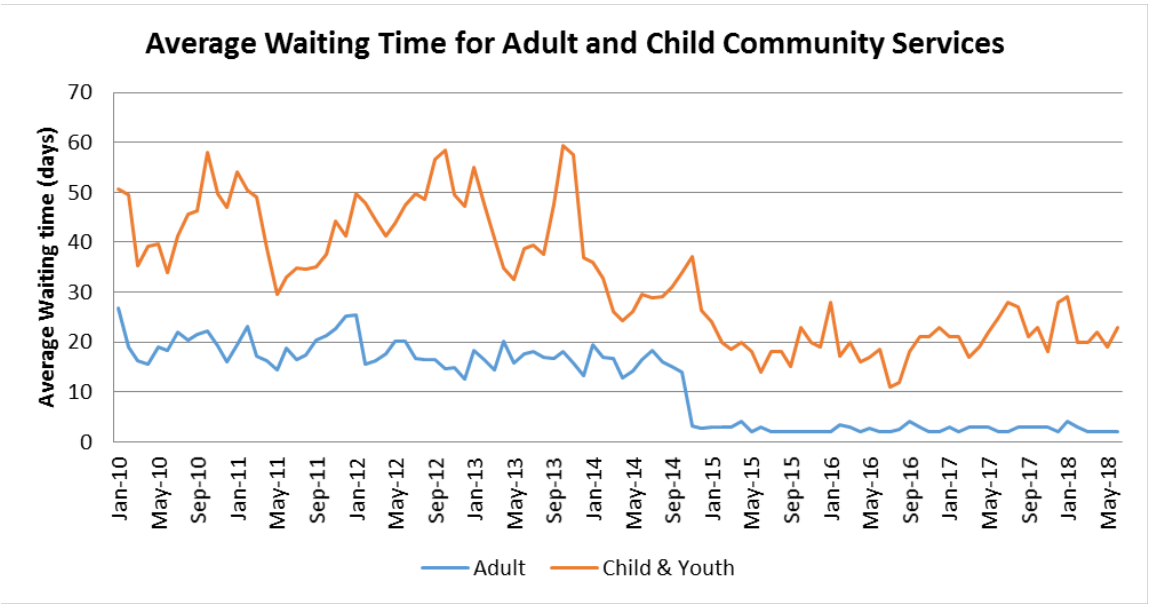
The graph above shows the readmission rate within 28 days of discharge. Of the 117 Te Awakura consumers discharged in May 2018, 16.2% were readmitted within 28 days. Readmission rates are closely monitored.



KPI 19 is a key suicide prevention activity and patient safety measure. In June 2018, 89.5% of consumers discharged from Te Awakura received a community care follow-up within seven days of discharge, and so met KPI 19.

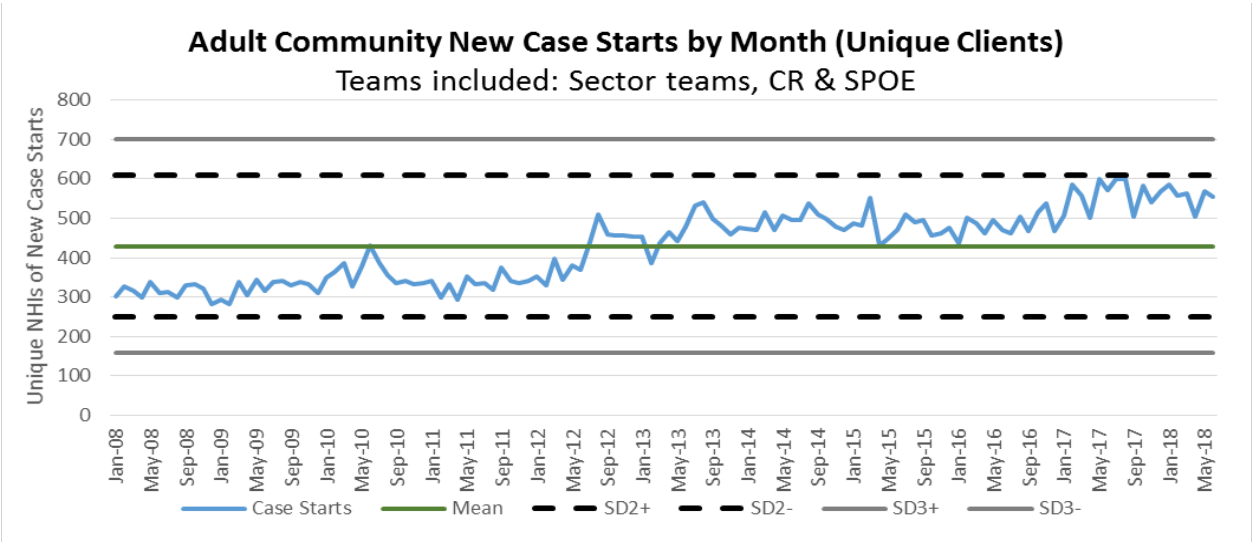
The graph below shows a weekly view of KPI19:



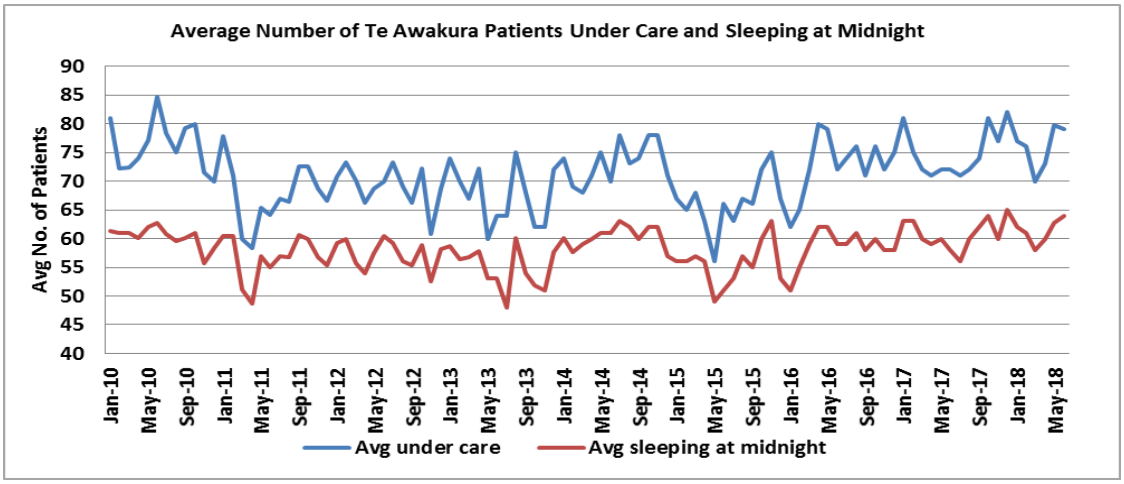


The graph above shows there has been an overall reduction in the time people spend waiting. Ministry of Health targets for these services require 80% of people to be seen within 21 days and 95% of people to be seen within 56 days. The average waiting time for adults was 2 days for June 2018. Our results for the Adult General Mental Health Service show 96.3% of people were seen within 21 days of referral in June 2018 and 99.4% were seen within 56 days of referral. This result is occurring in the context of significant increase in demand.

For child and family services the average waiting time was 23 days for June 2018. Reducing wait times has been a key focus for CAF services. Our results show 64.6% of people were seen within 21 days of referral in June 2018 and 90.1% were seen within 56 days of referral.

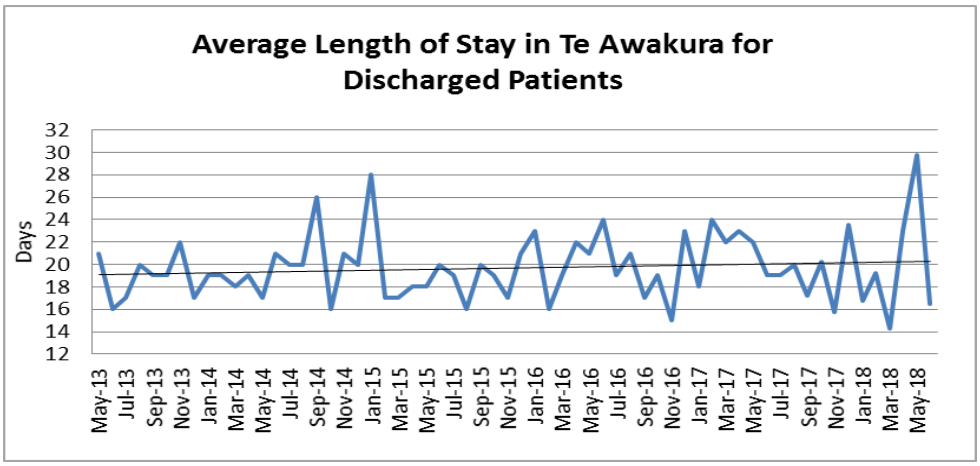


New cases were created for 555 individual adults (unique NHIs) in June 2018.

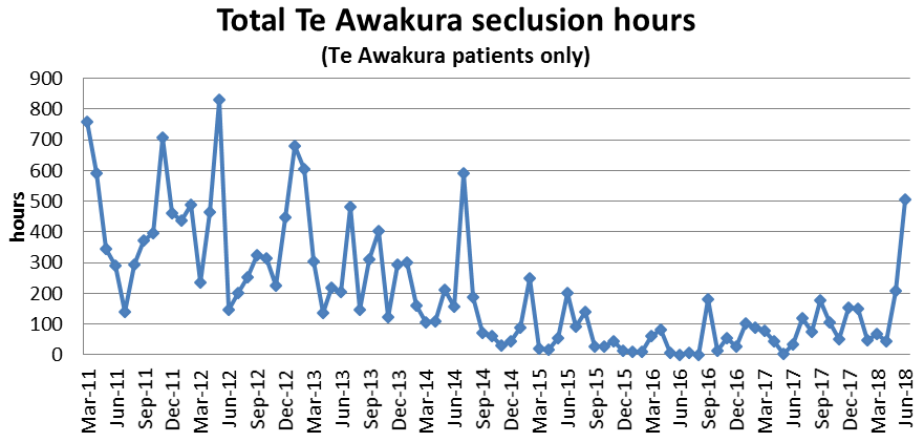


85% occupancy is optimal for mental health acute inpatient services.

Occupancy in Te Awakura (the acute inpatient service) remains above this figure. Occupancy was 98% in May and 100% in June 2018. The average number of consumers under care in this 64 bed facility was 80 in May and 79 in June 2018. There were 27 sleepovers during May and 35 sleepovers during June 2018.

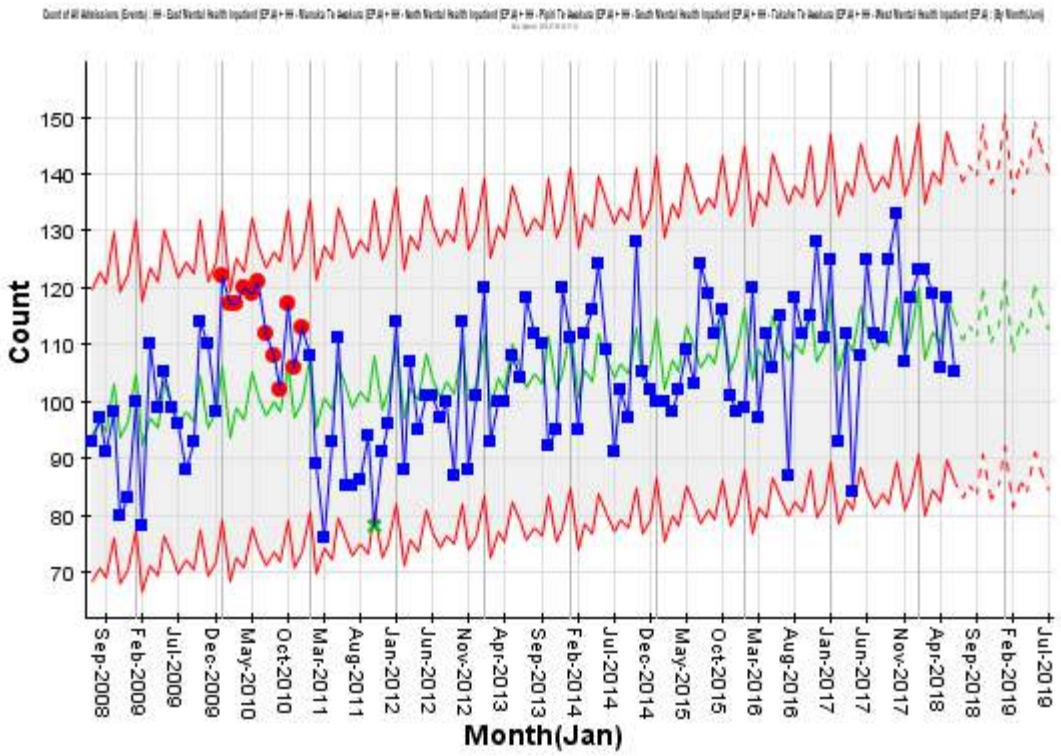


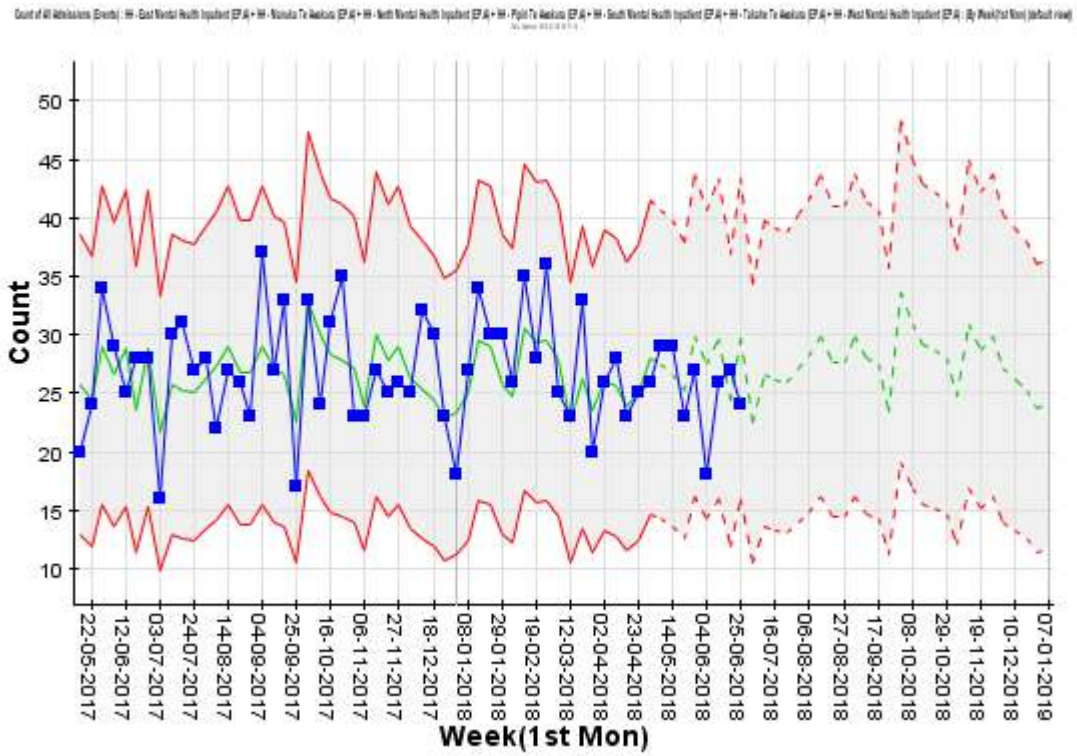
The average length of stay for consumers discharged from Te Awakura during May was 30 days and June 2018 was 17 days. We are closely monitoring length of stay in terms of difficulties with accommodation supply in Christchurch.



Our focus on reduction of seclusion in Te Awakura continues with a significant reduction overall. In June 2018, nine consumers experienced seclusion for a total of 504.2 hours. 80% of those hours were experienced by one person. There is strong and effective nursing leadership and staff dedication and commitment to maintain the focus of reduction.

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) continues to show an overall upward trend.



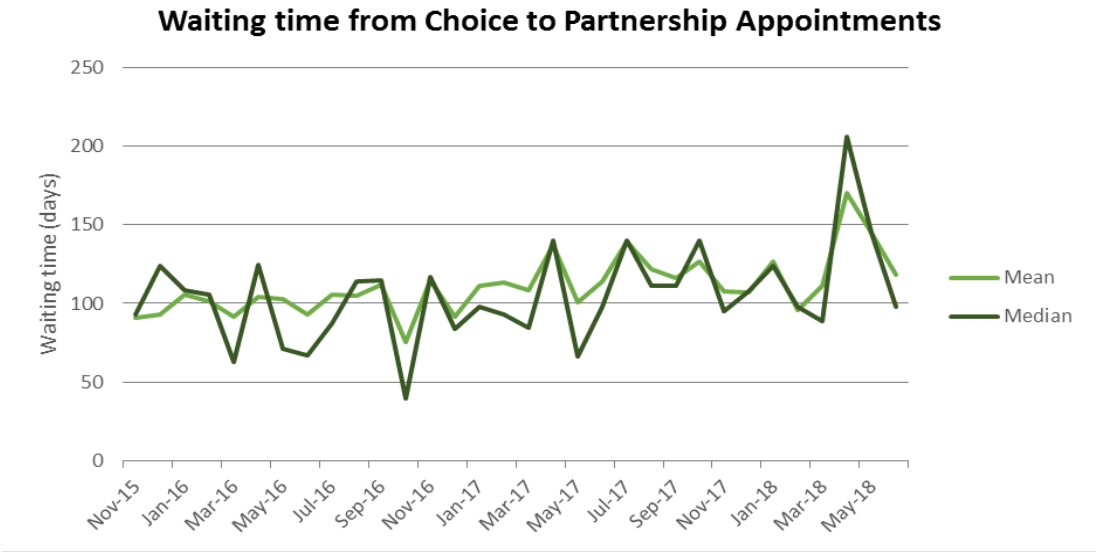


Child and Youth

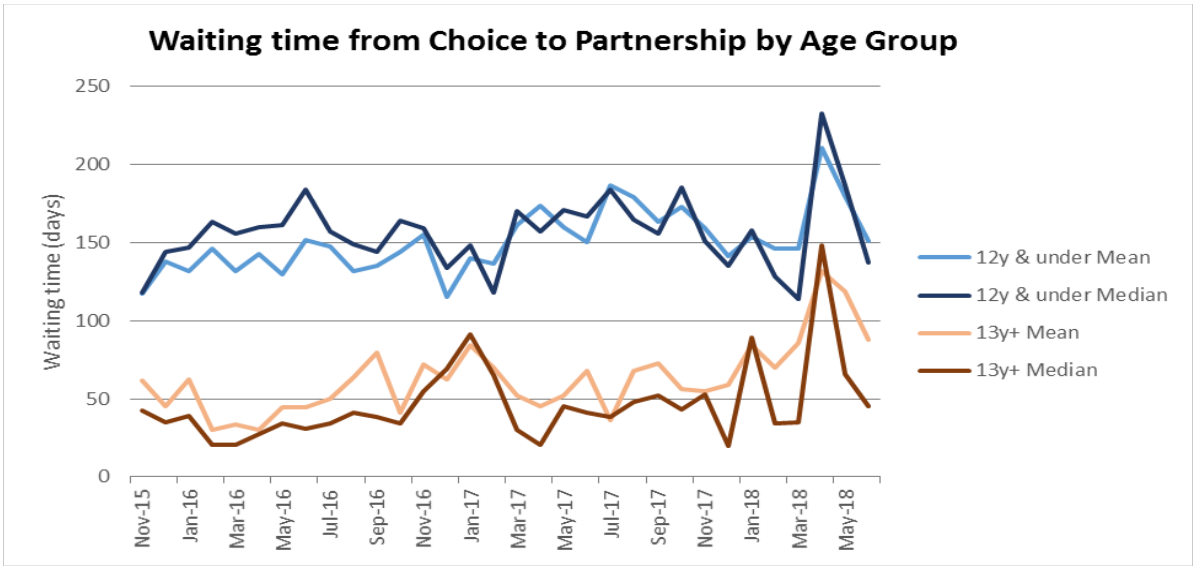
There has been a 100% increase in child and adolescent case starts in the past eight financial years.

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

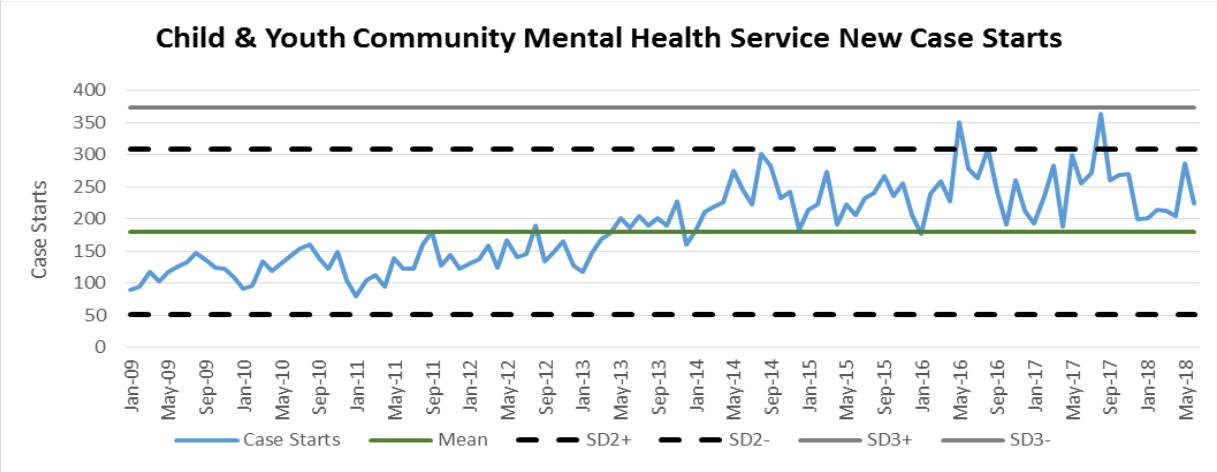
The graphs below show the waiting time between Choice (1st) and Partnership (2nd) appointments. Children and adolescents assessed as being of very high priority go straight to a Partnership appointment, bypassing the Choice appointment process.

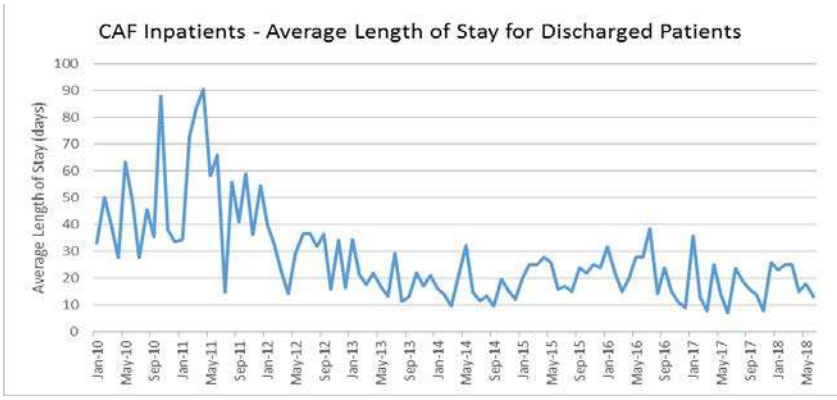


Lately Child, Adolescent and Family Services has been identifying consumers with possible ADHD and sending them straight to a Partnership appointment in an effort to reduce their waiting list. In April 2018 the majority of CAF North consumers who attended a Partnership appointment had not attended a Choice appointment (only five CAF North consumers are included in the April 2018 figure above). This was not the case for the CAF South team, who have a greater number of consumers waiting, and a longer average waiting time from Choice to Partnership. CAF South have been actively trying to target their consumers waiting the longest. As a result there is a marked increase in waiting time shown in the graph above for April 2018.



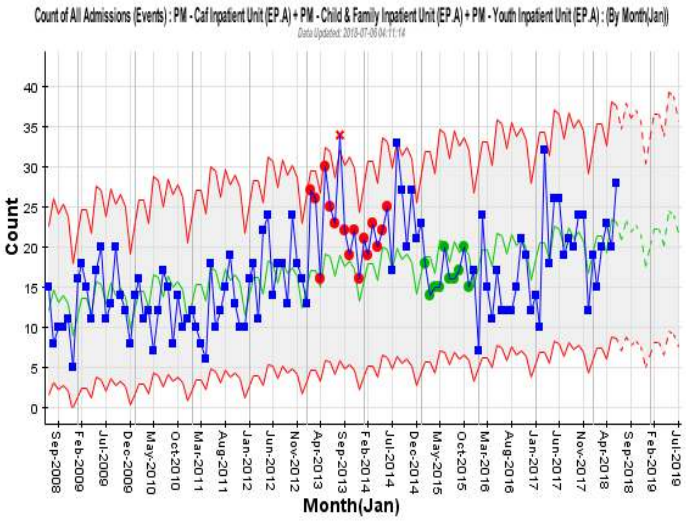
There were 224 new CAF case starts in June 2018. CAF services are making good progress with implementation of a Direction of Change that supports more integrated services across the age ranges.

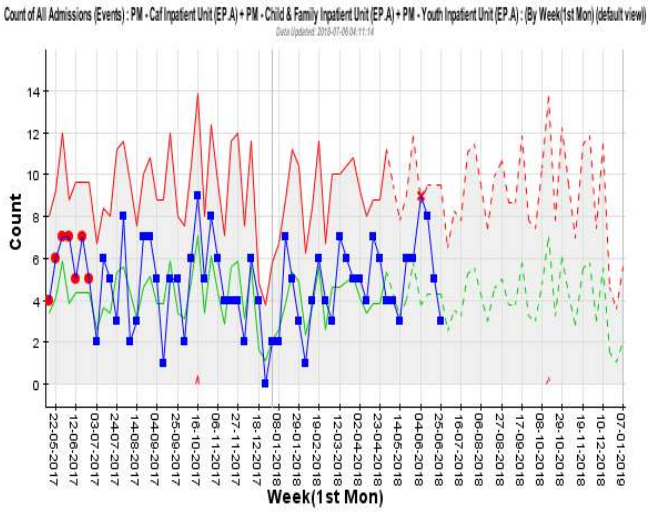




The average length of stay for discharged patients was 18 days for May and 13 days for June 2018.

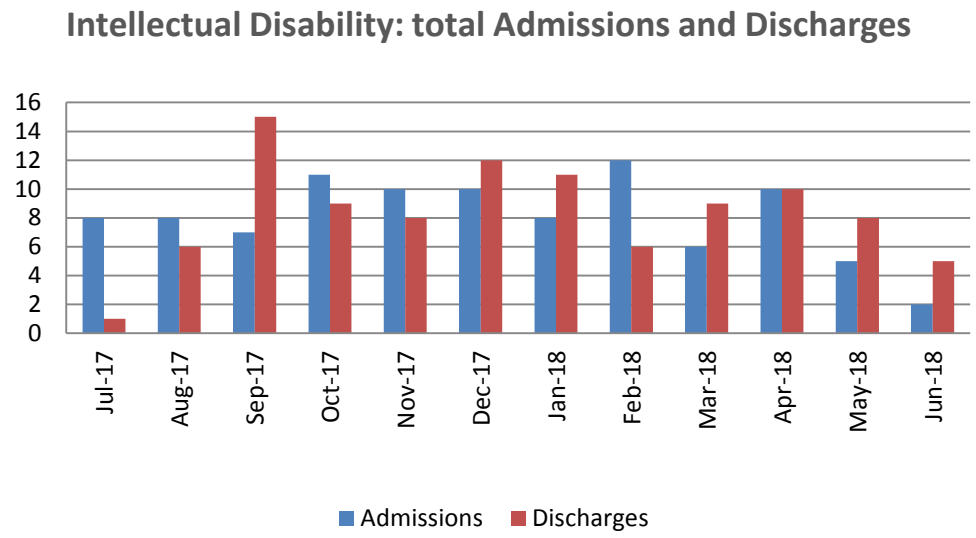
The graphs below show the number of admissions to the Child and Adolescent Unit and its predecessors. The first graph is a monthly view, and the second a weekly view.

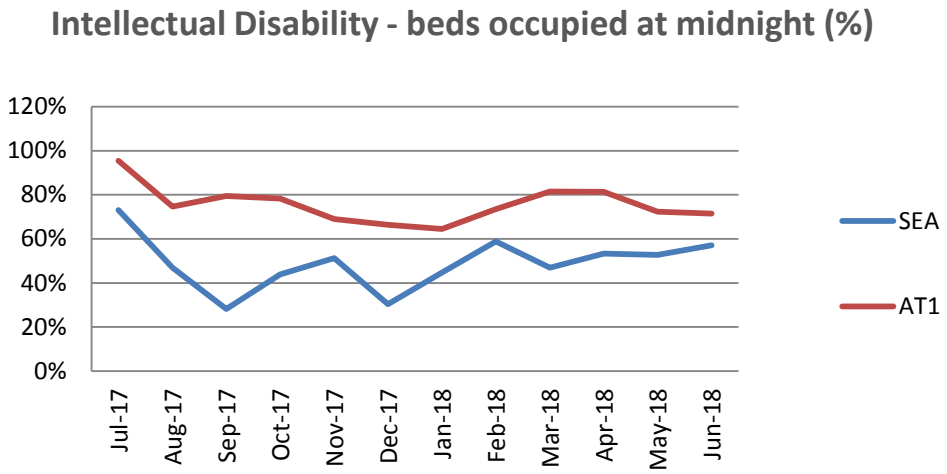




Intellectually Disabled Persons Health Service

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





Occupancy in AT&R (AT1) was 72% for the month of May and 71% for June 2018. The figures for PSAID (SEA) were 53% and 57% respectively.

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 12 Months Ended 30 June 2018

MONTH $'000						YEAR TO DATE				
17/18 Actual $'000	17/18 Budget $'000	16/17 Actual $'000	17/18 Variance $'000	17/18 vs 16/17 Variance $'000		17/18 Actual $'000	17/18 Budget $'000	16/17 Actual $'000	17/18 Variance $'000	17/18 vs 16/17 Variance $'000
					Operating Revenue					
503	275	319	228	184	From Funder Arm	7,095	3,291	3,388	3,804	3,707
1,617	1,955	1,991	(338)	(374)	MOH Revenue	18,479	24,470	22,173	(5,991)	(3,694)
3,576	4,501	5,122	(925)	(1,546)	Patient Related Revenue	49,901	53,857	49,696	(3,956)	205
1,355	1,231	651	124	704	Other Revenue	16,286	13,329	12,840	2,957	3,446
7,051	7,962	8,083	(911)	(1,032)	**TOTAL OPERATING REVENUE**	91,761	94,947	88,097	(3,186)	3,664
					Operating Expenditure					
					Personnel Costs					
57,581	56,121	52,485	(1,460)	(5,096)	Personnel Costs - CDHB Staff	670,387	658,382	630,961	(12,005)	(39,426)
2,136	1,770	2,067	(366)	(69)	Personnel Costs - Bureau & Contractors	22,422	20,020	19,709	(2,402)	(2,713)
59,717	57,891	54,552	(1,826)	(5,165)	**Total Personnel Costs**	692,809	678,402	650,670	(14,407)	(42,139)
11,693	12,600	11,444	907	(249)	Treatment Related Costs	141,729	143,084	136,331	1,355	(5,398)
3,368	3,723	4,950	355	1,582	Non Treatment Related Costs	43,323	47,053	47,192	3,730	3,869
74,778	74,214	70,946	(564)	(3,832)	**TOTAL OPERATING EXPENDITURE**	877,861	868,539	834,193	(9,322)	(43,668)
(67,727)	**(66,252)**	**(62,863)**	**(1,475)**	**(4,864)**	**OPERATING RESULTS BEFORE INTEREST AND DEPRECIATION**	**(786,100)**	**(773,592)**	**(746,096)**	**(12,508)**	**(40,004)**
					Indirect Income					
-	3	4	(3)	(4)	Donations & Trust Funds	46	37	92	9	(46)
-	**3**	**4**	**(3)**	**(4)**	**TOTAL INDIRECT INCOME**	**46**	**37**	**92**	**9**	**(46)**
					Indirect Expenses					
3,162	2,714	2,574	(448)	(588)	Depreciation	26,879	28,548	26,989	1,669	110
90	-	-	(90)	(90)	Loss on Disposal of Assets	136	-	14	(136)	(122)
3,252	**2,714**	**2,574**	**(538)**	**(678)**	**TOTAL INDIRECT EXPENSES**	**27,015**	**28,548**	**27,003**	**1,533**	**(12)**
-	-	-	-	-	Intra Division/Organisation Wide	-	-	-	-	-
(70,979)	**(68,963)**	**(65,433)**	**(2,016)**	**(5,546)**	**TOTAL SURPLUS / (DEFICIT)**	**(813,069)**	**(802,103)**	**(773,007)**	**(10,966)**	**(40,062)**

Summary of initiatives

Indication of Latest Efficiencies (including costs avoided)

		Core Financial Benefit			Ancillary Benefit	
		Budgetary Benefits			Non Budgetary Benefits	
Service	Name of initiative/project	Investment for project	$ savings	Financial year of savings	Costs avoided to date	Non-Financial Efficiency
Campus finance	Coordination of high volume capital purchases					Released time in creating and responding to BC
General Surgery	General Surgery's ongoing focus on admin team efficiency.					Previously accounted for
Pharmacy	E-pharmacy upgrade			✓		Released time in transacting imprest & charted medications
ChCH Campus	Improved processes for ACC prior approval		$130k	2017/18 forward		
Ashburton & Rural Health Services	Equipment/Mattress - end of rental	$71k (CAPEX)	$110k pa	18-19 onwards		
Ashburton & Rural Health Services	Park Street - End Lease	$27k (CAPEX)	$45k pa	18-19 onwards		
Ashburton & Rural Health Services	Medical Model of Care	-	$260k (2017-18 FY) $250k (2018-19 Budget)	17-18 onwards		
Ashburton & Rural Health Services	Community Tenants - end of the lease	-		18-19 (Sept'18 onwards)		Minimising insurance, H&S and insurance risks.
Ashburton & Rural Health Services	Service Contracts - vehicle maintenance and podiatry services	-	$9k pa	17-18 onwards		
Ashburton & Rural Health Services	Chatham Telehealth - reduction in patient transfers and life flights		$25-30k per patient	17-18 onwards		
Ashburton & Rural Health Services	AAU - increase in presentations (approx 34% increase)			17-18		Managed within the existing staffing resources.

Achievements/Issues of Note

Coordination of high volume capital purchases throughout the organisation.

Items such as beds, physiological monitors, intravenous pumps and refrigerators are used in wards right across the District Health Board. Previously purchasing of these items was coordinated at a facility level with the result that many business cases for the purchase of these relatively high volume minor capital items converged on Corporate Finance for processing each year. We are now taking a coordinated approach to managing these capital purchases centrally. Recent work in this area includes development of a single register of all beds owned by the organisation based on existing information in Maximo and the result of a bed audit. This has allowed analysis of the age and model of existing beds and is allowing us to prioritise replacement more deliberately. This has become more

important because over the past few decades the use of motorised technology in beds, required to support the health and safety of both patients and staff, has reduced the life expectancy of beds. Taking a coordinated approach will reduce transactional costs associated with developing and responding to multiple business cases from several sites, will enable a consistent approach to the prioritisation of replacement and allow us more leverage on prices through a more structured approach to procurement.

A system has been developed to analyse data from AeroScout, a centralised system used to measure and record refrigerator and drug room temperatures, enabling us to target our replacement of refrigerators. Priority has been given to replacing drug and vaccine refrigerators that were alarming the most often. The coordinated approach has enabled us to take a consistent approach to the specification of refrigerators purchased to store drugs in. Domestic refrigerators used for this task are being replaced with medical fridges. This approach has helped us to avoid the expense associated with discarding expensive medicines because of refrigerator failures.

General Surgery's ongoing focus on admin team efficiency paying off.

Previous updates have outlined changes put in place by the booking team in General Surgery that are allowing it to release time to other tasks including assisting other services. Over recent months this freed capacity has allowed it to focus on cleansing old data – an essential step as we prepare to transition from Homer to the Patient Information Care System. This has included assisting other services with cleansing their data, wait listing of their patients and sharing their experience so that all services are supported to continue their vital role of booking patients for clinics and surgery in an efficient manner throughout the upcoming changes.

General Surgery's Medical Secretaries have also been improving the way that they work with a focus on reducing the time taken to turn dictation around. Over the past six months the average turnaround time has reduced by nearly 20% from 2.2 to 1.8 days despite an increase in both the number of jobs and total time required to transcribe (there were 1,316 transcription jobs in November 2017 and 1,811 in May 2018, a 38% increase).

ePharmacy Upgrade Update

The Pharmacy Service in conjunction with ISG recently completed a major upgrade of its ePharmacy software and some associated hardware. Our previous ePharmacy version did not have the ability to talk with MedChart as they used different dictionaries of drug names. This meant that while charting occurred electronically in the wards pharmacy staff then manually transcribed the required information into the pharmacy system, printed off a dispensing request for the items required and dispensing was carried out on this basis.

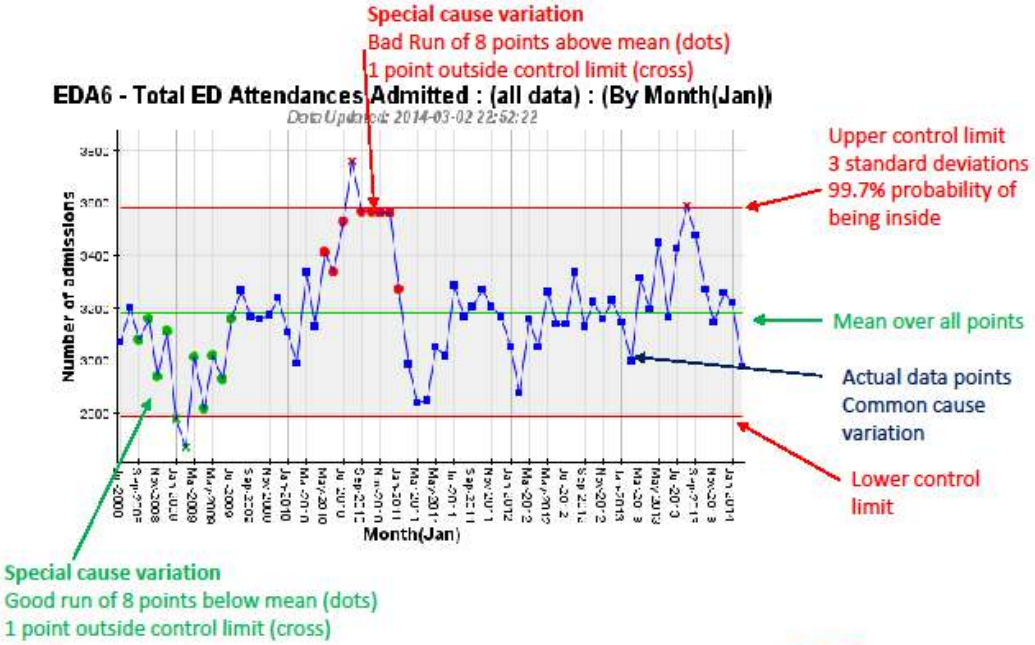
Implementing these two systems has occurred over several years and taken many hours of project manager, pharmacist and other clinician time. The upgrade means that the two systems will be able to be integrated later this year, once MedChart has undergone its next upgrade. This will enable MedChart to auto-populate the pharmacy system with dispensing requirements, avoiding manual transcription. Our aim is that it will also enable tracking of dispensing request status by nursing staff. It has also allowed the introduction of wireless, android bar-code scanners which enable real-time uploading of ward imprest stock requirements and more efficient processing of this data. This will impact most on nurse aide workflow as stock will be delivered sooner in the day. Integration will ensure transcription errors are avoided.

Later this year, the new system will enable our dispensaries to go paperless for all inpatient dispensing transactions, releasing time to other tasks and reducing paper record transport and storage costs.

Pilot - rapid FLU testing pathway

As the FLU season approaches, Canterbury Health Laboratories is implementing a pilot to assess new platforms for rapid respiratory virus testing. The two platforms will be trialled to assess the impact on patient flow within the Hospital, with results being available in approximately 30 minutes for the abbreviated panel and approximately 70 minutes for the extended panel. The current turnaround time is around 24 hours, during the working week. Multi-disciplinary conversations, involved acute clinical teams, infection prevention and control, data analysts and laboratories have resulted in co-design of a pilot protocol to see if rapid diagnosis (or exclusion) of respiratory viruses (in particular, influenza) can have any positive impacts on patient flow, utilisation of isolation spaces and patient cohorting, administration of anti-viral treatment and length of stay.

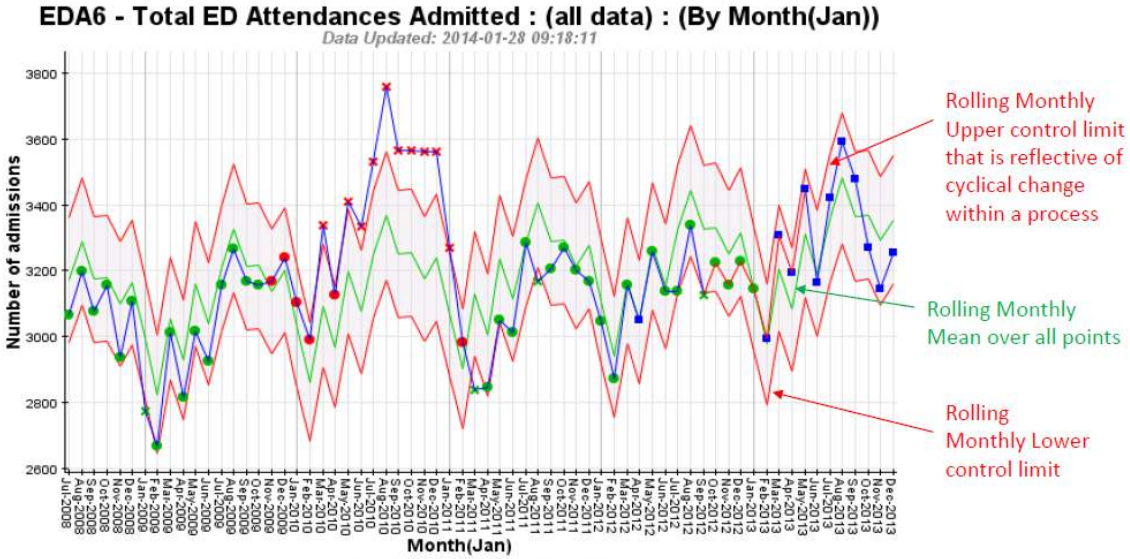
SPC: How to Interpret a Control Chart



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

SYSTEM LEVEL MEASURES FRAMEWORK

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

SOURCE: **Planning and Funding**

DATE: **2 August 2018**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This paper is to provide the Hospital Advisory Committee with an update of the Canterbury Health System's implementation of the national System Level Measures framework.

2. RECOMMENDATION

That the Committee:

i. notes Canterbury's Implementation of the System Level Measures Framework;
ii. notes Canterbury continues to trend favourably against the System Level Measures;
iii. notes the work underway to finalise Canterbury's 2018-19 System Level Measures Improvement Plan; and
iv. notes Canterbury's 2018-19 focus on wider health provider engagement in actions to progress Canterbury's performance.

3. SUMMARY

This report provides an update on the national System Level Measures framework and Canterbury's implementation of the System Level Measures within our broader Outcomes Framework. A presentation on Canterbury's performance against the System Level Measures will be provided to the Hospital Advisory Committee on 2 August 2018 to supplement this information.

4. DISCUSSION

Background

On 1 July 2016 the Ministry introduced an outcomes oriented approach to measuring health system performance through implementing the System Level Measures framework. This included the identification of six System Level Measures:

- number of acute hospital bed days per capita;
- ambulatory sensitive hospitalisations rates for 0 to 4 year olds;
- patient experience of care;
- amenable mortality rates;
- youth access to and utilisation of youth appropriate health services; and
- the number of babies who live in a smoke-free household at six weeks post-natal.

Each district Alliance was tasked with jointly driving the implementation of the System Level Measures framework, including:

- Agreeing on Milestones and a set of Contributory Measures for each of the System Level Measures;
- Submitting an Improvement Plan, jointly developed by the Alliance partners, that documents the locally agreed milestones and Contributory Measures; and describes specific activities that will be undertaken to achieve the measures; and
- Report quarterly on progress toward achieving the agreed milestones.

Canterbury's Implementation of the System Level Measures

In keeping with the Ministry's requirement over the last two years, Canterbury has:

- Annually agreed Milestones and Contributory Measures
  Leaders across the system continue to identify and refine Contributory Measures to reflect local priorities and agree on Milestones as a measure of progress.
- Embedded the System Level Measures into work plans across the Canterbury Health System
  Various specialist groups (including work streams, service level alliances and project groups within the Canterbury Clinical Network), are tasked with championing the Contributory Measures. This includes identification and delivery of activities that support improvement in the Contributory Measures and reporting on progress.
- Established a System Outcome Steering Group of System Leaders
  This group has guided Canterbury's implementation of the System Level Measure framework including: completion of Canterbury's Implementation Plan, monitoring overall performance against the measures, and engagement with the Ministry on future System Level Measures. Development.

Canterbury's Performance

Canterbury's System Level Measures Q3 2017/18 report indicates that Canterbury is progressing favourably against the six System Level Measures and completing the *Actions to Improve Performance* included in the 2017-18 Improvement Plan. Key achievements include:

- The completion of a summer studentship exploring the Ambulatory Sensitive Hospitalisation (*ASH*) rates for Pasifika children in Canterbury. This work contributes to Canterbury's understanding of the ethnic variation between the 0-4 year olds ASH rates for Canterbury's Total and Pacific populations and informs the next steps towards addressing this inequity.
- An increase in the proportion of pre-school children enrolled in Canterbury's Community Dental Service from 61% in 2016, to 76% in 2017. The LinKIDS multiple enrolment form, introduced in May 2017, has contributed to this change.
- An increase in the proportion of general practices using the Primary Care Patient Experience Survey to access information from their patients from 55% in Quarter Two to 62% in Quarter Three.
- An increase in the number of people with a mental illness getting support to improve their physical health and wellbeing from 964 people in Quarter Two, to 1,170 in Quarter Three.
- The establishment of an Oral Health Service Development Group to identify and prioritise actions that will increase the number of adolescents accessing Dental Services.

Next Steps

Completion of Canterbury's 2018-19 Improvement Plan

A draft 2018-19 Improvement Plan was submitted to the Ministry on 2 July 2018. An illustration of Canterbury's 2018-19 System Level Measures and its alignment with the Canterbury Outcomes Framework is provided in Appendices 1 and 2.

The Ministry has subsequently acknowledged Canterbury's draft 2018-19 Improvement Plan was "excellent with a clear line of sight, action oriented activities and clear accountability". In addition, the Ministry noted that Canterbury's Improvement Plan is viewed nationally as an exemplar and requested that further detail be provided on the selection and calculation of three System Level Measure Milestones in the plan. These refinements are currently being progressed ahead of submission of the Plan to the Ministry on 30 July 2018.

Implementing Canterbury's 2018-19 Implementation Plan

Over 2018-19 implementing the 2018-19 *Actions to Improve Performance* included in Canterbury's Improvement Plan will continue to be a priority. Alongside this, the System Outcomes Steering Group is looking to undertake a more comprehensive refresh of Canterbury's Contributory Measures, and explore how to engage a breadth of providers in actions that influence Canterbury's System Level Measures performance.

5. CONCLUSION

The national System Level Measures framework introduced in July 2016 further encourages a collective response to improving the health outcomes of our population, with the key metrics used as indicators of performance. Canterbury's implementation of the System Level Measures framework has progressed favourably with progress made against the measures and delivery of actions agreed in the 2017-18 Improvement Plan.

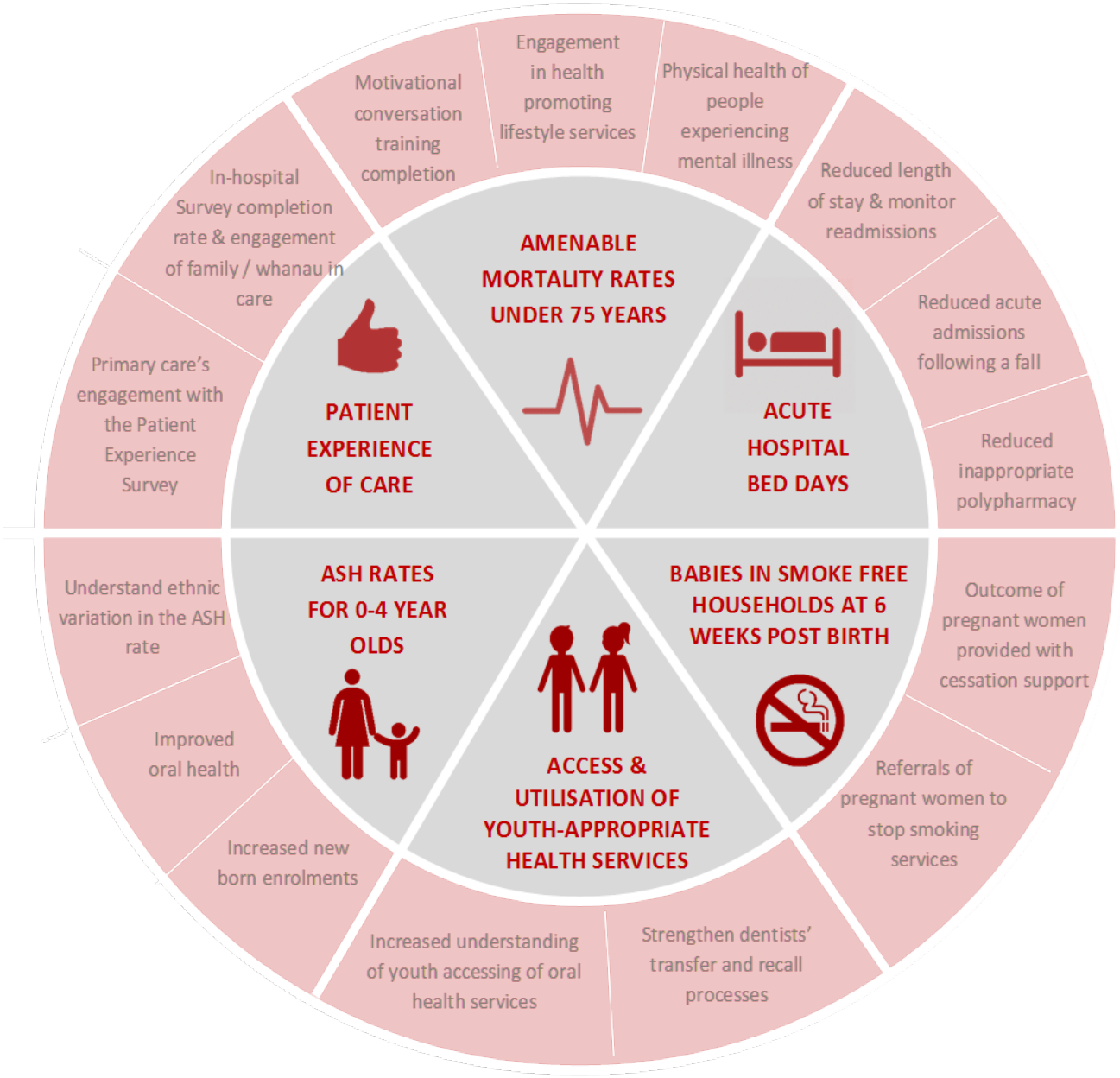
A presentation will be given to the Committee to summarise performance to date and our focus for 2018-19.

6. APPENDICES

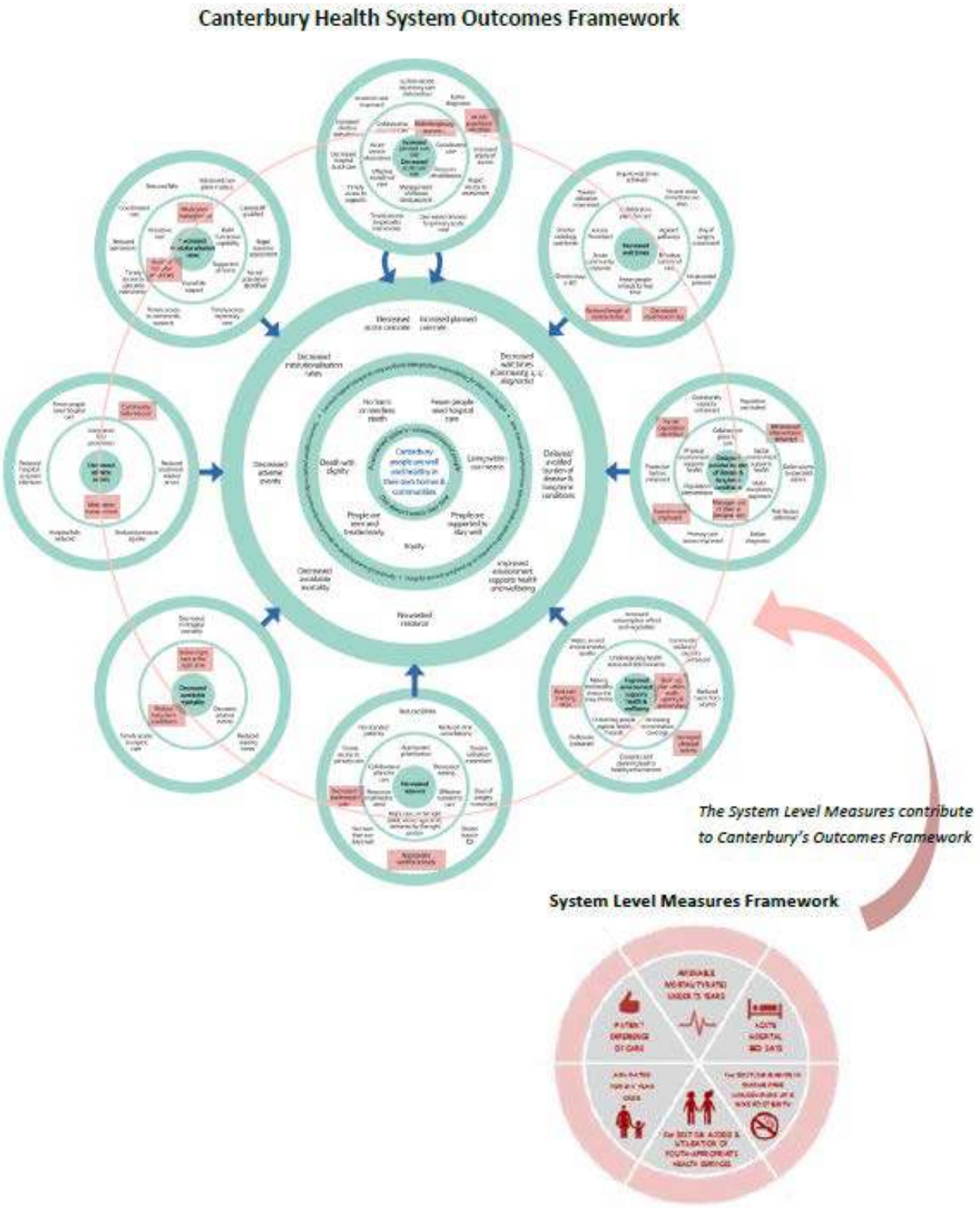
Appendix 1:	Canterbury's System Level Measures
Appendix 2:	The Alignment of the System Level Measures with the Canterbury Health System Outcomes Framework

Report prepared by:	Linda Wensley, Canterbury Clinical Network Programme Manager
Report approved for release by:	Carolyn Gullery, Executive Director, Planning Funding & Decision Support

Appendix1: Canterbury's System Level Measures



Appendix 2: The Alignment of the System Level Measures with the Canterbury Health System Outcomes Framework



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: **2 August 2018**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Committee:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of the minutes of the public excluded meeting of 31 May 2018	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(If required)*	Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)

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

3. SUMMARY

The Act, Schedule 3, Clause 32 provides:

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

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

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

Clause 33 of the Act also further provides:

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

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

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

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

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

Approved for release by: Justine White, General Manager, Finance & Corporate Services

	S/S	Mon	Tues	Wed	Thu	Fri	S/S	Mon	Tues	Wed	Thu	Fri	S/S	Mon	Tues	Wed
January 2019			NEW YEARS DAY 1	PUBLIC HOLIDAY 2	3	4	5/6	7	8	9	10	11	12/13	14	15	16
February						1	2/3	4	5	WAITANGI DAY 6	7	8	9/10	11	12	13
March						1	2/3	4	QFARC TC 9AM 5	6	CPH&DSAC 9AM 7	8	9/10	11	12	13
April		1	QFARC 9AM 2	3	HAC 9AM 4	5	6/7	8	9	10	11	12	13/14	15	16	17
May				1	2	3	4/5	6	QFARC TC 9AM 7	8	CPH&DSAC 9AM 9	10	11/12	13	14	15
June	1/2	QUEEN'S BIRTHDAY 3	4	5	6	7	8/9	10	11	12	13	14	15/16	17	18	19
July		1	QFARC TC 9AM 2	3	CPH&DSAC 9AM 4	5	6/7	8	9	10	11	12	13/14	15	16	17
August					HAC 9AM 1	2	3/4	5	6	7	8	9	10/11	12	13	14
September	1	2	3	4	5	6	7/8	9	10	11	12	13	14/15	16	17	18
October			QFARC 9AM 1	2	HAC 9AM 3	4	5/6	7	8	9	10	11	12/13	14	15	16
November						1	2/3	4	5	6	7	8	9/10	11	12	13
December	1	2	QFARC 9AM 3	4	HAC 9AM 5	6	7/8	9	10	11	CDHB BOARD MEETING 12	13	14/15	16	17	18

Thu	Fri	S/S	Mon	Tues	Wed	Thu	Fri	S/S	Mon	Tues	Wed	Thu	Fri	S/S	
17	18	19/20	21	22	23	24	25	26/27	28	QFARC 9AM 29	30	HAC 9AM 31			January 2019
14	15	16/17	18	19	20	CDHB BOARD MEETING 21	22	23/24	25	26	27	28			February
14	15	16/17	18	19	20	CDHB BOARD MEETING 21	22	23/24	25	26	27	28	29	30/31	March
CDHB BOARD MEETING 18	GOOD FRIDAY 19	20/21	EASTER MONDAY 22	23	24	ANZAC DAY 25	26	27/28	29	30					April
CDHB BOARD MEETING 16	17	18/19	20	21	22	23	24	25/26	27	QFARC 9AM 28	29	HAC 9AM 30	31		May
CDHB BOARD MEETING 20	21	22/23	24	25	26	27	28	29/30							June
CDHB BOARD MEETING 18	19	20/21	22	23	24	25	26	27/28	29	QFARC 9AM 30	31				July
CDHB BOARD MEETING 15	16	17/18	19	20	21	22	23	24/25	26	QFARC TC 9AM 27	28	CPH&DSAC 9AM 29	30	31	August
CDHB BOARD MEETING 19	20	21/22	23	24	25	26	27	28/29	30						September
CDHB BOARD MEETING 17	18	19/20	21	22	23	24	25	26/27	LABOUR DAY 28	QFARC TC 9AM 29	30	CPH&DSAC 9AM 31			October
14	CANTERBURY SHOW DAY 15	16/17	18	19	20	CDHB BOARD MEETING 21	22	23/24	25	26	27	28	29	30	November
19	20	21/22	23	24	CHRISTMAS DAY 25	BOXING DAY 26	27	28/29	30	31					December

WORKPLAN FOR HAC 2018 *(WORKING DOCUMENT)*

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