AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora o Waitaha

HOSPITAL ADVISORY COMMITTEE MEETING
to be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
Thursday, 3 June 2021 commencing at 9:00am

Administration			
	Apologies		9.00am
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 1 April 2021		
3.	Carried Forward / Action List Items		
Presentation			
4.	Making Our System Flow	Dr Jacqui Lunday-Johnstone *Executive Director, Allied Health, Scientific & Technical* Becky Hickmott *Executive Director of Nursing*	9.10-9.40am
5.	ESPI 2 & 5 Briefing	Pauline Clark *General Manager Medical/Surgical, Women's & Children's Health; & Orthopaedics*	9.40-10.10am
Reports for Noting			
6.	Hospital Service Monitoring Report: • Medical/Surgical; Women's & Children's Health; & Orthopaedics ESPIs • Specialist Mental Health Service • Older Persons Health & Rehabilitation • Hospital Laboratories • Rural Health Services	Pauline Clark *General Manager, Medical/Surgical; Women's & Children's Health; & Orthopaedics* Dr Greg Hamilton *General Manager, Specialist Mental Health Services* Kate Lopez *General Manager, Older Persons Health & Rehabilitation* Kirsten Beynon *General Manager, Laboratories* Win McDonald *Transition Programme Manager Rural Health Services*	10.10-11.00am
7.	Care Capacity Demand Management	Becky Hickmott	11.00-11.10am

	Update		
8.	Clinical Advisor Update (Oral) • Medical	Dr Helen Skinner *Chief Medical Officer*	11.10-11.20am
9.	Resolution to Exclude the Public		11.20am
ESTIMATED FINISH TIME			**11.20am**
	Information Items: • Quality & Patient Safety Indicators – Level of Complaints • 2021 Workplan		

NEXT MEETING: Thursday, 5 August 2021 at 9:00am

ATTENDANCE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE MEMBERS

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

Executive Support

(as required as per agenda)

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

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

COMMITTEE ATTENDANCE SCHEDULE 2020

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

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

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

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

MINUTES – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PRESENT

Andrew Dickerson (Chair), Jan Edwards; James Gough; Jo Kane; Naomi Marshall; and Dr Rochelle Phipps.

Attending via Zoom: Barry Bragg; and Catherine Chu.

APOLOGIES

Apologies for absence were received and accepted from Ingrid Taylor; and Sir John Hansen (ex-officio).
An apology for early departure was received and accepted from James Gough (9.55am).

EXECUTIVE SUPPORT

Dr Peter Bramley (Chief Executive); Becky Hickmott (Executive Director of Nursing); Dr Jacqui Lunday-Johnstone (Executive Director, Allied Health, Scientific & Technical); Kay Jenkins (Executive Assistant, Governance Support); and Anna Craw (Board Secretariat).

APOLOGIES

Apologies for absence: Kirsten Beynon (General Manager, Laboratories); Dr Richard French (Acting Chief Medical Officer); and Ralph La Salle (Acting Executive Director, Planning & Funding).

IN ATTENDANCE

Pauline Clark, General Manager, Medical/Surgical; Women's & Children's Health; & Orthopaedics
Dr Greg Hamilton, General Manager, Specialist Mental Health Services
Berni Marra, Manager, Ashburton Health Services
Win McDonald, Transition Programme Manager, Rural Health Services
Dr Helen Skinner, General Manager & Chief of Service, Older Persons Health & Rehabilitation

Item 4
Dr Sigi Schmidt, Chief of Psychiatry

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
James Gough – Terrace Carpark Ltd entry – remove "under construction".

There were no other additions/alterations.

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

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

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (03/21)
(Moved: Naomi Marshall/Seconded: Jan Edwards – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 28 January 2021 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION ITEMS

A member noted a recent presentation by Dr Peter Bramley, Chief Executive, on his three month plan. The member suggested it would be useful for the Hospital Advisory Committee (*HAC*) to receive an overview of that presentation. Dr Bramley advised he could translate that as it is relevant to HAC.

The carried forward action items were noted.

4. MENTAL HEALTH: THE ACUTE ADULT PATHWAY (PRESENTATION)

Dr Greg Hamilton, General Manager, Specialist Mental Health Services (*SMHS*); and Dr Sigi Schmidt, Chief of Psychiatry, presented on the Acute Adult Pathway.

Dr Hamilton noted the complexity that sits within the responses provided. It is not a single pathway, it is a multi-factorial pathway which tries to best meet the needs of people that are having mental health problems or are in distress.

Barry Bragg joined the meeting at 9.15am.

The presentation highlighted the following in relation to the Acute Adult Pathway:

- Person centred response to people with acute mental health needs.
- Ministry of Health's Mental Wellbeing Framework.
- What happens when a person has a mental health problem.
- SMHS Purpose & Strategy:
  - Core Purpose: to provide safe compassionate & effective services that enable people with serious or acute mental disorders in their recovery.
  - Five strategic pillars.
- From a service provision perspective – Pillar 1 (a clearly defined focus on people with serious or acute mental disorders and who are unable to be treated elsewhere).
- Adult community services – in 2020: 122,000 contacts; 6,500 people. There is a significant over-representation of Māori to this service.
- Adult inpatient services – in 2020: 1,356 admissions. Again, an over-representation of Māori to the service.
- Key measures for inpatients.
- Impact of COVID-19.
- Challenges.

Dr Hamilton assured the Committee that the processes are about risk management. If the risks are high, the response is immediate.

Committee members had the opportunity to ask questions.

James Gough retired from the meeting at 9.55am.

5. H&SS MONITORING REPORT

The Committee considered the Hospital and Specialist Services Monitoring Report for March 2021. The report was taken as read.

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

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

- In Ashburton there is a cohesive response around mental health.
- At the moment, long-term planning is underway for the Ashburton District Council. Housing for older people is on the agenda. There have been efforts to bring together a work group to provide a cohesive response to this because housing is a core component and often for rural communities it can become a little isolated when Councils are working in a smaller context.
- Integration Hub. The integration cluster incorporating NASC, district nursing and clinical nurse specialists have been detailing the flow of referral management and service response to primary care, with an intent to create a more proactive responsive community service. The journey from health pathway information, ERMS referral management through to service response has identified a number of areas for improvement.
- Final ratification is being progressed for one national network, which will incorporate the existing national rural hospital, national rural general practice, and national rural nursing networks.

There was discussion around access to primary health care. Ms Marra advised there were two components. With respect to building and infrastructure there are two new big primary care practices in Ashburton. However, buildings are not the solution alone. It is about working differently. Along with the challenge of recruiting general practitioners nationally, there is also the journey before you need to go to the GP that needs to be addressed. Ms Marra advised this is why an integration team has been structured, to look at refocussing the team to be at that partnership end for primary care so they can manage the demand flow coming through.

A member noted, from previous experience, that practices that:

- look at it as an integrated model;
- look at triaging patients the minute they have the first contact with them to determine whether the patient needs to be seen that day or not;
- include not just a GP consultation, but also provide nurse, allied health input, and in many instances focus on social determinants (invest in having social workers in the premises, care coordinators in the premises);

have no trouble replacing GPs when it comes to retirement; they have patients waiting to enrol with them; and their consultation rates per head of population are lower because they do not need to see those patients so often. There are a lot of preventative services. It can be done. Approximately 15% of practices across Canterbury have done this and talk about it openly. Whilst it is quite a journey, taking approximately four to five years, those practices that have been through the process have increased their GP capacity on average by about 25%. It is possible to release capacity at the GP point with the right input supporting practices.

Catherine Chu retired from the meeting at 10.00am.

Rural Health Services – Win McDonald, Transition Programme Manager

- Significant issues with workforce. The RN workforce is ageing, with 47% being over the age of 60 years. This is putting pressure on the whole system. There will need to be a wider discussion around what is the best use of that limited RN resource. Will it be better

to potentially have this workforce in the community dealing with many more clients, rather than a limited number of inpatients?

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

- Rise in presentations to the Emergency department.
- Rise in presentations to the Medical Assessment Unit.
- Occupancy of medical inpatient beds is significantly higher than the modeling in place.
- Neonatal is experiencing a constant demand for beds, which is all cots.
- Keeping up a very proactive leave care program on the campus.
- Progress being made with Accelerating Our Future initiatives.
- Patient experience for Waipapa building. Feedback following the first three months has been very positive.
- Roll out of the national Bowel Screening Program. This had a 'soft' launch. Almost at the 60% target. There is some excellent equity data coming through. The "Did Not Attend" (*DNA*) rate for initial consultations has significantly dropped, as have late cancellations. Since the model has shifted to RNs having the conversation with people over the phone directly and people being able to ring directly if they have any additional questions, there have been no cancellations. A real positive.

There was a query about the fragility of the Christchurch Hospital Campus workforce and whether the turnover of nursing staff was accelerating. Becky Hickmott, Executive Director of Nursing, advised that there may be more turnover in certain areas (for example, ED), but that is not totally abnormal. Ms Hickmott commented that overall turnover is greatly reduced because of COVID-19.

There was discussion around the three month review with regards to ED Observations and ED Paediatrics. Dr Bramley advised that this is wrapped up in the consideration of acute demand pressure at the front door at the moment. A system wide look is being undertaken. There is a lot of work within the ED environment and the broader hospital environment. Teams have been asked to look at where things are in terms of the need for opening up the additional beds in the child emergency care space and to what extent that might be staged when it is needed and how that might be staged. In response to a query, Ms Clark advised no effect has been seen on hospital flow from the lack of an ED Observations space.

There was discussion around ESPI compliance. Ms Clark stressed that every service has a very detailed plan. Services meet with the Planning & Funding leads on a fortnightly basis and it is really important that data is aligned. Ms Clark has regular meetings with clinical directors and admin leads.

Dr Bramley advised there is exceptional work at every service level and people are very engaged. There is additional money to support a lot of the initiatives. A point of clarification is that CDHB reports against 100 days, which is kind of exemplary and often paints a picture of services not necessarily looking in as good a shape as they are, because national reporting requires reporting to 120 days. It provides an indication of where the pressure points are, but not necessary performance on the national stage in terms of levels of wait times. Dr Bramley provided assurance that teams will be triaging really tightly against guidelines, so are doing what is needed for safe care. This is not a discretionary piece of work, it is crucial to delivering safe care for people.

A member commented that is was important to keep going to the 100 days because the evidence is that this is where the most effective, productive turnaround is. What is key is adjusting the amount of patients put on the list at every point in the day, because capacity changes.

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

- Dementia-Friendly Hospital. Alzheimers NZ's Accreditation Committee has now completed its assessment of Burwood Hospital against their Dementia Friendly Recognition Programme standards and criteria. Based on this, Burwood Hospital has been recognised as NZ's first hospital to be 'Working to be Dementia Friendly.' As part of the journey towards being certified as being a 'dementia friendly' hospital OPH&R are promoting the online training available at: https://www.alzheimers.org.nz/get-involved/become-a-dementia-friend with the aim of engaging as many staff as possible from across all workforces to support dementia awareness, provide excellent services for people with dementia and become a recognised 'dementia friend.'
- Safe Medication Administration. The OPH&R senior clinical leadership team have commenced an interdisciplinary working group looking at safe medication administration practice aimed at reducing medication errors within the division. Initial work was focused around gaining a better understanding of current practice relating to administration of medication and the group are now seeking input from all nursing staff working in the hospital to better understand barriers to best practice and how the working environment can support safe medication administration. To ensure learnings across the DHB, this group is working alongside union partners and nursing leads across CDHB.

There was discussion around reasons contributing to increased medication errors.

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

- The report highlights the speciality services which operate with a more specific mandate in terms of detail – Anxiety; Eating Disorders; Mothers and Babies; and Addictions.
- The workforce in these groups is, in general, probably easier to recruit because people have a more specific role and you get passionate individuals that drive specific pathways. Also tend to have a higher clinical psychology workforce.

In response to a query, Dr Hamilton advised that January is normally a time that waiting times go up for a couple of reasons: staff are off on leave, but also because people's willingness to engage in services drops away over the summer period.

Dr Hamilton spoke about Eating Disorders, noting that waiting times had gone up significantly to unacceptable levels. This was partly contributable to a six week period without an SMO in the role. The new recruit has done a lot of work in terms of process and that waiting time has now halved. Very positive progress.

The H&SS Monitoring report was noted.

6. CLINICAL ADVISOR UPDATE (ORAL)

Dr Jacqui Lunday-Johnstone, Executive Director of Allied Health, Scientific & Technical, provided the following updates:

- Workforce enablers. The Scientific and Technical workforce contributes to around 85-90% of all diagnosis in this organisation. They are a very diverse group. One is particularly critical to the delivery of all of the theatre activity - anaesthetic technicians. By the end of May, CDHB will have lost 30% of that workforce. That has a disproportionate effect on the workforce who are already under pressure, but clearly has an organisational impact as well in terms of sustaining the level of activity in that environment. It is illustrative of dependency on groups of staff who are invisible to the public and are largely not well understood within the health context. It is illustrative of some of the inherent challenges there are in the Scientific and Technical Workforce,

which tend to be much smaller, very specialised, and really key to the delivery of a whole raft of speciality services. We are a training organisation, but are not necessarily on the front foot with some of this.

- Two successes in terms of what has been delivered around some of the workforce enablers:
  - There has been consultation on leadership infrastructure for the big professional groups in Allied Health. Looking forward to getting an outcome from this in the near future.
  - An important issue for expert and experienced clinicians within Allied Health is the implementation of the Career Framework. Scoping work is nearly complete and will mean being able to give appropriate recognition to some of these staff.
- Ability to utilise Allied Health expertise in the service for more sustainable models of care. Looking at roles for allied health practitioners as first point of contact – individuals running pathways within respiratory, gynaecology, gastroenterology. Two other areas to focus on are hospital acquired conditions and also flow.
- Pae ora – Healthy Futures. Problems around ill health and non-communicable diseases within New Zealand, particularly the rise in multi morbidities at a much younger age. Looking at the targeted space between fantastic public health messaging about what we all should do, and actually supporting people, particularly our hard to reach groups within the most vulnerable parts of the community, to do something different. Looking to develop and address low levels of cardio respiratory fitness and poor diet.

Barry Bragg retired from the meeting at 10.55am.

Due to the lack of a quorum, the meeting lapsed at 10.55am.

Approved and adopted as a true and correct record:

_____ _____

Andrew Dickerson
Chairperson

Date of approval

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE
CARRIED FORWARD ITEMS AS AT 3 JUNE 2021

DATE RAISED		ACTION	REFERRED TO	STATUS
1.	01 Oct 2020	H&SS Monitoring Report – development of "Living Within Our Means" section	Dr Peter Bramley / David Green	Under action
2.	15 Apr 2021 (Board)	System Flow	Dr Jacqui Lunday-Johnstone Becky Hickmott	Today's agenda – Item 4
3.	03 May 21 (QFARC)	ESPI Performance	Pauline Clark	Today's agenda – Item 5

Making Our System Flow

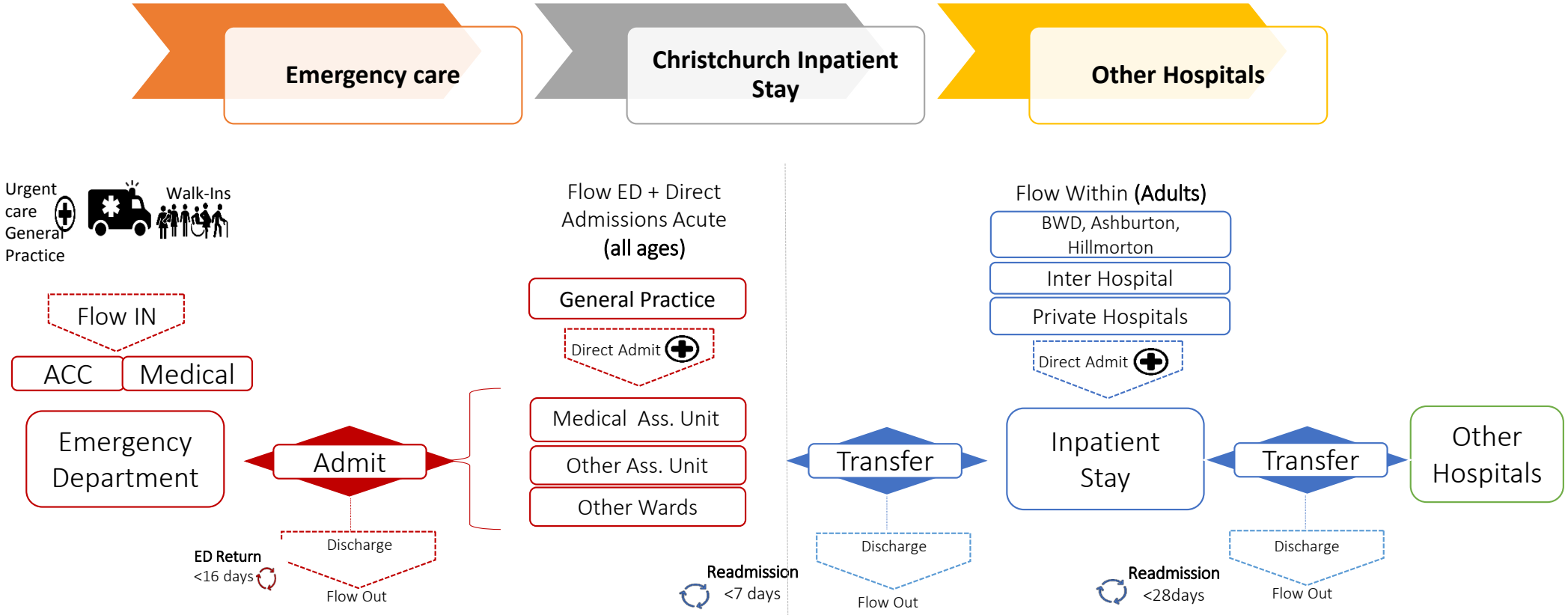
Patient Flow Update

Introduction

The system is experiencing pressure in a range of areas impacting on flow:

1. ED is a volume problem:
    - 50 - 80 additional attendances at ED per day
    - Mainly self-referrals with non-emergency needs
    - Many community factors affecting this change

2. Hospital bed demand is an increased length of stay (NOT volume):
    - Admissions to CHCH hospital remains consistent to forecast and previous years, however sheer volume of numbers has increased.
    - Increased length of stay impacting bed occupancy
    - Many factors affecting Length of Stay


Emergency care
Christchurch Inpatient Stay
Other Hospitals
Urgent care General Practice
Walk-Ins
Flow IN
ACC
Medical
Emergency Department
Admit
Discharge
ED Return
<16 days
Flow Out
Flow ED + Direct Admissions Acute (all ages)
General Practice
Direct Admit
Medical Ass. Unit
Other Ass. Unit
Other Wards
Readmission
<7 days
Flow Within (Adults)
BWD, Ashburton, Hillmorton
Inter Hospital
Private Hospitals
Direct Admit
Transfer
Discharge
Flow Out
Inpatient Stay
Transfer
Discharge
Flow Out
Readmission
<28days
Other Hospitals
Discharge
ED return
<16 days
IP Readmission
<7 days
<28 days
Home
Aged Residential care
Referred: Acute Demand, CREST
Inter Hospital
Alternatives to care

Current System Flow

ED Demand

Arrival Method	Value	%
Self	22842	70%
Ambulance	9319	29%
Police	253	1%
HELI - Helicopter (ED)	216	1%
UNK - Unknown (ED)	5	0%
Total	32635	

Referral Source	Value	%
SELF - Self (ED)	26705	83%
GP - General Practitioner (ED)	2427	8%
AG - Acute Gyne Assessment (ED)	1215	4%
OT - Other (ED)	837	3%
AE - A&E (ED)	474	1%
NH - Nursing Home (ED)	371	1%
Total	32029	

Flow In

32% (99-110 per day)

AMAU

26% (35 per day)

Children

11% (13-18 per day)

PCU

10% (12 per day)

Ward 12

7% (12 per day)

Flow Within

(32% 99 -110 per day)

Discharge from Same Ward Admitted

69 -83 per day

71% LOS 0 to 1 night

LOS > 7 nights

132-173 Occupied beds per day
(20 to 25 admission)

22% LOS >7 nights

59% 70+ yrs old

15- 16 beds NOF

12-17 beds Heart Failure and other Heart diagnosis

8-12 beds Stroke

6-8 beds Complications

Transfer from Christchurch to Burwood

5 to 13 Mon to Fri

Transfer from Christchurch to Ashburton

2 to 5 small numbers

Transfer from Christchurch to Hillmorton

Less 1 small numbers

Current System Flow

Discharge

Discharge from Christchurch

99 per day

71% LOS 0 to 1 night

IP Crest Referrals

40 -50 per week

From Private Home to ARC

6-10 per week

Readmission 7 days

Readmission

4 to 12 per day

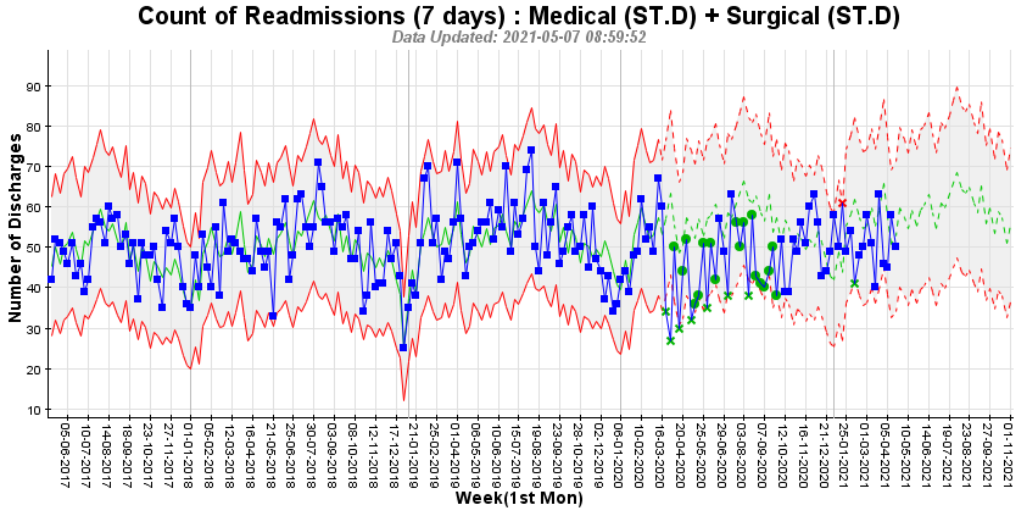
52% LOS 1 night

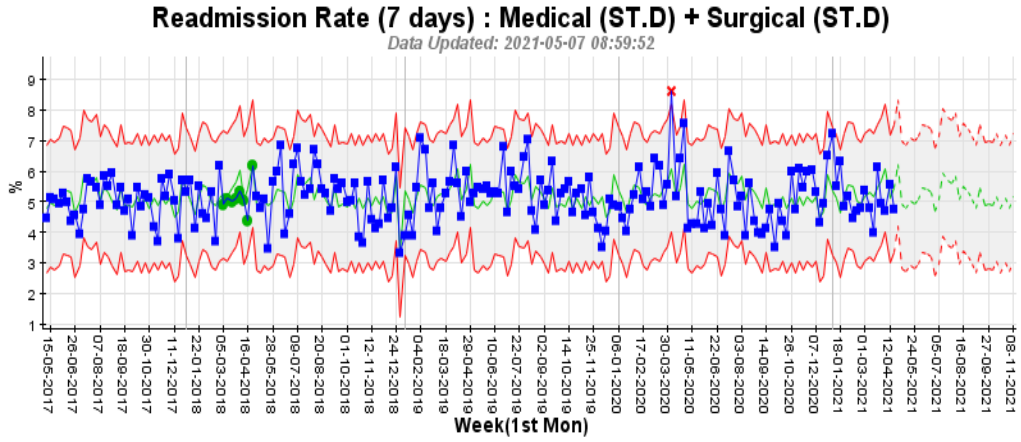
ED representation 16 days

16 per day

Presenting Complaint	Value	%
Abdominal pain	2069	9%
Shortness of breath	1508	7%
Chest pain	1147	5%
Fever symptoms	609	3%
Nausea/vomiting/diarrhoea	585	3%
General weakness/fatigue/unwell	384	2%
Overdose of drug	354	2%
Back pain (no recent injury)	327	1%
Headache	309	1%
Collapse and/or syncope	297	1%
Fall(s)	294	1%
Injury of lower limb	293	1%
Pain in lower limb (no recent injury)	269	1%
Palpitations	262	1%
Seizure	257	1%
Mental health problem	246	1%
Altered mental state	226	1%
Postoperative complication	222	1%
Dizziness/vertigo	207	1%

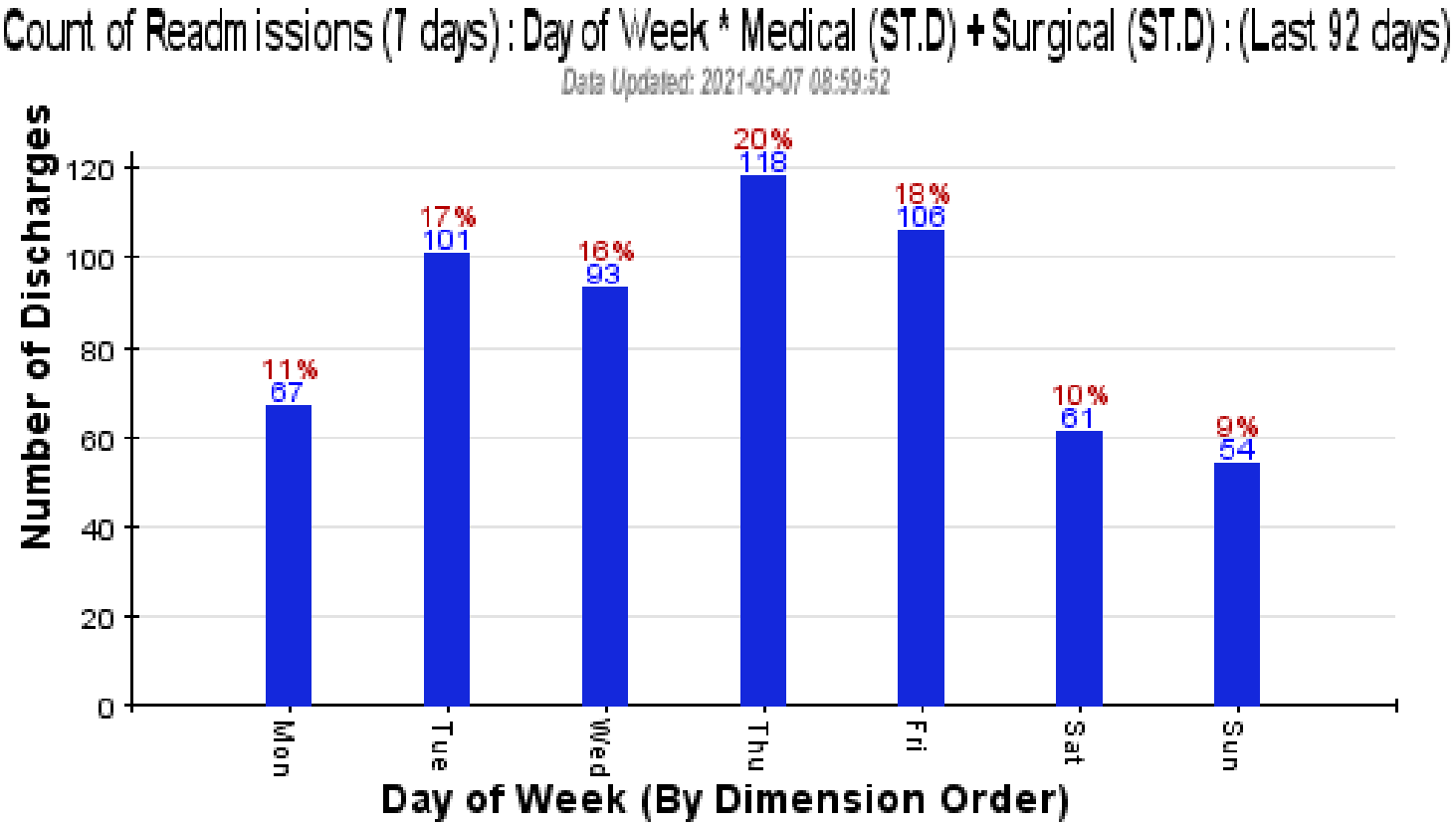
Patient Readmission 7 Days excl. Maternity





- Currently experiencing 50 to 60 readmissions per week
- Thursday discharges are more likely to be readmitted within 7 days
- 80+ are slightly overrepresenting the readmissions within 7 days
- Top 3 Representation diagnosis
  1. Complication of Medical and Surgical Care
  2. Unexplained abdominal diseases
  3. Other Intestinal issues
- Patients readmitted within 7 days spent longer in hospital during their readmission. 46% stay less than 3 days, compared to 56% during the previous admission.

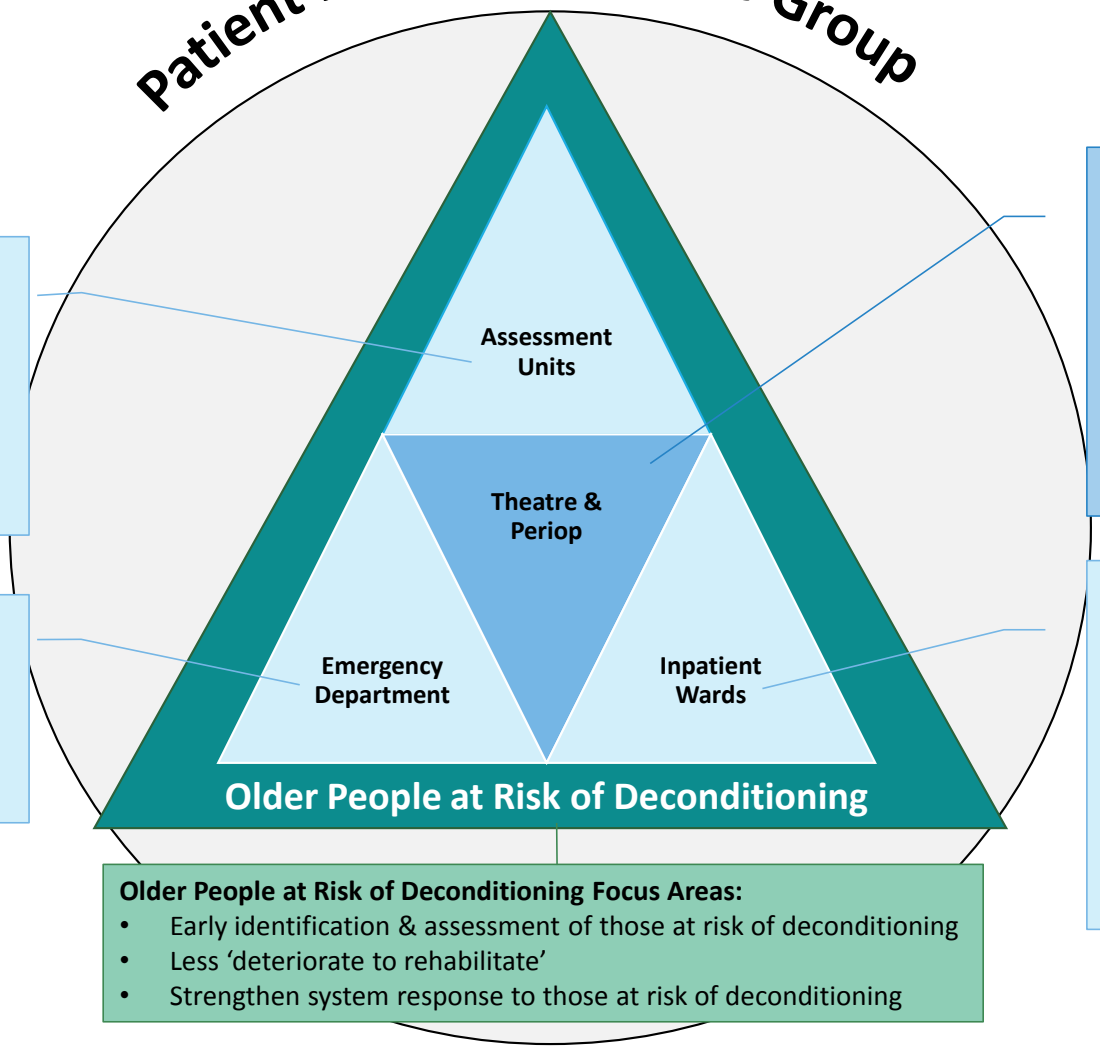
Patient Readmission 7 Days excl. Maternity



Functions of an Acute Flow Governance Group

- A clinical and operational governance body representing all staff groups with acute patients
- Designed to provide strong leadership and is mandated to improve all aspects of the inter-service acute flows
- Champions improvement measures
  - Patient outcomes
  - Professional standards
- Plans, monitors and manages performance based on evidence
- Manages the process of continuous service improvement
  - Portfolio of Focused Improvements
  - Rapid Improvement Initiatives
- Is the avenue through which all staff can contribute ideas to improve their workplace

Example Governance Framework



Assessment Units Focus Areas:
- Maximise short-stay patients / <2 day discharges
- Facilitate ambulatory emergency care
- Reduce volume of patients to wards
- *Workstream group can be combined with inpatient ward

ED Focus Areas:
- Optimise patient streaming & non-admitted pathway
- Consistent 'floor management'
- Timely work-up and exit of patients from ED

Periop Focus Areas (can be governed separately):
- Manage elective vs acute workload
- Standardise list construction process
- Align session resource, capacity and demand
- Improve flow of patients through periop

Inpatient Ward Focus Areas:
- Provide in-reach to AMAU/ED/SARA to pull & drive early management of non-short stay patients
- Reduce long stay patients
- Facilitate earlier time of day discharging
- *Workstream group can be combined with assessment units

Older People at Risk of Deconditioning Focus Areas:
- Early identification & assessment of those at risk of deconditioning
- Less 'deteriorate to rehabilitate'
- Strengthen system response to those at risk of deconditioning

Measures Matrix for Improvement

	Impact Metric	Trend	Process	Trend	Balancing	Trend	Patient Outcome	Trend
Emergency Department	Percentage of non-admitted patients departing ED with 6 hours	↑ is good	Percentage of patients seen within 15 mins of arrival by a nurse	↑ is good	Percentage of patients re-presenting to the Emergency Department within 7 days	↓ or = is good	Percentage of patients who did not wait	↓ is good
			Percentage of patients seen within 60 mins of arrival by a doctor	↑ is good				
			Percentage of patients referred or confirmed disposition decision within 150 mins of arrival	↑ is good				
			Percentage of patients referred seen by specialty withing 210 mins of arrival	↑ is good				
			Percentage of patients departed ED within 240 mins of arrival	↑ is good				
Assessment Units	Percentage of patients discharged with a LOS of 2 days or less	↑ is good	Percentage of patients with an Estimated Date of Discharge and Clinical Criteria for Discharge set on day 0 of admission	↑ is good	Percentage of patients re-admitted to hospital within 3 days	↓ or = is good	Percentage of patients who develop a hospital-acquired condition	↓ or = is good
			Percentage of patients [insert specialty] departed ED within 360 mins of arrival	↑ is good				
			Percentage of patients discharged from [insert assessment unit] for ambulatory emergency care	↑ is good				
Inpatient Wards	Percentage of patients at midnight (occupancy) with a LOS of 6 midnights or more	↑ is good	Percentage of patients discharged before midday	↑ is good	Percentage of patients re-admitted to hospital within 7 and 28 days	↓ or = is good	Percentage of patients who die in hospital	↓ or = is good
Theatre	Number of acute surgical patients at midnight (occupancy)	↓ is good	Percentage of patients [insert specialty] departed ED within 360 mins of arrival	↑ is good	Percentage of patients re-admitted to hospital within 7 and 28 days	↓ or = is good	Percentage of patients who die in hospital following a theatre event	↓ or = is good
			Cumulative hours of patients waiting for acute surgery	↓ is good				
			Number of unutilised theatre sessions	↓ is good				
			Theatre utilisation	↑ is good				
			Percentage of day cases vs inpatients	↑ is good				
Older People at Risk of Decondition-ing	Percentage of patients aged 75 or older at midnight (occupancy) with a LOS of 6 midnights or more	↓ is good	Percentage of patients discharged before midday	↑ is good	Percentage of patients aged 75 or oler re-admitted to hospital within 7 and 28 days	↓ or = is good	Percentage of patients discharged to their usual address	↑ is good
			Percentage of patients aged over 75 years with a Comprehensive Geriatric Assessment within four hours of admission	↑ is good				

Summary

Key operational constraints to plan:

- ED volumes – increase in self-referred with non-emergency needs (50-80 additional patients a day)
- Christchurch Hospital bed capacity – it IS NOT a volume problem but an increase in Length of Stay issue

Factors being focused on include:

- Better public understanding of accessing their GP 24x7 for all medical needs
- Enhanced access to multi-disciplinary support in the community for frail elderly (preventative actions before admission to hospital)
- Flow within the CHCH campus to reduce delays of care
- Flow between our facilities to reduce delays in care
- Cohorting general medicine patients to improve doctor decision making time
- Delayed discharge drivers
- Reasons for readmissions to hospital and reattendances to ED

HAC: ESPI 2 & 5 Briefing

Pauline Clark & Jacqui Summers

When ESPI Compliance is Expected

NOTE: THESE ARE DRAFT & YET TO BE CONFIRMED WITH MOH

Medical Specialties	ESPI 2 Compliance End Date	ESPI 5 Compliance End Date
Endoscopy	Mar 2022	N/A
General Medicine	Compliant	N/A
Cardiology	Dec 2021	Mar 2022
Dermatology	Compliant	N/A
Endocrinology	Jul 2021	N/A
Diabetology	Jul 2021	N/A
Gastroenterology	Jul 2021	N/A
Haematology	Compliant	N/A
Infectious Disease	Compliant	N/A
Neurology	Sept 2021	N/A
Oncology	Jul 2021	N/A
Paediatric Medicine	Mar 2022	N/A
Renal Medicine	Compliant	N/A
Respiratory	Sept 2021	N/A
Rheumatology	Compliant	N/A
Pain	Jul 2021	N/A

Surgical Specialties	ESPI 2 Compliance End Date	ESPI 5 Compliance End Date
General Surgery	Sept 2021	Mar 2022
Cardiothoracic	Compliant	Compliant
ENT	Dec 2021	Mar 2022
Dental	N/A	Jun 2022
Gynaecology	Jul 2021	Oct 2021
Neurosurgery	Compliant	Compliant
Ophthalmology	Dec 2021	Mar 2022
Orthopaedics	Jul 2021	Sept 2021
Paediatric Surgery	Compliant	Jul 2021
Plastics	Dec 2022	Jun 2022
Urology	Compliant	Jul 2021
Vascular	Jul 2021	Jul 2021

Current ESPI 2 Performance: Medical Specialties

Medical Specialities	Total on Waitlist	No. >120 days	% over 120 days	Nominal Max Waitlist	% of Nominal Max Waitlist
Endoscopy	1,946	496	25%	976	199%
General Medicine	164	7	4%	226	73%
Cardiology	555	70	13%	374	148%
Dermatology	69	0	0%	169	41%
Endocrinology	233	18	8%	228	102%
Diabetology	110	6	5%	150	73%
Gastroenterology	287	17	6%	328	88%
Haematology	62	2	3%	104	60%
Infectious Disease	9	3	33%	24	38%
Neurology	481	96	20%	309	156%
Oncology	348	19	5%	162	215%
Paediatric Medicine	514	155	30%	406	127%
Renal Medicine	46	0	0%	50	92%
Respiratory	370	13	4%	448	83%
Rheumatology	309	10	3%	358	86%
Pain	33	14	42%	11	300%

Key	
	Process & capacity issues
	Process issues
	Compliant specialties

New Columns

Based on the services' historic ability to see patients within the 120 day timeframe

Current ESPI 2 Performance: Surgical Specialties

Surgical Specialities	Total on Waitlist	No. >120 days	% over 120 days	Nominal Max Waitlist	% of Nominal Max Waitlist
General Surgery	874	85	10%	995	88%
Cardiothoracic	21	1	5%	65	32%
ENT	1,149	160	14%	1190	97%
Gynaecology	637	75	12%	504	126%
Neurosurgery	110	1	1%	232	47%
Ophthalmology	1,452	328	23%	957	152%
Orthopaedics	925	40	4%	940	98%
Paediatric Surgery	92	1	1%	190	48%
Plastics	375	148	39%	270	139%
Urology	717	18	3%	426	168%
Vascular	163	30	18%	242	67%

Key	
	Process & capacity issues
	Process issues
	Compliant specialties

New Columns

Based on the services' historic ability to see patients within the 120 day timeframe

Current ESPI 5 Performance: Surgical Specialties

Surgical Specialities	Total on Waitlist	No. >120 days	% over 120 days	Nominal Max Waitlist	% of Nominal Max Waitlist
Cardiology	332	117	35%	362	92%
General Surgery	931	286	31%	688	135%
Cardiothoracic	50	4	8%	74	68%
Dental	442	68	15%	208	213%
ENT	709	250	35%	514	138%
Gynaecology	306	43	14%	449	68%
Neurosurgery	46	0	0%	58	79%
Ophthalmology	640	53	8%	480	133%
Orthopaedics	653	60	9%	649	101%
Paediatric Surgery	113	13	12%	150	75%
Plastics	1157	125	11%	957	121%
Urology	376	13	3%	391	96%
Vascular	128	26	20%	180	71%

Key	
	Process & capacity issues
	Process issues
	Compliant specialties

New Columns

Based on the services' historic ability to see patients within the 120 day timeframe

Our Current State

- Most services are not meeting their Elective Service Performance Indicators (ESPIs) and are unlikely to before the end of June
- Two key reasons:
    1. **Capacity not matching demand**, with some capacity impacting all services (e.g. anaesthetic tech shortage) and some being service-specific (e.g. ophthalmology surgeon shortage)
    2. **Process / behaviour issues,** data errors, not booking patients by longest wait

What We're Doing (BAU)

- Focusing on the why and how: Not wasting patient's and staff time, reiterating the Orange Book principles
- Building capability and making best use of capacity within our services:
    1. Smoothing demand and freeing up SMO capacity through process improvements, threshold changes, updating Health Pathways, partnership working between services with all roles working top of scope
    2. Cleaning lists of data errors and reviewing lists size against nominal maximum lists for each service to support active management of demand and capacity

What We're Looking to Do Differently

- Shifting responsibility to promote booking patients in order of longest wait from SMOs to Booking Clerks with oversight from the Service Managers
- Service Managers and Clinical Directors to report to the General Manager and Chiefs of Service actions to resolve patients who have not been booked by 60 days and who have been waiting over 120 days
- New Service Manager and Clinical Directors to go through training programmes for reorientation and application of the principles of the Orange Book and active management of capacity and demand

Action	Responsible	Accountable	Consulted	Informed
Book patients by longest wait	BC	SM	CD	SMOs
Resolve and avoid long patient waits (not booked by 60 days and waiting over 120 days)	CD, SM	GM	SMOs	BC
Monitor and smooth demand	SMOs	CD	SM, P&F	GM, CoS
Monitor capacity to meet demand	SM, CD	GM, CoS	P&F, P&C	SMOs

Booking Clerks = BC Service Manager = SM Clinical Director = CD
Surgeons = SMOs General Manager = GM Planning & funding = P&F
People & capability = P&C Chief of Service = CoS

H&SS MONITORING REPORT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

DATE: **3 June 2021**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Committee:

i. notes the Hospital Advisory Committee Activity Report.

3. APPENDICES

Appendix 1: Hospital Advisory Committee Activity Report –June 2021

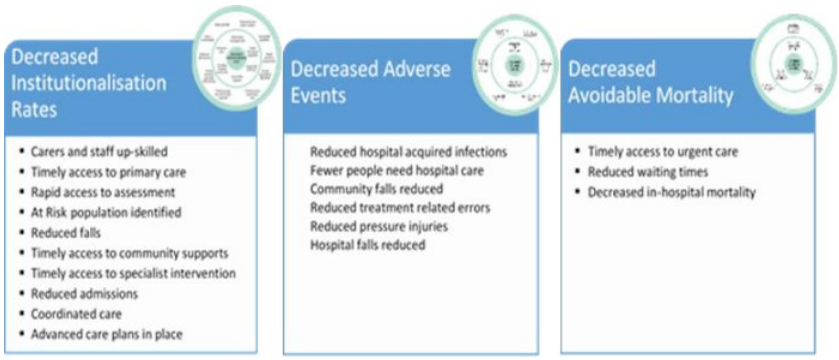
Appendix 1

Hospital Advisory Committee

Hospital Activity Report

June 2021

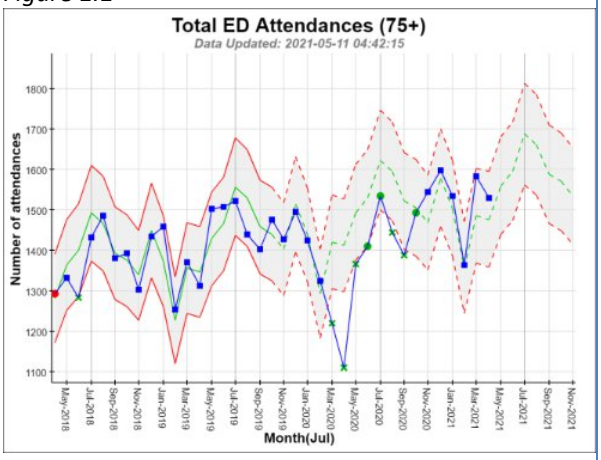
Index — Based on the CDHB Outcomes Framework and Five Focus areas plus Specialist Mental Health



Frail Older Persons' Pathway

Outcome and Strategy Indicators

Figure 1.1



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

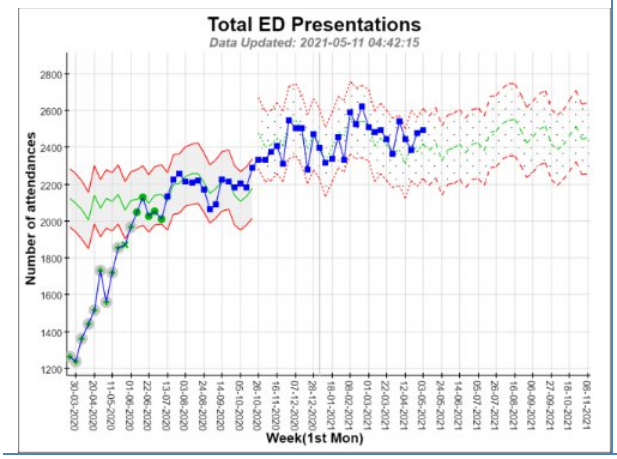
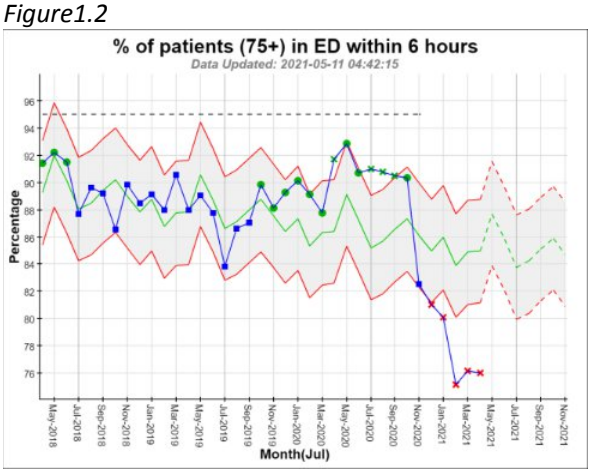


Figure1.2



Since mid-October total ED visits have increased by around 30 people a day, predominantly by those under 30 years old.

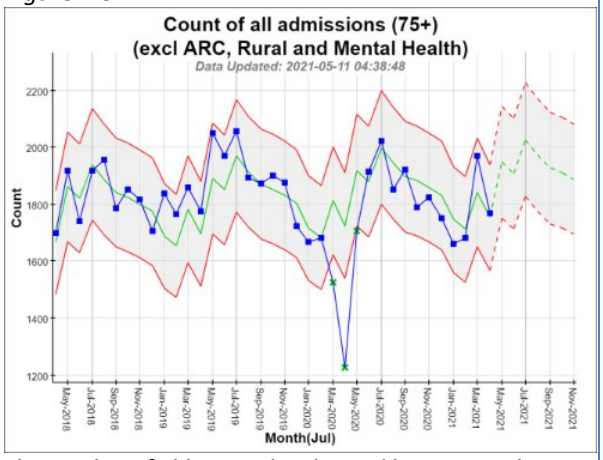
This mostly involves triage levels 4 and 5, and thus places demand within the ED as these patients are not generally admitted.

This, along with the team working in a new and larger unit, is providing challenges that contribute to patients spending a longer time in ED.

Planning and Funding, ED, the Communications team, Healthline and Urgent Care providers are working together to put in place plans to improve the system's ability to provide the care required by the population.

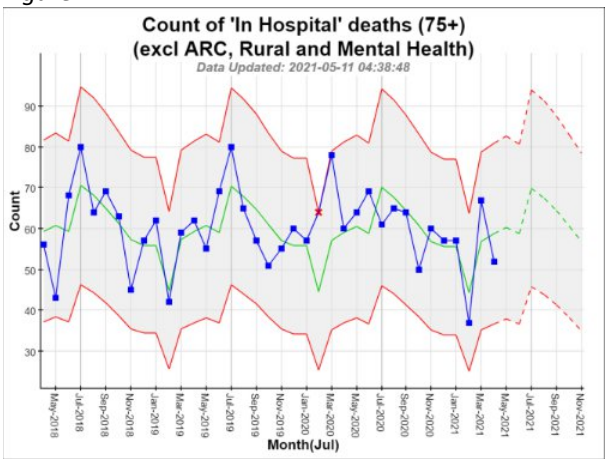
Key hospital services including General Medicine, Cardiology, Orthopaedics and General Surgery are also working with the Emergency Department to optimise timeliness of flow through the department for people requiring specialist service care.

Figure 1.3



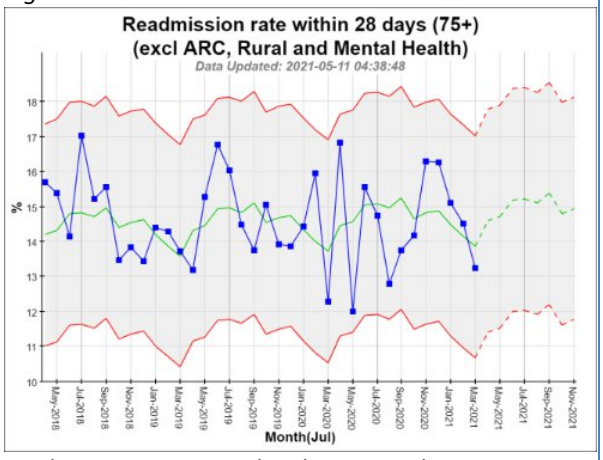
The number of older people admitted has returned to the forecast range following the COVID lockdown period.

Figure 1.4



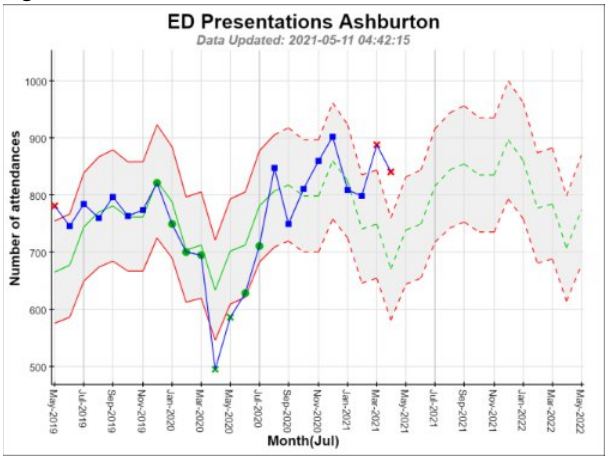
During the last nine months the number and rate of in-hospital deaths against admissions has been within forecast range, which reflects an underlying reducing trend in the rate.

Figure 1.5



Readmissions remain within the expected range.

Figure 1.6



Ashburton rate of attendances,75+ age group, has significantly exceeded the forecast range during the past two months.

Achievements/Issues of Note

Older Persons Health and Rehabilitation

Using Outpatient Clinics to Provide Patient Choice, Waitlist Reduction and Earlier Intervention

To date, referrals accepted to the OPH&R community teams for Speech-Language Therapy have largely been offered appointments within the home. Over time, this single model of service delivery has restricted opportunities to meet growing demand and has resulted in registered staff spending a significant amount of time travelling to patient homes where care in the home is not required or preferred by the patient.

In order to increase patient choice around how they would like to receive their care, in March 2021 OPH&R Speech Language Therapy began offering a mixed model of outpatient clinics and home visits. Outpatient appointments are now available for patients where there is no clinical requirement for care to be provided in the home and where the patient is happy to travel to an appointment.

This work has been successful in increasing overall capacity, with outpatient clinics being able to increase the number of patients seen each day by each therapist, but has also ensured that patients can choose how they access the service whilst maximising available resource. Feedback from staff to date has been positive as the use of a mixed service delivery model has led to further ideas around the increased use of telehealth and faster processes for referring for diagnostics due to the co-location of the clinic to testing facilities. Feedback from patients also includes that the option of an outpatient appointment allows them to take the opportunity to plan to visit friends and whanau on the same day or attend other services located in the same area, which would be more difficult if they had to wait at home for someone to visit and then leave the home afterwards.

OPH&R are planning to continue increasing the opportunity for patients to be seen in outpatient clinics closer to home by exploring other sites in which clinics could be provided across Canterbury; the OPH&R Allied Health leadership team are keen to extend this approach to other services.

Service Manager Patient Flow (Fixed term 12 months)
OPH&R have recruited a Service Manager for Patient Flow on a 12 month fixed term contract to begin 17 May 2021. In line with the organisational priority of patient flow, this role will work with bed management teams at the Christchurch campus to support and enhance transfer of care to Burwood Hospital and discharge processes out of the hospital to ensure that barriers to discharge are identified early and escalated for resolution to avoid wasting patients' time and ensure good patient flow across the system.

It is expected that the implementation of this role will identify opportunities to maximise patient flow at the Burwood campus, including supporting aspects such as overall bed management across the site including regional demand for specialist services, providing information for clinicians and managers on the bed state across the DHB each day and providing a single point of contact for Christchurch Hospital regarding patient flow from Burwood Hospital. This role will work alongside clinical leaders and operational managers to enhance relationships with our partners in primary and community-based care and assist with the collection of better data and information around what patients are waiting for to support their journey through the sub-acute pathway.

Surgical Volumes
OPH&R continue to collaborate with surgical specialties to appropriately resource the increased surgical volumes occurring and planned for at Burwood Hospital. This includes planning and resourcing in areas such as pre-assessment, theatres and sterile services, post-operative ward-based care and post discharge rehabilitation follow up.

In addition to supporting these increased levels of activity, we are taking the opportunity to identify and confirm the impact of changes in volumes for the Burwood Surgical Service and the wider OPH&R division. This will enable us to recalibrate for any changes that may occur to 2021/22 planned/elective care volumes.

Christchurch Hospital

Occupancy has been high over Summer and Autumn
Hospital occupancy has been high over summer and autumn months resultant overflow – particularly within General Medicine, General surgery and Orthopaedics

General Medicine occupancy has regularly sat between 160 and 200 patients in hospital since the beginning of 2021, against a home ward footprint of 135. General Medical teams are rounding on patients distributed across many wards (typically seven wards distributed over three buildings), which is impacting on the time it takes to complete these rounds. This is higher than is typically seen during summer and autumn months.

This is possibly impacting negatively on General Medicine length of stay, as teams are having to work in multiple clinical spaces, and with allied health staff who are not always familiar with the needs of this cohort of patient. General Surgery and Orthopaedics are similarly affected by patients being placed outside of home ward areas.

Campus clinicians, managers and planners are working to develop changes to the allocation of resourced beds and clinical service models to assess ways to minimise this collective impact. Some mitigations put in place include:

- Use of 6 unbudgeted beds in Ward 24 over recent weeks.
- Diversion of surgical, orthopaedic and paediatric medical patients from Ashburton to Timaru
- Review of elective surgical lists occurred on several days because of overall occupancy. Cancellations of all planned cases requiring overnight post-operative beds have occurred on two days.
- High unplanned leave along with occupancy impacted on availability of nursing resources-resulting in significant unmet need and overtime.
- Healthcare Assistant watches are high across the campus stretching resources.
- Some use of agency staff has been approved because of inability to cover gaps.
- Generally lower ICU occupancy over the last 2 weeks provided 852 hours of nursing resource to the campus-= 21.3 FTE. However, within this some spikes in ICU occupancy have led to rescheduling of a small number of cases.

Bronchiectasis – Redesigned Clinics Improving Patient Experience and Releasing Hospital Capacity
Bronchiectasis hospitalisations have increased by 45% over 15-years. Pasifika are six times and Māori three times more likely to be hospitalised compared with Pākehā.

A re-designed bronchiectasis clinic has been in place for 12 months. This clinic is achieving its aim of improving the treatment of this group of patients, making the process more acceptable for patients and ensuring they are safe to return home sooner. Given its disproportionate impact on Māori and Pasifika it contributes to equity.

Along with the patient centred improvement the reduced length of time spent in hospital is estimated to have released $60k of value.

Outcome and Strategy Indicators

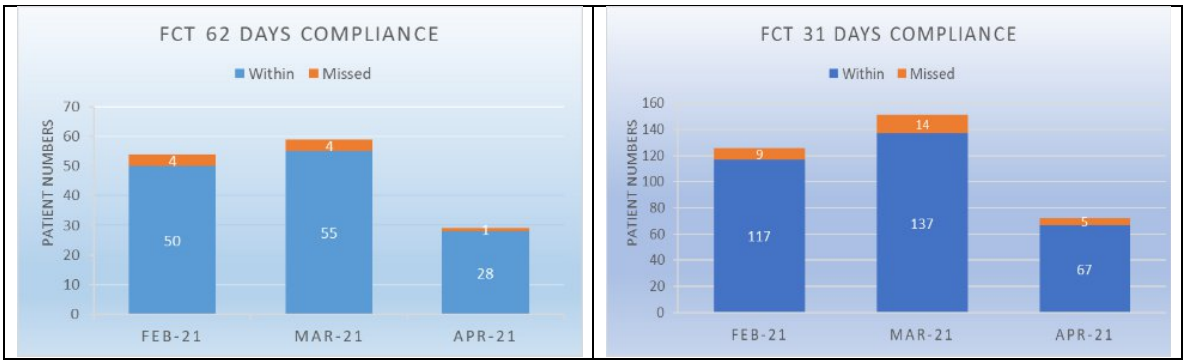
Key Outcomes - Faster Cancer Treatment Targets (FCT)

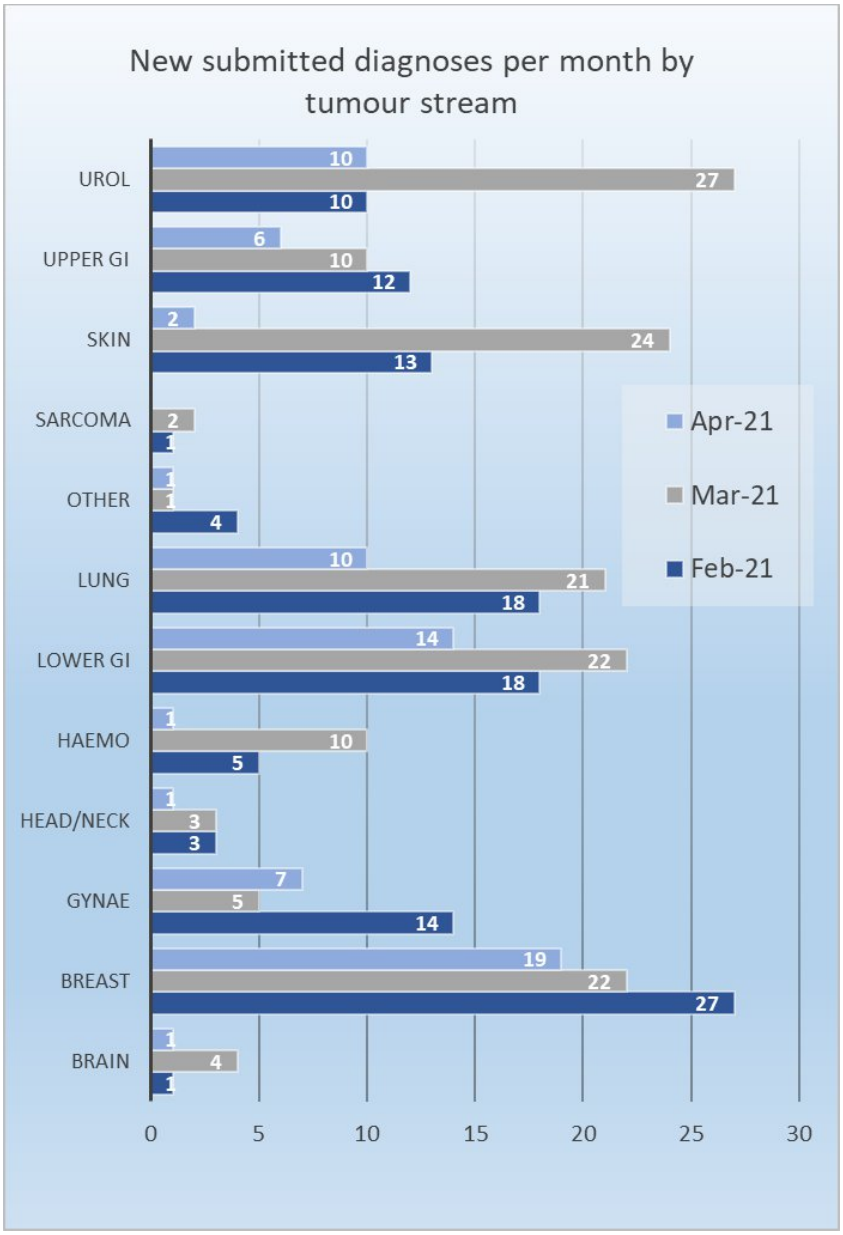
62 Day Target. In the three months to the end of April 2021 there were 184 records submitted by Canterbury DHB – slightly down on the 172 submitted for the three months to the end of December. Canterbury DHB missed the 62 days target for 51 patients, of those 42 were through patient choice or clinical reasons and are therefore excluded from consideration. Target was not met for 9 of the 142 remaining patients due to capacity issues thus Canterbury DHB's compliance rate was 93.7%, once again meeting the 90% target.

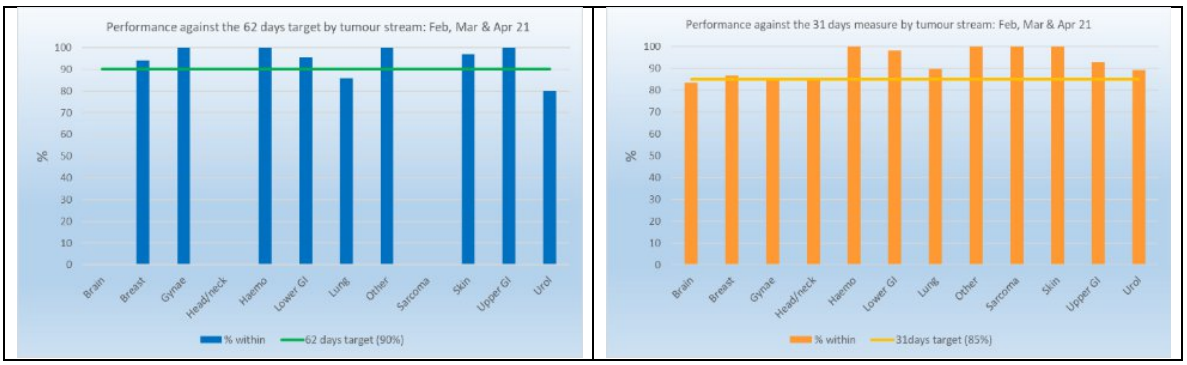
31 Day Performance Measure. Of 349 records submitted towards the 31-day measure Canterbury DHB met target of providing first treatment within 31 days of a decision to treat for 321 (92.0%) eligible patients. Canterbury DHB continues to meet the 85% target. Of the 28 patients not provided with treatment within 31 days, eight were missed by five days or less, five were due to clinical reasons and two through patient choice.

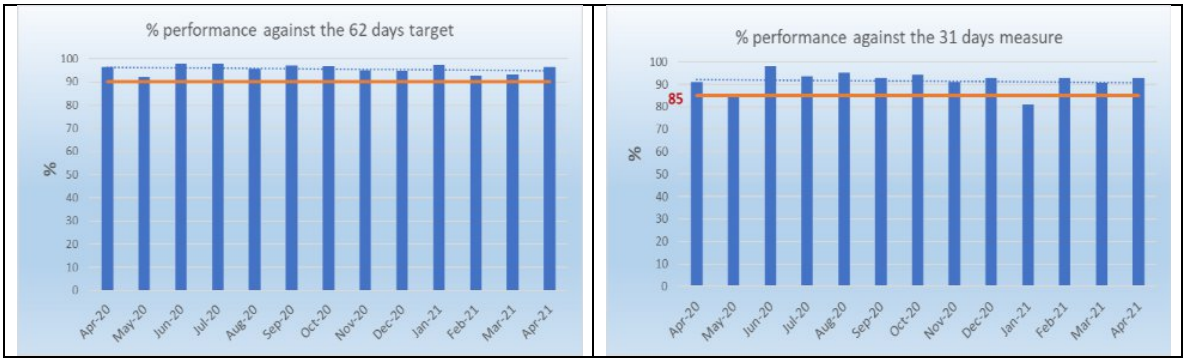
FCT Performance in CDHB

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




New submitted diagnoses per month by tumour stream
UROL
UPPER GI
SKIN
SARCOMA
OTHER
LUNG
LOWER GI
HAEMO
HEAD/NECK
GYNAE
BREAST
BRAIN
10
27
10
6
10
12
2
24
13
2
1
1
1
4
10
21
18
14
22
18
1
10
5
1
3
3
7
5
14
19
22
27
1
4
1
0
5
10
15
20
25
30
Apr-21
Mar-21
Feb-21


Performance against the 62 days target by tumour stream: Feb, Mar & Apr 21
%
Brain
Breast
Gynae
Head/neck
Haemo
Lower GI
Lung
Other
Sarcoma
Skin
Upper GI
Urol
% within
62 days target (90%)
Performance against the 31 days measure by tumour stream: Feb, Mar & Apr 21
% within
31days target (85%)



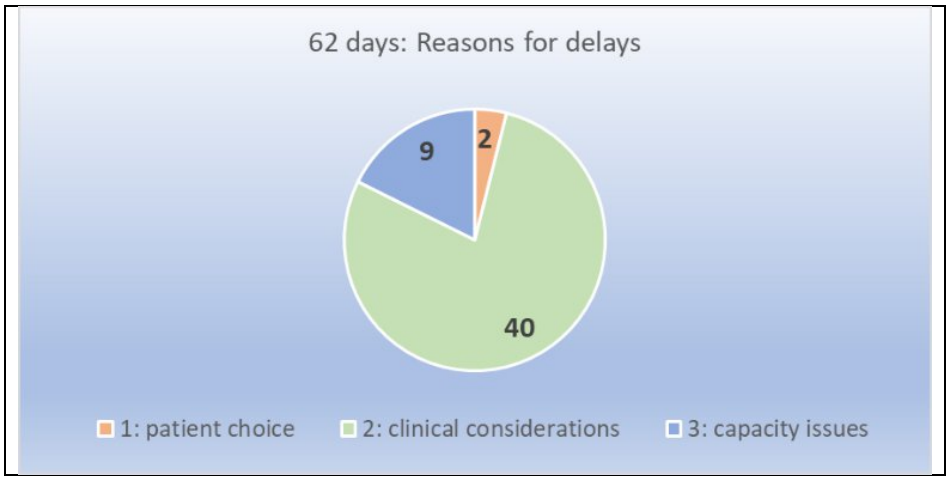
Patients whose treatment does not meet target.

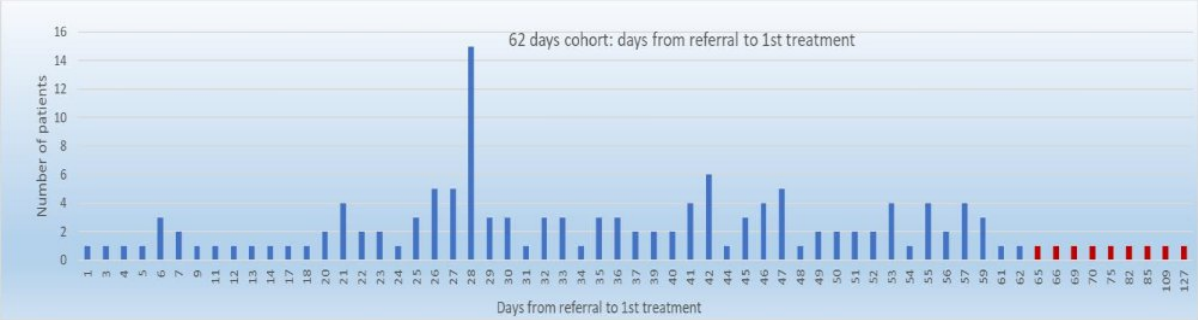
The MoH requires DHBs to allocate a code (referred to as a delay code) to all patients who are not treated in line with the 62 days target, Canterbury DHB does the same for those where treatment does not meet the 31 day target. There are three codes but only one can be submitted, even if the delay is due to a combination of circumstances, which is often the case. When this happens the reason that caused the greatest delay is the one chosen.

The codes are:

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

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





Achievements/Issues of Note

Oncology Service Development Project

The Canterbury DHB Medical Oncology Service is currently experiencing significant challenges affecting service performance, sustainability, staff wellbeing and patient care.

Along with adequate staff resourcing, historical models of care and cultural practices are being addressed and support a sustainable service that looks after its patients and staff.

Six workstreams are in place and all workstream activity is aligned with the following goals, which will be achieved in 2021:

- Understand service capacity
- The service is resilient to disruption
- The service has an agreed and documented Strategic Plan for the period 2021-2026

Current activity focusses on:

- Improving patient scheduling using prioritisation scoring
- Optimising all available clinic capacity
- Documenting practice guidelines on the intranet
- Implementing and troubleshooting a new outpatient clinic schedule
- Publishing updated criteria for patient entry to the service Health Pathways and ensuring effective communication
- Planning for additional nurse-led clinics as part of the SMO Outpatient team structure
- Identifying with the Canterbury Initiative, the services currently being provided by Medical Oncology that can be provided in the community with additional support and re-entry pathways.

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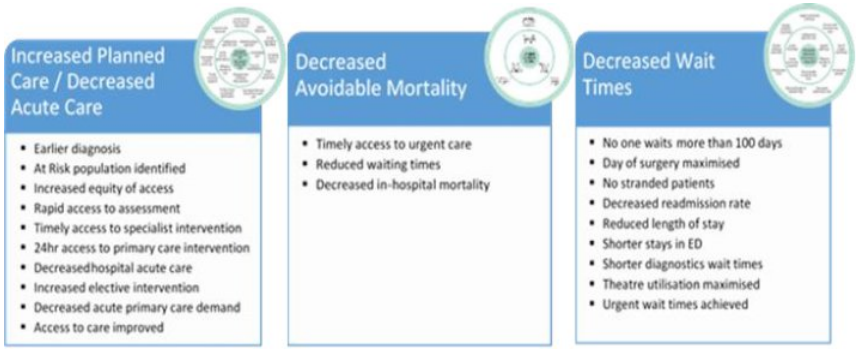
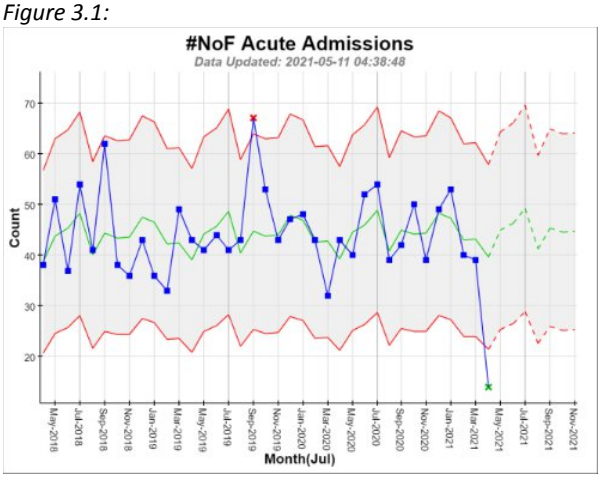


Enhanced Recovery After Surgery (ERAS)

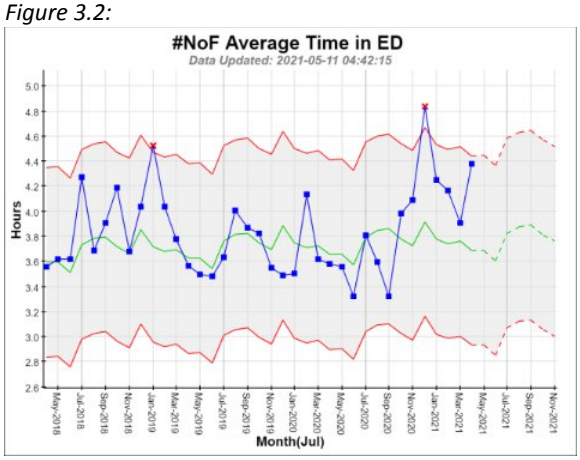
Outcome and Strategy Indicators – Fractured Neck of Femur (#NoF)

Figure 3.1:



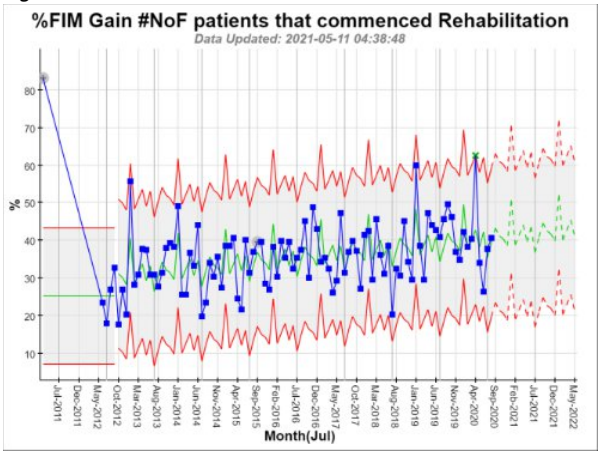
Admissions are generally following the expected mean count. The time taken to code discharges impacts the latest data point.

Figure 3.2:



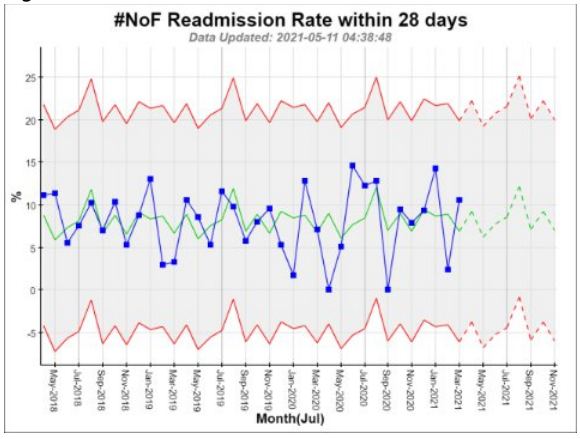
The time spent in the ED by people with a fractured neck of femur has increased. This is in line with the degradation in the proportion of people leaving ED within six hours of arrival that is commented on above. It is associated with a step change in the number of people attending ED that occurred in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

Figure 3.3:



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

Figure 3.4



Readmissions continue to remain within expected mean values.

Achievements/Issues of Note

Pre-operative Physiotherapy input for patients receiving major abdominal surgery

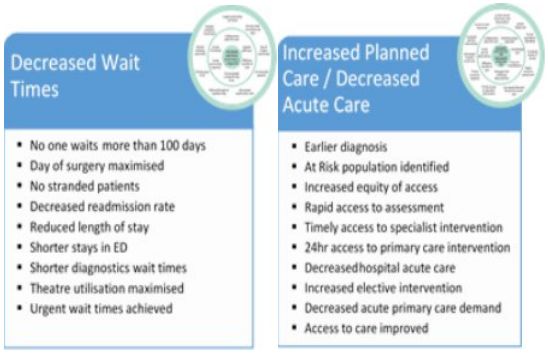
Evidence shows a significant decrease in post-operative pulmonary complications following provision of pre-operative physiotherapy education. This has been adopted in many health services in Australia.

The education includes guidance on optimising fitness prior to surgery, the importance of early mobilisation and commencing breathing exercises following their operation. This empowers patients to take early ownership of their recovery.

In response to this a twice weekly pre-operative physiotherapy clinic has been run in the Christchurch Outpatient building from December 2020.

It is still early days and there is insufficient data to demonstrate improvement, however it is expected that this will have reduced pulmonary complications and reduced length of stay in hospital with less post-operative physiotherapy intervention required.

Those 20 patients who have attended the clinic have reported positive outcomes. It is expected that the rate of referral will increase as the process becomes more streamlined.



Elective Surgery Performance Indicators 100 Days

Elective Services Performance Indicators

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

	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar	
	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %
1. DHB services that appropriately acknowledge and process patient referrals within the required timeframe.	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %
2. Patients waiting longer than four months for their first specialist assessment (FSA).	1964	23.6%	2244	28.7%	2273	28.9%	1815	21.5%	1200	13.3%	908	9.3%	995	9.6%	1076	9.8%	1313	11.6%	1877	15.7%	1864	15.5%	1815	15.2%
3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT).	1	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
5. Patients given a commitment to treatment but not treated within four months.	1382	26.7%	1311	28.0%	1139	25.1%	1247	26.4%	891	18.8%	666	14.8%	707	15.4%	743	15.8%	952	19.2%	1240	23.2%	1259	23.0%	1169	20.3%
8. The proportion of patients treated who were prioritised using nationally recognised processes or tools.	1	99.9%	0	100.0 %	1	99.9%	0	100.0 %	0	100.0 %	8	99.5%	1	99.9%	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %

Summary of ESPI 2 Performance –
From Ministry of Health Final Summary March 2021 (published on 3 May)

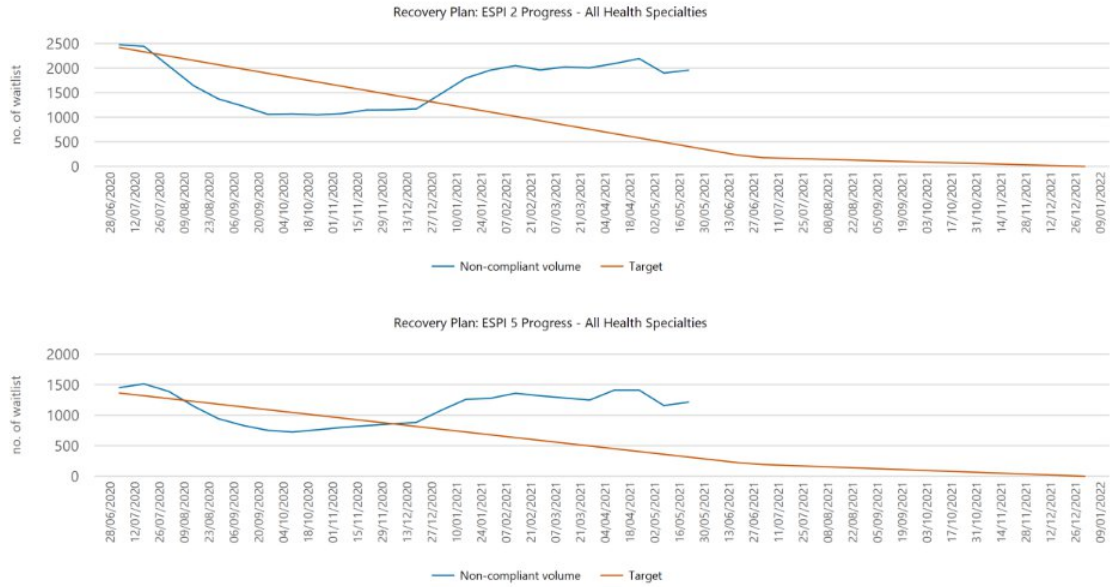
	Jan-20		Feb-20		Mar-20	
ESPI 2 (FSA)	Improvement required	Status%	Improvement required	Status%	Improvement required	Status%
Cardiothoracic Surgery	0	0.0%	5	17.2%	7	21.2%
Ear, Nose and Throat	120	11.6%	134	11.9%	135	12.5%
General Surgery	192	16.0%	226	20.1%	147	15.6%
Gynaecology	14	3.4%	16	3.3%	22	4.3%
Neurosurgery	3	1.9%	2	1.4%	2	1.8%
Ophthalmology	324	22.1%	274	18.9%	242	16.7%
Orthopaedics	171	16.4%	112	11.4%	68	7.8%
Paediatric Surgery	6	4.7%	1	0.9%	1	1.0%
Plastics	253	44.2%	225	42.1%	214	44.9%
Thoracic	0	0.0%	0	0.0%	0	0.0%
Urology	8	1.2%	11	1.6%	10	1.4%
Vascular	86	38.7%	69	30.9%	60	26.7%
Cardiology	31	6.7%	28	5.9%	28	5.7%
Dermatology	3	4.1%	0	0.0%	0	0.0%
Diabetes	37	21.3%	26	17.7%	8	6.9%
Endocrinology	27	8.9%	33	10.9%	47	15.2%
Endoscopy	298	20.7%	371	24.7%	458	27.6%

	Jan-20		Feb-20		Mar-20	
ESPI 2 (FSA)	Improvement required	Status%	Improvement required	Status%	Improvement required	Status%
Gastroenterology	29	10.2%	23	8.0%	33	10.4%
General Medicine	2	1.0%	5	2.6%	8	4.1%
Haematology	1	1.4%	2	2.7%	1	1.6%
Infectious Diseases	0	0.0%	0	0.0%	1	7.1%
Neurology	53	13.9%	50	12.2%	59	13.8%
Oncology	17	5.3%	20	6.8%	37	11.3%
Paediatric Medicine	158	28.3%	177	30.7%	182	33.1%
Pain	14	45.2%	13	38.2%	11	42.3%
Renal Medicine	0	0.0%	1	2.0%	2	3.9%
Respiratory	25	7.7%	34	9.4%	31	6.6%
Rheumatology	5	1.5%	6	1.7%	1	30.0%
Total	**1877**	**15.7%**	**1864**	**15.5%**	**1815**	**15.2%**
ESPI 5 (Treatment)						
Cardiothoracic Surgery	0	0.0%	2	4.3%	0	0.0%
Dental	78	23.9%	71	19.7%	72	18.8%
Ear, Nose and Throat	246	33.6%	279	38.8%	254	34.0%
General Surgery	275	35.2%	283	35.0%	277	32.6%
Gynaecology	48	14.0%	34	10.7%	31	9.3%
Neurosurgery	0	0.0%	0	0.0%	0	0.0%
Ophthalmology	62	13.6%	53	10.3%	46	7.9%
Orthopaedics	108	18.4%	93	17.9%	84	14.8%
Paediatric Surgery	24	21.1%	31	23.7%	27	20.1%
Plastics	230	20.7%	235	19.2%	204	16.8%
Urology	36	3.8%	44	11.1%	35	8.8%
Vascular	12	11.0%	12	13.0%	23	17.6%
Cardiology	121	35.0%	122	39.4%	116	35.5%
Total	**1240**	**23.2%**	**1259**	**23.0%**	**1169**	**20.3%**

Note - ESPI 5 figures and ESPI2 figures are taken from the Ministry of Health ESPI Finals report for March 2021, published 3 May 2021.

The CDHB Improvement Action Plan 20/21 is in place and focusses on CDHB achieving ESPI/Planned Care compliance in the majority of services by the end of June. As at 21 May the overall target is not being met with 1,960 people waiting longer than 120 days for their appointment. This is an improvement of 235 on the preceding four weeks. Ten specialty areas have no patients waiting for **First Specialist Assessment** for longer than 120 days and 29 are not meeting their recovery plan targets.

When considering patients **waiting times for admission and treatment** as at 21 May CDHB is not meeting the plan's targets, 1,216 people have waited longer than 120 days. This has reduced by 197 over the past four weeks. Three specialty areas are meeting their recovery plan target and eleven are not.



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

Hereditary Angioedema self-cannulation

Hereditary Angioedema, a rare genetic disease, involves recurrent swelling of the skin and upper respiratory and gastrointestinal tracts. While swelling resolves on its own after a few days, swelling of the respiratory track carries a risk of suffocation.

During recent years patients have been taught to self-administer a medication sub-cutaneously at home to manage attacks. This medicine was sometimes not sufficient to manage the attack. In such cases people then needed to present to the Emergency Department to receive an intravenous blood product treatment (Berinert – a C1 Esterase Inhibitor).

The Immunology Service is now seeing these patients and offering training on self-cannulation and administration of Berinert at home. This reduces the time to treatment and avoids a small number of presentations at the Emergency Department each year.

Venom Desensitisation in Outpatients Department

The Immunology service oversees desensitisation throughout the South Island for people who have anaphylaxis to venom, honey bee, yellow jacket wasp or paper wasp. Previously, desensitisation occurs in the Medical Day Unit (MDU) over 6 days.

Last year a rapid protocol was trialled that involved four days in the Medical Day Unit followed by four single appointments with care then being transitioned to General Practice for provision of four weekly injections for three years to complete venom desensitisation.

This has been modified further this year when a super rapid desensitisation has been introduced that requires two days in the Medical Day Unit with patients then visiting the Outpatients Department three times for injections before care transitions to General Practice.

This approach has proven successful with no reactions occurring in the Outpatients' building and scarce MDU capacity being released for other purposes.

Tocilizumab Infusions to be referred to Community Infusion Service

Since 2019 nine patients being intravenously given immunoglobulins and 29 rheumatology patients receiving Infliximab have been referred to Community Infusion Service for their regular infusions. This has released MDU capacity for other care processes that can only occur in that setting while enabling patients to receive care in a community setting.

Over time processes around referral and re scripting have been streamlined. The feedback from patients has been overwhelmingly positive.

Work is underway to develop criteria for patients receiving monthly Tocilizumab who would be suitable for transfer to the community for ongoing infusions. It is predicted that this initiative will release an additional 25 MDU spaces each month

Gastroenterology

Previously Gastroenterology appointments were booked by the administrative team, urgent patients were telephoned and routine/surveillance patients were sent appointments by letter. A nurse assessment was completed by the Gastroenterology Nursing staff on the day of the procedure when the patient arrived in the unit.

This process resulted in many vacant endoscopy slots each week due to patients cancelling their appointments at short notice (approx. 16-20/week) leaving insufficient time for the gap to be filled with another patient due to the time required for bowel preparation. Alongside this, many patients received appointments for days and times they couldn't attend, resulting in significant rework altering appointments

Having administrative staff from the service phone patients to check they were intending to attend their appointment did not improve the situation. To address this, Nurse pre-assessment has been shifted from the day of the procedure to four weeks prior to the procedure. As a part of this discussion:

- Patients are offered a choice between two weekday appointments and one weekend appointment to select an appointment time that suits the patient
- patient questions are answered, and information is provided to address patient anxiety at the time of booking. Only patients happy to proceed are given bookings.

There were no unfilled slots in the last two weeks.

Improving the lives of people living with advanced chronic kidney disease

Normally kidneys filter the blood, taking away harmful waste and excess fluid converting it to urine to be removed from the body. When kidneys stop working people are provided with dialysis to carry out this role. This often involves diverting blood supply through a dialysis machine.

Dialysis patients often have higher levels of phosphate in the body which can lead to problems with blood vessels and increase the risk of a heart attack or stroke, resulting in lower quality of life, shorter life expectancy and well as increased healthcare costs.

In line with international guidelines, dialysis patients in New Zealand have phosphate binders prescribed by their kidney specialist to lower blood phosphate levels the phosphate level in their blood stream. However, it is not clear whether reducing phosphate levels is associated with a net benefit by preventing a heart attack or stroke when the side effects of a build-up of calcium in tissue and blood vessels are considered.

The Nephrology service is taking part in an international study with other researchers internationally involving a total of 3,600 patients to ascertain the sweet spot for this aspect of management for people on dialysis.

Child Health

Saturday morning clinics have been put in place to address non-compliant waiting times for First Specialist Assessment in a range of paediatric areas. This is part of planned care initiative funded by the Ministry of Health.

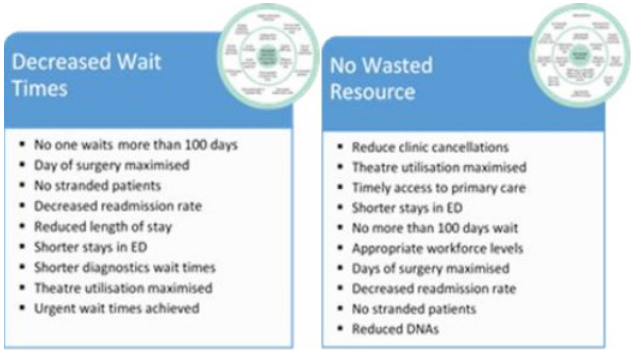
A fixed term Clinical Nurse Specialist is working with Paediatric Neurodevelopmental Senior Medical Officers to review patients on follow-up waiting list to establish if child and whānau needs can be met in the community.

Nurse Injectors in the Eye Service

People with certain types of macular degeneration require four weekly injections of medication into their eyes to prevent them from becoming blind. Demand for this service continues to increase and the majority of these patients remain within the service for life. Without good planning the requirement for this care could overwhelm the Eye Service.

Until recently the model used to provide this service involved nurses in the Eye Service pre-assessing patients before a Senior Medical Officer or a Registered Medical Officer made a decision to treat. If treatment was to be given, Senior Medical Officers, Registered Medical Officers or General Practitioners employed in the service would administer the injections.

Four Registered Nurses working in this area are now trained as injectors, meaning that these staff can now pre-assess and provide injections to patients. This increases the service's capacity and improves its resilience to periods of unplanned leave. It enables nurses to work towards the top of their scope and frees up Senior Medical Officers and Registered Medical officers to provide care that only they can. It also improves flow through clinics as it avoids nurses having to interrupt other practitioners to provide an injection following assessment of patients.

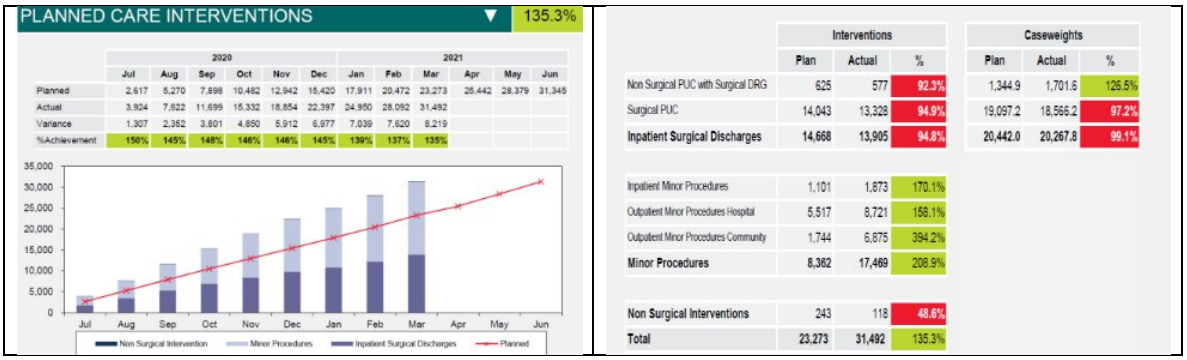


Theatre Capacity and Theatre Utilisation

Planned care targets have been provided to the Ministry of Health. As per last year, they incorporate planned inpatient operations as well as range of procedures provided to hospital inpatients, outpatients and patients in community settings.

As at year end our target is to deliver a total of 31,359 planned care interventions made up of 19,614 surgical discharges, 11,409 minor procedures and 336 non-surgical interventions. This is 2% higher than the 2019/20 target of 30,675.

Reporting from the Ministry of Health to the end of January shows that Canterbury DHB is exceeding its overall planned care targets by 35% however within this inpatient surgical discharges have fallen behind target.



Internal reporting to the week ending 21 May shows that 37,598 planned care events have been provided – this is 10,225 ahead of the target of 22,373.

Within this, 16,672 planned inpatient surgical discharges were provided - 276 below the phased target of 16,948. Planning and Funding, operational and production planning teams are working together to update plans to ensure that we successfully deliver against these targets.

20,116 minor procedures have been provided - 9,992 ahead of the target of 10,124. Inpatient, outpatient and community provision are all ahead of target.

Current theatre volumes

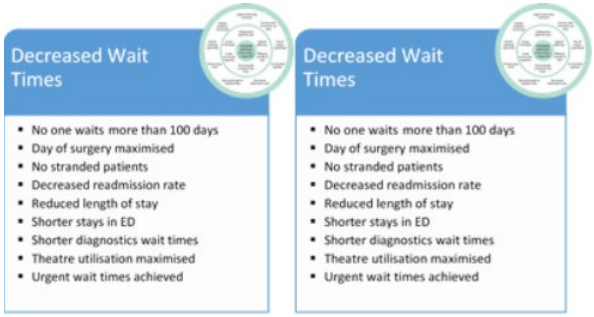
Overall, when all operating by or on behalf of Canterbury DHB is considered (in house, outplaced and outsourced) more operations were provided in theatres in March 2021 than in March 2020 (2,893 versus 2,303) and April 2021 than April 2020 (2,514 compared with 1,294). April 2020's volume was artificially reduced due to COVID lockdown. In order to counter this comparison against April 2019 was considered, it also shows an increase in surgery provided in 2021. This increased number of operations has been provided despite a significant reduction in the use of outplaced and outsourced surgery following transition to Waipapa.

Demand for surgery following arranged and acute admissions during March and April; was 29% higher than in those months in 2020 with 1,200 theatre events in March 2020 and 1,200 in April. This was a 6% reduction compared with the same months in 2019.

The number of planned operations carried out at Burwood Hospital was 7% higher in March 2021 compared with March 2020 and 10% higher in April 2021 than in April 2019 with 300 planned events in March 2021 and 264 in April 2021.

The number of outsourced and outplaced events has been reduced with increased in-house capacity enabling much of this work to be repatriated. The final tranche of outplaced surgery being repatriated occurred in the last week of February when dental operating returned to Christchurch campus. During March, 213 outplaced or outsourced theatre events were provided – 50% of March 2020, there were 199 such events in April – 60% of April 2019.

More elective surgery was provided at Christchurch Hospital during both March and April than previously with 1,196 elective theatre events in March 2021 and 875 in April 2021 compared with 668 in March 2020 and 494 in April 2019.



Mental Health Services

New Zealand has a network of regional forensic mental health services (FMHS) that provide inpatient care, community follow-up, and liaison/consultation to adult mental health services, prisons and the Courts. FMHS work with people at the intersection of the criminal justice system and mental health services. They have particular expertise and experience in assessing, treating and caring for people who have offended or may offend because of their mental illness. This includes provision of advice to the Courts regarding the medico-legal interface and special knowledge of the law concerning the mental state of an offender or alleged offender. This consumer group is often one of the most vulnerable in health services. People may present with complex issues due to socio-economic determinants, trauma, violence, alcohol and other substance misuse, offending as well as their illness. FMHS also has a role in working with individuals whose potential risk to themselves and others is such that adult mental health services cannot manage them safely.

To be treated by Canterbury's FMHS consumers must be 18 years of age or over with a suspected major mental disorder and have committed a serious violent offence with a clear nexus between their mental state and the offence. People referred from prison with moderate to severe mental health issues who may have become unwell subsequent to their offending, and those on less serious charges but requiring specialist mental health follow up, may also be accepted for care.

Forensic Mental Health Service Inpatient Services

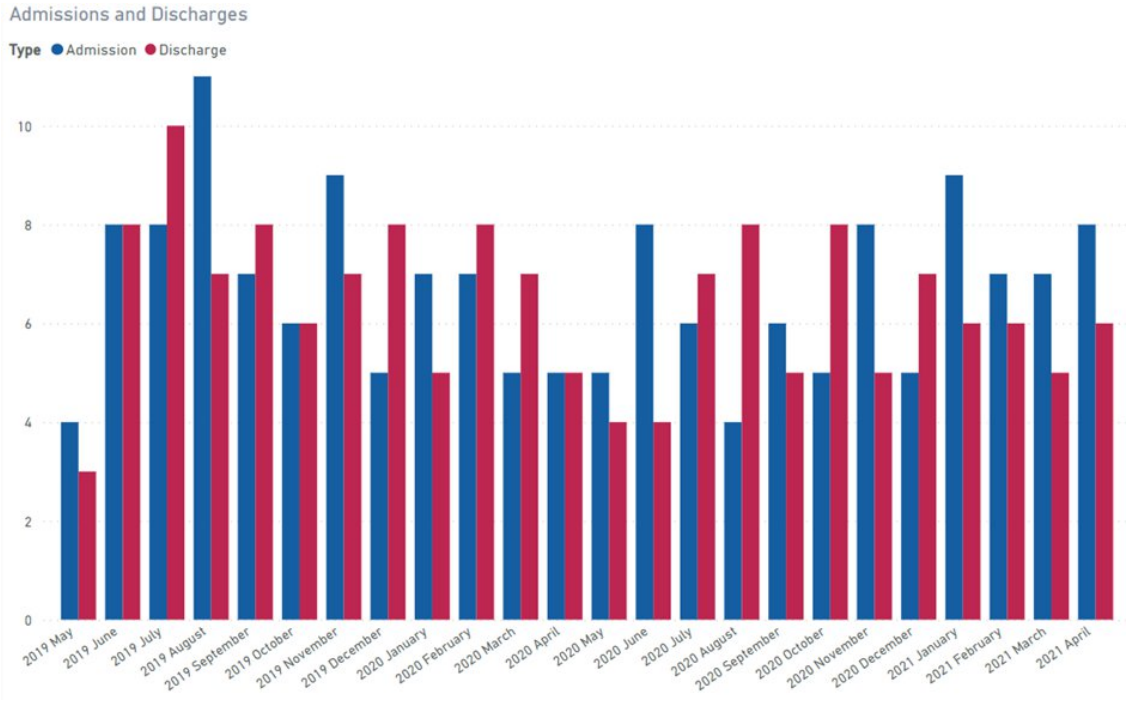
Canterbury's regional FMHS has three inpatient units on the Hillmorton Hospital site:

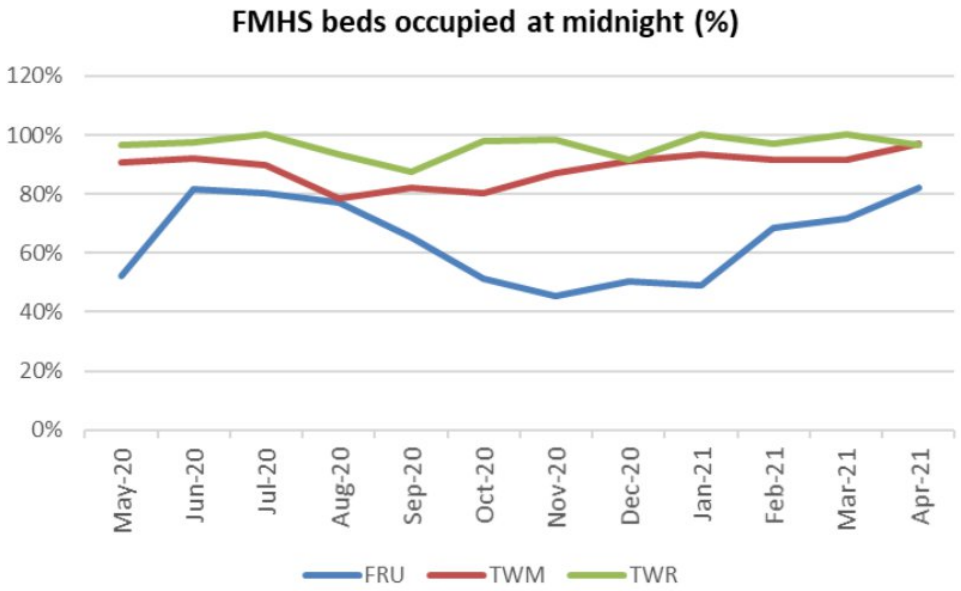
Te Whare Manaaki a 15-bed medium secure unit for consumers from the Canterbury, West Coast, Nelson/Marlborough regions. The service assesses and treats consumers who have or may have offended in the context of their mental illness. Consumers are referred from Canterbury Prisons, the Courts, the community and other mental health services. This is typically the first contact point for individuals coming into the inpatient setting.

Te Whare Hohou Roko a 9-bed medium secure unit, with the purpose of providing extended care to those consumers who have a longer journey through the forensic mental health service or require more extensive assistance to rehabilitate to the community.

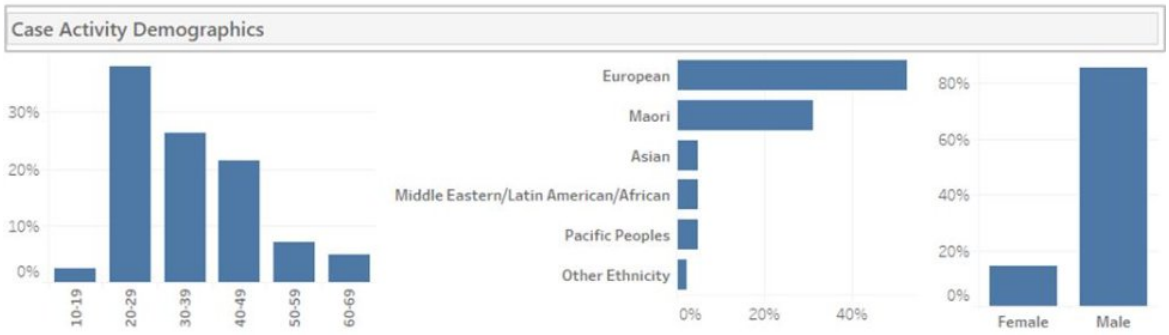
Te Whare Mauriora a 13-bed open forensic mental health rehabilitation ward based on the principles of the 'Good Lives Model.' The Te Whare Mauriora team provide a risk managed transition from a medium secure environment into the community.

FMHS Inpatient Admissions and Discharges and Occupancy





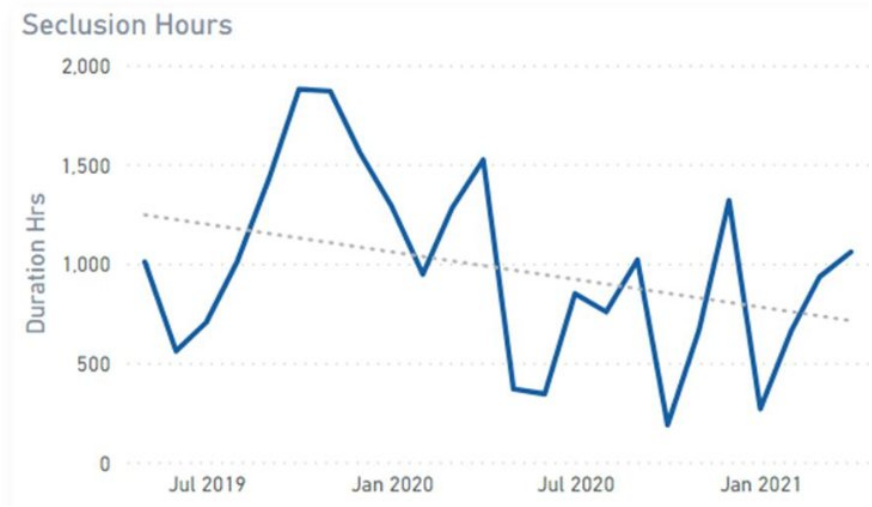
Demographic Breakdown of FMHS Inpatients



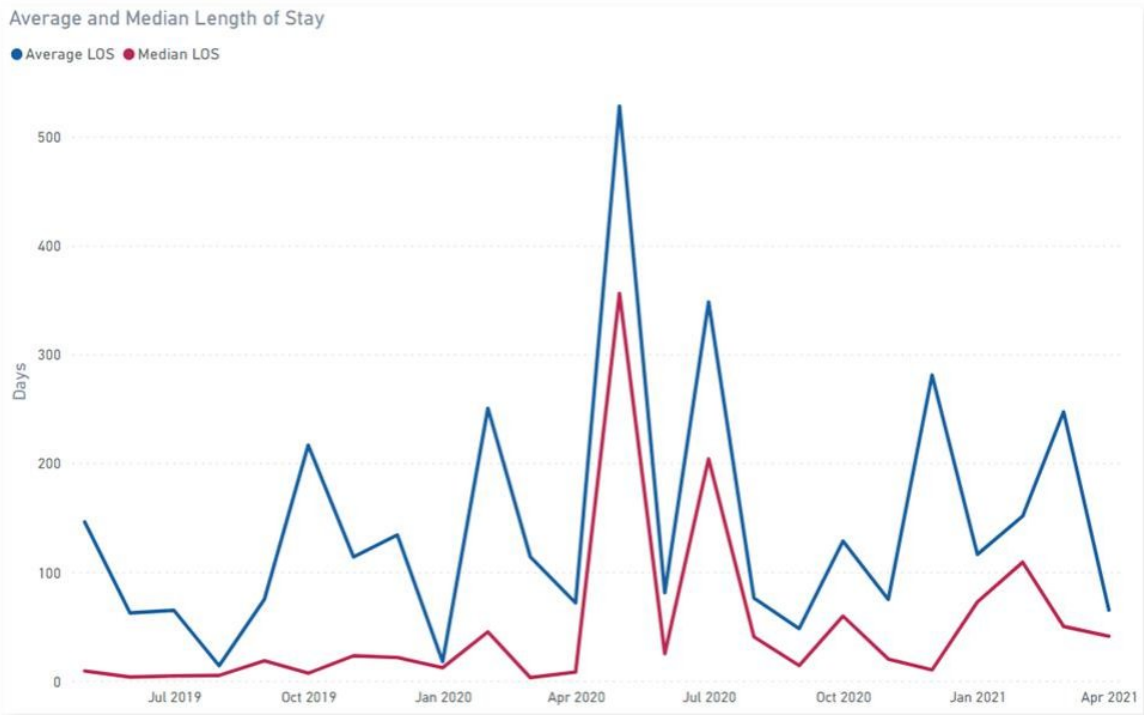
The majority of forensic mental health consumers are male and aged 29 to 49 years old. Māori are over-represented in this group, so cultural competence of clinicians is important.

FMHS Seclusion Hours

Seclusion hours have fluctuated, overall trending down since July 2019 but appear to be plateauing over the last 12 months. Seclusion hours for the FMHS represent approximately two thirds of all seclusion hours across Specialist Mental Health Services and FMHS consumers are secluded at a higher rate than people in the general adult acute unit. Drivers for this include high acuity admissions from prison, existing inpatient acuity and placement of consumers with complex needs from other services, eg: Intellectual Disability in a setting not conducive to their needs compounded by significant limitations of building design and difficulties staffing to meet high demand needs, eg: 3:1 specials (3 staff per person).



FMHS Inpatient Average and Median Length of Stay for Discharged Consumers



Consumer movement through the inpatient service is at times limited by the availability of community placements, and ongoing difficulty finding accommodation suited to the special needs of this consumer group. An increase in funding for community step down beds at Pathways Te Whare Paki Mai Forensic Residential service has provided some assistance.

Community Services

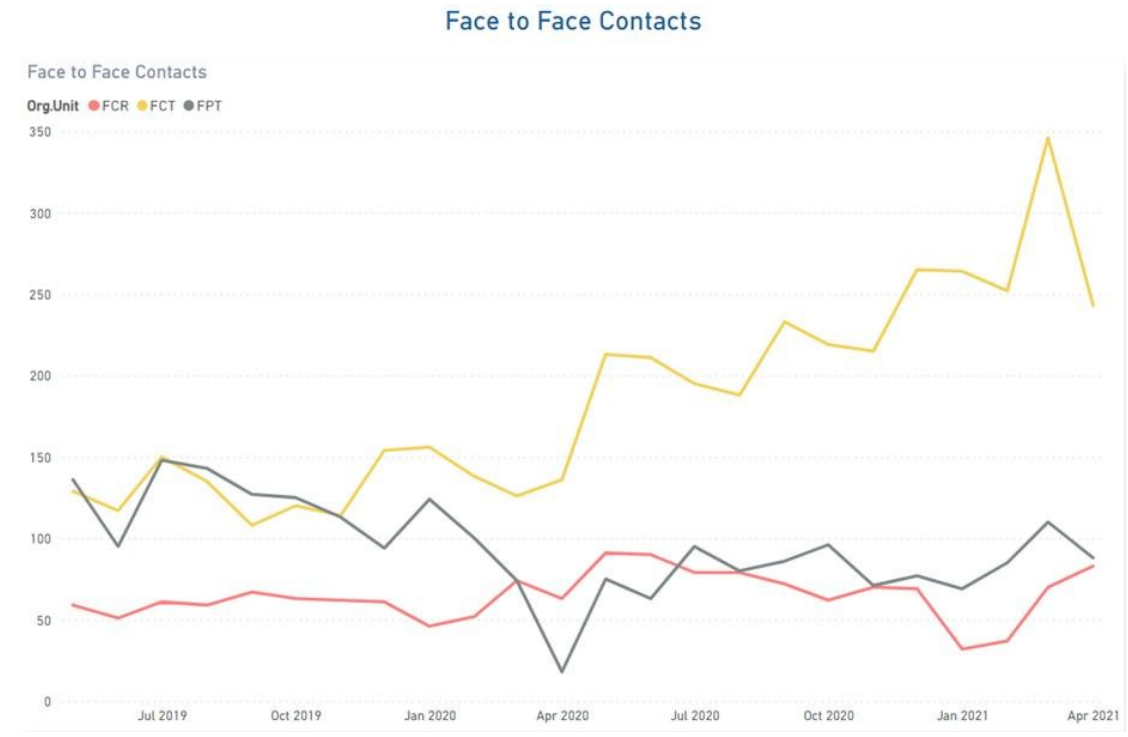
Forensic Community Team (FCT) - delivers assertive case management for consumers who pose a high risk to others and have complex needs. Interventions are tailored to the individual's needs and the length of time they will be under care is governed by their legal status, risk and reintegration needs. The service also coordinates regional support for the West Coast, Nelson/Marlborough and South Canterbury DHBs and conducts risk assessments for other mental health services.

Forensic Prison Team (FPT) - delivers mental health care for people in prison with moderate to severe mental health needs and consumers who had been under the care of community mental health services prior to imprisonment. The service uses a consult liaison model of care.

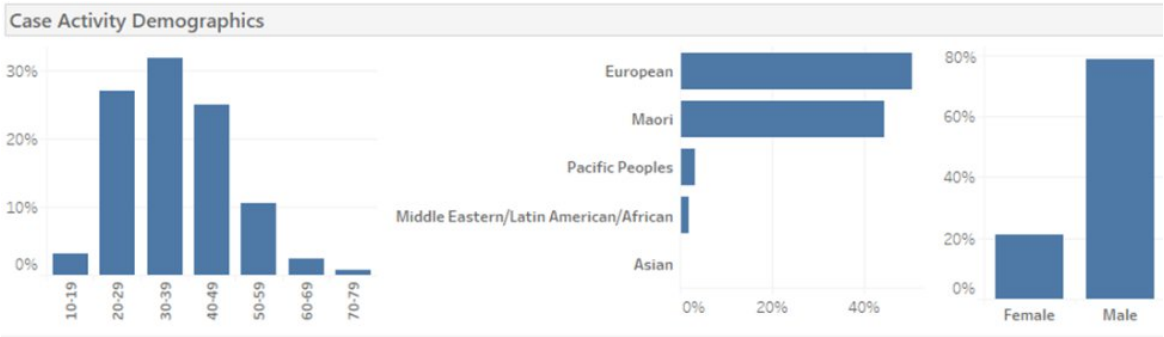
Forensic Court Team (FCR) – a 1.0 FTE specialist mental health nurse who is based at the Christchurch District Court. This role provides advocacy, advice, and mental health expertise pertaining to issues of fitness to stand trial and insanity. Consultant clinical psychologists and psychiatrists may also be appointed to prepare medico-legal reports directed by the Court.

FMHS Referrals (last 24 months)

FMHS Community Teams' Face to Face Contacts



Demographic Breakdown of FMHS Community Consumers



Challenges

Key challenges for FMHS:

- **Demand** - the Canterbury Prison muster has increased whereas the number of inpatient FMHS beds has remained the same. This has resulted in increased demand for inpatient beds and people being waitlisted for access, and their condition may deteriorate in the interim.
- **Buildings** - the size, layout and maintenance needs of the buildings. There is no privacy in the admission area of Te Whare Manaaki, and no high care area. This can result in consumers becoming more agitated or irritated by each other. The relatively small size and lack of purpose-built spaces results in restricted options for de-escalation (increasing the potential need for seclusion).
- **Intellectual Disability Consumers –** there is a need to care for consumers from the Intellectual Disability service due to lack of other suitable facilities.
- **Acuity** – some consumers have extremely complex needs and may require high staff input to provide adequate care and safety for all e.g. 3 staff to one consumer.
- **Staffing** – there are ongoing issues staffing units due to workforce pressures. Experienced nursing and allied health professionals are important to the staffing mix.

Living within our Means

The Hospital & Specialist Service Statement of Financial Performance covers the following hospital services:

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

Hospital & Specialist Service Statement of Comprehensive Revenue and Expense For the 10 Months Ended 30 April 2021

MONTH $'000				YEAR TO DATE $'000		
20/21 Actual $'000	20/21 Budget $'000	20/21 Variance $'000		20/21 Actual $'000	20/21 Budget $'000	20/21 Variance $'000
			Operating Revenue			
255	268	(13)	From Funder Arm	2,688	2,659	29
1,637	1,541	96	MOH Revenue	16,480	15,778	702
6,802	4,419	2,383	Patient Related Revenue	49,117	44,086	5,031
405	1,716	(1,311)	Other Revenue	25,850	17,092	8,758
9,099	7,944	1,155	**TOTAL OPERATING REVENUE**	94,135	79,615	14,520
			Operating Expenditure			
			Personnel Costs			
73,238	74,069	831	Personnel Costs - CDHB Staff	687,504	692,313	4,809
2,165	1,973	(192)	Personnel Costs - Bureau & Contractors	20,569	19,769	(800)
75,403	76,042	639	**Total Personnel Costs**	708,073	712,082	4,009
12,812	14,022	1,210	Treatment Related Costs	137,357	139,152	1,795
4,349	4,049	(300)	Non Treatment Related Costs	40,885	40,475	(410)
92,564	94,113	1,549	**TOTAL OPERATING EXPENDITURE**	886,315	891,709	5,394
(83,465)	**(86,169)**	**2,704**	**OPERATING RESULTS BEFORE INTEREST AND DEPRECIATION**	**(792,180)**	**(812,094)**	**19,914**
			Indirect Income			
49	1	48	Donations & Trust Funds	148	13	135
49	**1**	**48**	**TOTAL INDIRECT INCOME**	**148**	**13**	**135**
			Indirect Expenses			
2,789	2,377	(412)	Depreciation	28,227	24,463	(3,764)
-	-	-	Net (Gain) Loss on Disposal of Fixed assets	(330)	-	330
2,789	**2,377**	**(412)**	**TOTAL INDIRECT EXPENSES**	**27,897**	**24,463**	**(3,434)**
(86,205)	**(88,545)**	**2,340**	**TOTAL SURPLUS / (DEFICIT)**	**(819,929)**	**(836,544)**	**16,615**

Achievements/Issues of Note

Simple Swap - A Change for Good

A working group, tasked with reviewing continence products, has found that there are less costly alternatives to a product that is used in many ward areas in high volumes and that changing will have no impact on patient care.

High absorbency sheets, regularly known as “greenies”, are used as a continence product. The same product is also commonly used as a sheet to provide a clean surface for procedures where there might be some light spillage but where a high level of absorbency is not required.

Two alternative products have been identified. One provides sufficient absorbency for light spills, comes already folded (saving hospital aides’ time), and costs seven cents per item less than the ‘greenies’ they will replace. This has the potential to save tens of thousands of dollars over time and as more areas start ordering the new product.

Alongside this, an alternative supply of ‘greenies’ has been identified that offers the same absorbency but contains recycled cellular fluff. This ‘greener greenie’ costs two cents less per item and is already being distributed to some areas.

Rollout of these items is well underway with the old item being removed from the ordering system and clinical areas already using both new items. A forecast of annual savings will be made once an ordering history, that reflects the requirements of the clinical areas using these products, has been accumulated

Evaluation was made in line with the Treatment and Technologies Programme using the ECRI (Emergency Care Research Institute) electronic tool and in consultation with relevant clinical speciality stakeholders.

Surgical Telescope Repair and Assessment

Rigid telescopes are used within theatres to enable surgical care to be provided. Around five telescopes are damaged and repaired each month at an average cost of $3,000.

Previously servicing of theatre-based rigid telescopes was arranged by the Clinical Nurse Specialist for each individual operating theatre. This meant that there was not a clear view of the types of issues, costs for exchange or time taken to return telescopes to use.

Medical Physics and Bioengineering has now taken up responsibility for this process. This involves the Clinical Nurse Specialist sending the telescope to Medical Physics and Bioengineering and receiving one back in exchange.

This frees up valuable nursing time for tasks that only they can perform. It also enables a consolidated approach to the management of the fleet of rigid telescopes and maintenance of relationships with key supply partners.

This has already provided some benefits by reducing downtime and minimising exchange costs.

Birthing Suite Medication Costs

Changes in the drugs used for induction of labour are saving more than forecast. Overall medication cost savings for birthing suite over six months have totalled $117,669, an average of $19,611 savings per month. The original business case had estimated $125,000 savings over 12 months.

More than half of the drug cost savings is directly associated with the cost of the induction medication with an average cost of $11,790 per month when Cervidil was being used, against $305 per month on Misoprostol now.

Alongside this the rate of interventions amongst women receiving an induction of labour has reduced:

- Caesarean sections from 32% to 20%
- Assisted deliveries from 25% to 19%
- Epidurals in labour from 38% to 24%

- Use of oxytocin for augmentation was 44% to 35%

Vaginal birth rate in this cohort has increased from 43% to 62%.

Personal Protective Equipment and Chemotherapy

When preparing bags of cytotoxic drugs for intravenous administration the bag needs to be “spiked”. This involves pushing a plastic needle into a port, breaking a seal. This process carries a high risk of aeorsolisation of the bag contents, which can damage the health of those in proximity to the process, i.e. nursing staff and the patients’ whānau.

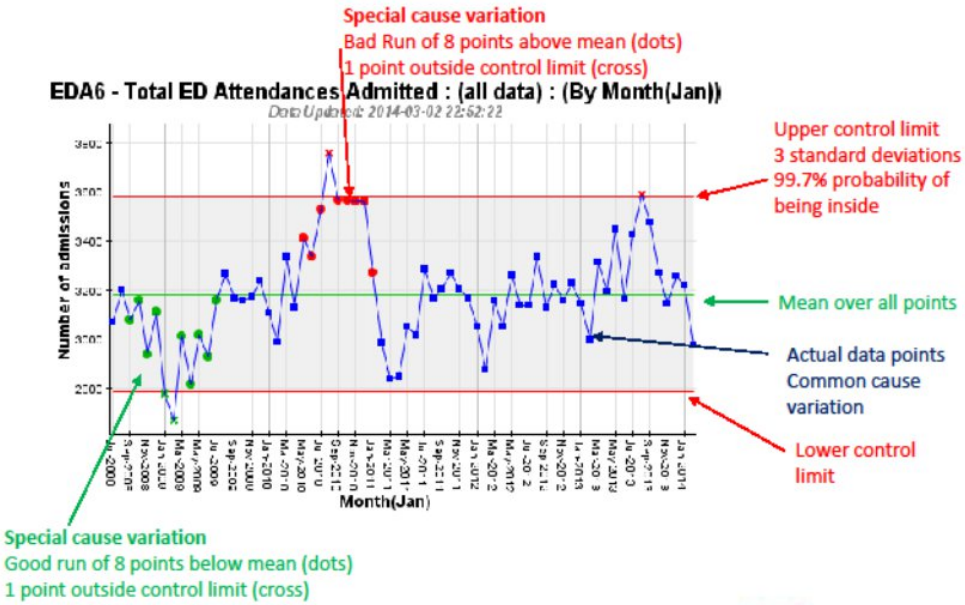
All other DHBs in the South Island pre-spike the chemo bags, delivering them to the bedside with a part of the giving line attached – which prevents aeorsolisation exposure.

In Canterbury this process is carried out beside the patient and necessitates increased requirements for personal protective equipment.

The Nursing Director for Oncology, Haematology and Palliative Care has followed the ECRI process to seek a change in chemo delivery that will see bags pre-spiked for patients in the adult cancer services. This requires approval of a robust business case at executive level for endorsement and funding by Baxter’s to pre-spike the chemo bags.

As a consequence of changing to this way of working, there will be reduced utilisation of personal protective equipment that will save approximately $30,000 per annum. More savings are possible if this is adopted in paediatric cancer services.

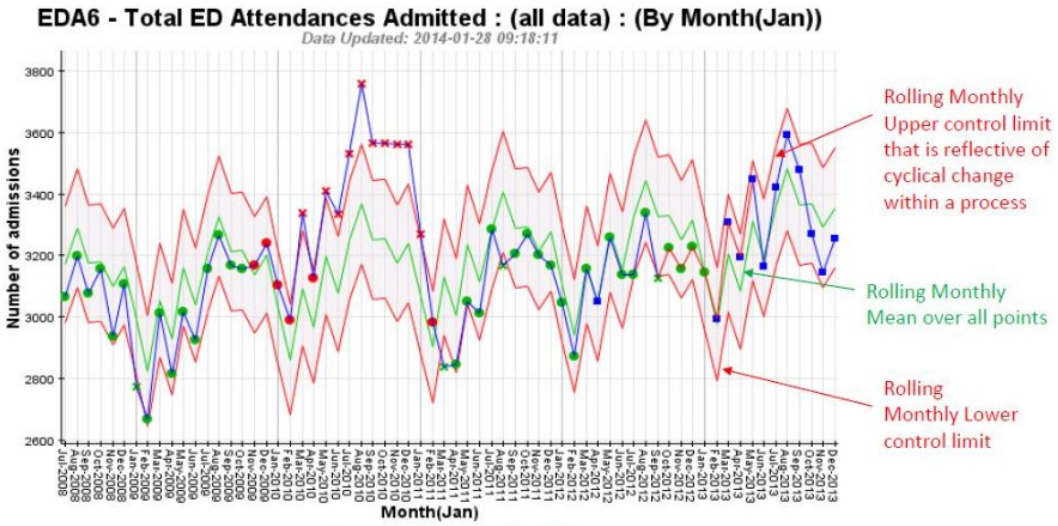
SPC: How to Interpret a Control Chart



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

CARE CAPACITY DEMAND MANAGEMENT UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

SOURCE: **Janette Dallas, CCDM Programme Manager**

APPROVED BY: **Becky Hickmott, Acting Executive Director of Nursing**

DATE: **3 June 2021**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report has been generated for the Committee as a bi-annual update on the Care Capacity Demand Management programme to better match nursing and midwifery supply to patient care demand, as well as providing a staffing model / workforce measure and methodology in the near future for allied health. It was approved by the Board for implementation in August 2019.

2. RECOMMENDATION

That the Committee:

i. notes that the Care Capacity Demand Management programme is well underway to meeting the commitment as required by the New Zealand Nursing Organisation (*NZNO*), DHB and Ministry of Health (*MoH*) Accord to implement better match of nursing and midwifery supply to patient care demand.

3. BACKGROUND

In July 2018 the NZNO, DHBs and MoH signed an Accord committing the parties to having sufficient nurses and midwives in public hospitals to ensure staff and patient safety. The Accord mandates a Care Capacity Demand Management (*CCDM*) programme be implemented by all DHBs by June 2021.

The implementation of the CCDM programme commenced in July 2019 at the CDHB. This required the investment of $3.465M for the software implementation and staff training costs that would be incurred. Staffing costs were allocated by the MoH for nine CCDM staff. Ongoing operational costs will be required to support the business as usual staff resourcing and software licensing.

4. UPDATE

CCDM is deemed *"fully implemented"* when we can demonstrate that all five CCDM Standards – governance, patient acuity, core data set, staffing methodology and variance response, is being met. CCDM was required to be fully implemented by 30 June 2021. Given we commenced this programme late, it is noted and accepted by the national programme office that we will not meet this target. Each standard has a range of criteria to be met. Seventy three (73) areas have implemented Trendcare over the past 18 months. This is a significant achievement that occurred in spite of interruptions with COVID-19. Full implementation will occur in 2022.

The national Safe Staffing Healthy Workplaces (*SSHW*) Governance Group (*GG*) will be evaluating the status of the implementation of the CCDM approach in Canterbury later in the year. The Canterbury DHB CCDM Governance group meets monthly with attendance averaging 75% attendance (standard is 80%).

Working groups that have been set up as part of meeting the CCDM requirements are working well and we have moved to a business as usual (*BAU*) model with the terms of reference revised.

a. Core Data Set

The work plan for the Core Data Set has achieved the target and the core data set is displayed on seeing our system.

Local Data Councils will be set up in each area and meet monthly to jointly identify and resolve issues, set goals and measure results. We have local data councils underway at Burwood, Specialist Mental Health, Ashburton and Christchurch public, and Maternity.

b. Variance Response Management

We have completed escalation plans for each site and have an approved deployment policy. We are currently working with the vendors and decision support to develop the Variance Indicator Scoring system to enable us to meet the requirements of full implementation of this standard.

c. FTE Calculations

The FTE Calculations working group has undertaken a substantial piece of work in partnership with the nursing reps, the unions, as well as our P&C, Decision Support, and Finance teams to finalise the Canterbury DHB's protocol for FTE Calculations. The work was signed of in principle by the Canterbury DHB CCDM Governance Group with an agreement that final meetings were to take place with the finance team regarding data assumptions made. The national Safe Staffing Health Workplace Unit has supported these discussions resulting in final amendments made in agreement with the union members.

An agreed process as to how FTE calculations will then be operationalised will be drawn up and appended to the protocol.

Finally, attached is an example of the new CCDM core data graphs that are live on "Seeing our System" that help to provide visual tools around each clinical area. The powerpoint shows the data from this high complex care environment and the challenges in staffing and care delivery in this complicated clinical space.

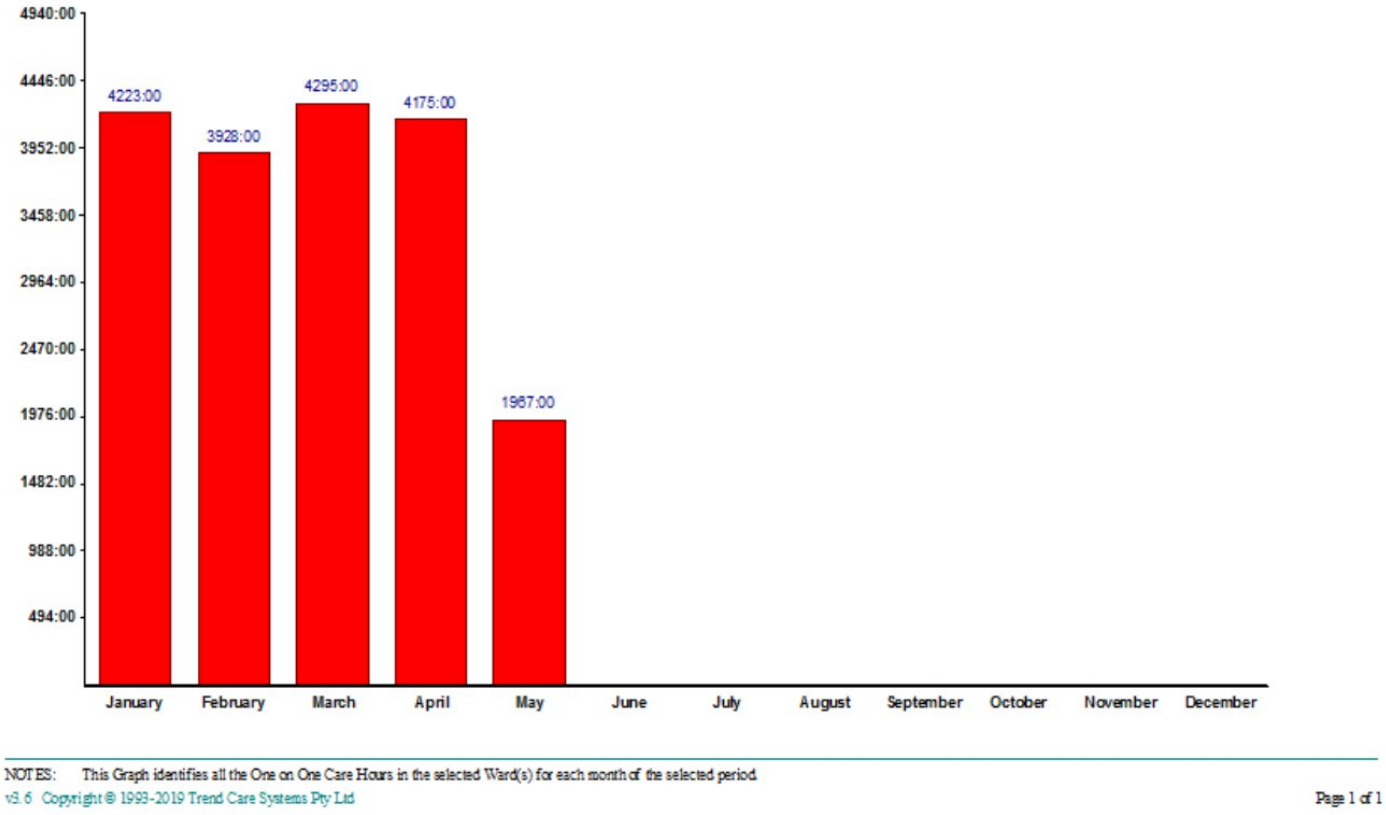
5. APPENDICES

Appendix 1: Powerpoint – "Example of high care area and data underpinning care requirements".

Example of a high care area and data demonstrating care delivery requirements

Core data set and trendcare data

Trendcare Ward one on one care hours



NOTES: This Graph identifies all the One on One Care Hours in the selected Ward(s) for each month of the selected period.

This area has a relatively static population of high need / risk consumers

The unit is currently closed to further admissions due to acuity and environmental limitations of the small consumers in care

Acuity is 1:1 care hours, with consumers in this high care can be 2:1 care due to the risk

Staffing allocation is consistent, fluctuations are to do with short periods of pt leave;

Predicted Required	Actual Required	Variance
18:00	18:00	0:00
18:00	18:00	0:00
9:00	9:00	0:00
18:00	18:00	0:00
18:00	18:00	0:00
9:00	9:00	0:00
11:00	11:00	0:00
9:00	9:00	0:00
9:00	9:00	0:00
12:00	12:00	0:00
18:00	18:00	0:00
18:00	18:00	0:00
9:00	9:00	0:00
18:00	18:00	0:00
18:00	18:00	0:00
9:00	9:00	0:00
9:00	9:00	0:00
9:00	9:00	0:00
9:00	9:00	0:00
18:00	18:00	0:00
18:00	20:00	2:00
9:00	9:00	0:00
18:00	18:00	0:00
14:00	14:00	0:00
9:00	9:00	0:00
9:00	9:00	0:00
9:00	9:00	0:00
9:00	9:00	0:00
0:00	9:00	9:00
9:00	9:00	0:00
18:00	18:00	0:00
18:00	18:00	0:00
9:00	9:00	0:00
18:00	18:00	0:00
14:00	14:00	0:00
9:00	9:00	0:00
9:00	11:00	2:00
9:00	9:00	0:00
9:00	9:00	0:00
9:00	9:00	0:00
12:00	9:00	-3:00
9:00	9:00	0:00
18:00	18:00	0:00
18:00	18:00	0:00
9:00	9:00	0:00
18:00	18:00	0:00
14:00	14:00	0:00
9:00	9:00	0:00
9:00	9:00	0:00
9:00	9:00	0:00

- Staff complete a “predication” of care required at the start of each shift
- At the end of the shift they “actualise” to capture the actual care delivered. This then determines the “variance”
- High level of 1:1 hours required
- This snip shows that for the most part there is no variance between predication and actual workload.
- There is a large negative variance between patient hours required and hours available, meaning either insufficient staffing or critical incidents have occurred
- When looking at the data much of the hours required are 1:1 for 18 hours for two of the four consumers.
- If the requirement is 18 hours 1:1 to manage risk but staffing does not allow for this, they have not been able to update the actualisation to reflect actual care delivered.
- This leads to the large positive variance that you see on the next three slides for each shift.

Ward Daily Hours Graph

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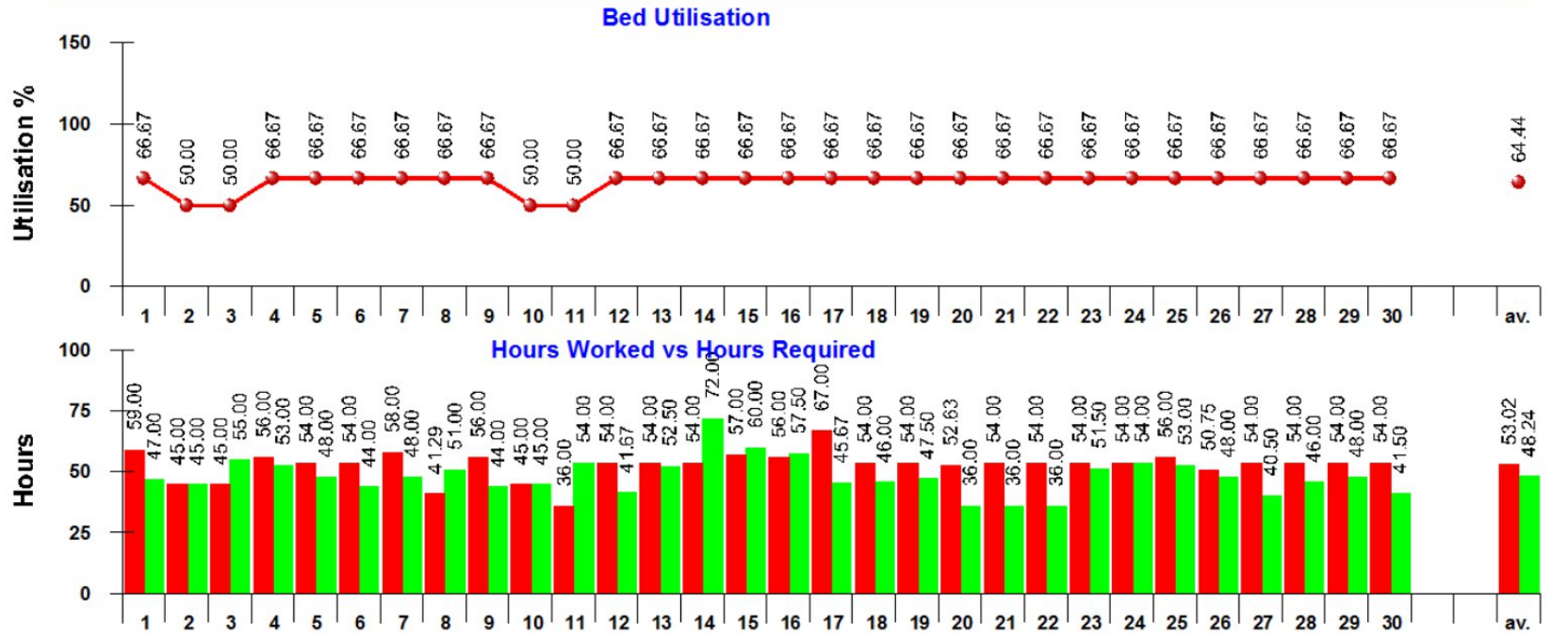
3:41:41 PM

Ward: HM[redacted]
Month: April, 2021



Productivity Index (%)	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	
	[126]	[100]	[82]	[106]	[113]	[123]	[121]	[81]	[127]	[100]	[67]	[130]	[103]	[75]	[95]	[97]	[147]	[117]	[114]	[146]	[150]	[150]	[105]	[100]	[106]	[106]	[133]	[117]	[113]	[130]	[109.90]

LEGEND
- Required Inpatient Clinical Hours
- Actual inpatient Clinical Hours Worked

NOTES: * This graph displays bed utilisation, the daily clinical hours required for inpatient care and the hours provided for inpatient care in the selected ward/department for the selected month. The productivity index is displayed for each day and rounded off to the closest whole precentage.

Page 1 of 3

Due to the nature of the consumer group, 1:1 hours are required to provide safe care.

So there are consistent requirements across all shifts

Ward Daily Hours Graph

Printed: 14/05/2021
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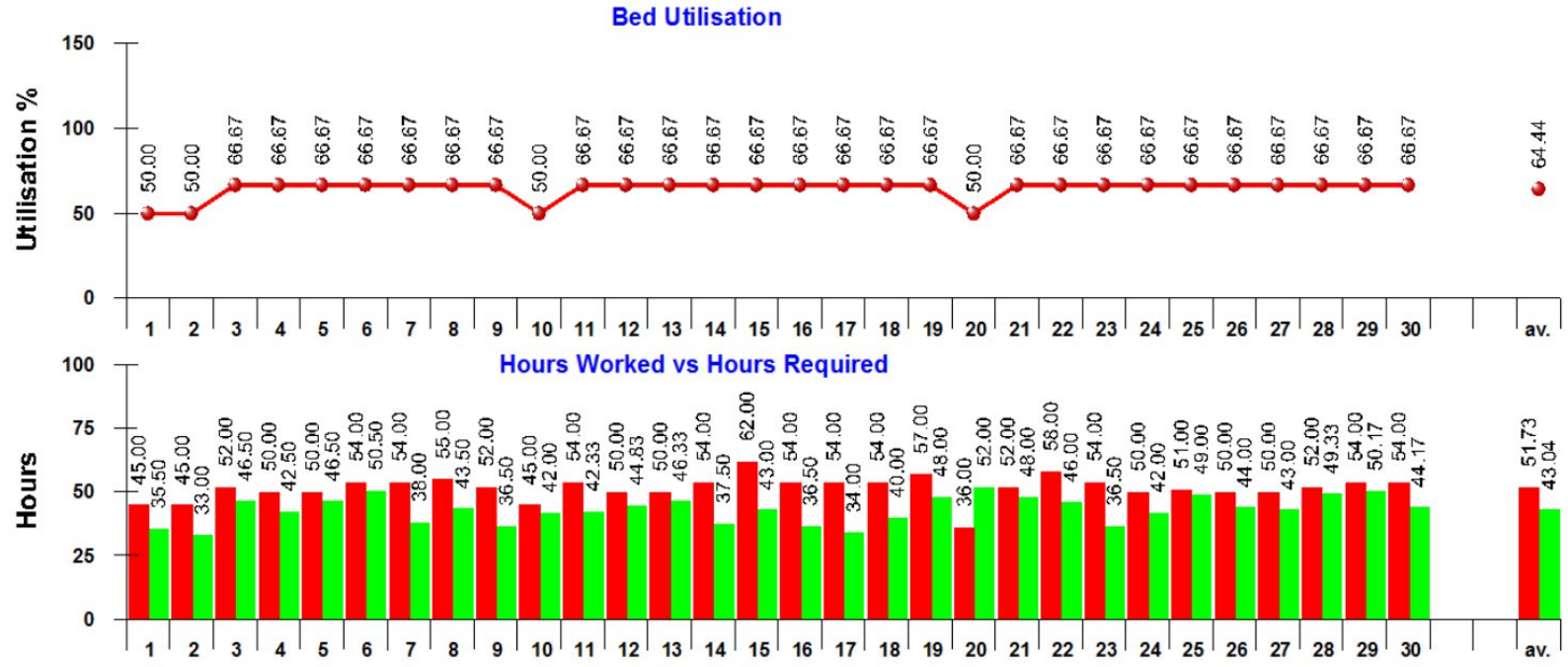
Month: April, 2021



Productivity	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	
Index (%)	[127]	[136]	[112]	[118]	[108]	[107]	[142]	[126]	[142]	[107]	[128]	[112]	[108]	[144]	[144]	[148]	[159]	[135]	[119]	[69]	[108]	[126]	[148]	[119]	[104]	[114]	[116]	[105]	[108]	[122]	[120.20]

LEGEND

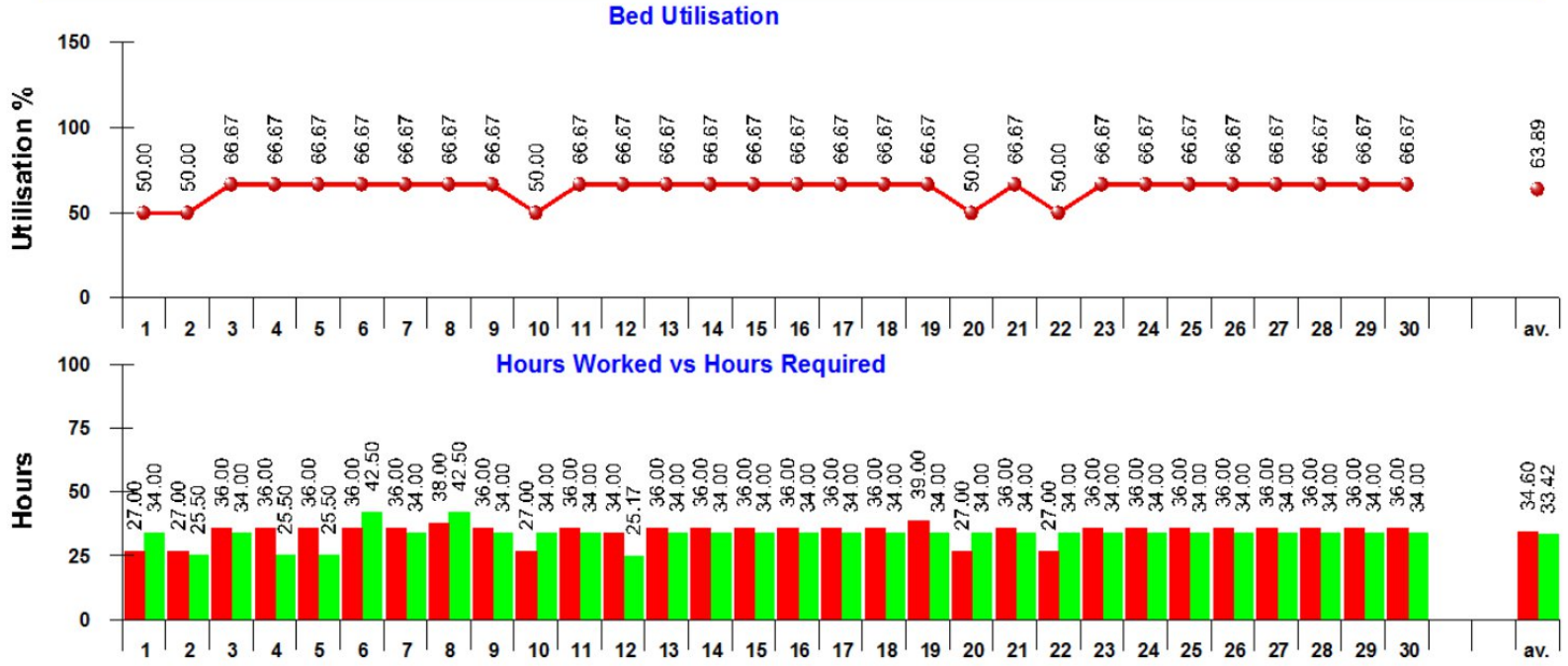
- Required Inpatient Clinical Hours
- Actual inpatient Clinical Hours Worked

NOTES: * This graph displays bed utilisation, the daily clinical hours required for inpatient care and the hours provided for inpatient care in the selected ward/department for the selected month. The productivity index is displayed for each day and rounded off to the closest whole precentage.

Ward Daily Hours Graph

Printed: 14/05/2021
3:41:41 PM

Month: April, 2021



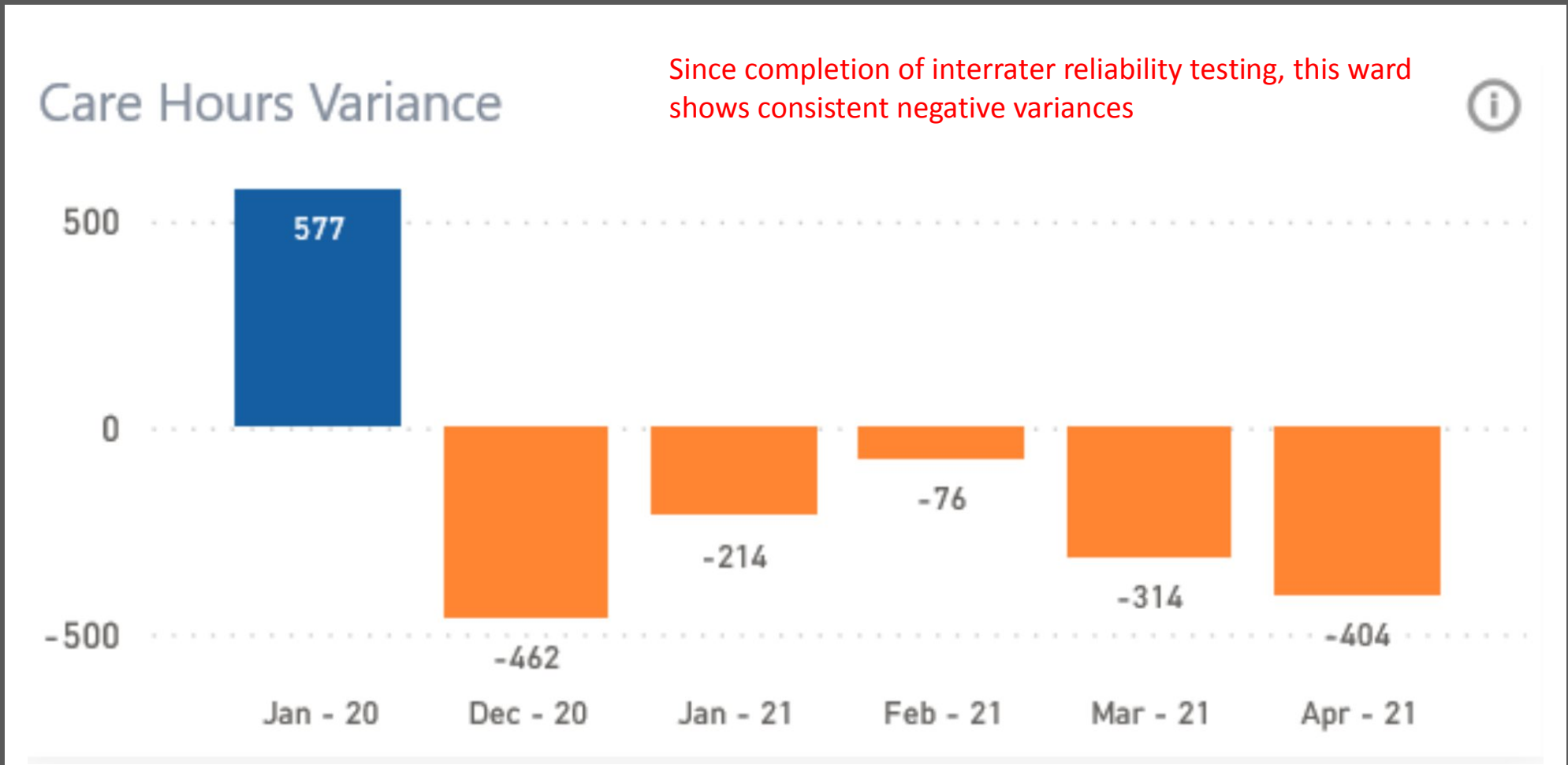
Productivity Index (%)	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	
	[79]	[106]	[106]	[141]	[141]	[85]	[106]	[89]	[106]	[79]	[106]	[135]	[106]	[106]	[106]	[106]	[106]	[106]	[115]	[79]	[106]	[79]	[106]	[106]	[106]	[106]	[106]	[106]	[106]	[106]	[103.52]

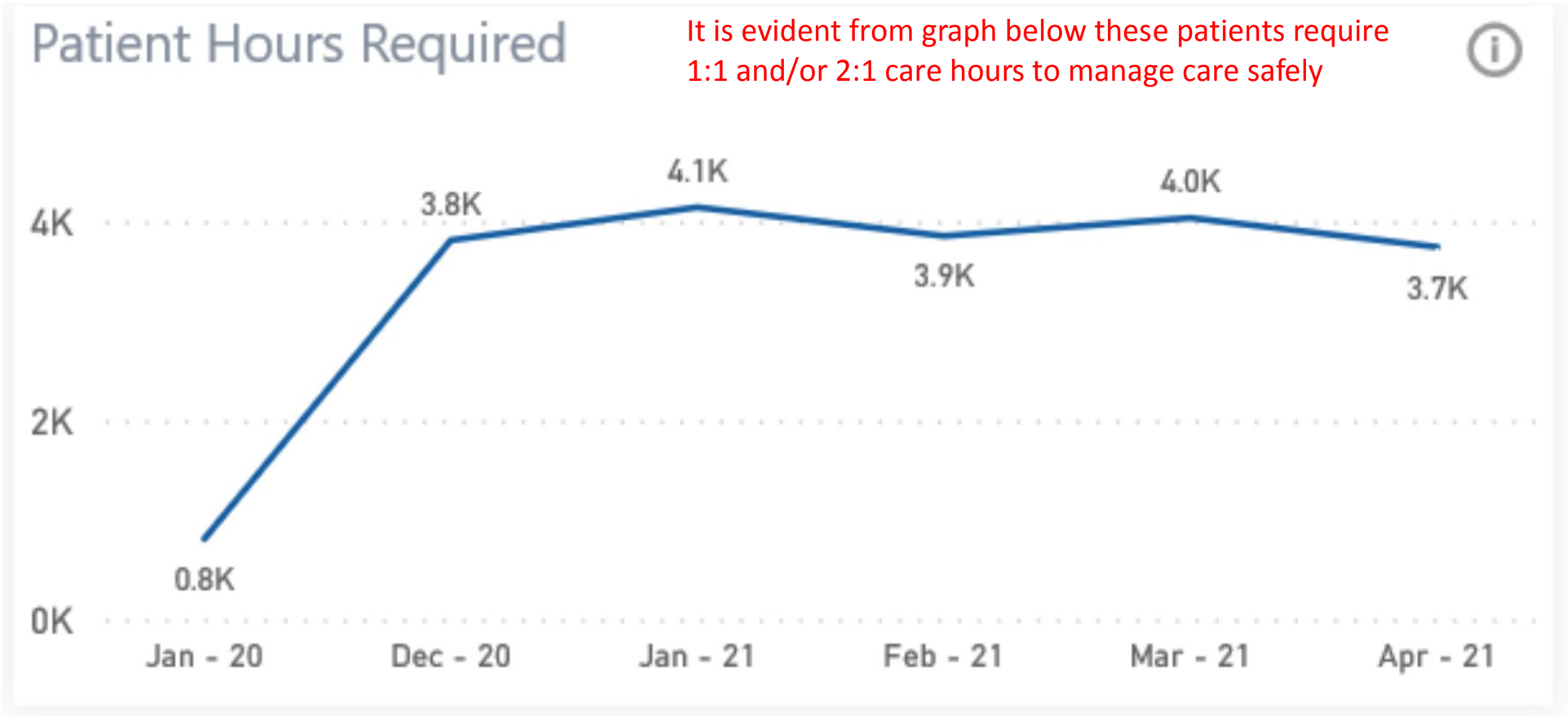
LEGEND

- Required Inpatient Clinical Hours
- Actual inpatient Clinical Hours Worked

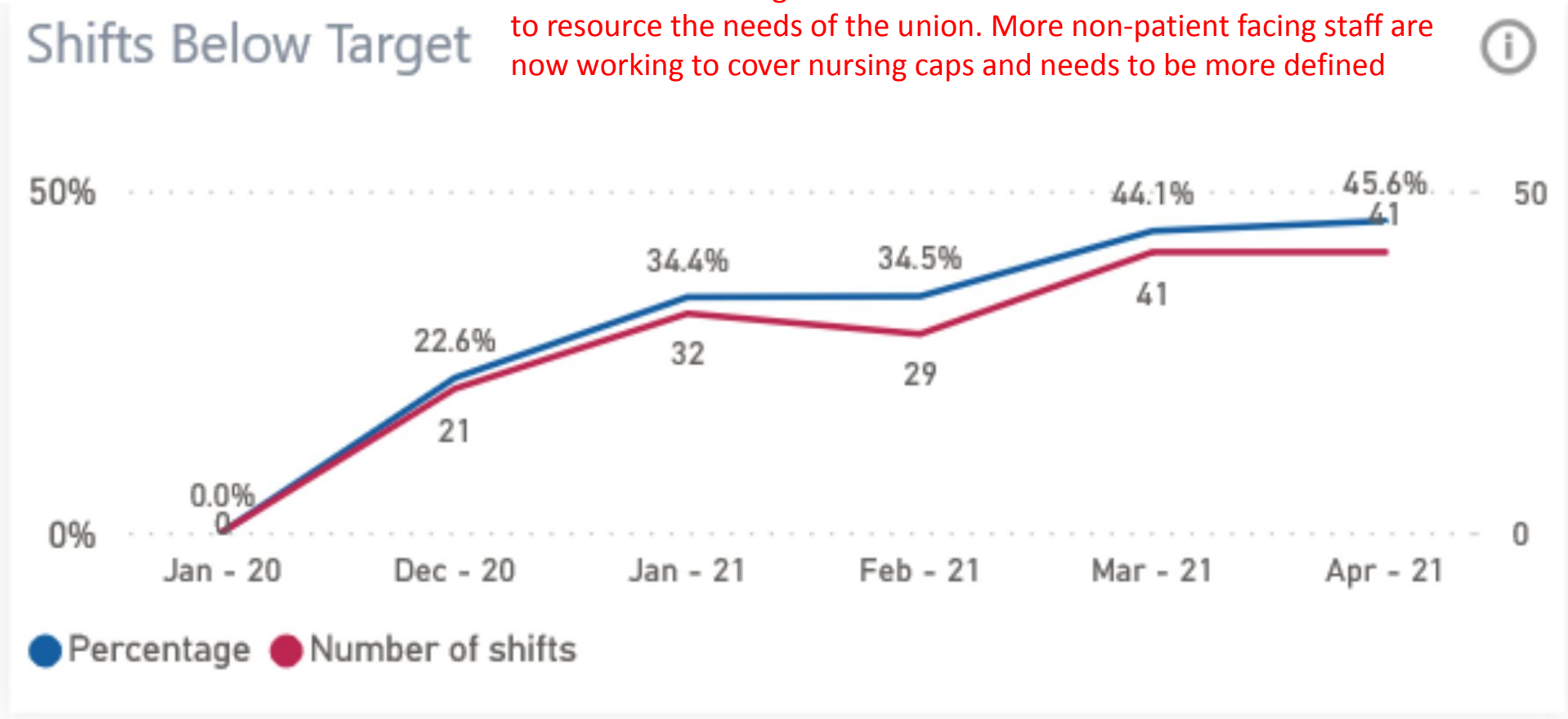
NOTES: * This graph displays bed utilisation, the daily clinical hours required for inpatient care and the hours provided for inpatient care in the selected ward/department for the selected month. The productivity index is displayed for each day and rounded off to the closest whole precentage.

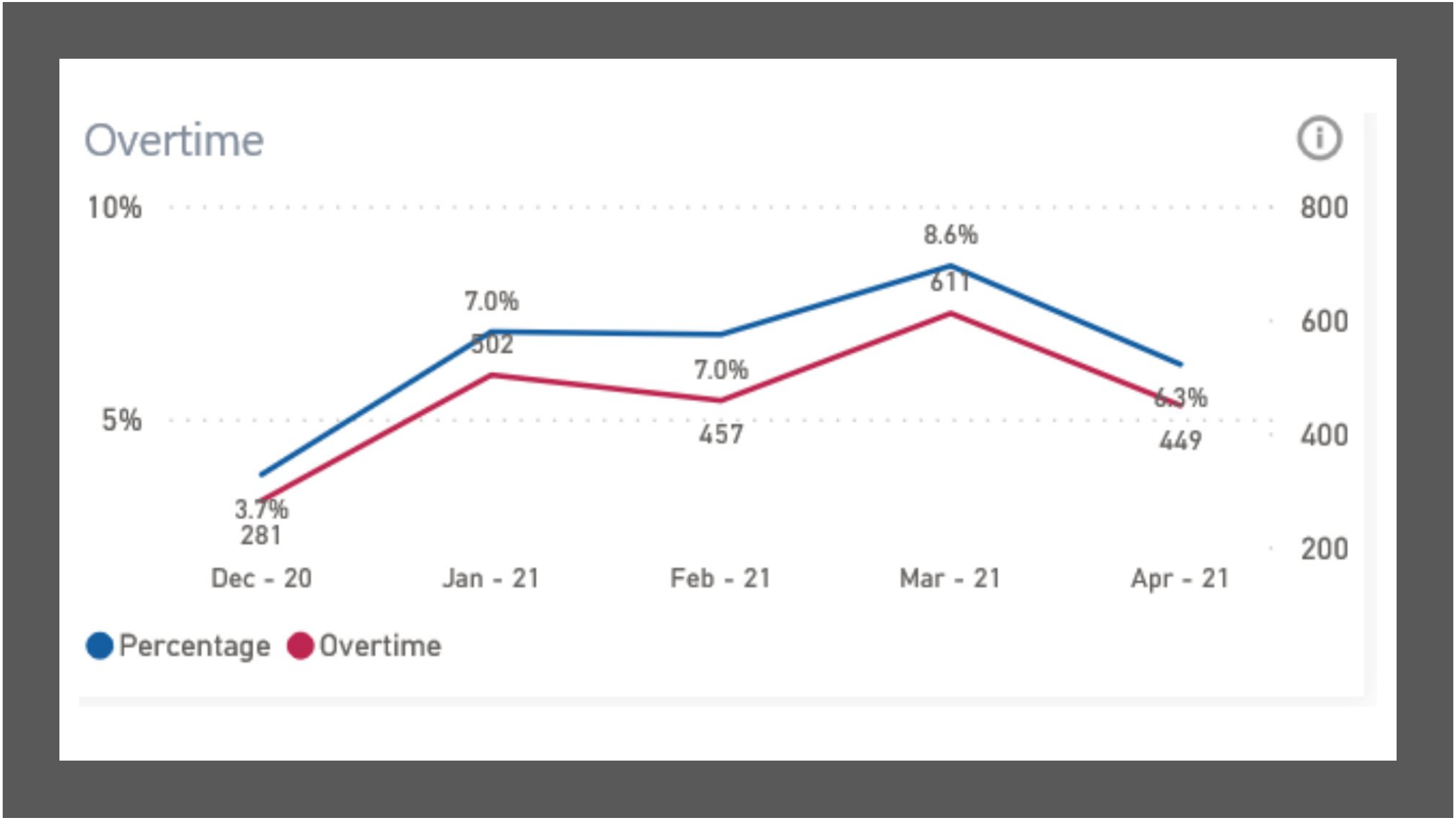
Page 3 of 3

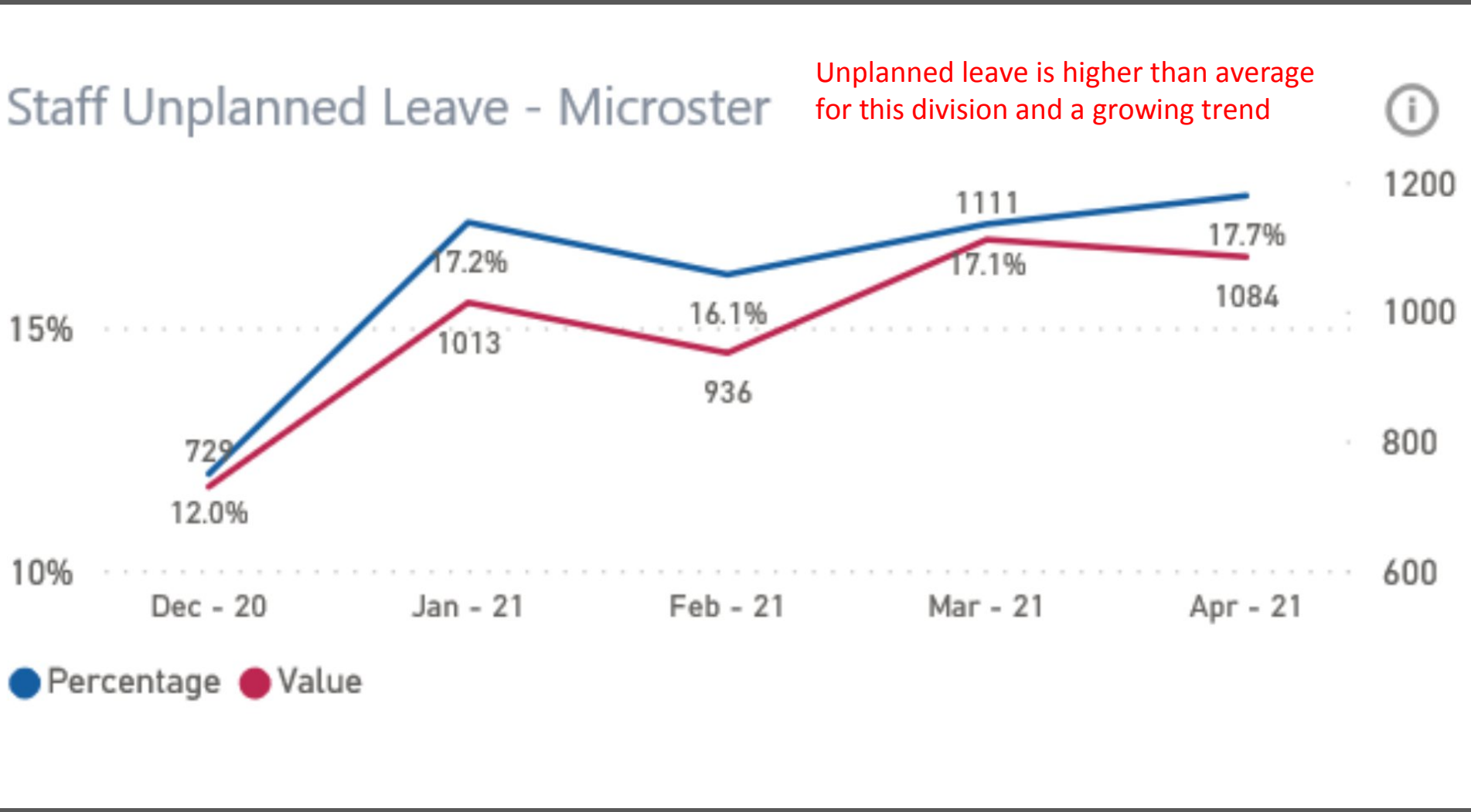

Care Hours Variance
Since completion of interrater reliability testing, this ward shows consistent negative variances
500
0
-500
577
-462
-214
-76
-314
-404
Jan - 20
Dec - 20
Jan - 21
Feb - 21
Mar - 21
Apr - 21

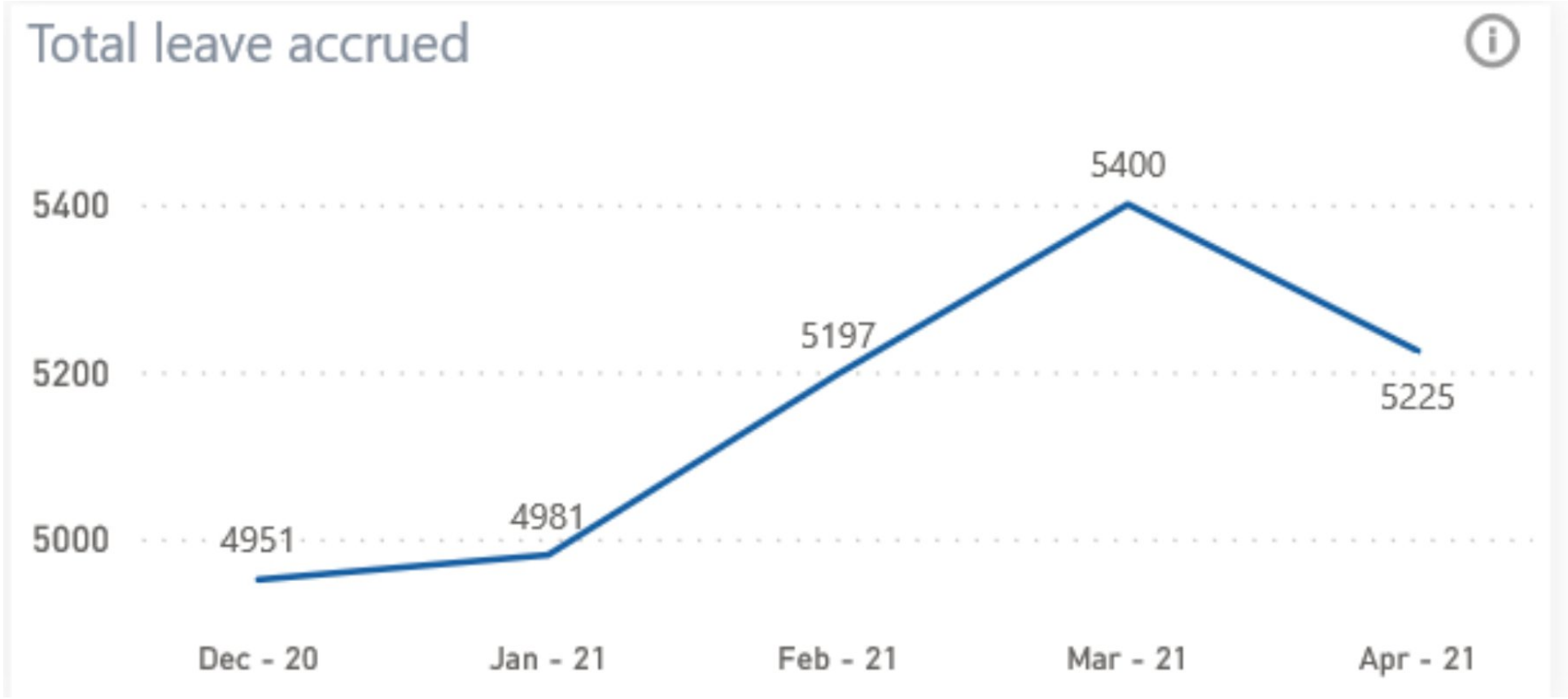

Patient Hours Required
It is evident from graph below these patients require 1:1 and/or 2:1 care hours to manage care safely
4K
2K
0K
0.8K
3.8K
4.1K
3.9K
4.0K
3.7K
Jan - 20
Dec - 20
Jan - 21
Feb - 21
Mar - 21
Apr - 21

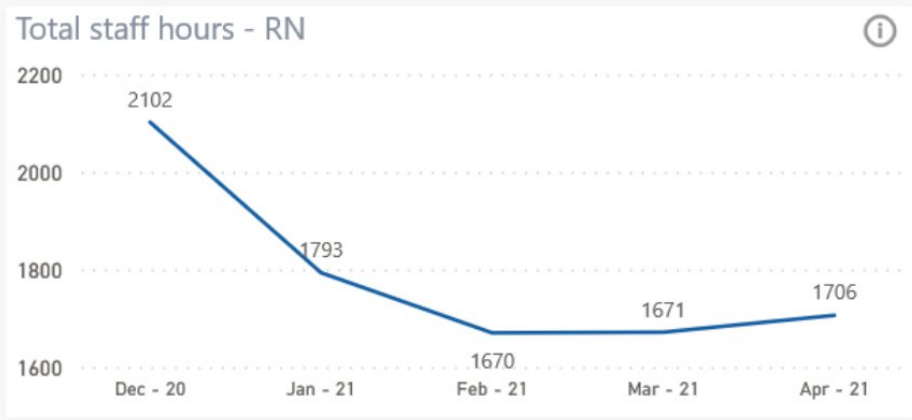
Shifts below the target have increased as this division has been unable to resource the needs of the union. More non-patient facing staff are now working to cover nursing caps and needs to be more defined

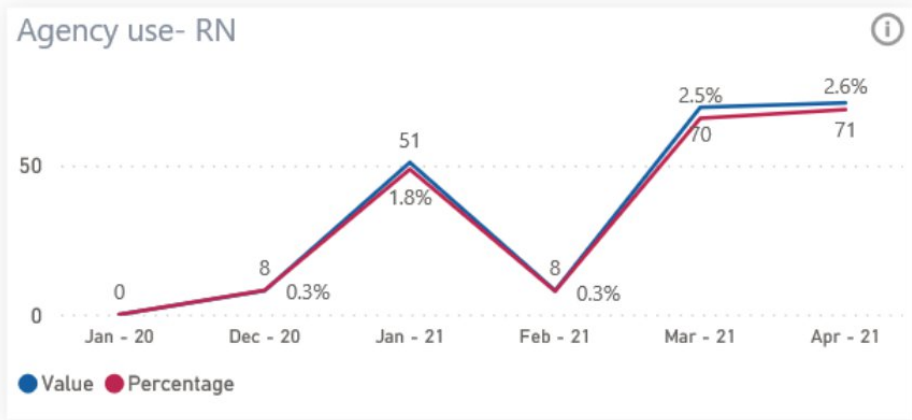


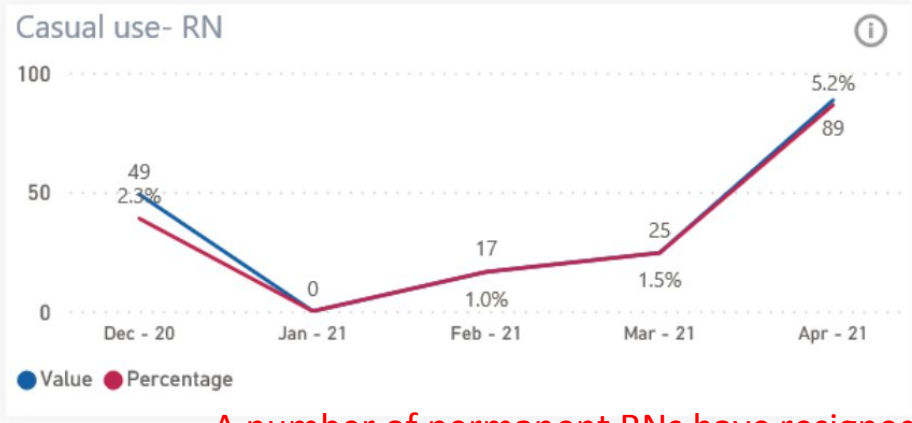

Overtime
10%
5%
800
600
400
200
3.7%
281
7.0%
502
7.0%
457
8.6%
611
6.3%
449
Dec - 20
Jan - 21
Feb - 21
Mar - 21
Apr - 21
Percentage
Overtime

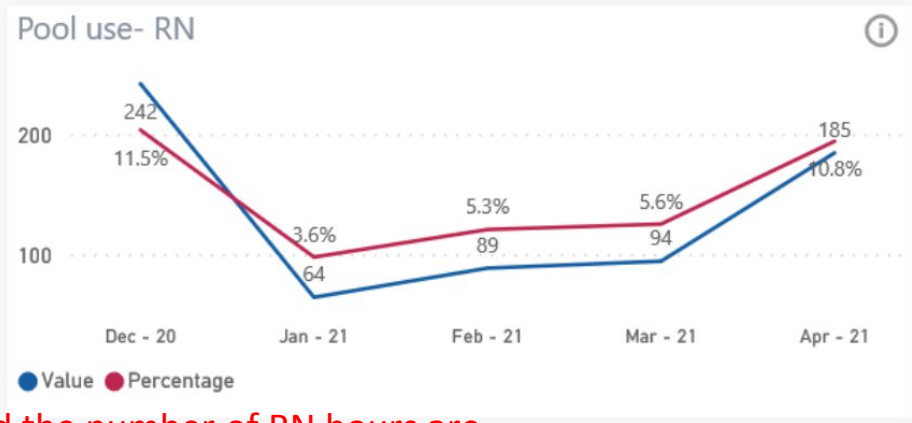

Staff Unplanned Leave - Microster
Unplanned leave is higher than average for this division and a growing trend
1200
1000
800
600
15%
10%
729
12.0%
17.2%
1013
16.1%
936
1111
17.1%
17.7%
1084
Dec - 20
Jan - 21
Feb - 21
Mar - 21
Apr - 21
Percentage
Value


Total leave accrued
5400
5200
5000
4951
4981
5197
5400
5225
Dec - 20
Jan - 21
Feb - 21
Mar - 21
Apr - 21



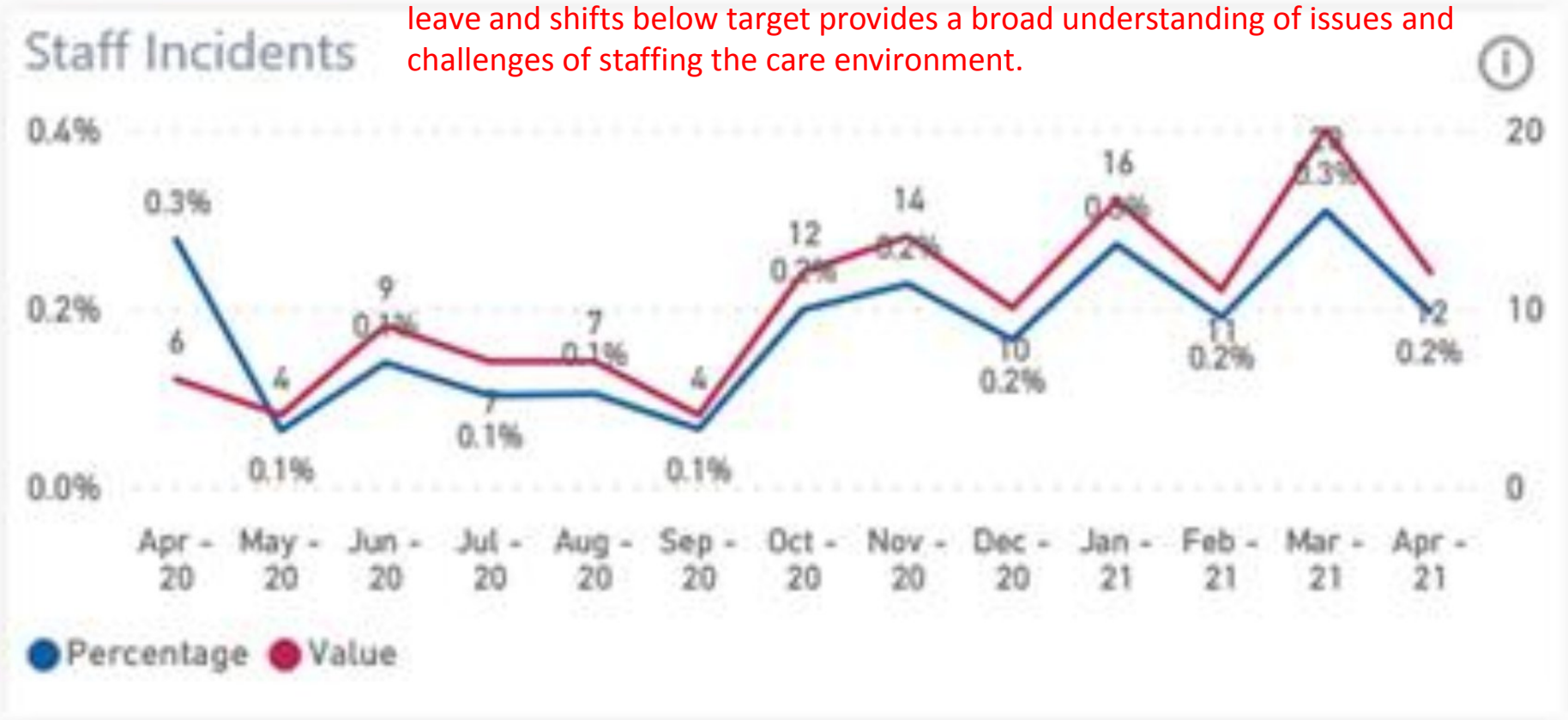






A number of permanent RNs have resigned, and the number of RN hours are decreased but agency and pool staff have increased. Agency staff do not have appropriate training and should be used minimally in this environment.

New graph shows staff incidents. In conjunction with unplanned leave, sick leave and shifts below target provides a broad understanding of issues and challenges of staffing the care environment.



CLINICAL ADVISOR UPDATE – MEDICAL

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NOTES ONLY PAGE

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

DATE: **3 June 2021**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Committee:

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

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

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

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

3. SUMMARY

The Act, Schedule 3, Clause 32 provides:

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

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

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

Clause 33 of the Act also further provides:

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

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

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

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

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

QUALITY & PATIENT SAFETY INDICATORS – LEVEL OF COMPLAINTS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **Susan Wood, Director, Quality & Patient Safety**

APPROVIED BY: **Becky Hickmott, Executive Director of Nursing**
Dr Jacqui Lunday-Johnstone, Executive Director of Allied Health, Scientific & Technical
Dr Richard French, Acting Chief Medical Officer

DATE: **3 June 2021**

Report Status – For:	Decision ☐	Noting ☐	Information ☑

1. ORIGIN OF THE REPORT

The purpose of this report is to place before the Committee information about the patient experience, gained through survey feedback and the complaints system. This is a regular six-monthly report on the Committee's work plan.

2. DISCUSSION

The Canterbury District Health Board is committed to providing quality healthcare. Understanding how people experience healthcare gives us valuable insight. Feedback is used by teams to monitor care provided and assists in identifying what went well and what could be done better.

This report provides an overview of patient experience feedback provided by the public, complaints data, as well as examples of improvement actions.

3. APPENDICES

Appendix 1: Patient Experience - Complaint Rates and Categories to March 2021
Appendix 2: Patient Experience – Survey Feedback

PATIENT EXPERIENCE: COMPLAINTS

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

In the last 9 months (Jul 2020 – Mar 2021) Canterbury District Health Board provided a total of 978,588 admissions, ED attendances and outpatient attendances and a total of 1,212 people made a complaint (Ratio 1 complaint :807 Admissions).

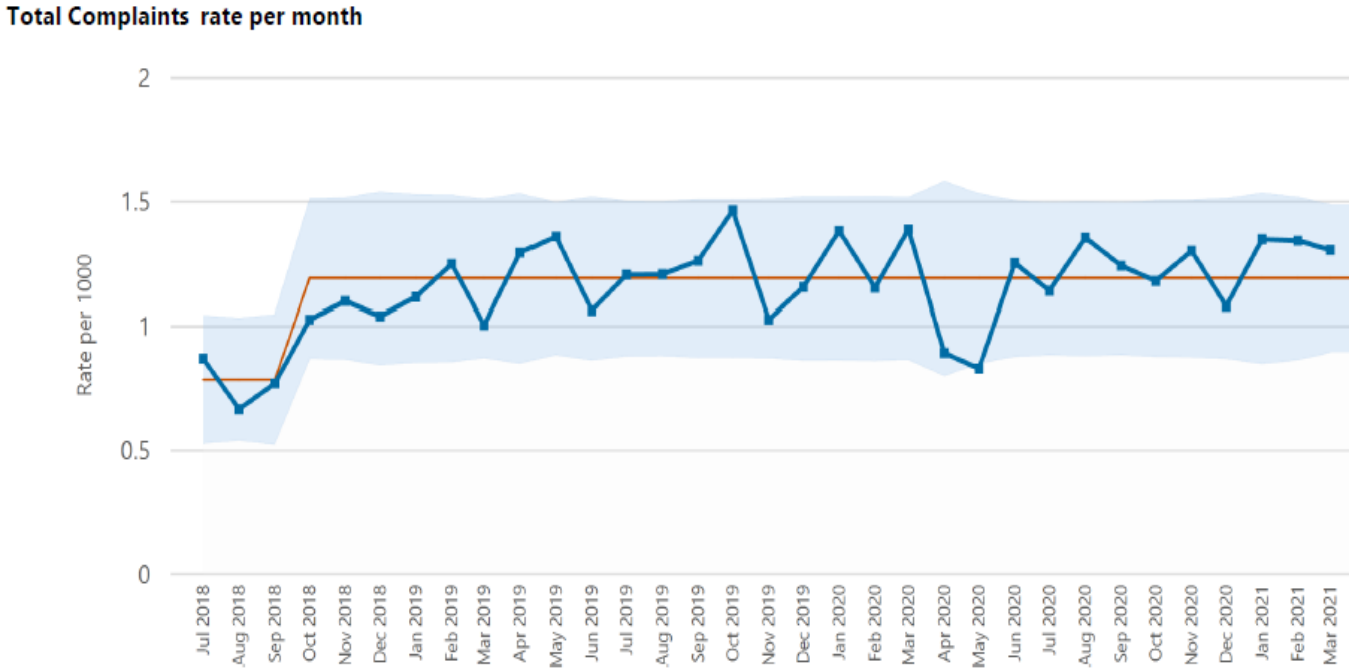
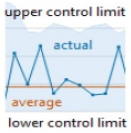


Figure 1. Outcome Indicator: Complaints Rate

Numerator: Total number of complaints received in the period.

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

Calculated as a rate per 1,000



Year	Range of Total Complaints reported per month
15/16	50 to 72
16/17	36 to 98
17/18	63 to 107
18/19	79 to 156
19/20	62 - 157

Note: The complaints rate indicates normal variation since the step up with the introduction of Safety1st Feedback module. The 2020 April/May result coincides with Lockdown.

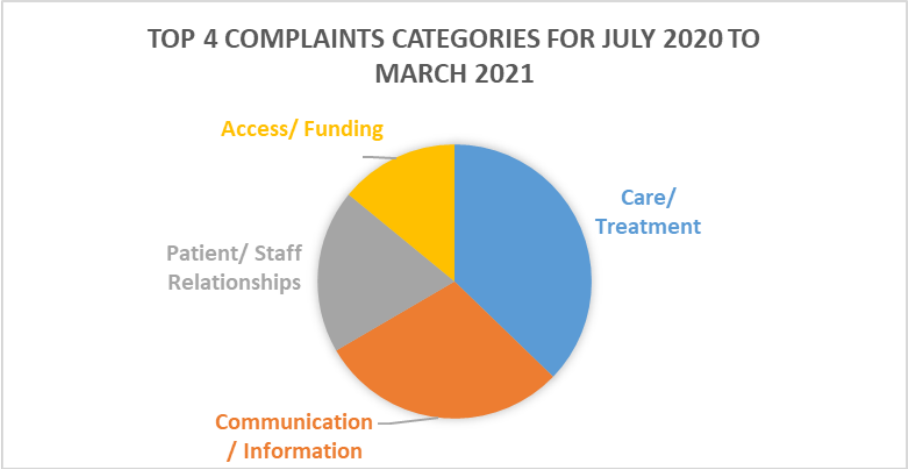
1

The TOP 4 complaint categories for the last 9 months were:

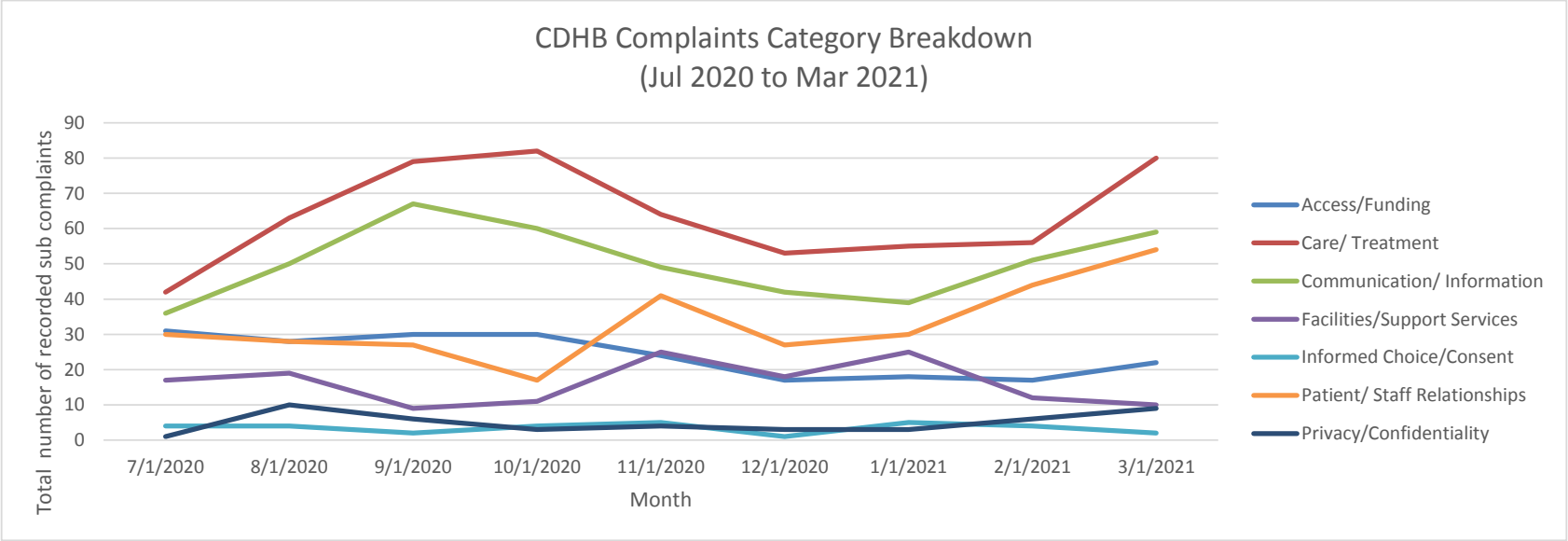
1. Care/Treatment 574 (33%)
2. Communication/Information 453 (26%)
3. Patient/Staff Relationships 298 (17%)
4. Access /Funding 217 (12%)

For the 2019/20 financial year the highest categories were the same but in a different order: Care/Treatment, Access and Funding, Communication/Information and Patient/Staff Relationships.

A question was included in the Feedback database in March 2020 to capture if the complaint related to a Covid activity. For the July 2020 to March 2021 period 29 complaints have been recorded.



Graphical View of Complaints Categories from 1 July 2020 to 31 March 2021



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Breakdown of Complaints Categories[1] July 2020 to March 2021

Start Date: 1/07/2020	1/07/2020	1/08/2020	1/09/2020	1/10/2020	1/11/2020	1/12/2020	1/01/2021	1/02/2021	1/03/2021	TOTAL
Total Complaint Forms	131	152	141	126	140	111	123	132	156	***1212***
Total Number of Categories per complainee										
1	99	100	69	60	76	55	65	72	77	***673***
2	18	28	35	30	25	22	29	28	36	***251***
3	6	10	13	16	10	17	14	15	20	***121***
4	6	9	12	12	13	9	6	6	9	***82***
>5	2	5	12	8	16	8	9	11	14	***85***
Is this feedback related to COVID-19 activity?	3	7	6	2	1	2	3	2	3	***29***
Access/Funding	31	28	30	30	24	17	18	17	22	***217***
Care/Treatment	42	63	79	82	64	53	55	56	80	***574***
Communication/Information	36	50	67	60	49	42	39	51	59	***453***
Facilities/Support Services	17	19	9	11	25	18	25	12	10	***146***
Informed Choice/Consent	4	4	2	4	5	1	5	4	2	***31***
Patient/Staff Relationships	30	28	27	17	41	27	30	44	54	***298***
Privacy/Confidentiality	1	10	6	3	4	3	3	6	9	***45***

Total number of categories per complainee (Jul 2020 to Mar 2021)

- **56%** of people who complained, complained about one category only
- **21%** of people who complained, complained about two categories
- **10%** of people who complained, complained about three categories
- **7%** of people who complained, complained about four categories
- **7%** of people who complained, complained about five or more categories

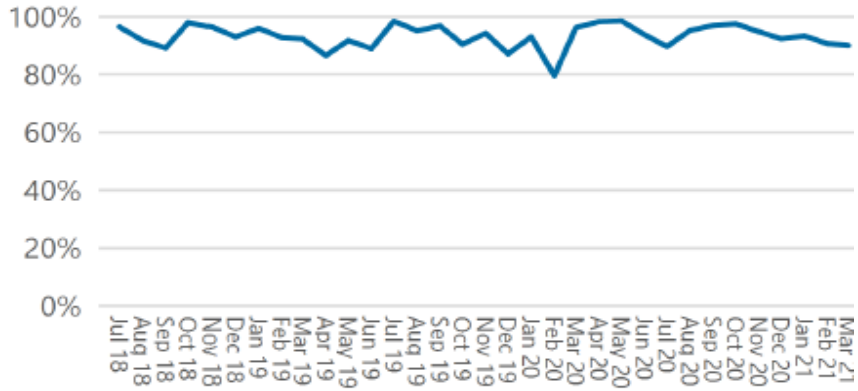
[1] The Breakdown of Complaints Categories data is refreshed monthly, reports are generated in the first week following the close of the month – hence the 'Total Complaints Forms' numbers may differ to the complaints numerator data as this is refreshed weekly.

Examples of Improvement Activity Related to Complaints Reviews

Location	Complaint Summary	Improvement Actions
Ashburton Access to Radiology and Laboratory Services	Multiple complaints about the fire exit door from the car park closest to the laboratory/radiology being closed, causing patients to have to walk a significant distance from the front door of the hospital to the laboratory/radiology	• More wheelchairs available at the front entrance and outside Radiology and Laboratory. • More seating placed along the corridors for patients to rest. • Encouraged receptionists to ask if patients require assistance. • Signage on the closed fire exit door improved so that it can be read from a distance. • All appointment letters for Radiology now include instructions to use the front of hospital entrance.
Ashburton Acute Assessment Unit Wait time	Multiple complaints about the length of time waiting for medical assessment especially after hours and weekends. Many consumers who present for care, self- discharge before being medically assessed.	• Nursing rosters altered to provide increased cover. • Two Associate Clinical Nurse Managers (ACNM's) have been employed to replace 3 CNM's. It is hoped they will have increased capacity to provide clinical support. • FACMS rostered over the weekends to assist the single MO with the workload.
OPH& R Ward BG Care and safety	Two complaints were received from family members of a patient who managed to leave the secure ward 1. Family concerns about the care and safety of their family member whilst an in-patient at Burwood Hospital 2. A multi-disciplinary group met with the family to work through their concerns the following day and apologised for the incident. Following the family meeting patient-specific care was discussed and agreed with the following strategies on the ward agreed to support the patient's safety and wellbeing. Following the meeting family were satisfied their concerns had been heard and addressed. The team continue weekly meetings with the family.	• A GPS pendant has been obtained from Search and Rescue, funded by the CDHB for use while the patient is a patient at Burwood Hospital. This will allow staff to quickly locate the patient if they leave the ward in the future • Signage at the front door has been made clearer • Additional staffing has been employed to increase monitoring of the front door • Ward door is now on override and staff walk visitors to the door, so they can check the exit is secure, rather than pressing a button at the office • Increased whereabouts checks during waking hours • Patient moved to a quieter room with less noise and foot traffic and more staff presence • Ongoing efforts to engage the patient in meaningful activities

5-day Compliance[2]

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



Numerator: Number of complaints acknowledged in writing within 5 working days, (excluding HDC/Privacy Commissioner/ Ombudsman/ Minister of Health Complaints)[3] within the period.

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

Data for 2020/2021 year to date:

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

Measure	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
Numerator	113	142	128	119	128	97	112	117	136				1092
Denominator	126	149	132	122	135	105	120	129	151				1169
Percentage	90%	95%	97%	98%	95%	92%	93%	91%	90%	0%	0%	0%	93%

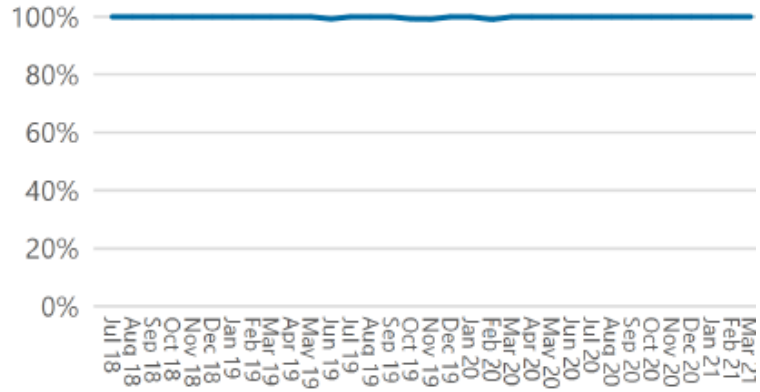
Comments for five month reporting period of 1 November 2020 to 31 March 2021

- The percentage of complaints acknowledged in writing within 5 working days varies below the expected level of 100%.

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

20-day Compliance[4]

Percentage of complaints responded to or resolved within 20 working days



Numerator: Number of complaints resolved or responded to within 20 working days, (excluding HDC/Privacy Commissioner/Ombudsman/Minister of Health Complaints)[5], within the period.

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

Data for 2020/2021 year to date:

Percentage of complaints responded to or resolved within 20 working days

Measure	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
Numerator	113	134	153	125	124	127	81	101	109				1067
Denominator	113	134	153	125	124	127	81	101	109				1067
Percentage	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%

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

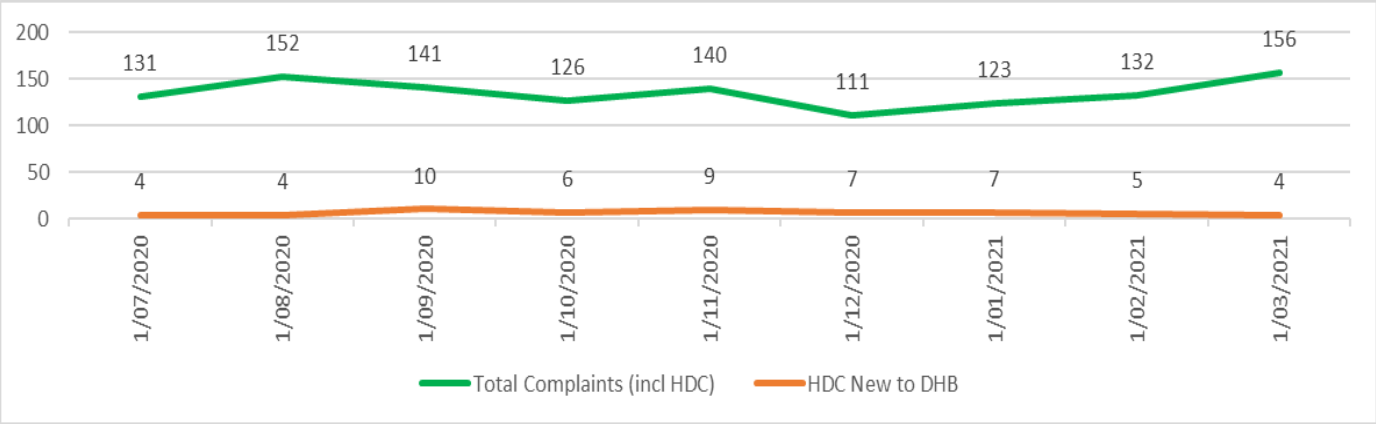
Comments for five month reporting period of 1 November 2020 to 31 March 2021

- 100% of complaints were responded to or resolved within 20 working days during the last five months.

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

Health and Disability Commissioner CDHB Complaints

CDHB HDC Complaint Trend Report 1 July 2020 to 31 March 2021



This graph shows the number of Health and Disability Complaints as part of the Total Complaints

PATIENT EXPERIENCE: Survey Feedback

The surveys ask questions about four areas - communication, partnership, co-ordination and physical and emotional needs.

Canterbury DHB
Patient Experience Survey
Te Rūri Wheako-ā-Tūroro

INPATIENT SURVEY RESULTS – FEBRUARY 2021

The Canterbury District Health Board is committed to providing quality healthcare. Every fortnight we invite patients who spent at least one night in hospital or have attended an outpatient clinic to participate in our patient experience survey.

Patients who are admitted to a mental health facility, transferred to another health facility, and those who are under 15 years of age are not included. An invitation to participate in the survey is delivered via email or a link in a text message. Taking part is voluntary. The survey asks patients to rate and comment on their experiences in four domain areas: communication, partnership, co-ordination and physical/emotional needs.

Responses are completely anonymous. Comments are reviewed to ensure staff and patient confidentiality. Feedback is verbatim, and comments are published as submitted (including spelling and grammatical errors).

Understanding how people experience healthcare gives us valuable insight and an opportunity to celebrate our success, do more of what we are doing well and to consider how we can do better. The patient experience portal is available on Seeing our System section on the intranet.

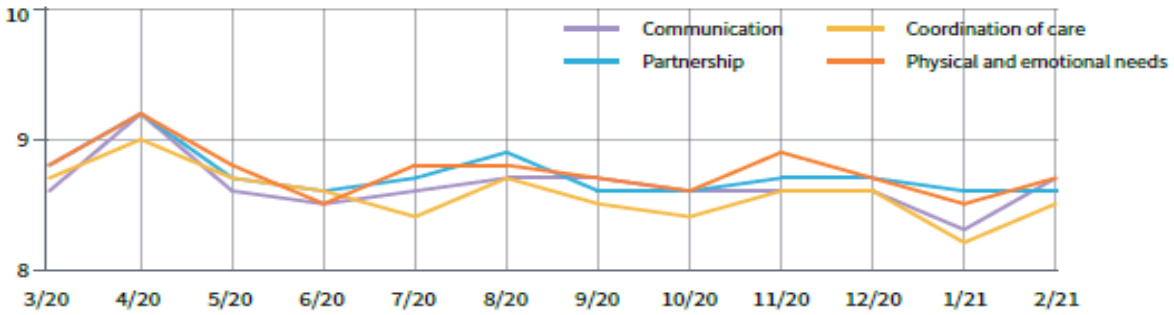
All staff have access to both inpatient and outpatient's feedback.

INPATIENT DOMAIN SCORES FOR FEBRUARY 2021

COMMUNICATION	87%
COORDINATION OF CARE	85%
PARTNERSHIP	86%
PHYSICAL AND EMOTIONAL NEEDS	87%

Inpatient Experience Survey – Domain score out of 10

Monthly comparison for the last 12 months



Additional questions were added to the inpatient survey March 2020 to monitor patient experiences of the COVID-19 pandemic and to ask about family/whānau being included in important discussion and staff cleaning hands when touching or examining.

- 81.4% of inpatients told us that staff always used hand sanitiser or washed their hands before touching or examining
- 51% of inpatients reported that their whanau were always included in important discussions

Additional questions about bedside boards will be added to the survey in April.

Ask what matters
Listen to what matters
Do what matters

1

WHAT WE ARE DOING WELL, AND WHAT WE COULD DO BETTER

HIGHEST RATED QUESTIONS	
Before the operation did staff explain the risks and benefits in a way you could understand?	93%
Overall, did you feel staff treated you with respect and dignity while you were in the hospital?	93%
Did you have confidence and trust in the staff treating you? *Doctors*	92%

LOWEST RATED QUESTIONS	
Did a member of staff tell you about medication side effects to watch for when you went home?	66%
Did the hospital staff include your family/ whānau or someone close to you in discussions about your care?	68%
Was religious or spiritual support available when you needed it?	73%

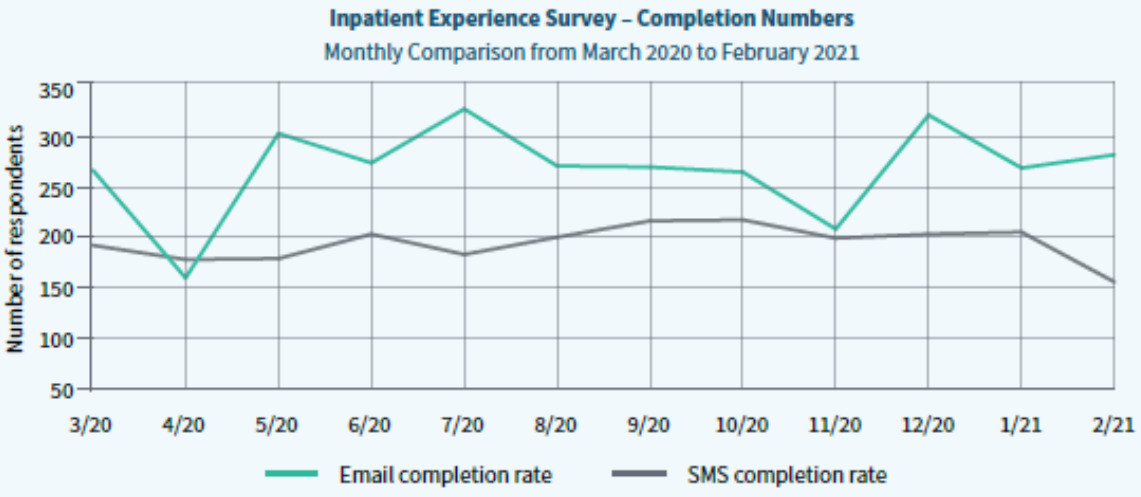
WHAT ARE OUR MĀORI CONSUMERS SAYING?

HIGHEST RATED QUESTIONS	
Before the operation did staff explain the risks and benefits in a way you could understand?	100%
Did you feel the following staff listened to what you had to say? Other members of your healthcare team	97%
If you needed help from the staff getting to the toilet or using a bedpan, did you get it in time?	95%

LOWEST RATED QUESTIONS	
Was religious or spiritual support available when you needed it?	40%
Was cultural support available when you needed it?	50%
Did a member of staff tell you about medication side effects to watch for when you went home?	55%

INPATIENT SURVEY COMPLETION RATE

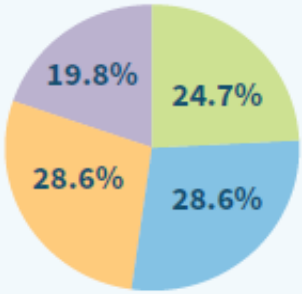
Patients are invited to participate in the survey via email. If no email address is available, they are invited via SMS. All patients from Ashburton, Burwood and Christchurch and Christchurch Womens Hospitals are invited to participate in the survey.



During February 2021, **2,716** invitations to participate in the survey were sent.
654 patients responded and completed the survey – a response rate of **16%.**

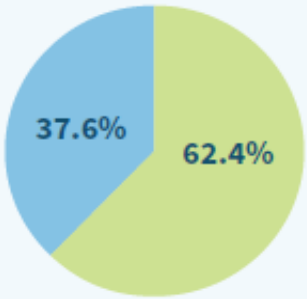
SURVEY DEMOGRAPHICS

Age groups



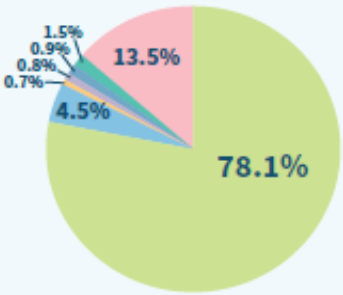
- 15 – 44 years **24.7%**
- 45 – 64 years **28.6%**
- 65 – 84 years **28.6%**
- 85 years and over **19.8%**

Gender



- Female **62.4%**
- Male **37.6%**
- Gender diverse **0%**

Ethnicity



- NZ European **78.1%**
- Māori **4.5%**
- Samoan **0.7%**
- Other Pacific peoples **0.8%**
- Indian **0.9%**
- Chinese **1.5%**
- Other ethnicity **13.5%**

IN THE LAST 12 MONTHS:

2,006 consumers commented specifically about **hand hygiene**

2,245 consumers commented specifically about **nurses**

396 consumers commented specifically about **communication**

WHAT ARE OUR CONSUMERS SAYING?

1,440 comments were published in February 2021

From admission to pre-op, to surgery and then to the ward was seamless. It was like one big well-oiled wheel!

I have no complaints in part, or the whole of my care package, I am so grateful for our great health system.

Everyone were great with hygiene. Staff were all friendly.

Overall it was a very good experience, especially being in Waipapa... but discharge wasn't explained. It has since been rectified and I realise it is because they are just so busy.

Couldn't fault my stay at Chch Hosp the staff were brilliant and very professional.

The midwives on the maternity ward and NICU were amazing. Really supportive and understanding.

I never saw the same doctor/ registrar during my stay and so I never knew how much they knew about me or my living situation.

I felt the nursing staff were completely "run off their feet".

I found being on a mixed ward with elderly men difficult.

They are busy but I believe they have tried their best.

DID YOU KNOW?

The Bedside Boards at Christchurch Hospital have recently been upgraded and repositioned within the bed space to promote staff completion and visibility for the patient

The bedside boards indicate to patients, whānau, and staff 'at a glance' the essential information and assistance a patient requires to maintain their safety in our hospital environment.

Keeping bedside boards up to date is important.

HERE'S WHAT OUR PATIENTS ARE SAYING ABOUT THE NEW BEDSIDE BOARDS

"Great concept. Reminded me to ask for help."

"The food delivery staff noticed the wrong information above my bed about what food I should have."

"Someone else's name was on the wall behind me. To be left under a wall sign with someone else's name again not ideal."

"On admission the info was correct, this felt welcoming and helped mum enormously given she had never been in hospital before."

"The only consistent info on the board was who the medical team was, this never changed so never required change."

"The Board was a talking point for us on a daily basis and was noted by mums visitors that it would have been a useful source of information, if accurate."

"What struck me was the risk this inaccurate information could have for everyone especially for mum, the patient."

Canterbury DHB
Patient Experience Survey
Te Rūri Wheako-ā-Tūroro

OUTPATIENT SURVEY RESULTS – FEBRUARY 2021

The Canterbury District Health Board is committed to providing quality healthcare. Every fortnight we invite patients who spent at least one night in hospital or have attended an outpatient clinic to participate in our patient experience survey.

Patients who are admitted to a mental health facility, transferred to another health facility, and those who are under 15 years of age are not included. An invitation to participate in the survey is delivered via email or a link in a text message. Taking part is voluntary. The survey asks patients to rate and comment on their experiences in four domain areas: communication, partnership, co-ordination and physical/emotional needs.

Responses are completely anonymous. Comments are reviewed to ensure staff and patient confidentiality. Feedback is verbatim, and comments are published as submitted (including spelling and grammatical errors).

Understanding how people experience healthcare gives us valuable insight and an opportunity to celebrate our success, do more of what we are doing well and to consider how we can do better. The patient experience portal is available on Seeing our System section on the intranet.

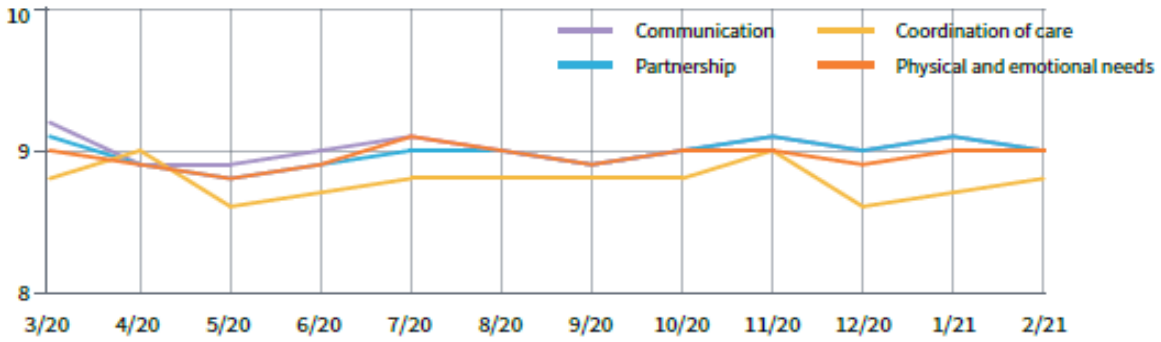
All staff have access to both inpatient and outpatient's feedback.

OUTPATIENT DOMAIN SCORES FOR FEBRUARY 2021

COMMUNICATION 90%	COORDINATION OF CARE 88%
PARTNERSHIP 90%	PHYSICAL AND EMOTIONAL NEEDS 90%

Outpatient Experience Survey – Domain score out of 10

Monthly comparison for the last 12 months



The outpatient survey is currently under review due to consumer feedback and a lower response rate.

"This survey is longer than my outpatient appointment!"

"I feel very content with the care that I received from the team and the technicians working in the Pacing Clinic. However, I cannot continue with this survey because it is entirely too long and too repetitive"

Ask what matters
Listen to what matters
Do what matters

WHAT WE ARE DOING WELL, AND WHAT WE COULD DO BETTER

HIGHEST RATED QUESTIONS

Overall did you feel the staff treated you with dignity and respect?	97%
Were you given enough privacy when discussing your condition or treatment?	96%
Did you feel the following staff listening to what you had to say?	96%

LOWEST RATED QUESTIONS

Where possible did staff include your family/whanau or someone close to you in discussions about your care?	81%
Did staff discuss the following in ways you could understand? Support needed for equipment and technology	83%
Were you confident staff were aware of your medical history?	84%

WHAT ARE OUR MĀORI CONSUMERS SAYING?

HIGHEST RATED QUESTIONS

Overall did you feel the staff treated you with dignity and respect?	98%
Did you feel the following staff listened to what you had to say? *Nurses*	96%
Were you given conflicting information by different staff members e.g. one staff member would tell you one thing and then another would tell you something different?	95%

LOWEST RATED QUESTIONS

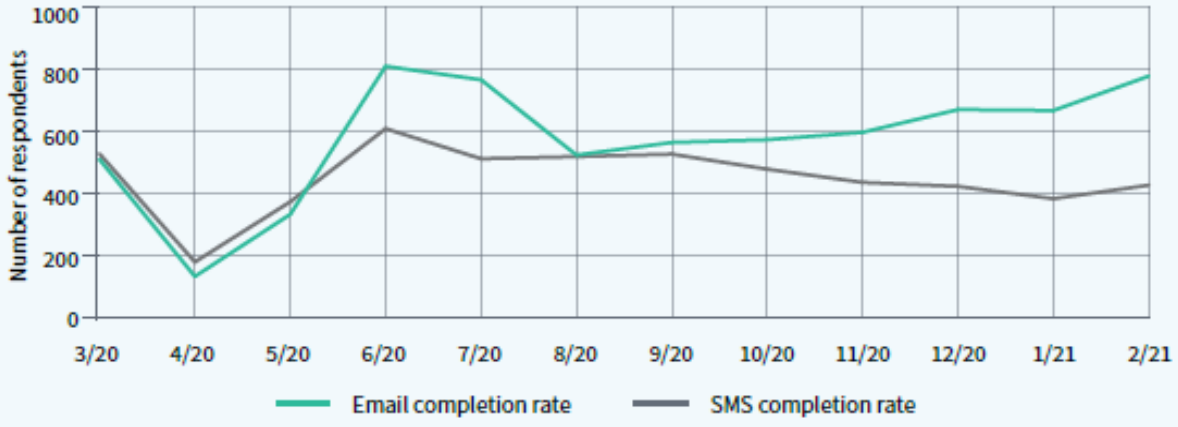
Where you confident that staff were aware of your medical history?	75%
Where possible did staff include your family/whānau or someone close to you in discussions about your care?	78%
Did staff discuss the following in ways you could understand? *Support needed for equipment and technology*	79%

OUTPATIENT SURVEY COMPLETION RATE

Patients are invited via email. If no email address available, then they are invited via SMS.
Those invited by email have had a higher response rate than those invited by SMS.

Outpatient Experience Survey – Completion Numbers

Monthly Comparison from March 2020 to February 2021

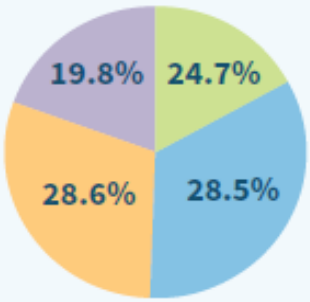


During February 2021, **7,458** invitations to participate in the survey were sent.
704 patients responded and completed the survey – a response rate of **16%.**

6

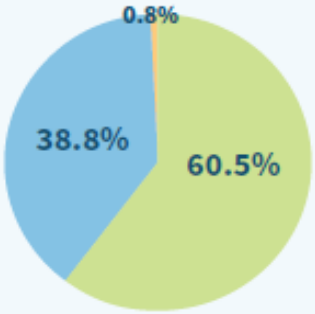
SURVEY DEMOGRAPHICS

Age groups



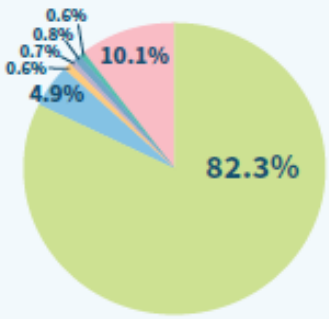
- 15 – 44 years **24.7%**
- 45 – 64 years **28.6%**
- 65 – 84 years **28.6%**
- 85 years and over **19.8%**

Gender



- Female **60.5%**
- Male **38.8%**
- Gender diverse **0.8%**

Ethnicity



- NZ European **82.3%**
- Māori **4.9%**
- Samoan **0.6%**
- Other Pacific peoples **0.7%**
- Indian **0.8%**
- Chinese **0.6%**
- Other ethnicity **10.1%**

IN THE LAST 12 MONTHS:

1,255 consumers commented specifically about **communication**

1,835 consumers commented specifically about **waiting**

1,673 consumers commented specifically about **nurses**

WHAT ARE OUR CONSUMERS SAYING?

3,529 comments were published in February 2021

"Waiting time to be seen was less than I expected."

"It's a very invasive and not at all dignified procedure I had done but staff were at all times respectful and friendly."

"From reception to seeing the doctor everyone seemed very caring and helpful."

"Thorough explanation of procedure, outcomes and possible side effects given."

"Appointment was on time, to the point, informative."

"I felt the DHB staff took the time to explain things to me. That made me feel at ease. They clearly have the appropriate knowledge and that meant a lot."

"Some were considerate some were not. Some treated me in a condescending manner during my last visit. However in the end a satisfactory result ensued and I am grateful for that."

"I left the clinic in tears. I could not believe I was treated as if I was wasting his time and that's not the first time either."

"I felt very written off, "see you again in 2 months, if it gets worse, go back to your GP"."

"Not enough time as clinic was running late."

WHAT ARE WE DOING WITH THE DATA?

OPHTHALMOLOGY IMPROVEMENT PROJECT

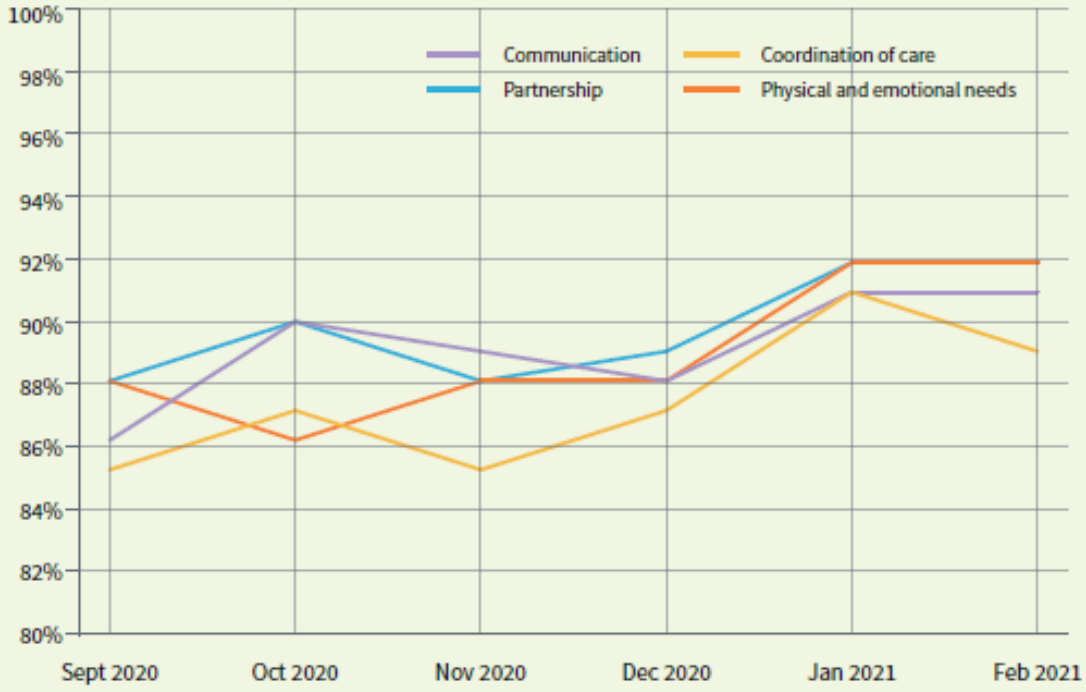
Patient feedback and experience is always a priority for every service however since December, this has been one of Ophthalmology's main focus areas. We have been utilising the patient portal to review feedback and share this with our team.

We communicate results and share feedback from our patients within our monthly newsletter and also via emails. Within this communication we present percentage panels and patient comments along with any compliments we have received via the 'blue box' that month. We appreciate not all feedback is positive and theses are the ones we need to look at in more detail as these are always where there are opportunities to improve arise.

We believe sharing this information and engaging with our teams has made a difference to our monthly averages (see below) and also builds staff morale to see how much their patients do appreciate them.

Opthalmology Patient Portal – Domain scores

Monthly Comparison from September 2020 to February 2021



WORKPLAN FOR HAC 2021 *(WORKING DOCUMENT)*

9am start	28 Jan 21	01 Apr 21	03 Jun 21	05 Aug 21	07 Oct 21	02 Dec 21
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 Services Supporting Older People Living in Rural Communities	Clinical Advisor Update – Allied Health	Clinical Advisor Update – Medical Care Capacity Demand Management Update	Clinical Advisor Update – Nursing H&SS 2020/21 Year Results	Clinical Advisor Update – Allied Health	Clinical Advisor Update – Medical Care Capacity Demand Management Update
Presentations		Mental Health: The Acute Adult Pathway	Making Our System Flow ESPI Performance			
Governance & Secretariat Issues	2021 Workplan					
Information Items		2021 Workplan	Quality & Patient Safety Indicators - Level of Complaints 2021 Workplan	2021 Workplan	2022 Meeting Schedule 2021 Workplan	Quality & Patient Safety Indicators - Level of Complaints 2021 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)