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, 31 January 2019 commencing at 9:00am

	Apologies		9.00am
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 29 November 2018		
3.	Carried Forward / Action List Items		
4.	Sleep Health Services in Canterbury (Presentation)	Pauline Clark	9.05-9.35am
5.	Hospital Service Monitoring Report: Medical/Surgical & Women's & Children's Health ESPIs Older Persons, Orthopaedics & Rehabilitation Mental Health Hospital Laboratories Rural Health Services	 Pauline Clark Pauline Clark Dan Coward Toni Gutschlag Kirsten Beynon Berni Marra	9.35-10.15am
6.	Clinical Advisor Updates (Oral): Nursing Allied Health	 Becky Hickmott Jacqui Lunday-Johnstone	10.15-10.30am
7.	Resolution to Exclude the Public		10.30am
ESTIMATED FINISH TIME – PUBLIC MEETING			**10.30am**
	Information Items: 2019 Workplan		

Morning tea will be held from 10.30 to 10.45am

NEXT MEETING: Thursday, 4 April 2019 at 9.00am

ATTENDANCE LIST – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE MEMBERS

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

Executive Support

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

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

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

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

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

	Te Kàhui o Papaki Kà Tai – Member A Canterbury-wide combined group of primary care organisations, clinicians, community organisations, Manawhenua, Maori community provider and District Health Board. The group is supported by Pegasus Health.
Ta Mark Solomon **Ex Officio – HAC** Deputy Chair CDHB	**Claims Resolution Consultation – Senior Maori Leaders Group** – Member This is an Advisory Board to MSD looking at the claims process of those held under State care. **Deep South NSC (National Science Challenge) Governance Board** – Member The objective of Deep South NSC is set by Cabinet, and is to understand the role of the Antarctic and Southern Ocean in determining our climate and our future environment. Building on this objective, the mission was developed to guide our vision, research priorities and activities. **Greater Christchurch Partnership Group** – Member This is a central partnership set up to coordinate our city's approach to key issues. It provides a strong, joined up way of working and ensures agencies are travelling in the same direction (so they do not duplicate or negate each other's work). **He Toki ki te Rika / ki te Mahi** – Patron He Toki ki te Rika is the next evolution of Māori Trade Training re-established after the earthquakes to ensure Maori people can play a distinguished role in the Canterbury rebuild. The scheme aims to grow the next generation of Māori leadership in trades by building Māori capability in the building and infrastructure industries in Canterbury. **Liquid Media Operations Limited** – Shareholder Liquid Media is a start-up company which has a water/sewage treatment technology. **Maori Carbon Foundation Limited** – Chairman The Maori Carbon Foundation has been established to deliver environmental, social and economic benefits through the planting of permanent carbon forestry, to Maori and New Zealand landowners throughout the country. **Ngāti Ruanui Holdings** – Director Ngati Ruanui Holdings is the Investment and Economic Development Arm of Ngati Ruanui established to maximise profits in accordance with Te Runanga directions in Taranaki. **NZCF Carbon Planting Advisory Limited** – Director NZCF Carbon Planting Advisory Limited is a company that carries out the obligations in respect of planting and upskilling relating to the Maori Carbon Foundation Limited. **Oaro M Incorporation** – Member 'Oaro M' Incorporation was established in 1968. Over the past 46 years successive Boards have managed and maintained the whenua, located at 'Oaro M', Kaikōura, on behalf of its shareholders. Over time shareholders have requested the Board consider establishing an education grant in order to assist whānau with their educational aspirations.

	Police Commissioners Māori Focus Forum – Member The Commissioner of Police has a group of senior kaumatua and kuia who meet with him regularly to discuss issues of mutual interest and concern. Known as the Commissioner's Māori Focus Forum, the group helps guide policing strategy in regard to Māori and provides advice on issues of the moment. The Māori Focus Forum developed The Turning of the Tide with help from Police. The forum plays a governance role and helps oversee the strategy's implementation. **Pure Advantage** – Trustee Pure Advantage is comprised of business leaders who believe the private sector has an important role to play in creating a greener, wealthier New Zealand. It is a not-for-profit organisation that investigates and promotes opportunities for green growth. **QuakeCoRE** – Board Member QuakeCoRE is transforming the earthquake resilience of communities and societies through innovative world-class research, human capability development, and deep national and international collaborations. They are a Centre of Research Excellence (CoRE) funded by the New Zealand Tertiary Education Commission. **Rangitane Holdings Limited & Rangitane Investments Limited** - Chair/Director The Rangitāne Group has these two commercial entities which serve to develop the commercial potential of Rangitāne's settlement assets. A Board of Directors oversee the governance of the commercial entities, and are responsible for managing Crown lease properties and exploring commercial development opportunities to support the delivery of benefits to Rangitāne members. **SEED NZ Charitable Trust** – Chair and Trustee SEED is a company that works with community groups developing strategic plans. **Sustainable Seas NSC (National Science Challenge) Governance Board** – Member This is an independent Board that reports to the NIWA Board and operates under the Terms and Conditions specified in the Challenge Collaborative Agreement. The Board is responsible for appointing the Director, Science Leadership Team, Kāhui Māori, and Stakeholder Panel for projects within the Sustainable Seas NSC. The Board is also responsible for approving projects within the Research and Business Plan and for allocating funding. **Te Ohu Kai Moana** – Director Te Ohu Kai Moana is an organisation that works to advance Maori interests in the marine environment, including customary commercial fisheries, aquaculture and providing policy and fisheries management advice and recommendations to iwi and the wider Maori community. **Te Waka o Maui** – Independent Representative Te Waka o Maui is a Post Settlement Governance Entity. **Interim Te Ropu** – Member An Interim Ropu has been established to work in partnership with the Crown, Ministers, and the joint venture to help develop and shape initial work on a national strategy to prevent and reduce family violence, sexual violence and violence within whānau. The interim Te Rōpū has been appointed by the Minister of Māori Development and the Lead Minister in consultation with the Minister of Māori/Crown Relations. It comprises up to ten members who bring appropriate

	skills and expertise and who can reflect communities, rangatahi and whānau, urban and regional Māori and wāhine Māori. The group will help inform the terms of reference of the permanent Te Rōpū, with advice due by April 2019.
Dr John Wood **Ex Officio – HAC** Chair CDHB	**Advisory Board NZ/US Council** – Member The New Zealand United States Council was established in 2001. It is a non-partisan organisation, funded by business and the Government, and committed to fostering and developing a strong and mutually beneficial relationship between New Zealand and the United States. The Advisory Board supports the day to day work of the Council by providing strategic and operational advice to both the Executive Board and the Executive Director. **Member of the Governing Board of the Office of Treaty Settlements, Ministry of Justice (as Chief Crown Treaty of Waitangi Negotiator)** – Ex-Officio Member The Office of Treaty Settlements, Ministry of Justice, are responsible for negotiating the settlement of historical Treaty of Waitangi claims, and the administration of the Marine and Coastal Area (Takutai Moana) Act 2011. They also advise and help claimant groups so they are ready to enter negotiations. **Chief Crown Treaty Negotiator for Ngai Tuhoe** Settlement negotiated. Deed signed and ratified. Legislation enacted. **Chief Crown Treaty Negotiator for Ngati Rangi** Settlement negotiated. Deed signed and ratified. Legislation awaiting enactment. **Chief Crown Treaty Negotiator, Tongariro National Park** Engagement with Iwi collective begins July 2018. **Chief Crown Treaty Negotiator for the Whanganui River** Settlement negotiated. Deed signed and ratified. Legislation enacted. **Chief Crown Negotiator & Advisor, Mt Egmont National Park Negotiations** High level agreement in principle reached. Aiming for deed of settlement end of 2018. **Governing Board, Economic Research Institute for ASEAN and East Asia (ERIA)** – Member ERIA is an international organisation that was established by an agreement of the leaders of 16 East Asia Summit member countries. Its main role is to conduct research and policy analysis to facilitate the ASEAN Economic Community building and to support wider regional community building. The governing board is the decision-making body of ERIA and consists of the Secretary General of ASEAN and representatives from each of the 16 member countries, all of whom have backgrounds in academia, business, and policymaking. **Kaikoura Business Recovery Grants Programme Independent Panel** – Member The Kaikoura Business Recovery Grants Programme was launched in May 2017 and is intended to support local businesses until State Highway One reopens by way of grants which can be applied for by eligible businesses. This programme is now closed.

	School of Social and Political Sciences, University of Canterbury – Adjunct Professor Teach into graduate and post graduate programmes in political science, trade policy and diplomacy – pro bono appointment. **Te Urewera Governance Board** –Member The Te Urewera Act replaces the Te Urewera National Parks Act for the governance and management of Te Urewera. The purpose of the Act is to establish and preserve in perpetuity a legal identity and protected status for Te Urewera for its intrinsic worth, its distinctive natural and cultural values, the integrity of those values, and for its national importance. Inaugural term as a Crown appointment, re-appointed as a Ngai Tuhoe nominee. **University of Canterbury (*UC*)** – Chancellor The University Council is responsible for the governance of UC and the appointment of the Vice-Chancellor. It sets UC's policies and approves degree, financial and capital matters, and monitors their implementation. **University of Canterbury Foundation** – Ex-officio Trustee The University of Canterbury Foundation, Te Tūāpapa Hononga o Te Whare Wānanga o Waitaha, is dedicated to ensuring that UC's tradition of excellence in higher education continues. From its earliest beginnings in 1873, philanthropic support and the generosity of donors and supporters has played a major part in making the university the respected institution it is today. The UC Foundation is dedicated to continuing that tradition. **Universities New Zealand** – Elected Chair, Chancellors' Group Universities New Zealand is the sector voice for all eight universities, representing their views nationally and internationally, championing the quality education they deliver, and the important contribution they make to New Zealand and New Zealanders.

MINUTES – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE HOSPITAL ADVISORY COMMITTEE MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch,
on Thursday, 29 November 2018, commencing at 9.00am

PRESENT

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

APOLOGIES

Apologies for absence were received and accepted from Trevor Read; Ta Mark Solomon; and Dr John Wood.

EXECUTIVE SUPPORT

Mary Gordon (Executive Director of Nursing); Dr Greg Hamilton (Team Leader, Intelligence & Transformation, Planning & Funding); Jacqui Lunday-Johnstone (Executive Director of Allied Health, Scientific & Technical); Dr Sue Nightingale (Chief Medical Officer); Anna Craw (Board Secretariat); Charlotte Evers (Assistant Board Secretariat); and Kay Jenkins (Executive Assistant, Governance Support).

IN ATTENDANCE

Item 4

Dan Coward – General Manager, Older Persons, Orthopaedics & Rehabilitation Service, Burwood Hospital
Heather Gray – Director of Nursing, Christchurch Campus
Dr Peri Renison – Chief of Psychiatry, Specialist Mental Health Services (*SMHS*)
Bernice Marra – Manager, Ashburton Health Services

Item 5

Ralph La Salle, Team Leader, Secondary Care, Planning & Funding

Andrew Dickerson, Chair, welcomed Jacqui Lunday-Johnstone to her first meeting of the Committee, and asked her to introduce herself as the newly appointed Executive Director of Allied Health, Scientific & Technical.

1. INTEREST REGISTER

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

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

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

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (19/18)
(Moved: Sally Buck/Seconded: Dr Rochelle Phipps – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 4 October 2018 be approved and adopted as a true and correct record."

3. CARRIED FORWARD/ACTION ITEMS

Item 1, AT&R Unit Update: remove from carried forward list.

The Committee noted the remaining carried forward items.

4. H&SS MONITORING REPORT

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

General Managers spoke to their areas as follows:

Ashburton Health Services – Bernice Marra, Manager Ashburton Health Services
Ms Marra highlighted the Signal for Noise (*SFN*) graph on inpatient occupancy and the continuing focus on the frail elderly pathway. A workshop was held recently on re-focusing this service, with a new model for falls in rural hospitals underway.

There is ongoing research in chemotherapy delivery in the oncology unit, including expanding treatment to five days a week.

A new Director of Nursing starts in December.

Jo Kane joined the meeting at 9.10am.

There was discussion around the upcoming change in GP fee structure and the impacts on GP service. Work is underway with Service Level Alliance (*SLA*) operations groups to utilise opportunities in acute demand and with nurse practitioners. Recruitment is continuing for more nurse practitioners.

The chemotherapy service was discussed, with questions around whether it is for only adults and if patients stay in the unit overnight. Ms Marra confirmed children travel to Christchurch for treatment. How a patient's treatment is handled depends on the regime, with patients attending weekly or monthly. It is a day stay unit.

Discussion was held around recent media coverage of job vacancies in Ashburton and the impact on health services. This is largely due to population growth and diversity. Work is ongoing on a 10-15 year health plan, in conjunction with the Ashburton District Council.

Medical/Surgical & Women's & Children's Health – Heather Gray, Director of Nursing, Christchurch Campus (for Pauline Clark)
Ms Gray highlighted the recent successful rollout of the South Island Patient Information Care System (*SIPICS*). Operational matters are currently being worked through.

The move to the Outpatients building was also highlighted, with Ms Gray commenting on its success. A daily meeting is held regarding service issues. The defect process is underway. Access to the building has been better than expected, and staff and patients are enjoying the new facilities.

A Committee member queried what measures had been taken towards sustainability. Discussions were held around natural light, air flow and energy sources, with the model of care re-designed before migration to look at what equipment was surplus to requirements. A Sustainability Committee works across all services to develop long-term strategies for efficient, sustainable facilities.

Discussion was held around migration planning for the Acute Services Building (*ASB*). The governance group has been re-set to allow broader representation. Agile movement practices were learned from earthquake moves.

Specialist Mental Health Services (*SMHS*) – Dr Peri Renison, Chief of Psychiatry (for Toni Gutschlag)

Dr Renison discussed the level of assaults in the in-patient unit. Staff are working on finding solutions.

The planned shift from The Princess Margaret Hospital (*TPMH*) was discussed. Planning work is underway, with teams working on detail in anticipation of a move. Staff engagement in this is high, and staff morale has lifted.

Discussion was held around growth in adult community cases and the source of these. The main route is GP referrals. A Committee member queried how many of these patients are likely to be undergoing earthquake related stress. Dr Renison commented it is difficult to know the exact number, but commented it is an ongoing issue.

Discussion was held around the inquiry into Mental Health and Addiction, with it noted that a report is due for release before the end of the parliamentary year.

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

Mr Coward highlighted the falls and introduction of the Safe Recovery Programme at Burwood Hospital. This has involved a three month pilot and has included patient surveys in order to shape tools and resources. Data from the pilot will be included in the Committee's January 2019 report. This will be an ongoing programme.

Specialist gerontology statistics have shown a decrease in patients seen by consultants, now being seen by Clinical Nurse Specialists. This allows for better interaction between services and a reduction in waiting times.

A query was raised on the redevelopment of the Spinal Unit. Mr Coward advised that the demolition component is complete, and strip out is nearly complete. The project is on track.

Discussion was held around the artificial limb centre. Mr Coward confirmed that the New Zealand Artificial Limb Centre is undertaking a nationwide review of facilities and are in the early stages of re-thinking their Canterbury operations. Burwood will continue to support the current arrangement.

Mary Gordon, Director of Nursing, commented on the recent Gateway Review of the Burwood Hospital redevelopment. A group of four independent reviewers visited the campus last week, undertaking patient and staff interviews. Early findings show that the benefits of the redevelopment were achieved, with outstanding patient outcomes. It was requested that formal recognition of staff be made by the Board.

Resolution (20/18)
(Moved: David Morrell/Seconded: Jan Edwards – carried)

"That the Committee:

i. notes the Hospital Advisory Committee Activity Report."

5. PLANNING & FUNDING ELECTIVES UPDATE

Ralph La Salle, Team Leader, Secondary Care, Planning & Funding, presented the report.

2019 will be a challenging year, due to population increases and the continued use of operating theatres at Christchurch Hospital in acute surgical cases. Outsourcing/placing of surgeries will remain high, with complex and complicated cases driving a new standard for care.

Discussion was held around intervention rates and how they drive volume. There are complexities in outsourcing surgical care, particularly spinal, which is a nationwide issue. There is a strategy around recruitment, but this will remain challenging.

A Committee member put a question to Dr Sue Nightingale, Chief Medical Officer, on the level of risk. While it is a tenuous position, daily work is ongoing in finding alternatives and creating rosters that have flow-on effects in other areas.

A query was made around what further electives planning has been done beyond 2018/19, particularly when ASB is open. Mr La Salle confirmed conversations are ongoing, but there are still decisions to be made around the order of services to be brought back in-house.

Resolution (21/18)
(Moved: Jo Kane/Seconded: David Morrell – carried)

"That the Committee:

i. notes the Planning & Funding Electives Plan for 2018/19."

6. 2018 WINTER PLANNING REVIEW – PRESENTATION

Dr Greg Hamilton, Team Leader, Intelligence and Transformation, Planning & Funding presented the review, highlighting the following:

- Growth in population is driving Emergency Department (*ED*) attendances.
- Higher ACC attendances as a result of accidents.
- Increase in re-admission rate to Acute Medical Admitting Unit (*AMAU*) and ED.
- Higher volume of pneumonia care in over 75 year olds.
- High pressure in ICU July to September.
- ED demand is in line with projections, with summer spikes driven by various factors.
- Inpatient admissions, total occupied beds and patients over 75 are in line with projections.

Planning for winter 2019 is underway.

A Committee member queried whether a second 24 hour clinic would help decrease demand. Due to the concentrated workforce in the current 24 hour clinic, a second one would split resources and would be of no benefit.

Dr Anna Crighton, Co-Chair, Community & Public Health and Disability Support Committee (*CPH&DSAC*), asked what work had been done in extending free flu jabs to the wider population. Dr Hamilton commented that special authority is needed from Pharmac for this, as well as a review of the literature on how effective it would be. Dr Hamilton undertook to present a report to the next CPH&DSAC meeting in March 2019.

Discussion was held around what drove the summer peak. In October 2017, private radiology practices raised their ACC co-payments, which was then withdrawn in December. ACC presentations also increased. However there were no obvious trends. It was queried whether summer planning is needed, but Dr Hamilton confirmed this comes under daily planning, whereas winter planning needs complex and additional resources.

7. CLINICAL ADVISOR UPDATE – MEDICAL – ORAL

Dr Sue Nightingale, Chief Medical Officer, provided her clinical advisor update. There was no discussion.

8. DRAFT 2019 WORKPLAN

The Committee received the Draft Workplan for 2019. The Chair welcomed suggestions from the Committee.

It was requested that the Quality & Patient Safety Indicators – Level of Complaints report be included as a standing agenda item, rather than an information item. The Chair undertook to consider this.

9. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (22/18)
(Moved: Dr Anna Crighton/Seconded: David Morrell – carried)

"That the Committee:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of the minutes of the public excluded meeting of 4 October 2018.	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(If required)*	Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)

iii notes that this resolution is made in reliance on the Act, Schedule 3, Clause 32 and that the public conduct of the whole or the relevant part of the meeting would be likely to

result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982."

INFORMATION ITEMS

- Quality & Patient Safety Indicators – Level of Complaints
- 2018 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 10.59am.

Approved and adopted as a true and correct record:

_____ _____

Andrew Dickerson Date
Chairperson

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE
CARRIED FORWARD ITEMS AS AT 31 JANUARY 2019

DATE		ISSUE / ACTION	REFERRED TO	STATUS
1.	04 Oct 2018	SLM Data Viewer – provide access to Committee members	Nicky Smithies	Today - Workshop

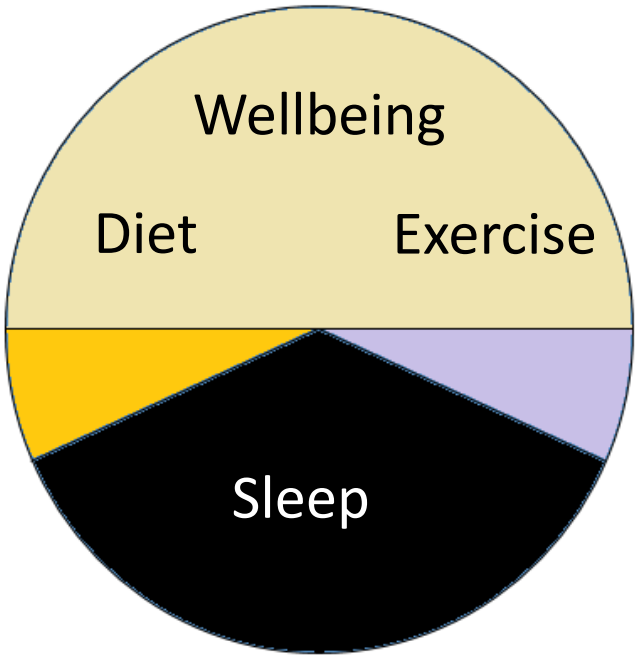
Sleep Health Services in Canterbury

Paul T Kelly
Robin Rutter-Baumann
Michael Hlavac

The CDHB Sleep Team

Importance of good sleep

Sleep is the foundation of good health



Good sleep = Good wake

Bad sleep = Bad wake

Prevalence of Sleep Disorders

- Inadequate sleep affects 1/3 people
- Medical sleep conditions are very common
  - Sleep Apnoea 8%
  - Insomnia 20%
  - Restless legs 18%

10%	depression
5%	stroke
5%	workplace injuries
4%	MVA

- 17% miss work because of sleepiness, 17% fall asleep on the job
- 29% report making errors due to sleepiness
- People with sleep problems more likely to have decreased productivity

Driving Risk

- 29% driving while drowsy in the month
- 20% have nodded off while driving
- 5% report a sleep related accident in the last year

https://www.sleephealthfoundation.org.au/public-information/special-reports/reawakening-the-nation.html

https://www.sleephealthfoundation.org.au/pdfs/surveys/SleepHealthFoundation-Survey.pdf

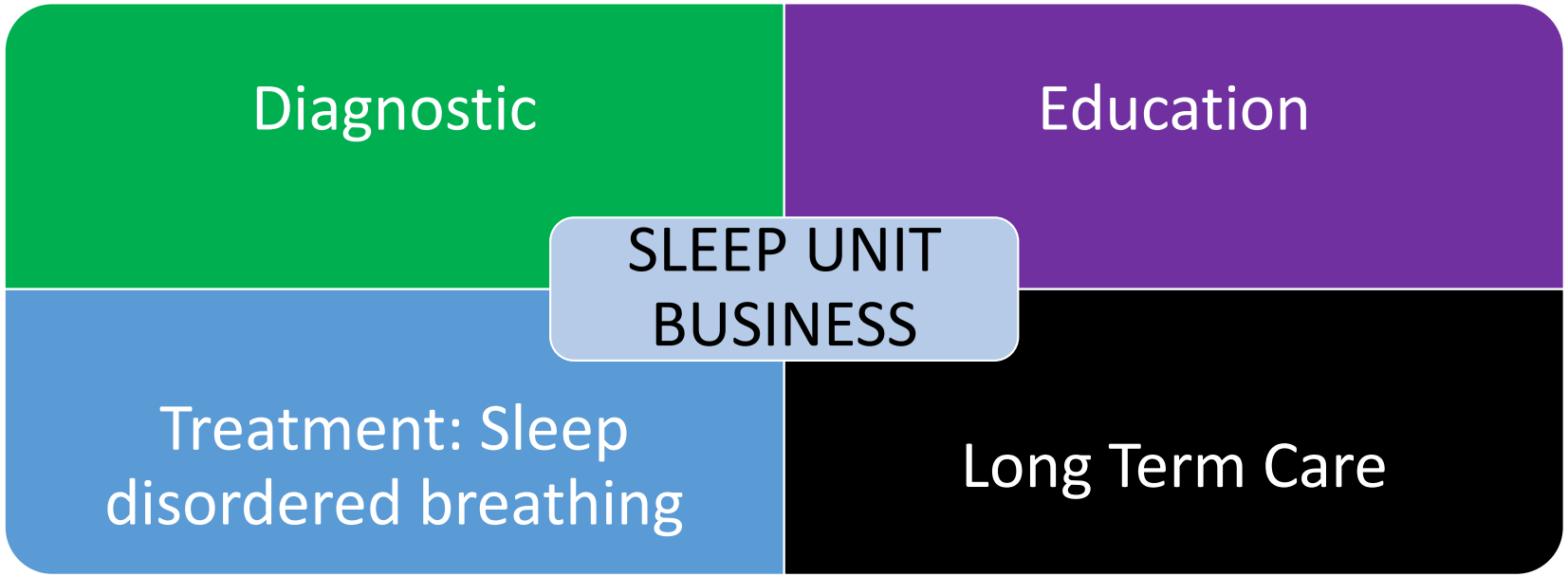
Associated Costs of Poor Sleep

Australia
Healthcare costs alone
$5.1 billion per year

NZ
Current costs not known

Why sleep matters — the economic costs of insufficient sleep by Marco Hafner, Martin Stepanek, Jirka Taylor, Wendy M. Troxel, Christian Van Stolk, RR-1791-VH, 2016 (available at www.rand.org/t/rr1791).

What do the Sleep Team do?

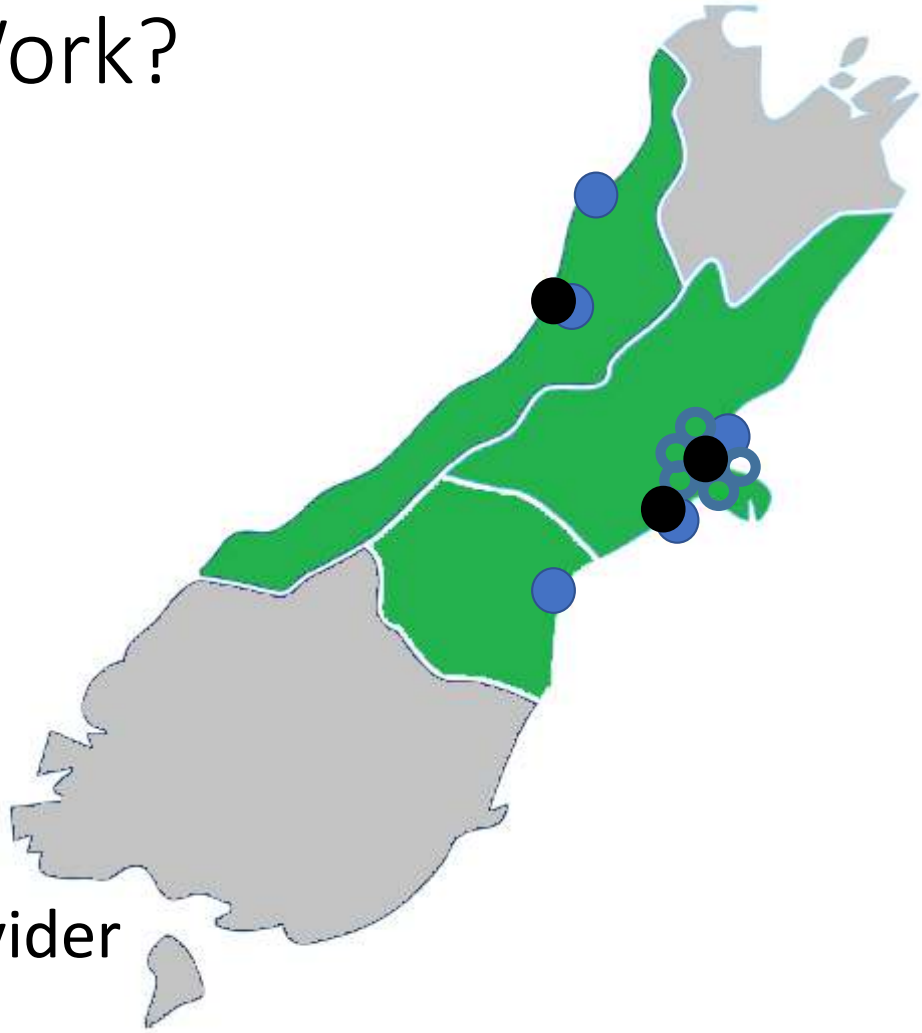


Mission: To improve the Sleep Health of the people living in Canterbury

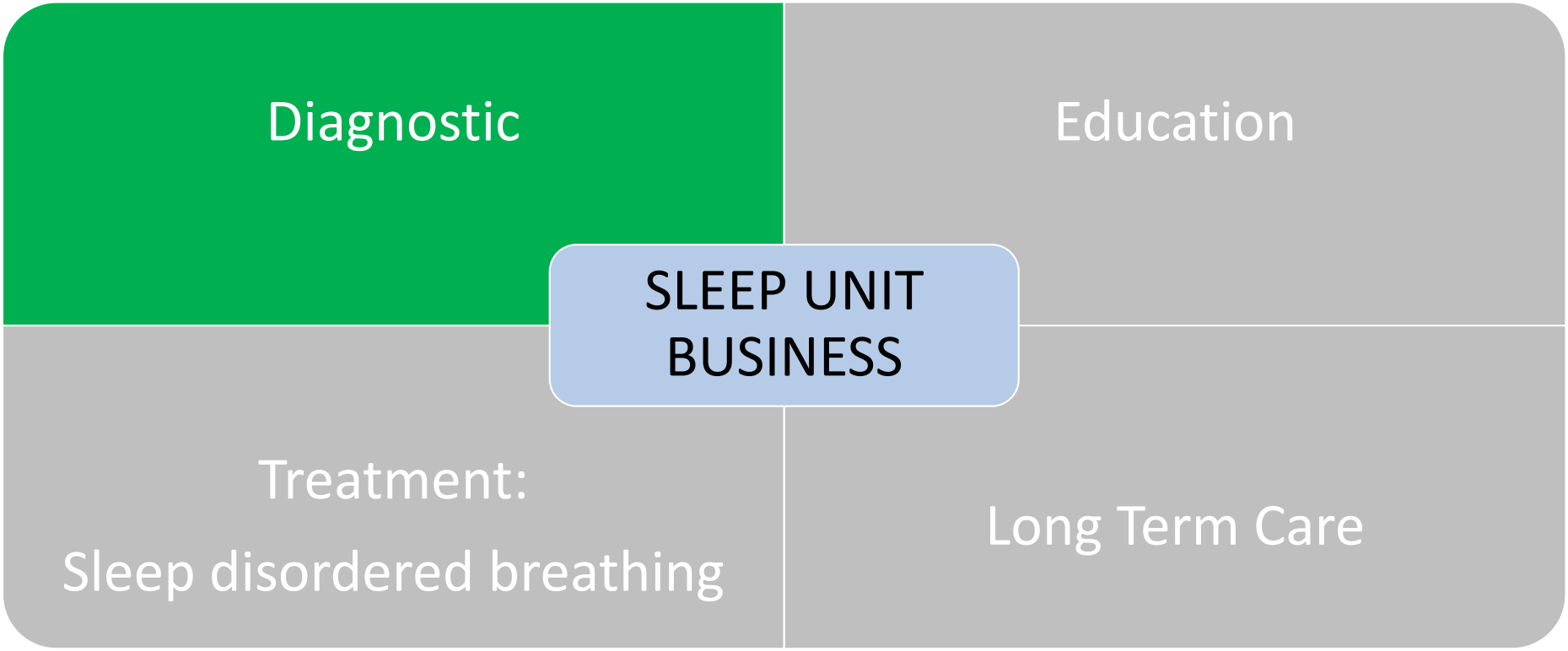
Principal Objectives: Provide high quality services for the investigation, diagnosis and treatment of patients with sleep disordered breathing and other sleep disturbances.

Where Do We Work?

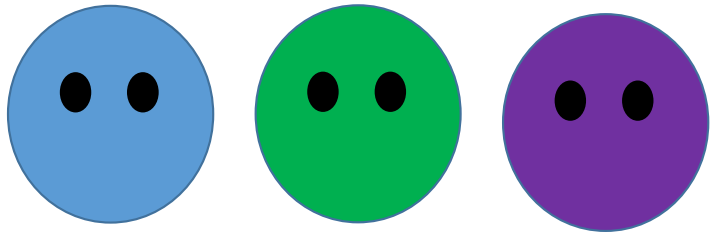
- Christchurch Hospital
- Burwood Hospital
- Ashburton Hospital
- Grey Hospital
- SCDHB services
- Buller CNS
- GP approved sleep provider

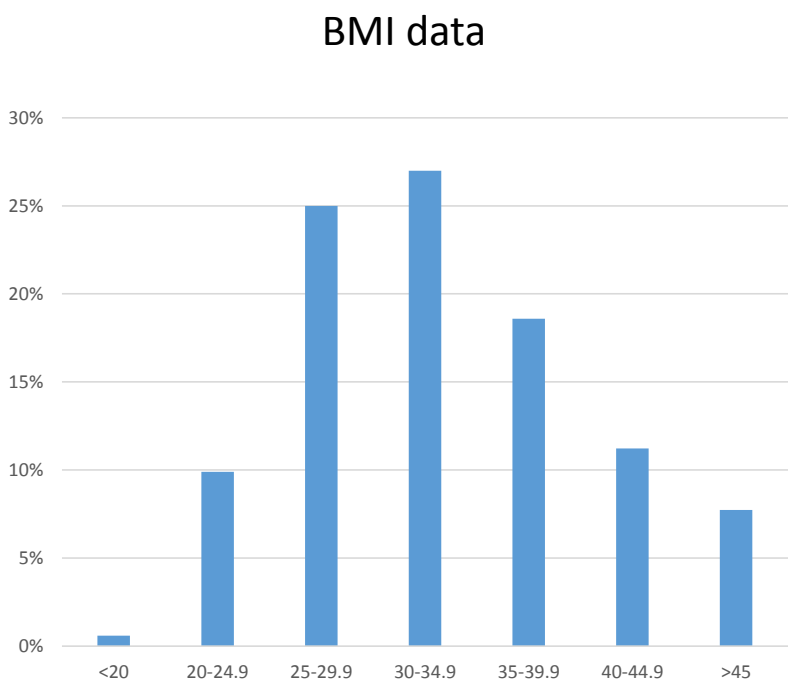


Diagnostic

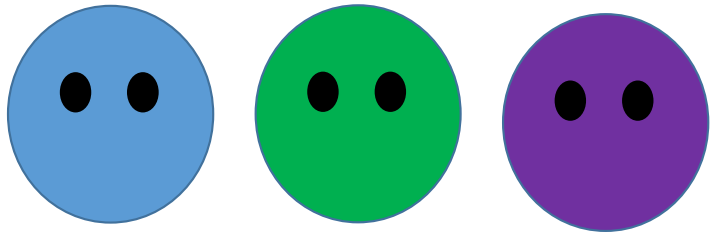

Diagnostic
Education
SLEEP UNIT BUSINESS
Treatment:
Sleep disordered breathing
Long Term Care

Common Referrals “Bob the Patient”

	
Age-gender	38% Female:62% Male Average age 51 ± 15 (16-92)
BMI	>30
Symptoms/Observations	Sleepy during the day, falls asleep anywhere, anytime Morning headache Snoring at night, breathing pauses, dry mouth Low mood
Clinical Q	Does this patient have sleep apnoea
Occupation	Milk tanker driver Digger driver Farmer Teacher



Common Referrals “Bob the Patient”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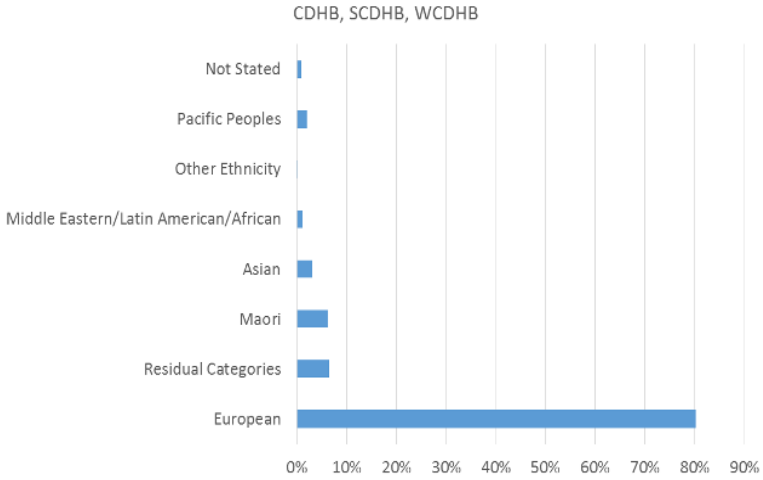
Clinical Q	Does this patient have sleep apnoea
Occupation	Milk tanker driver Digger driver Farmer Teacher

Ethnicity data



Primary Care Sleep Assessment Service

npj | Primary Care Respiratory Medicine

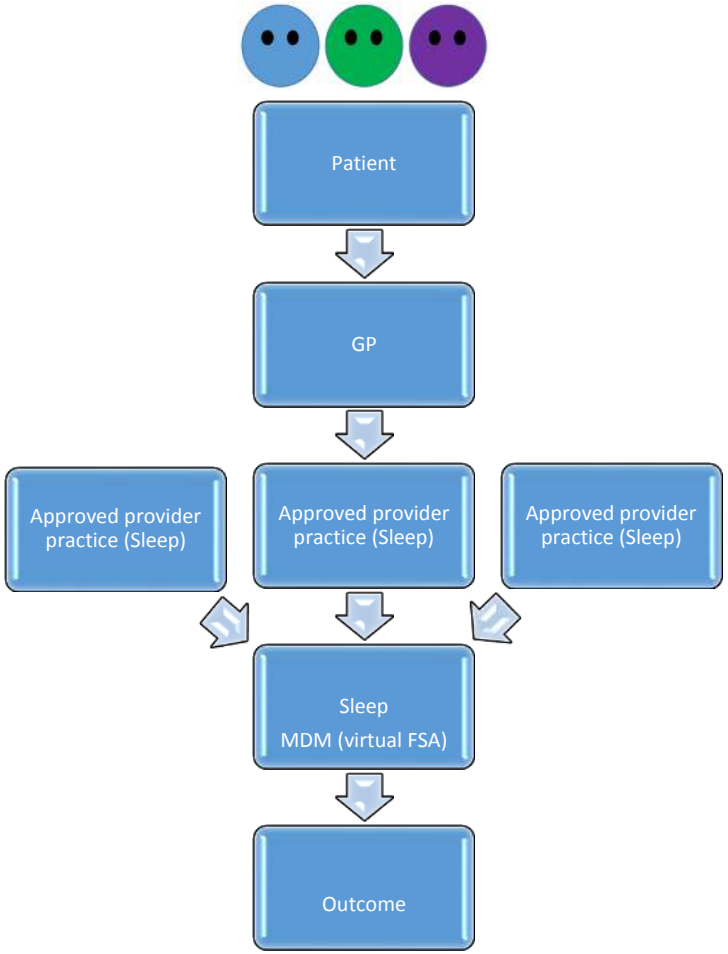
www.nature.com/npjpcrm

ARTICLE OPEN

Development and outcomes of a primary care-based sleep assessment service in Canterbury, New Zealand

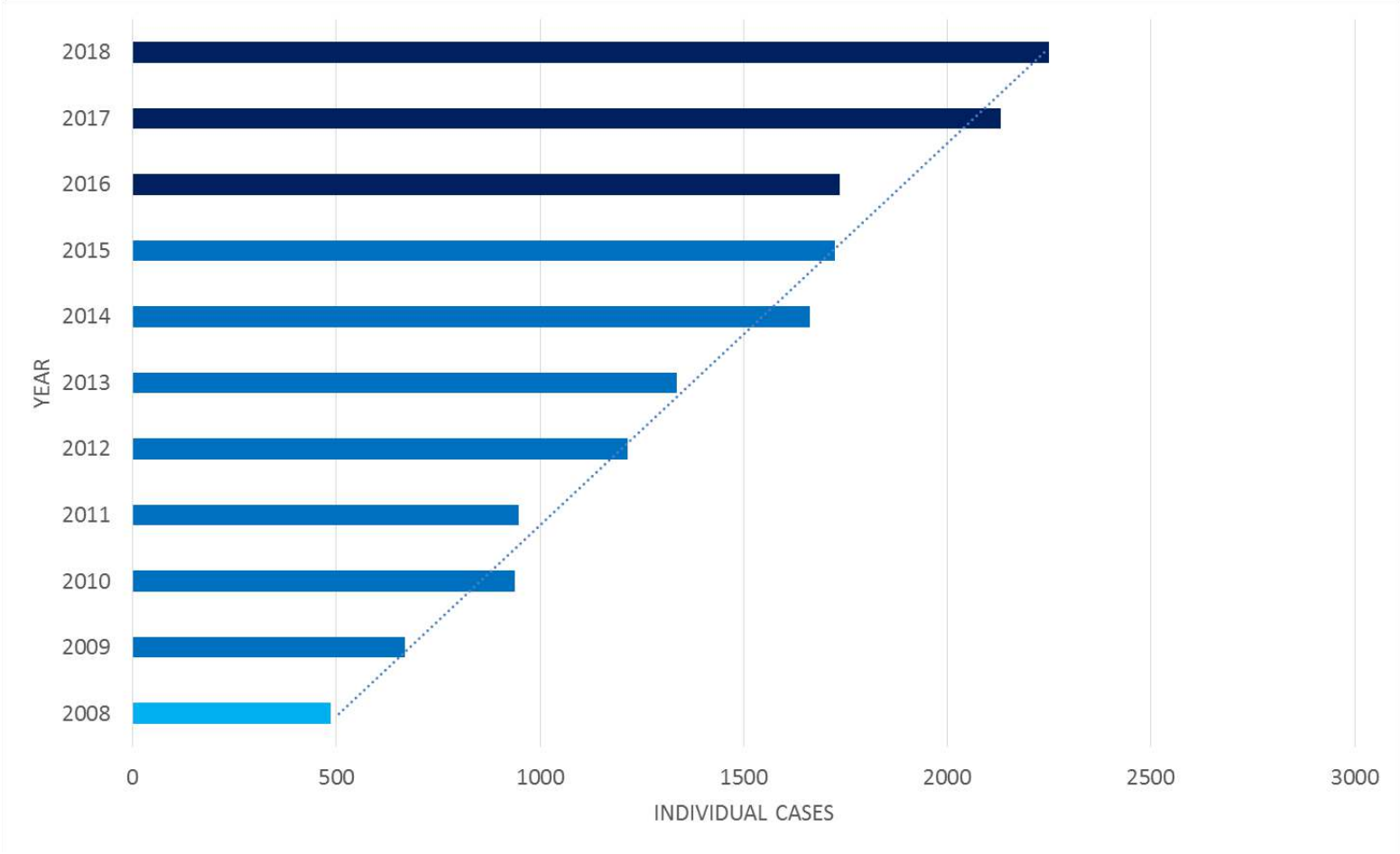
Michael J. Epton[1,2], Paul T. Kelly[1], Brett I. Shand[3], Sallyanne V. Powell[1], Judith N. Jones[2], Graham R. B. McGeoch[3] and Michael C. Hlavac[1,2]

"the establishment of a community sleep assessment service and sleep MDM, led to significantly **more assessments**, with **short waiting times for treatment**, especially in high-risk patients with severe obstructive sleep apnoea. Most patients can be assessed without more complex studies or face-to-face review by a sleep specialist"



npj Primary Care Respiratory Medicine (2017) 27:26 ; doi:10.1038/s41533-017-0030-1

New Patient Referrals “more assessments”

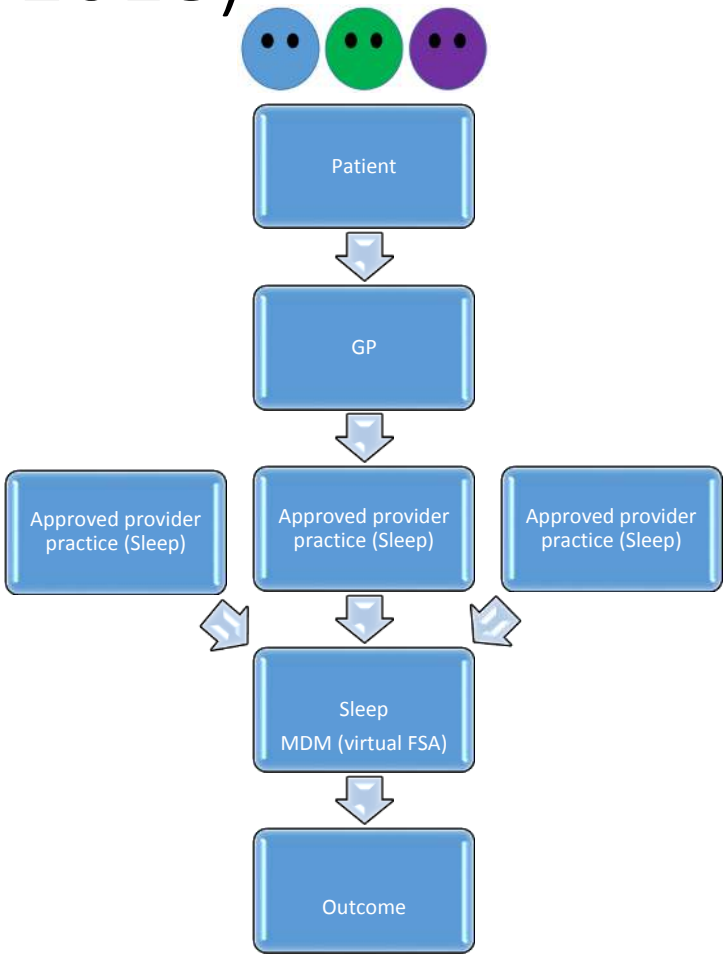


“Shorter wait time” Data (2015-2018)

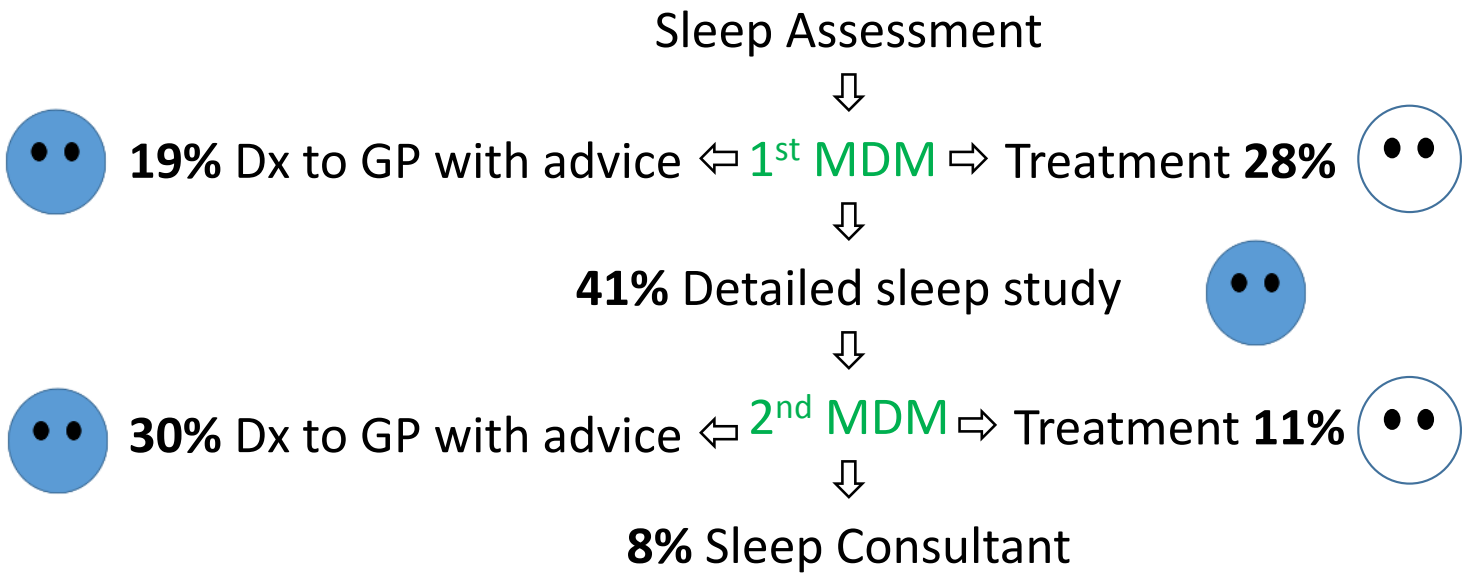
Target 28 days
Median 32 days

Target 7 days
Median 0 days

Target 28 days
Median 15 days

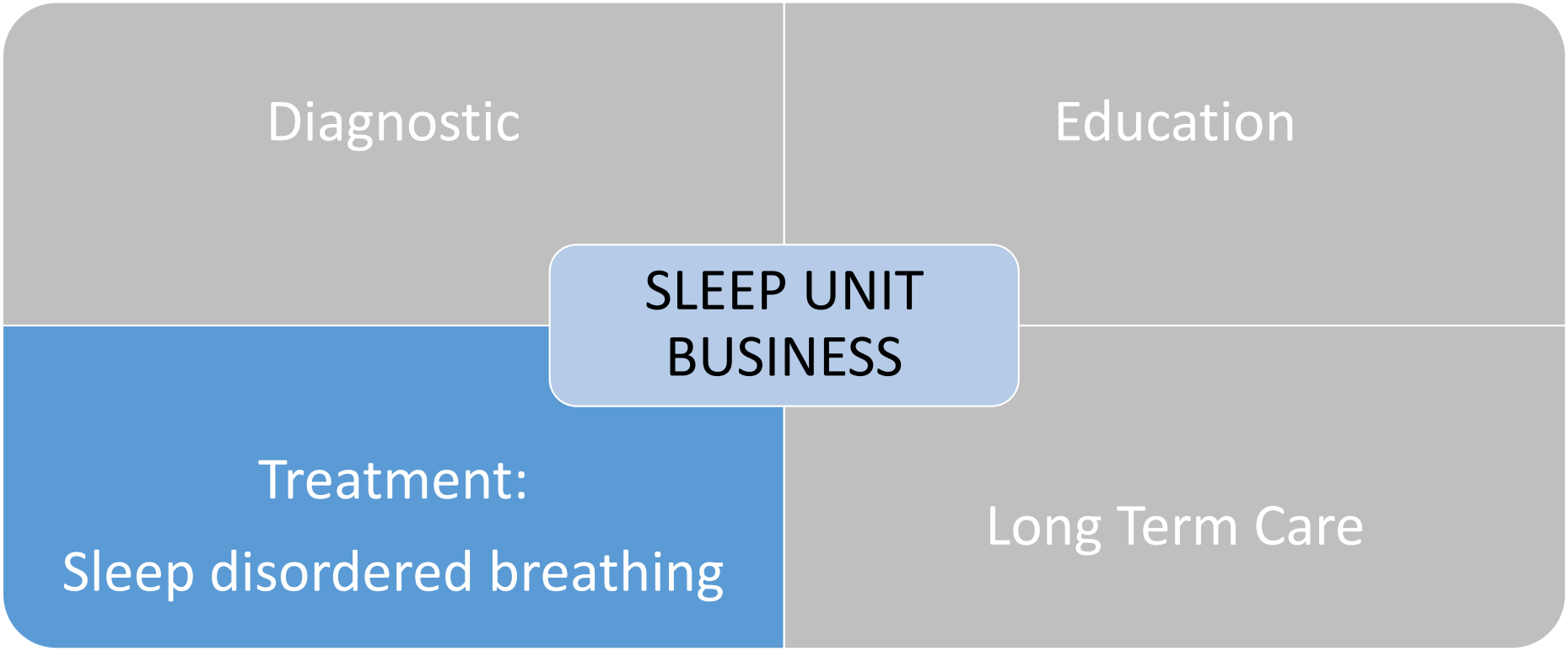


Sleep Assessment Outcomes (3 years n=5317)



50% Dx to GP with advice **10%** Consultant **40%** Treatment

Treatment

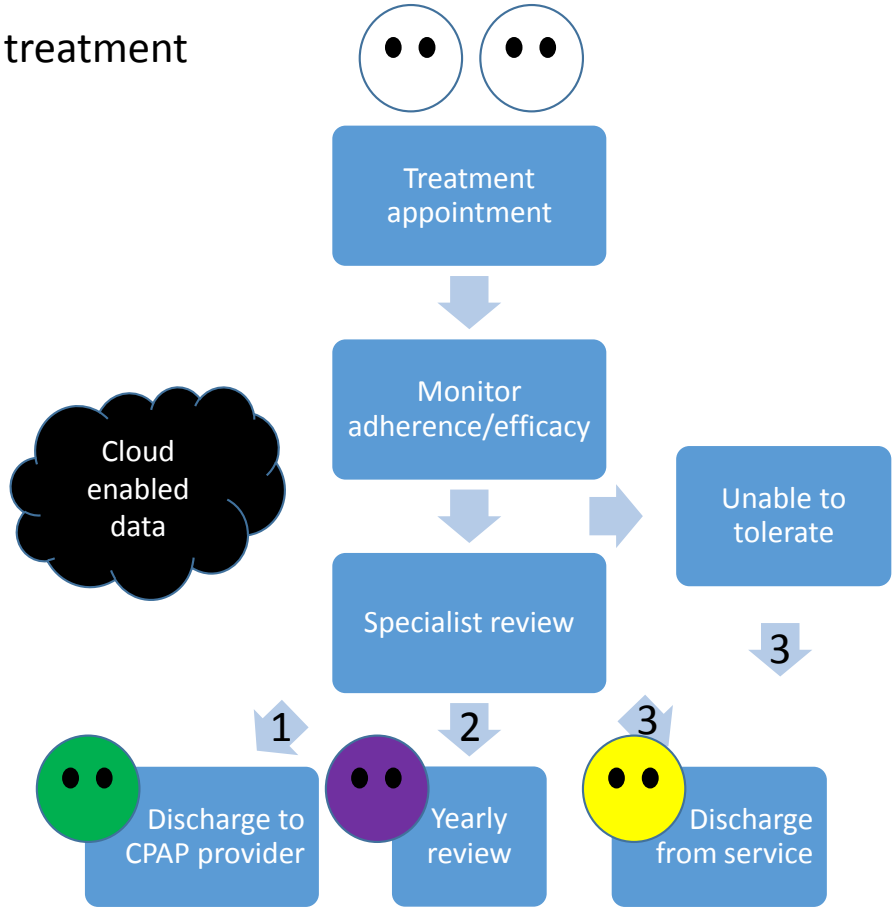

Diagnostic
Education
SLEEP UNIT BUSINESS
Treatment:
Sleep disordered breathing
Long Term Care

Sleep Disordered Breathing: Treatment

Continuous positive airway pressure (CPAP) is mainstream treatment

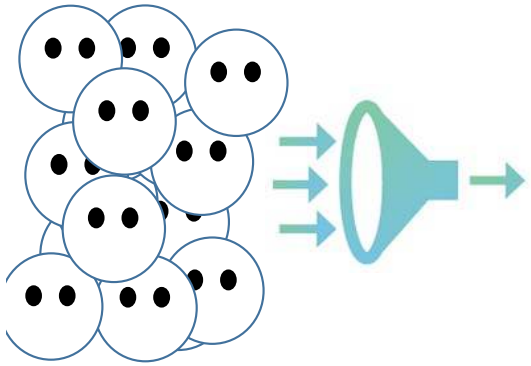
<u>Criteria for funded CPAP therapy in CDHB</u>

- Severe sleep apnoea (>30 breathing pauses per hour)
- Evidence of mild/moderate in combination with:
  - *Severe subjective daytime somnolence*
  - *Occupational risk*
  - *Significant co-morbidities*



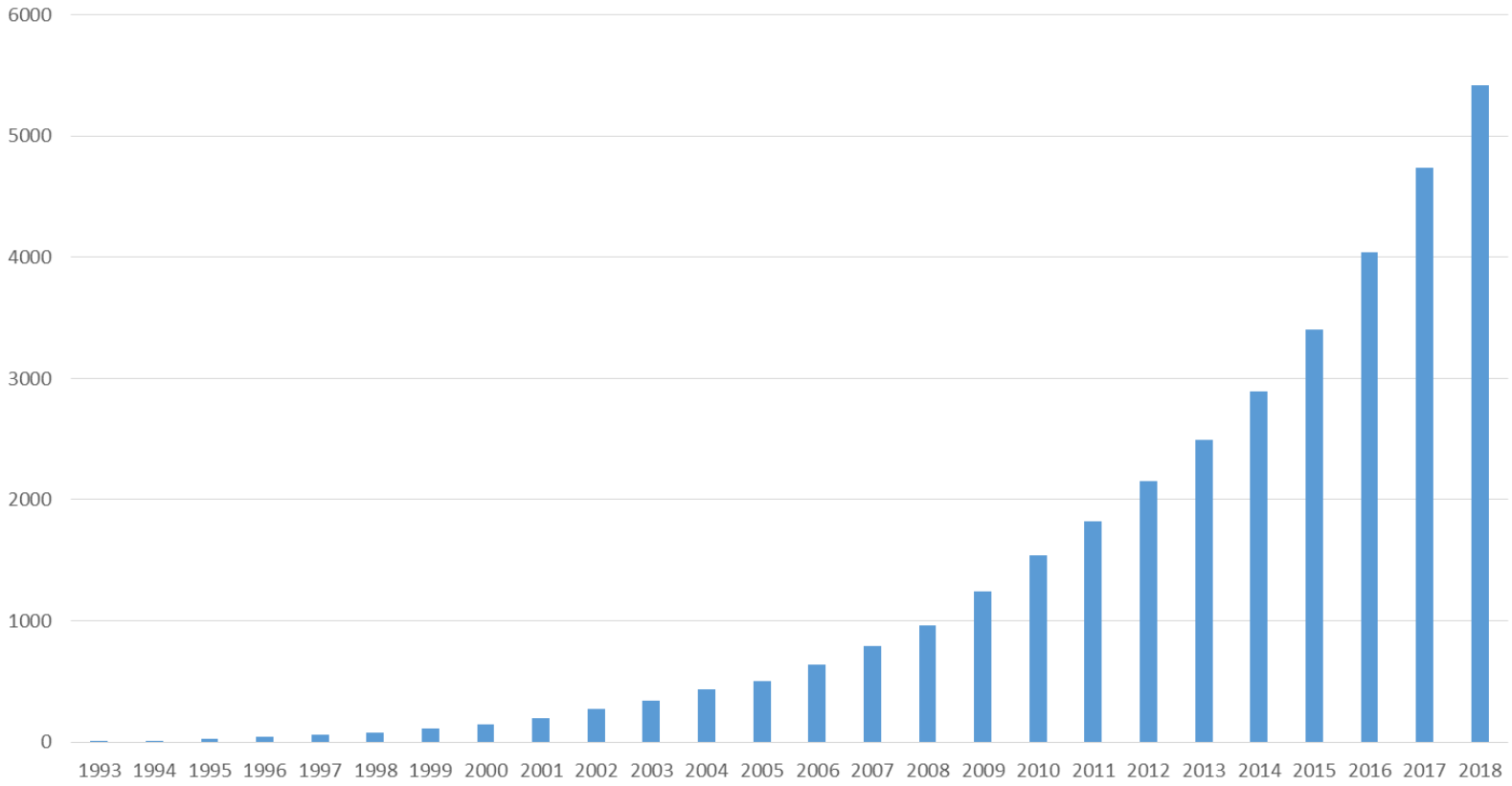
CPAP Demand Model

New patient demand



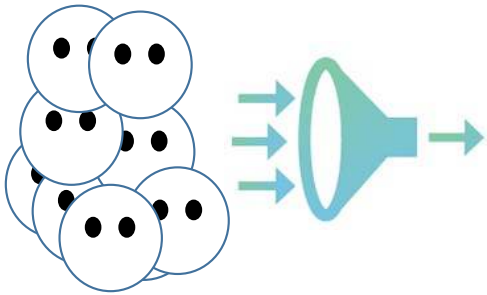
900 trialled therapy per annum

Follow up demand (patients with CPAP device)



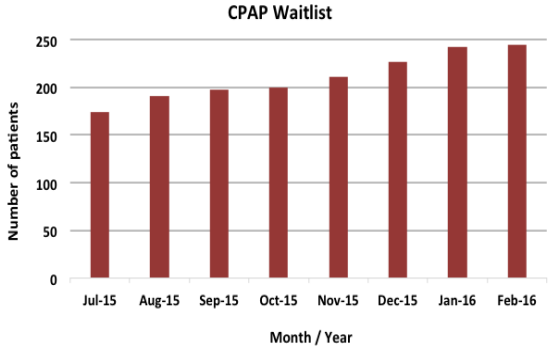
New Patient Demand

Current demand
900 PA



"an integrated health system that keeps people healthy and well in their own homes by providing the right care and support, to the right person, at the right time and in the right place"

1) Issue: Long wait time for treatment



2) Aim

- Reduce patient waiting time for routine CPAP trials to <100 days by June 2017 by reducing the number of patients on the waiting list to <100.
- Maintain our high standard of patient care.

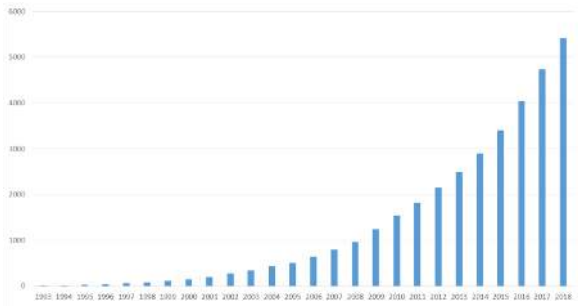
3) Plan

FORMER AND EXISTING MODEL	PROPOSED MODEL
Individual CPAP trial (1 patient) Appointment with Sleep Physiologist OR CNS	Group CPAP trial (8 patients) Appointment with Sleep Physiologist AND CNS
	Education session (one hour) - Obstructive sleep apnoea/CPAP education
CPAP trial (45 minutes) - Obstructive sleep apnoea/CPAP education - Mask fitting - CPAP machine tutorial	CPAP trial (one hour) - Mask fitting - CPAP machine tutorial
CPAP review (30 minutes) - Datacard download - Troubleshooting - Oximetry	CPAP review (45 minutes) - Datacard download - Troubleshooting - Oximetry

4) Results and sustainability

- Waitlist reduced to 100 days for a sustained period
- Patient care was not compromised in a group setting
- Project was a CDHB quality award winner
- Evolved into mini-groups with 1 clinician

Follow Up Demand



CDHB CPAP USERS
Every year

- 1 replacement mask
- 1 replacement hose
- Replacement consumables

Machine breakages

- Replace machine

1) Issue

Unsustainable demand for long term CPAP patients

Resulting in:

- Treatment delays
- Inappropriate use of staff skillset
- Patients having to come into hospital for minor interactions.

2) Aim

- Provide a new CPAP model with initial tertiary nurture and education leading to discharge package
- Ensure long term service users can access parts and advice without coming to hospital.
- Free up specialist care for new OSA treatment, and regular follow up for complex OSA service users.

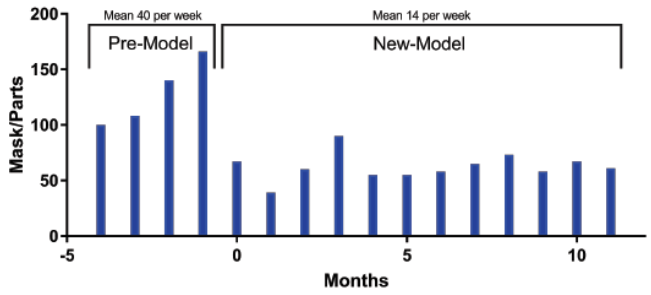
3) Model

80% discharge patients to community provider

20% complex patient continued FU care with hospital

4) Results and sustainability

- Community support is scalable.

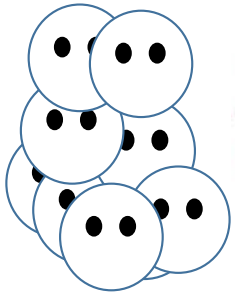


Follow Up Demand

Current CPAP
demand = 900 PA

COMPLEX SERVICE USERS
(occupation/medical)

20 %

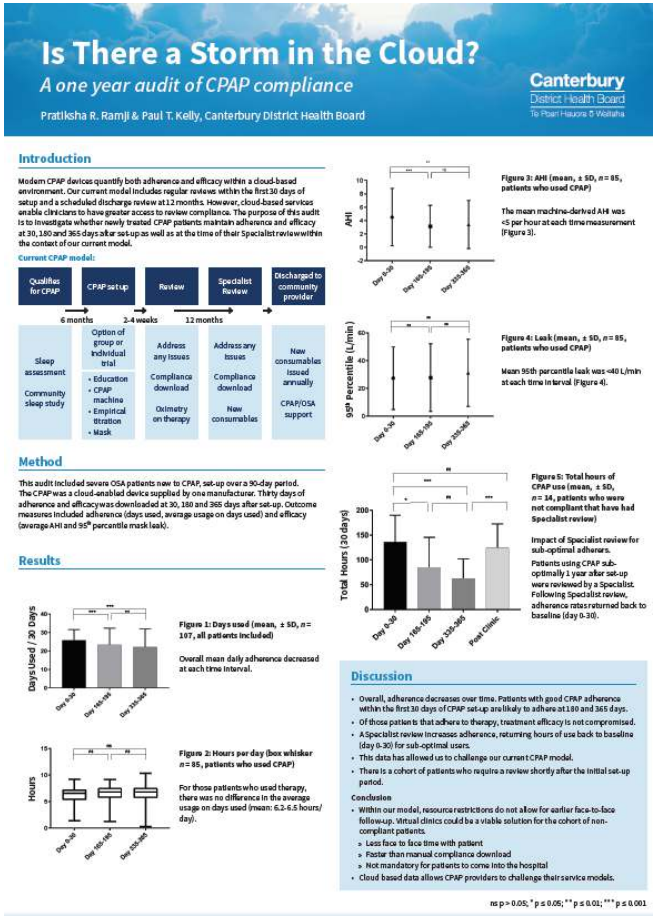


Treatment appointment

80 %

NON COMPLEX SERVICE USERS

Lean Thinking: New CPAP model for 2019



Is There a Storm in the Cloud?

A one year audit of CPAP compliance

Pratiksha R. Ramji & Paul T. Kelly, Canterbury District Health Board

Canterbury District Health Board Te Poari Hauora O Waitaha

Introduction

Modern CPAP devices quantify both adherence and efficacy within a cloud-based environment. Our current model includes regular reviews within the first 30 days of setup and a scheduled discharge review at 12 months. However, cloud-based services enable clinicians to have greater access to review compliance. The purpose of this audit is to investigate whether newly treated CPAP patients maintain adherence and efficacy at 30, 180 and 365 days after set-up as well as at the time of their Specialist review within the context of our current model.

Current CPAP model:

Qualifies for CPAP → 6 months → CPAP set up → 2-4 weeks → Review → 12 months → Specialist Review → Discharged to community provider

Sleep assessment; Community sleep study

Option of group or individual trial
- Education
- CPAP machine
- Empirical titration
- Mask

Address any issues; Compliance download; Oximetry on therapy

Address any issues; Compliance download; New consumables

New consumables issued annually; CPAP/OSA support

Method

This audit included severe OSA patients new to CPAP, set-up over a 90-day period. The CPAP was a cloud-enabled device supplied by one manufacturer. Thirty days of adherence and efficacy was downloaded at 30, 180 and 365 days after set-up. Outcome measures included adherence (days used, average usage on days used) and efficacy (average AHI and 95th percentile mask leak).

Results

Figure 1: Days used (mean, ± SD, n = 107, all patients included)

Overall mean daily adherence decreased at each time interval.

Figure 2: Hours per day (box whisker n = 85, patients who used CPAP)

For those patients who used therapy, there was no difference in the average usage on days used (mean: 6.2-6.5 hours/day).

Figure 3: AHI (mean, ± SD, n = 85, patients who used CPAP)

The mean machine-derived AHI was <5 per hour at each time measurement (Figure 3).

Figure 4: Leak (mean, ± SD, n = 85, patients who used CPAP)

Mean 95th percentile leak was <40 L/min at each time interval (Figure 4).

Figure 5: Total hours of CPAP use (mean, ± SD, n = 14, patients who were not compliant that have had Specialist review)

Impact of Specialist review for sub-optimal adherers.

Patients using CPAP sub-optimally 1 year after set-up were reviewed by a Specialist. Following Specialist review, adherence rates returned back to baseline (day 0-30).

Discussion

- Overall, adherence decreases over time. Patients with good CPAP adherence within the first 30 days of CPAP set-up are likely to adhere at 180 and 365 days.
- Of those patients that adhere to therapy, treatment efficacy is not compromised.
- A Specialist review increases adherence, returning hours of use back to baseline (day 0-30) for sub-optimal users.
- This data has allowed us to challenge our current CPAP model.
- There is a cohort of patients who require a review shortly after the initial set-up period.

Conclusion

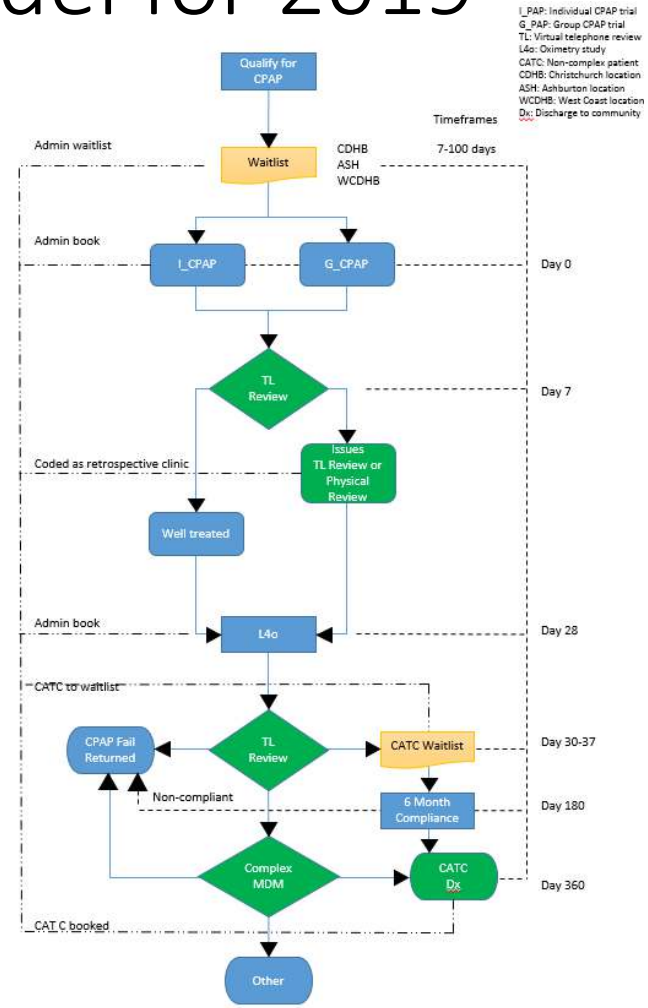
- Within our model, resource restrictions do not allow for earlier face-to-face follow-up. Virtual clinics could be a viable solution for the cohort of non-compliant patients.
  - Less face to face time with patient
  - Faster than manual compliance download
  - Not mandatory for patients to come into the hospital
- Cloud based data allows CPAP providers to challenge their service models.

ns p > 0.05; * p ≤ 0.05; ** p ≤ 0.01; *** p ≤ 0.001

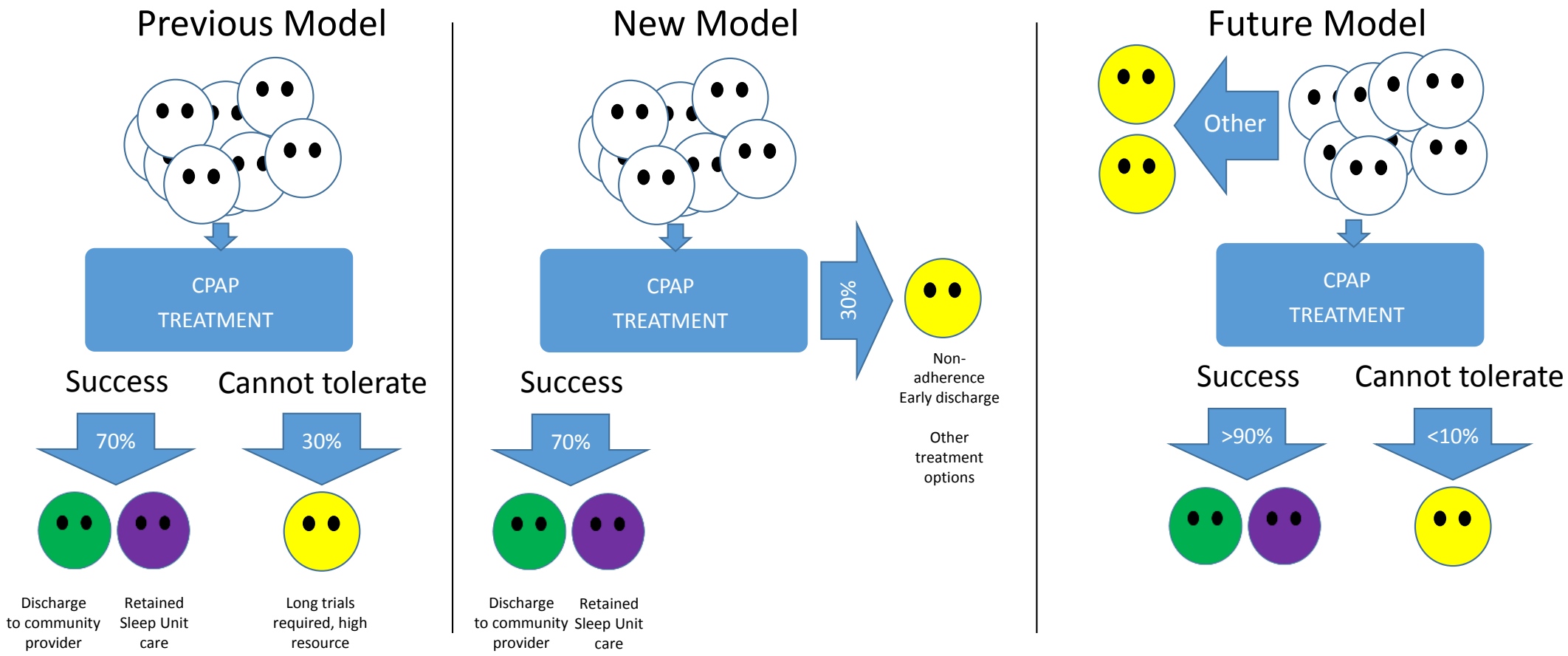
ASA/ASTA Conference Presentation 2018

Cloud enabled data

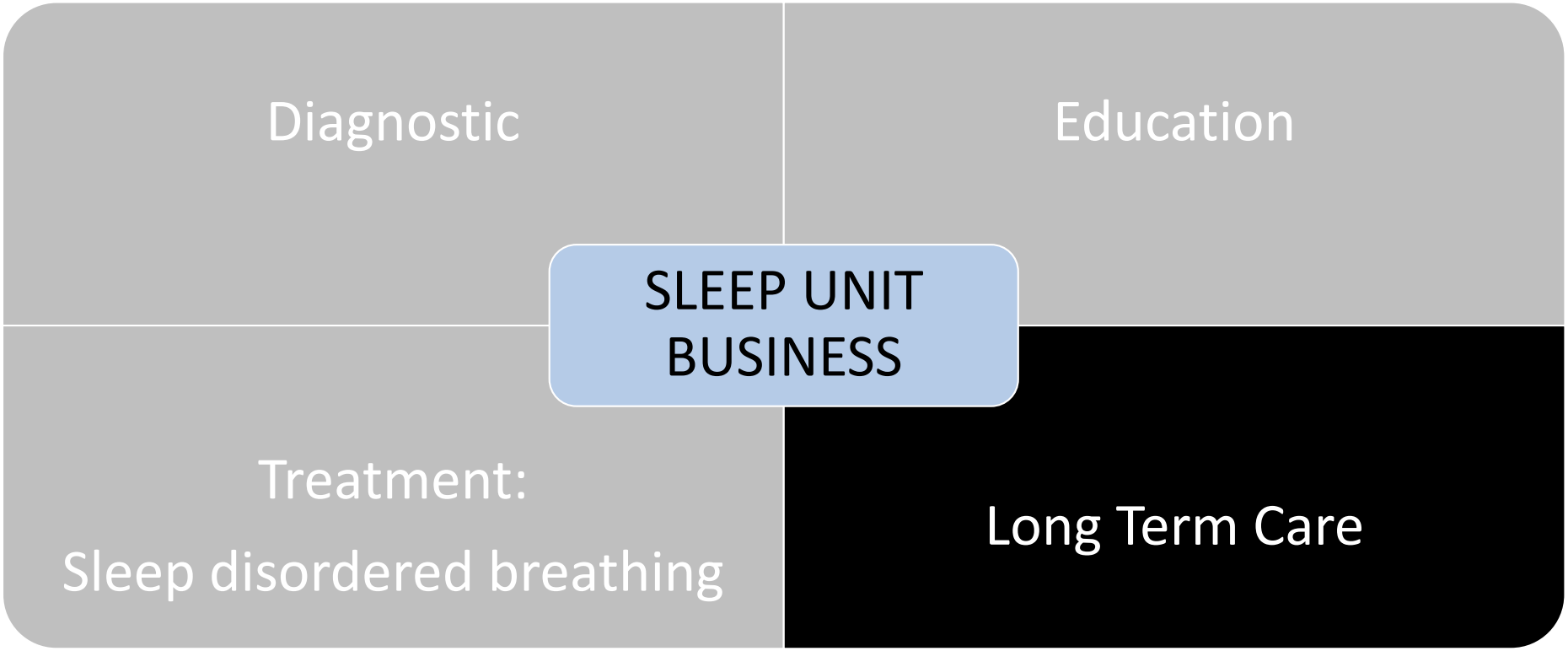
Use cloud data to identify poor adherence early and discharge where appropriate.



Lean Thinking: New CPAP model for 2019



Long Term Care



Treatment Follow Up

- Some patients require yearly reviews
  - Complex medical
  - Occupational (regulatory)
- Complex patient cohort increasing
- Non complex cohort backlog
- At 2 nurse FTE

CATEGORY	Demand (# required)	Capacity (appointments)	Shortfall
Complex	895	682	24%
Non complex	1111	717	35%

Treatment Follow Up

- Some patients require yearly reviews
  - Complex medical
  - Occupational (regulatory)
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- Non complex cohort backlog
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CATEGORY	Demand (# required)	Capacity (appointments)	Shortfall
Complex	895	682	24%
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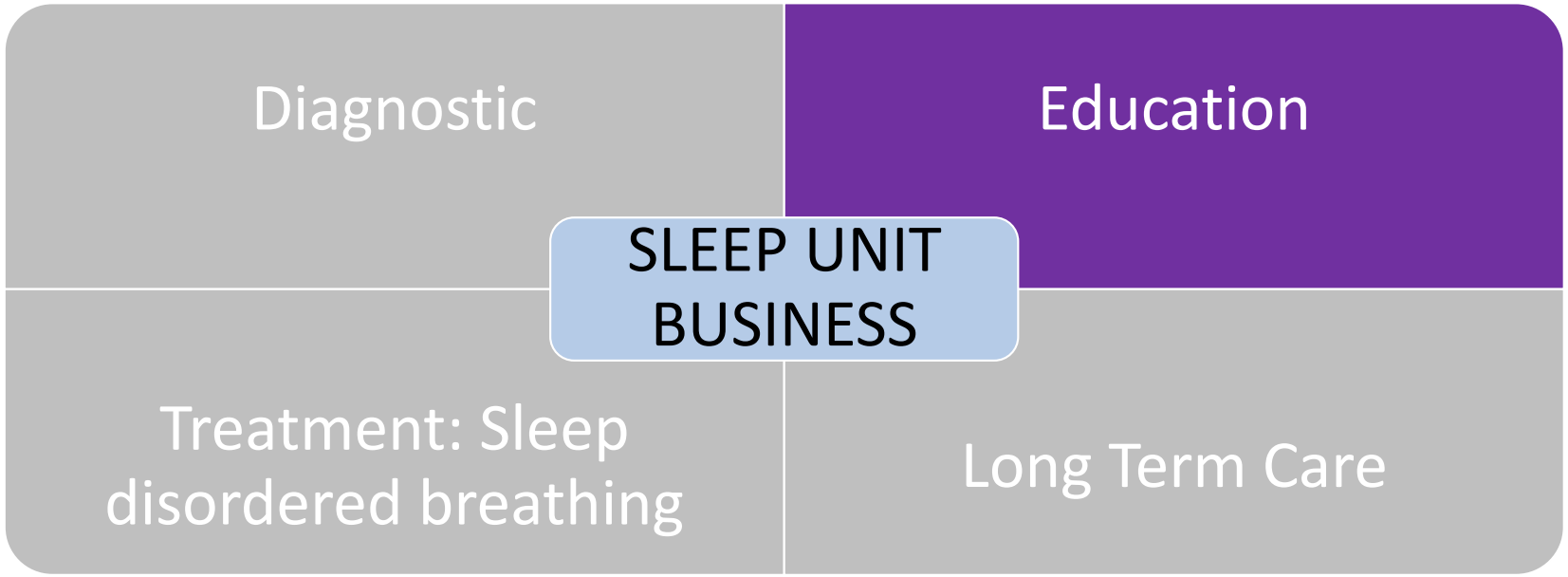
Strategic Project 2019-2020

Where do the regulatory patients sit?

Education


Diagnostic
Education
SLEEP UNIT BUSINESS
Treatment: Sleep disordered breathing
Long Term Care

Education

Regular education session for:

- Community providers of sleep services
- NETP (new nurse programme)
- Better breathing programmes

Community groups:

- Sleep health, making sleep a priority
- How to identify sleep issues
- Where to go to get help

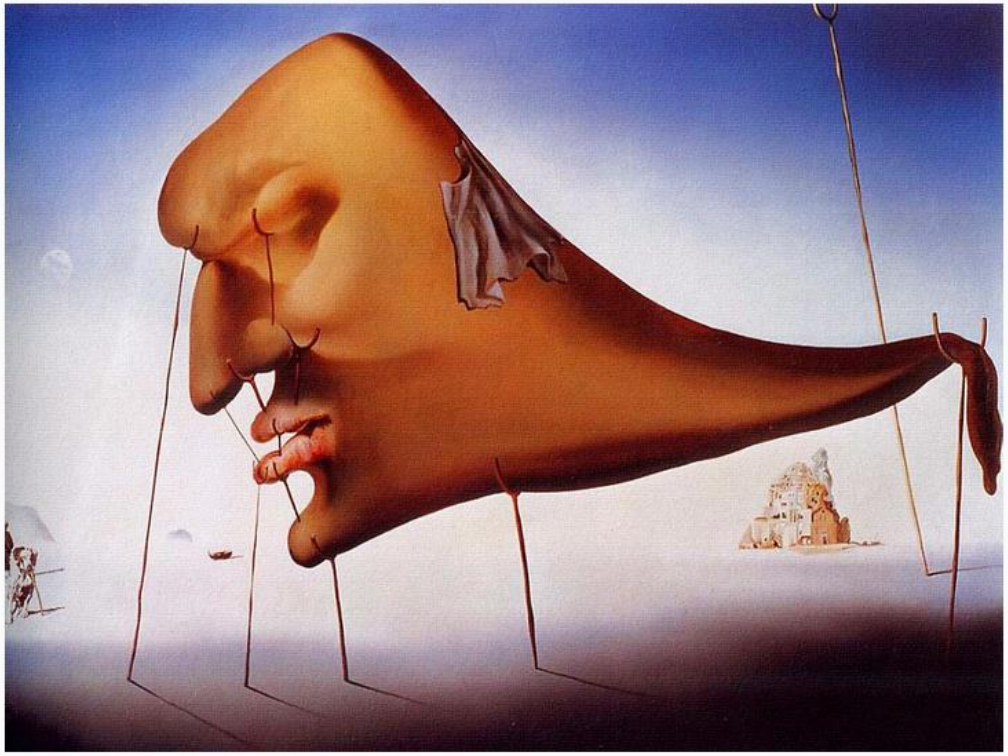
Current and future projects

Project	Action	Improvement Type	Priority
Large geographic spread of patients	Bring clinics closer to patients	Strategic	High
Cramped facilities impacting processes	CDHB lean coach and OT to decrease waste and improve workspace	Focussed improvement	High
No insomnia treatment programme	Train 1-2 staff to create for insomnia clinic	Strategic	Medium
Occupational patients	Work out discharge/self manage plan	Strategic	Medium
Sleep Nurse Practitioner	Utilise the full scope of sleep NP for the patients of Canterbury	Strategic	Medium
Accreditation	NATA standard accreditation	Accreditation	Medium
National CPAP Audit	QA to go to all public sleep facilities	Audit	Medium
A Sleep in the classroom	Student looking at current sleep habits in Y7-Y8, and their educators	Research	Medium

Summary

- Sleep is essential for good health
- Treating sleep is cost effective
- Demand for service is increasing
- CDHB responding to demand with strategic projects
- Education is key “making sleep a priority”

Le Sommeil (Sleep), 1937 by Salvador Dali



https://www.dalipaintings.com/sleep.jsp

H&SS MONITORING REPORT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

SOURCE: **General Managers, Hospital Specialist Services**

DATE: **31 January 2019**

Report Status – For:	Decision	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Committee:

i. notes the Hospital Advisory Committee Activity Report.

3. APPENDICES

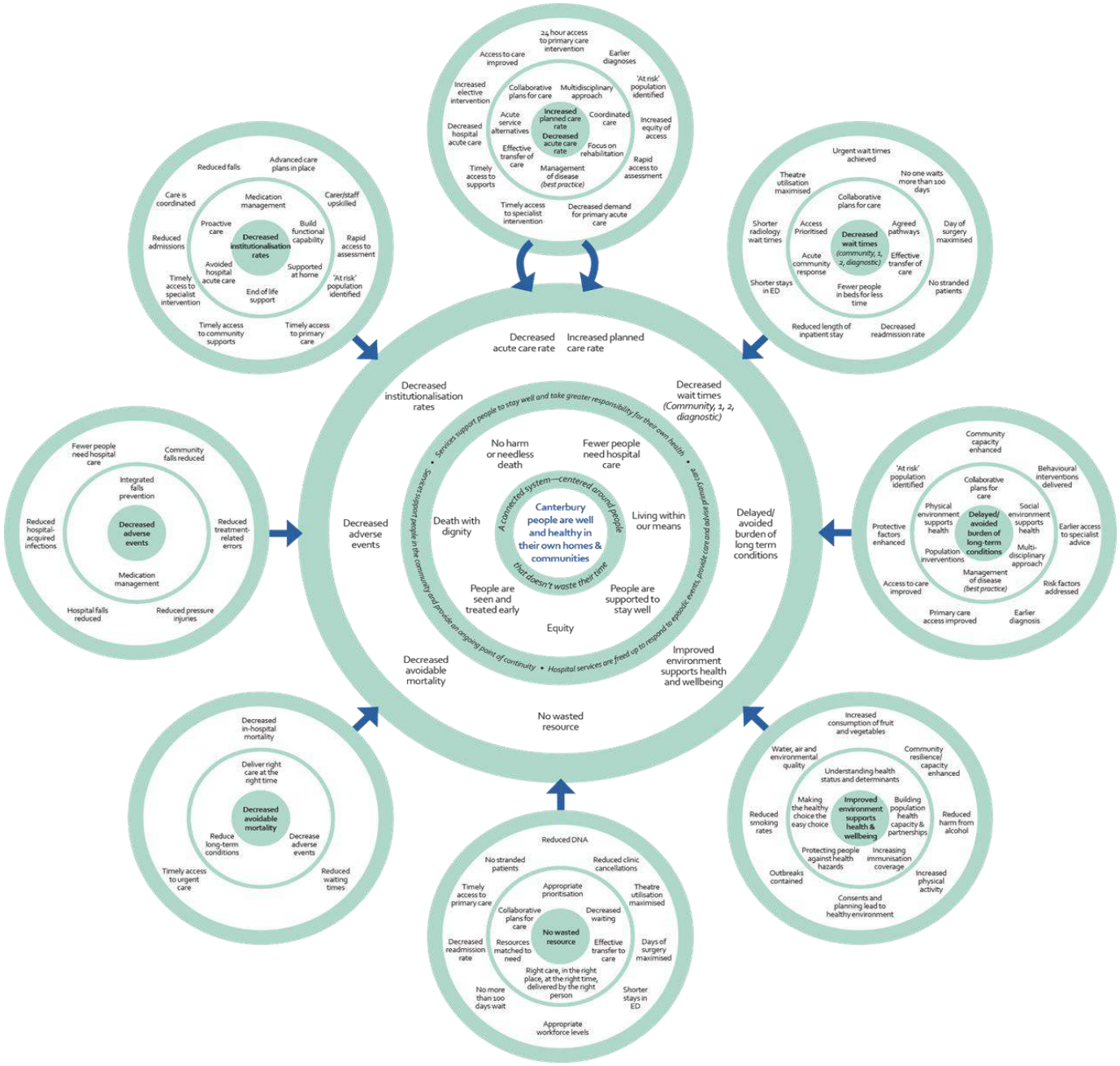
Appendix 1: Hospital Advisory Committee Activity Report – January 2019

Report prepared by: General Managers, Hospital and Specialist Services

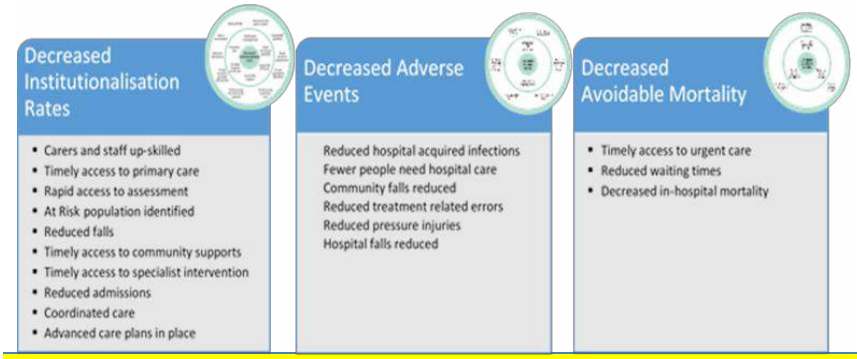
Report approved for release by: Justine White, Executive Director Finance & Corporate Services

Hospital Advisory Committee

Activity Report



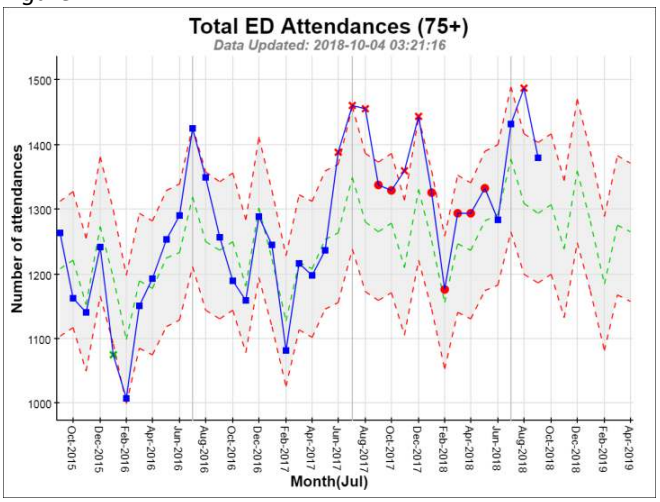
January 2019



Frail Older Persons' Pathway

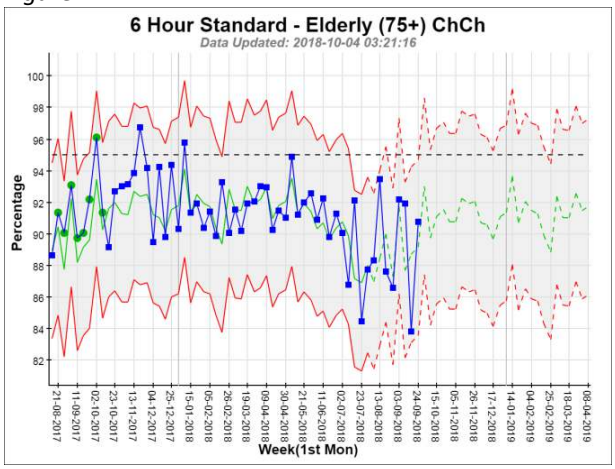
Outcome and Strategy Indicators

Figure 1.1



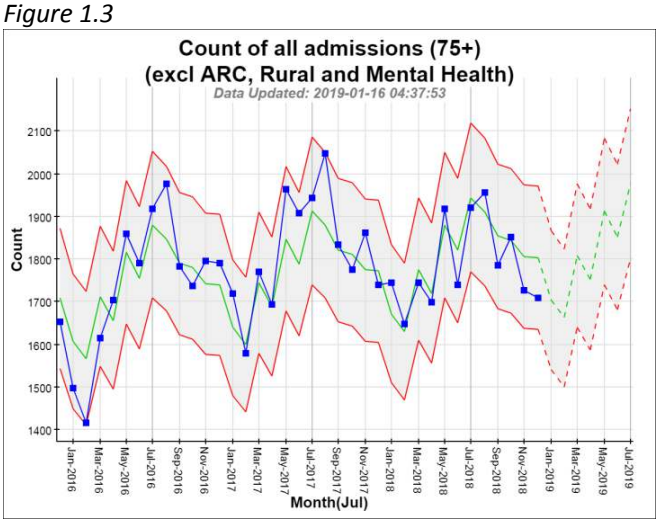
Total ED attendances of people over 75 has increased at a higher rate than the established trend. This increase is in line with that seen for the overall population.

Figure1.2



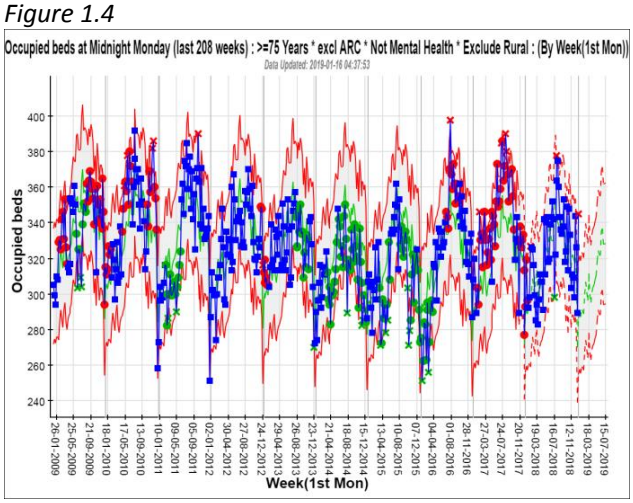
Patients 75+ leaving ED within the 6 hour target is tracking within the expected range, despite the high ED attendance rate.

Figure 1.3



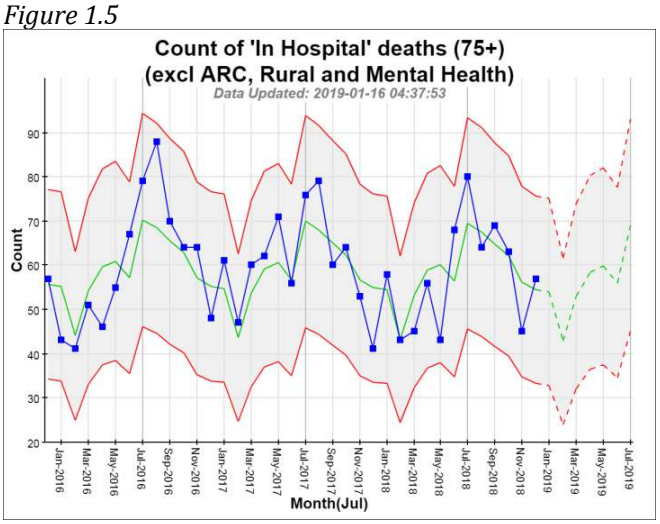
The count of all admissions for people 75 years and over continues to increase consistent with the established trend.

Figure 1.4



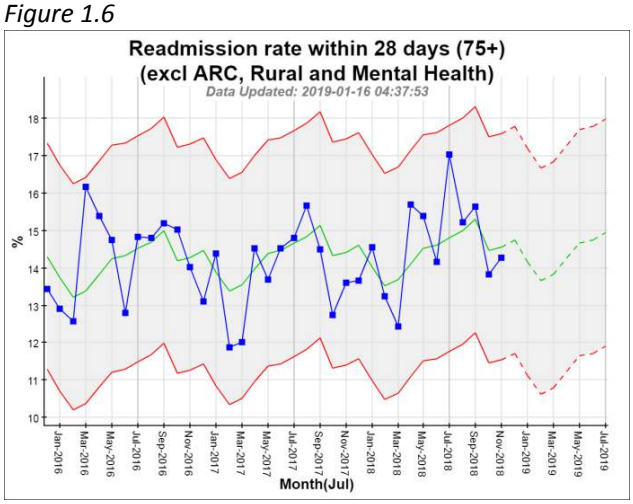
In winter 2017 and 2018 Older Persons' Health increased the number of beds across the inpatient environment to support flow. Beds available at Burwood return to lower levels outside of this period.

Figure 1.5



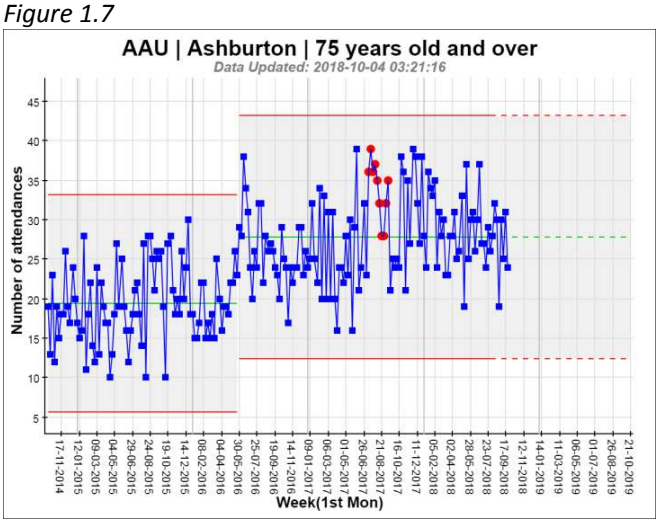
The number of in hospital deaths is within the expected range and continues the established trend of reducing rates of in hospital mortality.

Figure 1.6



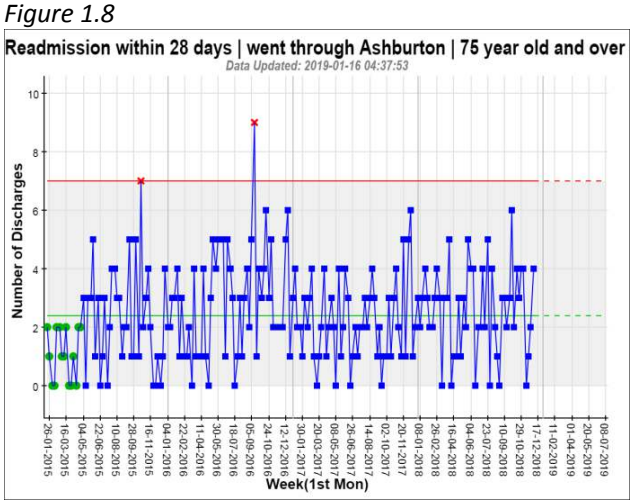
The readmission measure (balancing metric) for people aged 75 years and over continues to be within the expected range.

Figure 1.7



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

Figure 1.8

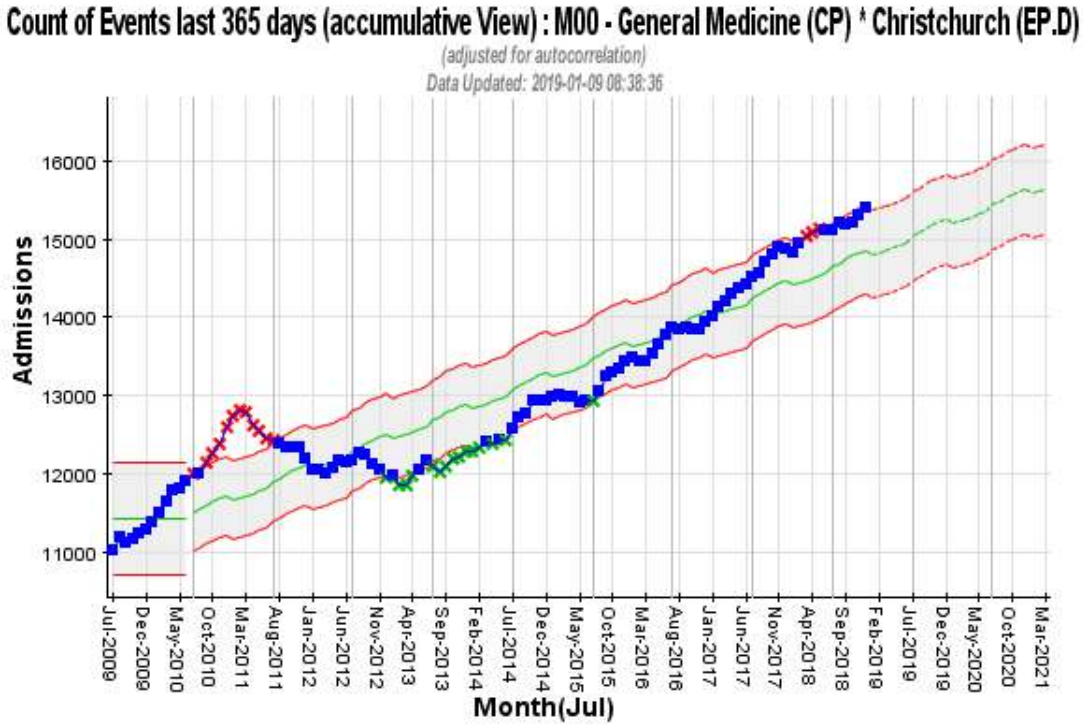


The readmission measure (balancing measure) for people aged 75 years and over continues to be within the expected range with no extreme decrease or increase indicated.

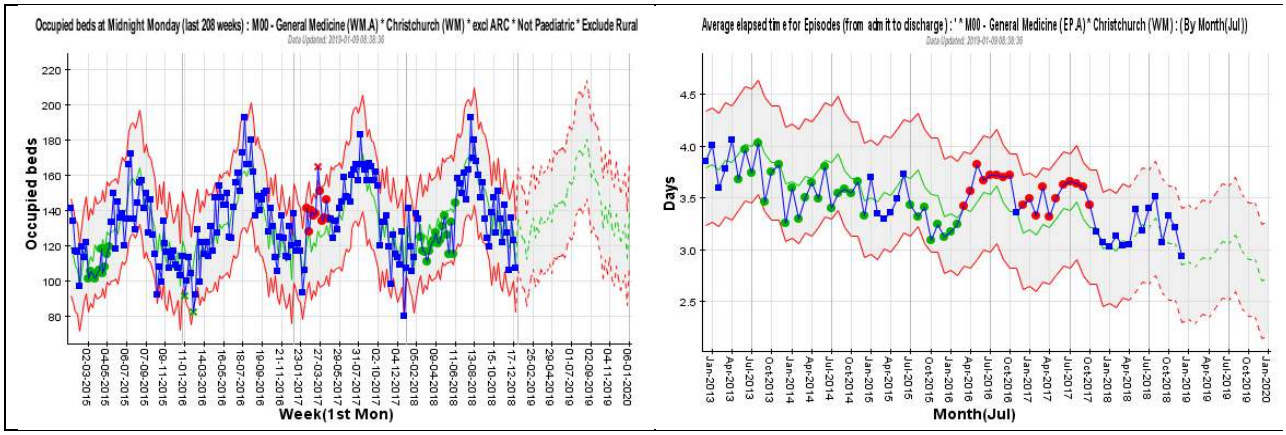
Achievements/Issues of Note

General Medicine continuing to improve the way it provides care

The number of patients cared for in hospital by the General Medicine service continues to grow with close to 15,400 patients being cared for in the 12 months to the end of December 2018.



As a result the number of patients in hospital at any one time continues to challenge the service, with maximum occupancy regularly reaching over 160 patients in the service at some times during the winter. Despite the volumes experienced, the length of patient stay has been slightly lower than in the previous year, which has allowed the service to accommodate the higher level of activity.



As progress towards opening the new Acute Services Building next year continues, General Medicine continues to work with nursing leaders to plan an appropriate bed space footprint that avoids the risk of patients overflowing to other areas, potentially blocking beds needed for other specialities. A desire to see dedicated medical wards and continuity of care are the essence of the service's strategy for improving patient care.

However this is not the only strategy that the service is pursuing to ensure it can continue to provide high quality care to the people that need it. General Medicine is finalising its planning to move from a 12 acute team model to a new 16 team acute model. More senior and junior doctor capacity has been recruited and the service anticipates implementing the new model from January 2019. This will increase the number of medical teams who are on acute-duty on any day, enabling better and timelier review of new patients. We expect that this will contribute to a further reduction in length of stay. Recruiting to the service should also be less problematic, as workloads will be more manageable when there are peaks in admission numbers.

A restorative model of care is being rolled out across medical wards, following a trial in Ward 23. The focus of this restorative approach is to help people sustain and regain as much of their function as possible, with an aim of a quicker return to previous functional levels and a quicker discharge from medical care. It requires a change in culture right across the entire medical, nursing and allied health workforce. It also needs a change in mind-set from patients and this is being promoted through a communications plan.

An Ambulatory care pathway has been instigated, this allows for urgent, intensive investigation and care for a cohort of patients in the Acute Medical Assessment Unit without any requirement for them to be admitted. Measures are not yet available, but we expect to show a growing number of people are receiving the care they need to return home, without the need for an overnight stay in hospital.

Restorative Care model in use at Christchurch Hospital

It is widely known that spending time in hospital can be associated with significant time in bed, which leads to deconditioning and contributes to a reduction in people's ability to cope with normal daily activities when they return home. Recently a new patient-centred healthcare model called 'Restorative Care' was introduced throughout the general medicine wards in Christchurch Hospital.

This model aims to counteract the expectation that people come to hospital to rest, and is built on the basis of getting those able practicing normal routines while they are still inpatients. This includes getting up, dressed and moving during the day. Staff in wards are working to support this; for example, the physiotherapist on Ward 27 designed an exercise corner called 'Move it or lose it'. This area was initiated to combat the sedentary lifestyle that is unfortunately apparent on an acute ward. The area includes instructions for five simple exercises for patients to complete. It also has a brief description of what restorative care aims to achieve and why we encourage movement. This approach is a part of our aim to create a health system where patients take greater responsibility of their own health in order to maintain independence. The implementation of restorative care will encourage normal habits similar to those that are required when people are in their own homes.

Physiotherapists providing front line musculoskeletal assessment in the Emergency Department

In October 2018 Physiotherapists experienced in musculoskeletal assessment began offering an extended hours service in the Emergency Department on a seven day per week basis. These clinicians will see patients direct from the waiting room, rather than waiting for medical or nursing assessment to occur first. The Emergency Department Physiotherapists can refer for x-ray examination, provide simple analgesics via standing order and make referrals to community services. Having this role in place will reduce patient wait times and maintain patient flow through the department. In addition to this the Physiotherapists continue to provide a secondary service for assessment of patient mobility and respiratory issues following medical examination.

ICU Ultrasound Collaboration

In late October 2019, Clinical Engineering confirmed that the S-Cath Ultrasound machine in ICU was broken and following their discussions with Sonosite recommended that it would likely be uneconomical to repair the out of warranty machine.

Within days a group of people from a range of disciplines (Service Manager, Finance Project Manager, Charge Sonographer, ICU Charge Technologist, Intensivist and a Biomedical Technician) had come together to discuss whether to repair or replace the ultrasound machine. This resulted in CEO contingency funding being sought to replace the machine with a better machine. A business case was quickly developed and submitted; this was approved within 48 hours of submission, allowing a new machine to be ordered.

The experience demonstrates the effectiveness of positive collaborations across clinical, technical and finance teams, and with vendors to ensure that busy departments have the right investigative and diagnostic equipment to support appropriate and timely patient care. All parts of the decision making process and the funding process worked efficiently.

Maternity Services encouraging use of community maternity units

As previously reported in August 2018, maternity services are provided from a number of facilities throughout Canterbury. Information is provided to women and midwives describing the facilities available to ensure that

women receive good information to support their choice of an appropriate birthing site. In August we had noted that a walkthrough video tour of the Rangiora facility was available. This has now been joined by a video showing the Lincoln Maternity facility and one featuring two new mothers talking about the reasons they chose to give birth at that facility. These videos can be found at https://www.cdhb.health.nz/health-services/lincoln-community-maternity-unit (viewable outside of the CDHB network environment or using Chrome within the CDHB network).

Allied Health Digital Notes

A strategic aim that had been set for the Acute Site Allied Health services in 2014, known as passive data integration, has recently been realised. The Clinical Lead for Allied Health Informatics and Director of Allied Health services for Christchurch Campus, have been keen to eliminate waste for patients and staff by releasing clinicians from the need to enter data in addition to that created through documentation required to support clinical care.

Following national engagement and participation, the Allied Health Data Set Standard was published in March 2018. Subsequently, local development and co-design of the inpatient Allied Health digital notes, within Cortex, has aligned to this standard, enabling the first acute inpatient Allied Health eNotes with passive data integration.

This provides data supporting planning and allocation of capacity to areas and tasks without requiring distinct entry of workload data as this is gleaned directly from clinical notes.

Otorhinolaryngology acute capacity

Prior to 2017, patients presenting for acute care from the Otorhinolaryngology team within office hours were sent to the department's outpatient area to be seen by the on-duty registrar. These patients often waited for a long time because the registrar providing this care was also rostered to provide clinics or theatre duties. Sometimes patients would give up and go home, requiring the Charge Nurse Manager to arrange for them to come back at a suitable time. Many patients who could be treated in an outpatient setting were admitted due to a lack of capacity to provide the level of attention required in clinic.

A workshop held under the Realign banner in December 2016 identified a number of improvements required within the service. Lack of registrar capacity to manage acute work presenting to the service was identified as the priority issue within the service. Based on this, an additional full time registrar position was approved and filled from early January 2017.

The duties of this registrar position include staffing an acute clinic along with some other tasks that have released capacity for other registrar positions. During 2017 3,000 patients were seen in the acute clinic. These patients were seen more promptly than would otherwise have been the case with the number of patients choosing not to wait dropping to single figures during the year. This meant that addition to this time spent by nurses arranging for patients who did not wait to come into clinic has been almost eliminated. Along with this, the number of patients acutely admitted after presenting at clinic has reduced from over 500 a year to between 200 and 250. This increased capacity has improved the care of patients requiring acute care and released inpatient capacity for those that cannot be treated in another setting.

Guerilla Sim – team training and testing the work environment

Simulation methods have become an important part of training teams to work together in complicated clinical scenarios. Generally these are scheduled well ahead of time, carried out in a simulation centre and attended by people who have applied to be a part of the exercise.

The Emergency Department has put in place a series of "Guerilla Sim" team simulation exercises. These exercises are occurring without announcement and at any time within the Emergency Department as a part of testing and improving process and facilities in environments used within the department and improving the ability of team members to work together. This training allows exploration of team work and human factors, exposure to infrequent by high stakes crisis situations, interdisciplinary team training using all clinicians who are typically involved in a case (doctors, nurses, paramedics, orderlies etc.) and testing of the work environment to pick up problems with equipment processes and systems.

The handful of Guerilla Sim sessions that have been carried out so far have enabled a number of facility and equipment problems to be discovered and fixed.

Orderly Mobile Service Launched

Early in December, the Christchurch campus celebrated the launch of a new mobile orderly request service. Orderly Mobile is a fully digital service which sees orderlies armed with mobile devices, enabling them to accept, respond to and fulfil work requests on the go. This means that staff can now make requests for orderly services online, and orderlies receive and complete tasks which are tracked on a mobile phone app.

Co-designed by orderlies, nurses and ward clerks, it was delivered in just five weeks and provides full visibility of the nearly 1000 daily requests for this critical service across the Christchurch Hospital campus.

The app was developed by the People and Capability and Information Services teams as a part of People and Capability's commitment to streamline working practices for our more than 10,500 employees.

The Orderly team is really excited about this new way of working. In the past they had received printed requests and instructions; this new way of working is saving reams of paper and bringing new efficiencies to the process of assigning jobs and having them completed. Most of the team had turned their radios off within just 24 hours of the launch of the new digital service, and is now one of the first fully digital and paper-free services in the organisation.

The system also delivers data about service demand in real time and the analytics can help us improve the efficiency of what's already a fantastic service.

Older Persons Health

We are trialling new sensor mats for a chair in two wards across Older Persons Health (*OPH*) that connects to the bell system. Initial feedback is positive, with links to how we continue to reduce and undertake different activities for fall prevention. Patients are being admitted as much as able to the pod where the night staff sit so that new patients can be monitored more closely on their first night within the service where falls risk is identified. We discuss falls at all staff handovers and at interdisciplinary team (*IDT*) meetings where the IDT forms are being correctly filled in and focus on the estimated date of discharge (*EDD*). There are now three meal break times allocated in each ward, resulting in only two staff away at any one time, leaving more staff on the ward to supervise and help patients.

Intentional Rounding education has been completed in all wards. All wards are now embedding this into their practice on all shifts.

The Safe Recovery Program has been extended until the end of November. The pilot of the Safe Recovery program has now been ongoing at Burwood hospital for three months, on four Older Persons' Health Rehabilitation wards. The goal of this evidence based intervention is to reduce the rate of patient falls during their rehabilitation and their subsequent injuries. The program is currently delivered to patients that are over 65 years of age, are mobile and have intact cognition suitable for the education. They are shown a video on an iPad, go through a written booklet and guided through a discussion to identify patient-centred goals they can follow to reduce their risk.

We have four retired nursing volunteers who are also providing the education, hoping to draw on some of their clinical and personal experiences as well as peer support for our patients. At the time of writing, there have been 203 unique patients provided with the education of which half has been given by the volunteers.

As we are still ongoing the results are yet to be processed for the falls rate. We have collected 72 individual patient surveys and 11 patient interviews. We are currently planning on collecting our post intervention staff surveys, staff focus groups and an overall process evaluation. Hopefully from this we can make a robust plan for the program should it be considered a valuable intervention to prevent falls at Burwood hospital.

OPH have been reviewing the data from the clinical nurse specialist (*CNS*) role based at Christchurch campus. Since its pilot and subsequent confirmation of the importance and contribution to flow, we have seen changes in the way in which we ensure timely transfer of care between the two sites. The role's key function is to ensure timely assessment with referral and pulling of patients into the service. Since this began in July 2017, 3,028 patients have been through this service. Of the 1,772 general medicine (and associated speciality) patients, 327 were seen solely by a consultant (some of these patients were assigned to teams with a geriatrician in 2017). In 2018, 81.5% of consults are now seen by the CNS role. The other timely benefit seen is the reduction in the average length of time on the waitlist for being seen. The average length of time on waitlist of 2.00 days in 2017, has reduced to an average length of time on waitlist of 1.59 days in 2018 and continues to reduce.

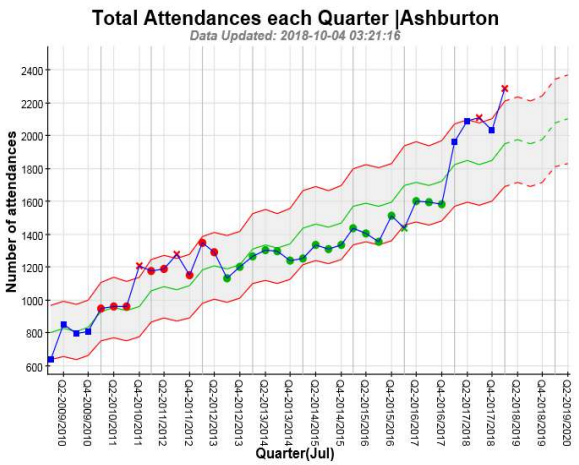
Other benefits seen include:

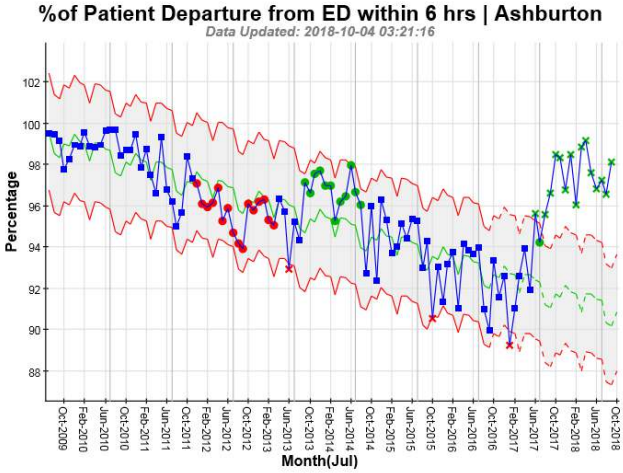
- patients being assessed in timely fashion (average time to assessment);
- other patients being identified before formal referral therefore reducing waste in referral;
- single point of contact for staff at Christchurch – particularly junior medical staff;
- improved communication between sites;
- updated information for Christchurch about likely date of transfer through updates made on Floview;
- thorough assessment of patients prior to transfer;
- reduction in patients transferring when not well enough;
- reduction in patients transferring who don't need inpatient rehabilitation;
- monitoring of patients while on waitlist and assessed for alternative pathways if condition changes;
- early review of patients well known to OPH and discussion with OPH teams about appropriateness of another inpatient rehab stay;
- early information for Burwood wards about patients with particular requirements;
- released SMO time.

Ashburton Health Services

In December, the Ashburton Health Services Team warmly welcomed a new Director of Nursing, Ashburton and Rural. The team has been strengthened by their wealth of knowledge, after they recently returned from working in rural and remote communities. The local community and representation from the DHB Maori and Pacific teams joined us in welcoming them with a powhiri at Hakatere Marae. In addition to spending time with the Ashburton Health Services divisions and departments, they have travelled to each of the Rural Hospitals. They provide the professional nursing leadership to these sites and will continue to have an active role in site visits.

Acute Demand



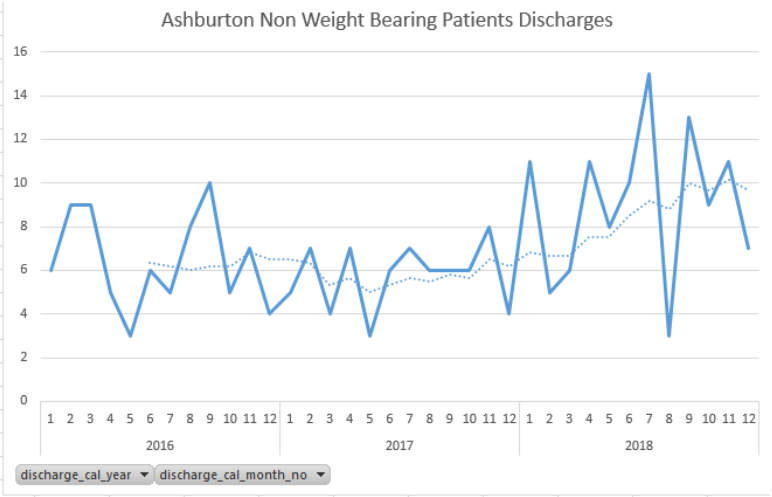


- Acute presentations continue on the upward trend for the Acute Assessment Unit (AAU) in Ashburton. Weekends continue to fluctuate significantly, with up to 40 presentations in one day over the Christmas period. The trend is similar to the increase in presentations experienced in Christchurch ED; we are working through the detail to understand the specific drivers.
- The Ashburton Service Level Alliance (*ASLA*) Operations group continues to focus on access to acute care across the system. Working in partnership, information has been collated for each practice providing a snapshot of six months of presentation to the Unit. The information collates presentations into three cohorts of 0-14, 15-74, and 75+. Information incorporates a profile of the practice demographic, rates of presentation by age band and ethnicity, referral source and utilisation of acute demand. The intention is for this information to be shared with each practice in February, with representation from the PHO and the AAU present. The information has been carefully developed and reviewed over the past months to ensure that it provides a general picture of flow; these meetings are opening introductions to a discussion and opportunities for working together more collaboratively.

- In addition to this, the first meeting with all Practice Managers was held at the end of 2018, hosted by the PHOs and CCN. The practice managers warmly received the opportunity to get together with hospital representation at planned meetings throughout the year and appreciated the opportunity to provide their perspective on challenges the practices are facing regarding enrolment and acute appointments. It is intended that these meetings will continue throughout 2019 led by the PHOs.
- As "winter planning" is clearly on our horizon, the ALSA operations group are committed to work that prepares the system for increases in acute demand within the community and hospital setting.

Ward 2

- Towards the end of 2018 we moved Ward 6 into their refurbished Ward and renamed them Ward 2. The Ashburton facility operates two main inpatient wards on site, Ward 1 with 21 beds predominately provides acute medical inpatient care with an average length of stay of 2.8 days; Ward 2 has 18 beds but the capacity to increase to 22, predominately providing care for non-weight baring (*NWB*) patients and AT&R. The length of stay in this ward varies, with the NWB consistent occupancy of 42 days and the AT&R patients up to 15 days. With the move complete, we are embarking on a series of activities that support this ward to operate as cohesive teams of Nursing and Allied Health professionals leading the Ashburton implementation of restorative care and rehabilitation. A core component of this is stronger engagement with our local primary care practices to identify the unmet/unknown demand for AT&R, as work underway in 2018 identified that many practices were under the impression this service was not available in Ashburton. A Gerontologist from the Canterbury DHB Older Persons Health Team is supporting this work with primary care; the outcomes will be mapped into the work we commenced mid-2018 with the ASLA developing a Frail Elder Pathway for Ashburton. The recent appointment of a new co-ordinator for the ASLA has enabled us to bring this work to fore and again will be a strong contributor to our winter planning.
- A core challenge we have faced with Ward 2 is understanding the demand for NWB. This has been a challenge across the system to identify an appropriate data source, however the recent implementation of PICS is enabling us to pick up more detailed information on the demographic on a monthly basis. In addition to this, we have been working with DSU to identify any trend data possible. The graph below demonstrates the monthly occupancy of the Ward with NWB patients over the past three years; note the peak of 14 patients in a 18 bed ward in July 2018. We are mindful to maximise the full facility and occupancy across the hospital as pressures in this ward translate our inability to pull more from Christchurch. Hence our focus to work as one team across hospital and across the system.



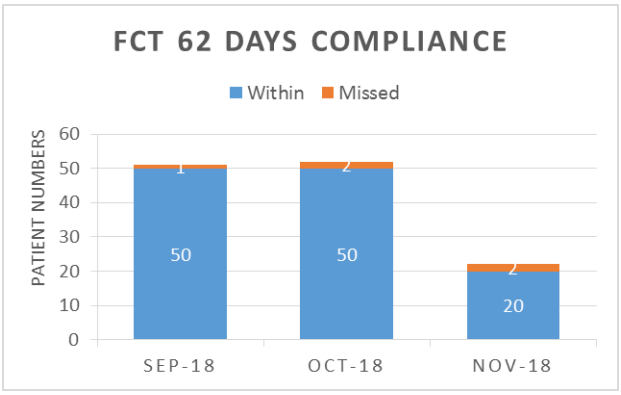
Outcome and Strategy Indicators

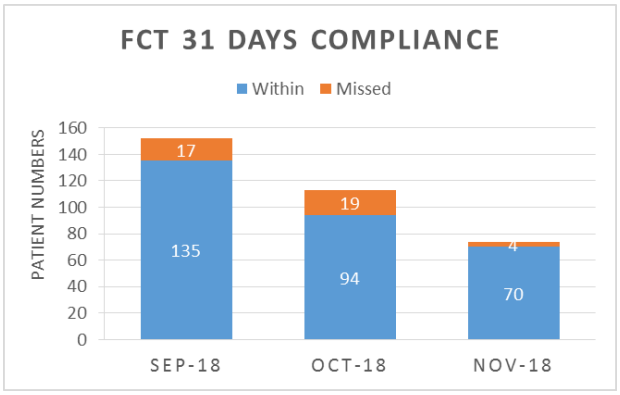
Key Outcomes - Faster Cancer Treatment Targets (FCT)

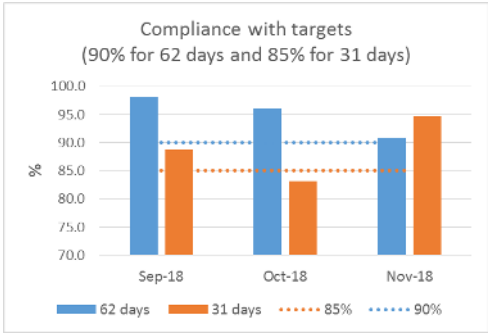
62 Day Target. For the three months of September, October and November 2018, Canterbury DHB submitted 142 records to the Ministry. Of the 22 who missed the 62 days target, 17 did so through patient choice or clinical reasons and are therefore excluded by the MoH in compliance calculations. This leaves 125 patients eligible for inclusion in the target calculations.

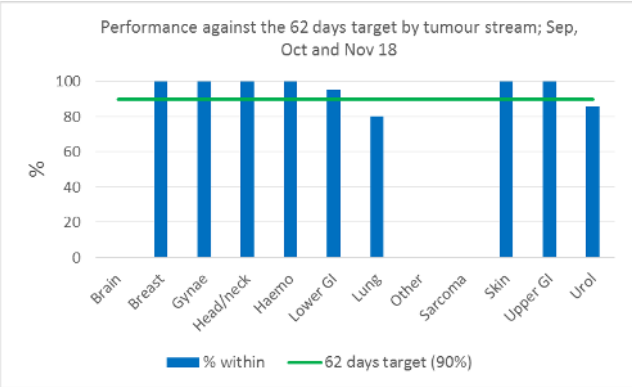
With five of the 125 patients missing the 62 days target through capacity issues, our compliance rate was 96% so once again the CDHB met the 90% target.

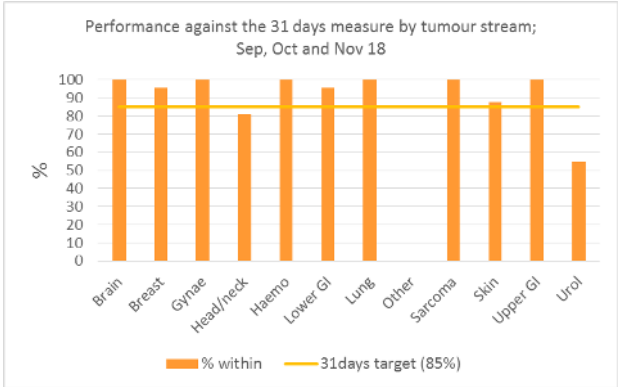
31 Day Performance Measure. CDHB submitted 339 records towards the 31 day measure in the same three month period. Unlike the 62 days target, all reasons for missing the target are included: there are no exceptions made for patient choice or clinical considerations, but the threshold remains at 85% rather than 90% as is the case for the 62 days target. With 299 of the 339 (88.2%) eligible patients receiving their first treatment within 31 days from a decision to treat, the CDHB continues to meet the 85% target.

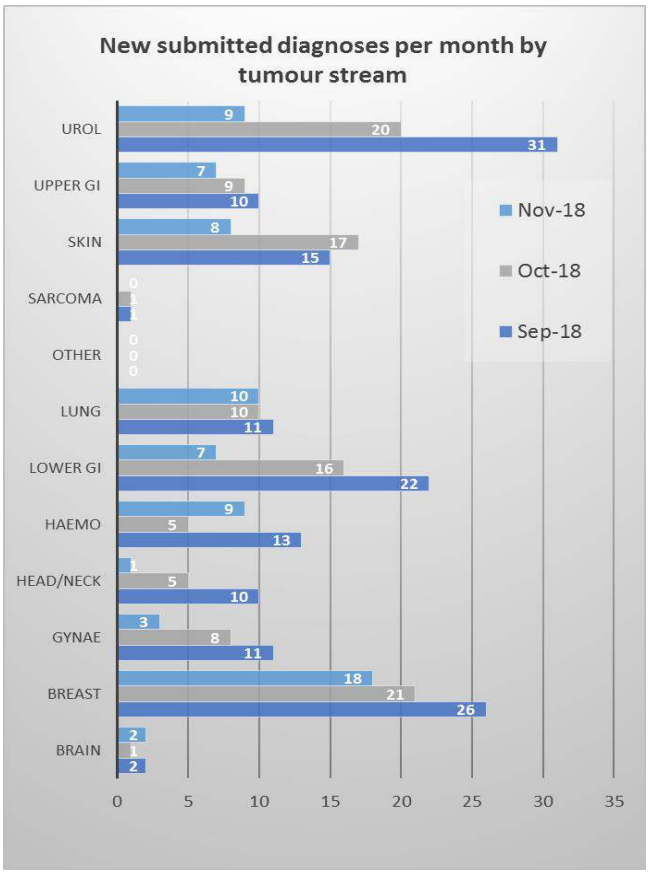










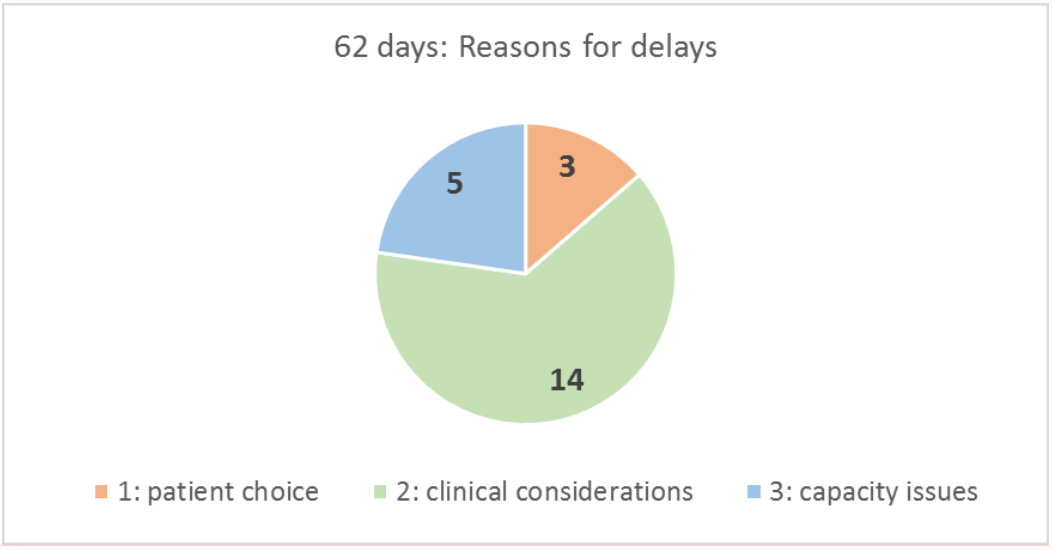


Patients whose treatment time misses the targets

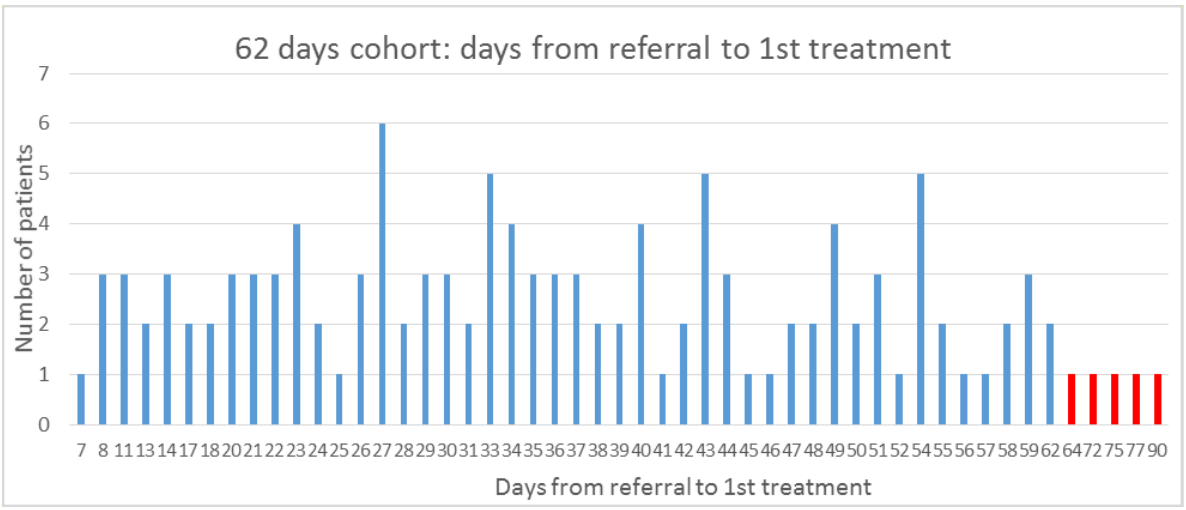
The Ministry of Health (*MoH*) requires District Health Boards to allocate a "delay code" to all patients who miss the 62 days target. There are three codes and only one can be used even when the delay is due to a combination of circumstances. In this circumstance the reason that caused the most delay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

The codes are:

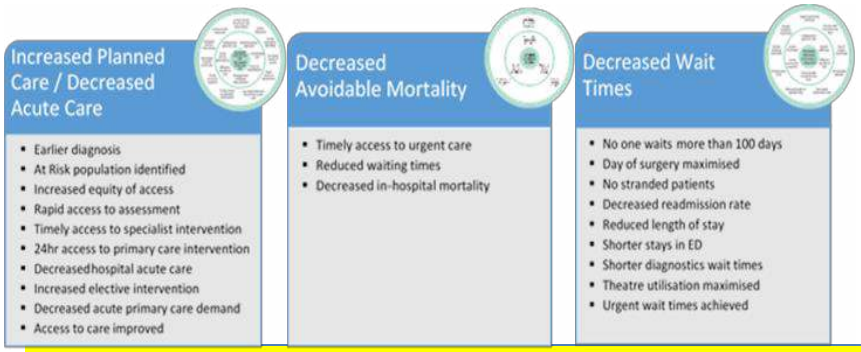
1. Patient choice: e.g. the patient requested treatment to start after a vacation or wanted more time to consider options.
2. Clinical considerations: includes delays due to extra tests being required for a definitive diagnosis, or a patient has significant co-morbidities that delays the start of their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



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



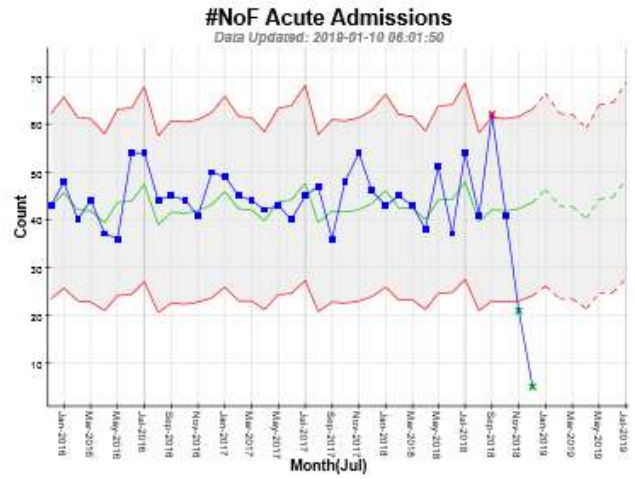
Each patient that does not meet the target is reviewed to see why. This is required in order to determine and assign a delay code, but where the delay seems unduly long then a more in-depth check is performed. These cases are usually discussed with the tumour stream Service Manager(s) to check whether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



Enhanced Recovery After Surgery (ERAS)

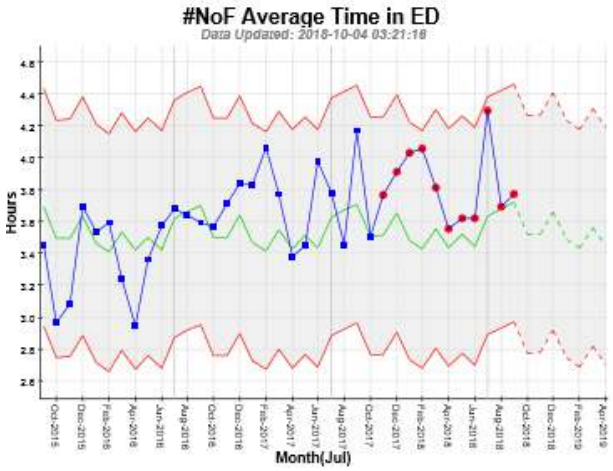
Outcome and Strategy Indicators – Fractured Neck of Femur (#NoF)

Figure 3.1:



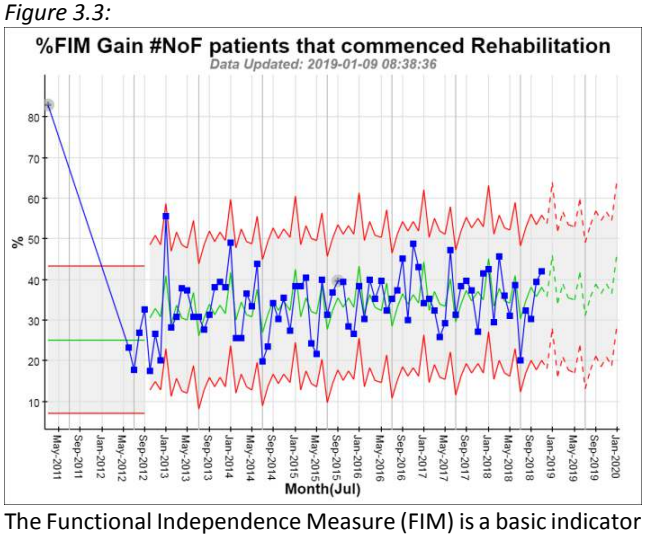
A backlog in coding means that November and December data for many measures should be discounted. The number of #Nof admissions per month generally continues at the expected rate with an unexpected increase in September.

Figure 3.2:



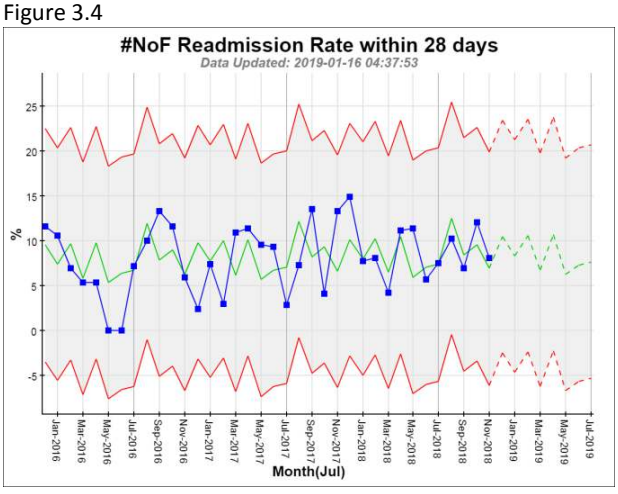
Patients with #NOF show a variable length of stay in ED. The red signals show that a statistically significant increase in the time spent in ED has occurred.

Figure 3.3:



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

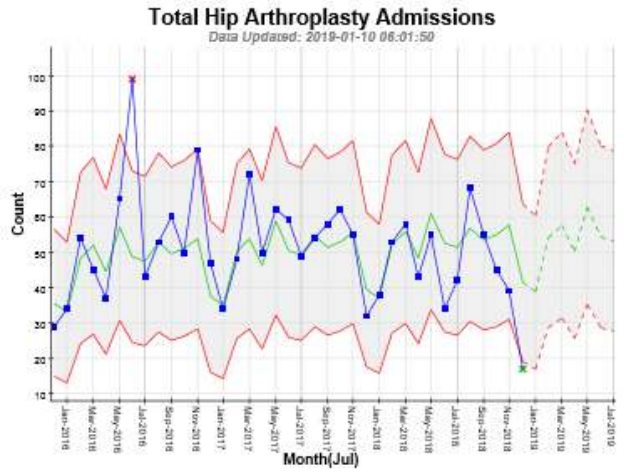
Figure 3.4



Readmissions continue to remain within expected mean values.

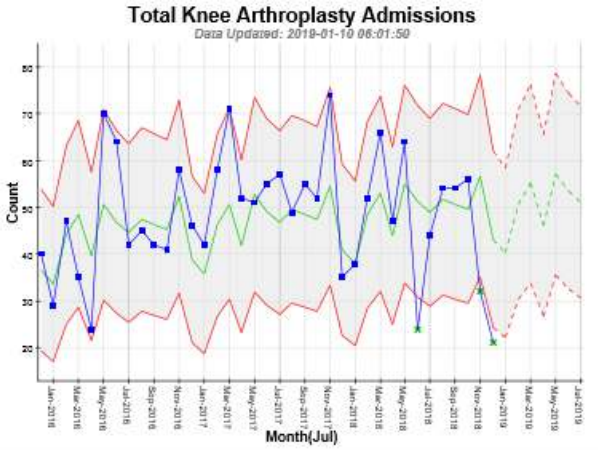
Outcome and Strategy Indicators – Elective Total Hip Replacement(THR) and Knee Replacement(TKR)

Figure 3.5



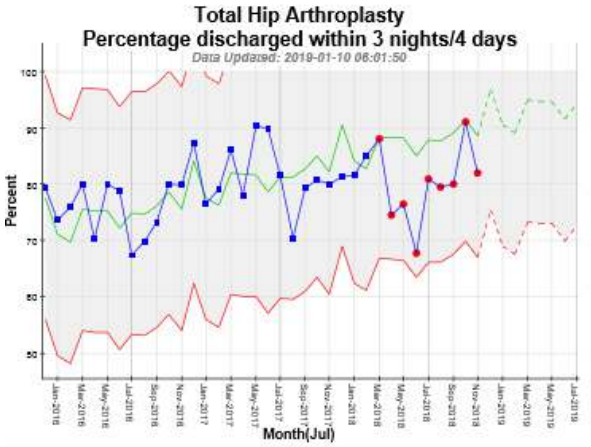
In recent months hip replacements have been tracking within projected levels.

Figure 3.6



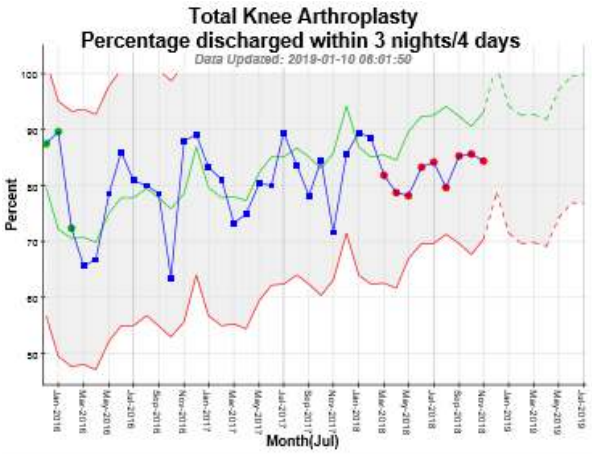
Apart from June 2018, knee replacement admissions over the previous 12 months have been at or above projected levels.

Figure 3.7



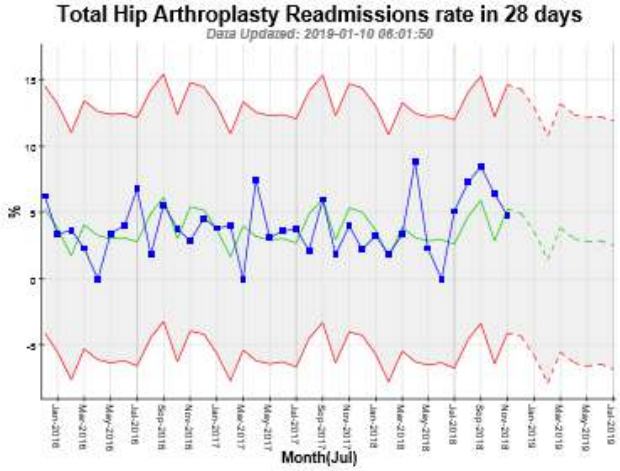
The proportion of patients clinically safe to be discharged within 3 nights/4 days has fallen significantly below the established, increasing trend.

Figure 3.8



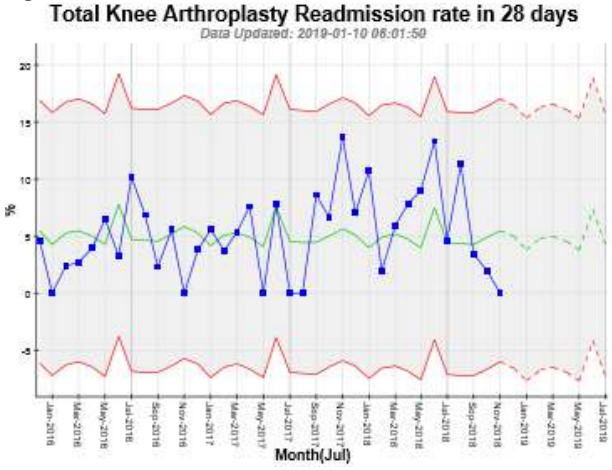
The proportion of patients clinically safe to be discharged within 3 nights/4 days has fallen significantly below the established, increasing trend.

Figure 3.13

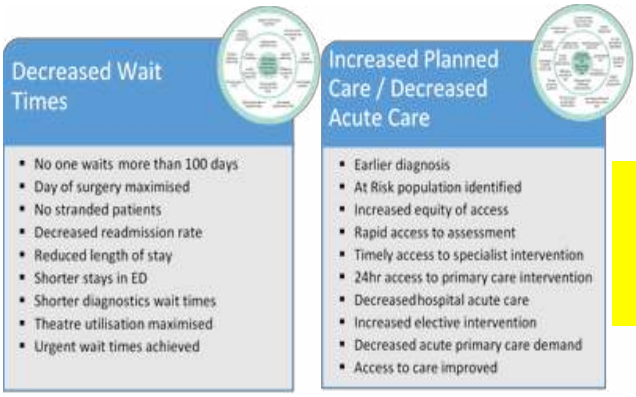


Readmission rates remain close to the midline of the expected range.

Figure 3.14



Readmission rates are maintaining within tolerances.



Elective Surgery Performance Indicators 100 Days

Achievements/Issues of Note

Elective Services Performance Indicator (ESPI) Outcomes

Since the transition to the South Island Patient Information Care System (*SIPICS*), Canterbury DHB has not provided the usual elective services waiting time data extracts to the MoH. Accordingly the Ministry's Elective Service Performance Indicator (*ESPI*) reports are not correct and are not reported on here.

Internal waiting time reports also do not provide current information. Work is required on both transitioned data and processes used within the SIPICS to provide useful waiting time data.

The MoH has provided Canterbury DHB with dispensation from financial penalties for non-achievement of ESPI achievement between January 2018 and June 2019 to recognise the pressures associated with facility limitations and issues associated with data transition. Canterbury DHB remains committed to working towards its goal that patients will not wait longer than 100 days for elective services they have been offered and planning and actions towards fixing the current deficiencies continue.

Blood Borne Virus and STI screening at Christchurch Men's

In 2018 the Christchurch Prison's Health Service has been supported to conduct a site wide screen for blood borne viruses and sexually transmitted infections. Specialist staff from the Sexual Health Service and Infectious Diseases Department have had two highly successful visits already, with fantastic uptake by prisoners and support from Department of Corrections' staff. These clinics provide an opportunity to carry out screening for Hepatitis B and C, HIV and Syphilis, and other diseases. The focus has been on education and prevention as well as detection and treatment in this vulnerable population.

This has required the services to work together closely to explore and resolve numerous operational and logistical issues with a shared goal of improving the health of this group of men, along with those that they have contact with both while imprisoned and when they return to the community.

The Corrections Health Service has noted its appreciation of the efforts made to run this busy clinic specifically noting the team's personal qualities, combined clinical strengths and ability to engage with the men with openness and unfailing good humour.

Review of the way that Haematology Outpatients' works

Two infrastructure changes, the transition to SIPICS, and the shift from providing outpatient activity in rooms in the Laboratory building to the new Outpatients' building has provided an opportunity for the Haematology Service to carry out a top to toe review of its outpatient clinic processes and routines.

The existing routines and processes had developed over time in the context of the old facility and involved a "lumpy" schedule that placed uneven demands on the facility and staff through and across weeks. On some days the facility and clinic nurses were working at full capacity, while other days involved a light clinic demand. Alongside this, Consultants were sometimes expected to be in clinic and conducting ward rounds at the same time and overflow clinics, staffed by registrars, were used to see patients with urgent needs. Depending on when they presented, new

patients sometimes waited for an appointment longer than is ideal, spent time sitting in waiting rooms that could be avoided and registrar supervision at overflow clinics was not ideal.

A review, led by a Haematology Consultant and a Clinical Nurse Specialist, has led to agreement by Haematologists, Nursing and Administrative staff to a series of new routines that address these, and other deficiencies.

New routines and schedules are being put in place to reduce variation in scheduling that waste patient and staff time. These now:

- Standardise clinic and new patient loads assigned to Senior Medical Officers. This includes ensuring that clinic, ward and laboratory duties are scheduled so that consultants are committed to just one area at a time.
- New patients are assigned to Consultants at a time when they have clinic capacity scheduled, and a new patient load does not accrue while the Senior Medical Officers are scheduled on ward duties.
- Smooth the work schedules for Senior Medical Officers and clinic requirements throughout and across weeks.
- Provide tandem clinics, with Senior Medical Officers and Registrars working in adjacent clinics, to ensure that excellent patient care and support for registrar education and experience are provided.
- Tandem clinics run by Clinical Nurse Specialists will commence in 2019. These clinics will support Senior Medical Officer workloads as specific cohorts of patients will have alternate follow up appointments with the Senior Medical Officer and Clinical Nurse Specialist. The Clinical Nurse Specialists will be allocated to specific Senior Medical Officers to ensure continuity of care and to be the point of contact for the patient in the Senior Medical Officer's planned or unplanned absence.
- Updated and agreed patient triage rules and processes are now more streamlined and visible for all staff to follow.
- Define the delivery schedule and flow for notes, with the opportunity for consultants to identify patients that they do not need notes for, contributing to our paperlite journey.
- Patient flow is further standardised, by ensuring that administrative, nursing and medical staff know the order that various patient processes and tasks are expected to occur in. This reduces the opportunity to confuse our patients and reduces their time spent waiting on the day of appointment.
- Standards for responses to various types of telephone calls from patients have been set, so that all staff will provide a consistent and beneficial response.

These changes take advantage of the new environment we are working in and enable us to provide better services to our patients, whilst ensuring that all staff have transparency and certainty in their ways of working and improving the training experience for registrars and Clinical Nurse Specialists.

Reducing time spent waiting for General Medicine Outpatients

General Medicine conducts a relatively small volume of outpatient clinic per annum that care for around 1,600 people with syncope, heart failure, hypertension, and patients with general undifferentiated illness each year. The service also provides rapid response clinics for patients referred from primary care, for those patients who might otherwise present to ED for assessment and possible admission.

Due to more consistent and robust triaging, the service has managed to reduce the overall waiting time for patients being seen in clinic, and minimise any risk of patients waiting longer than the 120 day target.

Success at supporting breastfeeding in hospital

Success at supporting breastfeeding by mothers who have given birth in our facilities is an important part of Canterbury DHB's Baby Friendly Hospital accreditation and efforts to ensure that people are supported to spend minimal time in hospital and maintain good health in the community. Measures to improve breastfeeding rates require an integrated and collaborative approach from facilities, families, communities, services and government.

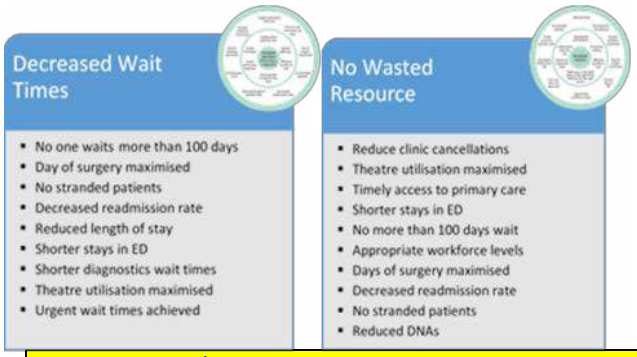
Recent information provided to the MoH from the New Zealand Breastfeeding Alliance shows that all units with Canterbury DHB are performing well. The report notes that the Rangiora Maternity Unit continues to maintain a high exclusive breastfeeding standard at 91%. This is on par with the national average for a primary unit. Lincoln and Ashburton have shown improvement compared with 2017 with exclusive breastfeeding rates of around 94%, well above the national average. Lincoln, Rangiora and Ashburton continue to have very low artificial feeding rates, all around 1-2%. Of the 20 babies who went home from Kaikoura, 17 did so being exclusively breastfed. Transfers

to these units are well supported to maintain breastfeeding. This achievement is particularly significant as there continues to be a decline in breastfeeding rates in NZ over the last year.

Physiotherapy group sessions reducing waiting times

Women referred for physiotherapy for support with continence issues or prolapse have previously waited between five and six months for their first appointment. A review of waiting lists and referrals recommended that the initial appointment could be replaced with a group session, in line with current practice in other areas. This new way of working was launched in early October; 20 women are invited to each session. The group is being evaluated through an anonymous satisfaction survey and results so far are promising.

The waiting time has already reduced to less than four months. A formal review and audit will be carried out during 2019.



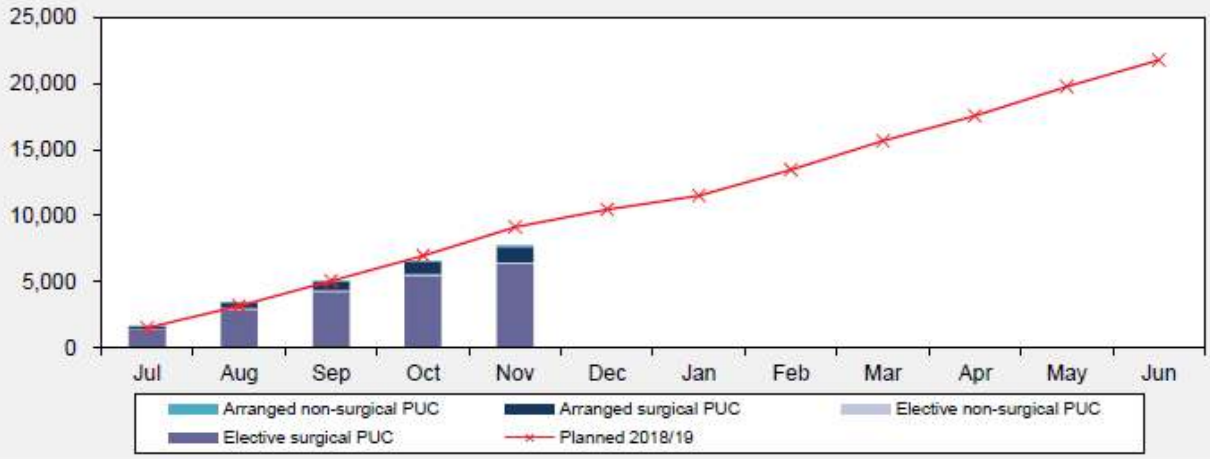
Theatre Capacity and Theatre Utilisation

Achievements/Issues of Note

Elective Services Discharges

Elective Surgical Discharges ▼ **85.1%**

	2018						2019					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Planned	1,520	3,182	5,065	6,985	9,132	10,470	11,532	13,474	15,676	17,548	19,773	21,782
Actual	1,617	3,473	5,114	6,589	7,770							
Variance	97	291	49	-396	-1,362							
%Achievement	106%	109%	101%	94%	85%							



A phased plan for provision of the 21,782 elective surgical discharges to be delivered in 2018/19 has been agreed with MoH. Increased volumes will generally be achieved through increases in outsourced and outplaced operating and are focussed on Ear, Nose and Throat and Plastic Surgery.

Reporting from MoH shows that Canterbury DHB met its elective discharges objectives at the end of the first quarter (September 2018), but indicates a significant under delivery by the end of November.

However internal reporting shows that at the end of December over 9,900 elective and arranged discharges have been completed. While this is a shortfall of around 500 cases compared with our agreed target, it is expected that data corrections will reduce this shortfall significantly.

Patient Surgical Journey Video

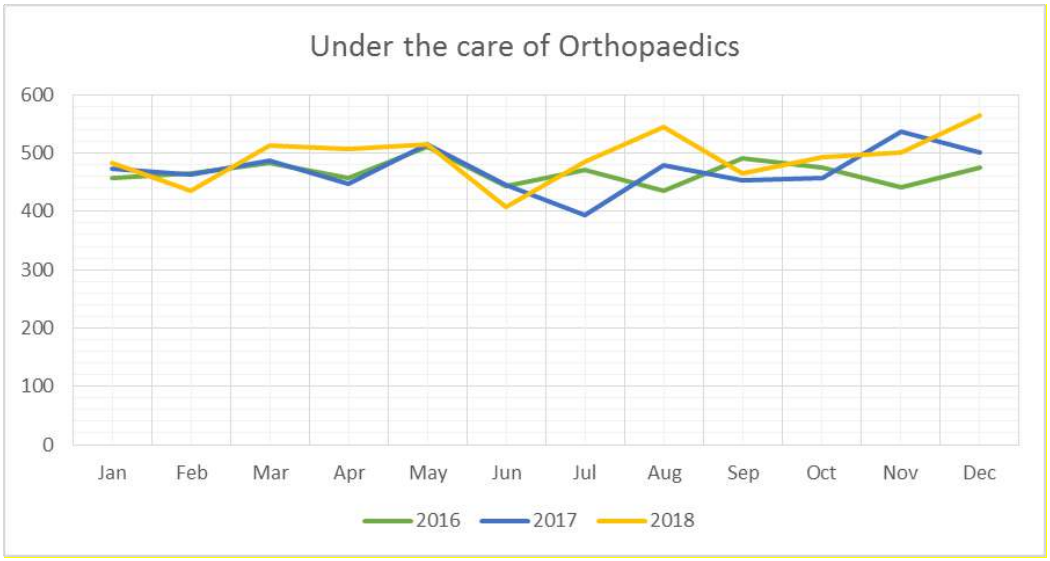
Members of the Anaesthesia and Theatre teams have recently worked together to produce a video to explain to patients what will happen along their surgical journey. It covers pre-admission, anaesthetics, the consent process, admission, the surgery and recovery. The team producing the videos worked hard to ensure that language was appropriate to the audience, including working with the Department of Internal Affairs to create a version of the video with Māori subtitles.

This was done in response to patient requests and can be found on Health Info www.healthinfo.org.nz or via the intranet page (Look under Surgery: 'Overview of Surgery'). Plans are developing to have this video played in the pre-surgery assessment area and to be part of an education package available to patients pre-operatively at home. This is just one part of our communication with patients that aims to ensure that they feel as comfortable as possible about their time in hospital. Ensuring that patients know what to expect helps them to be prepared for their surgery, reducing cancellations and ensuring effective use of patient and staff time.

Burwood Hospital

Activity for orthopaedics has been high over the December and festive seasons, with multiple additional theatres being made available to cope with volumes. There have been 565 patients admitted under Orthopaedics care in December, with 333 acute procedures undertaken. Of note:

- Higher volume of patients admitted in December 2018 compared with December 2017 (502), and December 2016 (475).
- 34 of the 333 procedures transferred to Burwood for surgery up until 20 December 2018.
- Average wait for theatre increased in December to 1.14 days compared with November (0.96) days, due to demand.
- Higher volume of upper limb/hands cases in December 2018 compared with the previous three months.



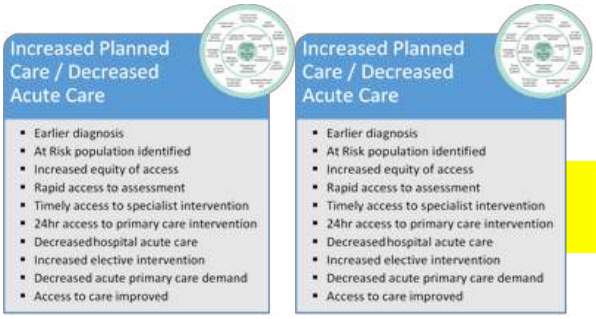
Transferred to Burwood for surgery:

The number and type of surgery transferring to Burwood includes:

Lower limb	13
Upper Limb	17
Foot	3
Hands	1
Spines	-
Hip NOF	-
Hip revision	-
Knee revision	-

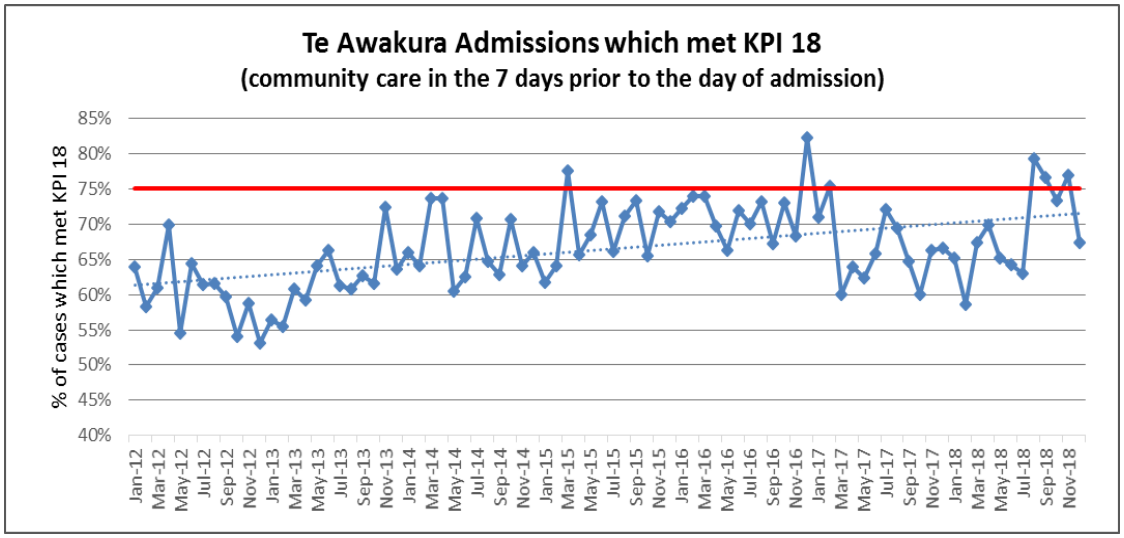
The impact on electives has resulted in some cases being cancelled to enable the volume of acute cases to be undertaken. Cases are rebooked.

- Five Carpel Tunnel Release cancelled.
- Five electives cancelled.
- Two cases added to elective lists without cancellations.

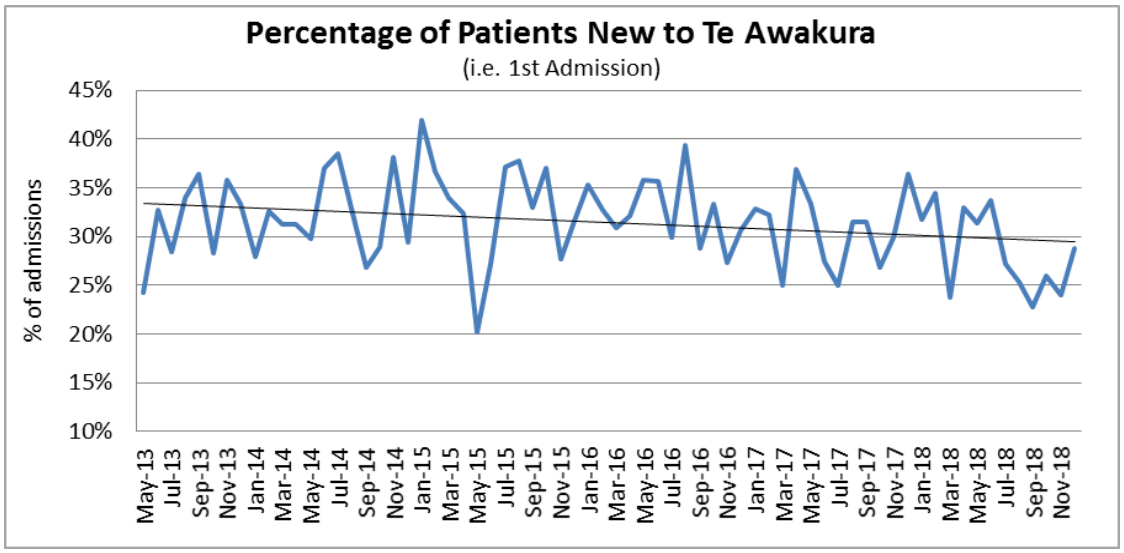


Mental Health Services

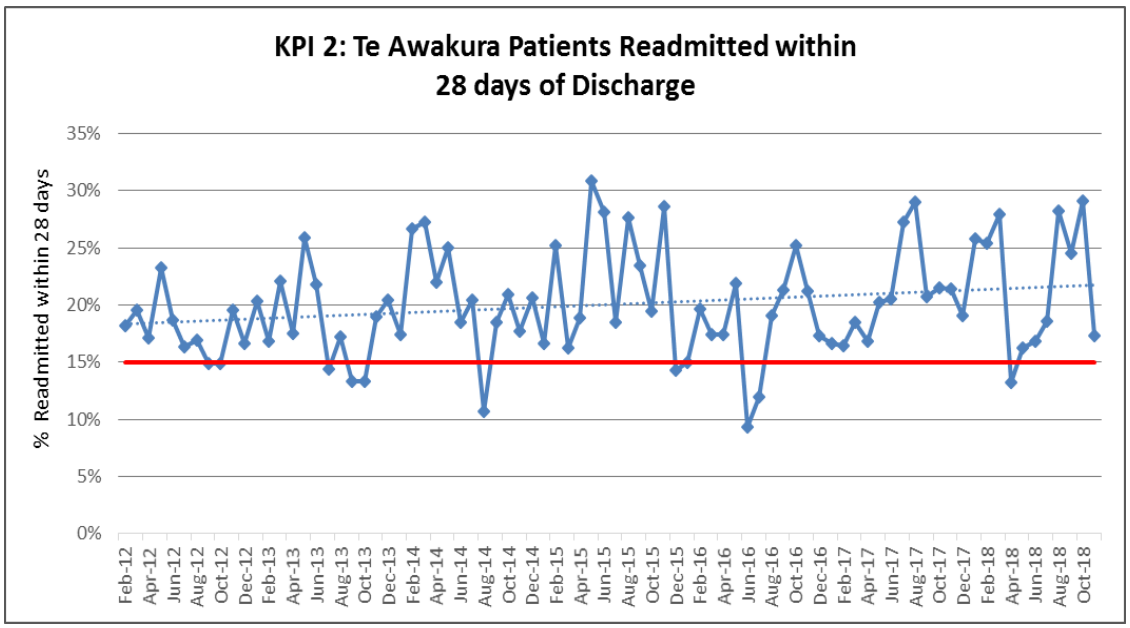
Adult Services



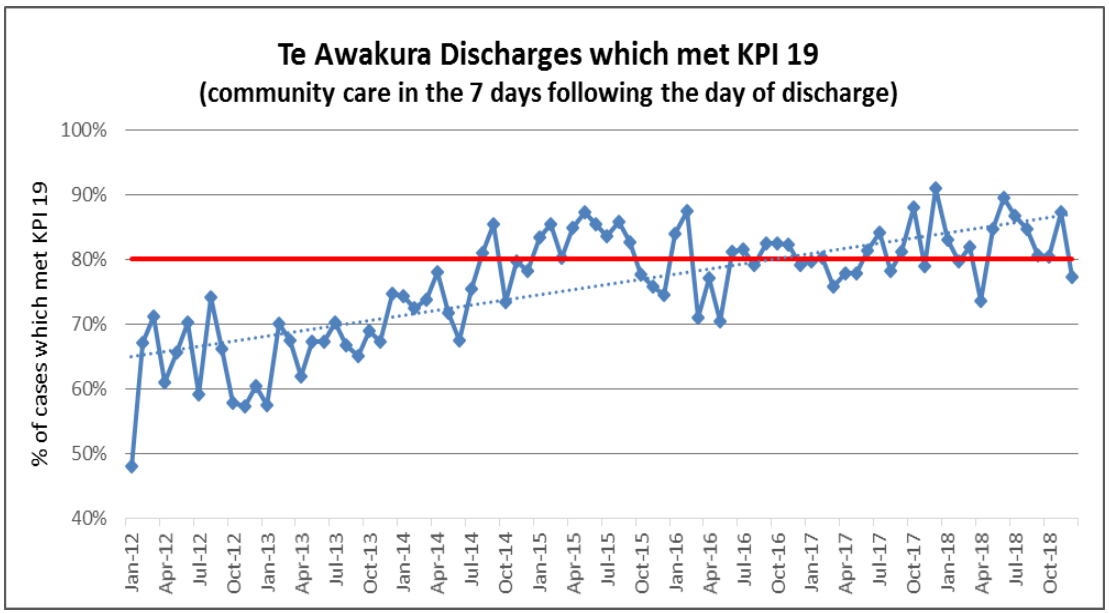
KPI 18 is an indicator of how well engaged we are with the consumers in our services. In November 2018, 77.0% of acute admissions to Te Awakura had a community contact in the seven days prior to the date of their admission. In December 2018, the figure was 67.3%.



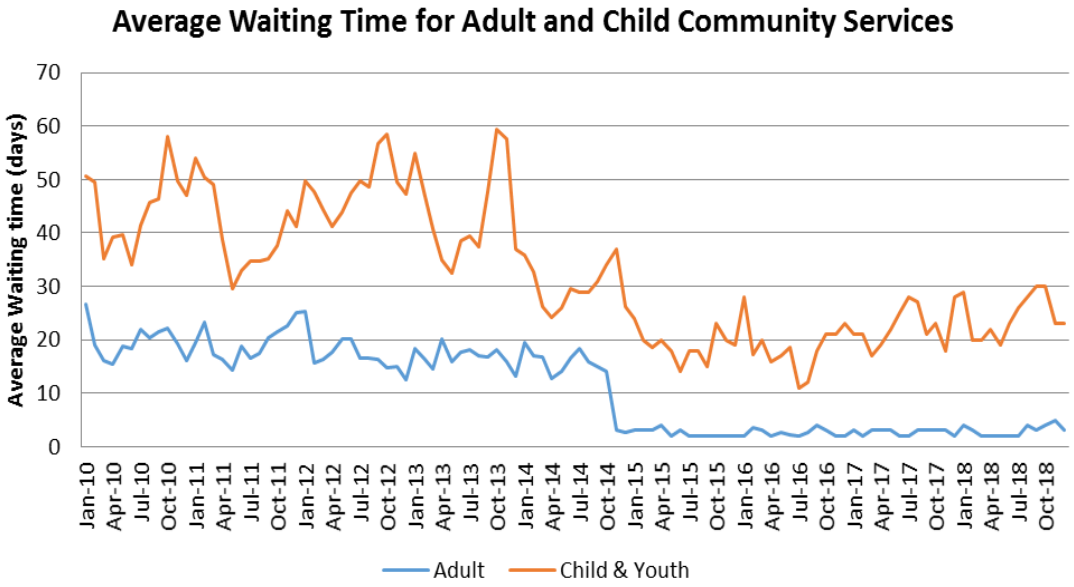
In November 2018, 24% of people admitted to Te Awakura were new (had not been admitted there previously), in December 2018, the figure was 29%.



The graph above shows the readmission rate within 28 days of discharge. Of the 110 Te Awakura consumers discharged in November 2018, 17.3% were readmitted within 28 days. Readmission rates are closely monitored.

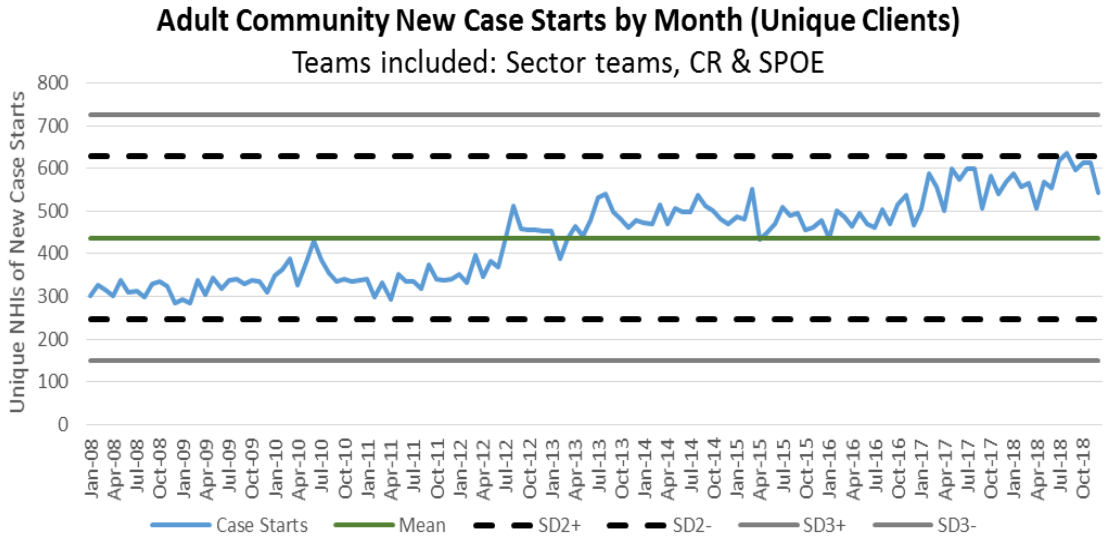


KPI 19 is a key suicide prevention activity and patient safety measure. In November 2018, 87.3% of consumers discharged from Te Awakura received a community care follow-up within seven days of discharge, and so met KPI 19. In December 2018, the figure was 77.3%.

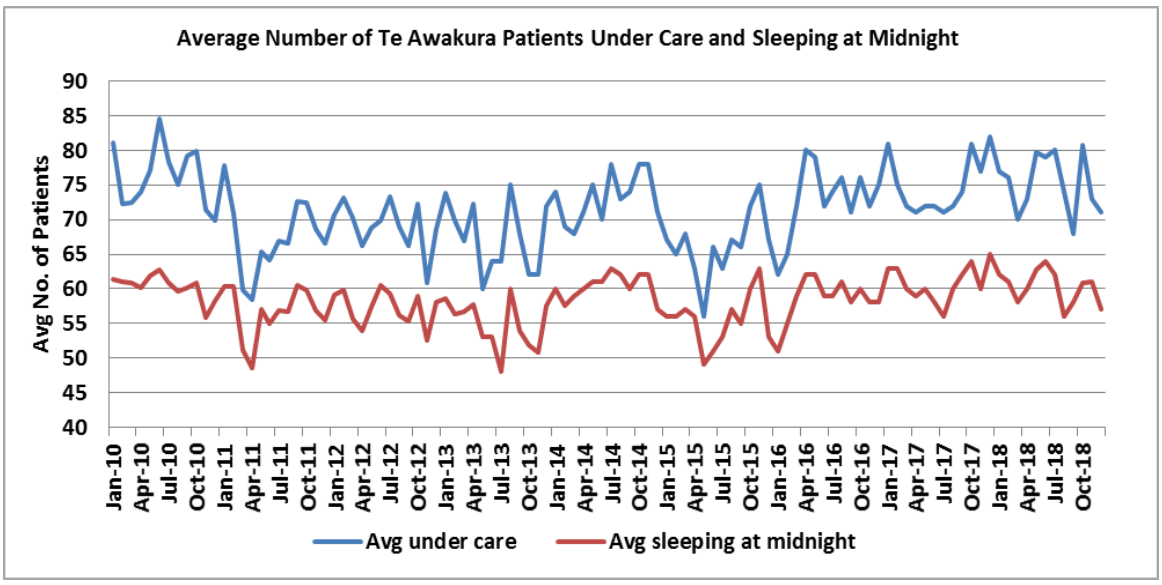


The graph above shows there has been an overall reduction in the time people spend waiting. MoH targets for these services require 80% of people to be seen within 21 days and 95% of people to be seen within 56 days. The average waiting time for adults was five days for November 2018 and three days for December 2018. Our results for the Adult General Mental Health Service show 92.9% of people were seen within 21 days of referral in November 2018 and 99.0% were seen within 56 days of referral. In December 2018, these figures were 94.4% and 99.2% respectively. These results are occurring in the context of significant increase in demand.

For child and family services, the average waiting time was 23 days for both November and December 2018. Reducing wait times has been a key focus for CAF services and activity has included seeing more people for a partnership appointment as the first contact. Whilst this initially led to an increase in overall wait times, it is resulting in less people waiting for a partnership appointment and eliminating the two step process. Our results show 67.8% of people were seen within 21 days of referral in November 2018 and 88.4% were seen within 56 days of referral. In December 2018, these figures were 76.1% and 92.2% respectively.



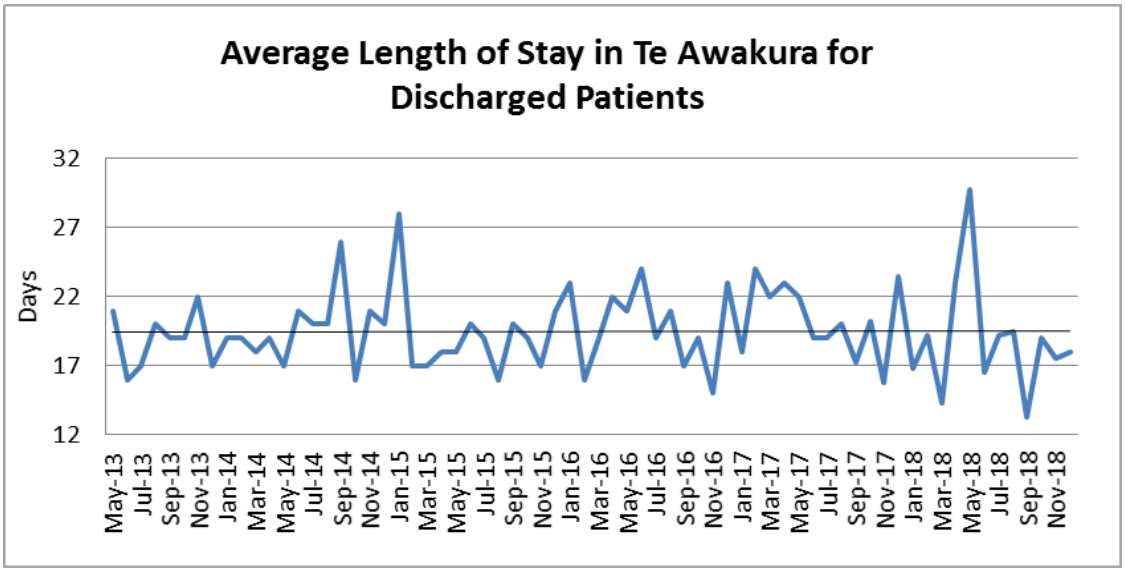
New cases were created for 614 individual adults (unique NHIs) in November 2018 and 542 in December 2018. We are concerned about ongoing growth in demand for these services.



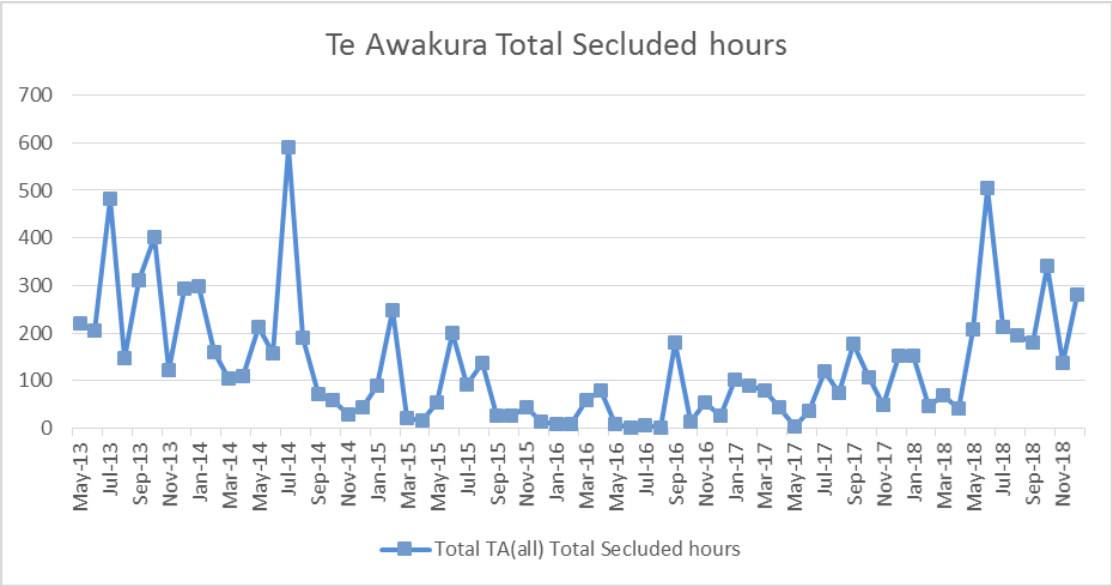
85% occupancy is optimal for mental health acute inpatient services.

Occupancy in Te Awakura (the acute inpatient service) remains above this figure. Occupancy was 95% in November 2018 and 89% in December 2018.

The average number of consumers under care in this 64 bed facility was 73 in November 2018 and 71 in December 2018. There were 10 sleepovers during November 2018 and 48 sleepovers during December 2018.



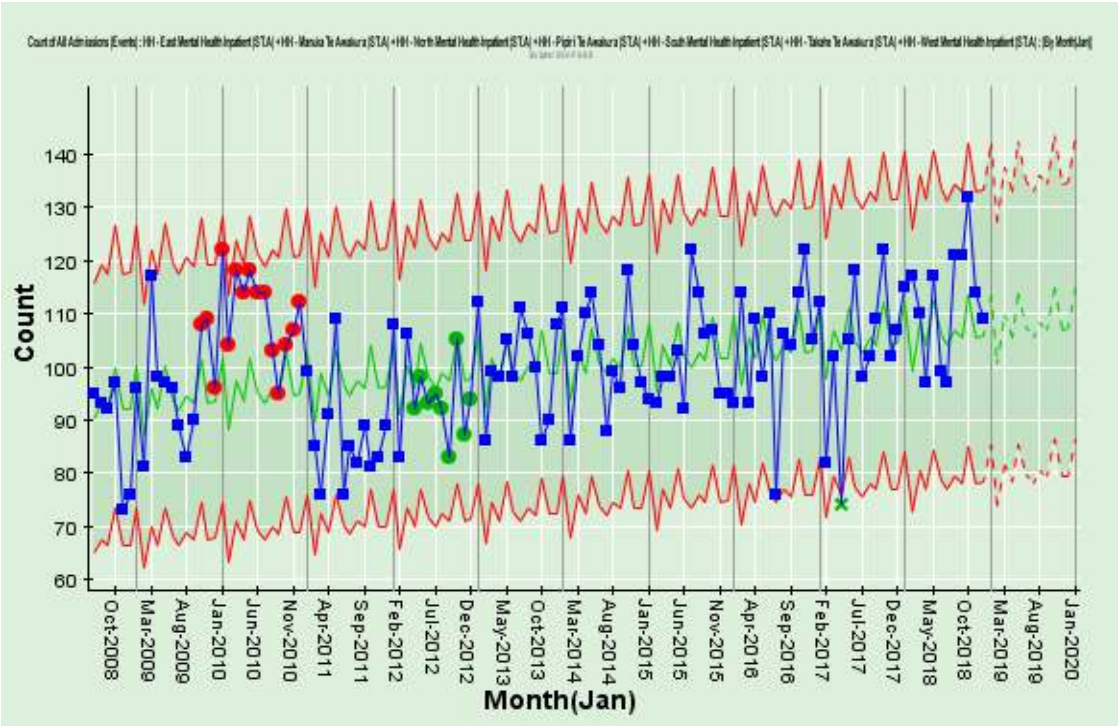
The average length of stay for consumers discharged from Te Awakura was 18 days for both November and December 2018. We are closely monitoring length of stay in terms of difficulties accessing suitable accommodation with intensive support. Approximately one-third of Te Awakura patients have been in service for longer than 30 days.

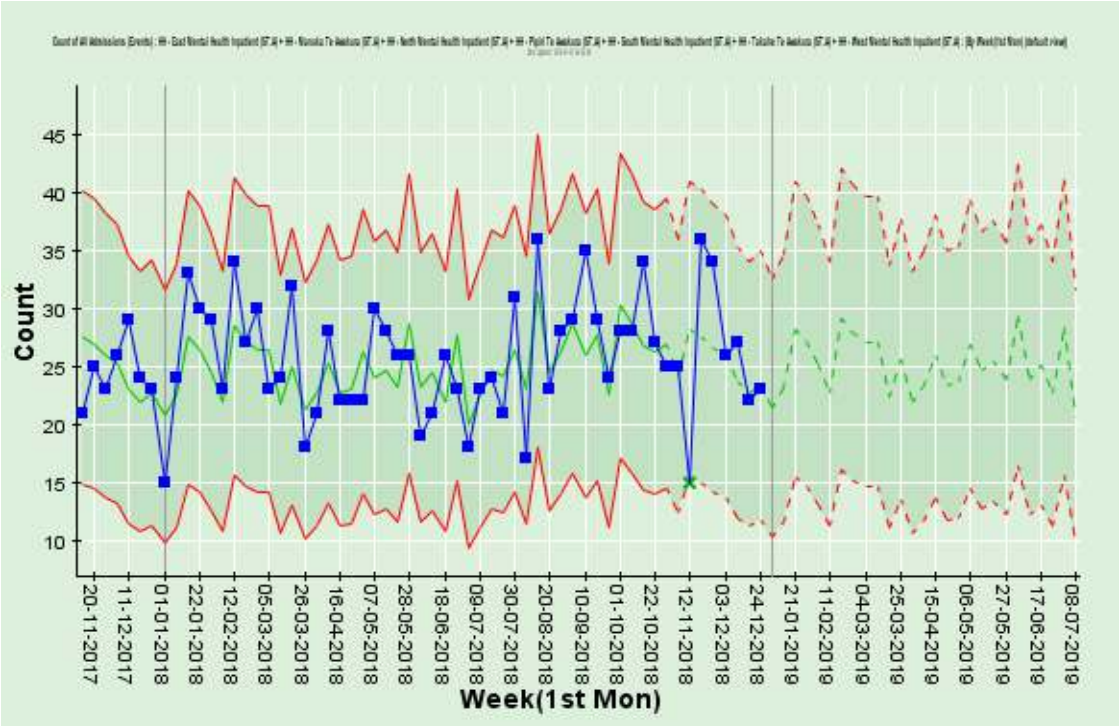


In November 2018, four consumers experienced seclusion for a total of 138.2 hours. In December 2018, seven consumers experienced seclusion for a total of 281.7 hours.

There has been a recent change in focus with regards to seclusion use. As part of the Health Quality & Safety Commission "Zero Seclusion" programme, we are moving forward with a new initiative "Safer for All". This initiative focusses on the causes that result in the use of seclusion, namely violence and serious threats of violence, rather than simply focusing on reducing seclusion itself. The goal is to reduce violence and therefore support a safe and sustainable environment for all consumers, families and staff.

The next two graphs show a count of admissions to Te Awakura (the acute adult unit) – the first is a monthly view, and the second a weekly view.



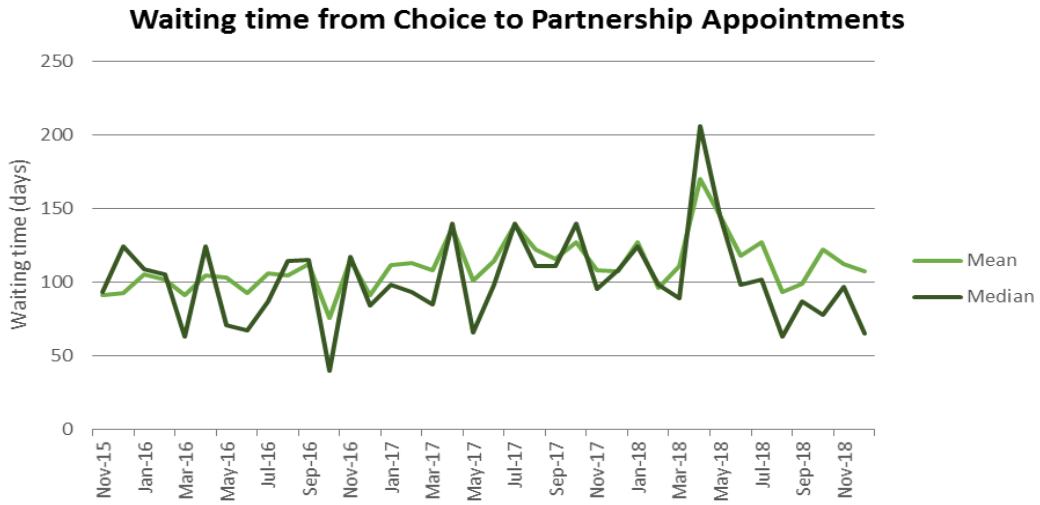


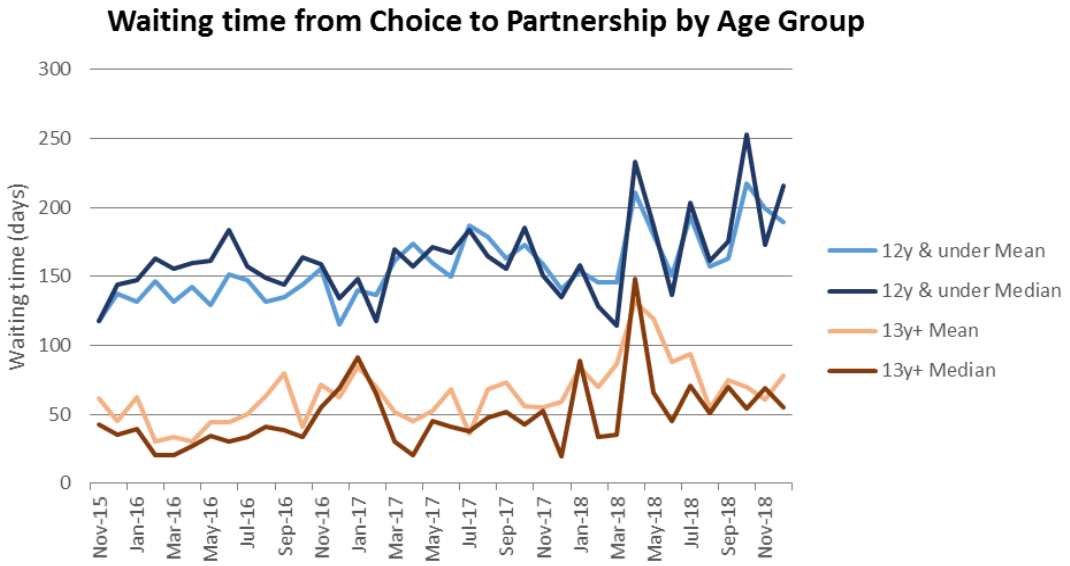
Child and Youth

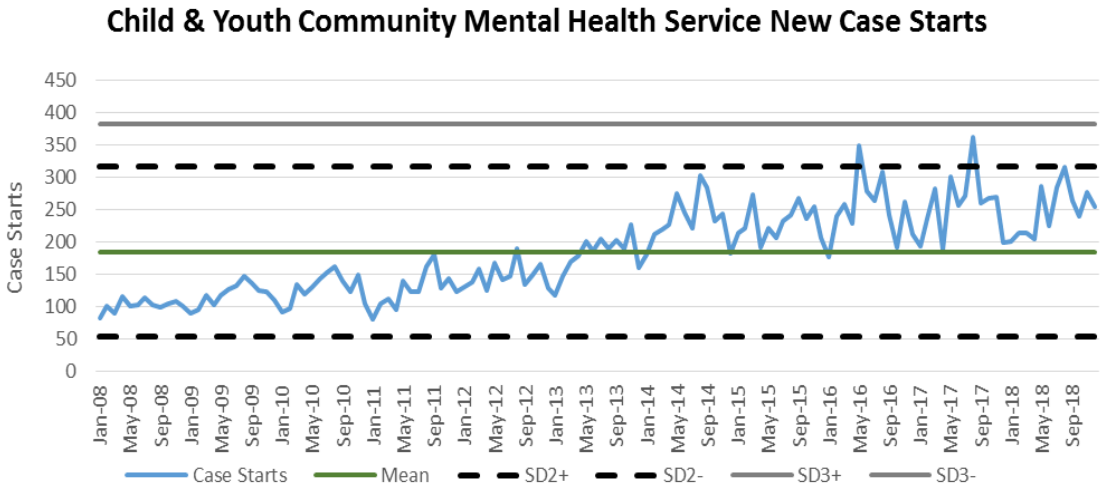
There has been a 100% increase in child and adolescent case starts in the past six financial years.

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

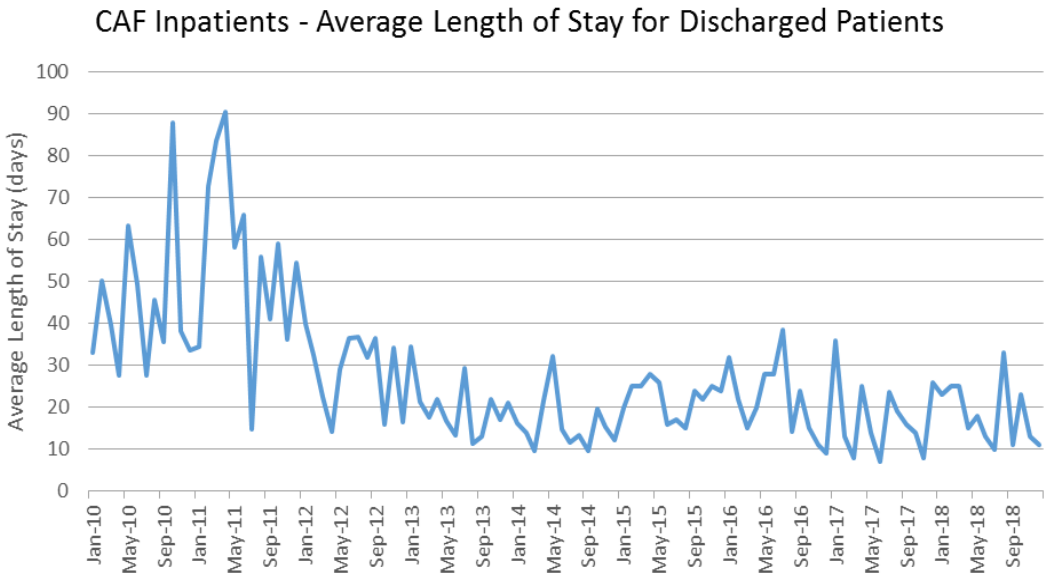
The graphs below show the waiting time between Choice (1st) and Partnership (2nd) appointments. Children and adolescents assessed as being of very high priority go straight to a Partnership appointment, bypassing the Choice appointment process.





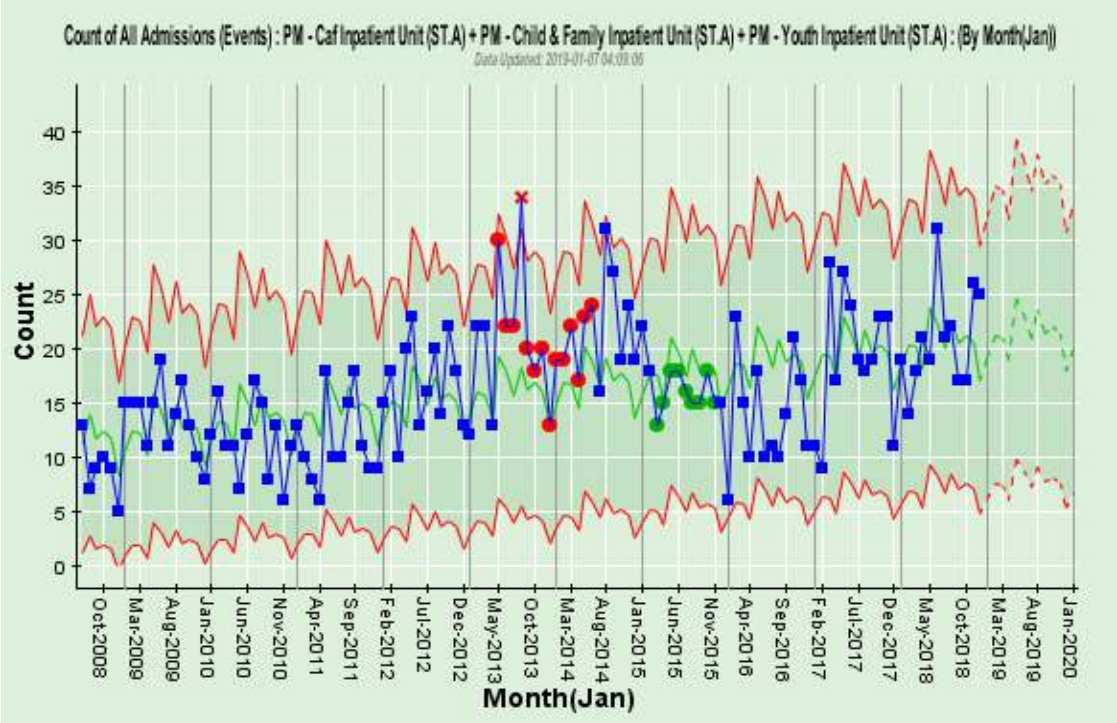


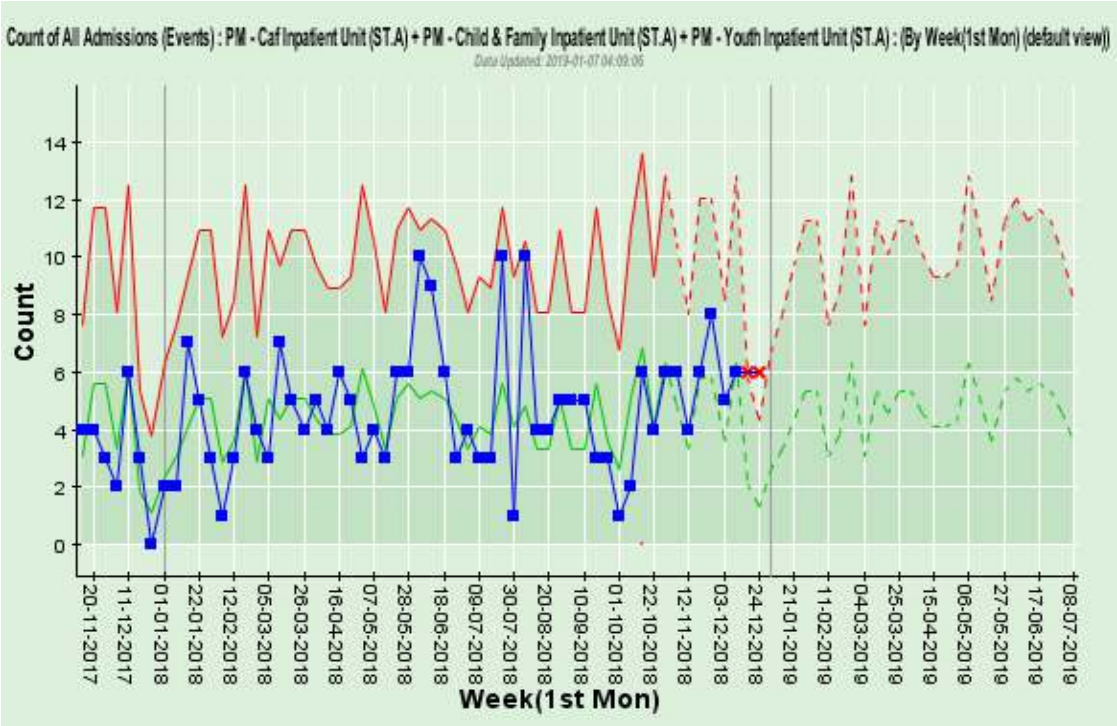
There were 276 new CAF case starts in November 2018 and 255 in December 2018. CAF services are making good progress with implementation of a Direction of Change that supports more integrated services across the age ranges.



The average length of stay for discharged patients was 13 days for November 2018 and 11 days for December 2018.

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





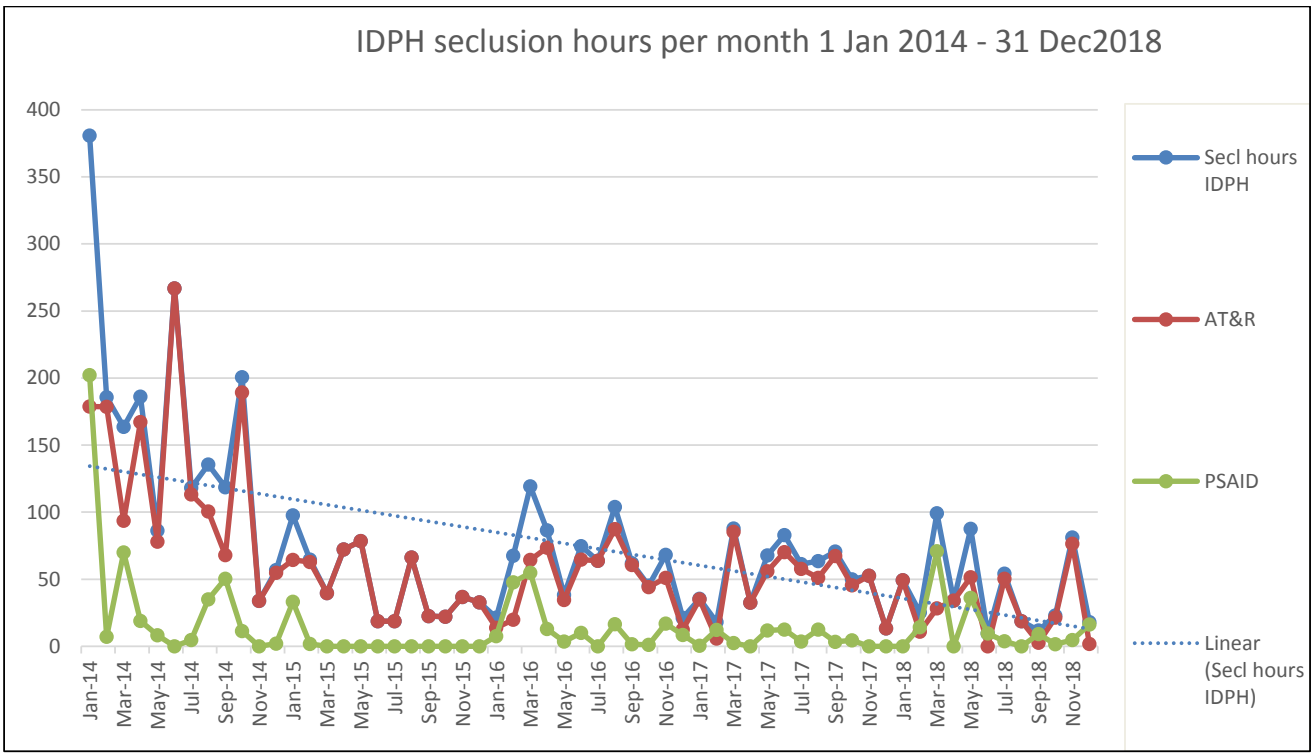
Intellectually Disabled Persons Health Service (*IDPH*)

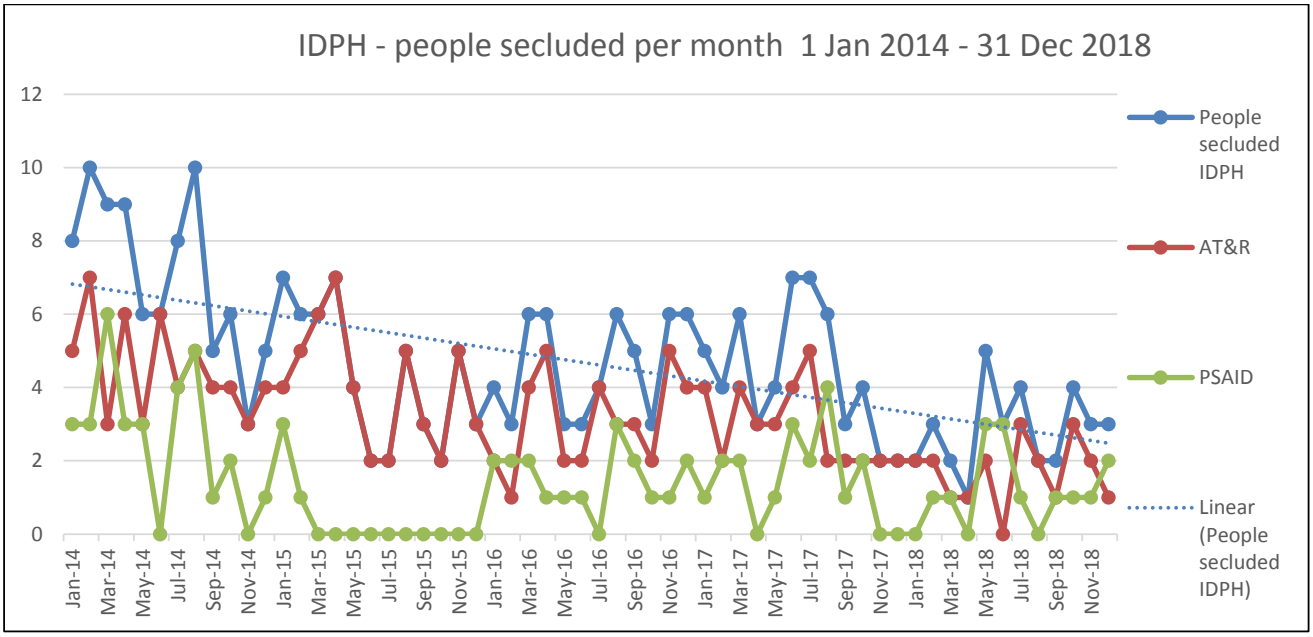
The IDPH Service inpatient units comprise a 7-10 bed secure unit, Assessment, Treatment and Rehabilitation (*AT&R*), and a 15 bed dual disability unit, Psychiatric Service for Adults with Intellectual Disability (*PSAID*) within the Aroha Pai Unit, Hillmorton Hospital.

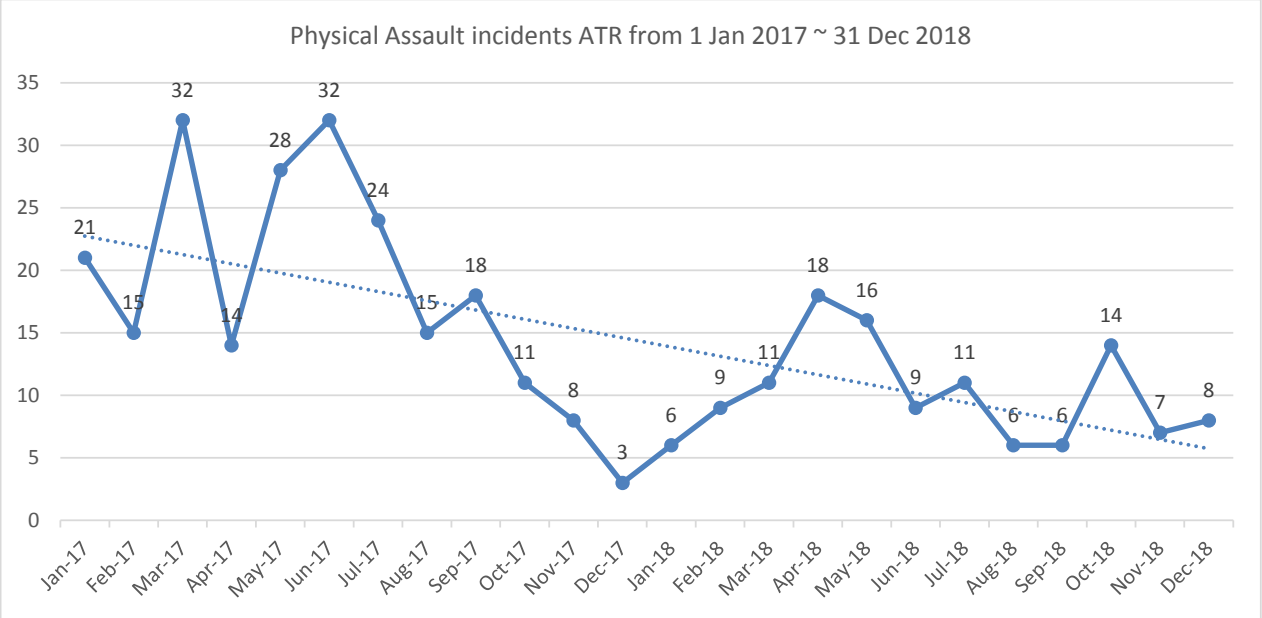
There have been longstanding delays in discharge for patients in the AT&R Unit. The delays continue to place pressure on the service and, for some of the patients, can lead to a deterioration in their presentation, affecting their readiness for discharge.

We work closely with the National Forensic Service (previously known as the National intellectually Disabled Care Agency or NIDCA) and Lifelinks Needs Assessment Service Coordination to seek solutions for placements. We provide both training for staff and carefully developed transition to discharge plans. A monthly teleconference with MoH takes place to inform and discuss the delays in discharge.

The AT&R Unit has recently completed an interim environmental modification to address significant health and safety concerns. Whilst this has reduced the admitting capacity of the unit, there has been a significant improvement in seclusion reduction, a reduction in physical assaults and improved safety for patients and staff. The increase during the September/October period was directly related to the acuity of an individual consumer, combined with conflict between peers.


IDPH seclusion hours per month 1 Jan 2014 - 31 Dec2018
400
350
300
250
200
150
100
50
0
Jan-14
Mar-14
May-14
Jul-14
Sep-14
Nov-14
Jan-15
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Jul-18
Sep-18
Nov-18
Secl hours IDPH
AT&R
PSAID
Linear (Secl hours IDPH)


IDPH - people secluded per month 1 Jan 2014 - 31 Dec 2018
12
10
8
6
4
2
0
Jan-14
Mar-14
May-14
Jul-14
Sep-14
Nov-14
Jan-15
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Jul-18
Sep-18
Nov-18
People secluded IDPH
AT&R
PSAID
Linear (People secluded IDPH)


Physical Assault incidents ATR from 1 Jan 2017 ~ 31 Dec 2018
35
30
25
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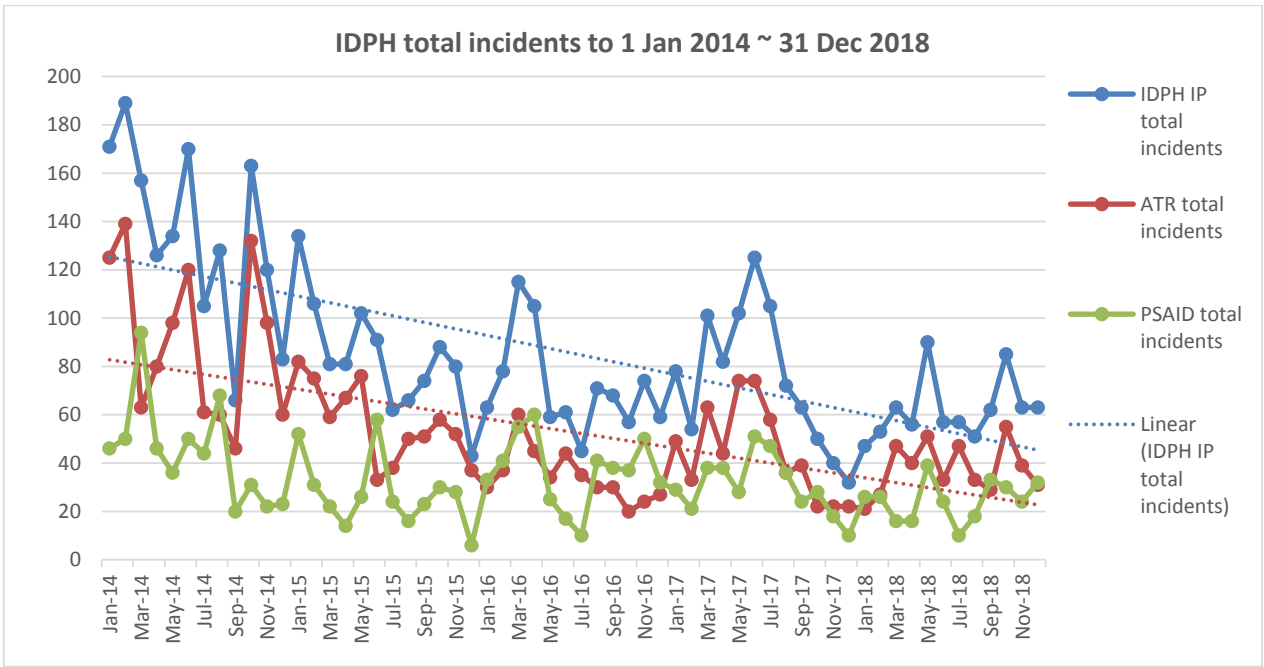
IDPH total incidents to 1 Jan 2014 ~ 31 Dec 2018
200
180
160
140
120
100
80
60
40
20
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Jan-14
Mar-14
May-14
Jul-14
Sep-14
Nov-14
Jan-15
Mar-15
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Sep-15
Nov-15
Jan-16
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Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Jul-18
Sep-18
Nov-18
IDPH IP total incidents
ATR total incidents
PSAID total incidents
Linear (IDPH IP total incidents)

Living within our means

Living within our Means, including No Wasted Resource

Financial Performance

Canterbury District Health Board

Statement of Financial Performance

Hospital & Specialist Service Statement of Comprehensive Revenue and Expense
For the 6 Months Ended 31 December 2018

MONTH $'000						YEAR TO DATE				
18/19 Actual $'000	18/19 Budget $'000	17/18 Actual $'000	18/19 Variance $'000	18/19 vs 17/18 Variance $'000		18/19 Actual $'000	18/19 Budget $'000	17/18 Actual $'000	18/19 Variance $'000	18/19 vs 17/18 Variance $'000
					Operating Revenue					
329	403	507	(74)	(178)	From Funder Arm	2,936	2,406	3,541	530	(605)
1,480	1,565	1,520	(85)	(40)	MOH Revenue	9,152	9,486	9,227	(334)	(75)
3,495	4,370	3,757	(875)	(262)	Patient Related Revenue	24,529	27,955	24,818	(3,426)	(289)
1,353	1,194	1,270	159	83	Other Revenue	9,260	7,748	8,410	1,512	850
6,657	7,532	7,054	(875)	(397)	**TOTAL OPERATING REVENUE**	45,877	47,595	45,996	(1,718)	(119)
					Operating Expenditure					
					Personnel Costs					
61,307	58,358	54,967	(2,949)	(6,340)	Personnel Costs - CDHB Staff	357,709	350,235	324,716	(7,474)	(32,993)
1,494	1,892	1,626	398	132	Personnel Costs - Bureau & Contractors	11,167	11,887	11,298	720	131
62,801	60,250	56,593	(2,551)	(6,208)	**Total Personnel Costs**	368,876	362,122	336,014	(6,754)	(32,862)
12,594	13,228	11,576	634	(1,018)	Treatment Related Costs	76,812	78,126	70,625	1,314	(6,187)
3,322	3,282	3,437	(40)	115	Non Treatment Related Costs	21,470	20,289	22,356	(1,181)	886
78,717	76,760	71,606	(1,957)	(7,111)	**TOTAL OPERATING EXPENDITURE**	467,158	460,537	428,995	(6,621)	(38,163)
(72,060)	**(69,228)**	**(64,552)**	**(2,832)**	**(7,508)**	**OPERATING RESULTS BEFORE INTEREST AND DEPRECIATION**	**(421,281)**	**(412,942)**	**(382,999)**	**(8,339)**	**(38,282)**
					Indirect Income					
-	(46)	-	46	-	Donations & Trust Funds	4	(229)	10	233	(6)
-	-	(2)	-	2	Gain on Disposal of Assets	-	-	(21)	-	21
-	**(49)**	**(2)**	**49**	**2**	**TOTAL INDIRECT INCOME**	**4**	**(245)**	**(11)**	**249**	**15**
					Indirect Expenses					
2,089	2,153	2,145	64	56	Depreciation	12,631	12,181	12,903	(450)	272
-	-	-	-	-	Loss on Disposal of Assets	(8)	-	-	8	8
2,090	**2,154**	**2,145**	**64**	**55**	**TOTAL INDIRECT EXPENSES**	**12,623**	**12,184**	**12,903**	**(439)**	**280**
(74,150)	**(71,431)**	**(66,699)**	**(2,719)**	**(7,451)**	**TOTAL SURPLUS / (DEFICIT)**	**(433,900)**	**(425,371)**	**(395,913)**	**(8,529)**	**(37,987)**

Summary of initiatives

Indication of Latest Efficiencies (including costs avoided)

		Core Financial Benefit			Ancillary Benefit	
		Budgetary Benefits			Non Budgetary Benefits	
Service	Name of initiative/project	Investment for project	$ savings	Financial year of savings	Costs avoided to date	Non-Financial Efficiency
Hospital Services	New cannula			$20,000		Increased placement success and occupational health and safety management

Achievements/Issues of Note

Christchurch Hospital involved in the worldwide launch of a new cannula

Peripheral intravenous cannulae are, at first view, an apparently simple piece of technology used to provide administration of intravenous fluids, medication and blood products. They are the most prevalent medical device used in the healthcare setting. It is estimated that over half of all patients admitted to hospital have a cannula inserted. A new product, the Cathena™ safety IV Cannula, has been designed by Becton Dickinson and builds on existing improvements that make it easier to locate the cannula in a vein through the triple flash system increasing placement success. Additional technology ensures healthcare practitioners are protected from needle-stick injuries and occupational blood exposure through a unique multiguard technology that contains blood spill on insertion and access into a vein. The cannula has power injection capabilities which is essential for acute care settings.

Canterbury has been a pilot site for the rollout of this new cannula, and our feedback has been used to improve the product further. The trial was so successful that we are rolling out this cannula across Canterbury DHB over the coming months. In addition, Southern DHB has also decided to use this cannula based on our trial feedback.

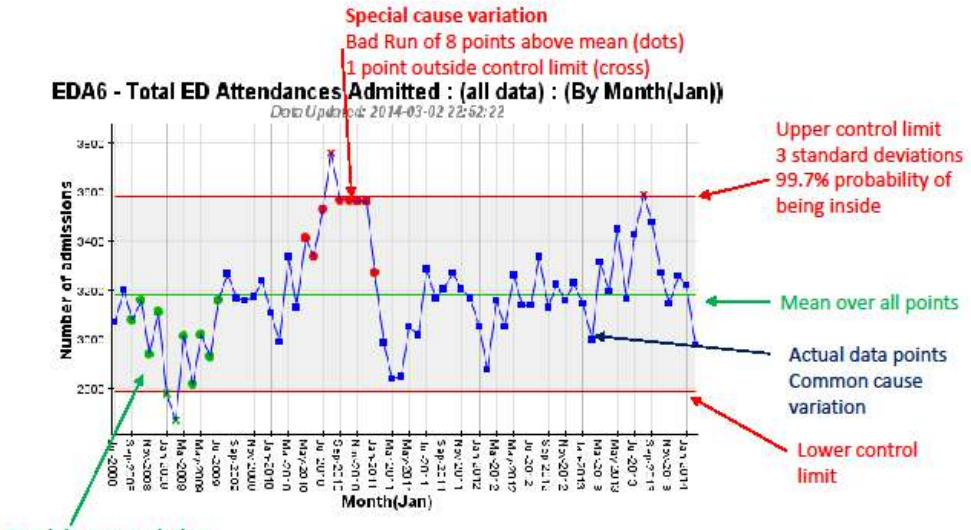
Becton Dickinson is supporting the training we are putting in place for our staff through the provision of free cannulae and use of a simulator arm.

Not only is this cannula better, making the process more comfortable for patients and safer for staff, but it saves us money. Canterbury DHB uses 203,000 cannulae a year. We are paying $5 less per box of 50 compared with the old product, a saving of over $20,000 per year.

Improved coding of nursing employee allocation

Duties for the majority of staff working for the DHB are transacted using Microster. The way this task is done for both permanent and casual nursing staff at Christchurch Hospital is being updated from the beginning of December, with additional coding being utilised. This coding will enable much better analysis of staffing patterns, including trends behind the reasons for requests for casual capacity. While this will mean that Microster entry takes slightly longer, it will enable us to more effectively monitor and manage the way that we use our staff.

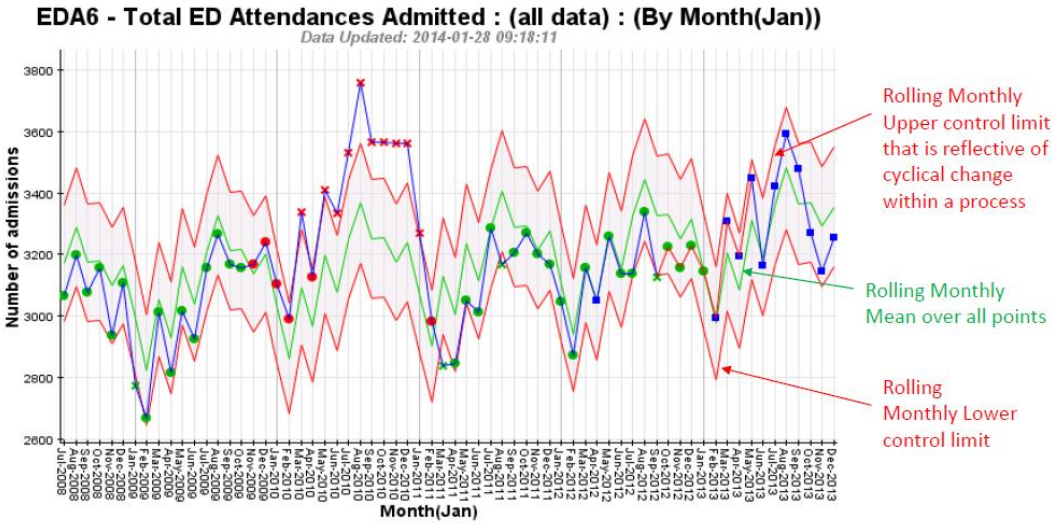
SPC: How to Interpret a Control Chart



sfn signals from noise

make it better

SPC: How to Interpret Cyclical and Trended Data



Criteria for a Cyclical Process:

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

sfn signals from noise

make it better

CLINICAL ADVISOR UPDATES – NURSING AND ALLIED HEALTH

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NOTES ONLY PAGE

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

SOURCE: **Corporate Services**

DATE: **31 January 2019**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Committee:

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

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

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

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

3. SUMMARY

The Act, Schedule 3, Clause 32 provides:

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

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

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

Clause 33 of the Act also further provides:

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

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

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

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

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

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

WORKPLAN FOR HAC 2019 *(WORKING DOCUMENT)*

9am start	31 Jan 19	04 Apr 19	30 May 19	1 Aug 19	3 Oct 19	5 Dec 19
Standing Items	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes
Standing Monitoring Reports	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report
Planned Items	Clinical Advisor Update - Nursing (Becky Hickmott) & Allied Health (Jacqui Lunday-Johnstone)	Clinical Advisor Update –Medical (Dr Sue Nightingale) 2019 Winter Planning Update	Clinical Advisor Update - Nursing (Mary Gordon) & Allied Health (Jacqui Lunday-Johnstone)	Clinical Advisor Update –Medical (Dr Sue Nightingale) H&SS 2016/17 Year Results	Clinical Advisor Update - Nursing (Mary Gordon) & Allied Health (Jacqui Lunday-Johnstone)	Clinical Advisor Update – Medical (Dr Sue Nightingale) 2019 Winter Planning Review
Presentations	Sleep Health Services in Canterbury	Burwood Campus	Christchurch Campus - Child Health	SMHS	Christchurch Campus – ORL (ENT) TBC: Ashburton / Rural Health	TBC: Christchurch Campus – Dept. of Anaesthesia TBC: Labs
Governance and Secretariat Issues						2020 Workplan
Information Items	2019 Workplan	2019 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 2019 Workplan	2019 Workplan	2020 Meeting Schedule 2019 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 2019 Workplan
Public Excluded Items	CEO Update (as required)	CEO Update (as required)	CEO Update(as required)	CEO Update (as required)	CEO Update (as required)	CEO Update (as required)