HOSPITAL ADVISORY COMMITTEE MEETING

Thursday, 31 May 2018
9.00am

Board Room
Level 1
32 Oxford Terrace
Christchurch

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

AGENDA - PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE MEETING
To be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
32 Oxford Terrace, Christchurch
Thursday, 31 May 2018 commencing at 9.00am

ADMINISTRATION			**9.00am**
	Apologies		
1.	**Interest Register** *Update Committee Interest Register and Declaration of Interest on items to be covered during the meeting.*		
2.	**Confirmation of the Minutes of the Previous Committee Meeting** ▪ *29 March 2018*		
3.	**Carried Forward/Action List Items**		
MONITORING			**9.05am**
4.	**Older Persons Health and Rehabilitation Services - Presentation**	Dan Coward *GM, Older Persons, Orthopaedics & Rehabilitation*	9.05-9.35am
5.	**Hospital Service Monitoring Report** • *Hospital Laboratories* – Kirsten Beynon • *Older Persons, Orthopaedics & Rehabilitation* – Dan Coward • *Mental Health* – Toni Gutschlag • *Rural Health Services* – Berni Marra & Win McDonald • *Medical/Surgical* & *Women's & Children's Health* – Pauline Clark • *ESPIs* – Pauline Clark		9.35-10.30am
MORNING TEA			**10.30-10.45am**
6.	**2018 Winter Planning Update**	Dan Coward	10.45-11.00am
7.	**Clinical Advisor Update (Oral)** • Nursing	Mary Gordon *Executive Director of Nursing*	11.00-11.15am
8.	**Resolution to Exclude the Public**		11.15am
ESTIMATED FINISH TIME			**11.15am**

INFORMATION ITEMS

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

NEXT MEETING: Thursday, 2 August 2018

ATTENDANCE LIST - PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE MEMBERS

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

Executive Support

David Meates – *Chief Executive*
Mary Gordon – *Executive Director of Nursing*
Stella Ward – *Chief Digital Officer*
Carolyn Gullery – *Executive Director Planning, Funding & Decision Support*
Justine White – *Executive Director Finance & Corporate Services*
Sue Nightingale – *Chief Medical Officer*
Kay Jenkins – *Executive Assistant – Governance Support*
Anna Craw – *Board Secretariat*

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

	identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance. **Hospital Lady Visitors Association** - Wife is a member of this, but no potential conflict of interest is expected. Should one arise it will be declared at the time. **Nurses Memorial Chapel Trust** –Chair (CDHB Appointee) Trust responsible for Memorial Chapel on the Christchurch Hospital site. Note the chapel is now owned by the Christchurch City Council.
Dr Rochelle Phipps	**Accident Compensation Corporation** – Medical Advisor **Institute of Directors in New Zealand** – Chartered Member **OraTaiao: New Zealand Climate & Health Council** – Founding Member **Royal New Zealand College of General Practitioners** – Christchurch Fellow and Former Board Member
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 **Deep South NSC Governance Board** - Member **Greater Christchurch Partnership Committee** - Member **He Toki ki te Rika / ki te Mahi** - Patron **Liquid Media Operations Limited** - Shareholder **Ngāti Ruanui Holdings** – Director **Oaro M Incorporation** - Member **Police Commissioners Māori Focus Forum** - Member **Pure Advantage** – Trustee **QuakeCoRE** – Board Member **Rangitane Holdings Limited & Rangitane Investments Limited** - Chair/Director **SEED NZ Charitable Trust** – Chair and Trustee **Sustainable Seas NSC Governance Board** - Member **Te Ohu Kai Moana** - Director **Te Waka o Maui** – Independent Representative

Dr John Wood **Ex Officio – HAC** Chair CDHB	**Advisory Board NZ/US Council** – Member **Chief Crown Treaty Negotiator for Ngai Tuhoe** **Chief Crown Treaty Negotiator for Ngati Rangi** **Chief Crown Treaty Negotiator for the Whanganui River** **Chief Crown Treaty Negotiator, Tongariro National Park** **College of Arts – External Advisory Committee Member** **Governing Board, Economic Research Institute for ASEAN and East Asia (ERIA)** – Member **Kaikoura Business Recovery Grants Programme Independent Panel** – Member **Member of the Governing Board of the Office of Treaty Settlements, Ministry of Justice – Ex-officio (as Chief Crown Treaty of Waitangi Negotiator)** – Ex-officio member. **School of Social and Political Sciences** – Adjunct Professor **Te Urewera Governance Board** – Inaugural Member **University of Canterbury** - Chancellor **University of Canterbury Foundation** – Ex-officio Trustee **Universities New Zealand** – Chair, Chancellors' Group

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 March 2018, commencing at 9.00am

PRESENT
Andrew Dickerson (Chair); Barry Bragg; Sally Buck; Dr Anna Crighton; David Morrell; Jan Edwards; Dr Rochelle Phipps; Trevor Read; and Dr John Wood.

APOLOGIES
Apologies for absence were received and accepted from Jo Kane (Deputy Chair); and Ta Mark Solomon.
Apologies for lateness were received and accepted from David Morrell (9.07am); and Dr John Wood (10.05am).
An apology for early departure was received and accepted from Dr Anna Crighton (11.00am).

EXECUTIVE SUPPORT
David Meates (Chief Executive); Carolyn Gullery (General Manager, Planning & Funding and Decision Support); Dr Sue Nightingale (Chief Medical Officer); Kay Jenkins (Executive Assistant, Governance Support); and Charlotte Evers (Assistant Board Secretariat).

IN ATTENDANCE

Item 4
Dr David Jardine – Clinical Director, General Medicine
Dave Nicoll – Service Manager, General Medicine
Mark Crawford – Medical Nursing Director, General Medicine
David Smyth – Physician, General Medicine

Item 5
Kirsten Beynon – General Manager, Hospital Laboratories
Dan Coward – General Manager, Older Persons, Orthopaedics & Rehabilitation
Toni Gutschlag – General Manager, Specialist Mental Health Services
Berni Marra – Manager, Ashburton Health Services
Win McDonald – Transition Programme Manager, Rural Health Services
Heather Gray – Director of Nursing, Christchurch Hospital

1. INTEREST REGISTER

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

Declarations of Interest for Items on Today's Agenda
Item 5 – Jan Edwards indicated a potential conflict due to her work with large practices in Ashburton.

There were no other 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 (05/18)
(Moved: Jan Edwards/Seconded: Trevor Read – carried)

"That the minutes of the meeting of the Hospital Advisory Committee held on 1 February 2018 be confirmed as a true and correct record."

3. CARRIED FORWARD/ACTION ITEMS

Item 2 Maternal Health Strategic Direction –good progress is being made, with a proposal to be presented to the Committee/Board in approximately two months.

Item 3 Status of drink dispensing machines – the CPH&DSAC Committee would like to delay the impetus on sugar free drinks for a few months.

The Committee noted the carried forward items.

4. GENERAL MEDICINE - PRESENTATION

David Morrell joined the meeting at 9.07am.

Heather Gray – Director of Nursing, Christchurch Hospital, introduced Dr David Jardine, Clinical Director; Dave Nicoll, Service Manager; David Smyth, Physician; and Mark Crawford, Medical Nursing Director; who presented to the Committee on General Medicine.

The presentation provided an overview in terms of:

- Who they are, who they work with and what they do.
- Challenges faced, including increased demand on beds in General Medicine and Acute Medical Assessment Unit (*AMAU*), particularly in winter, as well as staffing pressures.
- Local and regional challenges.
- What the department is doing to overcome these challenges, as well as what it needs now and longterm to ensure demand is met.

There was a query about how the overflow of admissions in General Medicine and AMAU impact on other wards of the hospital. The Committee noted that the focus is not just to move patients out of General Medicine, but to continue to provide treatment as well as rehabilitation, particularly given that the average age of patients is 80 years old, and they often have a range of complex and acute conditions. The department's focus is to provide continuity of care.

There was a query around the length of stay in General Medicine and what impact the policy to keep people in their homes had on this figure. There was discussion held that since the policy was adopted in 2008/9, there has been a steady downwards trend in the length of stay in the department, plateauing in 2016/17. This is due to good post-discharge support through various agencies such as CREST and acute demand. 30% of patients are less likely to be admitted to General Medicine in Canterbury compared to the rest of New Zealand.

There was a query around predicted climate change and whether this will provide a need for summer planning as well as winter planning. At this stage, there has been no investment or forward planning in this, as plans are based on historical data.

There was a query around whether medical officers are able to cover the shortfalls in staffing. The Committee noted that having more staff in the space creates more challenges, and that this would detract from the continuity of care model the department has adopted.

There was a query around what the ideal General Medicine department would look like. It was noted that the department sees four-five patients a day that do not need to be admitted and can be seen for a one-two hour appointment and sent home. This ambulatory care model is running as a pilot and has proven so far to be effective in reducing the demand for overnight beds. It is crucial the right questions are asked. The other thing noted that may be of use are outreach clinics in GP or after hours clinics, as well as upskilling GPs in picking up more complex conditions.

There was a query around how beds required in General Medicine impacts on beds available, and the impact on elective surgery. It was noted there is a risk of cancelling elective surgery when the department is at capacity, but they work hard to mitigate this, as it is a driver for sustaining elective services. The trend is that less electives results in more acute conditions, therefore increasing the demand in General Medicine.

Andrew Dickerson, Chair, thanked those in attendance for the presentation, noting that the General Medicine department is under high levels of pressure and their efforts are commendable and should be regarded as an exemplar within Christchurch Hospital.

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

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

General Managers spoke to their areas as follows:

Hospital Laboratories – Kirsten Beynon, General Manager

- Key focus is on winter planning and monitoring Institute of Environmental Science and Research (*ESR*) engagement.
- Workforce modelling in phlebotomy to support all acute 24 hour services and shifting staffing to meet demand.
- Two vacancies currently exist, which are being recruited.

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

- There will be communications around winter planning from early April, with particular focus on flu vaccinations.
- Trials of beds that allow rehabilitation in bed-bound patients have been successful, with no negative incidents and high patient satisfaction.
- The South Island Alliance are currently working with the pandemic team and looking at their activity.
- Acute spinal and elective orthopaedic operations are impacting on the service, as there is an international trend showing that spinal surgery is not considered an orthopaedic specialty. There are currently no new specialist spinal surgeons available in New Zealand until 2023. Work is required around this to increase the number of surgeons being trained in spinal surgery and to meet the ESPI orthopaedic compliance.

There was a query around the management of non-acute spinal conditions and whether there is any work being done to offset the demand on spinal surgery, given the lack of capacity for these complex cases. The Committee noted there is work being done with the Canterbury Initiative to formulate a plan around this.

There was a query around what impact the demand on spinal surgery has on the pain management service. It was noted that changes made to the base programme 18 months ago have mitigated some of this demand.

There was a query around workforce planning with regards to acute spinal conditions. It was noted by the Committee that Burwood is currently the only facility with accreditation in this area, meaning that there are a good number of next generation fellows and trainees on board.

Dr John Wood joined the meeting at 10.05am.

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

- Acknowledgement was made of the assault incident at Hillmorton Hospital. While this was a serious incident, some of the facts reported by media were incorrect. Staff are coping well. Due to an increased ability to access drugs in Canterbury, this is a most challenging environment. Police and SMHS have a strong relationship and are working together to establish a protocol in response to serious events.
- There is communication currently between the Ministry of Health (*MoH*) and the Director of Mental Health Services regarding buildings and capacity. MoH have visited the wards to assess space needs and robustness of the buildings.
- Workforce planning shows the recruitment of new graduates is more than funding allows.
- Positive things are underway in child/adolescent/family mental health, with stable leadership in this team. An ADHD clinic is currently under development.
- There has been an overall reduction in the volume of incidences in AT&R, but some increase in assaults.

There was a query around the business case underway regarding moving services from The Princess Margaret Hospital. At this stage, it is on the fast track to be completed in around three and a half years. To pull back this timing requires changes to central approvals.

There was a query around the impact on the service of mixing patients, in particular detox patients and others. The Committee noted that while this is not ideal, space constraints mean at times this is unavoidable.

There was a query around KPI 18 and why that includes people that have never had community contact outside of Te Awakura. It was noted that there is no explanation why, that the intent of the graph is to show the measure of engagement in the community.

There was a query around the number of police attending assaults, after a media report stating that four officers attend most incidents. It was noted that this is becoming more common, even though events of this nature are extraordinary. These events are more likely to happen in seclusion units, with the likelihood of harm increasing when staff have to enter the units to administer medications. Staff are being fully supported by the leadership team and the DHB.

Ashburton Health Services – Berni Marra, Manager Ashburton Health Services

- There will be a workshop held in June to discuss the development of a localised frail elderly pathway amongst community providers.
- Trend for high presentations in the Acute Assessment Unit (*AAU*).

There was a query around whether the AAU is stretched in summer as well as winter. It was noted by the Committee that winter is worse. There is a mixed model for 24 hour care in Ashburton, with GPs running on rotation to cover the service. It is hoped that a single care model can be adopted in the future.

There was a query around the rise in ED presentations, but an improvement in the number of patients treated within six hours. It was noted that this is due to the model of care that was developed, focusing on patients flowing to Ward 1 (Acute Medical Ward) and working with the nursing teams to admit patients under AAU not ED.

There was a request for a presentation on Ashburton Health Services.

Rural Health Services - Win McDonald, Transition Programme Manager

- An increase in frailty in rural populations has been noted.
- Nurse managers and practice managers are talking about community care.
- South Island PICS has been introduced and the rollout has gone well. Data on this rollout will be available in the near future.
- Chatham Islands – the current locum has observed an increase in frailty in the population, as well as an increase in drug and alcohol issues, although less than evident on the mainland.
- Chatham Islands – the provision of a mental health provider, working remotely, has resulted in a significant decrease in the need for patients to leave the island to seek Specialist Mental Health Services.

There was a request for a presentation on Rural Hospitals.

Medical/Surgical & Women's & Children's Health – Heather Gray, Director of Nursing

- A heart failure clinic will be established in North Canterbury.
- Current focus is on the key services of orthopaedics and the growth in demand for beds and population and treatment changes in oncology. There is collaborative work being done with Planning & Funding around this.

ESPIs

Heather Gray advised that it is difficult to meet ESPI compliance without available theatres. While CDHB has long been one of two spinal injury services in New Zealand, the increasing subspecialisation of surgical care is leading to increasing inter-regional flow for pelvic and vascular injuries and repairs. There are more operations performed by the Canterbury DHB than by the Auckland DHB, making Canterbury the largest acute and elective surgery provider in New Zealand. It was noted that all health boards nationally are struggling to meet ESPI compliance.

There was a discussion around delays in MoH-led building projects and the impact this has on elective surgeries.

Discussion took place around the Canterbury DHB being nationally acknowledged as the largest surgery provider in the country, and therefore needing to be funded and resourced accordingly, while still working collaboratively with MoH.

Resolution (06/18)

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

"That the Committee:

i. notes the Hospital Advisory Committee Activity Report."

6. CLINICAL ADVISOR UPDATE

Dr Sue Nightingale, Chief Medical Officer, provided updates on the following:

- The Chiefs and Chairs Group is working to include services that are not currently covered in their discussions such as anaesthetics, ICU, hyperbaric medicine etc.
- Anja Werno has stepped in as the Acting Chief of Pathology and Laboratories; this role is currently advertised.

- David Smyth is covering the role of Chief of Medicine.
- A process is underway to formalise the election of David Jardine to the position of Director of General Medicine.
- Workforce planning around SMOs is underway, requiring recruitment two years in advance.
- 12 services met their credentialing target in 2017, and there are more departments asking to go through the process.
- Richard French is currently working on system improvements to help address issues around serious incidents, which are improving.
- Pressure injuries are down.
- A stocktake in quality was performed, which showed the need for a Clinical Governance committee to approve multiple initiatives.
- An appointment of an Infection Prevention Nursing Director will be made soon.
- An independent panel review of the Research Committee will be undertaken shortly; terms of reference have been agreed.
- Current special projects include improving discharge summaries; one template will be used by hospital and primary care.
- GP information dashboards are currently going through IT.
- Dr Mary Hunter and Richard French are working on scrutinising departments, as to where cost savings can be made.
- Health Emergency Planning now comes under the Chief Medical Officer, Dr Sue Nightingale.

There was a query around the morale of SMOs and RMOs. The Committee noted that overall it is good, but can vary as some departments are under a lot of pressure due to a number of factors, including the day to day nature of their work and trying to find new ways to do things.

Dr Anna Crighton retired from the meeting at 11.00am.

7. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (07/18)
(Moved: Jan Edwards/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 1 February 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.	s 9(2)(ba)(i) s 9(2)(j)

		To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege	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

- 2018 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 11.00am.

Confirmed as a true and correct record.

_____ _____

Andrew Dickerson
Chairperson

Date

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE
CARRIED FORWARD ITEMS AS AT 31 MAY 2018

DATE		ISSUE / ACTION	REFERRED TO	STATUS
1.	02 Aug 2016	AT&R Unit Update	Toni Gutschlag	Verbal Update.
2.	30 Nov 17	Progression of Maternal Health Strategic Direction	Carolyn Gullery	Report to 2 August 2018 meeting.
3.	01 Feb 18	2018 Winter Planning Update	Dan Coward	Today's Agenda – Item 6.
4.	29 Mar 18	Rural Hospitals presentation	Win McDonald	Scheduled for 2 August 2018 meeting.
5.	29 Mar 18	Ashburton Health Services presentation	Berni Marra	Scheduled for 4 October 2018 meeting.
6.	19 Apr 18 (Board)	Ophthalmology Department - update on follow-up appointments for glaucoma patients	Carolyn Gullery	Scheduled for 2 August 2018 meeting.

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 May 2018**

Report Status – For:	Decision	Noting	☑	Information	☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Committee:

i. notes the Hospital Advisory Committee Activity Report.

3. APPENDICES

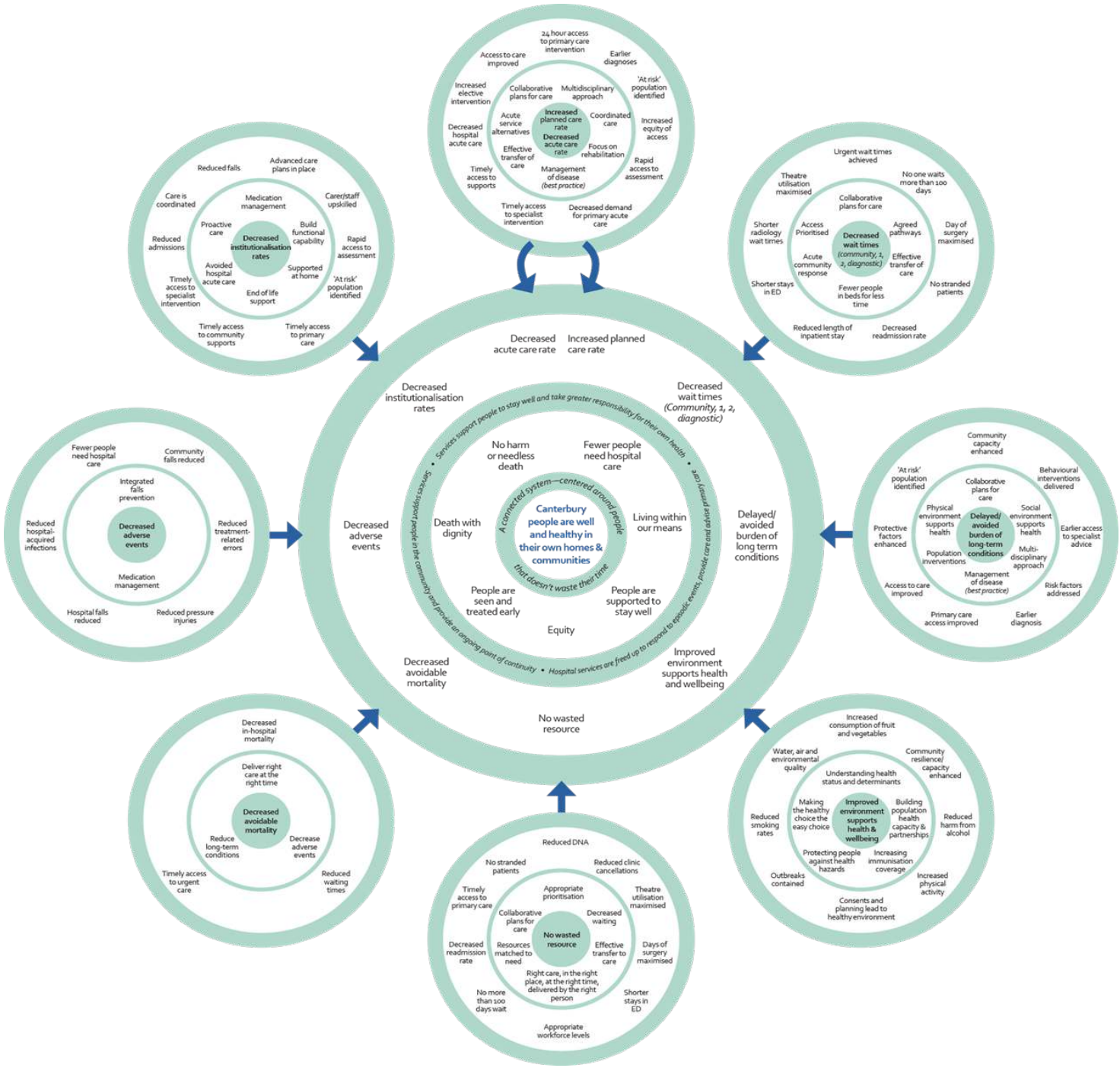
Appendix 1: Hospital Advisory Committee Activity Report – May 2018

Report prepared by: General Managers, Hospital and Specialist Services

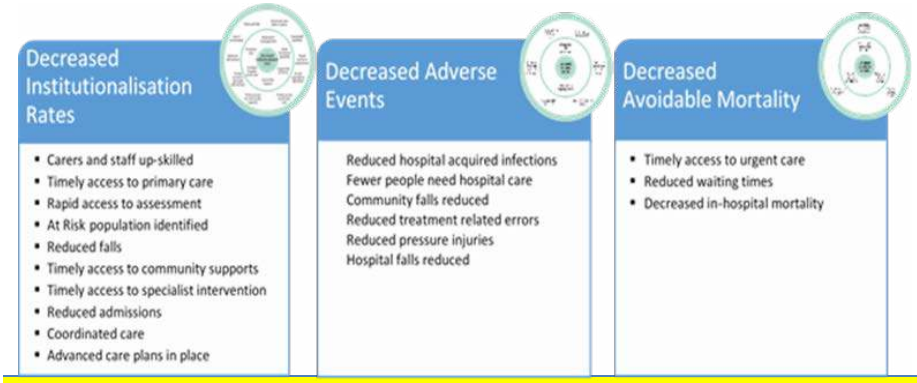
Report approved for release by: Justine White, Executive Director Finance & Corporate Services
Carolyn Gullery, Executive Director Planning, Funding & Decision Support

Hospital Advisory Committee

Activity Report



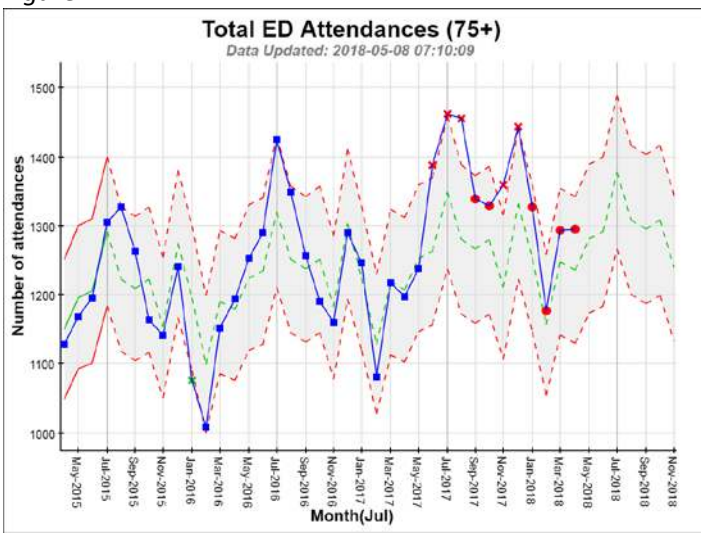
May 2018



Frail Older Persons' Pathway

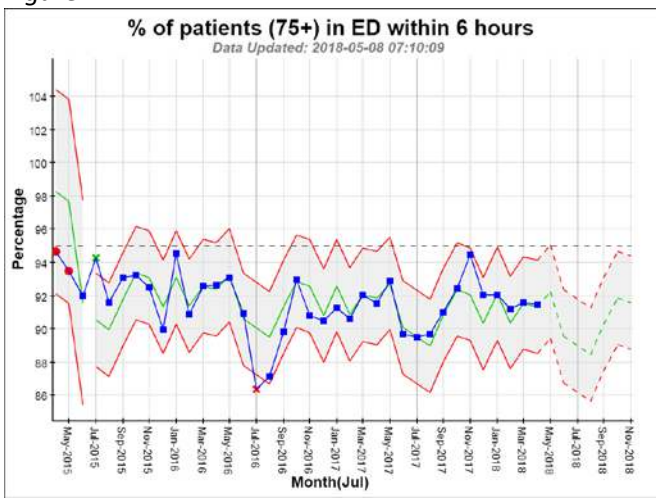
Outcome and Strategy Indicators

Figure 1.1



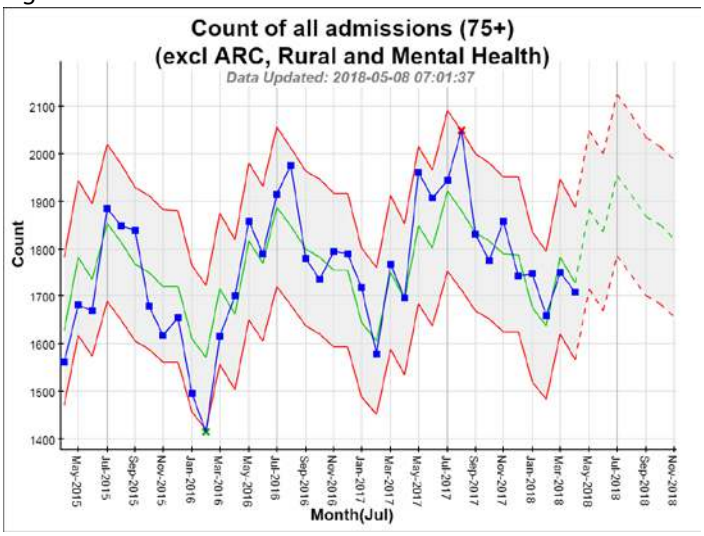
Total attendances of people over 75 has increased at a higher rate than the established trend. This increase is in line with that seen for the overall population

Figure1.2



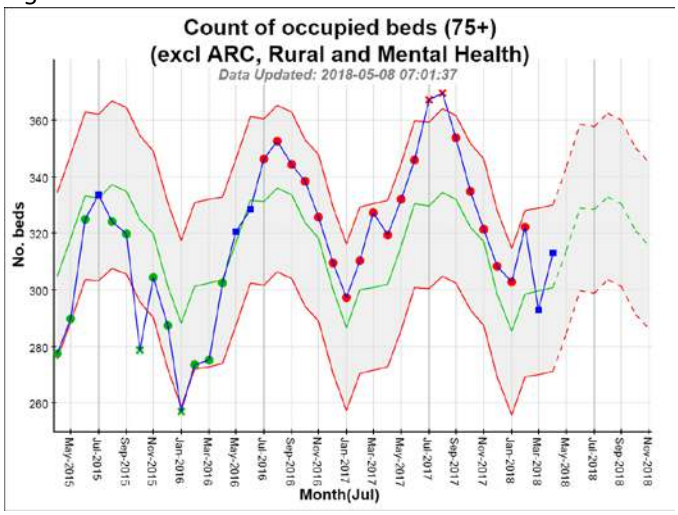
Patients 75+ seen within the 6 hour target is tracking within the expected range.

Figure 1.3



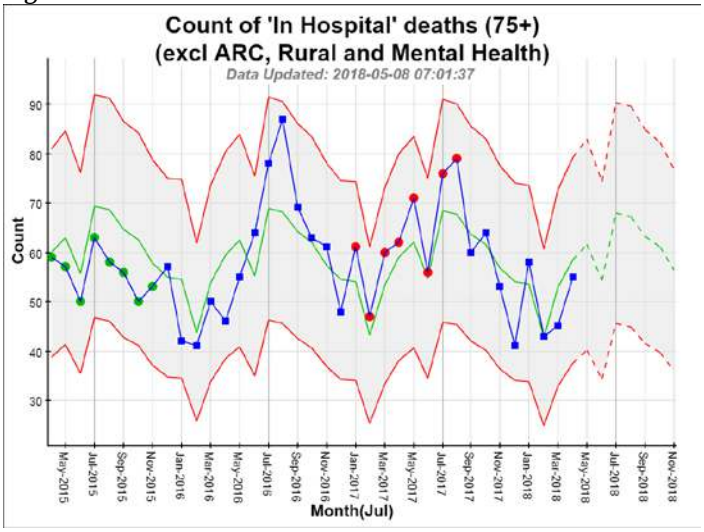
The count of all admissions for people 75 years and over continues to increase consistent with the established trend.

Figure 1.4



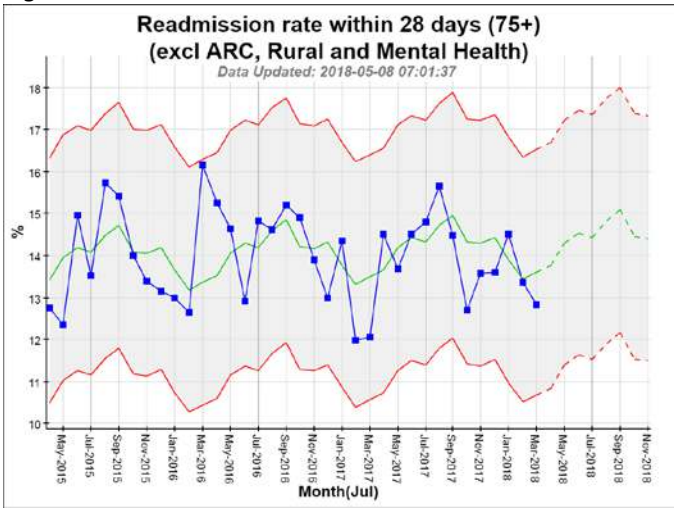
Winter 2017 Older Persons' Health increased the number of beds across the inpatient environment to support flow. Levels return to lower levels outside of this period. During winter 2018 an increase of 20 OPH beds is planned.

Figure 1.5



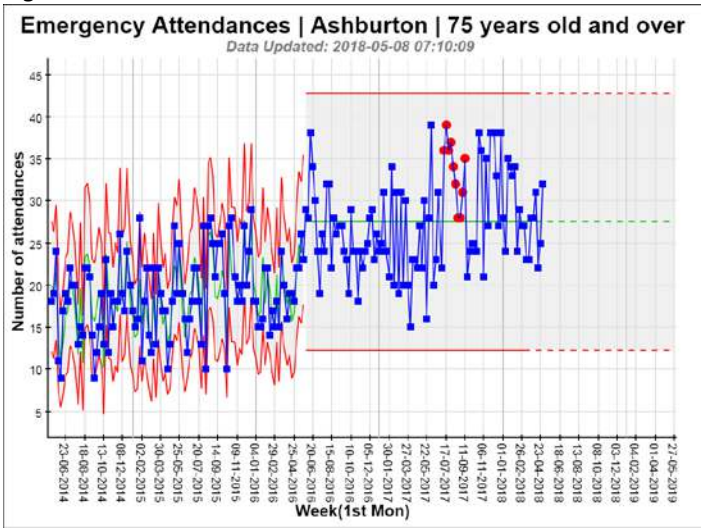
The number of in hospital deaths is within the expected range and continues along the established trend of reducing in hospital mortality.

Figure 1.6



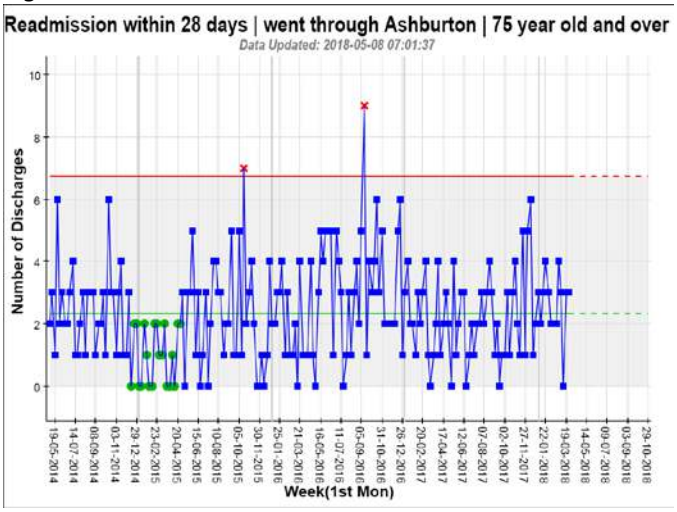
The readmission measure (balancing metric) for people aged 75 years and over continues to be within the expected range.

Figure 1.7



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

Figure 1.8

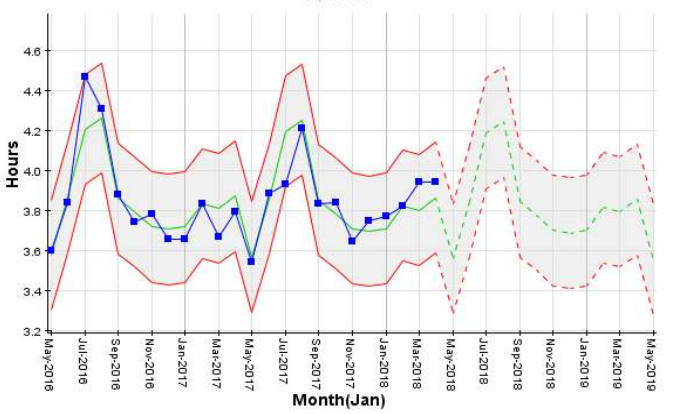
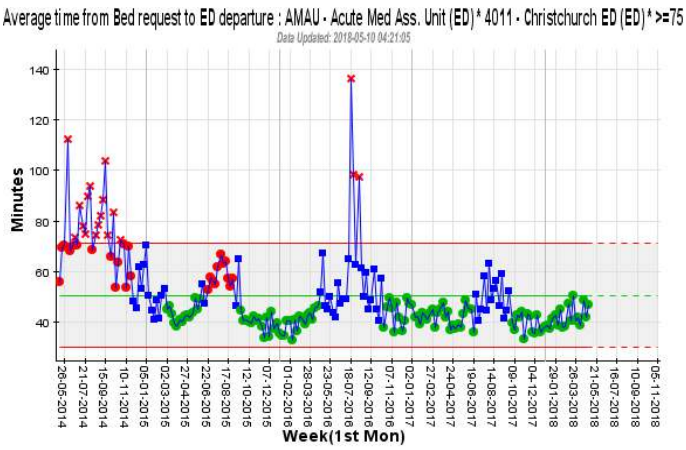


The readmission measure (balancing measure) for people aged 75 years and over continues to be within the expected range with no extreme decrease or increase indicated.

Achievements/Issues of Note

FloView as a tool to improve flow within General Medicine

Flow of acute frail elderly people within our hospitals has been a focus for some time now. There are several pathways into hospital, for many people this involves presentation at the Emergency Department for brief assessment so that they can be placed under the care of the right service. Many older people are admitted under the care of the General Medicine Service and the first step in their stay is usually the Acute Medical Assessment Unit (AMAU). Apart from one month last winter, the average time spent in the Emergency Department by this cohort over the past 18 months has been less than four hours. In order to maintain or shorten the time spent in the Emergency Department once a bed is requested for a patient the bed needs to be allocated and patient "pulled" to the unit in a timely manner. During those 18 months, apart from one week in August 2017, patients have left the Emergency Department in an average of less than 60 minutes following a bed request. In recent months this has sat between 35 and 50 minutes.

Average time spent in ED by people >75 years who are admitted to AMAU	Average time between bed request and leaving ED by people >75 years who are admitted to AMAU
	

Achieving this requires that the Acute Medical Assessment Unit has sufficient capacity to accept patients in a timely way, which in turn relies on timely flow of patients to the inpatient wards. Improving this part of our patient journey has been hampered by a lack of time stamps to monitor and inform fine tuning of the way that we work.

Introduction of the electronic tool called FloView, coupled with the use of an electronic handover document in Health Connect South has enabled us to make changes to the way that transfers from the Acute Medical Assessment Unit are arranged. Patients are transferred to the wards following allocation of a ward bed in FloView and electronic provision of handover information. This means that we no longer need to wait until nurses at both ends of the transfer have time to speak with one another to provide a verbal handover and should shorten the time taken for transfer of patients to the ward. It also ensures the quality of information provided is appropriate and consistent. This system also allows us to measure the time taken to arrange transfers – and use this as one measure of whether changes to the way we work are providing the intended benefits. A number of improvements will be explored over the coming weeks and updates provided as these are put in place.

Improving the care of readmitted inpatients

The use of icons in FloView to identify people who have been discharged and readmitted in the last seven days or four times in the last 12 months was initially demonstrated in General Medicine from approximately September 2017 and has now been rolled out to all specialties.

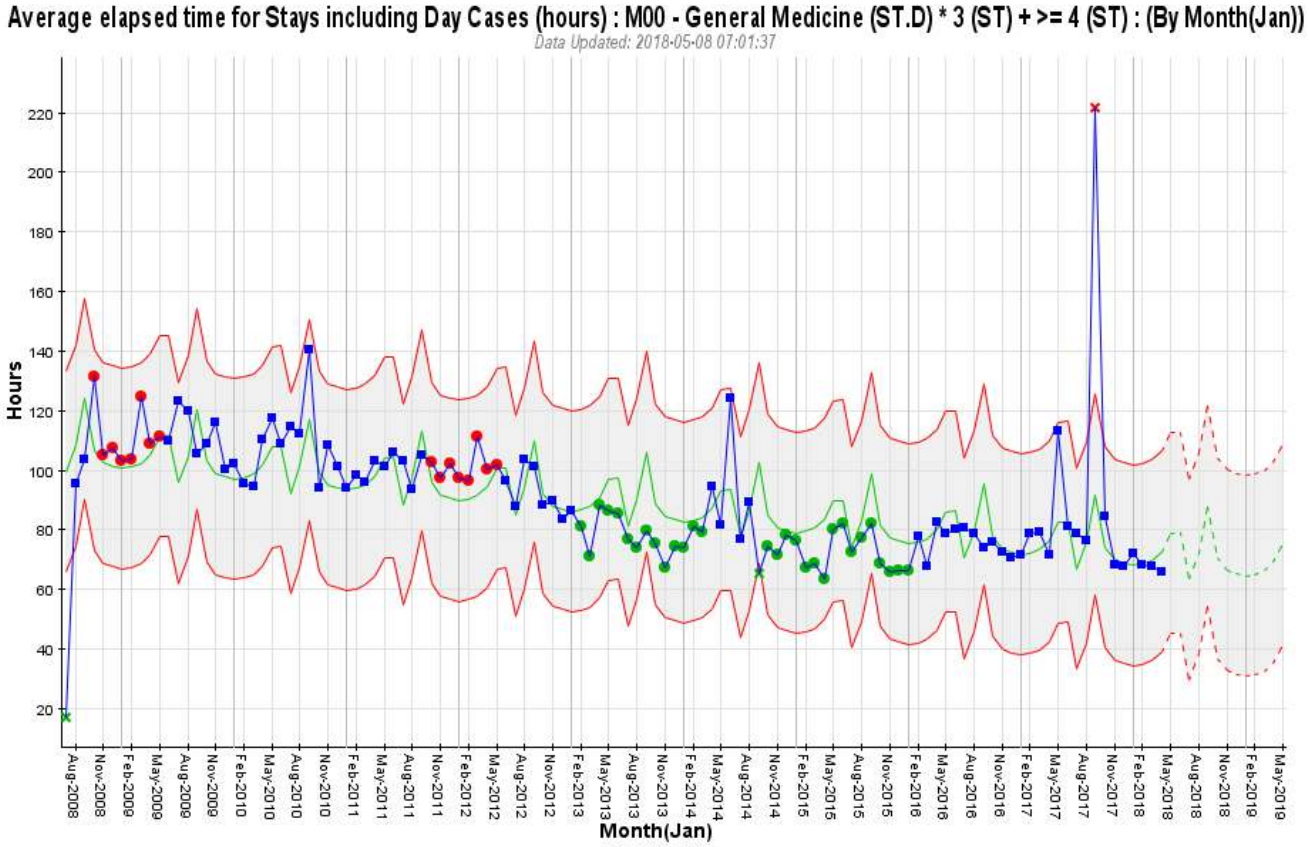
Initially the icons were populated from a central point. However, as engagement with FloView has increased, this function has been naturally picked up by more ward teams - over 50% of wards now populate the readmission icons in FloView without the need for centralised intervention.

Highlighting this information has enabled Nursing and Allied Health teams to avoid some duplication of activity, for example some assessments do not need to be carried out when they have recently been completed during an earlier admission. This reduces the amount of time that people spend in hospital awaiting those assessments. The icons also prompt nursing and allied health teams to take a more robust approach to discharge planning for this cohort of patients and to involve Transfer of Care Nurses and external agencies early in an admission.

Between October 2017 and April 2018, people who have experienced three or more admissions in the past year and were most recently discharged from General Medicine are spending an average of six hours less in hospital than they would have a year earlier. Over the longer term the length of stay is shorter than the corresponding months in any prior year.

The Respiratory service also provides care for a group of people with complex needs whose chronic disease can lead to regular admission to hospital. This change was implemented in Respiratory wards early in 2018. In this group the length of stay is nearly 30 hours shorter than it was in the first four months of 2017. Across these two services this group of patients has spent 838 days less in hospital over the first four months of this year than they would have in 2017, ensuring they returned home more quickly while also freeing up hospital capacity for other patients.

We believe that the heightened vigilance of the need for early preparation of robust pre-discharge planning for patients who have been admitted to hospital several times in the year is a significant contributor to the noted reduction in length of stay.



Improving care for people with stroke
Improved thrombolysis pathway.

In order to provide effective care to people with acute health needs a number of services need to coordinate their activity. This is true in the case of people with stroke. A number of changes across the system over recent years are combining to significantly improve outcomes for people that have a stroke. These include:

- The "FAST" campaign has informed the public of the signs of a stroke and the activity they need to take (Face drooping on one side, Arm weakness on one side, Speech jumbled, slurred or lost, Time to call 111);
- St John provides early indication that an ambulance is about to arrive with a person suspected to have had a stroke. This "stroke call" results in staff meeting the arriving ambulance already knowing the immediate actions they are going to take;
- The patient is assessed on the ambulance trolley by the stroke team and, if deemed suitable for stroke treatment, taken directly for a computed tomography scan on the ambulance trolley. This avoids using vital time to transfer from trolley to bed and allows patient to have direct access to the stroke team without first being seen by the Emergency Department;
- If the scan shows no contraindications for thrombolytic (clot dissolving) drugs, these are given while the patient is still in the radiology suite, rather than waiting until the patient is transferred to a ward;
- Computed tomography scanning has improved over recent years with perfusion scanning techniques providing clear information about the likely benefit of thrombolytic or thrombectomy (clot retrieval) therapy;
- Christchurch Hospital was the only New Zealand centre involved in a recent acute stroke trial comparing effectiveness of a new thrombolytic drug to standard drug in patients with large clot going for clot retrieval. This demonstrated improved efficacy in the new drug, dissolving large clots before clot retrieval treatment. This study has recently been published in the New England Journal of Medicine.

- Christchurch Hospital is the lead New Zealand site in the second part of the study which is assessing the optimal drug dose to use in patients with ischaemic stroke from a large blood clot.

Any change that reduces the time between a patient having a stroke and therapy being provided improves their outcomes as every minute without an effective blood supply results in more brain tissue dying. The success of thrombolysis treatment in acute ischaemic stroke relies heavily on time to treatment. Each minute delay in treatment results in nearly 2 disability free days lost.

These changes, combined, have led to a number of improved measures:

- 67 patients were provided with thrombolytic therapy in Christchurch Hospital during 2017. The treatment rate is increasing and in first quarter of 2018 we have already treated 22 patients with thrombolysis;
- Having a rapid "door to needle time" (time from the patient arriving at hospital until thrombolytic treatment is given) translates into improvements in patient outcome. Door to needle time, has reduced from a median of 87 minutes to 33 minutes. The proportion of people treated within a target of 60 minutes has improved from 12% to 79%. This compares with a national average of 36% in 2016. Our record for door to needle time so far has been nine minutes.

Provision of a helicopter pad on the Christchurch campus will further improve outcomes for people being transported long distances to Christchurch Hospital following a stroke.

Clot retrieval service for people with stroke

Alongside these changes a clot retrieval service has been developed at Christchurch Hospital. This service involves using endovascular techniques to physically remove clots from blood vessels within a patient's brain when scanning indicates that this is expected to be viable and provide benefit. Christchurch Hospital is the only hospital in the South Island that has the capacity to provide this service. This service is currently limited to patients from the Canterbury district.

Clot retrieval has dramatically changed the outlook for stroke patients with a large clot. Without clot retrieval there is an 80-90% risk of death or disability. With clot retrieval treatment around 50% of treated patients are independent at 3 months. Some patients have been able to return home the next day, avoiding an extensive stay in the acute hospital and the requirement for ongoing rehabilitation or a lifetime of disability. This results in people being able to return home with a much better chance of living independently, continuing to contribute to society in the same way they previously did and not needing intensive social and health system support;

Improvement in scanning techniques means that patients who have awoken with stroke symptoms, i.e. where the time of the stroke is uncertain, and patients who have required transport over a long distance can now be considered for clot retrieval therapy. This is because time from stroke till therapy was previously the best indicator of ability to benefit from therapy, whereas new scanning techniques now provide much clearer guidance

Thorough application of selection criteria means that of the 32 people from the Canterbury district received clot retrieval therapy at Christchurch Hospital during 2017 close to 50% achieved a very positive outcome. It is expected that the number of people receiving this treatment will increase to between 50 and 60 in 2018.

Stroke nurses providing care to improve life for all of those hospitalised following a stroke

While the most arresting improvements in outcome are available to patients for whom thrombolysis or clot retrieval are beneficial there is a much larger cohort of patients that benefit from care by the team of stroke nurses that work in Christchurch Hospital.

A team of 11 nurses provides specialist nursing input into the care of all patients admitted to the hospital following a stroke. Members of this team attend stroke calls between 08:00 and 22:30, seven days a week. They ensure that an appropriate and consistent service is provided to patients after a stroke no matter when they come to hospital. Many of the 1,882 patients that they cared for during 2017 were not nursed in the stroke unit with most going home directly from the emergency department, the Acute Medical Assessment Unit or a ward.

Members of the team work with patients, providing testing and education to ensure that patients can return home safely and with the right level of support. Benefits include keeping patients safe from driving when they should not,

avoidance of aspiration pneumonia with resulting lengthy hospital stays due to complications and ensuring that patients are set on the right path for rehabilitation at home by the community stroke rehabilitation team.

Older Patients Benefit from the Clinical Nurse Specialist Role

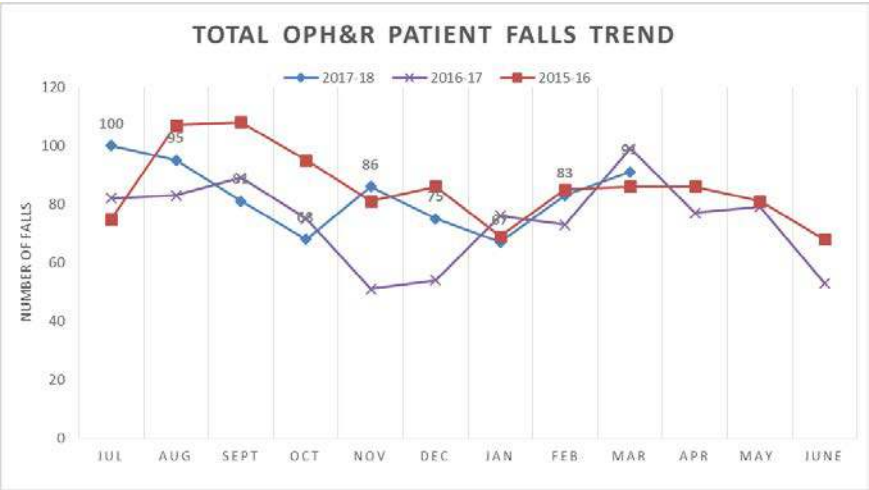
The Clinical Nurse Specialist (CNS) role has provided significant benefits for the health system, and most importantly benefits to the older patients and their families. Since the beginning of August 2017 the CNS has received 1092 referrals. As this is a dedicated role, the CNS liaises with patients and their families ensuring the patient voice is heard. The position means that patients are given a clear understanding of what is the most appropriate discharge or transfer options for them, and help come to a decision about what is right for them. A key function of the role is to provide clinical leadership for rehabilitation nursing practice and act as a mentor and resource person for assessment, treatment and rehabilitation of the older person in the acute environment of Christchurch Hospital. If the patient requires transfer to Burwood Hospital then the CNS is proactive about providing patients with information about transferring to Burwood. The CNS is able to appropriately prioritise patients with highest clinical need for transfer. Patients are more often coming to Burwood ready to rehab.

The role also enables more of a clinical perspective and overview once patients are on the waitlist. The CNS will pro-actively follow up patients on the list, making sure that transfer is still the best option - on occasion she has noted improvements and arranged for CREST discharge, or deterioration which means transfer is no longer appropriate.

Senior Medical Officers (SMO) have noted that the CNS role allows them to make better use of their time and clinical skills, for example, to spend time managing a complex family meeting at Burwood, rather than spending that time driving to Christchurch Hospital finding notes/patients/Registered Medical Officers in order to make what is often a relatively straightforward decision. The background work that the CNS does saves a significant amount of SMO time, and many weeks now consults which would have normally spent 4-5 hours being seen by an SMO are able to be managed over the phone with the CNS's assistance.

OPH&R Falls

There were 106 reported falls for the month of April 18, an increase of 15% (14) over March 18. Year to date there have been 853 reported falls, an increase of 12% (94). This increase is spread across all the OPH Inpatient Wards. With increased occupied beds, an increase of falls occurred, however our overall trend has stayed the same. Focus on initiatives for fall reduction is being carried out. Our spike in harm related to falls is known across the ward AG and BG with a complex mix of dementia and Parkinson's which is requiring alternative supports for the ward.



With the increase of the falls, we are approaching how we manage this differently. What is different about this approach, compared to other previous falls prevention?

- Focuses on the "end" goal (Safe Recovery Programme/rehabilitation), not falls
- Focuses on adult educational techniques, not pamphlets or information alone.
- A proven multimedia approach is used

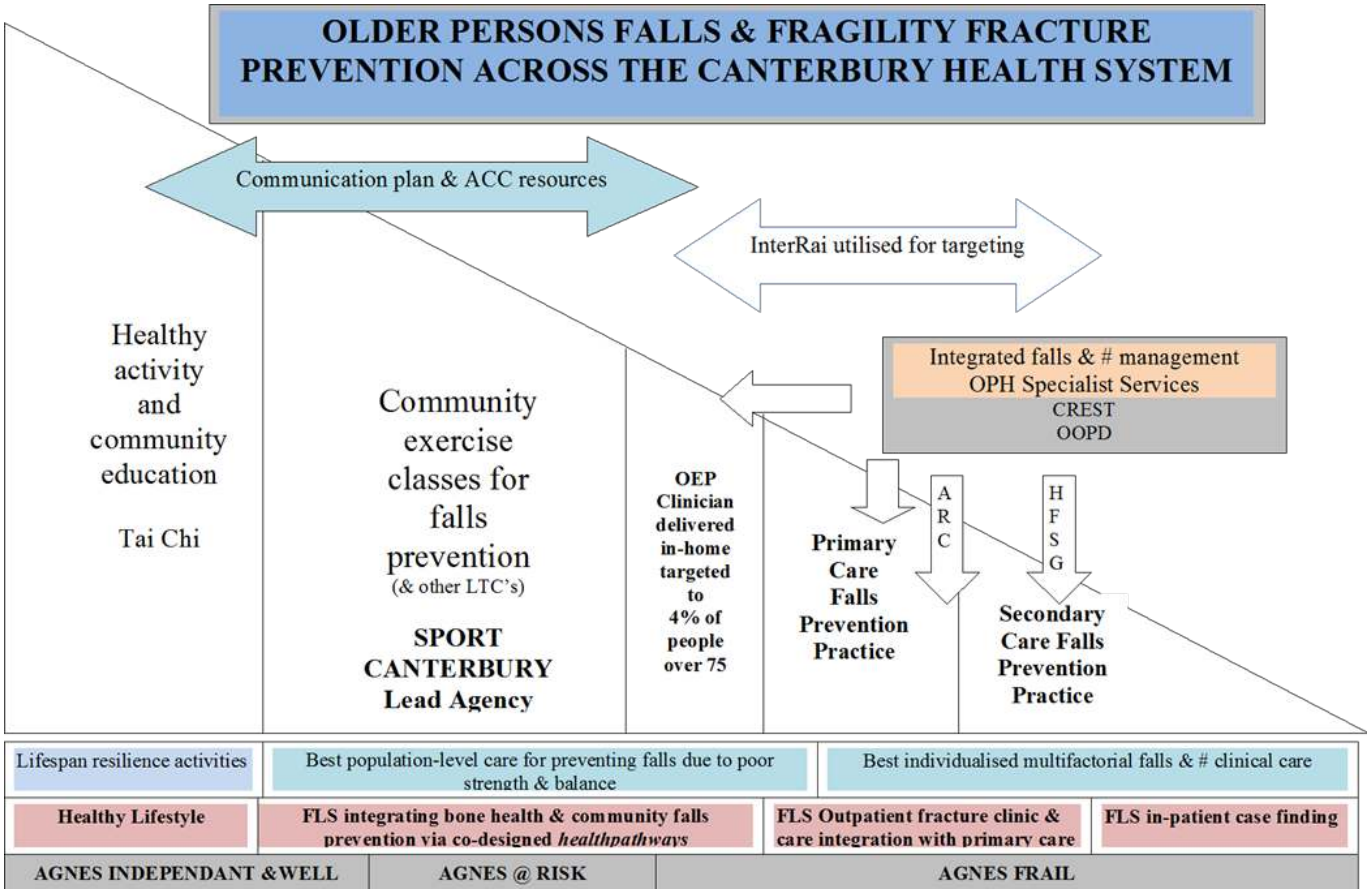
- Personalises the issues for each patient (most grossly underestimate their risks of falling, giving them reasons to change behaviour
- The success of the educators role in changing risk taking behaviour is dependent on reinforcement and support from ward staff

Components of the Safe Recovery Programme, includes:

- The independent (from the ward team) educator undertakes 3 inter-related educational activities educating patients about their:
  1. risk of falling and personalises this risk
  2. motivate them to mitigate this risk and
  3. get them involved in or engaged in their own falls prevention strategies.

  This is a multimedia educational approach, using DVD, patient workbook and 1:1 sessions with the patient.
- Staff training about the interventions and falls prevention, and how they can positively reinforce the messages with patients
- Feedback from patients (fed back via the educator) to staff about perceived barriers. Patients also encouraged to speak up and proactively seek help from staff and encourage staff to carry out the prevention strategies

Their approach differs in that it is an educational programme targeted primarily at cognitively able patients, with components of staff education as well as feedback from patients to staff. The intervention (education) was applicable to approximately 50% of the admissions to their wards. The educators visit each ward 2-3 times per week, spend a median of 2 sessions per patient. It took a median of 45 minutes to educate each patient (IQR 35-55 minutes). The educator assists patient to formulate their own goals.



Restraint Minimisation

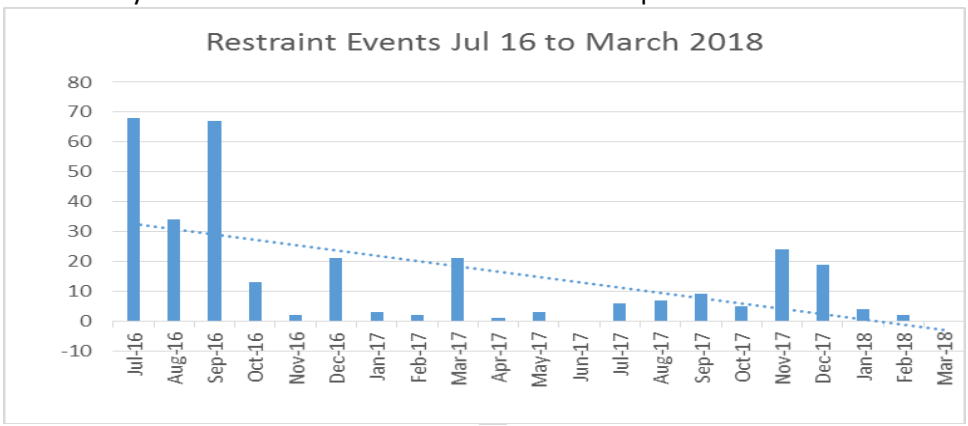
Older Persons Mental Health (OPMH) has actively worked to meet the aims of the Restraint Minimisation and Safe Practice Standards (NZS 8134.2:2008)

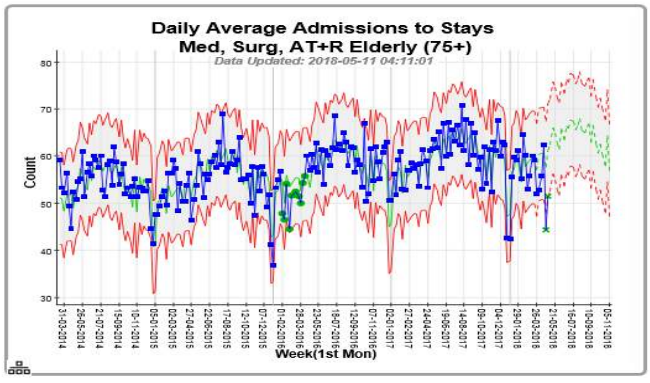
After a certification audit in 2015 the CDHB was given corrective actions regarding restraint and seclusion which have led to changes in practice and a significant reduction in the use of restraint. Specifically

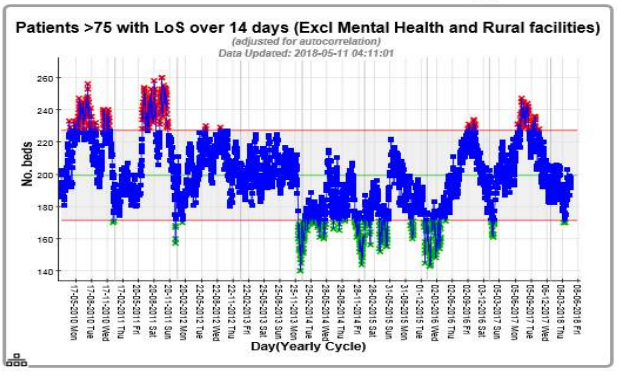
- Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback and current accepted good practice
- If individual plans of care/support identify alternative techniques to restraint and show restraint evaluation
- Whether changes to policy, procedures or guidelines are required and
- Whether there are additional education or training needs or changes required to existing education

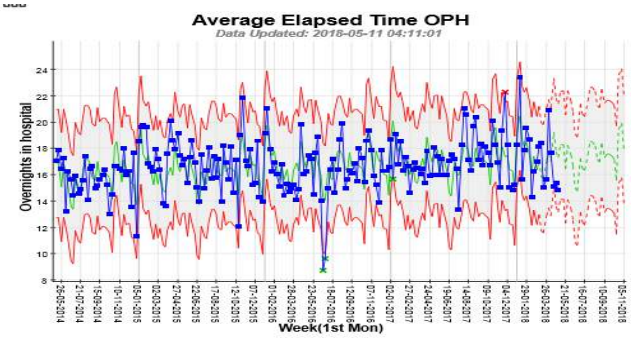
This led to the removal of certain restraint devices such as 5 point chair belts and the introduction in partnership with Specialist Mental Health Service (SMHS) of SPEC Training for all hands on staff to ensure that only safe approved methods of personal restraint were used.

The OPMH wards at Burwood Hospital are less than 2 years old and provide a purpose built, light filled, pleasant and spacious ground floor environment which has had massive benefits for the patient group and ability of staff to respond to challenging behaviour in a more therapeutic manner. While seclusion was never a big feature within the ward environment it has only been used on four occasions and for brief periods since the wards were commissioned.

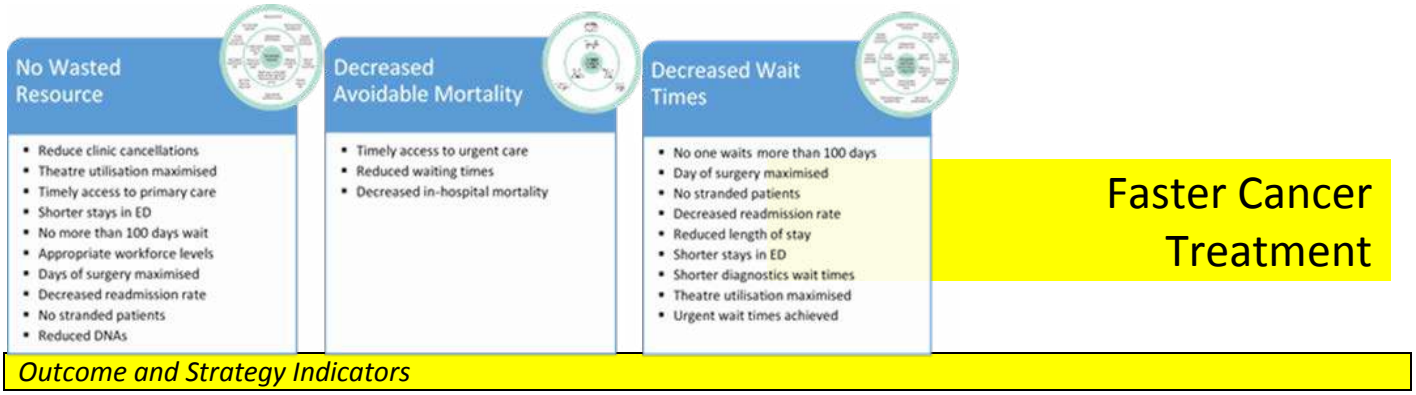








We continue to see small growth of over 75 years of age being admitted to stays, with length of stay over 14 days within the norms. Elapsed time within OPH continues within the norms. The work undertaken in 2017 around a clinical nurse specialist liaison role from OPH within the CHCH Campus has continued to maintain the reduction in overall length of stay within the system. The reduction of 40 hours has been maintained and core to flow across the system.

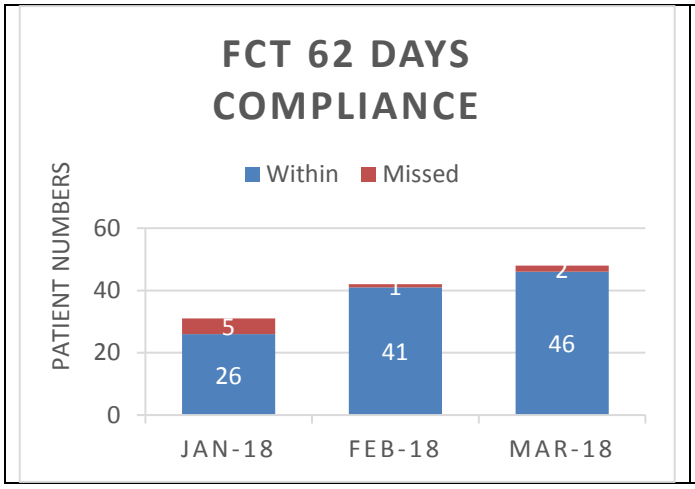


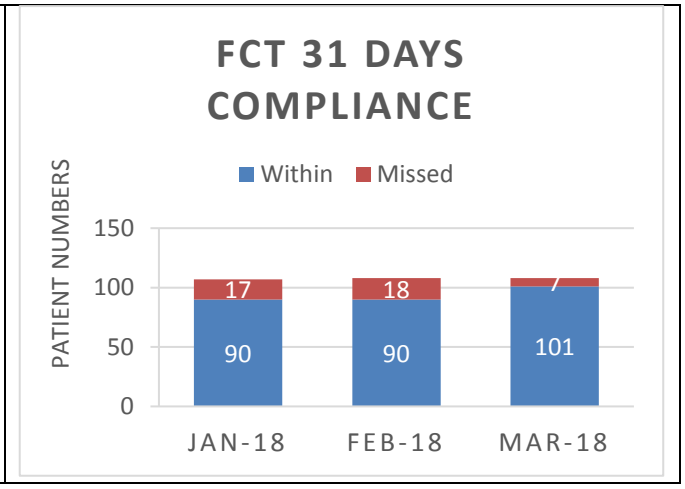
Outcome and Strategy Indicators

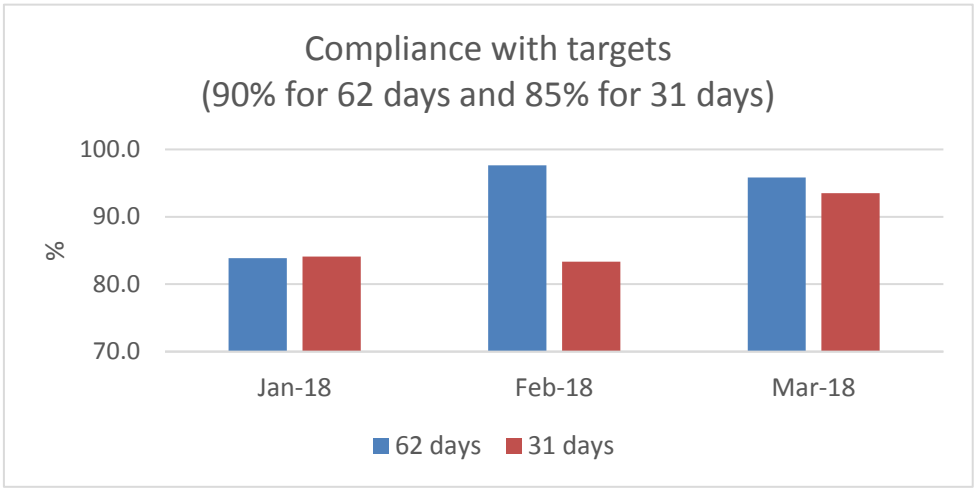
Key Outcomes - Faster Cancer Treatment Targets (FCT)

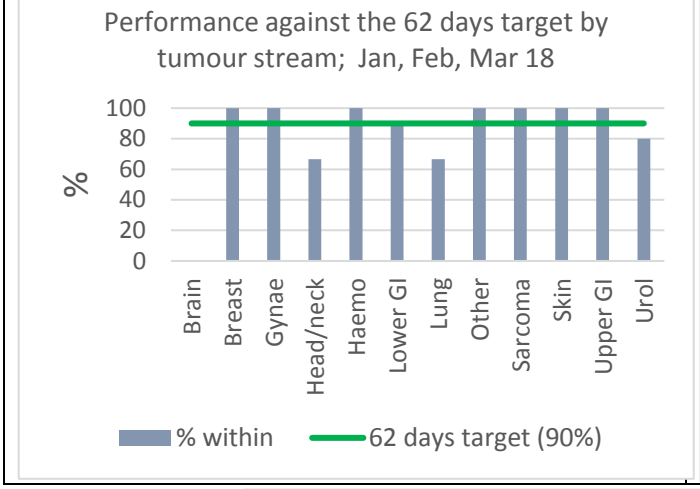
62 Day Target. For the months of January to March 2018 Canterbury District Health Board submitted 140 records to the Ministry of Health (MoH). 121 of these met criteria for inclusion in this measure, of these 8 missed the 62 days target meaning that Canterbury District Health Board once again met the 90% target with an achievement of 93%. A further 19 people were not treated within 62 days due to patient preference or clinical requirements and are excluded from the measure according to the definitions provided by the Ministry of Health.

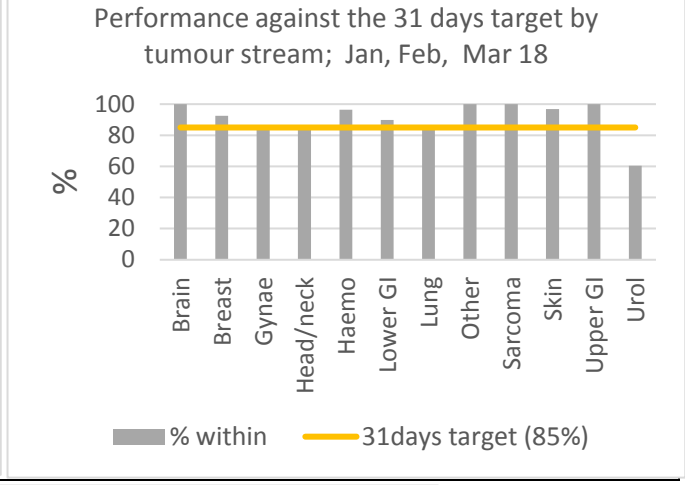
31 Day Performance Measure. Canterbury DHB submitted 323 records in January to March 2018. This figure includes patients also eligible for the 62 days target. In this period 87% of eligible patients met the 31 day measure. Canterbury District Health Board continues to be compliant.

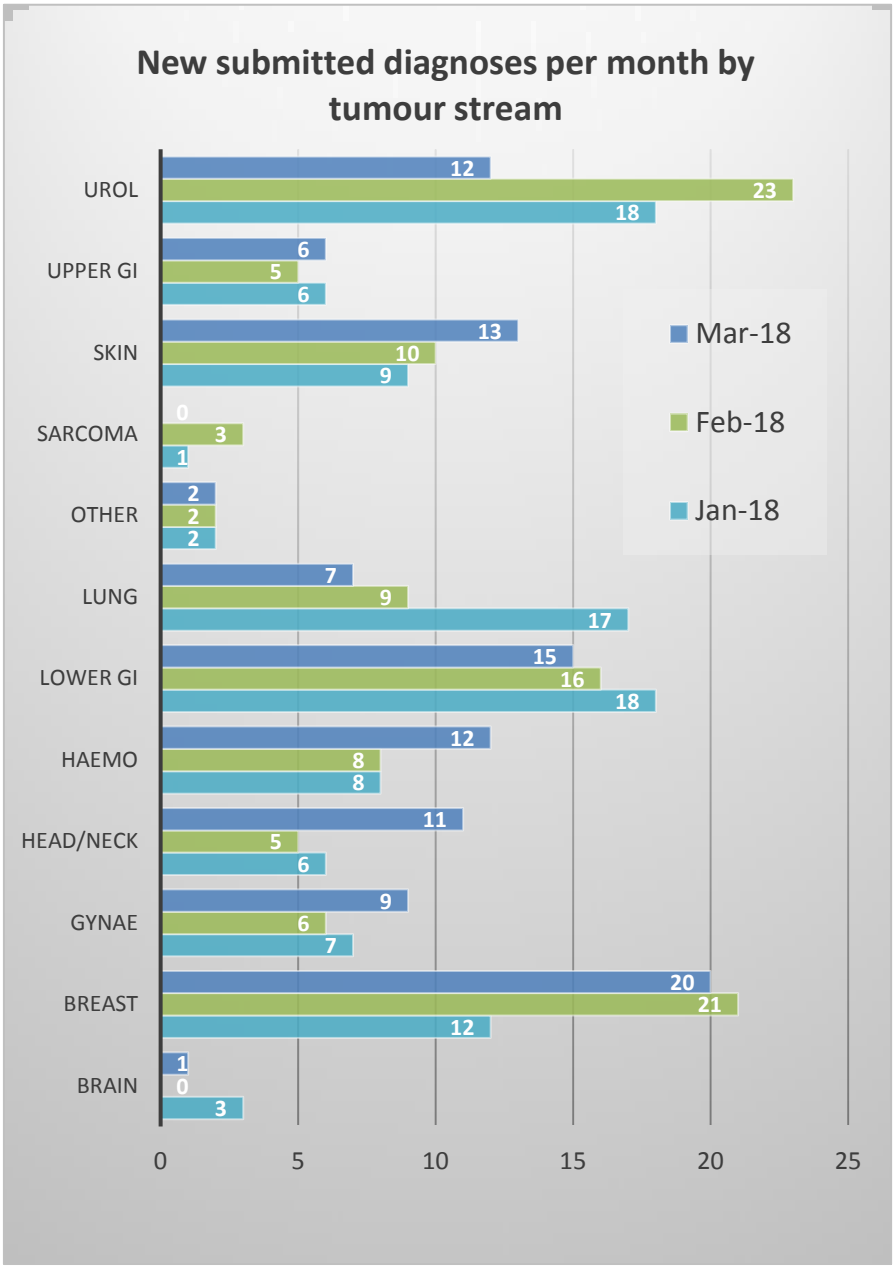







Performance against the 62 days target by tumour stream; Jan, Feb, Mar 18
100
80
60
40
20
0
%
Brain
Breast
Gynae
Head/neck
Haemo
Lower GI
Lung
Other
Sarcoma
Skin
Upper GI
Urol
% within
62 days target (90%)

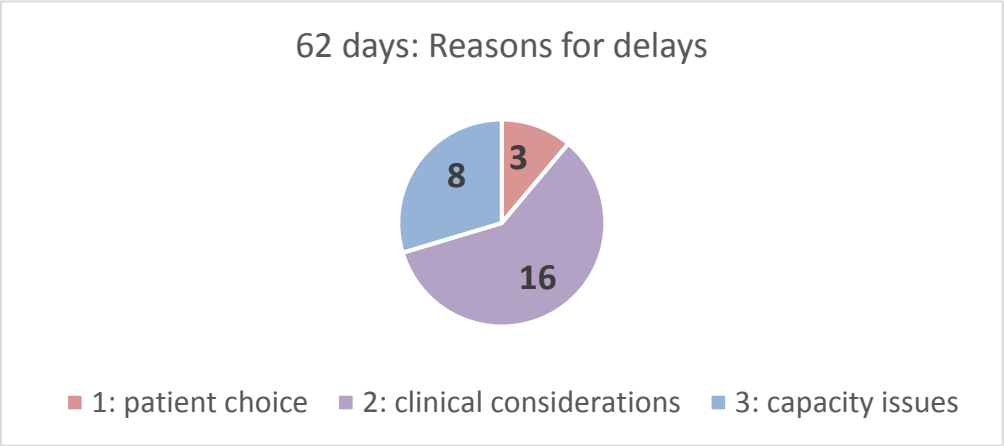

Performance against the 31 days target by tumour stream; Jan, Feb, Mar 18
100
80
60
40
20
0
%
Brain
Breast
Gynae
Head/neck
Haemo
Lower GI
Lung
Other
Sarcoma
Skin
Upper GI
Urol
% within
31days target (85%)


New submitted diagnoses per month by tumour stream
UROL
12
23
18
UPPER GI
6
5
6
SKIN
13
10
9
SARCOMA
0
3
1
OTHER
2
2
2
LUNG
7
9
17
LOWER GI
15
16
18
HAEMO
12
8
8
HEAD/NECK
11
5
6
GYNAE
9
6
7
BREAST
20
21
12
BRAIN
1
0
3
Mar-18
Feb-18
Jan-18
0
5
10
15
20
25

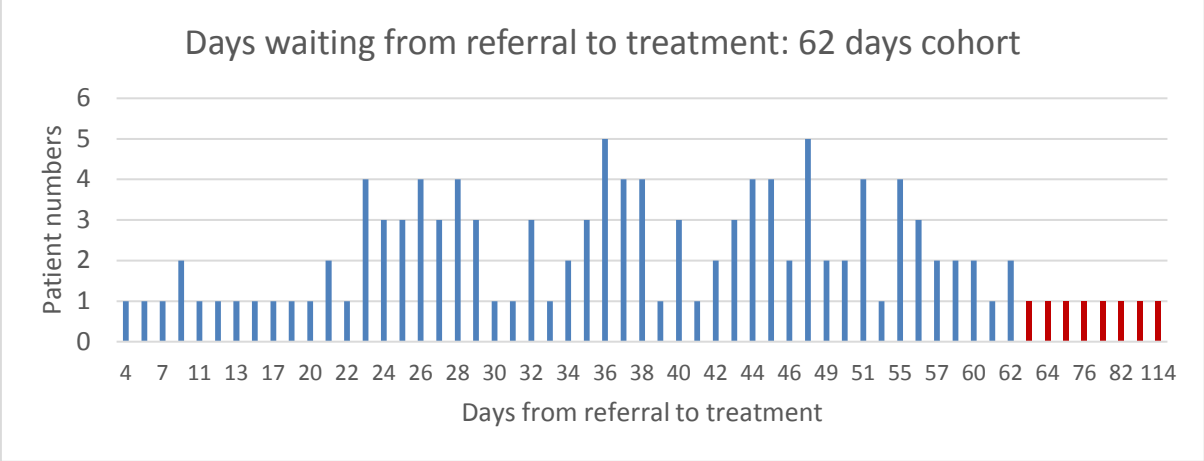
Patients who miss the targets

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

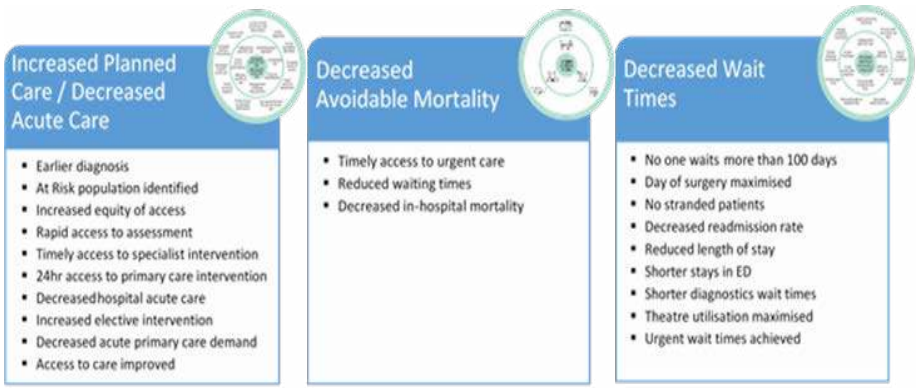
1. Patient choice: e.g. the patient requested treatment to start after a vacation or wanted more time to consider options
2. Clinical considerations: includes delays due to extra tests being required for a definitive diagnosis, or a patient has significant co-morbidities that delays the start of their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



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



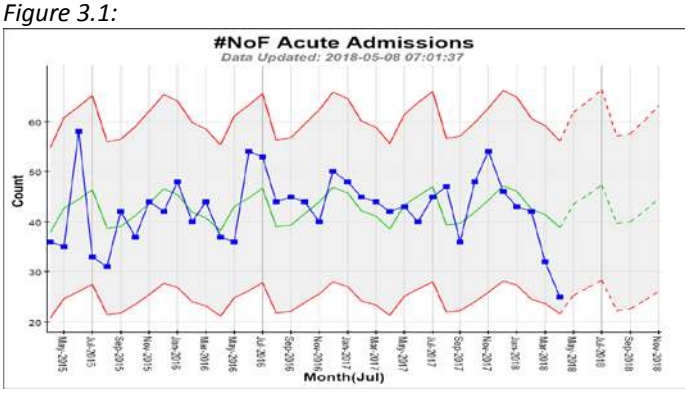
Each patient that does not meet the target is reviewed to see why. This will have happened in order to assign a delay code, but where the delay seems unduly long then a more in-depth check is performed. These cases are usually discussed with the Service Manager to see if any corrective action is required.



Enhanced Recovery After Surgery (ERAS)

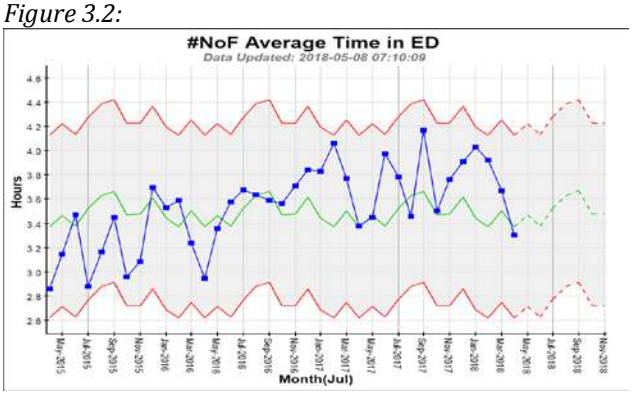
Outcome and Strategy Indicators – Fractured Neck of Femur (#NoF)

Figure 3.1:



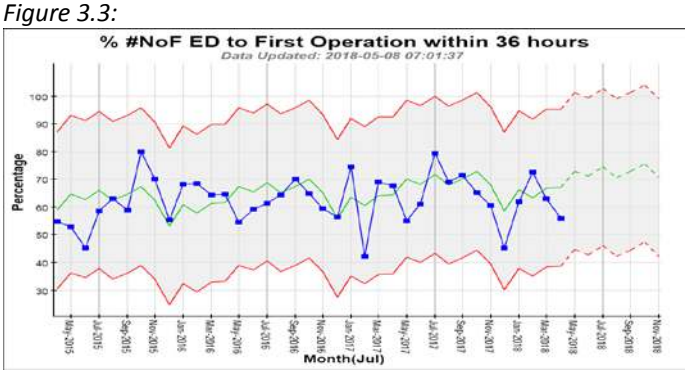
The number of #Nof admissions per month continues at the expected rate. The apparent reduction in the past two months is expected to correct when all discharges are coded.

Figure 3.2:



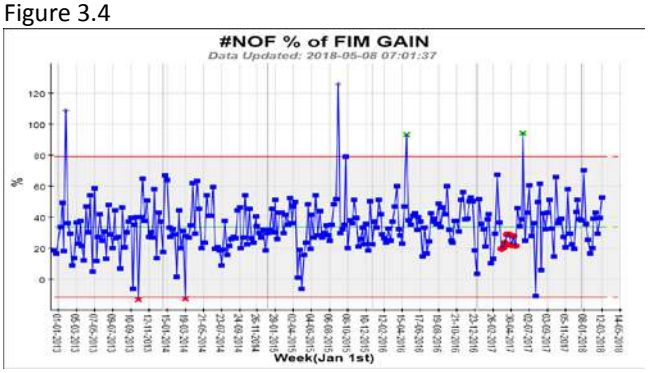
Patients with #NOF show a variable length of stay in ED but within the tolerances.

Figure 3.3:



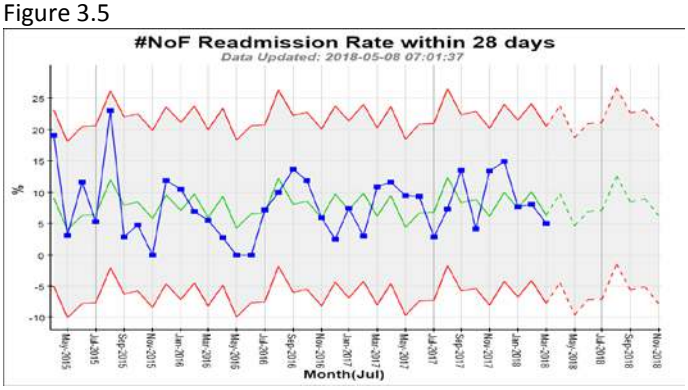
The target is set for patients to be operated on within 36 hours 'when clinically ready'. The proportion of people receiving treatment within this timeframe follows the established trend which indicates an ongoing improvement.

Figure 3.4



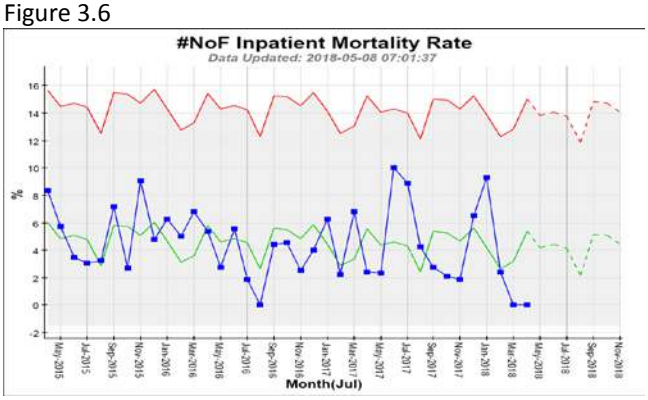
The Functional Independence Measure (FIM) is a basic indicator of severity of disability. The above graph shows the percentage gain for #NOF patients.

Figure 3.5



Readmissions continue to remain within expected mean values.

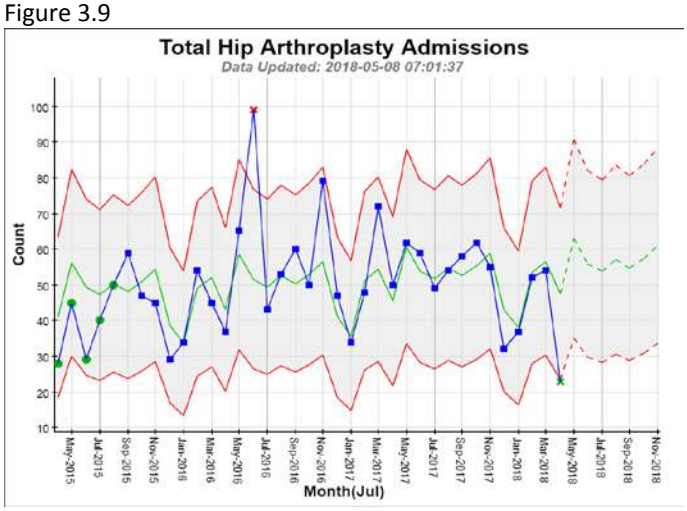
Figure 3.6



The mortality rate remains within the anticipated range.

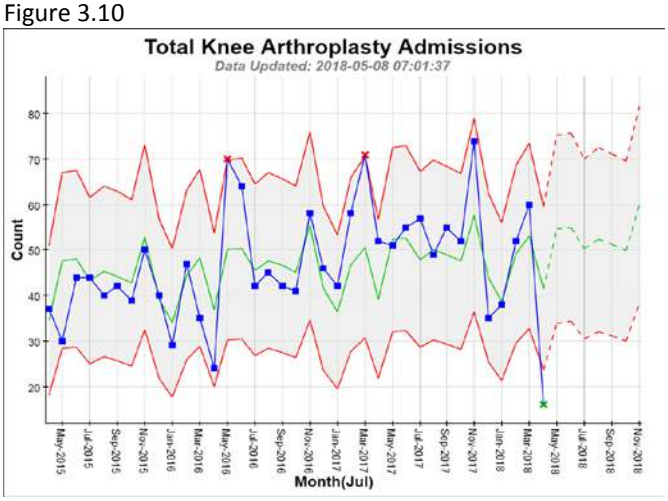
Outcome and Strategy Indicators – Elective Total Hip Replacement(THR) and Knee Replacement(TKR)

Figure 3.9



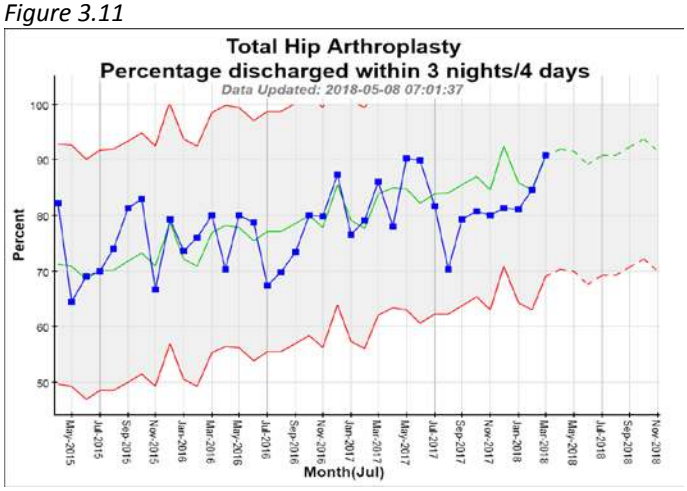
In recent months hip replacements have been tracking within projected levels.

Figure 3.10



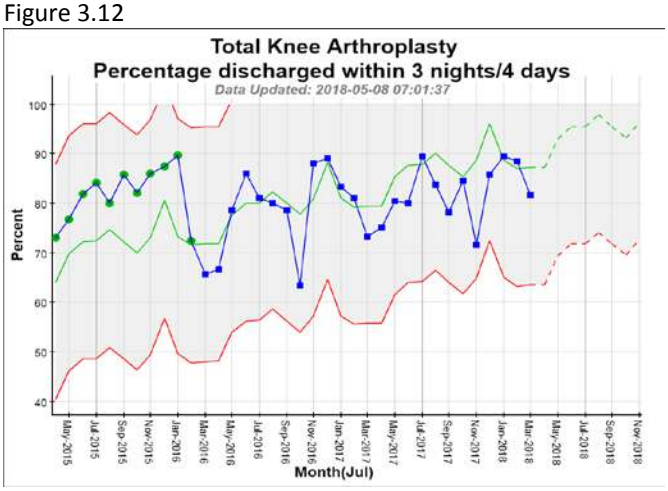
Knee replacement admissions over the previous twelve months have been at or above projected levels.

Figure 3.11



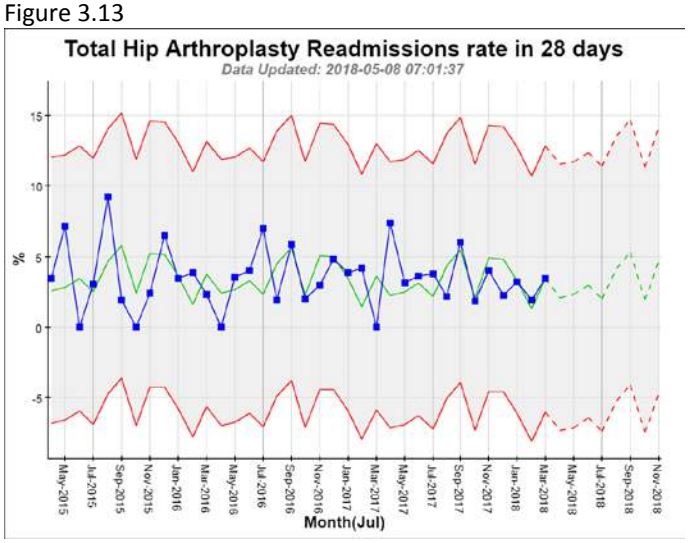
The proportion of patients clinically safe to be discharged within 3 nights/4 days is following established, increasing trend.

Figure 3.12



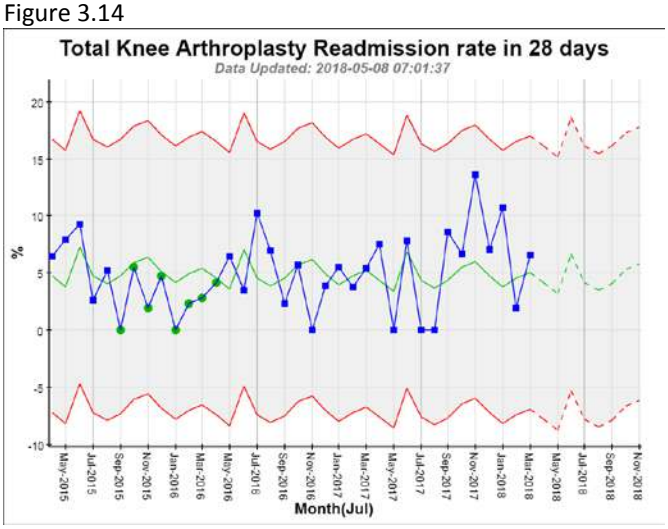
The proportion of patients clinically safe to be discharged within 3 nights/4 days is following established, increasing trend.

Figure 3.13



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

Figure 3.14

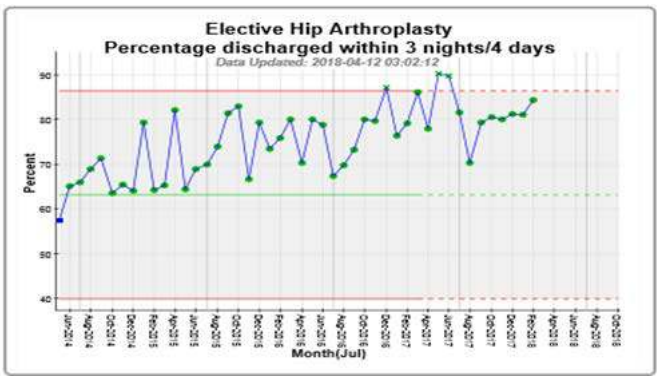


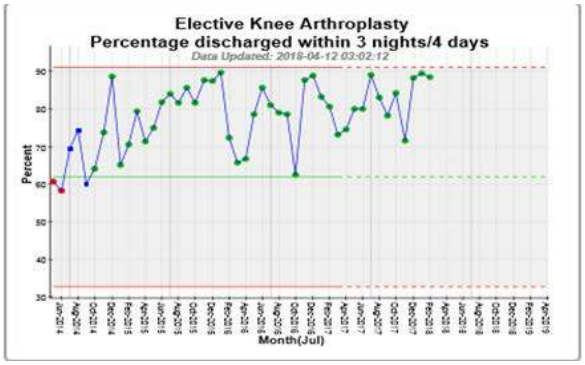
Readmission rates are maintaining within tolerances.

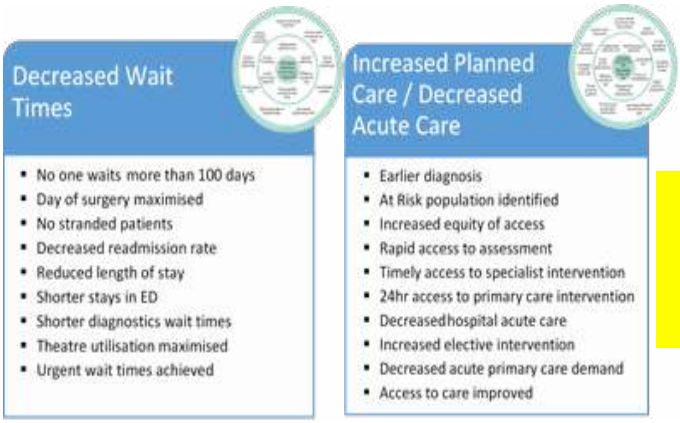
Achievements/Issues of Note

ERAS

Enhanced Recovery After Surgery (ERAS) – Overall trend for both Elective Hips and Knees seeing improvement in the percentage of patients discharged within the target. Still some variation however variation on the positive line of improvement. Review to be undertaken of moving our benchmark within SFN to demonstrate the continued improvement demonstrated.







Elective Surgery Performance Indicators 100 Days

Outcome and Strategy Indicators

Figure 4.1:

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

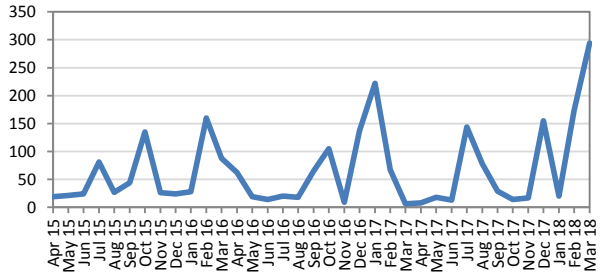


Figure 4.2:

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

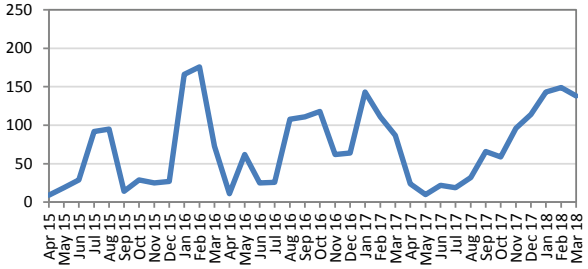


Figure 4.3:

ESPI 2 Result By Specialty – Surgical

Specialty	Number	%	Change
Cardiothoracic	0	0.0%	0
ENT	69	5.4%	14
General Surgery	2	0.3%	-3
Gynaecology	0	0.0%	-3
Neurosurgery	0	0.0%	0
Ophthalmology	48	7.4%	22
Orthopaedics	45	34.9%	32
Paediatric Surgery	0	0.0%	-1
Plastics	12	6.0%	4
Urology	24	3.5%	22
Vascular	27	10.9%	17

ESPI 2 Result By Specialty - Medical

Specialty	Number	%	Change
Cardiology	0	0.0%	0
Dermatology	0	0.0%	0
Diabetes	1	0.9%	0
Endocrinology	2	1.2%	-6
Endoscopy	0	0.0%	0
Gastroenterology	64	12.5%	29
General Medicine	0	0.0%	0
Haematology	0	0.0%	0
Infectious Disease	0	0.0%	0
Neurology	0	0.0%	0
Oncology	0	0.0%	0
Paediatric Medicin	0	0.0%	-1
Pain	0	0.0%	0
Renal	0	0.0%	0
Respiratory	0	0.0%	-8
Rheumatology	0	0.0%	0

Figure 4.4

ESPI 5 Treatment by Specialty

Specialty	Number	%	Change
Cardiothoracic	0	0.0%	0
Dental	0	0.0%	0
ENT	17	3.4%	0
General Surgery	15	3.8%	5
Gynaecology	0	0.0%	0
Neurosurgery	0	0.0%	0
Ophthalmology	4	1.2%	-4
Orthopaedics	80	15.6%	-5
Paediatric Surgery	3	2.9%	-1
Plastics	1	0.2%	0
Urology	14	4.5%	8
Vascular	2	4.9%	-2
Cardiology	2	1.2%	2

ESPI Results

Waiting > 120 Days

	Number	%	Status
ESPI 2 (FSA)	294	3.4%	
ESPI 5 (treatment)	138	3.9%	

Achievements/Issues of Note

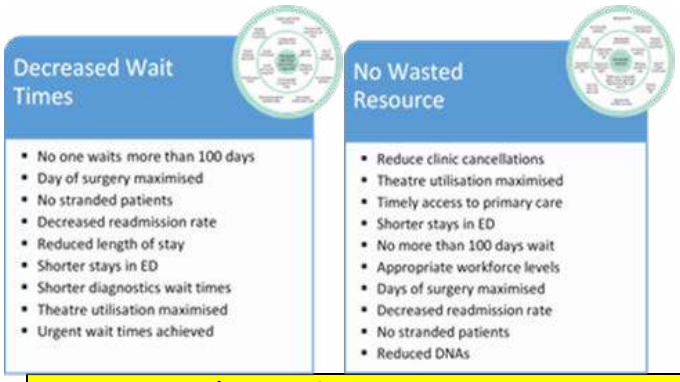
Elective Services Performance Indicator (ESPI) Target Outcomes

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

The same report shows that Canterbury District Health Board achieved a red result for elective services performance indicator five (covering waiting time for surgery) for the seventh month in a row.

Data issues associated with the transition of data between patient management systems is one cause for this ongoing apparent failure to make target. The Ministry of Health has provided Canterbury District Health Board with dispensation from financial penalties for Elective Services Performance Indicator achievement to recognise the pressures associated with facility limitations and issues associated with data transition. These measures will continue to be published and Canterbury District Health Board remains committed to working towards its goal that patients will not wait longer than 100 days for elective services they have been offered.

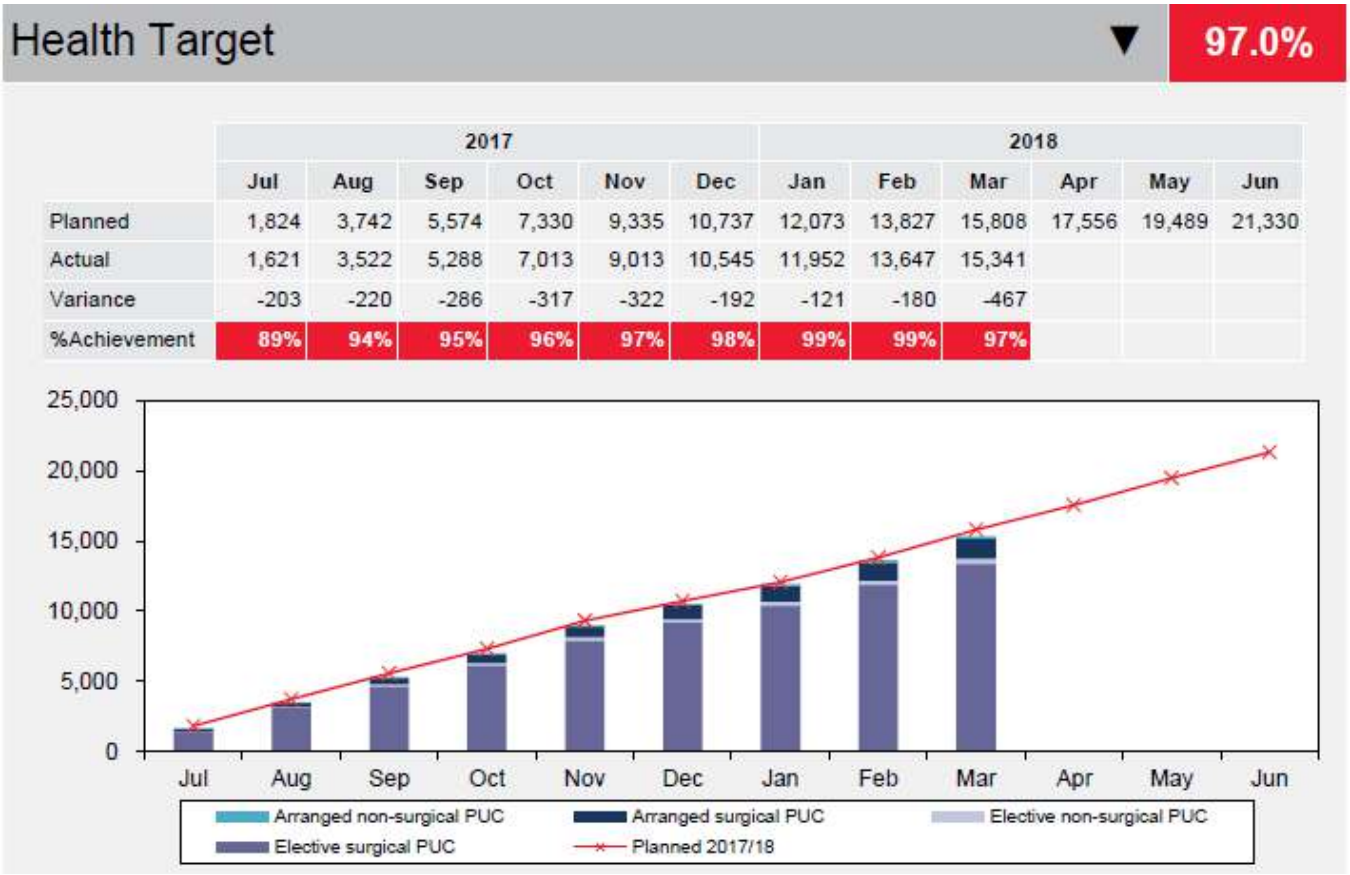
The indicators above (figures 4.1 – 4.4) provide an up to date reflection of the status at the time this report went to print.



Theatre Capacity and Theatre Utilisation

Achievements/Issues of Note

Ministry of Health reporting for 2017/18 showed that following March 2018 CDHB was running behind the Elective Health Target.



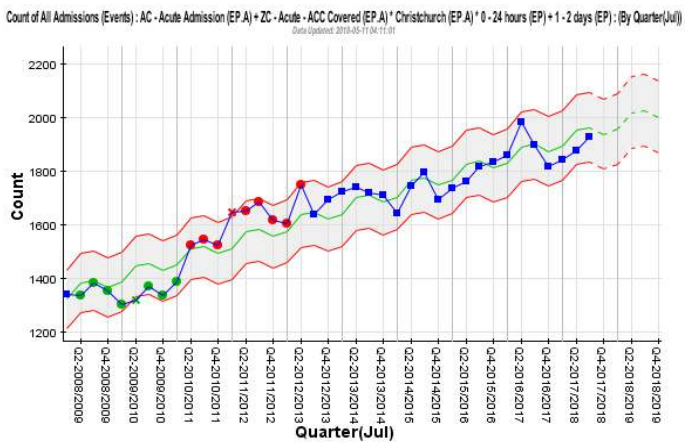
Internal reporting shows a total deficit of 300 discharges against planned volumes. In house delivery is sitting above planned levels and outsourced discharges are running around 420 shy of target. We are confident that this will be corrected prior to the end of June 2018 meaning that Canterbury District Health Board is on track to achieve the overall Elective Health Target volumes. Note however that there is a mismatch between target and delivery in the various sub-categories (i.e. arranged versus elective and between specialties). For example 214 more arranged discharges have occurred than planned, this represents good practice, as it ensures that patients receive surgery soon after an acute event, without having to be waitlisted. Canterbury District Health Board is working through these mismatches with the Ministry of Health.

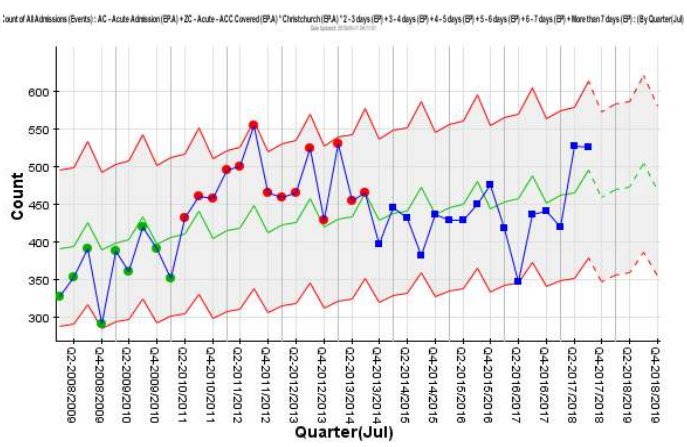
Increase in Outplacing in order to enable more timely acute surgery

Striking the right balance in allocation of theatre capacity between acute and elective duties and ensuring that capacity is provided to the right services requires ongoing attention from the Theatre Utilisation Workgroup.

Over the past year it has been evident that acute theatre capacity was under increasing pressure. One indicator that provides evidence of this is that the number of people who have been admitted acutely to hospital who have waited less than two days for their first operation has been similar to the previous year whereas those waiting longer than that has increased over the past six months.

Acute admissions – waiting <2 days for first operation	Acute admissions waiting ≥2 days for first operation



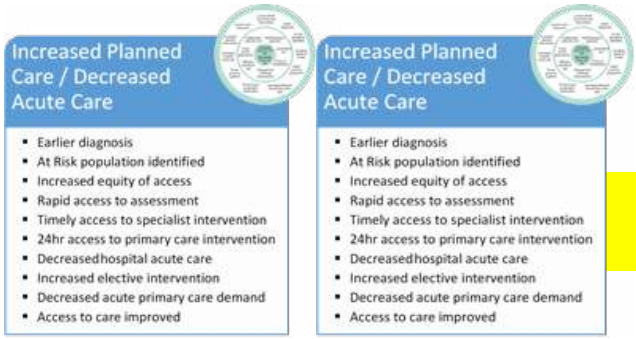


In response to this The Chief of Surgery and Service Manager for Anaesthesia have been working with surgical services to identify further surgical work that can be carried out on an outplaced basis – i.e. Canterbury District Health Board Surgeons and Anaesthetists operating at St Georges Hospital, Southern Cross Hospital or Christchurch Eye Surgery allowing additional theatre capacity for acute surgery.

Our initial goal has been to identify six additional half day sessions each week that can be added to the acute allocation. So far we have identified an additional four half day sessions.

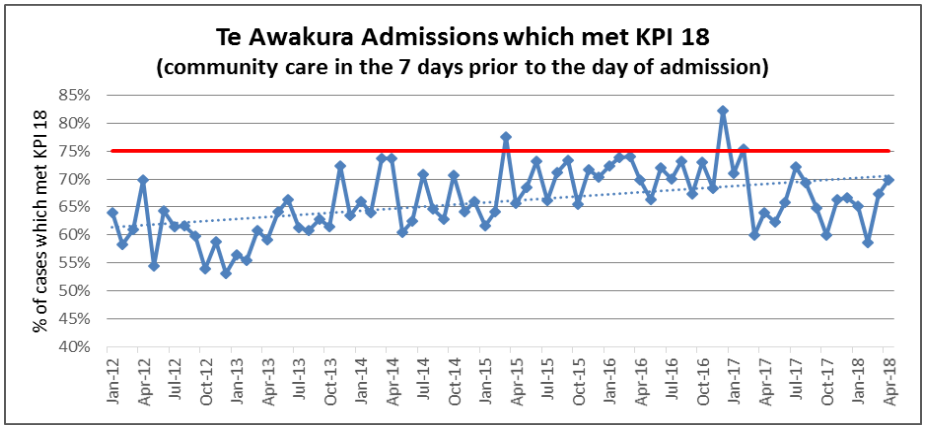
This will provide some additional capacity throughout the remainder of 2018 and will help bridge the gap until significant new acute capacity is brought on line with the opening of the Acute Services Building.

The Theatre Utilisation Workgroup will continue to monitor requirements for theatres and make changes to optimise access.

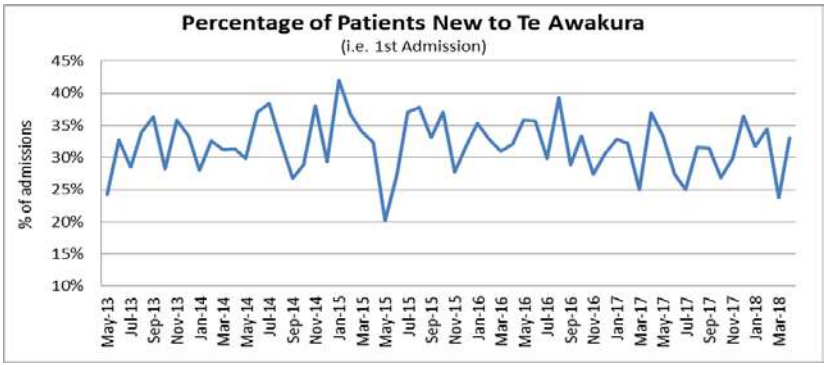


Mental Health Services

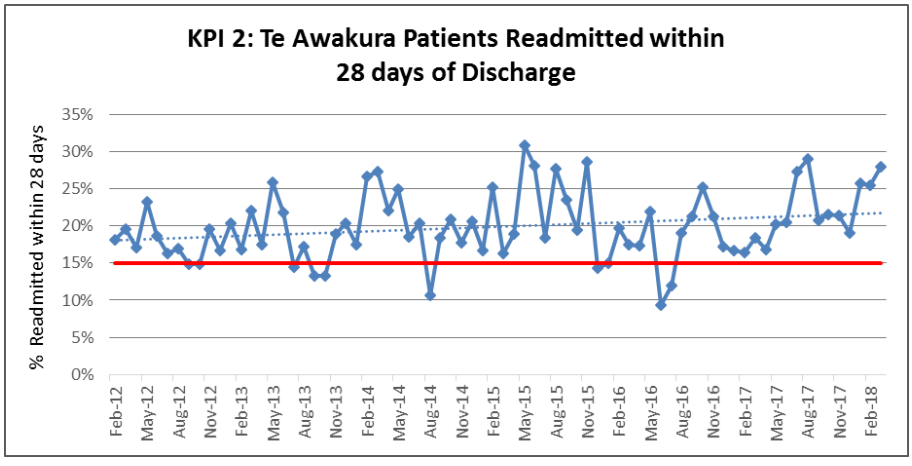
Adult Services



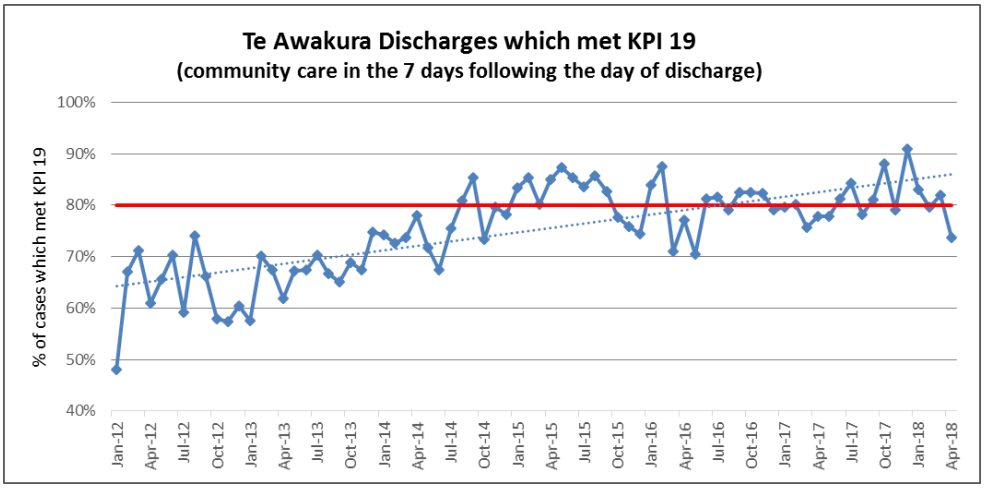
KPI 18 is an indicator of how well engaged we are with the consumers in our services. In March 2018, 67.4% of acute admissions to Te Awakura had a community contact in the seven days prior to the date of their admission. In April 2018 the figure was 69.9%



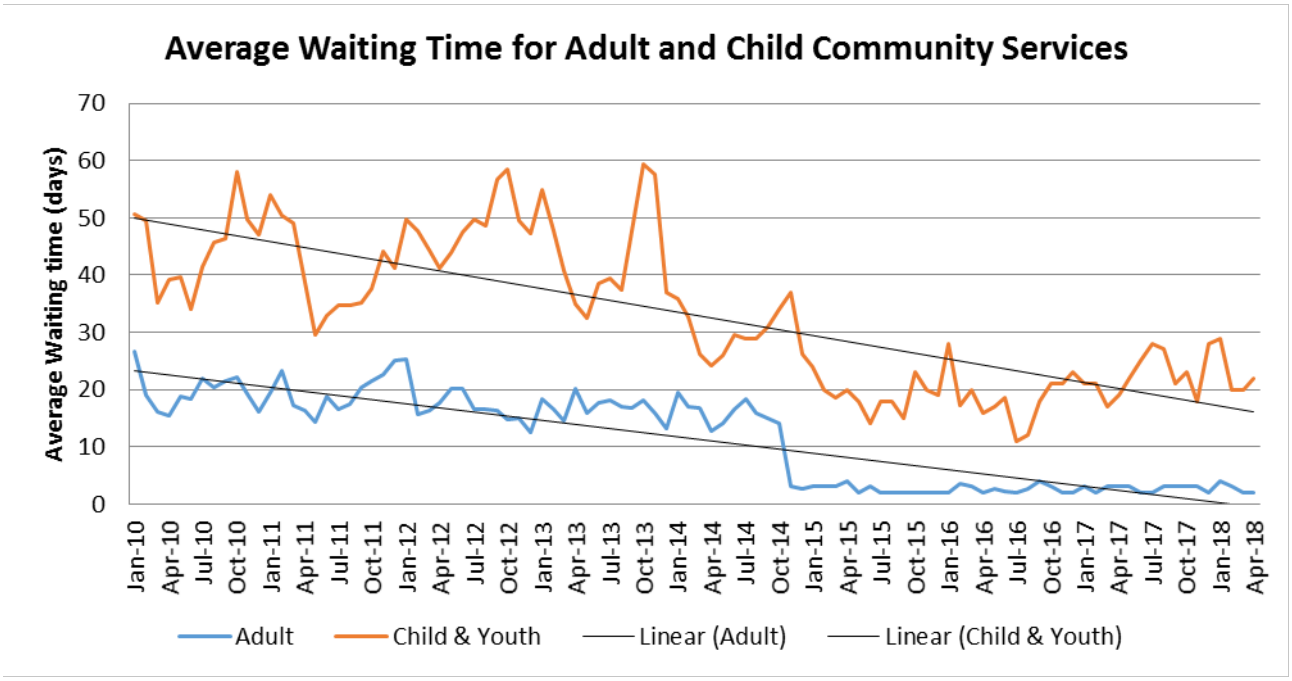
In April 2018, 33% of people admitted to Te Awakura were new (had not been admitted there previously).



The graph above shows the readmission rate within 28 days of discharge. Of the 111 Te Awakura consumers discharged in March 2018, 27.9% were readmitted within 28 days. Readmission rates are closely monitored.

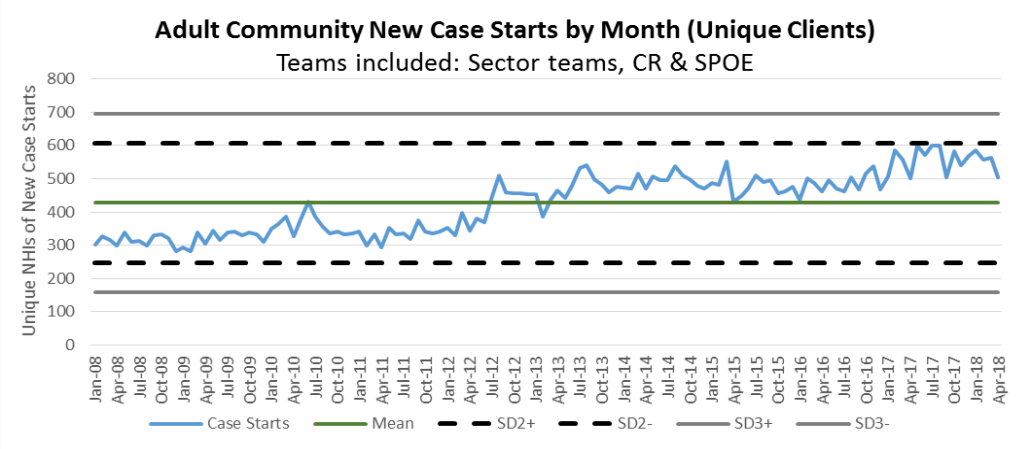


KPI 19 is a key suicide prevention activity and patient safety measure. In April 2018, 73.6% of consumers discharged from Te Awakura received a community care follow-up within seven days of discharge. We are investigating the reasons for this decline in followup.

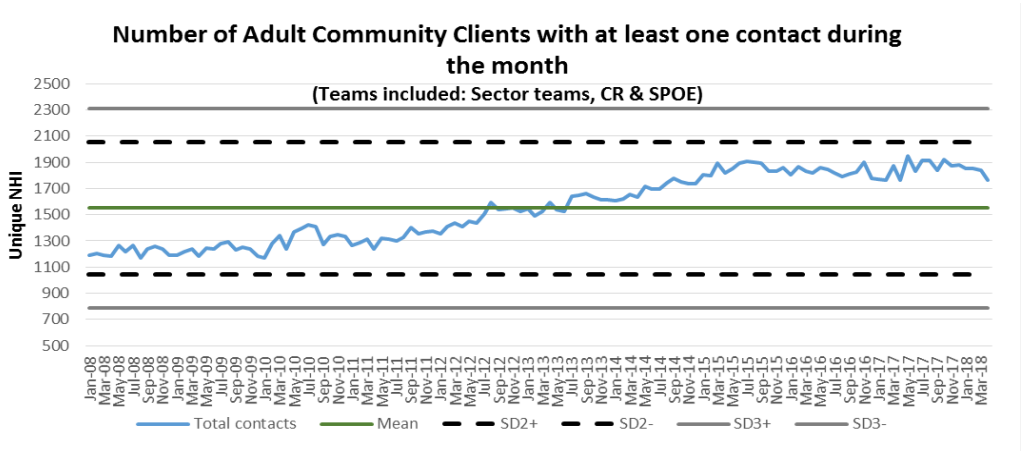


The graph above shows there has been an overall reduction in the time people spend waiting. Ministry of Health targets for these services require 80% of people to be seen within 21 days and 95% of people to be seen within 56 days. The average waiting time for adults was 2 days for April 2018. Our results for the Adult General Mental Health Service show 96.2% of people were seen within 21 days of referral in April 2018 and 99.7% were seen within 56 days of referral. This result is occurring in the context of significant increase in demand.

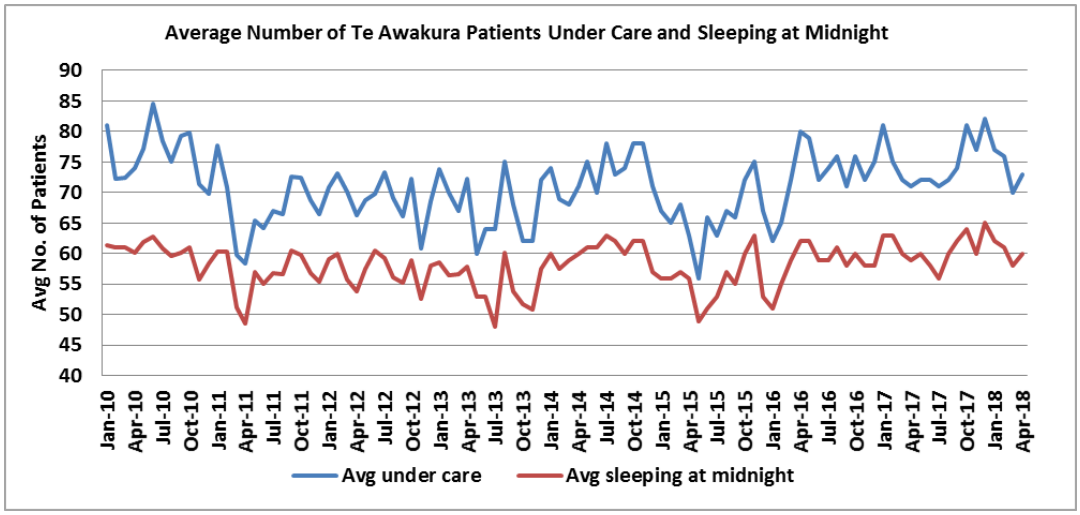
For child and family services the average waiting time was 22 days for April 2018. Reducing wait times has been a key focus for CAF services. Our results show 62.2% of people were seen within 21 days of referral in April 2018 and 91.0% were seen within 56 days of referral.



New cases were created for 505 individual adults (unique NHIs) in April 2018.



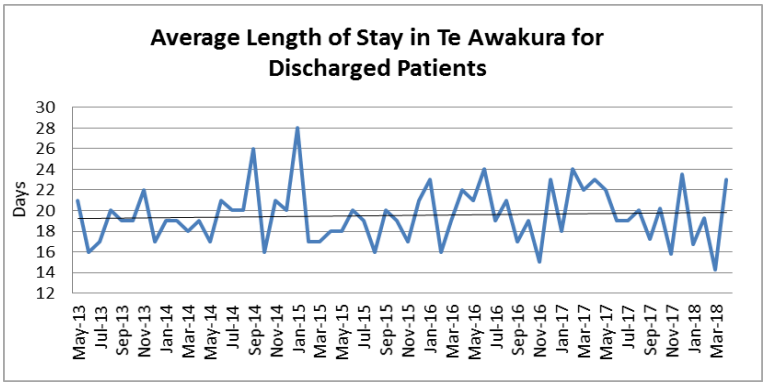
In April 2018 there was at least one contact recorded for 1763 unique adult community mental health consumers.



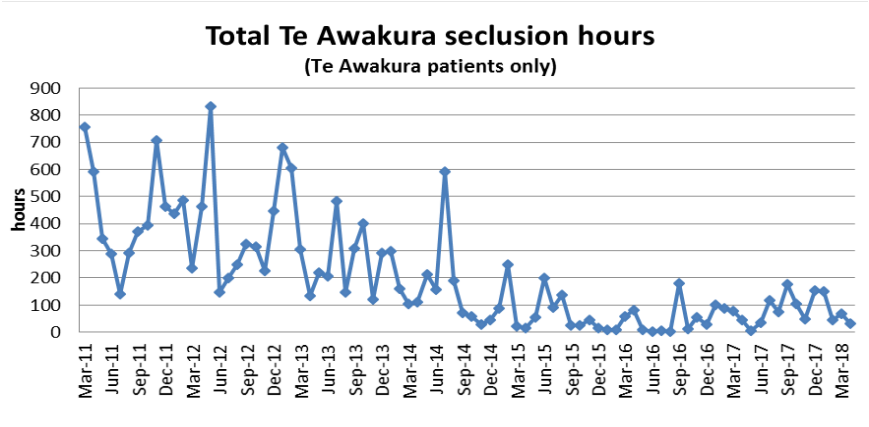
85% occupancy is optimal for mental health acute inpatient services.

Occupancy in Te Awakura (the acute inpatient service) remains above this figure. Occupancy was 91% in March and 94% in April 2018.

The average number of consumers under care in this 64 bed facility was 70 in March and 73 in April 2018. There were 3 sleepovers during March and 10 sleepovers during April 2018.

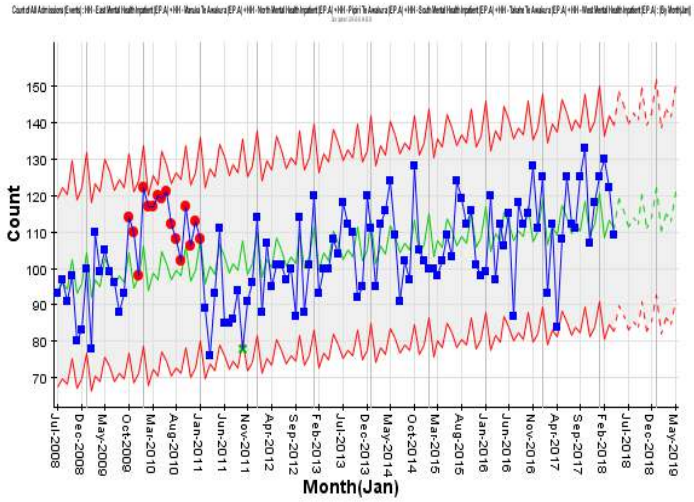


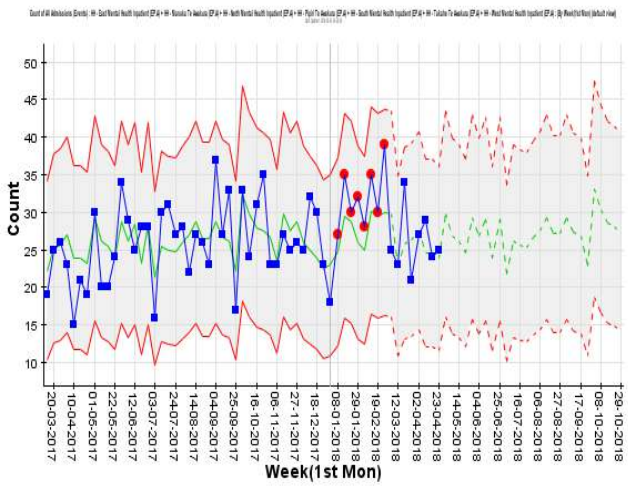
The average length of stay for consumers discharged from Te Awakura during March was 14 days and April 2018 was 23 days. We are closely monitoring length of stay in terms of difficulties with accommodation supply in Christchurch. We are working with Comcare to source emergency and social housing options for people in inpatient services.



Our focus on reduction of seclusion in Te Awakura continues with a significant reduction overall. In April, four consumers experienced seclusion for a total of 42.4 hours. There is strong and effective nursing leadership and staff dedication and commitment to maintain the focus of reduction.

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



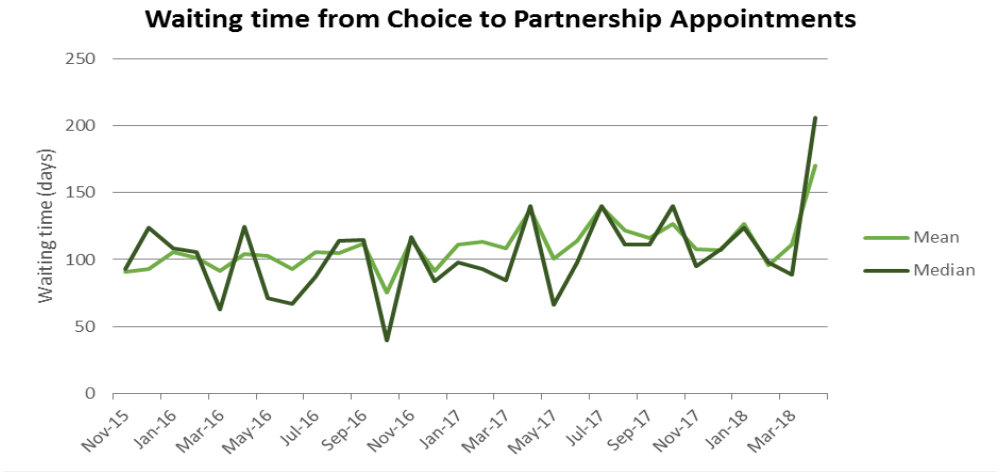


Child and Youth

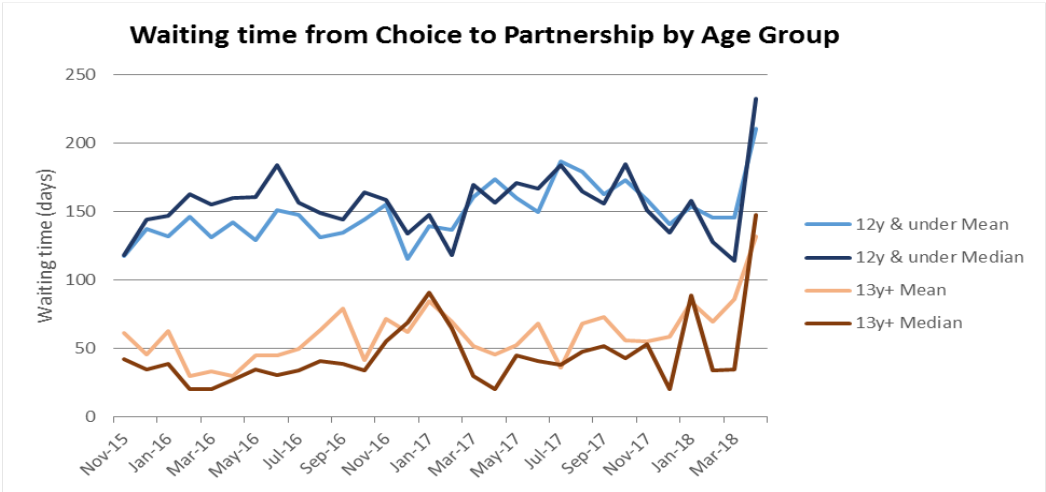
There has been a 98% increase in child and adolescent case starts in the past six financial years.

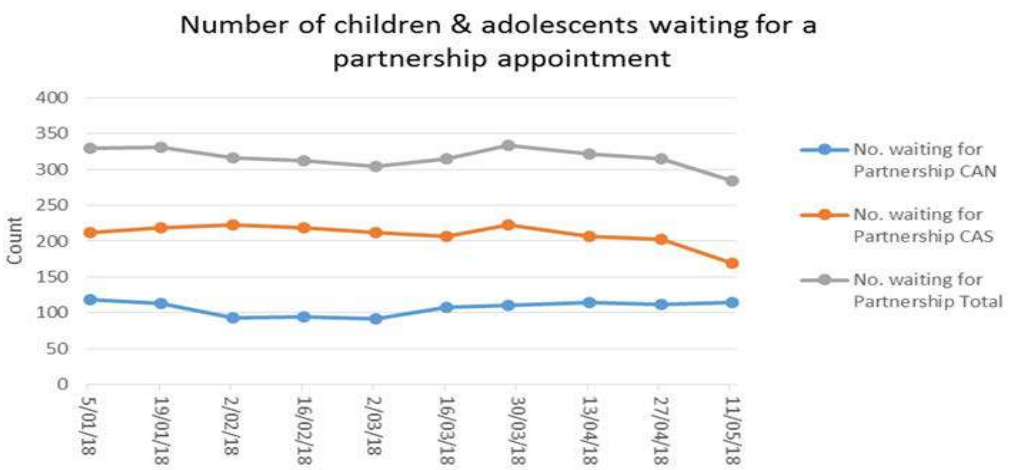
The focus on reducing wait times in the child and adolescent services is resulting in an internal wait of up to 20 weeks for some children and their families. Being seen early for the first contact is still important as it enables clinicians to make informed decisions about who is able to wait and who 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.

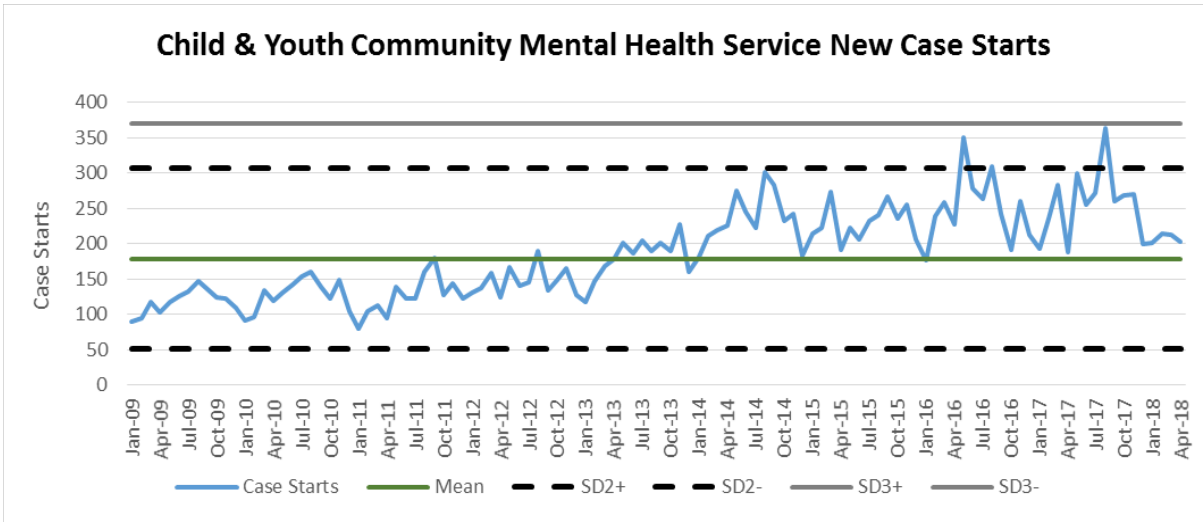
The graphs below show the waiting time between Choice (1st) and Partnership (2nd) appointments. Children and adolescents assessed as being of very high priority go straight to a Partnership appointment, bypassing the Choice appointment process.



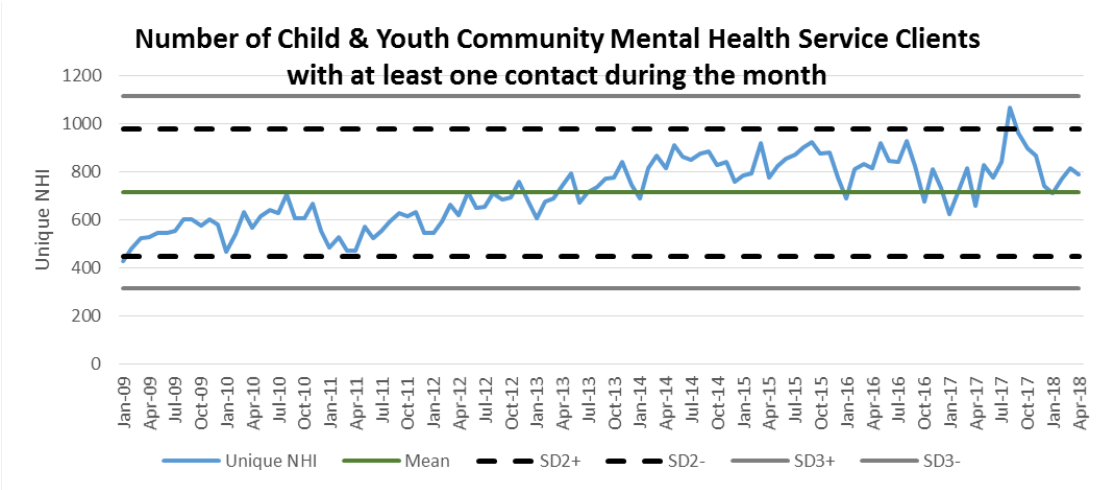
Lately Child, Adolescent and Family Services has been identifying consumers with possible ADHD and sending them straight to a Partnership appointment in an effort to reduce their waiting list. In April 2018 the majority of CAF North consumers who attended a Partnership appointment had not attended a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



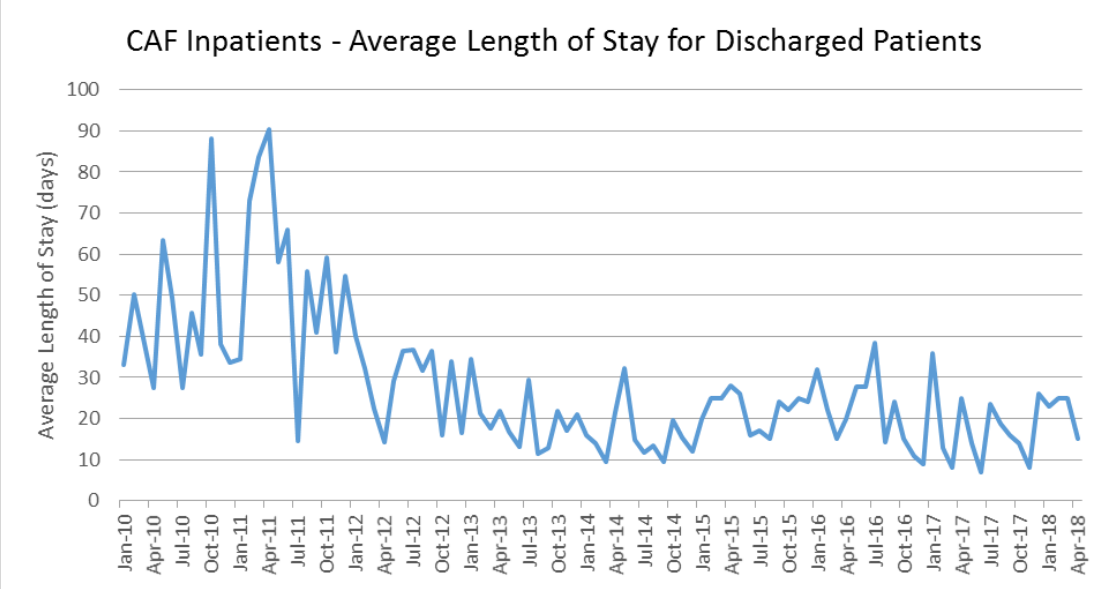




There were 203 new CAF case starts in April 2018. CAF services are making good progress with implementation of a Direction of Change that supports more integrated services across the age ranges.

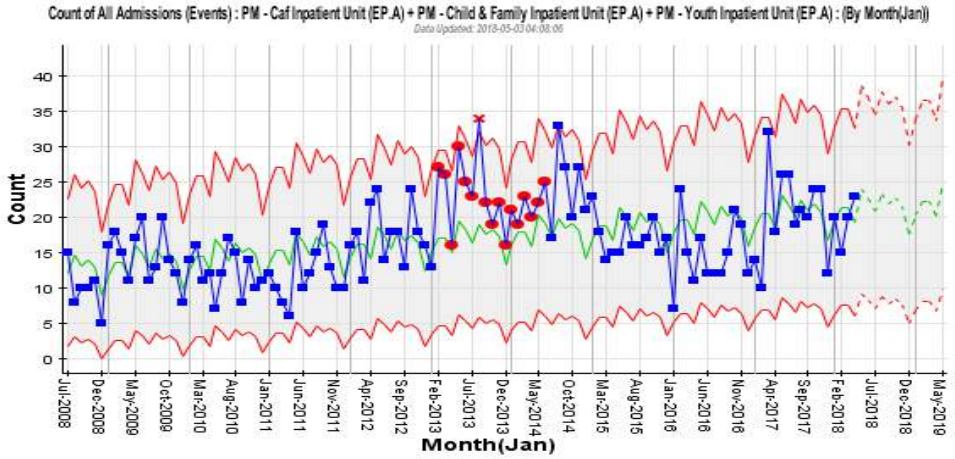


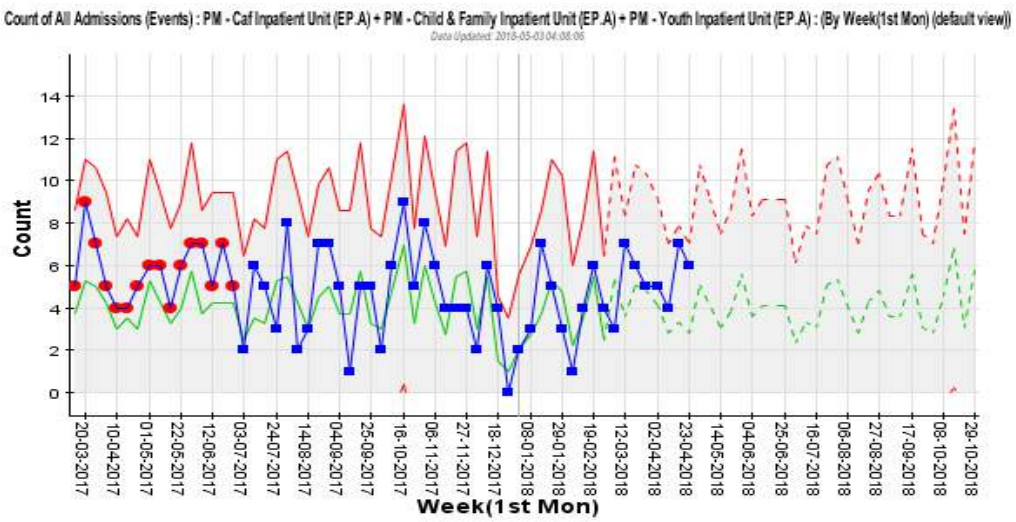
The number of unique clients with contacts above shows a similar pattern to new case starts graph, which demonstrates an increase in demand for Child and Youth community Mental Health Service. There were 792 unique patients with at least one contact during the month of April 2018. In August 2017 the CAF Service ran a drive on improving data accuracy and ensuring all contacts were being entered into the patient information system in a timely manner.



The average length of stay for discharged patients was 25 days for March and 15 days for April 2018.

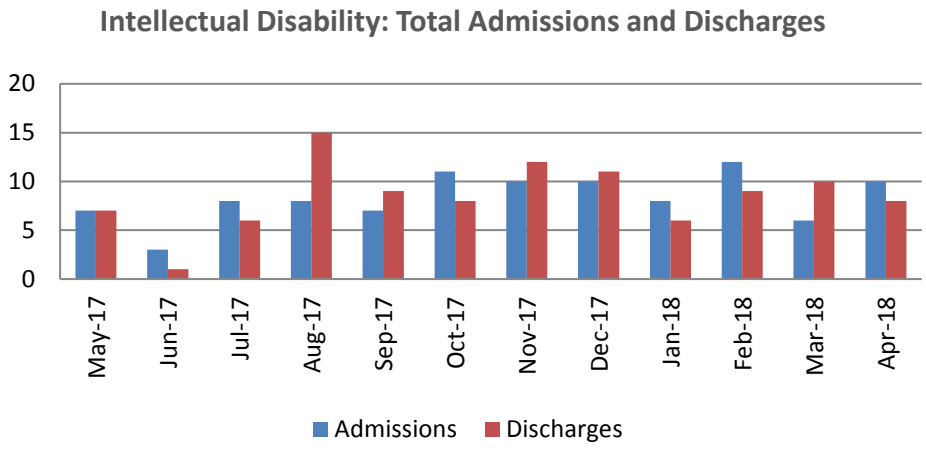
The graphs below show the number of admissions to the Child and Adolescent Unit and its predecessors. The first graph is a monthly view, and the second a weekly view.

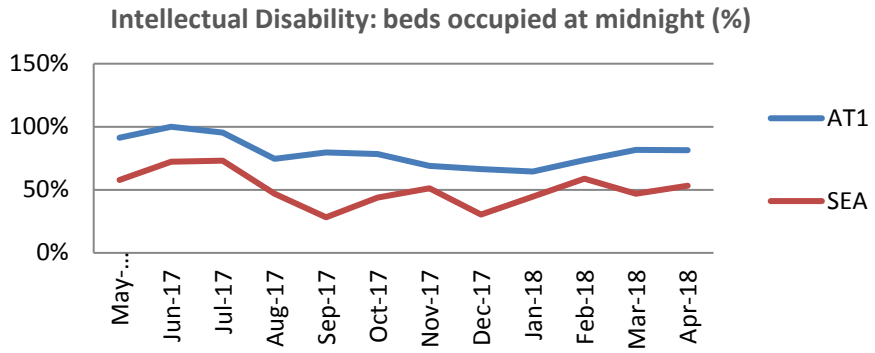




Intellectually Disabled Persons Health Service

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

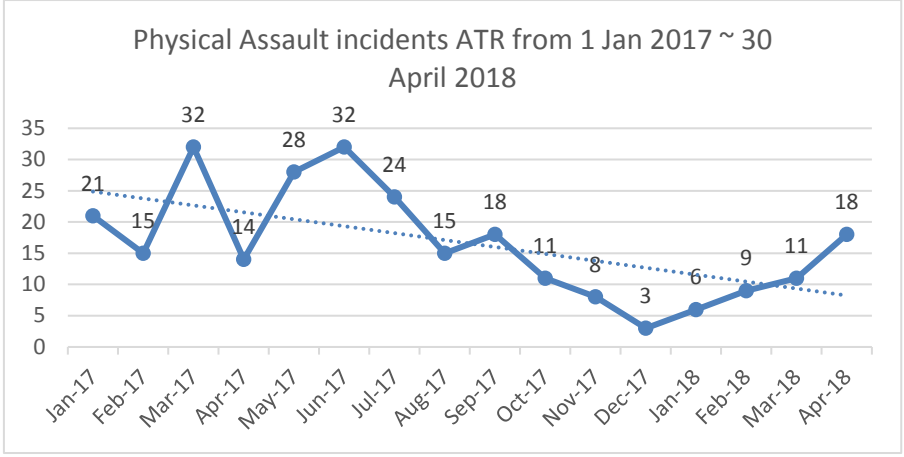


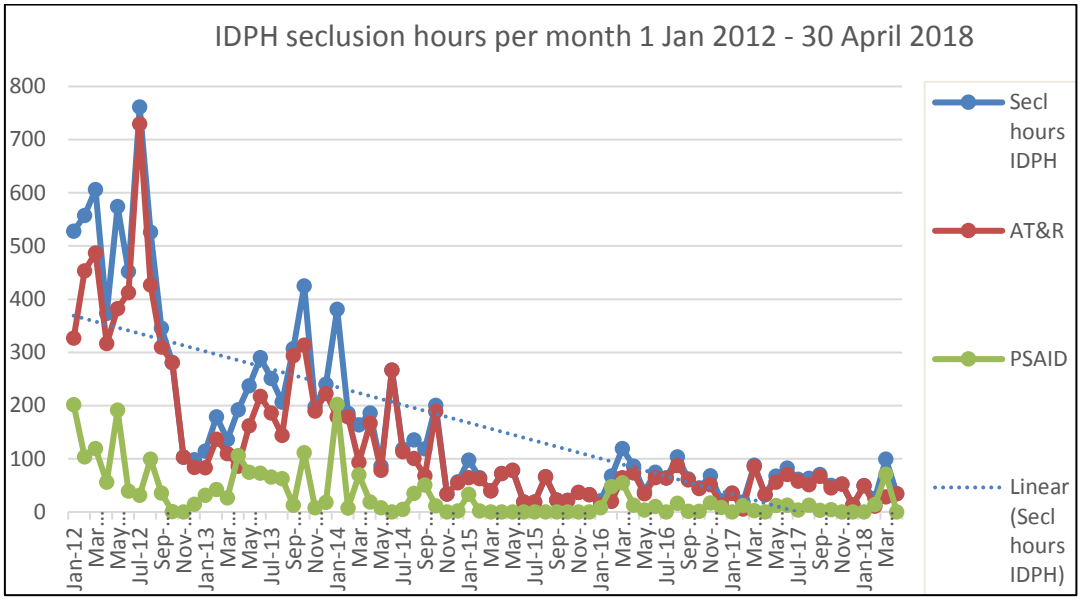


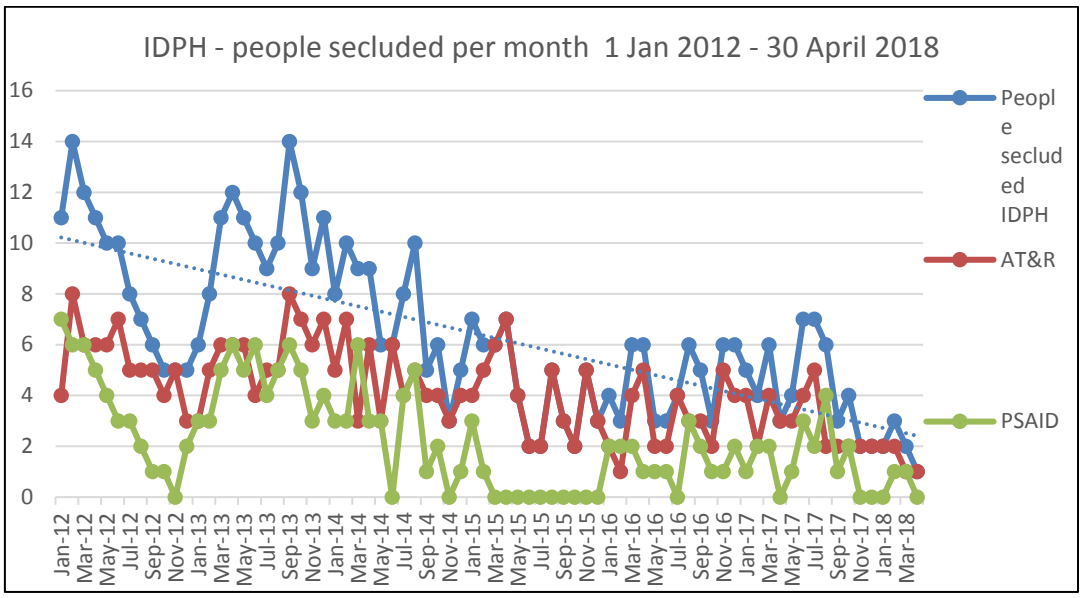
Occupancy in AT&R (AT1) was 82% for the month of March and 81% for April 2018. The figures for PSAID (SEA) were 47% and 53% respectively.

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 Forensic Coordination Service (Intellectual Disability) FCS(ID) and Lifelinks NASC (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 the Ministry of Health takes place to inform and discuss the delays in discharge.




IDPH seclusion hours per month 1 Jan 2012 - 30 April 2018
800
700
600
500
400
300
200
100
0
Jan-12
Mar...
May...
Jul-12
Sep-...
Nov-...
Jan-13
Mar...
May...
Jul-13
Sep-...
Nov-...
Jan-14
Mar...
May...
Jul-14
Sep-...
Nov-...
Jan-15
Mar...
May...
Jul-15
Sep-...
Nov-...
Jan-16
Mar...
May...
Jul-16
Sep-...
Nov-...
Jan-17
Mar...
May...
Jul-17
Sep-...
Nov-...
Jan-18
Mar...
Secl hours IDPH
AT&R
PSAID
Linear (Secl hours IDPH)


IDPH - people secluded per month 1 Jan 2012 - 30 April 2018
16
14
12
10
8
6
4
2
0
Jan-12
Mar-12
May-12
Jul-12
Sep-12
Nov-12
Jan-13
Mar-13
May-13
Jul-13
Sep-13
Nov-13
Jan-14
Mar-14
May-14
Jul-14
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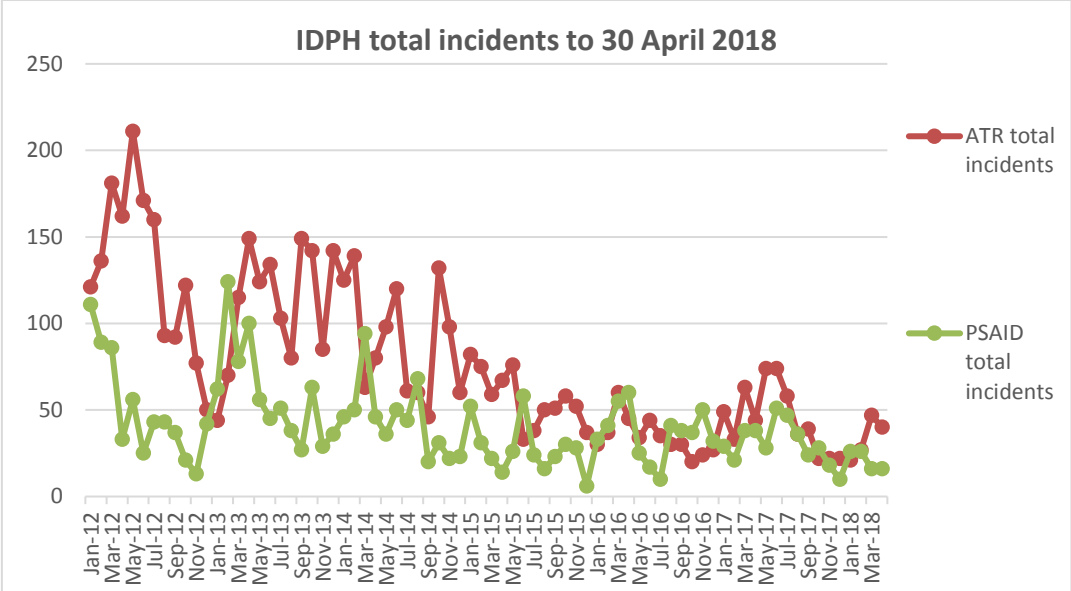
Mar-18
People secluded IDPH
AT&R
PSAID


IDPH total incidents to 30 April 2018
250
200
150
100
50
0
Jan-12
Mar-12
May-12
Jul-12
Sep-12
Nov-12
Jan-13
Mar-13
May-13
Jul-13
Sep-13
Nov-13
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
ATR total incidents
PSAID total incidents

Living within our means

Living within our Means, including No Wasted Resource

Financial Performance

Canterbury District Health Board

Statement of Financial Performance

Hospital & Specialist Service Statement of Comprehensive Revenue and Expense
For the 10 Months Ended 30 April 2018

MONTH $'000						YEAR TO DATE				
17/18 Actual $'000	17/18 Budget $'000	16/17 Actual $'000	17/18 Variance $'000	17/18 vs 16/17 Variance $'000		17/18 Actual $'000	17/18 Budget $'000	16/17 Actual $'000	17/18 Variance $'000	17/18 vs 16/17 Variance $'000
					Operating Revenue					
647	267	309	380	338	From Funder Arm	5,900	2,737	2,744	3,163	3,156
1,506	2,091	1,798	(585)	(292)	MOH Revenue	15,232	20,466	18,358	(5,234)	(3,126)
4,259	4,512	3,391	(253)	868	Patient Related Revenue	41,344	44,848	35,779	(3,504)	5,565
1,226	1,102	1,353	124	(127)	Other Revenue	13,402	11,000	15,375	2,402	(1,973)
7,638	7,972	6,851	(334)	787	**TOTAL OPERATING REVENUE**	75,878	79,051	72,256	(3,173)	3,622
					Operating Expenditure					
					Personnel Costs					
58,733	56,934	54,390	(1,799)	(4,343)	Personnel Costs - CDHB Staff	553,230	545,201	528,378	(8,029)	(24,852)
1,749	1,615	1,730	(134)	(19)	Personnel Costs - Bureau & Contractors	18,306	16,506	15,926	(1,800)	(2,380)
60,482	58,549	56,120	(1,933)	(4,362)	**Total Personnel Costs**	571,536	561,707	544,304	(9,829)	(27,232)
11,639	11,622	9,742	(17)	(1,897)	Treatment Related Costs	117,369	117,727	112,330	358	(5,039)
3,568	4,018	3,821	450	253	Non Treatment Related Costs	36,227	39,383	39,993	3,156	3,766
75,689	74,189	69,683	(1,500)	(6,006)	**TOTAL OPERATING EXPENDITURE**	725,132	718,817	696,627	(6,315)	(28,505)
(68,051)	**(66,217)**	**(62,832)**	**(1,834)**	**(5,219)**	**OPERATING RESULTS BEFORE INTEREST AND DEPRECIATION**	**(649,254)**	**(639,766)**	**(624,371)**	**(9,488)**	**(24,883)**
					Indirect Income					
2	3	1	(1)	1	Donations & Trust Funds	45	31	79	14	(34)
2	**3**	**1**	**(1)**	**1**	**TOTAL INDIRECT INCOME**	**45**	**31**	**79**	**14**	**(34)**
					Indirect Expenses					
2,147	2,555	2,650	408	503	Depreciation	21,544	23,213	22,165	1,669	621
19	-	2	(19)	(17)	Loss on Disposal of Assets	41	-	14	(41)	(27)
2,166	**2,555**	**2,652**	**389**	**486**	**TOTAL INDIRECT EXPENSES**	**21,585**	**23,213**	**22,179**	**1,628**	**594**
-	-	-	-	-	Intra Division/Organisation Wide	-	-	-	-	-
(70,215)	**(68,769)**	**(65,483)**	**(1,446)**	**(4,732)**	**TOTAL SURPLUS / (DEFICIT)**	**(670,794)**	**(662,948)**	**(646,471)**	**(7,846)**	**(24,323)**

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
Cardiology	Stock Management. Reduction in expired stock wastage.				Between $27k - $30k/ year	
Radiology	Stock Management. Reduction in expired stock wastage.				Between $7 - $12K /year	
Administration	Winscribe. Additional Admin staff predicted no longer required				360,000	
Gynaecology	Paperlite					15 hours per week of administrator time
CDHB wide	PICC line improvements. Reduction in blood stream infections associated with these catheters				$360 000	
CDHB wide	Central venous access devices. Heparinised saline has now been replaced by saline		$13,000	1819		

Achievements/Issues of Note

Cardiology Stock Management

Every year approximately 3,000 diagnostic and interventional procedures are carried out in the two cardiac catheter labs Christchurch Hospital. All procedures require the availability of specific consumables to ensure our patients are provided with the right care at the right time by the right person.

Ensuring that the consumables and products are available requires a robust process to avoid over or under ordering and avoid the need to discard expired items. Challenges to this include communication with a range of vendors, technological changes to cardiology products, cardiologist preferences, various expiry dates and storage space limitations.

While previously we regularly needed to write off expired stock, a review of our systems and processes has ensured that we have a more efficient system that avoids this waste of product.

This was achieved by:

- Improved communication with the company representatives who do an inventory with the purchasing officer monthly when on site;
- Ceasing reordering and holding items that are not regularly used;
- Regular review and adjustment of minimum/maximum stock levels;
- Improved accountability and communication between the Cardiology Purchasing Officer, Consultants and Charge Nurse Manager. This has stopped the purchase of new products that are not used.
- Improved management of consignment stock with addition of lot numbers on bar code stickers to facilitate inventory control;
- Expiry dates of all stock is checked on delivery and exchanged for a longer expiry date if necessary;
- Stock rotation improved with end users;

- Better understanding of the Oracle system and how to run reports.

This has provided benefits:

- Processes are reliable, consistent and more streamlined;
- Improved communication between cardiologists, vendors, Charge Nurse Manager and the Purchasing Officer;
- Use of consignment stock – this is under the management of the company representative and at no cost to Canterbury District Health Board until used;
- Improved use of storage space through elimination of over-stocking makes it easier to track items;
- The holding of seldom used specialty items has been minimised, with a focus on holding generic items;
- Between 2014 and 2016 the cost of expired stock to Canterbury District Health Board varied between $27k and $30k per year. This was reduced to nil in 2017.

Improved stock management in radiology.

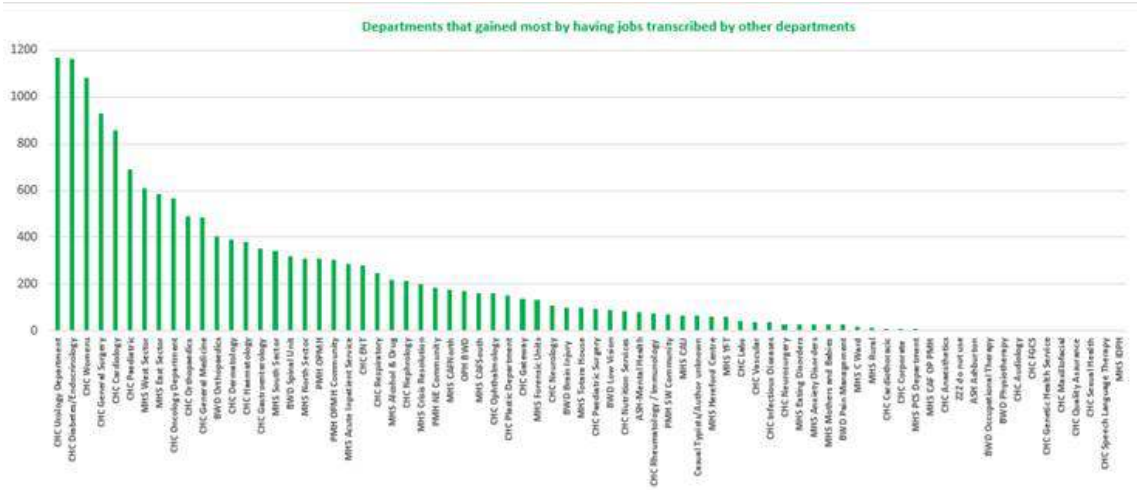
Similar improvements have been put in place in Radiology with a Hospital Aide developing expertise in the department's stock management. Stock levels are now more regularly checked and minimum and maximum levels fine-tuned, short date stickers are used and new and high cost items are held on consignment rather than purchased. Company representatives manage consignment items, reconciling stock levels on a monthly basis. Stock take is carried out by the same staff so that there is familiarity with the process and where various goods are stored.

Prior to putting these changes in place we generally wrote off between $10,000 and $15,000 of stock per year. This has been significantly reduced with $3,353 being written off in 2017.

Winscribe – delivering the promised improvements

An update was provided in November showing the impact of a system, developed during the Winscribe implementation, which provides performance feedback, enabling improvement in the way that dictation and transcription are provided and the resulting saving of over $500,000 in licence fees and maintenance costs since implementation. This report does not repeat that detail – but does look into the whether the investment in Winscribe technology has delivered the promised benefits.

Winscribe is a system that enables electronic recording and transcription of dictation. This means that the two activities can be carried out without the exchange of physical tapes. Implementation of this system was promoted in order to improve sound quality, eliminate the potential loss of tapes and subsequent failure to document clinical interactions including the provision of information about the next step in a clinical journey. This was a significant risk to the organisation. This has been achieved in over 78 service areas that have taken up the use of this system. It has also provided visibility over this previously unmeasurable component of clinician and transcriptionist workload and allowed for services with a lull in transcriptionist workload to assist those services experiencing a peak. This ability to shift work between transcriptionists in the same or other services is an important part of enabling capacity to match workload across the system. The chart below show the number of jobs for the last 6 months that have been able to be transcribed by other departments to help teams facing peak pressure, staff shortages etc.



One financial benefit committed to prior to implementation was that 4.0 FTE of savings would occur in the administration workforce over the first four years. This has been well and truly achieved with Medical Secretary establishment remaining flat since implementation – avoiding a projected increase of 8.9 FTE. This represents an avoided cost of around $360k in the final year of that period. The role of transcriptionists has become more complicated by the increased use of various IT systems, tasks and roles they now have to undertake compared to 2013. In many cases, it is the time savings achieved in WinScribe that have enabled teams to maintain their through put despite increases in workload. Average time spent on each transcription job has reduced by around 12% - from nearly 3 minutes per job to 2:36.

Prior to implementation Canterbury District Health Board was spending an average of $36k on tapes and machines per year. This reduced to $600 in 2014/15, a saving of around $35k per year.

Errors, such as associating documents with the wrong patient, have been avoided due to the involvement of clinicians and transcriptionists in the development and implementation of "best practice" guidelines for dictation.

The urgency of jobs is clearly visible, enabling transcriptionists to easily tackle tasks in the right order. This function, along with the guidelines which have reduced the time taken to carry out each transcription task, improved clarity of the recording and the provision of performance feedback have meant that jobs are more likely to be provided within the target time nominated for each job, ensuring that other clinicians have timely access to information supporting the treatment of patients.

Our next step in this journey is to explore the use of speech recognition. This is already used in Radiology and Pathology and it is expected that its broader implementation would lead to further improvements in quality and efficiency. The review of pathology dictation via speech recognition shows average transcription times are reduced by more than 50% when compared to conventional WinScribe dictation. Radiology has also proven that speech recognition can eliminate the demand for transcriptionist input for a majority of the dictation work, releasing time for other tasks.

Paperlite gynaecology clinics

Gynaecology has become one of the expanding group of services that is on the pathway to running paperlite clinics. There is an average of 23 gynaecology clinics running per week, each of these currently requires around 40 minutes of administrator time to obtain, collate and return paper records to the medical records department – a total of over 15 hours per week just within the service. This is time that could be usefully employed to improve booking practices and communication with patients or support implementation of the Patient Information Care System within the service.

Along with the need to free up administrator time for other purposes the journey towards paperlite supports our strategy of ensuring that relevant information is available where and when it is needed anywhere in our health system.

Recognising this, the service is working to reduce the need for paper records to run its clinics to a safe minimum. This has required some changes in practice to ensure that information that we need to keep is recorded within our electronic systems rather than on pieces of paper. In order to ensure that we're supporting clinicians to continue to successfully provide safe, effective and timely care we are putting changes in place in a staged manner with nearly three quarters of consultants committed to providing clinics on a paperlite basis. For this transition phase we have continue to order paper notes but not provide them to clinicians unless requested to ensure that we do have a "safety net". The signs are currently positive and it appears likely that we will be able to dispense with this practice, at least for the majority of patients, within the coming months.

PICC line improvements

An update was provided in the January report describing the benefits demonstrated following implementation of a product called SecurAcath® that reduces the risk of these catheters migrating in or out of the vein. That update focussed on the reduction in reinsertions required and additional care not required due to a reduction in associated hospital acquired blood stream infections in a selection of wards.

Since then a review of the number of blood stream infections associated with these catheters has been completed. This showed a reduction from 22 infections in 2015 to 10 in 2017, infection rate reduced from 1.4% to 0.6%. This is

a significant improvement for patients, avoiding much discomfort and time spent in hospital and avoids additional costs of $360 000 associated with treatment of blood stream infections each year.

Changes in port locking protocols reducing risk of infection and saving materials and time

Central venous access devices is a term used to cover a range of catheters that provide long term intravenous access. Historically the implanted ports have been "locked" with a solution of heparin in saline to ensure that they do not get clogged up with clots. When the line is not being used this lock solution has been refreshed on a monthly basis. However studies have found that using this solution can lead to development of a biofilm in the catheter that increases the risk of associated blood stream infection. It has been found that replacing the heparinised saline with plain saline eliminates the formation of a biofilm without increasing the incidence of clotting even when they are not used for weeks.

Heparinised saline has now been replaced by saline for this purpose at the CDHB. In addition to reducing the risk of blood stream infection this has reduced the expenditure on heparinised saline by $13,000 a year.

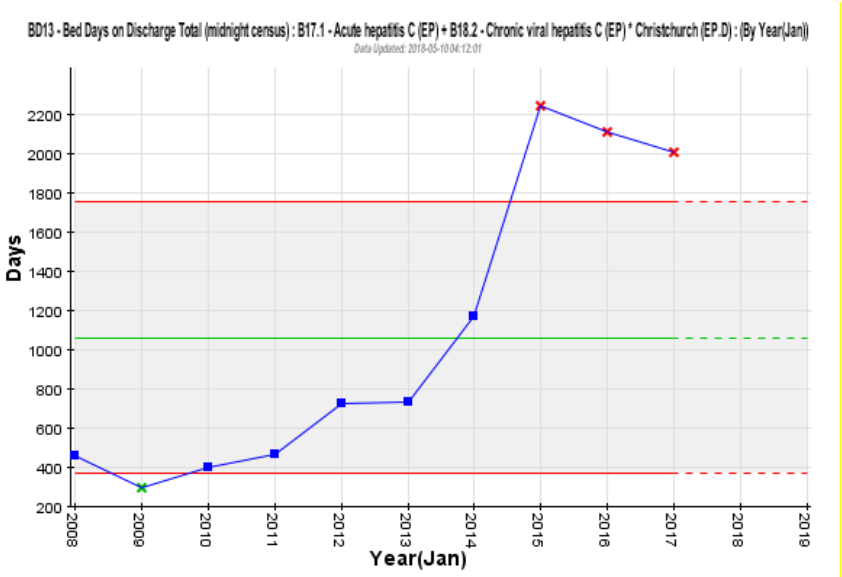
In addition to this a review of the literature has identified that reducing the frequency that refreshing the lock solution from monthly to three monthly does not increase the rate at which ports become occluded. Accordingly our practice is being changed so that adult patient's ports are locked every three months with saline. This saves patient and staff time and reduces the consumables required. This will be a positive impact, especially for adults with Cystic Fibrosis whose ports stay in place for many years. The impact of these changes on infection and occlusion rates will be monitored closely over the coming months.

Hepatitis C treatment benefitting patients and reducing demand on hospitals.

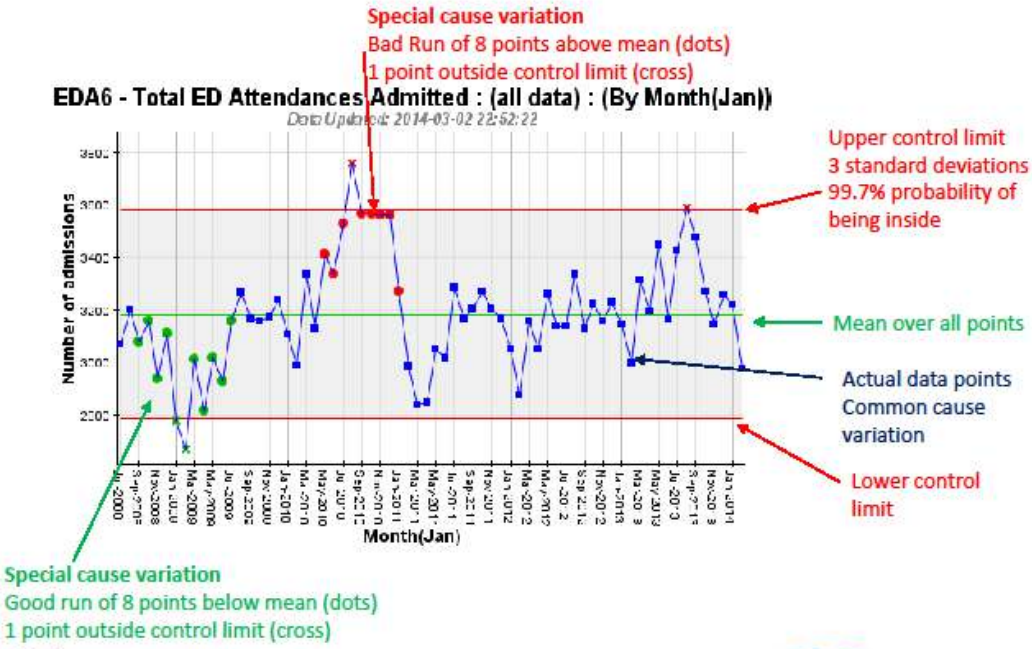
In July 2016 PHARMAC began fully funding drugs that eliminate the Hepatitis C virus. These drugs cure around 95% of patients with hepatitis caused by genotypes 1a and 1b of the virus. These genotypes cause around 55% of this disease in New Zealand. Later that year eligibility was widened so that this treatment could be provided in the community.

Due to its whole of system approach to this disease involving specialist services at Christchurch Hospital, community based clinics and general practices Canterbury District Health Board is leading the country in uptake of this treatment. Viekira Pack has been provided to around 2,000 people throughout New Zealand so far, with 378 of these receiving this treatment in Canterbury.

Eradicating the virus has the significant benefit of halting any further progression of scarring in the liver which often leads to liver failure or liver cancer, and also decreases the prevalence and subsequent transmission of the virus in the wider population. As a result of this work we've seen far fewer bed days needed in Christchurch Hospital by people with Chronic Hepatitis C – 2,173 bed days in 2015 and 1,995 in 2017 – a saving of nearly 200 days.



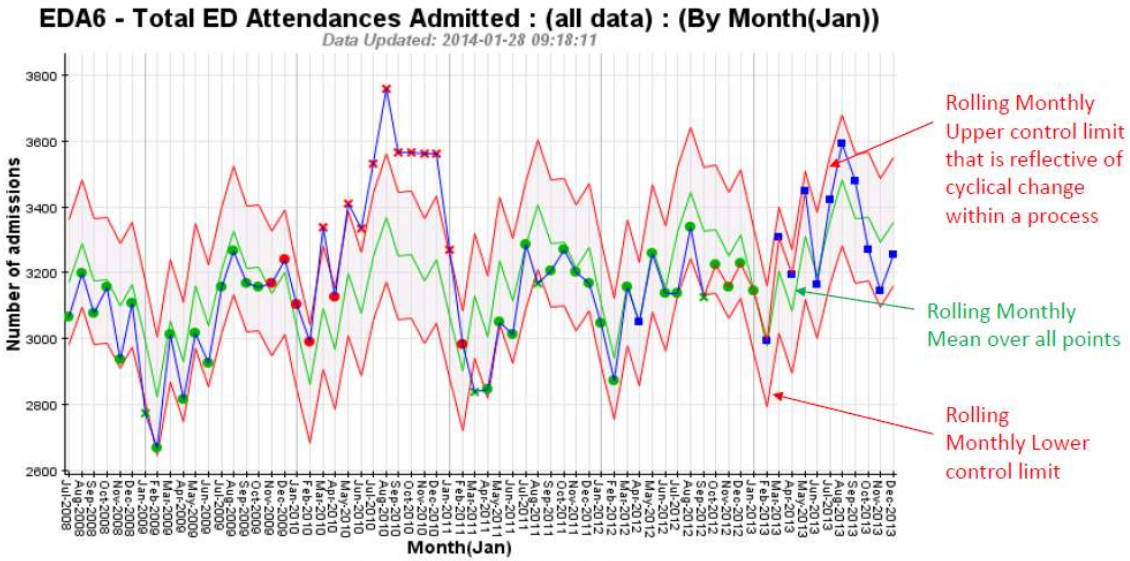
SPC: How to Interpret a Control Chart



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

2018 WINTER PLANNING UDPATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

SOURCE: **Planning and Funding**

DATE: **31 May 2018**

Report Status – For:	Decision	Noting	☑	Information

1. ORIGIN OF THE REPORT

This report has been prepared at the request of the Board, to provide the Committee with an overview of 2018 winter planning underway for the 2018 winter.

2. RECOMMENDATION

That the Committee:

i. notes the 2018 Winter Planning Update.

3. SUMMARY

In preparation for forecast winter impacts we are continuing with the joint approach to winter planning. The lessons learnt around activity from 2017 continue, with a number of the actions indicated in the Winter Review document now embedded as our new norm of activity. This includes our 0830 huddle, and confirmation of the clinical nurse specialist liaison role at Christchurch Campus.

A set of principles across the South Island DHB have been agreed to winter planning and flow:

- Patients will be treated as close to home as possible.
- Pull rather than push.
- Plan and do in parallel rather than sequentially.
- Every patient needs a planned date of departure.
- Handbacks to primary care need to be done well – reverse ERMS.
- Specialists will manage the programme of care from available data via available technology and request tasks/roles of others in the system including surveillance.
- Education/training/communications will be readily available to support the system continuum.

A series of focus areas have formed part of an ongoing action plan for the combined campus and linking in with system partners such as Canterbury Clinical Network, Acute Care Service Level Alliance (SLA) and primary care for influenza planning.

The dashboard that made visible the data that was available during 2017 continues to be used, along with clinical leadership from the Chief of Medicine and Chief of Service for this activity.

4. DISCUSSION

We identified a number of work streams we felt would add value to the changes needed for the winter in 2018 and to build on our lessons learnt in 2017. Our ongoing focus across the system includes:

- Ongoing forecasting demand and capacity options within the CDHB provider arm.
- Workforce recruitment for the CDHB provider arm with winter flex resourcing for Burwood wards to increase the resourced beds, increased nursing across the CHCH Campus and recruitment specialists to maintain the demands of recruitment levels alongside our ongoing wellbeing and occupational health.
- Promoting wellness across the sector.
- Continuing to connect our response with the wider health services of Canterbury.

At the Health Emergency Group (*HEG*), the pandemic planning across primary care, community and public health and our emergency management teams is being presented. Draft sector pandemic influenza response framework, developed based on MoH action plan guidance, is well underway.

Across the South Island our focus areas include:

- System flows for patients in/out of CDHB: discharge planning and repatriation process agreed beforehand will be supported (NB: CDHB daily patient report to CEOs/COOs by NHI will be extended to different groups within the DHB).
- Use of the Air Desk for transfer and patient repatriation.
- Sharing information and updated plans across DHB.
- The establishment of an operational group twice weekly across South Island DHBs to ensure conversation, reviewing information and ensuring flow is occurring before peak periods are reached.

Within the Acute Care SLA, focus areas cover:

- Targeted messaging for the winter period, including messaging through the Chamber of Commerce, schools and early childhood centres.
- Hand sanitiser campaign and messaging for aged care facilities, general practice and pharmacy (this will be similar to the one implemented after the quakes).
- Opportunities for pharmacy to take some of the acute load off general practice, particularly during the winter period.
- Looking at opportunities where pathways could be enhanced to improve flow through the system.

The aim of the Acute Care SLA is to ensure:

- Reduction in demand from the community on ED and acute admissions.
- Use of shared information across the urgent care centres and ED.
- Reinforcing communication about the community services available.
- Improving frail elder pathway flows (ED to AMAU or home).
- Reinvigorating key messages to be delivered under the Care Around the Clock banner. .The messaging will increase through the winter period with refreshed graphics.
- Communications plan is being developed which will identify system wide messages that are already in existence and identify gaps. .The plan will help to ensure there is consistent winter messaging across the system.
- Exploring whether the Acute Demand criteria should be further flexed to cope with ACC.

All these actions continue to build on our connected and coordinated approach to the winter flow and winter periods expected.

5. CONCLUSION

The focus on winter planning has produced results that enables the system to cope with the increasing population demands while balancing the demand on service and beds. Ongoing work is needed to maintain this focus and delivery.

Report prepared by:	Dan Coward, General Manager, Older Persons, Orthopaedics & Rehabilitation
Report approved for release by:	Carolyn Gullery, Executive Director Planning, Funding & Decision Support

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 May 2018**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Committee:

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

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

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

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

3. SUMMARY

The Act, Schedule 3, Clause 32 provides:

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

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

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

Clause 33 of the Act also further provides:

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

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

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

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

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

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

QUALITY AND PATIENT SAFETY INDICATORS – LEVEL OF COMPLAINTS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

SOURCE: **Quality and Patient Safety, Corporate Services**

DATE: **31 May 2018**

Report Status – For:	Decision ☐	Noting ☐	Information ☑

1. ORIGIN OF THE REPORT

The purpose of this report is to place before the Committee information on the number of external complaints received from patients of the CDHB. This is a regular six monthly information report on the Committee's work plan.

2. DISCUSSION

Attached (Appendix 1) is a report outlining the "All Hospitals Complaint Rate" expressed by rate of 1000 contacts for the period July 2015 to April 2018.

The report provides information on the number of complaints received in relation to the total number of: admissions; ED attendances (where the patient was not subsequently admitted); and outpatient attendances in the period at all CDHB hospitals. The total complaints rate data now includes complaints to the office of the Health and Disability Commissioner (*HDC*) about care provided by the CDHB.

CDHB has implemented the South Island electronic Consumer Feedback module in Safety 1st. From 1 December 2017 all hospitals feedback data is entered into Safety 1st. This module includes compliments, complaints and suggestions, and has been in use in other DHBs since 2015. It provides more visibility of data, including HDC complaints, as well as easier analysis of trends to identify themes. Alongside this work, the CDHB Complaints Policy and associated documentation is being reviewed.

Complaints data is reported as part of the Harm and Patient Indicator Report and monitored by the Clinical Board, the General Managers Group, and the Quality, Finance, Audit and Risk Committee (*QFARC*).

3. APPENDICES

Appendix 1: All Hospitals Complaint Rate to April 2018

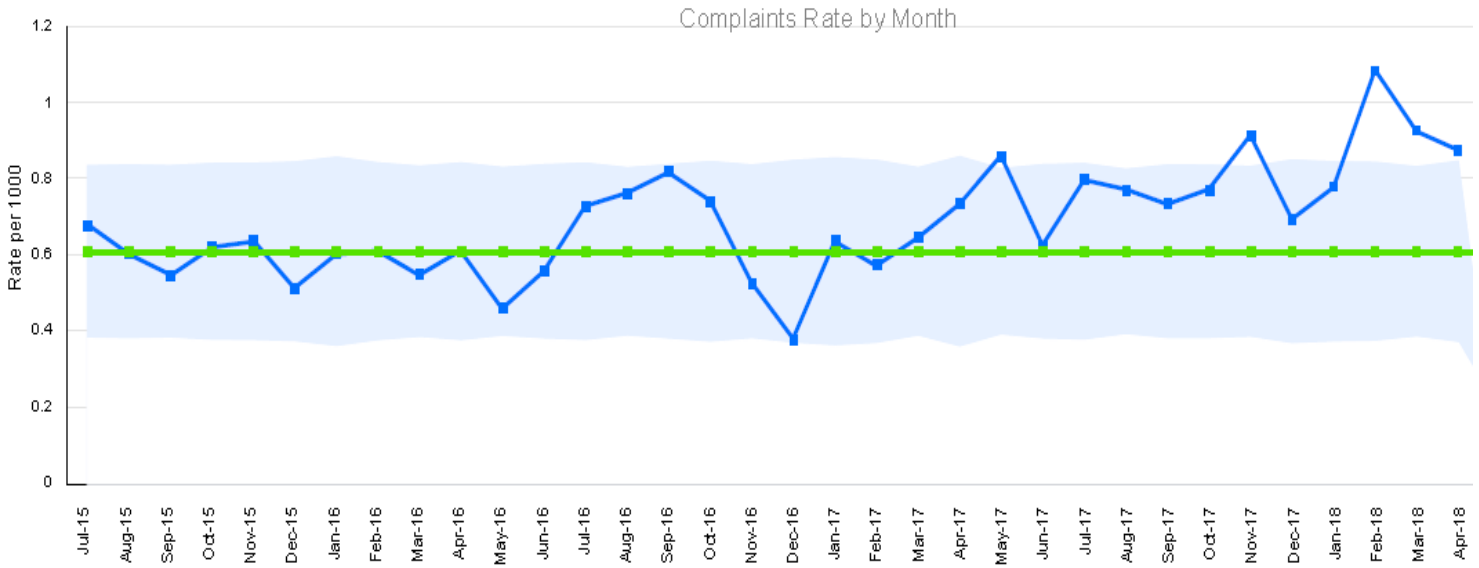
Report prepared by: Susan Wood, Director Quality & Patient Safety

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

PATIENT EXPERIENCE: COMPLAINTS

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

Outcome Indicator: **All Hospitals Complaints Rate**

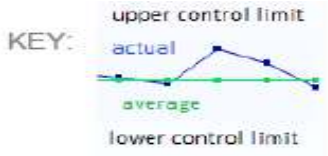


Numerator: Total number of complaints received in the period.

Denominator: The sum of the:

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

Calculated as a rate per 1,000



Data for 2017/2018 year to date:

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	2016/17	2015/16
Complaints															
Numerator	81	89	77	81	99	65	76	107	101	84			860	816	713
Denominator	101,431	115,528	104,856	105,019	108,453	93,759	97,538	98,665	109,031	96,117			1,030,397	1,212,813	1,227,410
Rate per 1000	0.80	0.77	0.73	0.77	0.91	0.69	0.78	1.08	0.93	0.87			0.83	0.67	0.58

Comments for April 2018 period:

- The CDHB Services complaint rate for the month of April 2018 was 0.87; 84 complaints were received.
- The increase in the rate of complaints has shifted. This is indicated by the sustained increased rate, 10 consecutive data points being above the average (6 consecutive points above average indicate a shift). The control chart limits and average will need to be adjusted

- This shift coincides with the updated South Island Consumer Feedback module on Safety1st being rolled out across the Canterbury DHB, with preparatory work occurring altering data counting in the second half of 2017. The Health and Disability complaints and all feedback via the complaint channels are now included, so this may have contributed to increase in numbers.

Complaints to HDC involving District Health Boards – Canterbury DHB Report for 1 July 2017 and 31 December 2017[1]

This national report details the trends in complaints received by HDC about DHBs between 1 July and 31 December 2017. The number of complaints received about DHBs in July-December 2017 is very similar to the average number of complaints received over the past four six month periods. The total number of complaints received in Jul–Dec 2017 (440) shows an increase of 6% over the average number of complaints received in the previous four periods, but a decrease of 8% over the number of complaints received in the previous six month period. The 440 complaints received related to 452 services.

Number of Complaints received in the last five years

	Jan–Jun 13	Jul–Dec 13	Jan–Jun 14	Jul–Dec 14	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Average of last 4 6-month periods	Jul–Dec 17
Number of complaints	324	330	330	368	389	422	383	386	477	**417**	**440**

The rate of complaints received during Jul–Dec 2017 (89.78) shows a 4% increase over the average rate of complaints received for the previous four periods, but a decrease of 9% over the rate of complaints received in the previous six month period.

National Rate of complaints received in last five years by HDC

	Jan–Jun 13	Jul–Dec 13	Jan–Jun 14	Jul–Dec 14	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17[2]	Average of last 4 6-month periods	Jul–Dec 17
Rate per 100,000 discharges	72.67	71.15	72.99	76.65	84.60	87.57	81.44	78.79	99.08	**86.72**	**89.78**

[1] Note: The HDC rates use a different denominator to the CDHB Complaints indicator.

Nationally the most commonly reported complaints by service type continue to be surgical, mental health and general medicine services. Issues in relation to DHB services tend to fall into the categories of: care/treatment; communication; consent/information; and access/funding. Failure to communicate effectively with the consumer being the most common issue in complaints.

In around one fifth of complaints about DHBs, complainants raised concerns regarding coordination of care. Additionally, inadequate coordination of care is a common finding on HDC's assessment of complaints about DHBs.

For Canterbury District Health Board, in the period Jul–Dec 2017, the HDC received a total of 56[2] complaints about care provided.

The rate for Jul–Dec 2017 (102.14) shows an increase of 32% over the average rate of complaints received for the previous four periods, and is the highest rate of complaints ever received by Canterbury DHB. When DHBs were ranked according to their rate of complaints, Canterbury DHB was DHB 12. Canterbury DHB was DHB 8 in the previous six month period.

Number and rate of HDC complaints per total discharges received in last five years for CDHB:

	Jan–Jun 13	Jul–Dec 13	Jan–Jun 14	Jul–Dec 14	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17[9]	Average of last 4 6-month periods	Jul–Dec 17
Complaints received	31	29	29	30	35	34	45	44	52	**44**	**56**
Rate per 100,000 discharges	58.59	51.95	53.83	53.46	63.91	59.64	81.95	76.99	91.79	**77.59**	**102.14**

Similar to national trends and as seen in the last period, surgery (32.1%) and mental health services (26.8%) were the most common service types receiving complaints at Canterbury DHB. Within this, the most commonly surgical specialties at Canterbury DHB were orthopaedics (8.9%) and neurosurgery (7.1%). Canterbury DHB saw an increase in the proportion of complaints regarding neurosurgery in Jul-Dec 2017.

The most common primary complaint categories for Canterbury DHB were: care/treatment (53.6%); and consent/information (19.6%). Similar to national trends and as per last period for Canterbury DHB, the most common specific primary issue was 'missed/incorrect/delayed diagnosis' (16.1%).

Complaints primarily regarding consent/information issues increased from 5.8% in Jan-Jun 17 to 19.6% in Jul-Dec 17.

[2] Provisional as of date of extraction (19 January 2018)

Complaints to the Nationwide Health and Disability Advocacy Service involving District Health Boards - Report and Analysis for the period 1 July 2016 to 30 June 2017

National

This national report details the trends seen in complaints received by the Advocacy Service about DHBs in the 2016/17 year.

In 2016/17 the Advocacy Service received 1,113 complaints about services provided by DHBs. This is a complaint rate of 115 complaints per 100,000 discharges.

For individual DHBs the number of complaints ranged between 7 and 150 complaints, and the rate of complaints ranged from 54 per 100,000 discharges to 447 per 100,000 discharges. The wide range of complaints is consistent with the 2015/16 data. Large variability in complaint numbers is not unexpected given the similar variability in the size of populations served and the number of services delivered by different DHBs. Additionally, the number of complaints received can be indicative of an individual DHB's approach to complaints management.

The complaints received by the Advocacy Services in 2016/17 were spread across many different services, the most commonly complained about services were surgical services (27%), mental health (20%), general medicine (19%) and emergency department services (11%). The breakdown of the DHB services complained about is below.

Local

During this period the Advocacy Service received 150 complaints about services provided by CDHB. This is a complaint rate of 132 per 100,000 discharges.

WORKPLAN FOR HAC 2018 *(WORKING DOCUMENT)*

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