AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora o Waitaha

HOSPITAL ADVISORY COMMITTEE MEETING

To be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
Thursday, 30 January 2020 commencing at 9:00am

Administration			
	Apologies		9.00am
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 5 December 2019		
3.	Carried Forward / Action List Items		
Presentations			
4.	Department of Anaesthesia	Pauline Clark *General Manager, Medical/Surgical & Women's & Children's Health*	9.10-9.40am
Reports for Noting			
5.	Clinical Advisor Update (Oral) • Nursing	Mary Gordon *Executive Director of Nursing*	9.40-9.50am
6.	Hospital Service Monitoring Report: • Medical/Surgical & Women's & Children's Health ESPIs • Older Persons, Orthopaedics & Rehabilitation • Mental Health • Hospital Laboratories • Rural Health Services	Pauline Clark Dan Coward *General Manager, Older Persons, Orthopaedics & Rehabilitation* Barbara Wilson *Acting General Manager, Specialist Mental Health Services* Kirsten Beynon *General Manager, Laboratories* Win McDonald *Transition Programme Manager, Rural Health Services* Berni Marra *Manager, Ashburton Health Services*	9.50-10.40am

7.	2020 Draft Workplan	Andrew Dickerson *Chair*	10.40-10.50am
8.	Resolution to Exclude the Public		10.50am
Estimated Finish Time			**10.50am**

NEXT MEETING: Thursday, 2 April 2020 at 9:00am

ATTENDANCE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE MEMBERS

Andrew Dickerson (Chair)
Jo Kane (Deputy Chair)
Barry Bragg
Sally Buck
Wendy Dallas-Katoa
Jan Edwards
Dr Rochelle Phipps
Trevor Read
Sir John Hansen (Ex-officio)
Gabrielle Huria (Ex-officio)

Executive Support

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

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

COMMITTEE ATTENDANCE SCHEDULE 2020

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NAME	30/01/20	02/04/20	04/06/20	06/08/20	01/10/20	03/12/20
Andrew Dickerson (Chair)						
Jo Kane (Deputy Chair)						
Barry Bragg						
Sally Buck						
Wendy Dallas-Katoa						
Jan Edwards						
Dr Rochelle Phipps						
Trevor Read						
Sir John Hansen (ex-officio)						
Gabrielle Huria (ex-officio)						

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

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

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

Andrew Dickerson **Chair – HAC** Board Member	**Canterbury Health Care of the Elderly Education Trust** - Chair Promotes and supports teaching and research in the care of older people. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Canterbury Medical Research Foundation** - Member Provides financial assistance for medical research in Canterbury. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Heritage NZ -** Member Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance and Heritage NZ has already been involved with CDHB buildings. **Maia Health Foundation -** Trustee Is a charitable trust established to support health care in the CDHB area. Current projects include fundraising for a rooftop helipad and enhancements to the children's wards at Christchurch Hospital. **NZ Association of Gerontology** - Member Professional association that promotes the interests of older people and an understanding of ageing.
Jo Kane **Deputy Chair – HAC** Board Member	**Christchurch Resettlement Services** - Member Christchurch Resettlement Services provides a range of services to people from refugee and migrant backgrounds. It works alongside refugee communities in delivering services that aim to achieve positive resettlement outcomes. **HurriKane Consulting** – Project Management Partner/Consultant A private consultancy in management, communication and project management. Any conflicts of interest that arise will be disclosed/advised. **Latimer Community Housing Trust** – Project Manager Delivers social housing in Christchurch for the vulnerable and elderly in the community. **NZ Royal Humane Society** – Director Provides an awards system for acts of bravery in New Zealand. It is not anticipated any conflicts of interest will arise.
Barry Bragg Board Member	**Air Rescue Services Limited** - Director Subsidiary of the Canterbury West Coast Air Rescue Trust. Has gaming licenses with specified purpose of fundraising for air rescue services. **Canterbury West Coast Air Rescue Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air rescue and air ambulance services. Garden City Helicopters has

	a long-term air ambulance contract with the CDHB. **CRL Energy Limited** – Director CRL Energy Limited provides air quality testing and asbestos sampling and analysis services; methamphetamine contamination testing; dust; gas and noise workplace monitoring services in New Zealand. There is the potential for future work with the CDHB. **Farrell Construction Limited** - Shareholder Farrell's Construction Limited is a commercial and light commercial construction company based in Christchurch. **New Zealand Flying Doctor Service Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB. **Ngai Tahu Farming** – Chairman Farming interests in North Canterbury and Queenstown Lakes District and Forestry interests in Canterbury, West Coast and Otago regions. **Quarry Capital Limited** – Director Property syndication company based in Christchurch **Stevenson Group Limited** – Deputy Chairman Property interests in Auckland and mining interests on the West Coast.
Sally Buck Board Member	**Christchurch City Council (*CCC*)** – Community Board Member Chair of the Central/Linwood/Heathcote Community Board which has delegated responsibilities from the CCC. **Registered Resource Management Act Commissioner** From time to time, sit on Resource Management Act panels for the CCC. Specific interests will be declared at the time. **Rose Historic Chapel Trust** – Member Charitable voluntary body managing the operation of the Rose Historic Chapel, a CCC owned facility.
Wendy Dallas-Katoa Manawhenua	**Greater Healthy Christchurch** – Runanga Representative **IHI Research –** Social Change and Innovation Researcher **Manawhenua Ki Waitaha** – Representative of Onuku Runanga 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 and the CDHB. **NZBA** – Maori Advisory Group **Population Health Alliance SLA** – MKW Representative **RANZCOG** – Cultural Advisor, He Hono (Wahine Maori Collective of Obstetrics and Gynaecologists) **Te Kahui o Papaki ka Tai** – Mana Whenua Representative (Cultural Advisor) Maori Advisory Group to Pegasus Health/PHO

	Victoria University – Women's Health Representative
Jan Edwards	No conflicts at this time.
Dr Rochelle Phipps	**Accident Compensation Corporation** – Medical Advisor ACC is a Crown entity responsible for administering NZ's universal no-fault accidental injury scheme. As a Medical Advisor, I analyse and interpret medical information and make recommendations to improve rehabilitation outcomes for ACC customers. **OraTaiao: New Zealand Climate & Health Council** – Founding Executive Board Member (no longer on executive) The Council is a not-for-profit, politically non-partisan incorporated society and comprises health professionals in Aotearoa/New Zealand concerned with: • the negative impacts of climate change on health; • the health gains possible through strong, health-centred climate action; • highlighting the impacts of climate change on those who already experience disadvantage or ill health (equity impacts); and • reducing the health sector's contribution to climate change. **Royal New Zealand College of General Practitioners** – Christchurch Fellow and Former Board Member The RNZCGP is the professional body and postgraduate educational institute for general practitioners.
Trevor Read	**Lightfoot Solutions Ltd** – Global Director of Clinical Services Lightfoot Solutions has contracts with CDHB, and other health providers who have contracts with CDHB, to provide business intelligence tools and related consulting services. Should a conflict arise, this will be discussed at the time.
Sir John Hansen **Ex-Officio – HAC** Chair CDHB	**Bone Marrow Cancer Trust** – Trustee **Canterbury Clinical Network Alliance Leadership Team** - Chair **Canterbury Clinical Network Oxford and Surrounding Area Health Services Development Group** - Member **Canterbury Cricket Trust** - Member **Christchurch Casino Charitable Trust** - Trustee **Court of Appeal, Solomon Islands, Samoa and Vanuatu** **Dot Kiwi** – Director and Shareholder **Ministry Primary Industries, Costs Review Rulings Panel** **Rulings Panel Gas Industry Co Ltd**

Gabrielle Huria **Ex-Officio – HAC** Deputy Chair, CDHB	**Emerge Aotearoa Housing Trust** – Chair **Emerge Aotearoa Limited** – Chair **Emerge Aotearoa Trust** – Chair Mental health, addiction and housing non-government organisation (*NGO*). **Nitrates in Drinking Water Working Group** – Member A discussion forum on nitrate contamination of drinking water. **Pegasus Health Limited** – Sister is a Director Primary Health Organisation (*PHO*). **Sumner Health Centre** – Daughter is a General Practitioner (*GP*) Doctor's clinic. **Te Runanga o Ngai Tahu** – General Manager Tribal Entity. **The Royal New Zealand College of GPs** – Sister is an "appointed independent Director" College of GPs.

MINUTES – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE HOSPITAL ADVISORY COMMITTEE MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch,
on Thursday, 5 December 2020, commencing at 9.00am

PRESENT
Andrew Dickerson (Chair); Jo Kane (Deputy Chair); Sally Buck; Wendy Dallas-Katoa; Jan Edwards; David Morrell; Dr Rochelle Phipps; Trevor Read; Ta Mark Solomon; and Dr John Wood.

APOLOGIES
Apologies for absence were received and accepted from Barry Bragg; and Dr Anna Crighton.

EXECUTIVE SUPPORT
David Meates (Chief Executive); Carolyn Gullery (Executive Director, Planning Funding & Decision Support); Sue Nightingale (Chief Medical Officer); and Anna Craw (Board Secretariat).

EXECUTIVE APOLOGIES
Mary Gordon; Jacqui Lunday-Johnstone; Berni Marra; and Win McDonald for absence.
David Meates for lateness.

IN ATTENDANCE

Item 4
Laura Corrigan, Clinical Team Coordinator
Debbie Hamilton, Nursing Director, Haematology/Oncology/Palliative Care/Ambulatory Care & Afterhours.

Item 5
Richard French, Clinical Director, Service Improvement
Mary Hunter, Clinical Director, Special Projects
Natalie King, Programme Lead, Treatments & Technologies

Item 8
Kirsten Beynon, General Manager, Laboratories
Pauline Clark, General Manager, Medical/Surgical & Women's & Children's Health
Dan Coward, General Manager, Older Persons, Orthopaedics and Rehabilitation
Toni Gutschlag, General Manager, Specialist Mental Health Services

Andrew Dickerson, HAC Chair, opened the meeting.

Dr John Wood, CDHB Chair, noted that the terms of appointment for himself and Ta Mark Solomon expired yesterday, however, the process is that they remain in position until such time as new appointments or reappointments are made. Therefore, at this time, he and Ta Mark remain ex-officio members of the Committee.

Mr Dickerson welcomed Wendy Dallas-Katoa to the meeting, noting she is Manawhenua ki Waitaha's nominated representative to the Committee. This nomination was endorsed at CDHB's Board's meeting on 21 November 2019.

Mr Dickerson noted that today is David Morrell's last meeting as a CDHB Board member, thanking him for his many years of contribution. It was also noted that today would have been Dr Anna Crighton's last meeting as a CDHB Board member had she been in attendance.

Mr Dickerson also welcomed Lisa Mulholland, trainee intern doing her elective placement in medical administration with the clinical leadership team.

1. INTEREST REGISTER

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

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

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

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (15/19)
(Moved: Trevor Read/Seconded: Dr Rochelle Phipps – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 3 October 2019 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION ITEMS

The carried forward action items were noted.

4. CLINICAL TEAM CO-ORDINATORS (PRESENTATION)

Pauline Clark, General Manager, Medical/Surgical and Women's & Children's Health introduced Laura Corrigan, Clinical Team Co-ordinator (*CTC*); and Debbie Hamilton, Nursing Director, Haematology/Oncology/Palliative Care/Ambulatory Care & Afterhours.

Ms Corrigan presented to the Committee on the role of the Clinical Team Co-ordinators whose key focus is "right person, right patient, right time". Committee members were provided the opportunity to ask questions.

There was a query around the introduction of Cortex, an electronic patient notes portal. Ms Corrigan advised that CTCs have been quite involved with Cortex's development. Once fully functional, it will close the loop of communication, which will prove very useful. CTCs have appreciated being involved in the process.

It was noted that CDHB's CTC role is attracting a lot of interest both nationally and internationally.

The Chair thanked Ms Corrigan and Ms Hamilton for the informative presentation.

5. NEW TREATMENTS AND TECHNOLOGIES (PRESENTATION)

Dr Nightingale introduced Richard French, Clinical Director, Service Improvement; Mary Hunter, Clinical Director, Special Projects; and Natalie King, Programme Lead, Treatments & Technologies.

The Committee received a presentation on the New Treatments & Technologies programme, and were provided the opportunity to ask questions.

There was a query on the process around disinvestment. It was noted that at this stage, the focus is on new items and ensuring the process is trusted and embedded. The programme is very much about peer moderation, generating questions and getting things right at the department level. Achieving this will enable the programme to move up and disinvestment will become a key part of the ongoing process.

A member raised the importance of ensuring double accounting does not occur. Ms King advised that the programme team has developed its own templates, enabling the right information be provided, to ensure true realisable benefit is evident.

The Chair thanked those in attendance for the presentation, noting this was a very positive piece of work.

6. CLINICAL ADVISOR UPDATE – MEDICAL (ORAL)

Dr Nightingale provided updates on the following:

- Work is underway with People & Capability to establish principles on the size of SMO jobs and a consistent approach to remuneration, rostering etc.
- Credentialing of services continues to go well.
- Training sessions for Clinical Directors (*CDs*) is ongoing.
- Leadership training of some sort is now required for all CDs. This has taken on momentum, with great enthusiasm and feedback. Otago University in Dunedin provides a course that has been very popular. CDHB has now developed its own in-house training which covers a greater time span and fits better with other commitments. This is currently being piloted.
- With respect to recent issues with new Trainee interns, it was noted that all CDHB interns are registered and working.
- There is to be a re-set of clinical governance for the provider arm.
- The Clinical Board has been re-set with a whole of system focus. Some preliminary meetings have been held and is expected to be operating at full strength by February 2020.
- Infection Prevention and Control. New system and governance is going well. Looking for a new CD following the retirement of the previous one.
- A review of the Research Committee and its processes is complete. A CD of Research has been appointed in a leadership role across the DHB. There will be a focus on process improvement and looking at models from other DHBs.
- There has been significant involvement in IT projects. This has helped with clinical engagement.
- Service Continuity Service. There has been a lot of work over the last couple of years to develop this service, which is going from strength to strength. There is a designated Business Continuity Planner who is assisting services in developing their plans. Good progress is being made. Policies are being reviewed, including the Mass Casualty Plan, and electronic resources are being developed to assist.
- Ethics Committee: A preliminary meeting has been held, with a view that this will be fully established early 2020.

Dan Coward provided an update on Spinal Surgery, service configuration and responding to patient need.

There was discussion around Dermatology, recruitment issues and the future of the service.

7. 2019 WINTER PLAN OUTCOMES

Ms Clark presented the report, which was taken as read, noting that 2019 has been the busiest winter ever experienced. Teams have done a brilliant job and have been well supported by Primary Care colleagues, as well as various CDHB divisions. It has been a true team effort.

It was noted the official winter plan period has only just concluded. Once analysed, learnings will be taken to assist with 2020 planning.

The report was received.

The meeting adjourned for morning tea from 10.45 to 11.05am.

8. H&SS MONITORING REPORT

Mr Dickerson noted the recent resignation of Toni Gutschlag. He thanked her for her significant contribution to the DHB, often under challenging circumstances, and wished her well in her new position with the Ministry of Health (*MoH*).

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

General Managers spoke to their areas as follows:

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

- Whilst still experiencing demand pressures and workforce recruitment issues, things are going reasonably well. Staff engagement is good.
- The preliminary design phase for new services coming across from The Princess Margaret Hospital has been signed off.
- Hillmorton Masterplan is going to the Board for consideration in December. Happy with where this is sitting, noting there is coherence around arrangements for the different zones; retention of green space has been strongly advocated for; and the creation of a cultural and spiritual centre will be valued.
- There have been a number of incidents at SMHS over the past couple of weeks. There is a lot of support in place for both staff and patients, with significant support being provided by People & Capability.

In response to a query, Ms Gutschlag advised that the PODs are progressing and are on track for completion in September 2020.

Discussion took place on increased support for individuals identifying with issues below an express mental health condition. It was noted the MoH is developing an access and choice programme which will assist in this area. Also, making better use of existing tools and national resources needs to be encouraged.

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

- Rethinking rehabilitation: within the workstream the following focus areas continue to support outcomes:
  - Goal setting – the workgroup is focusing on finalising the process for goal setting and standardising where to incorporate into the patients notes.
  - Use of Volunteers – Ward B1 continues to trial the use of volunteers to have group sessions as part of rehabilitation activities within the ward and act as

companions with patients with mild cognitive difficulties. This will now be rolled out to Ward C2.

- Orientation to Burwood for patient expectations – the workgroup is proposing to replace the current pamphlets with flipcharts. This will be more sustainable and will provide a visual aid to activities and expectations towards rehabilitation while in Burwood.
- Ward D1 – is trialling no Interdisciplinary Team (*IDT*) meetings on a Monday, with more robust board rounds similar to the acute model. This has freed 24 hours of nursing and allied health time, which has gone back into patient activity and patient contact time. Another consequence is that Length of Stay (*LOS*) has reduced by another day.

Discussion took place around orthopaedic volumes. Presentations have been significantly higher, as has the level of complexity. Mr Coward provided an overview of how this is being managed, with a strong focus on maximising all resources available to ensure cancellation of sessions is minimised.

Hospital Laboratories – Kirsten Beynon, General Manger, Laboratories

- Teams continue to absorb increasing volumes.
- A number of complex procurements projects are underway.
- Ongoing industrial action is requiring constant planning and response, in order to minimise the impact on patients.

In response to a query, an update was provided on Lab facilities.

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

- Acute admissions into the two largest acute services: General Medicine and General Surgery, have increased at a rate faster than expected.
- The ongoing increase in the volume of acute surgery drives an increase in demand for theatre capacity. Requirements increased by more than 1,000 hours over the previous 12 months, and that period had already required 1,300 more hours than the year to October 2017. This is an increase in acute theatre requirements by 20-25 hours per week over each of the past two years.
- General medicine has 135 allocated beds. During the past 365 days there have been only 36 days where General Medical 10.00am occupancy has been less than 135. Average has been 169 and the maximum 232.
- Impact of the mosque attacks is ongoing. As at 18 November 2019:
  - 129 people have received hospital services as a result of the attacks;
  - 121 people have visited the Emergency Department;
  - 67 people have spent time as a hospital inpatient;
  - 38 people have required an operation in theatre; and
  - there have been a total of 1,588 outpatient visits.

  The results of this attack will impact individuals and their families for many years to come. Between July and November there have been 440 outpatient visits with nearly 100 of these in the last month alone.

There was discussion about understanding barriers to heath equity, in particular disparities in cancer outcomes between Maori and non-Maori. It was suggested there is a need for screening to start earlier for Maori and Ms Dallas-Katoa advised that the Maori Medical Practitioners Association has requested the Crown to look at this. It was also suggested that it would be beneficial to look at the 62-day pathway to see who had stepped off it and how these individuals could be better supported. A detailed analysis of how people progress through the pathway, and an analysis on people who opt off or diverge, would be useful.

The report was received.

9. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (16/19)
(Moved: Ta Mark Solomon/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 3 October 2019.	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(If required)*	Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)

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

INFORMATION ITEMS

- Quality & Patient Safety Indicators – Level of Complaints
- 2019 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 12.05pm.

Approved and adopted as a true and correct record:

Andrew Dickerson
Chairperson

Date of approval

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE
CARRIED FORWARD ITEMS AS AT 30 JANUARY 2020

	DATE RAISED	ACTION	REFERRED TO	STATUS
1.	01 Oct 2019 (QFARC)	Strategic Paper on Maternity / NICU Services, following completion of national piece of work.	Carolyn Gullery	Awaiting completion of national piece of work.
2.	5 Dec 2019	Cancer Treatment - analysis of 62-day pathway	Carolyn Gullery	Report to 2 April 2020 meeting.
3.	5 Dec 2019	People & Capability Report	Michael Frampton	Report to 2 April 2020 meeting.

Department of Anaesthesia CDHB

- Work Force
- What does an Anaesthetist do
- What to we do outside the theatre environment
- What are some of the ways we contribute to the CDHB
- How do we fare as a department
- Challenges


DEPARTMENT OF ANAESTHESIA
EDUCATION
LEAD SMO
Rob Young
CME COORDINATOR
Rob Young
HOUSE SURGEON TEACHING
Alexis Ghisel & Graham Neilson
JOURNAL CLUB COORDINATOR
MEETING COORDINATOR
PART I TUTORS
Christian Brett / Wayne Morris / Nick Abbott
PART II TUTORS
Neil Wylie / Frances Cammack
SIGS COORDINATOR
SIMULATION COORDINATORS
TECH TEACHING LIAISON
Mark Chapman
GOVERNANCE
CLINICAL DIRECTOR
Ashley Padayachee
DEPUTY CD
Jeremy Hickling
DEPARTMENT REPS
SMO
Richard Seigne
SMO
RMO
CHARGE TECHNICIAN
Cathie Hepworth
SERVICE MANAGER
Carole Stuart
INFRASTRUCTURE
LEAD SMO
Wayne Morriss
FACILITIES
Ross Kennedy / David Linscott
CAPITAL EQUIPMENT / PLANT
Ross Kennedy
CONSUMABLES
Cathie Hepworth
PHARMACY
Trudy Ballantine
OPERATIONS
LEAD SMO
A/H SMO ROSTER COORDINATOR
General, Obs W/end - Rob Young
CARDIAC CALL ROSTERS COORDINATOR
Duncan Williams
HO ROSTERS COORDINATOR
LEAVE COORDINATOR
David Bain
PAED ROSTERS COORDINATOR
Karen Ryan
REG A/H ROSTERS COORDINATOR
Neil Wylie
SHO SUPERVISORS
Alexis Ghisel & Graham Neilson
SMO WORK PATTERNS
Carole Stuart
W/E SMO ROSTER COORDINATOR
SUBSPECIALITY
ACUTE PAIN
Tim Chapman
AIRWAY
Nick Abbott
ALLERGY
Susan Nicoll
ASHBURTON
BURWOOD
Richard Seigne
CARDIAC
Duncan Williams
ECT
Duncan Williams
NEURO
Hamish Gray
OBSTETRICS
Nigel Skjellerup
ORTHO
Tim Chapman
PACU
Andrew Marshall
PAED
PERIOPERATIVE MEDICINE
Dick Ongley
PREADMISSION
Dick Ongley
RESUSCITATION SERVICE
Wayne Morriss
VASCULAR
Jon Jarratt
WELFARE
Sue Nicoll / David Wium
QUALITY & AUDIT
LEAD SMO
INCIDENT REPORTING
M & M COORDINATOR
Sam Grummitt
RESEARCH COORDINATOR
Ross Kennedy (with Margie McKellow
SPECIFIC AUDIT COORDINATOR
EXTERNAL RELATIONSHIPS
ANZCA
Jennifer Woods (Chair)
Chris Harrison / Hamish Gray (Committee Members)
NZSA
Ian Williams
MCNZ
Carole Stuart
WCDHB
UNIVERSITY OTAGO
Prof Shipton
TRAINING
SOT'S
James Dalby-Ball
Frances Cammack
SCHOLAR ROLE TUTOR
Ruth Brown & Gillian Mann
CARDIAC & CARDIOLOGY SSU
Phil Garbutt
GENERAL, UROL & GYNAE SSU
Jeremy Hickling
HEAD & NECK SSU
Morag Aldridge
INTENSIVE CARE SSU
David Closey
NEUROSURGERY
VERONICA GIN
OBSTETRICS SSU
Nigel Skjellerup
OPHTHALMOLOGY SSU
Janet MacPherson
ORTHOPAEDICS SSU
Tim Chapman
PAEDIATRICS SSU
Ben van der Griend
PLASTICS SSU
THORACIC SSU
Duncan Williams
VASCULAR SSU
Jon Jarratt


Senior Medical Officers
Rogues Gallery
Fellows
Registrars
Senior House Officers
Other Department Personnel

Administration

- Service manager - Carole Stuart
- 4 Administration staff,including a rosterer

Workforce

- SMOs - 70
- RMOs -
- 29 Registrars (ANZCA trainees and independent trainees
- PFYS -5
- SHOs - 12/Year (6 month runs)

Anaesthetic Technicians

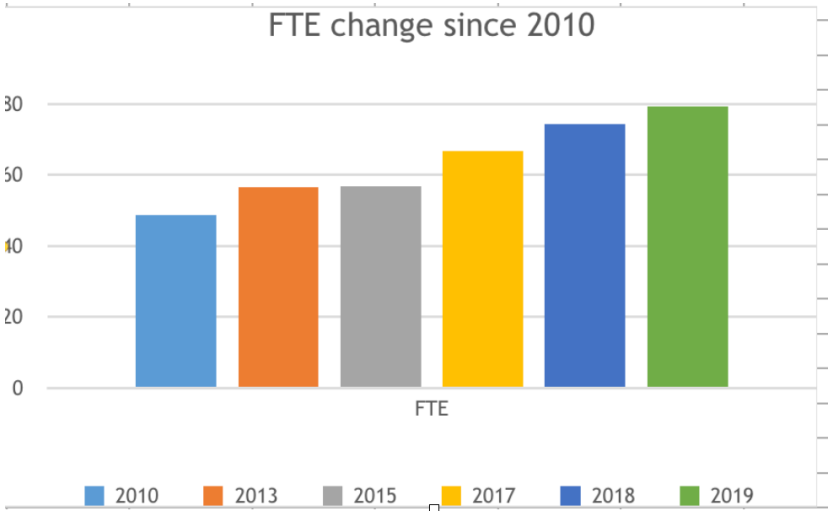
- 74 FTE including 21 trainees
- Charge technician and 6 team leaders
- At present 3 year apprenticeship model- Changing to a degree soon.

Workforce

- Acute Pain Nurses
- Resuscitation for the hospital
- Research Co-ordinator

SMOs

- 2020 - 70 SMOs
- 30% female
- Recruitment



What does an anaesthetist do

- 11 Theatres in Parkside
- 5 DSU
- 2 CWH
- 4 Burwood
- Non OT GAs - MRI,CT,Gastroscopy

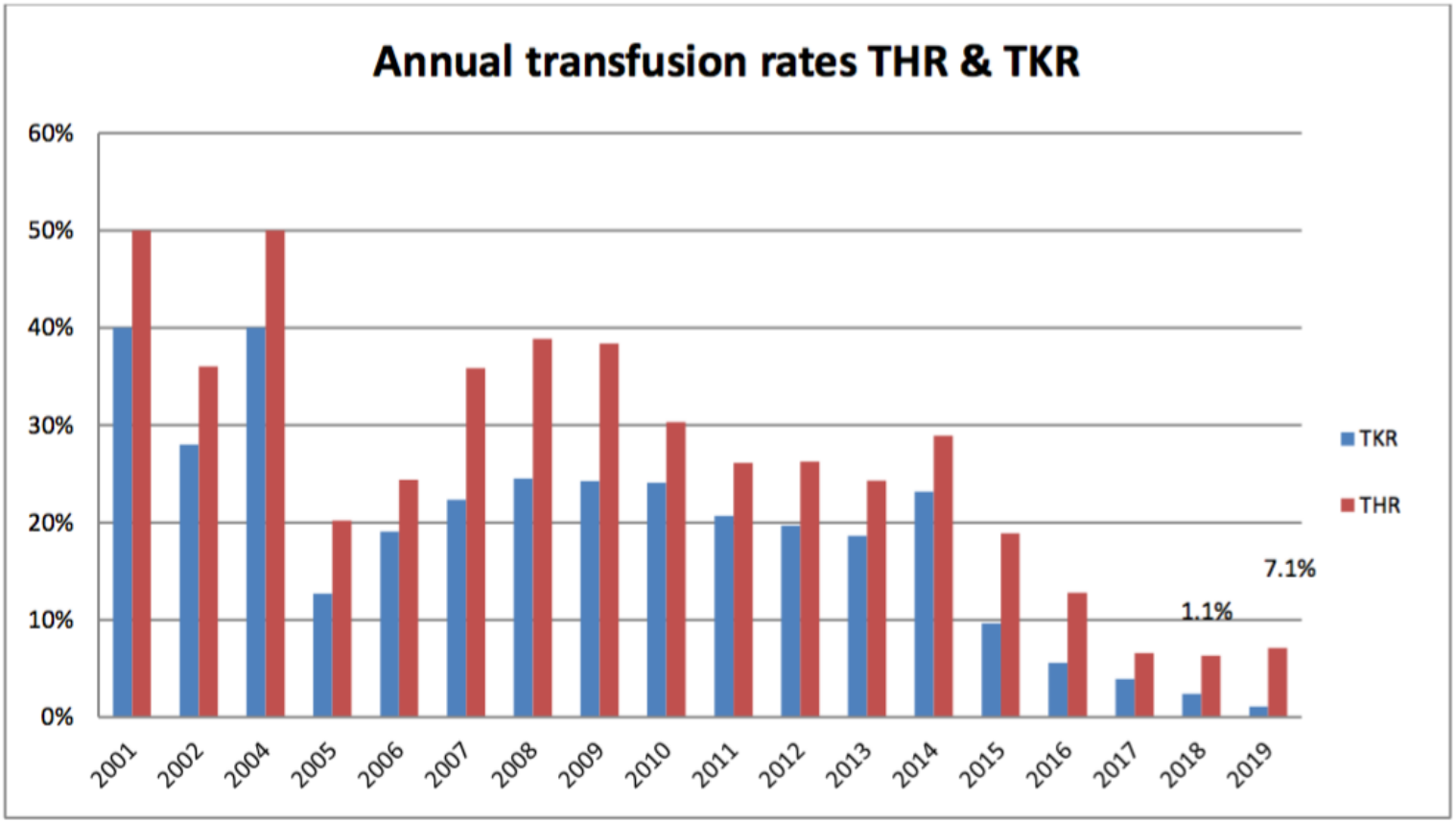
Rosters

- General/Obstretrics
- Paediatrics
- Cardiac
- Weekend Roster

Outside Theatre

- Daily co-ordination- Duty Anaesthetist
- Weekly and General co-ordination-Carole Stuart
- Teaching
- Christchurch Womens hospital
- Pre-Admission-BWD and Public

BWD


Annual transfusion rates THR & TKR
60%
50%
40%
30%
20%
10%
0%
2001
2002
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
1.1%
7.1%
TKR
THR

Airway Leads Anaesthetist Goals

- Liaising specifically with other specialities in particular ICU ED and ENT to ensure consistency and standardisation throughout the hospital. Liaison and collaboration with other anaesthetic departments in NZ via the Airway Leads Network.
- Overseeing local training for anaesthetists and promoting comprehensive airway management education.
- Ensuring that local policies for airway emergencies exist and are disseminated and translated into practice.
- Ensuring that appropriate difficult airway equipment is available, complies with the local guidelines and is standardised within the organisation (reference ANZCA Professional document, PS56, 2012, Equipment to Manage a Difficult Airway).
- Actively engaging in airway device procurement and ensuring that equipment is fit for purpose and complies with a minimum standard, as outlined in the DAS ADEPT study.

Airway Leads Anaesthetist Actions (abbreviated)

- We have formed a hospital airway committee to ensure that the above is put in place
- We now undertake multidisciplinary teaching sessions, audit and morbidity and mortality reviews. Ensuring a collaborative approach to managing complex acute life-threatening complications.
- Provides institutional safety by ensuring best practice, closed loop audit and hospital wide agreed protocols.
- The major barrier to implementation of a more comprehensive programme is lack of resource to staff teaching, simulation and multidisciplinary sessions.

Department of Anaesthesia

Global and Regional Impact – Some Examples

Global Engagement: WFSA

- World Federation of Societies of Anaesthesiologists
  - Represents anaesthesiologists in 150 countries worldwide
  - Official liaison role with WHO
- Dr Wayne Morriss is current Director of Programmes and nominee for President 2020-2024.

Benefits

- *Increased CDHB profile*
- *Representation at international meetings*
- *Opportunities for collaboration*

Pacific Engagement

- Pacific Anaesthesia Fellowship
  - For senior Pacific trainees
  - 1 year Hawkes Bay / 1 year Christchurch
- New Zealand Medical Assistance Team
  - Dr Wayne Morriss and Dr Bryce Curran are members
  - Disaster assistance in the Pacific
- Surgical and teaching visits to the Pacific
  - Dr David Linscott, Dr Ben Van der Griend and others

Benefits

- *Increased CDHB profile*
- *Increased clinical expertise*
- *Social responsbility*

Australian-NZ Engagement: Courses

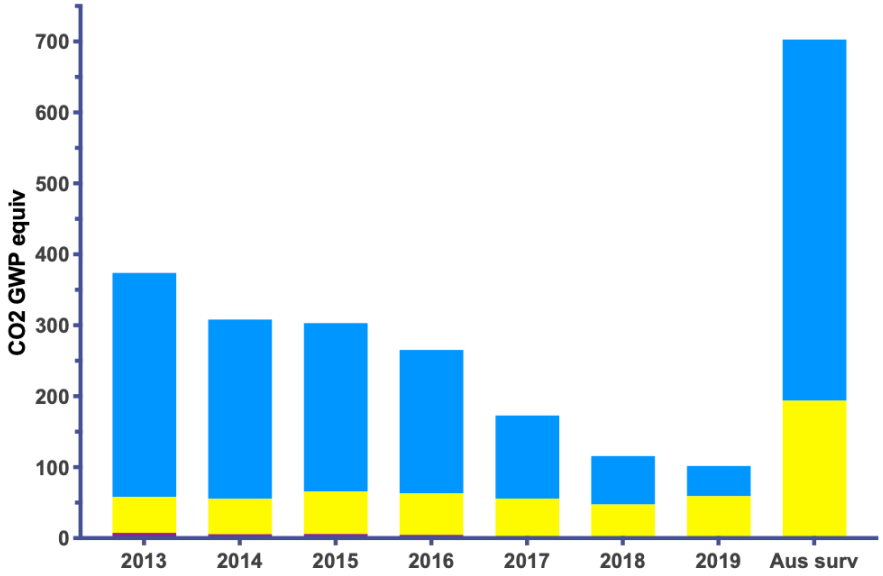
- Primary Revision Course
  - Pre-examination preparation
- Real World Anaesthesia Course (RWAC)
  - Knowledge and skills for people working in disaster or low-resource settings
- Paediatric Anaesthesia Teaching: Christchurch (PAT:CH)
  - Paediatric anaesthesia refrehser

Benefits

- *Increased CDHB profile*
- *Increased clinical expertise*
- *Recruitment opportunities*

Anaesthetic Vapour Use

- We have 18yr high quality data
- Improved efficiency driven by:
  - Our own data
  - Collaboration with GE
  - Investment by DHB in technology



- Graph shows reduction in CO2 footprint over 6 yr
  - 370 -> 103 t CO2 equiv
- If we were “typical” A/NZ users
  - CO2 footprint 7x greater
  - Cost 4x greater (saving $500,000 pa)

Simulation

- Actively support simulation for our department -both SMOs and Trainees
- Hope to familiarise our staff with a Simulation program when moving into Hagley- Our Simulation team have gathered data on how Simulation has shaped the various new hospital moves in Nz and Australia

How do we fare as a department

- What does good look like.
- Quality improvement - 2 week audit cycle
- The March 15th Shooting

Quality Improvement

CDHB Christchurch, Women's and Burwood Hospitals		
Symptomatic PONV	**Numerator**	77
	Denominator	760
	%	10.1
Temperature <36C	**Numerator**	11
	Denominator	716
	%	1.5
Pain review required	**Numerator**	40
	Denominator	787
	%	5.1
Prolonged PACU stay > 2hrs	**Numerator**	82
	Denominator	795
	%	10.3
Respiratory/airway input required	**Numerator**	11
	Denominator	783
	%	1.4

Christchurch Mosques MCI

(preliminary Data assessment)

ISS		Estimated Mortality	Mosques MCI number	Mosques MCI Mortality
1-8	Minor	1%		0%
9-15	Moderate	2%	6+	0%
16-24	severe	7%	7	0%
>24	Very Severe	30%	8	12.5%

Challenges

- Growing size of department and campus
- Influence of private
- Clinical governance
- Research
- Electronic record keeping
- Capex

CLINICAL ADVISOR UPDATE – NURSING

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NOTES ONLY PAGE

H&SS MONITORING REPORT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

DATE: **30 January 2020**

Report Status – For:	Decision	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Committee:

i. notes the Hospital Advisory Committee Activity Report.

3. APPENDICES

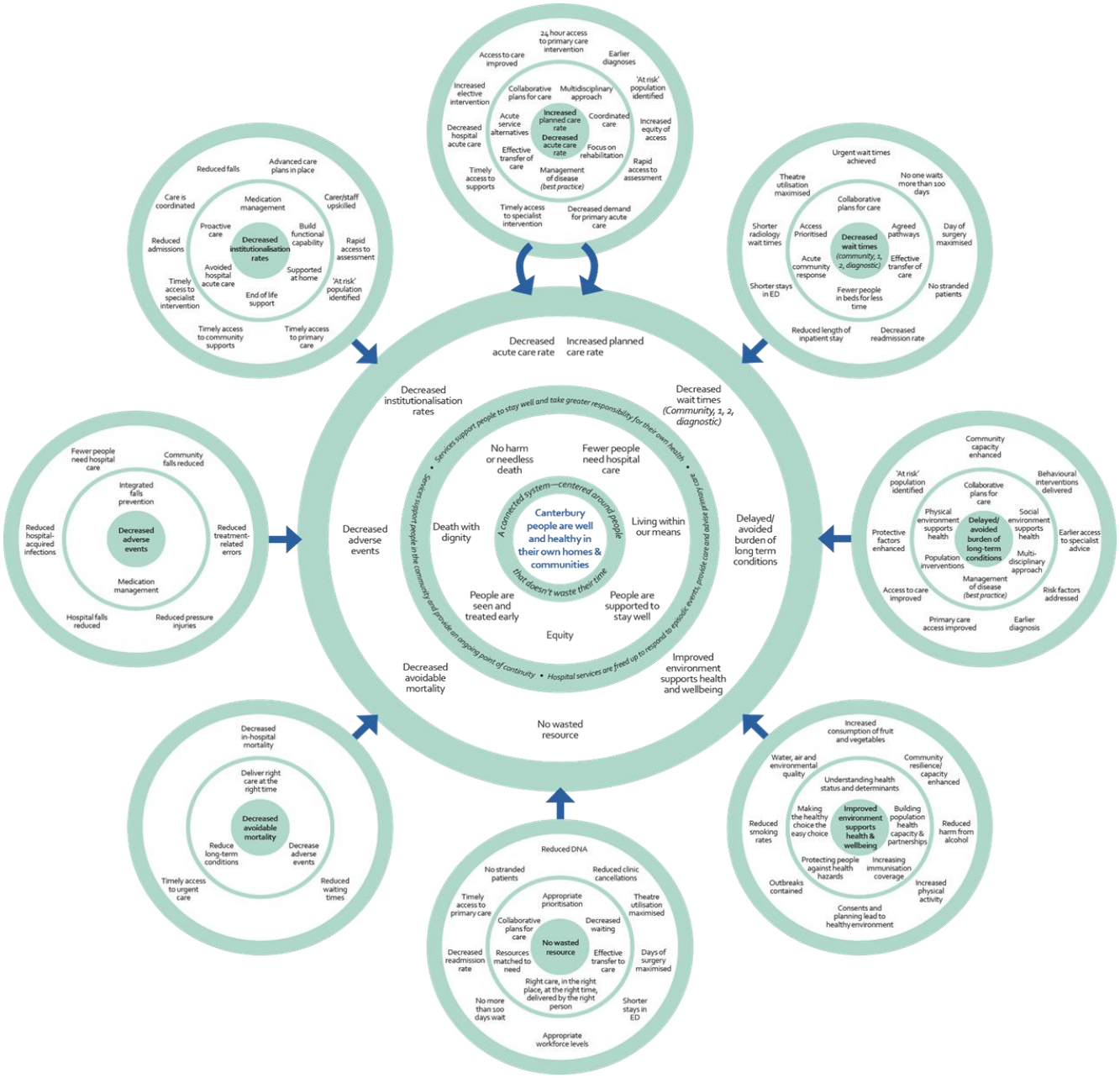
Appendix 1: Hospital Advisory Committee Activity Report –January 2020

Report prepared by: General Managers, Hospital and Specialist Services

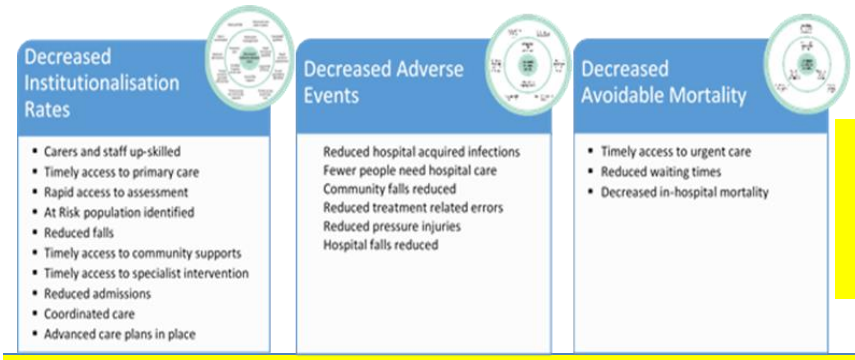
Report approved for release by: Justine White, Executive Director, Finance & Corporate Services

Hospital Advisory Committee

Activity Report



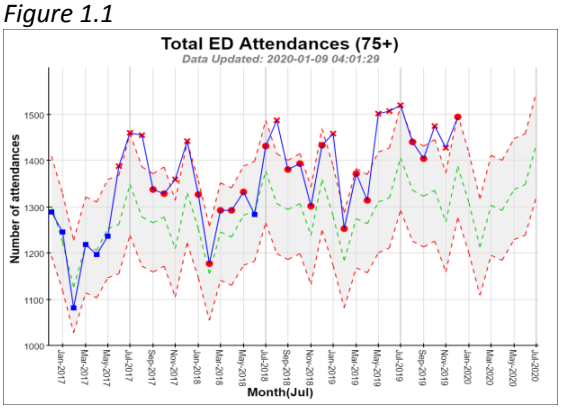
January 2020



Frail Older Persons' Pathway

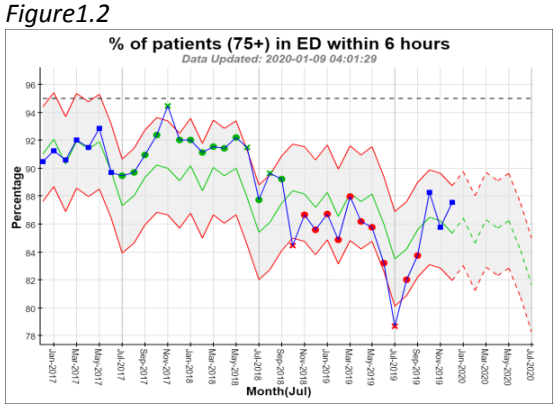
Outcome and Strategy Indicators

Figure 1.1



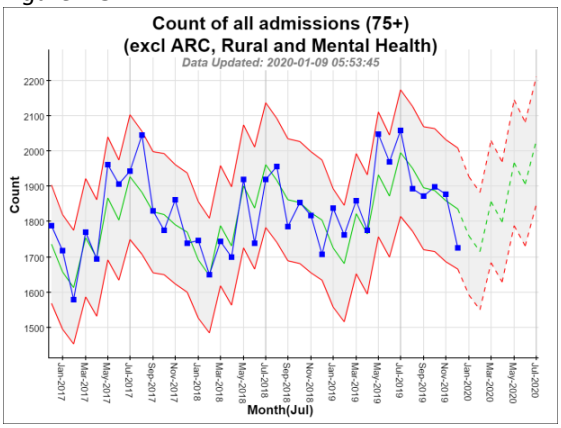
Total ED attendances of people over 75 has increased at a significantly higher rate than the established trend. More patients were seen in the past six and 12-month periods than in any other preceding.

Figure1.2



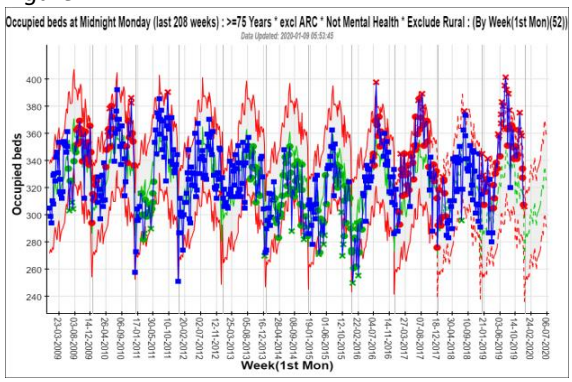
During the past three months the percentage of patients (75years+) seen in ED within 6 hours is greater than the previous year, however is still lower than earlier years.

Figure 1.3



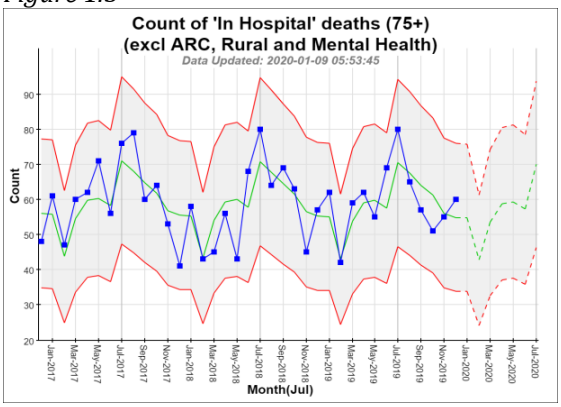
The count of all admissions for people 75 years and over continues to increase in line with the established trend.

Figure 1.4



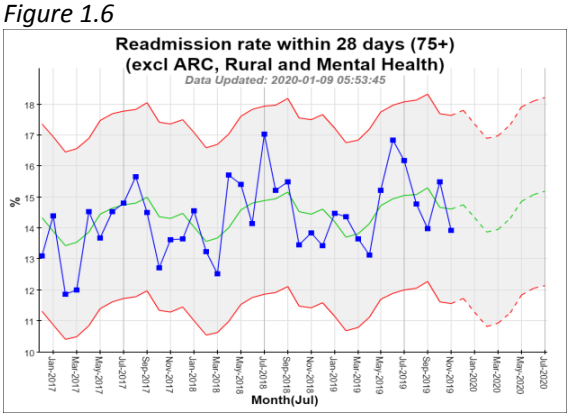
Significantly more beds have been occupied by people >75 than projected for 2019. The winter peak occurred earlier than in 2018 with occupancy by this group of patients continuing to be higher than during similar months in previous years.

Figure 1.5



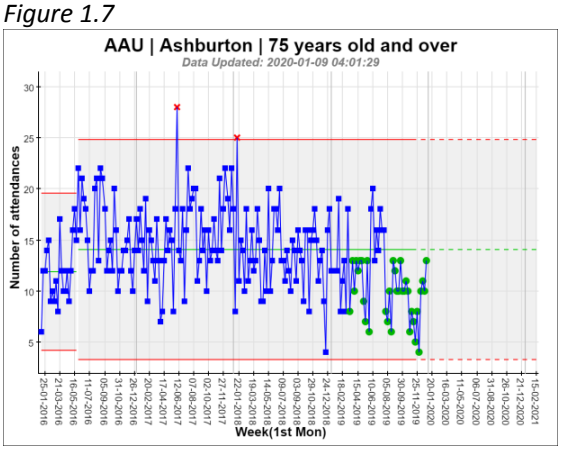
The number of in hospital deaths is within the expected range. Other analysis shows that the established trend of reducing rates of in hospital mortality continues.

Figure 1.6



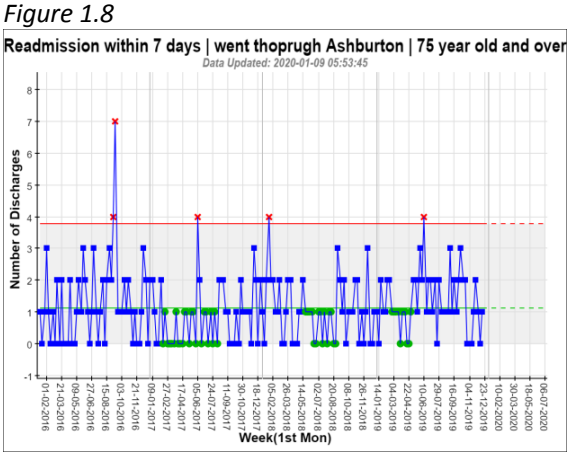
The readmission rate for people aged 75 years and over continues to be within the expected range, which shows a gradual ongoing increase.

Figure 1.7



Ashburton rate of attendances in the 75+ age group is currently running below the mean number of expected attendances.

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

Assessment and identification of pressure injuries and risk

- Development of pressure injuries is a key risk for people who have limited mobility and is associated with spending time in hospital, particularly for the most frail or immobile patients. Pressure injuries can delay a patient's recovery, limit quality of life and mean that longer hospital stays are required.
- Having good information about patients' risk factors for the development of pressure injuries and whether they came into hospital with pressure injuries or developed them while admitted helps us to continually improve the way we care for our patients.
- A new pressure injury alert sticker has been launched in our hospitals late in 2019 that supports the identification and coding of pressure injuries when a person is admitted to hospital.
- Care processes have been improved so we are provided with accurate coding and reporting of pressure injuries, whether they are present on admission to hospital or develop during a hospital admission.

- A pressure injury dashboard that provides pressure injury data trends by rates, length of stay, diagnosis grouping, ward and patient demographics has been created.
- These actions will enable us to better target investigation of pressure injuries, improvement of processes and provision of training to ensure ongoing improvement in this area.

Cortex Nursing and Allied Health Care Plans

- Nursing documentation for patients being cared for as inpatients generally includes the use of a Care Plan in conjunction with progress notes each shift. There has previously not been a standard format for progress notes, paper notes were only available to the person holding the notes and there was significant duplication as the entire paper document was re-written every 24 hours.
- This has been improved by developing the Cortex Inpatient Care Plan (Nursing and Allied Health) to record, update and store information. The functionality developed specifically for the Care Plan ensures a comprehensive document that can be easily created and maintained.
- A range of risk assessments including pressure injury risk, falls risk, nicotine dependence and others are recorded and trigger prompts for actions to be taken further down within the document.
- A 'snapshot' of the Care Plan is then taken at the end of each shift.
- The development of the Cortex Inpatient Care Plan and nursing documentation now provides electronic access to these documents either via the Cortex application or Health Connect South to any clinician that needs this information within the health system.
- Duplication of assessment and documentation has been eliminated both when patients stay in a single ward and when they are transferred between wards.
- Succinct and standardised recording of information is supported.
- Many hours of nursing time are released each day., and significant time is released to patient care tasks each day by decreasing the time that had previously been spent by nurses recording their documentation at the end of each shift.

Development of a telestroke service throughout the South Island

- Over recent months the rollout of a telestroke service has occurred throughout the South Island. It has been in place for West Coast patient for some time now and commenced for patients from Dunedin, Timaru and Invercargill during September and October.
- This service involves provision of neurologist consultation using telehealth tools to guide imaging and treatment choices for people who may have had a stroke.
- Imaging is carried out at the hospital of presentation, images are viewed electronically by a specialist neurologist and telehealth supports evaluation of the patient and communication between clinical teams.
- Information is entered in Health Connect South to enable immediate access by clinicians throughout the South Island.
- This enables timely advice to be provided about whether thrombolysis should start, or the patient transported to Christchurch for clot retrieval. Rapid treatment through initiation of thrombolysis or clot retrieval where it is judged as being beneficial is key to reducing function lost following a stroke.
- Improved processes to support collection of data to support clinical audit and continuous improvement are being explored.

Allocation of staff to ensure surgical flow.

- Hagley was initially going to open in November 2019 and now has no confirmed open date.
- Staff for the extended Day Surgery service were employed for January 2020 to return outsourced surgery.
- Some of the staff appointments have been deferred. However, appointments that have not been able to be deferred have been used to support changes in acute patient pathways.

- Patients returning from leave for acute surgery have been relocated to the Day Surgery Unit to reduce workload and additional staffing demand in wards previously housing these patients in lounges.
- The additional staff will be used for cover across the hospital on a shift to shift basis – replacing some of our external agency use.

Improved management of hoist slings in orthopaedic wards releasing time for care

- Patients in orthopaedic wards who are unable to weight bear rely on physiotherapists and nurses to transfer them from bed to chair. Hoists, with washable slings, are used to affect this in a way that is safe for patients and staff.
- The slings used for this purpose come in several sizes and other variations. A physiotherapist carrying out a Collabor8 improvement project recognised that time was being wasted each day by nurses and physiotherapists searching for the appropriate slings.
- To improve this the area used to store this equipment has been reorganised with containers put in place for each sling variation so that stock levels are easily visible and a laminated stock control sheet for staff to mark when they remove an item has been put in place.
- This enables hospital aides to easily ensure that stock levels are managed.
- This simple change has released at least 26 hours of nursing and physiotherapist time to care tasks each year – the true benefit is likely to be larger than this due to avoidance of the need to arrange for delivery of stock outside of our normal cycles.

Improving care for out of hospital heart attacks

- Ensuring that the right care is provided very quickly to people that have an ST elevation myocardial infarction is key to ensuring that as much heart muscle as possible remains viable, in turn ensuring the best recovery possible from this form of heart attack.
- The South Island Cardiac workstream, in conjunction with the National Cardiac Network and the Ambulance sector has developed a South Island pathway for patients having an ST elevation myocardial infarct outside of hospital.
- If patients from Canterbury, South Canterbury and the West Coast can be transported to Christchurch Hospital within 90 minutes then this is given priority.
- If this cannot be achieved, the pathway provides direction to St John personnel about how to evaluate a patient's suitability for fibrinolytic therapy.
- Electronic transmission of electrocardiogram results to the Cardiac Team and Emergency Department at Christchurch Hospital allows the clinical team to provide advice to St. John staff in the field if required and prepare the Cardiac Catheter Lab in expectation of an arriving patient.
- Once at Christchurch Hospital patients are transferred to the cardiac catheter lab on the ambulance stretcher, to avoid delay.
- Approximately 200 patients with ST elevation myocardial infarct are treated in the Cardiac Catheter Laboratory each year.
- Approximately 100 patients per year will benefit directly from the agreed pathway by receiving fibrinolytic therapy within 90 minutes. Providing people with ST elevation myocardial infarction assessment in the community by St. John paramedics will decrease time associated with transfer to hospital, preserve cardiac function and improve outcomes for patients through the region.

Use of Early Warning Scores to improve the care of new mothers.

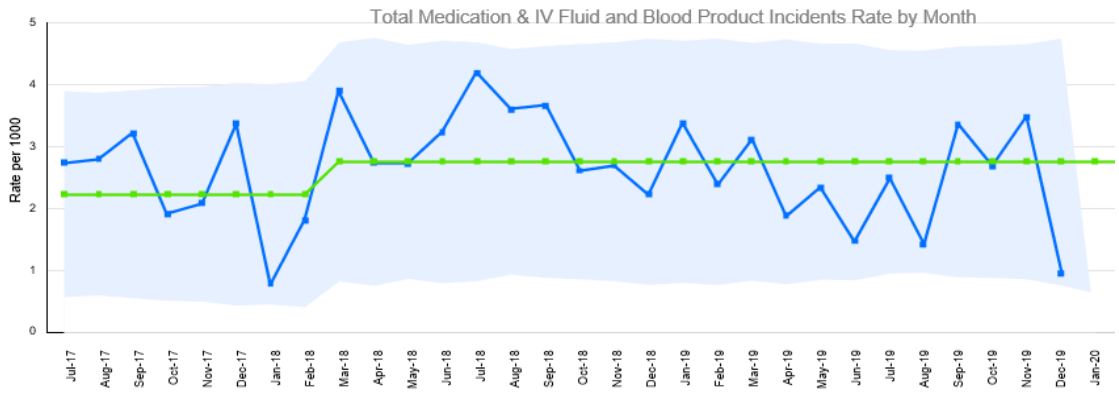
- Phase one rollout of the national Maternity Early Warning System was introduced in the Maternity ward, Birthing Suite, Women's Outpatient clinics and the Maternity Assessment Unit.
- This is based on the New Zealand adult Early Warning Score system that was implemented throughout Canterbury DHB as a part of the patient deterioration programme.
- It is designed specifically to address the unique physiology related to pregnancy which can mask early indicators of deterioration and helps clinicians identify when a pregnant woman's condition is becoming worse, prompting a rapid response using the tailored escalation pathway.

- The system has been developed nationally and provides a standardised chart regardless of ward setting and is from the time of a positive pregnancy test through to 6 weeks postnatal.
- Canterbury District Health Board is part of the first cohort nationally to implement this system. The West Coast has also recently implemented the system.
- Work has now begun on implementing this system in the seven primary birthing units and will then be introduced to our non-maternity areas to ensure that a consistent approach is applied to recognising risk of deteriorating during pregnancy no matter where we provide this care.
- Future plans include implementing PatientTrack within Women's and the Neonatal Early Warning Score as a lead cohort within the national programme of work.

Promotion of Te Reo Māori in the Emergency Department.

- The Emergency Department is often the first entry into hospital, which can be a stressful environment, and cultural support can make a difference.
- To encourage everyday use of te reo, lanyard cards and booklets were created to promote te reo throughout the hospital, especially when Emergency Department staff are interacting with others from different departments and have been well received by staff.
- Feedback from patients has also been positive, and that being greeted with 'kia ora' and hearing te reo gives a sense of belonging and feeling welcome, as some tūroro have fed back information that being an inpatient is very overwhelming and can cause anxiety for some.
- This initiative helps make that better.

Medication Incidents Older Persons Health and Rehabilitation (OPH&R)

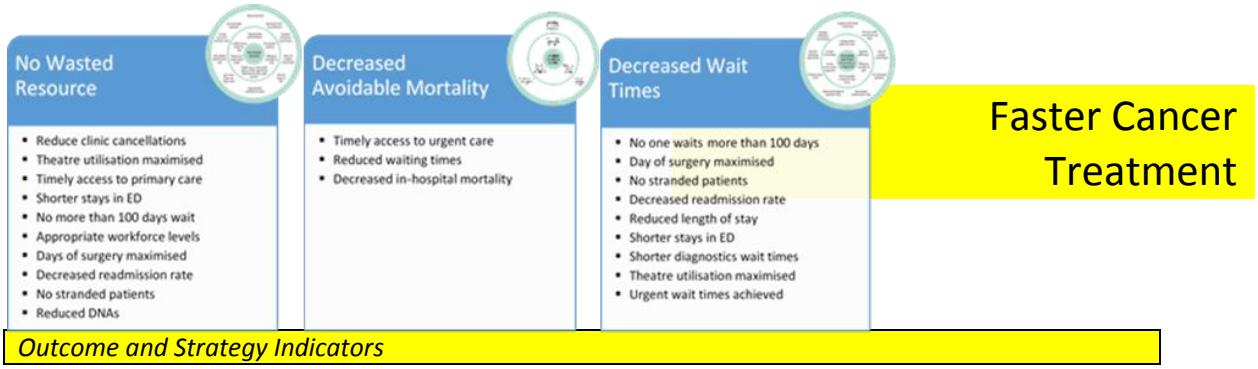


Medication incidents are a key focus area within OPH&R. The Quality Facilitators produce a monthly Medication Clinical Indicator Report that provides a breakdown by ward of all reported medication errors. Missing medication data from Safety1st that classes a medication error as 'other' are reviewed by the Quality Facilitators to ensure classification of the incident is correct to provide the greatest integrity to results. Reports and results are discussed at OPH&R Leadership group meetings, OPH&R Clinical Governance, and with individuals as appropriate. Results are presented by Quality Facilitators at ward-based meetings and are loaded into the quality improvement service library. In addition, the OPH&R Serious Event Review group review all OPH&R SAC 3 & 4 incidents weekly, including wrong drug, wrong dose and wrong patient.

The OPH&R Serious Event Review group have implemented a new process in 2019 to learn more about these preventable medication errors (wrong drug, wrong dose and wrong patient). The new process involves all clinical staff, Safety1st incident submitters, and Charge Nurse Managers /supervisory Senior Medical Officers and aims to understand more about where in the process medication errors occur; increase our knowledge to inform improvements so that we can strengthen our systems, processes, communication and clinical environments. By doing so, we aim to promote our patients' right to safe care.

Ashburton Health Services

- The presentation and balancing measure for people over 75 presenting to Ashburton hospital remains within trend, the clinical and operational teams are focused on system level activity that enables care to be delivered in the community within the constraints reported by primary care. This is preparation work for seasonal pressures, “winter planning”.
- Allied Health Clinical Manager and the Community Charge Nurse manager have a short term project focus to increase the application of careplans in Ashburton. Working Canterbury Clinical Network, the goal is to ensure care plans are implemented, reviewed and updated when patients connect with any member of the local hospital or community team. The updated plans are then visible in primary care, supporting the intent of system readiness for future presentations, with medium term outcome of reduced presentations to AAU.
- This quarter we are increasing our focus on community service providers and the opportunity to build “reach in” models and practice that remove barriers to discharge, with the focus of restorative care. Included in this is the implementation of the new case mix model for home support services. Through this we have established an operations group that brings together community pharmacy, all home-based support providers, Needs Assessment and Service Coordination (NASC), district nursing and local NGO providers, identifying integrated approaches for community service delivery.
- An overt practice of cross campus bed management and resource deployment has been in place for the previous six months, with work underway to implement a single roster for nursing and health care assistants to fully embed this practice. This ensures resources are deployed to occupancy as the team follow the patient load and reduces the pressure to roster additional staff in local wards. FloView and e-transfer are fully utilised by the team locally and reaching into Christchurch campus to identify patients that can be transferred through to Ashburton. A comprehensive hand over from all service areas to Duty Nurse Manager in the evening has enabled the overnight team to deploy the same approach.
- Alongside this the Allied Health Physiotherapy Team Leader has introduced the SARA Steady in Ward 2. This equipment helps the nursing team with patient mobilisation and transfers, reducing the requirement for two staff members to assist the patient, which in turn reduces the pressure on nursing and health care assistant staff. Following a successful trial, donated funds for patient equipment have enabled us to order a further two pieces of equipment to be used.
- Challenges remain in identifying local primary care providers who will accept the enrolment of patients moving into Aged Residential Care (ARC) facilities in our community. This can delay discharge from the hospital bed and is a stressful time for families who are working through a significant change. Having identified a suitable rest-home they are unable to progress their desired change in home. We continue to work the local practices and primary care workers (PCWs) to improve Ashburton community members enrol with general practice.



Outcome and Strategy Indicators

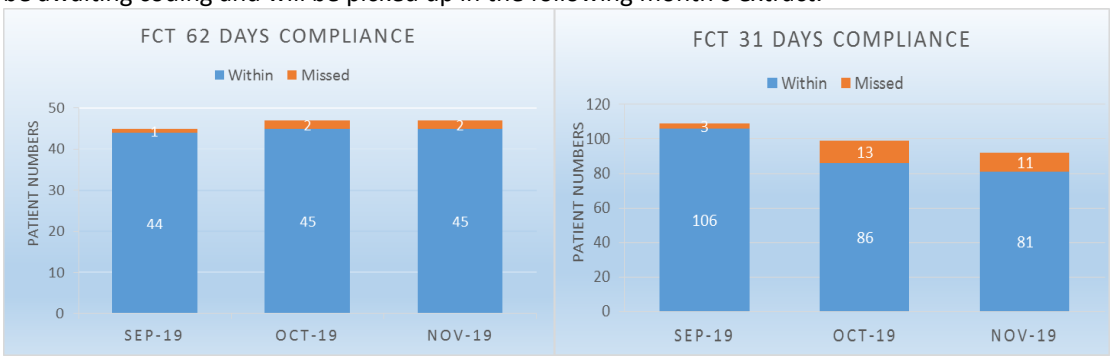
Key Outcomes - Faster Cancer Treatment Targets (FCT)

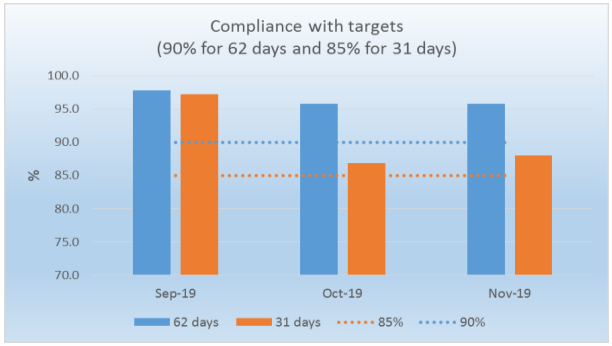
62 Day Target. In the three months of September, October and November 2019, of the 160 records submitted by Canterbury District Health Board 26 patients missed the 62 days target, 21 did so through patient choice or clinical reasons and are therefore excluded from consideration. With 5 of the 139 included patients missing the 62 days target our compliance rate was 96%, meeting the 90% target.

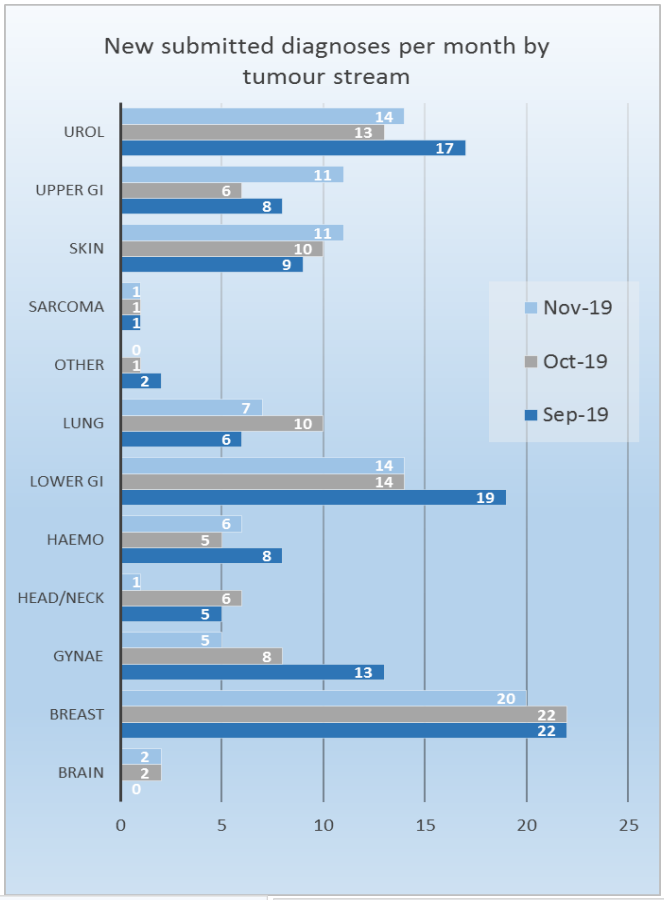
31 Day Performance Measure. Of 300 records towards the 31-day measure 273 (91%) eligible patients received their first treatment within 31 days from a decision to treat, meeting the 85% target. Of the 27 patients who missed the 31 day target, 15 missed it by five days or less and 5 through patient choice or clinical considerations.

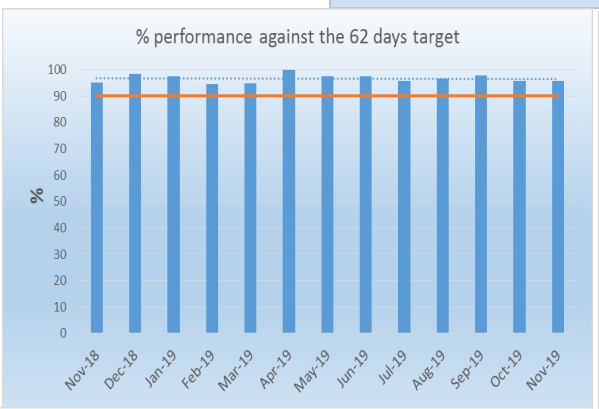
FCT performance in CDHB

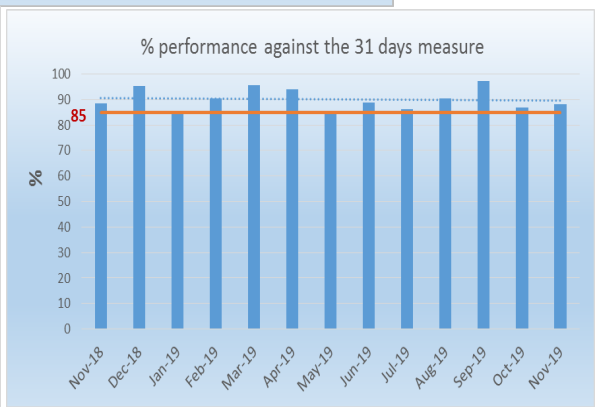
The dip in numbers in the last month of every report (November in this case) reflects the timing of when the report is compiled which is governed by the reporting requirements of the Ministry. A significant number of the patients who have a first treatment date in the period this report covers will be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

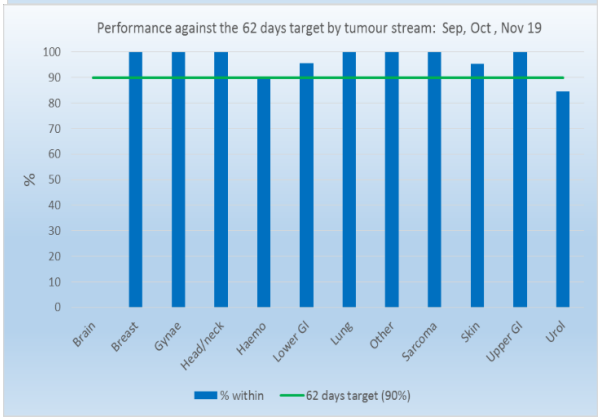


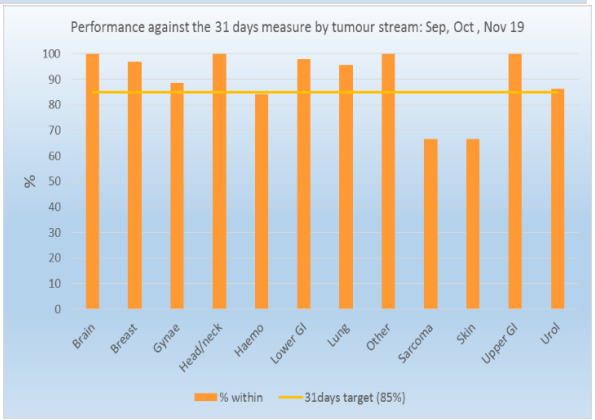



New submitted diagnoses per month by tumour stream
UROL
UPPER GI
SKIN
SARCOMA
OTHER
LUNG
LOWER GI
HAEMO
HEAD/NECK
GYNAE
BREAST
BRAIN
Nov-19
Oct-19
Sep-19
0
5
10
15
20
25


% performance against the 62 days target
%
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19


% performance against the 31 days measure
85
%
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19


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

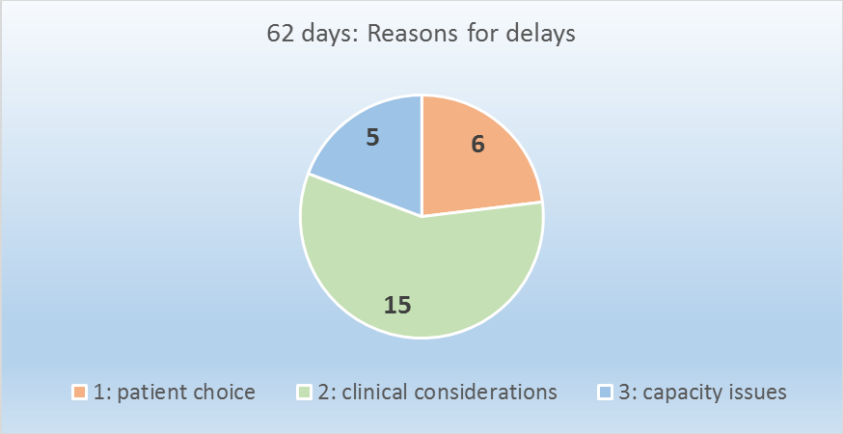

Performance against the 31 days measure by tumour stream: Sep, Oct , Nov 19
%
Brain
Breast
Gynae
Head/neck
Haemo
Lower GI
Lung
Other
Sarcoma
Skin
Upper GI
Urol
% within
31days target (85%)

Patients who miss the targets

The Ministry of health (MoH) requires DHBs to allocate a code (referred to as a delay code) to all patients who miss the 62 days target. There are three codes but only one can be used, even if the delay is due to a combination of circumstances, which is often the case. When this happens the reason that caused the greatest delay is the one chosen.

The codes are:

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



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

Achievements/Issues of Note

Improving patient safety in the brachytherapy service

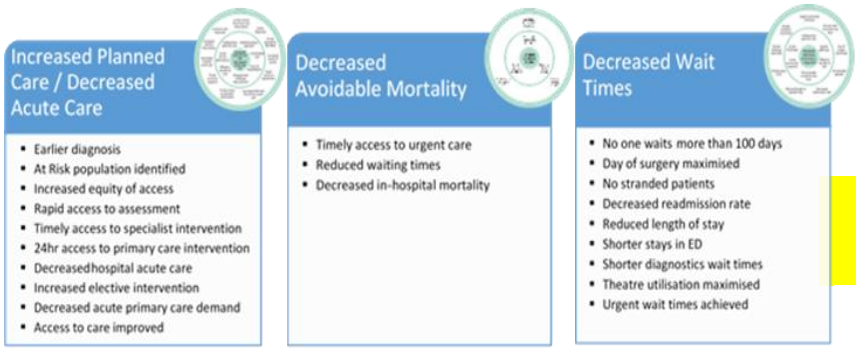
- The brachytherapy service at Christchurch Hospital treats gynaecological and prostate cancers using a small radioactive source that is delivered by a machine on a wire, into a tube inserted into the patient.
- Brachytherapy procedures are complicated, incorporating many steps that have potential for error, this can have significant consequences including reduced chance of curing cancer or increased chance of radiation damage to healthy tissue.
- Some of the most damaging errors can occur at treatment – due to mistakes such as connecting tubes incorrectly or delivering the wrong plan.
- Changes have been made so that the information required is now on laminated printed sheets in the patient room, a time-out period has been introduced where a checklist of tasks is used to ensure that all tasks have been carried out.
- These changes will support the safe provision of this complex care, reducing potential for errors and poor outcomes for our patients.

Tailoring care for adolescents and young adults in the Bone Marrow Transplant Unit

- Adolescents and young adults, people aged between 16 and 24, are regularly cared for in the Bone Marrow Transplant Unit and have a unique set of needs. A group of cancers particularly afflicts this age group and do so at a time when people are developing their ideas about who they are and are becoming independent of their parents.
- A scholarship has been put in place by the family of Nicola Robinson that provides an opportunity for nursing and allied health staff to undertake postgraduate study in this specialist field
- Over the past two years this has enabled two nurses to undertake study that enables improvement in the way that we care for group of people. The expert knowledge this develops within our nursing team supports the rest of the team in providing quality care to this group.
- This expertise has been key in the development of the Adolescents and Young Adults area of the new unit. The design process has included focus group evenings with the Canteen Group
- It also supports the development of care pathways for this group. These include development of ideas about food preferences, time of doctor rounds and development of a patient profile form that helps communication about likes and dislikes with the team that is providing care.
- As a result of this study two new HealthLearn packages have been developed for staff working with this group in Haematology and Oncology wards. These support the provision of high quality care to this group

Improvement of patient information about oncology treatment

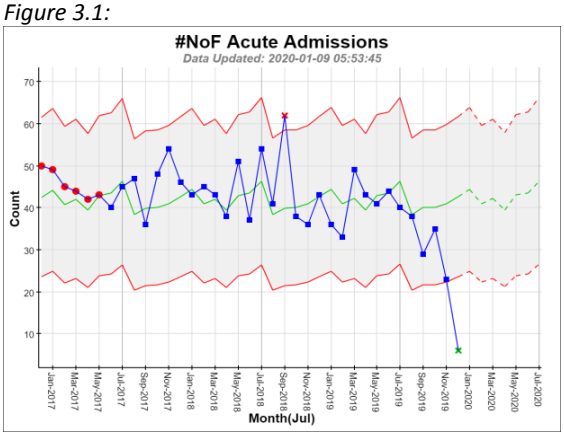
- Supporting people with cancer to gain a good understanding of the treatment they will be receiving ensures that they are able to prepare themselves well, engage with what is necessary to maximise their recovery and reduces anxiety.
- People do not always remember all relevant details after discussions with clinicians. This is understandable given the level of anxiety that can be associated with a diagnosis of cancer and the requirement for chemotherapy or radiation therapy.
- Prior to receiving chemotherapy patients have an appointment with a Medical Oncologist and are provided with both verbal and written information about chemotherapy in general and the treatment being planned for them specifically.
- A registered nurse spends an hour with each patient providing information about their treatment. Ongoing increase in demand for this, and other nursing care, has challenged the capacity available within the nursing team.
- A video has been developed that provides general information about the process of receiving chemotherapy, the different types of therapy available, what to expect and what you need to do on treatment days, what side effects can happen and who to call if they do and a description of support services that are available.
- This film can be watched at home and with family members or other supporters prior to meeting the Registered Nurse and helps patients to think through many questions before the meeting. It helps ensure familiarity with the ideas that will be discussed and improves the chance that these ideas will be retained and processed. This provides the required information, while managing demands for nursing capacity.
- It has been found that many patients watch the video several times, returning to it as they process the information.
- Production of the film was supported by a donation from Jean Proctor's estate to the Oncology Trust Fund.
- Plans are in place to add subtitles for Māori, the hearing appeared and those for who English is not their primary language.
- A similar video has been put in place by the Radiation Oncology Service covering the Radiation Therapy treatment.



Enhanced Recovery After Surgery (ERAS)

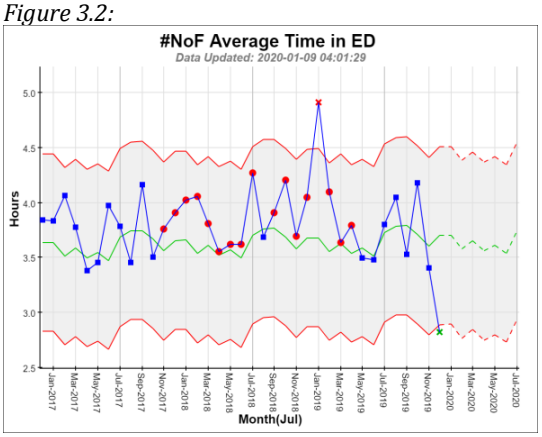
Outcome and Strategy Indicators – Fractured Neck of Femur (#NoF)

Figure 3.1:



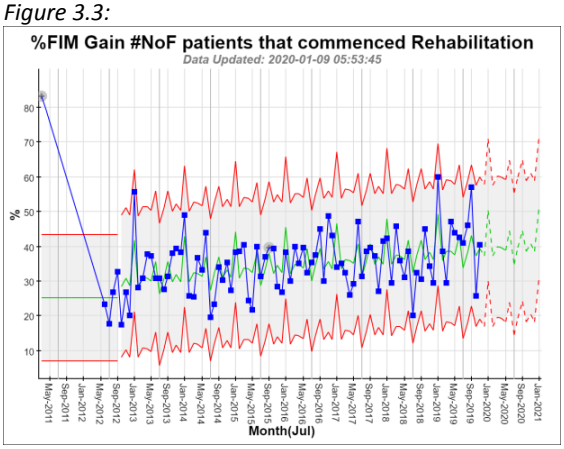
Coding delay has impacted on the latest data record for admissions. Otherwise #NOF admissions is tracking within the expected range.

Figure 3.2:



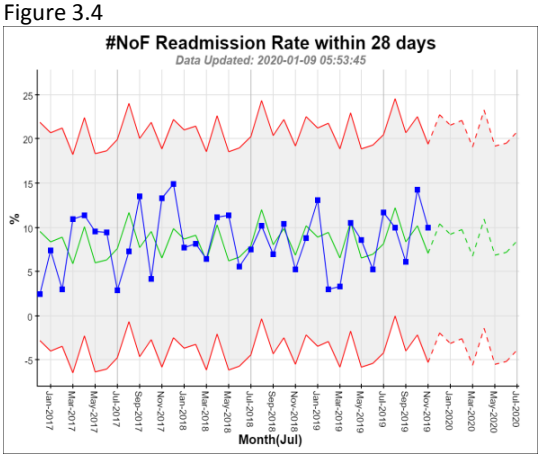
Patients with #NOF show a variable length of stay in ED. Coding delay has impacted the latest data record.

Figure 3.3:



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

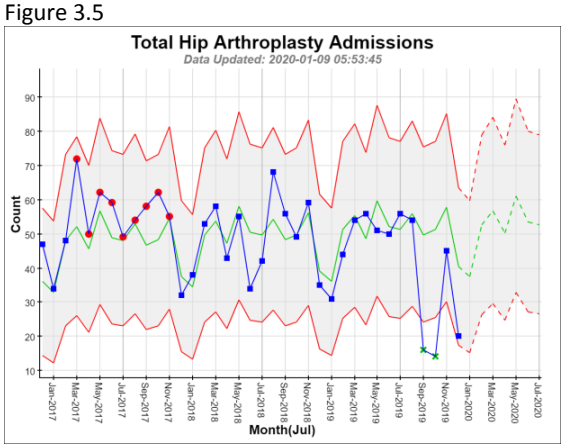
Figure 3.4



Readmissions continue to remain within expected mean values.

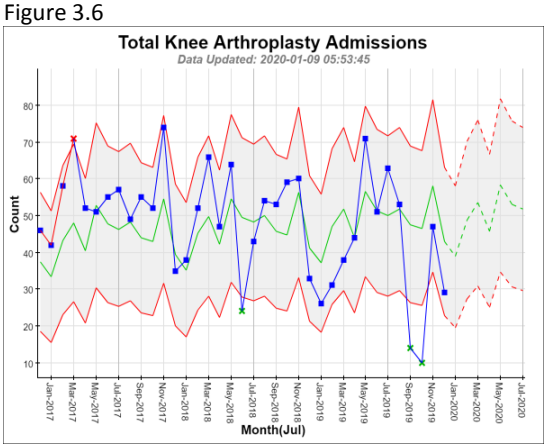
Outcome and Strategy Indicators – Elective Total Hip Replacement(THR) and Knee Replacement(TKR)

Figure 3.5



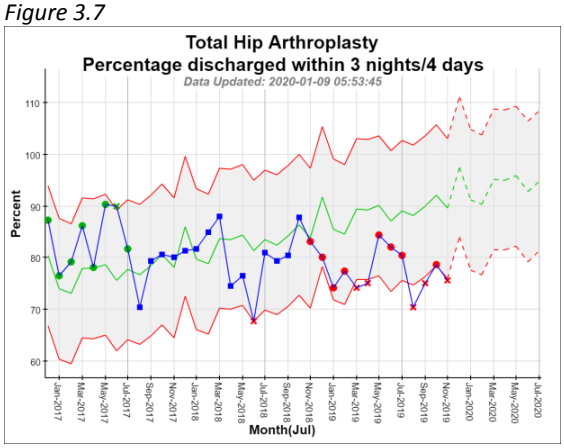
Admissions are trending within the expected range. The increase in demand for acute surgeries in September & October 2019 impacted on the planned admissions

Figure 3.6



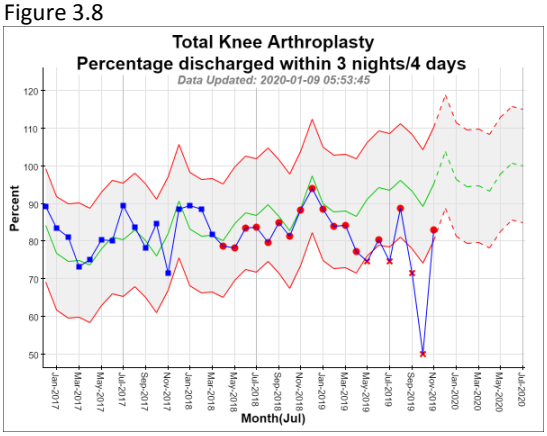
Admissions are trending within the expected range. The increase in demand for acute surgeries in September & October 2019 impacted on the planned admissions

Figure 3.7



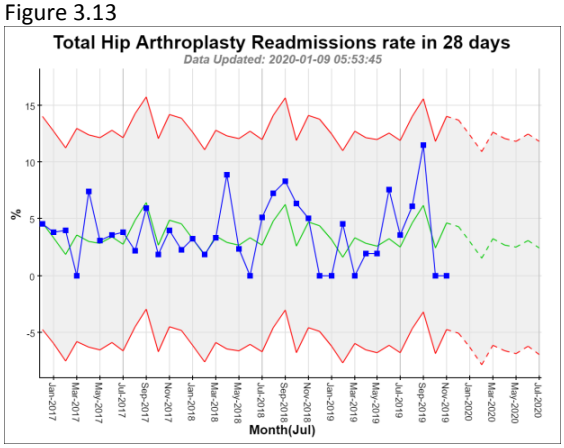
The percentage of patients clinically safe to be discharged is within 3 nights/ 4 days is trending below the expected percentage.

Figure 3.8



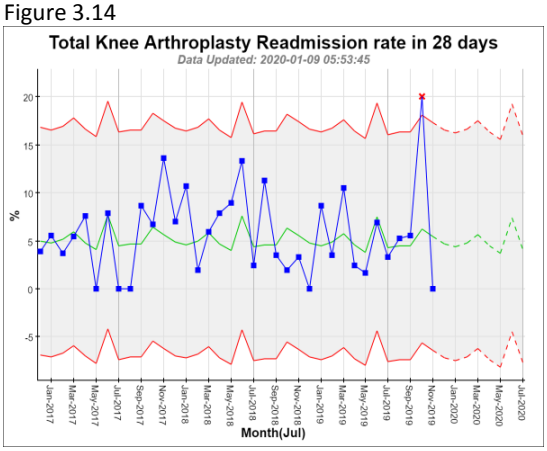
The percentage of patients clinically safe to be discharged is within 3 nights/ 4 days is trending below the expected range.

Figure 3.13

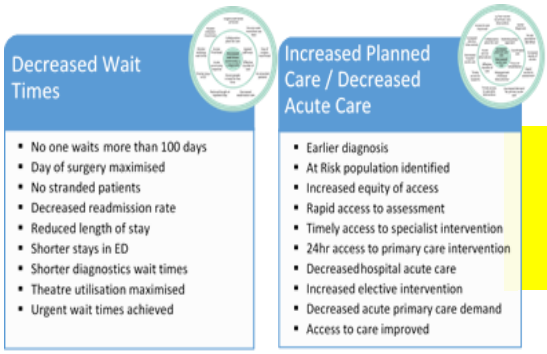


Readmission rates remain close to or above the midline of the expected range.

Figure 3.14



Readmission rates are maintaining within tolerances.



Elective Surgery Performance Indicators 100 Days

Achievements/Issues of Note

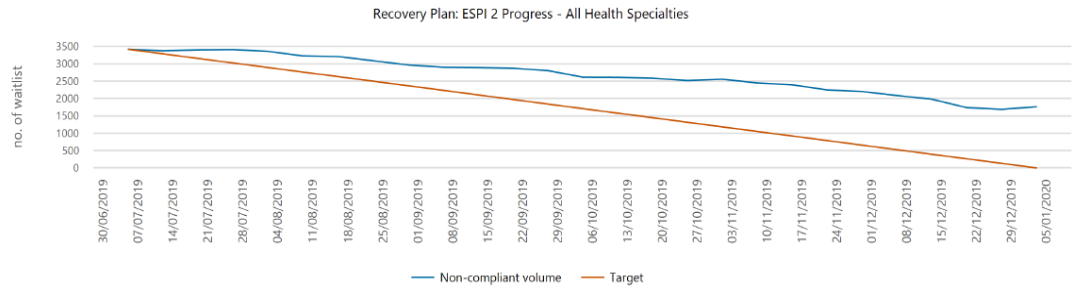
Elective Services Performance Indicators

- Services now have access to more targeted information that helps them to identify and correct data anomalies. For example, we can identify waitlist entries for either a first specialist assessment or surgery that relate to patients who have been seen already and not removed from the wait list.
- Summary reports provided by the Ministry now reflect our internal reporting about the number of people waiting longer than target for their First Specialist Assessment, however Ministry reports about waiting time for surgery require further updating and show significantly higher results than our internal reporting.

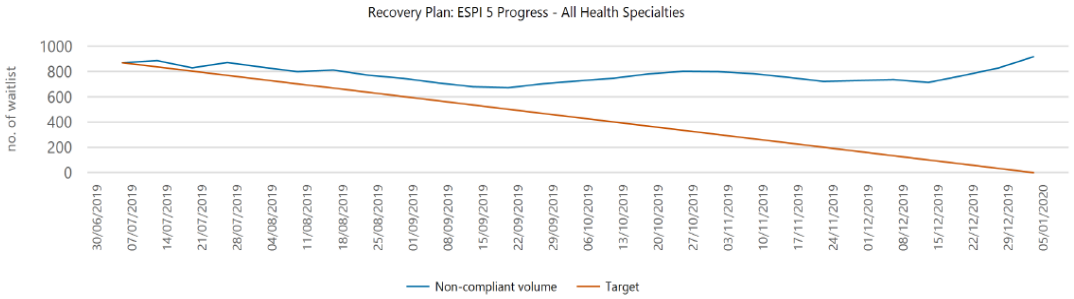
Summary of Patient Flow Indicator (ESPI) results
DHB: Canterbury

	Dec		Jan		Feb		Mar		Apr		May		Jun		Jul		Aug		Sep		Oct		Nov	
	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %
1. DHB services that appropriately acknowledge and process patient referrals within the required timeframe.	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %
2. Patients waiting longer than four months for their first specialist assessment (FSA).	2627	25.2%	3074	29.3%	2805	23.8%	3267	26.6%	3752	29.1%	3736	34.2%	3573	31.2%	3297	26.7%	2633	22.5%	2542	22.7%	2383	21.7%	2042	19.5%
3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT).	1091	7.5%	1005	7.0%	951	6.6%	1015	7.1%	1028	7.2%	648	4.5%	540	3.7%	220	1.5%	288	1.9%	306	2.0%	227	1.5%	249	1.7%
5. Patients given a commitment to treatment but not treated within four months.	925	31.3%	1282	37.0%	1126	30.8%	1113	30.0%	1185	29.9%	1271	27.5%	1350	28.8%	1450	26.9%	1493	28.4%	1694	31.5%	1939	33.4%	2257	36.5%
8. The proportion of patients treated who were prioritised using nationally recognised processes or tools.	119	87.5%	130	90.3%	130	90.1%	166	87.2%	153	86.5%	246	83.3%	261	77.4%	388	73.7%	307	77.4%	196	84.7%	268	79.4%	179	85.5%

- Internal reports show 1,762 patients (18% of the total) waiting for First Specialist Appointment for longer than 120 days while 918 patients (18% of the total waitlist) have waited for surgery for longer than 120 days.
- A recovery plan was agreed with the Ministry of Health that would see both of these measures in green or yellow status by the end of 2019 however this has not been achieved for either waiting lists. Industrial action, our response to the mosques' shootings, flooding of the outpatient department building and the part that we played in the national response to the Whakaari – White Island eruption have affected our ability to achieve green status as planned
- The number of people waiting for longer than 120 days continues to decrease and we are confident that our ongoing efforts will see us working within our own target of 100 days



- The challenges in meeting our recovery plan for surgery waiting time are more troubling. As we make progress in reducing the number of patients waiting for their first appointment with a specialist it inevitably increases the number who are accepted for an elective surgical solution.



- The ongoing delays in the completion of Hagley Hospital are restricting our ability to provide elective surgery. While we can outsource a significant percentage of our elective surgeries to other providers there are many patients who are unsuitable for treatment anywhere other than in the public hospital where theatre time is at a premium.

Otolaryngology waiting list management

- An update provided late in 2019 described some of the work underway to manage waiting times within our target of 100 days in the Otorhinolaryngology (also known as Ear, Nose and Throat) department. This update provides further information.
- In March 2019 the service had 2,000 patients on its waiting list for first specialist assessment, many waiting longer than 100 days. Advice from lean coaches is that this service's waitlist should not exceed 800 patients.
- The service and General Practice Liaison have developed clear definitions about which, work can be carried out by general practices, and which work requires the specialist team.
- The threshold for accepting referrals has been raised and follow up care that can be achieved in the community has been returned to General Practice. Tools have been provided to General Practice to support these changes.
- The model for caring for children with severe cases of sleep apnoea has been changed so that more children to be seen during each clinic. Teaching previously provided to parents during the clinic is undertaken by a nurse.
- Review of the Resident Medical Officers' schedule has enabled a further 21 clinic sessions to be provided (around 210 patients) each month.
- The introduction of E-triage has made communication between general practitioners and the service much more efficient. Management of referrals that provide insufficient information to enable triage of cases is now easily managed by the triaging Consultant.
- Booking Clerks now book for Audiology and specialist clinics enabling a more integrated approach.
- The booking team has demonstrated ongoing commitment to improvements in the way that it works.

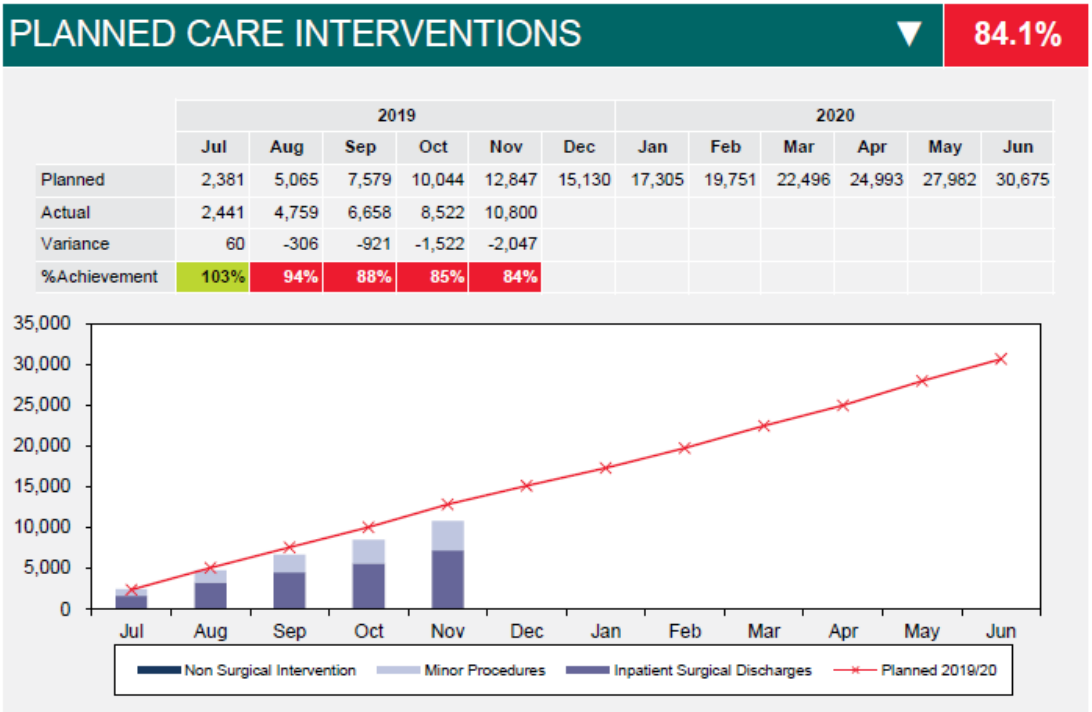
- The team ran a Saturday super clinic for First Specialist Assessments. 120 patients were seen, all patients booked attended.
- Between April and December the number of people waiting for a first specialist assessment has reduced from 2,000 to 1,347, the number of people waiting for longer than 120 days has reduced from 900 to 464.
- People not requiring specialist services are being cared for in the community, releasing capacity for more timely care of people whose care can only able to be provided by the specialist service, support the organisation's aim to see patients within our target periods.

Nuclear Medicine facility redevelopment increases capacity to meet demand –

- Nuclear Medicine and Medical Physics and Bioengineering Departments occupy one side of the second floor of the Clinical Services Building. This area has changed little since its initial commissioning in 1970. Until recently this area housed a gamma camera and a scanner known as a SPECT-CT. This area has been redeveloped over the past year. As a part of this a modern SPECT-CT system has been installed that provides images with improved diagnostic quality
- Both Gamma Cameras and SPECT-CT involve the use of a small quantity of radioactively tagged molecules. Whereas a gamma camera provides two dimensional images, SPECT-CT provides three dimensional, anatomically correlated images that allow clinicians to gain very clear information about the location and extent of disease and its involvement with normal tissue, thus providing a valuable tool in targeting cancer.
- The introduction of a second SPECT-CT scanner will lead to a moderate increase in the number of SPECT-CT scans per year because the machines are dual-purpose and need to perform regular gamma camera imaging as well. More importantly, it will halt the 30% of patients who had to be moved from the gamma camera to SPECT-CT because of image findings on the gamma camera. This will significantly improve patient flow. It enables us to provide more prompt imaging and higher diagnostic accuracy for people with cancer plus increased patient throughput for cardiac imaging and timely treatment of other life-threatening conditions such as pulmonary embolism.
- A previously cramped patient waiting area has been rebuilt to provide a more comfortable space for patients.
- Patient privacy rooms and a shielded inpatient bed bay have been created to ensure that inpatients are no longer cared for in a corridor and that patients receive their care in a private setting.
- A staff room has been replaced with an improved procedure room for cardiac stress testing and injection of radiopharmaceuticals. This provides much larger and safer clinical space, with access to both sides of the bed, room for all the required equipment and ordered storage space for the equipment used.

Planned Care Interventions

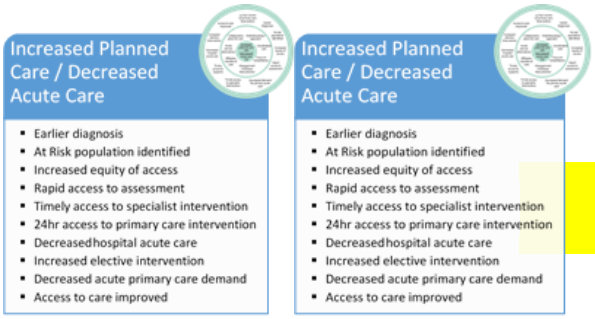
- Planned care targets have been agreed with the Ministry of Health and incorporate planned inpatient operations as well as range of procedures provided to hospital outpatients and patients in community settings.



- At 13 December 2019 we have provided 8,891 planned inpatient surgical discharges, 161 discharges, or 1.8%, less than the phased target of 9,052. The target for inpatient planned volumes is set at the same level as last year's target. There is confidence that in the absence of the extraordinary circumstances experienced in 2018/19 the end of year target will be met.
- Our overall target for minor procedures at this point of the year is 5,200 our plan is that 4,120 of these will be carried out in a hospital setting (either inpatient or outpatient). This is a new component in our planned procedure reporting and work practices to ensure all relevant data are counted against the target are being worked through. 3,899 minor procedures have been recorded in a hospital setting against the plan of 4,120 - 221 procedures, or 5%, less than target.
- The final component added to this year's planned procedure target is the provision of publicly funded procedures and non-surgical intervention in community settings. This is an area in which Canterbury has led the country. Provision of data from primary care to the Ministry of Health's National Minimum Dataset collection is being worked on so that these volumes are counted.

Acute surgical flow over Christmas and New Year.

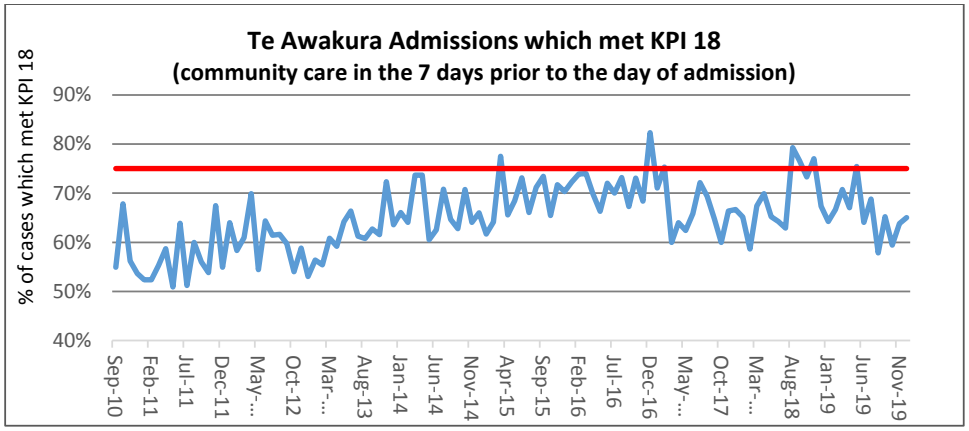
- There was a large volume of people requiring surgery during the holiday period. Patients admitted during the holiday period spent more time in theatre than those admitted in any previous Christmas/New Year period with 673 hours of theatre demand created by acute admissions from Friday20th December until Friday 3rd January. Orthopaedics experienced high demand with 260 hours of acute operating generated during this period and General Surgery 162 hours.
- More theatre capacity was scheduled than during any other prior Christmas and New Year Period. The number of hours operating provided in the 15 days until 3rd January exceeded that associated with the acute presentations during this period - with 775 hours of acute surgery provided during the 15 day period.
- A small 'scrum' focused planning group was put in place involving anaesthesia, surgeons, senior theatre nursing and subject experts.
- Additional acute theatres were staffed on 2nd during the weekend of 4th and 5th January to meet the orthopaedic demand and fully utilise available surgeons.
- This saw capacity matching demand by 6 January 2020.
- A temporary increase in inpatient beds was required for the immediate post-operative patients, but the additional capacity provided prevented the extended list of patients waiting that we saw the previous year. The extended waitlist for acute surgery took 3-4 weeks to clear in January 2019.

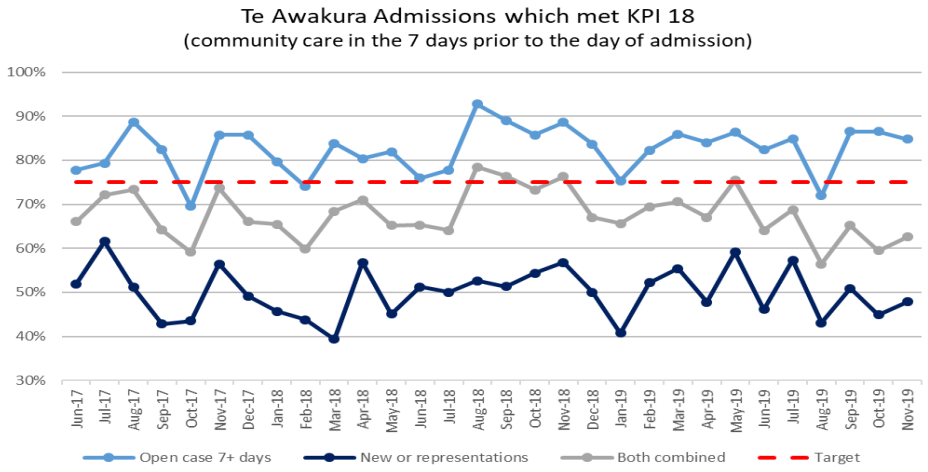


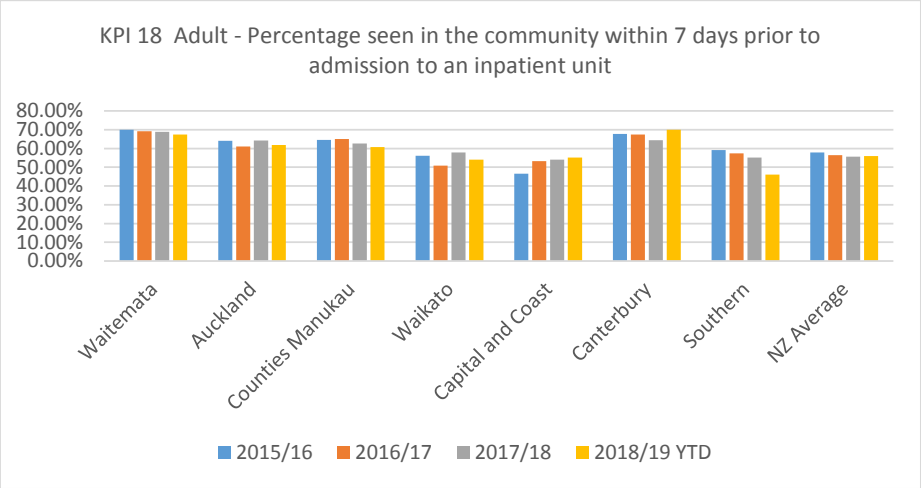
Mental Health Services

Adult Services – Inpatient demand

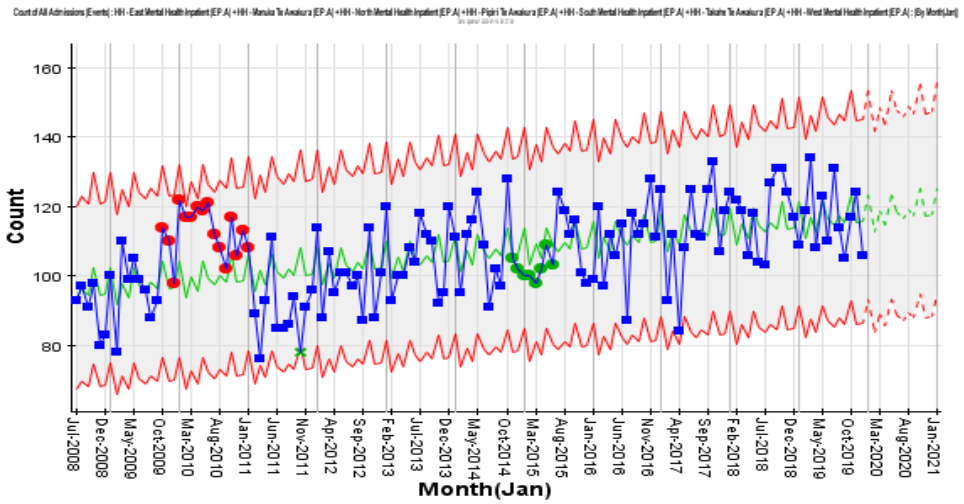
Our goal is to support consumers within a community context and avoid inpatient admission wherever possible. KPI 18 is one of the key indicators used by the national KPI programme (a national benchmarking and quality improvement programme for mental health services, more information is available at www.mhkpi.health.nz). It is a consumer engagement measure and identifies the percentage of consumers in contact with community mental health services prior to an acute inpatient admission. We want to minimise the number of people encountering SMHS for the first time via an acute admission, however people often present to services for the first time, very unwell necessitating an admission. In November 2019, 63.8% of admissions to the adult acute inpatient service (Te Awakura) had been engaged with a community mental health team in the seven days prior to the date of their admission. In December 2019 the figure was 65%.

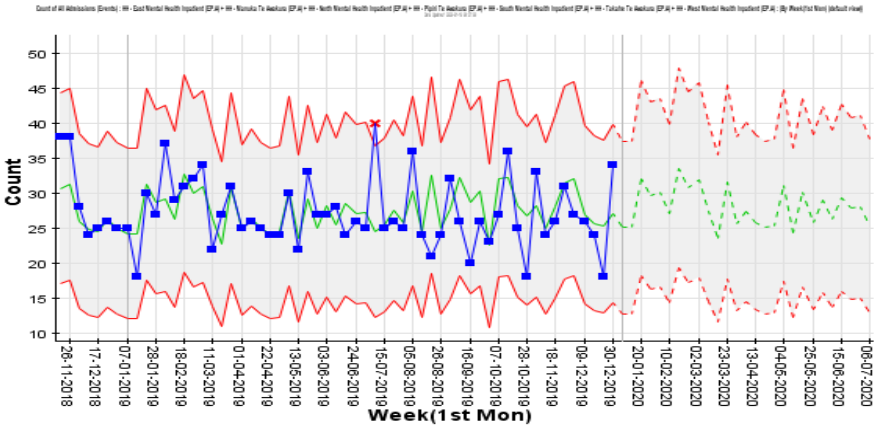






The two graphs below show a count of admissions to Te Awakura. The first is a monthly view, and the second a weekly view. There has been a sustained increase in admissions since 2008 and this increase is forecasted to continue. This puts enormous pressure on both inpatient and community teams, length of stay has reduced to create capacity to respond to the increased demand which can be challenging in terms of therapeutic impact.

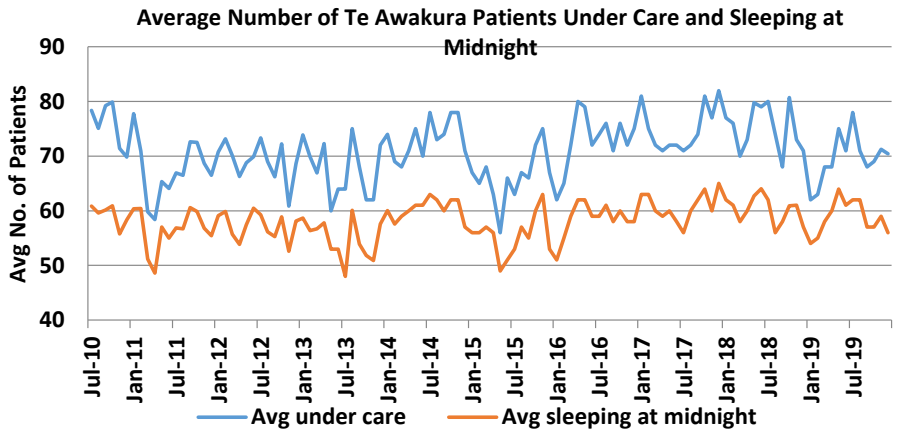




As well as tracking admissions, we monitor the number of people under inpatient care, which includes people who may be on leave from the inpatient unit, and the associated occupancy levels. The average number of consumers under care in the 64-bed Te Awakura facility was 71 in November 2019 and 70 in December 2019.

85% **occupancy** is optimal for mental health acute inpatient services. Occupancy in Te Awakura has regularly been above this. It was 92% in November 2019 and 87% in December.

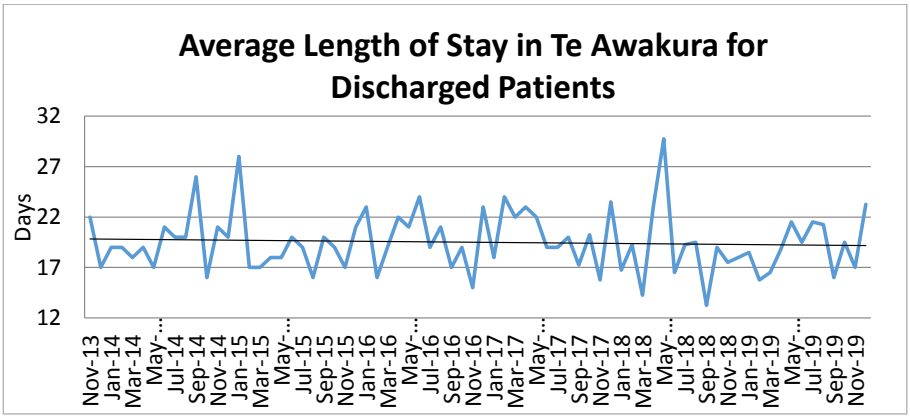
Over-occupancy is managed using leave for consumers that are well enough, or sleepovers to other units within Specialist Mental health Services. There were 2 sleepovers during November 2019 and 6 sleepovers during December 2019. Careful consideration is always given to any decision to sleep people outside of the adult acute inpatient unit as we acknowledge the impact that this can have on the consumer themselves and our ability to provide consistency of care and a positive therapeutic experience.



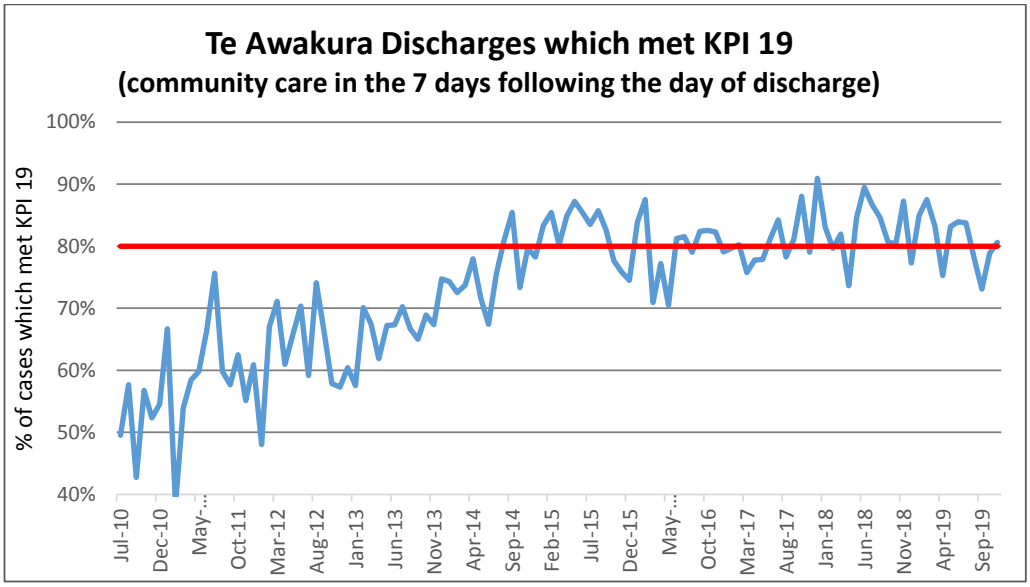
The average length of stay in the acute unit was 17 days for November 2019 and 23 days for December 2019.

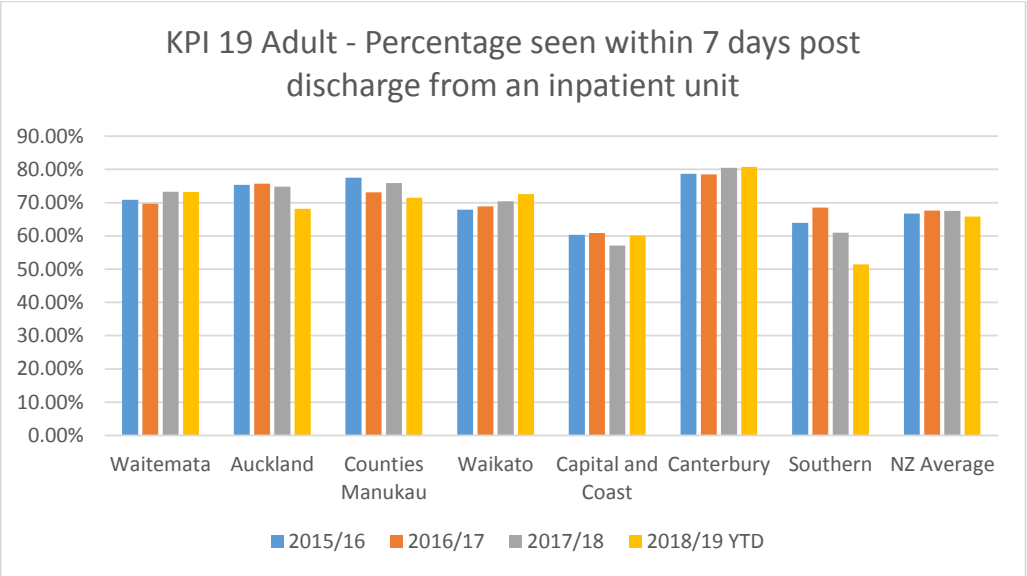
As at 9 January 2020 23 acute inpatient beds were occupied by people who have been in the service for longer than 30 days, 9 for longer than 60 days, 5 have been in for longer than 90 days and 2 people have been in the unit for more than a year.

We aim to minimise the length of time people spend in an inpatient service, however there are many contributing factors to lengthy stays including acuity, complex presentations which can include physical health complications, limited community-based support options, in particular, appropriate community residential providers for our most complex consumers. Work is underway, led by planning and funding, to look at additional community-based resources for this particular consumer group.

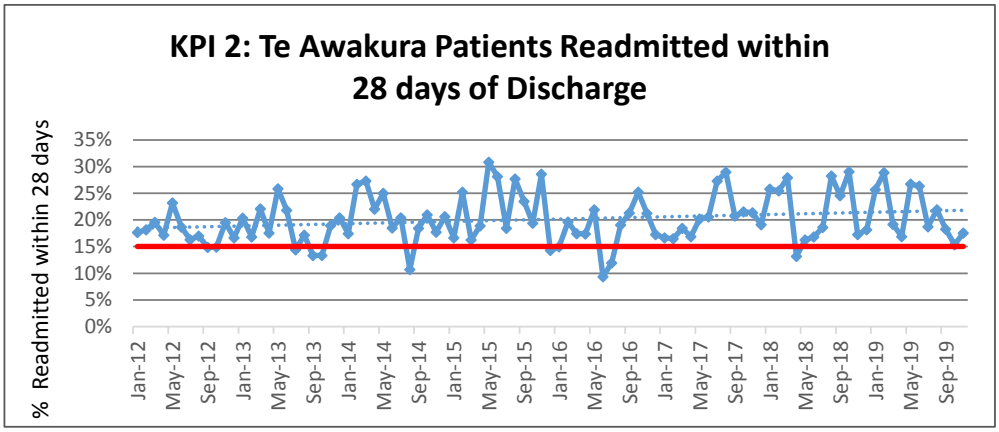


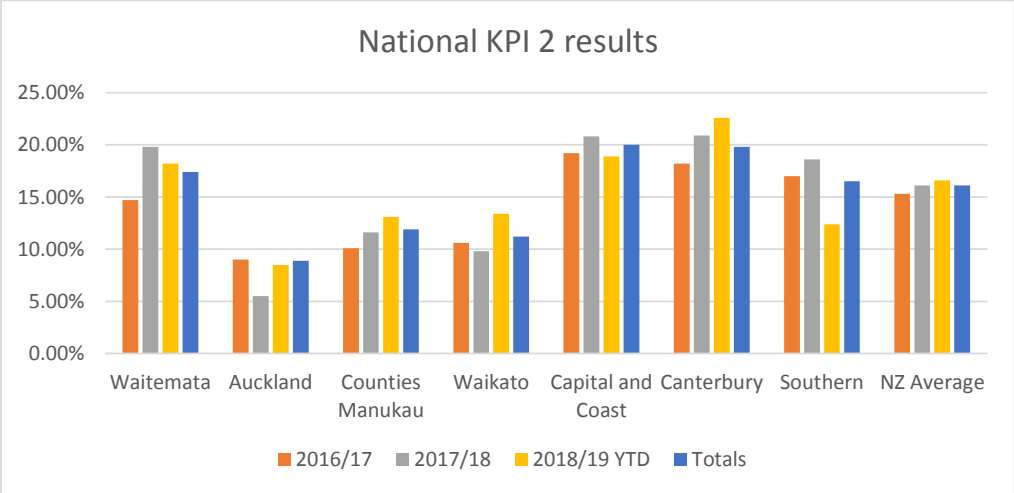
Supporting people well after an acute admission is a key suicide prevention activity and patient safety measure. We use KPI 19 to monitor this, it identifies the percentage of people who received community follow up by SMHS within 7 days post discharge. In October 2019, 78.8% of consumers discharged from Te Awakura received a community care follow-up within seven days. In November 2019, the figure was 80.6%. We pro-actively review the cases not seen within 7 days to identify any barriers to follow up. The key reasons are consumers decline follow up or are difficult to engage, and people have moved out of area.





The graph below shows the **readmission rate within 28 days of discharge**. Of the 104 Te Awakura consumers discharged in October 2019, 15.4% and in November 2019 of the 97 Te Awakura consumers discharged 17.5% were readmitted within 28 days. The reasons for a high readmission rate are multi-faceted including the increasing demand for inpatient services requiring shorter lengths of stay; the frequent use of crisis admissions (a brief pro-active intervention to manage risk factors during an immediate crisis); the level of acuity in the community; increasing impact of substance misuse.



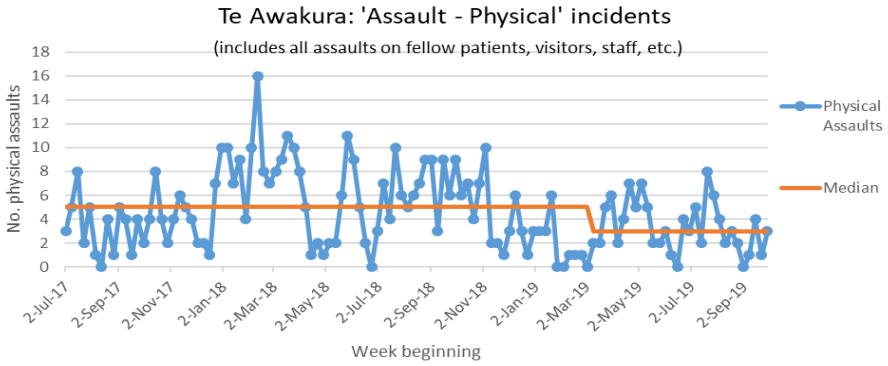


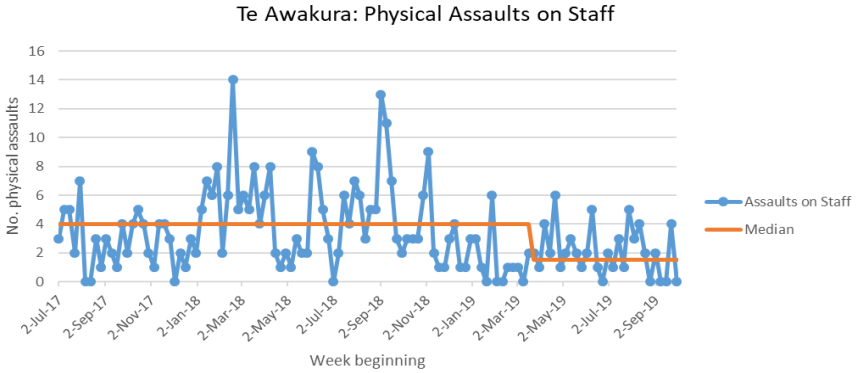
Adult Services – Safer for All

Specialist Mental Health Services is participating in the Health Quality and Safety Commission national mental health and addiction improvement programme. The programme includes 5 priority areas, one of which is reducing seclusion use. Seclusion is a specific type of environmental restraint, whereby a consumer is placed alone in an approved, designated seclusion room to manage the imminent risk of physical harm to others. It is acknowledged seclusion use is a difficult and challenging intervention that is incongruous with the aims of recovery focused and trauma informed care and treatment.

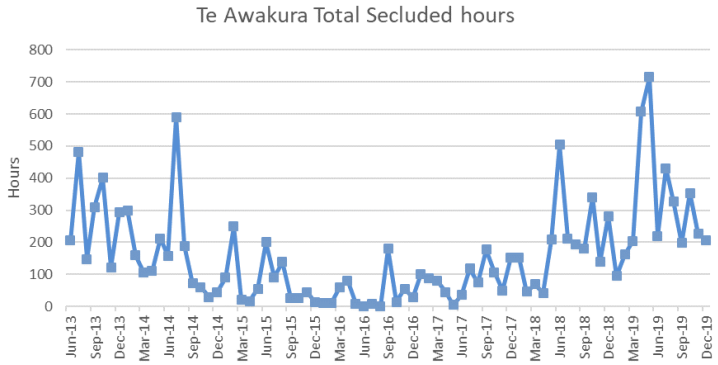
SMHS has been focussed on creating an adult acute inpatient environment that is 'safer for all' including consumers and staff. This was in the context of a number of serious assaults resulting in harm to staff and other consumers. Several initiatives have been implemented within this environment and there has been a noticeable reduction in incidents of violence and aggression. These initiatives include environmental improvements, increased clinical leadership, the introduction of safety officers and the introduction of individualised management plans for those consumers known to present a high risk of violence or aggression.

These initiatives are further supported by building clinician capability to manage complex and highly distressed consumers. Nurse coaches provide in-house education, guidance and support; staff are trained in techniques to maintain personal safety as well as de-escalation and the safe management of distressed consumers. Staffing levels are monitored, reviewed and adjusted, where possible, according to acuity.





The focus of the Safer for All working group is now turning to the use of seclusion which has seen a recent increase in terms of hours, events and the number of people secluded. The reason for these increases is multi-factorial including acuity, increase in challenging presentations due to drug and alcohol use, and the limitations of the physical environment. The project group will be looking at additional opportunities for learnings and alternative approaches, including the involvement of Pukenga Atawhai in supporting Tangata Whaiora (people seeking wellness).

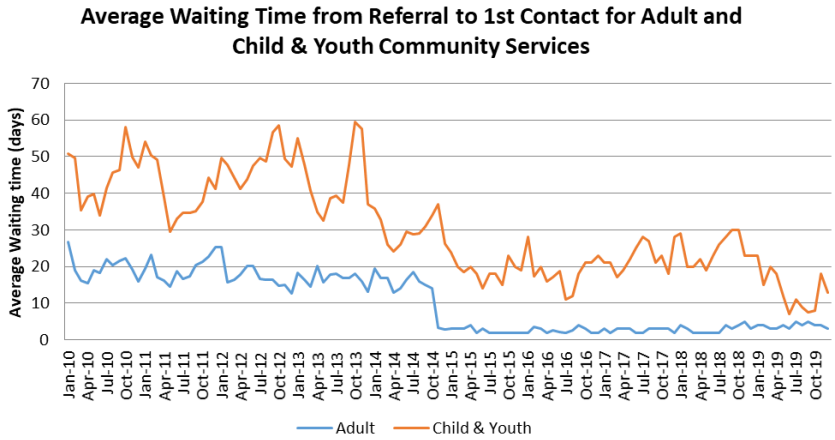


In November 2019, 9 consumers experienced seclusion for a total of 226.6 hours. In December 2019, 7 consumers experienced seclusion for a total of 206.7 hours.

Wait-times

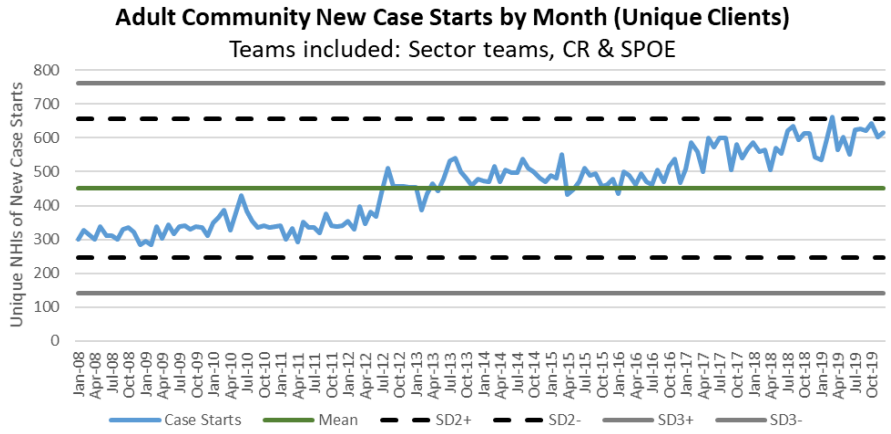
The graph below shows that despite the ongoing demand, there has been an overall reduction in the time people spend waiting for services. Ministry of Health targets require 80% of people to be seen within 21 days and 95% of people to be seen within 56 days. The average waiting time for adults was 4 days for November 2019 and 3 days for October 2019. Our results for the Adult General Mental Health Service show 92.8% of people were seen within 21 days of referral and in November 2019 and 99.3% were seen within 56 days of referral. In December, these figures were 94.4% and 99.3% respectively.

For child, adolescent, and family services, the average waiting time to first contact (which may be by telephone) was 18 days in October 2019 and 13 days in December 2019. Our results show 57.7% of children and youth were seen within 21 days of referral in November 2019 and 77.7% were seen within 56 days of referral. In December 2019, these figures were 57.7% and 77.6% respectively.

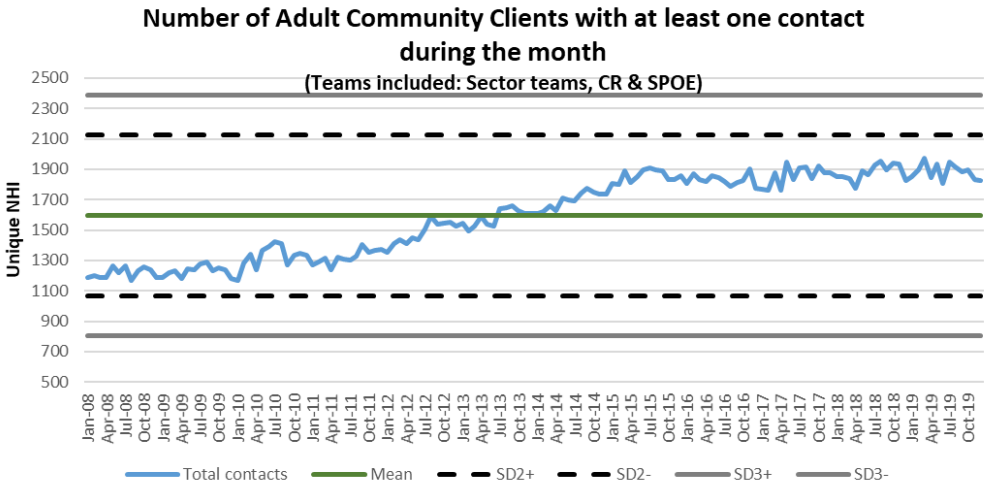


Adult Services – Community demand

As for inpatient services, adult community services have seen a sustained increase in demand. New cases were created for 602 individual adults (unique NHIs) in November 2019 and 617 in December 2019. The increased demand is evident across all aspects of the community-based services, in our crisis resolution services, our ongoing treatment and case management provision and our specialty services such as the anxiety disorders service. To support the clinicians in sustaining therapeutic service delivery, there has been an increase in clinical leadership and a re-focus, through the SMHS purpose and strategy work, on appropriate, effective services for those with the most serious or acute mental disorders.



Despite demand, we are sustaining service activity, with at least one contact recorded for 1834 unique adult community mental health consumers in November 2019 and 1828 in December 2019.

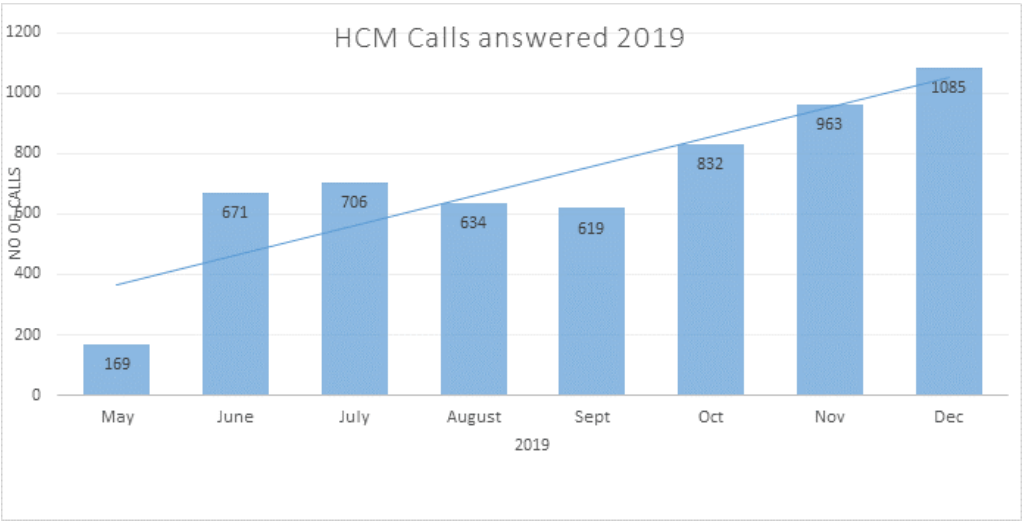


Home Care Medical

To assist in managing the level of demand, particularly for the crisis resolution service, CDHB have contracted Homecare Medical (HCM) to provide an afterhours telephone triage service for the SMHS 0800 line. The service was established in late May 2019 between the hours 16.30-midnight, and then extended to weekends and public holiday cover from October 2019.

The HCM service operates using Registered Mental Health Nurses who respond to caller needs and provide the best pathway of support which may be a community/NGO response or an urgent referral through to the SMHS Crisis Resolution. The service is averaging around 800 calls per month with around 30% having immediate access to CR staff and the other 70% of calls being resolved by HCM staff.

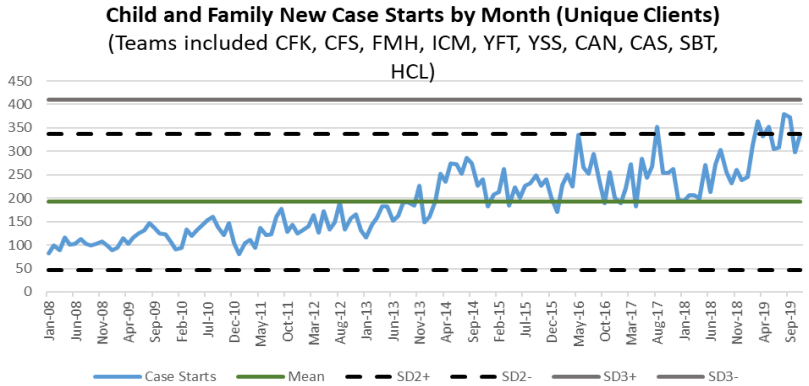
Consumers receive suitable and timely support and CR staff clinical time has been released to focus on providing more enhanced follow up care for those consumers already under care, including intensive intervention options focused on admission prevention and timely discharge.

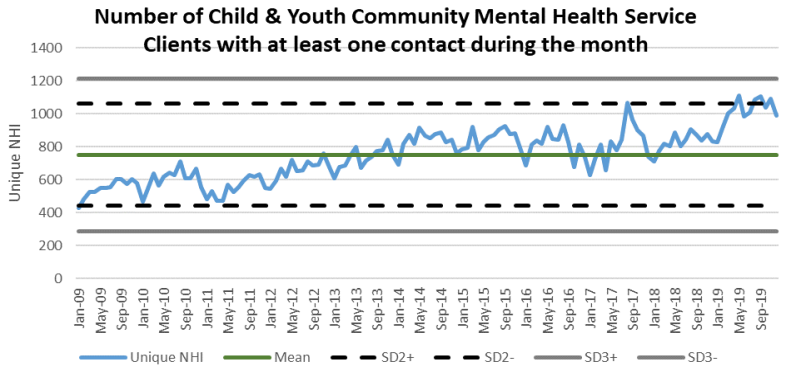


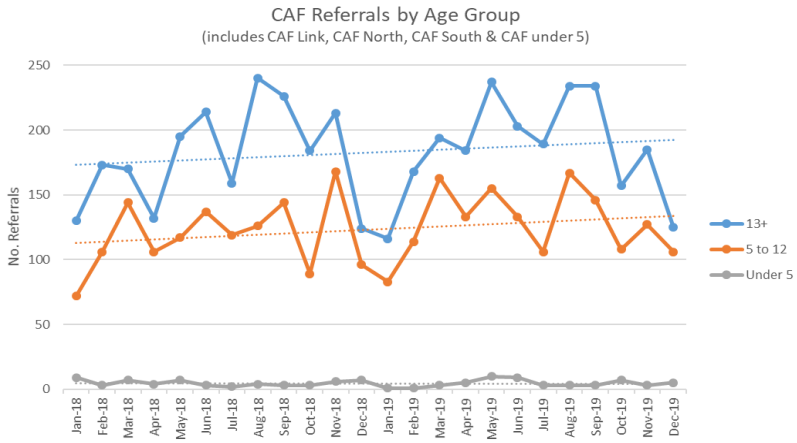
Child and Youth Services (CAF) demand

CAF have experienced a sustained and ongoing increase in demand. New cases were created for 335 children and adolescents (unique NHIs) in November 2019 and 273 in December 2019. This amounts to a 146% increase over 9 years with an average of 85 referrals per week.

There were 1105 unique patients with at least one contact during the month of November 2019 and in December 2019 there were 988.



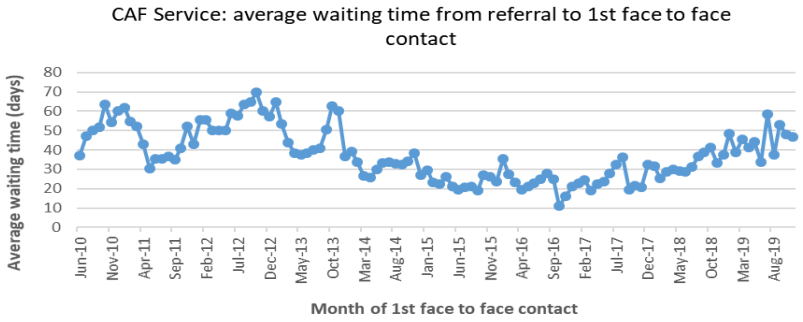




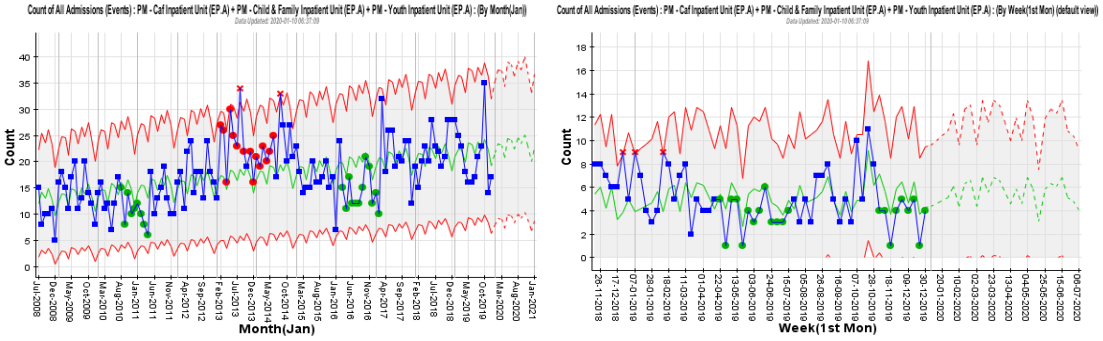
Despite an ongoing increase in referrals, CAF have worked hard to reduce the wait time from referral to treatment. The Service's Access team has been redesigned to make the most effective use of clinical resource. This has improved waiting times to first contact and enabled the provision of short-term assessment and treatment to crisis presentations. The timely initial contact is an essential feature of managing risk as it provides the opportunity to clinically prioritise the young people waiting, whilst

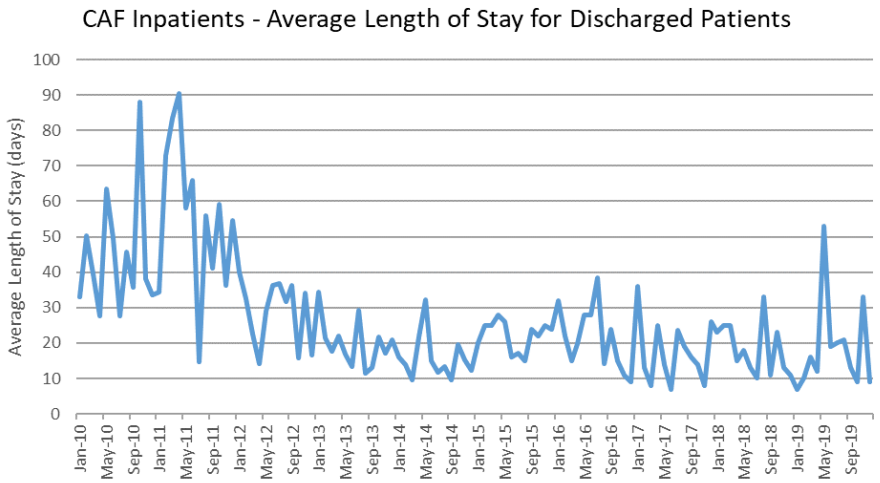
ensuring those people that do not require specialist services are re-directed as soon as possible to services better able to meet their needs.

The ongoing demand is however impacting wait time to first face to face contact and engagement in treatment.



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.





The average length of stay for discharged patients was 33 days for November 2019 and 9 days for December 2019.

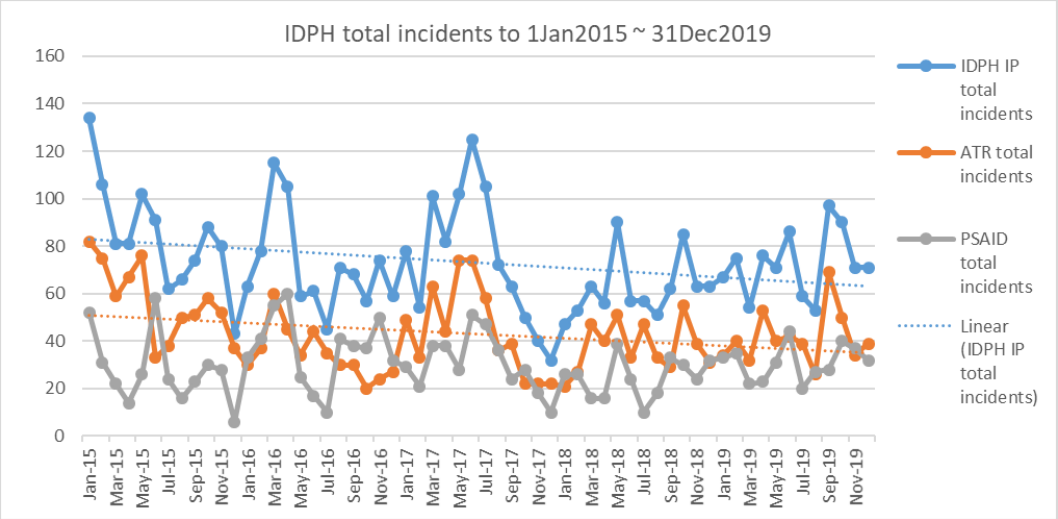
Intellectually Disabled Persons Health Service (IDPH)

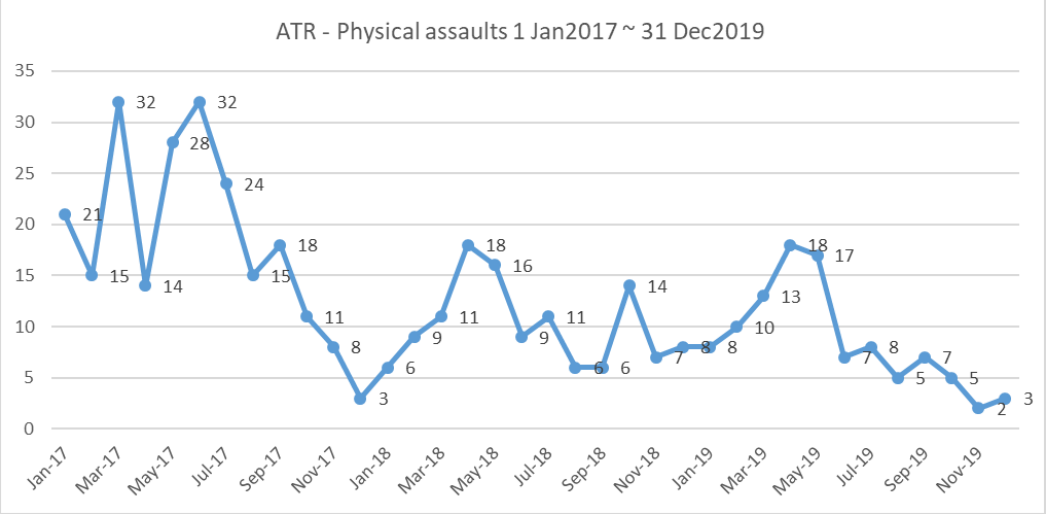
The IDPH Service comprise a secure forensic ID unit (Assessment, Treatment and Rehabilitation - AT&R), currently operating as a 6-bed unit, a 14-bed dual disability unit, Psychiatric Service for Adults with Intellectual Disability (PSAID) and associated outpatient services. This service provides care for some of our most complex, high risk consumers and historically has been the area experiencing the most incidents of harm to staff.

The AT&R Unit in particular, is poorly configured to meet both clinical and safety needs. Following a robust planning and approval process the building footprint is being extended to include four separate apartments for individuals who require intensive inpatient care, due for completion in late 2020.

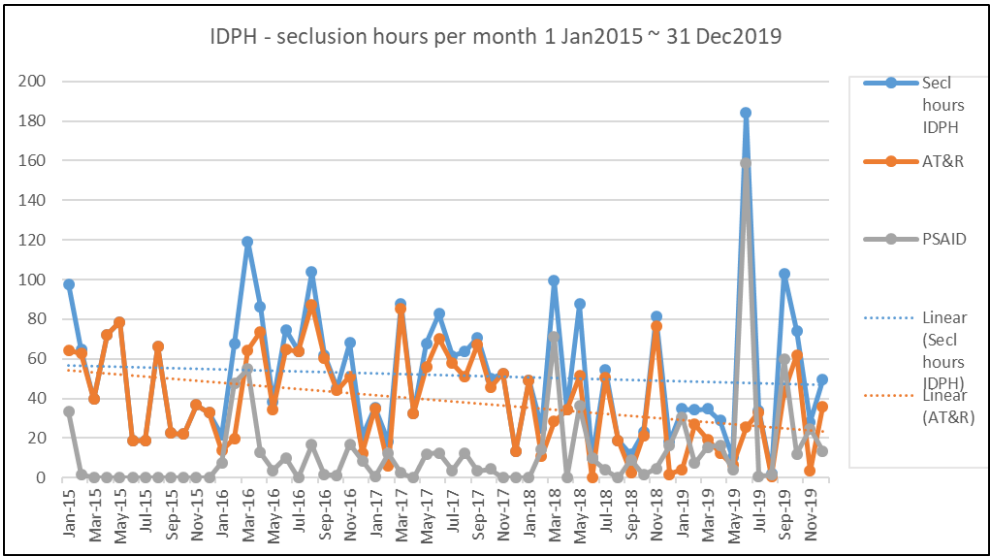
In order to respond to significant risk concerns, interim internal modifications have also been progressed, creating two annex areas within the footprint of the existing build. Whilst this has reduced the admitting capacity of the unit, it has resulted in a reduction in physical assaults and the use of seclusion for the individuals cared for within the annexes.

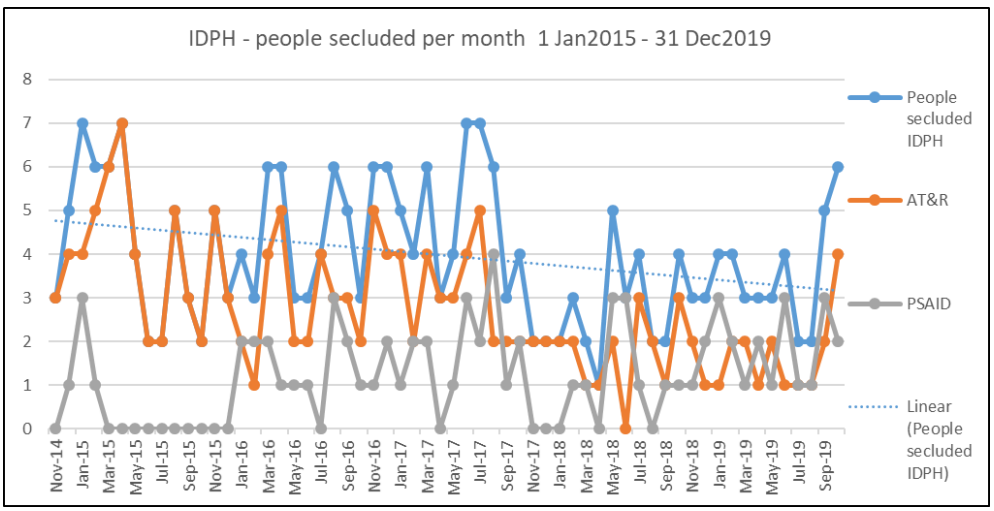
Alongside these environmental modifications, the clinicians are also building capability for working with this consumer group, including the introduction of positive behaviour support, an evidence-based approach aimed at improving quality of life and decreasing frequency and severity of challenging behaviours.





In November 2019 the total seclusion used in IDPH had reduced significantly to 28.2 hours. In December 2019 the total seclusion for IDPH was 49.4hours. There was an increase in AT&R from 3.5 hours to 36 hours but a decrease in hours for PSAID from 24.7 hours to 13.4 hours





Living within our means

Living within our Means, including No Wasted Resource

Financial Performance

Canterbury District Health Board

Statement of Financial Performance

Hospital & Specialist Service Statement of Comprehensive Revenue and Expense
For the 6 Months Ended 31 December 2019

MONTH $'000					YEAR TO DATE			
19/20 Actual $'000	19/20 Budget $'000	18/19 Actual $'000	19/20 vs 18/19 Variance $'000		19/20 Actual $'000	19/20 Budget $'000	18/19 Actual $'000	19/20 vs 18/19 Variance $'000
				Operating Revenue				
311	439	329	(18)	From Funder Arm	2,806	2,732	2,936	(130)
1,687	1,736	1,480	207	MOH Revenue	10,748	9,577	9,152	1,596
4,343	3,964	3,495	848	Patient Related Revenue	26,314	26,717	24,529	1,785
1,952	1,631	1,353	599	Other Revenue	10,974	10,912	9,260	1,714
8,293	7,770	6,657	1,636	**TOTAL OPERATING REVENUE**	50,842	49,938	45,877	4,965
				Operating Expenditure				
				Personnel Costs				
66,760	63,836	61,307	(5,453)	Personnel Costs - CDHB Staff	386,812	382,984	357,709	(29,103)
2,264	1,650	1,494	(770)	Personnel Costs - Bureau & Contractors	13,179	11,277	11,167	(2,012)
69,024	65,486	62,801	(6,223)	**Total Personnel Costs**	399,991	394,261	368,876	(31,115)
13,391	12,890	12,594	(797)	Treatment Related Costs	77,896	76,750	76,812	(1,084)
3,847	3,282	3,322	(525)	Non Treatment Related Costs	24,330	19,786	21,470	(2,860)
86,262	81,658	78,717	(7,545)	**TOTAL OPERATING EXPENDITURE**	502,217	490,797	467,158	(35,059)
(77,969)	**(73,888)**	**(72,060)**	**(5,909)**	**OPERATING RESULTS BEFORE INTEREST AND DEPRECIATION**	**(451,375)**	**(440,859)**	**(421,281)**	**(30,094)**
				Indirect Income				
8	1	-	8	Donations & Trust Funds	115	10	4	111
-	-	-	-	Gain on Disposal of Assets	-	-	-	-
8	**1**	**-**	**8**	**TOTAL INDIRECT INCOME**	**115**	**10**	**4**	**111**
				Indirect Expenses				
2,566	4,419	2,089	(477)	Depreciation	15,347	19,033	12,631	(2,716)
-	(1)	-	-	Loss on Disposal of Assets	8	(4)	(8)	(16)
2,566	**4,418**	**2,090**	**(476)**	**TOTAL INDIRECT EXPENSES**	**15,355**	**19,029**	**12,623**	**(2,732)**
(80,527)	**(78,305)**	**(74,150)**	**(6,377)**	**TOTAL SURPLUS / (DEFICIT)**	**(466,615)**	**(459,878)**	**(433,900)**	**(32,715)**

Achievements/Issues of Note

Sterile Production Unit Cost-Saving Initiative

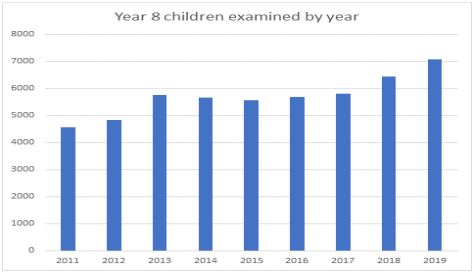
The Sterile Production Unit incorporates a range of rooms and functions which have different requirements for the clothing worn by staff. The most demanding environment and functions require use of a disposable non-particle shedding coveralls, whereas other functions can be carried out wearing reusable scrubs, overshoes and head cover.

A review of our processes and their associated costs made it clear that disposable coveralls, costing of $33 each, were being used for functions that did not require that option. Replacing the use of these suits where this is appropriate will save around 200 suits per year –around $6,600 savings per year.

Technological solutions are being evaluated that could eliminate the need for disposable coveralls.

Community Dental Service – treatment of Year 8 Children

The Community Dental service has had a focus this year of ensuring that all Year 8 school children receive a final check up with the service prior to finishing primary school year and moving onto High School. For the year ended 31 December the service treated 99% of year 8 children up from 92% for 2018 and 85% for 2017.



The service has focused both staffing dental van resources to ensure that the number of Year 8 children was as close to 100% as possible. This focus has ensured that the year 8's have seen and treated in a timely manner and the service haven't had to release them early to the Oral Health contact – which is a fee for service based contract for High School students.

Graduated Compression Stockings (TEDS)

Systematic reviews show that thigh-high stockings are no better than knee-high stockings in the prevention of DVT in surgical patients. Thigh-high stockings cost 54% more than knee high stockings with knee high stockings generally preferred by patients for comfort. Surgical services who move to knee-high stockings, would collectively purchase approximately 8,700 less pairs of thigh-high stockings per year.

Routine use of Filter Needles

An ECRI commissioned report to review clinical evidence demonstrates no meaningful benefit to the use of filter needles for the drawing up of medications that are being given intravenously, intramuscularly or subcutaneously. Therefore the routine use of filter needles for the drawing up of drugs which are to be administered by these routes is no longer required. This change in practice is endorsed by the Medicines & Therapeutics Committee and the Fluid & Medication Management Committee.

Anti-slip socks

Clinical evidence suggests that for most patients' bare feet or good fitting footwear is more effective in preventing falls than anti-slip socks. CDHB used 15,500 pairs last year. The quality team has reviewed the current policies and guidelines and communication have been made with the high user departments.

Wrap up of 2019 reports

During 2019 HAC reports featured many items that contribute to the organisation living within its means. Some of the stories were featured in this section and had quantifiable cost savings clearly identified. Other items were difficult to quantify in terms of dollars saved, but do play a part in limiting cost growth, reducing wasteful use of resources, freeing capacity, improving overall efficiency of the system or ensure clinicians have more face to face time with patients.

These items are listed here.

Items from this report section:

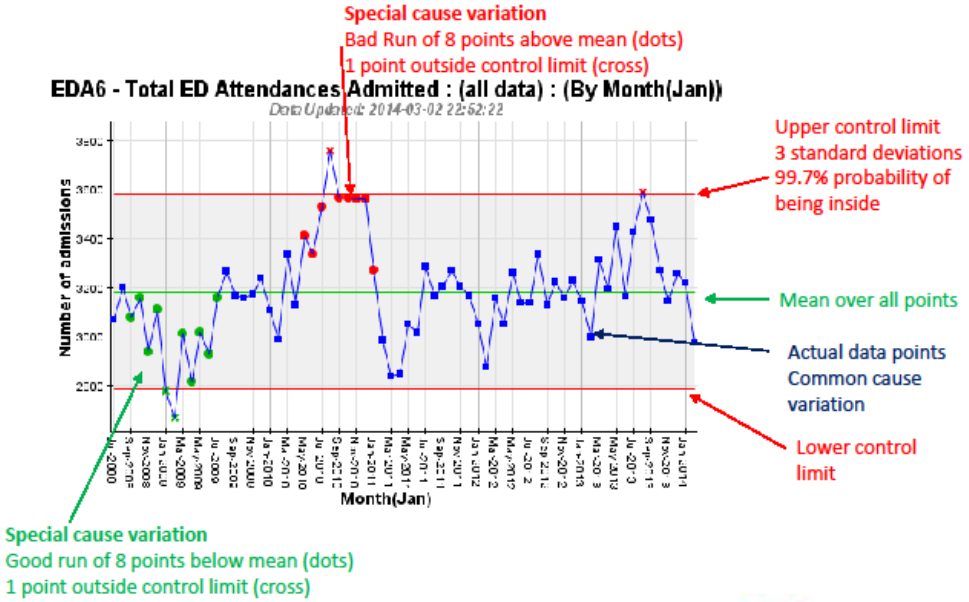
- Christchurch Hospital involved in the worldwide launch of a new cannula
- Improved coding of nursing employee allocation
- Improved processes identifying nursing staff available for vacant shifts at Christchurch Hospital
- Overseas Chargeable Patients (improving charging process)
- Financial savings realised after audit of cytokeratin ImmunoHistoChemistry (IHC) in breast sentinel nodes
- Reduction of overall spend and use of FTE in Haematology, and faster turnaround times achieved
- Deep Vein Thrombosis Prophylaxis in the intensive care unit
- New Oral Care Regime for Ventilated Patients in ICU
- Technology Assessment – improved information about the goods we purchase
- Audit of leave patterns is leading to improvements
- Review of pricing for inter-district flow.
- NADIA: Nurse Audit Data Insight Application - OPH&R
- Fine tuning our approach to high protein energy drinks
- Outsourcing routine sterile hydration product compounding
- Lean process: Making processing of laparoscopic operating equipment more efficient

Items from other sections:

- Restorative Care model in use at Christchurch Hospital
- ICU Ultrasound Collaboration
- Maternity Services encouraging use of community maternity units
- Otorhinolaryngology acute capacity
- Orderly Mobile Service Launched
- Reducing time spent waiting for General Medicine Outpatients
- Physiotherapy group sessions reducing waiting times
- Patient Surgical Journey Video
- Expediting acute admissions into General Surgery
- Ambulatory model for people requiring acute general surgery care
- Improved Central Line insertion continues to provide benefits for patients.
- Treatment now available to all people with Hepatitis C
- Avoidance of unnecessary intravenous antimicrobial therapy at Canterbury District Health Board hospitals
- Cortex implementation continues
- Children’s Respiratory Outreach Nurse can now prescribe
- Clot retrieval service continues to develop
- Emerging uses for hyperbaric therapy
- Canterbury District Health Board Clinical Pharmacology supporting good medicine use nationally
- Measles Vaccinations for Midwives
- Clinical Nurse Specialist support for children with allergy and eczema
- Electronic referral system benefitting patients needing dermatology care
- Telehealth in Dermatology

- Gynae Outpatient Clinic Changes
- Tertiary Survey Form Developed for Trauma Patients
- Reallocating nursing tasks to timely achievement and patient flow
- Integrated Respiratory Nursing Service providing benefits to our community
- Older Persons Health and Rehabilitation, pressure injury management and Rethinking Rehab
- Radiation Oncology Service: Changes in clinical practice that are right for the patient and the system (reduction in radiation therapy time and associated side effects)
- Cervical Brachytherapy treatment pathway streamlined
- Christchurch Outpatient Florence Self Check-in Touchscreen Kiosks
- Orthoptist Botox Clinics
- Providing faster care following heart attack
- Acute Stroke Imaging Service
- Emergency Department - Front of House Model
- Physiotherapists in the Emergency Department
- Priority Placement Policy: Patients with Hypertriglyceridaemia Induced Pancreatitis
- Providing timely wound and drain reviews following discharge from General Surgery
- Maternity Assessment Unit
- Further progress towards paperlite in General Surgery
- South Island Ketogenic Dietary Therapy Service
- Technologist Led Computed Tomography Colonography Service
- Hepatitis C Treatment successful in Canterbury
- Enhanced Recovery After Surgery for people following knee and hip joint replacement
- Reducing time spent waiting for appointments with the autism spectrum disorder coordinator (incorporating the use of group sessions).
- Changing the way that we work in the outpatients' building
- Continuing focus on reducing falls in medical wards
- Children's Outreach Nursing Service Nurse Prescribing
- Oxygen Prescribing
- Study shows faster assessment of risk of heart attack is possible
- Update on progress with streamlined Vascular ward rounds
- Supporting enhanced recovery of people following colorectal surgery
- A new nutritional pathway to support recovery following hip fracture
- Changes made to improve waiting times for Otorhinolaryngology specialist assessment

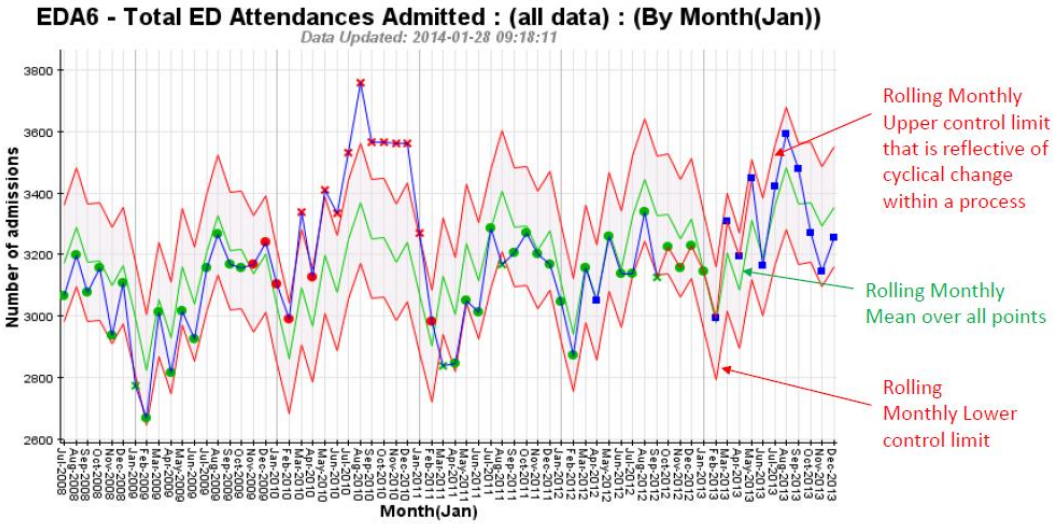
SPC: How to Interpret a Control Chart



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

WORKPLAN FOR HAC 2020 *(WORKING DOCUMENT)*

9am start	30 Jan 20	02 Apr 20	04 Jun 20	06 Aug 20	01 Oct 20	03 Dec 20
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 Care Capacity Demand Management Update	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report Care Capacity Demand Management Update	H&SS Monitoring Report
Planned Items	Clinical Advisor Update – Nursing	Clinical Advisor Update – Allied Health 2020 Winter Planning Update People & Capability Report	Clinical Advisor Update – Medical	Clinical Advisor Update - Nursing H&SS 19/20 Year Results	Clinical Advisor Update – Allied Health	Clinical Advisor Update – Medical 2020 Winter Planning Review
Presentations	Department of Anaesthesia	TBC: Burwood Hospital	TBC: SMHS	TBC: Christchurch Hospital	TBC: Rural Hospitals	TBC: Labs
Governance and Secretariat Issues	2020 Workplan	Terms of Reference Review				
Information Items		2020 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) HAC Terms of Reference - Amended 2020 Workplan	2020 Workplan	2021 Meeting Schedule 2020 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 2020 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)

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: **30 January 2020**

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

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

3. SUMMARY

The Act, Schedule 3, Clause 32 provides:

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

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

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

Clause 33 of the Act also further provides:

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

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

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

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

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

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