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, 6 August 2020 commencing at 9:00am

Administration			
	Apologies		9.00am
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 4 June 2020		
3.	Carried Forward / Action List Items		
Reports for Noting			
4.	Maternity Assessment Unit – 9 Month Update	Norma Campbell *Director of Midwifery*	9.05-9.25am
5.	Hospital Service Monitoring Report: • Mental Health • Hospital Laboratories • Rural Health Services • Medical/Surgical; Women's & Children's Health; & Orthopaedics ESPIs • Older Persons Health & Rehabilitation	Dr Greg Hamilton *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* Pauline Clark *General manager, Medical/Surgical; Women's & Children's Health; & Orthopaedics* Helen Skinner *General Manager, Older Persons Health & Rehabilitation*	9.25-10.20am
6.	Clinical Advisor Update (Oral) • Nursing	Mary Gordon *Executive Director of Nursing*	10.20-10.30am
MORNING TEA			**10.30-10.45am**
7.	ED Presentations - Over 75 Years Old –	Carolyn Gullery	10.45-10.55am

	Analysis Paper		
8.	Faster Cancer Treatment	Carolyn Gullery	10.55-11.05am
9.	South Island Bariatric Surgery Service – Summary 2019/20	Carolyn Gullery	11.05-11.15am
10.	Resolution to Exclude the Public		11.15am
Estimated Finish Time			**11.15am**
	Information Items: Quality & Patient Safety Indicators – Level of Complaints 2020 Workplan		

NEXT MEETING: Thursday, 1 October 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
Catherine Chu
James Gough
Naomi Marshall
Ingrid Taylor
Jan Edwards
Dr Rochelle Phipps
Michelle Turrall
Sir John Hansen (Ex-officio)
Gabrielle Huria (Ex-officio)

Executive Support

(as required as per agenda)

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 Meeting Cancelled	04/06/20	06/08/20	01/10/20	03/12/20
Andrew Dickerson (Chair)	√		√			
Jo Kane (Deputy Chair)	√		√			
Barry Bragg	√		√			
Sally Buck	√		~	** 08/07/2020		
Catherine Chu		* 16/04/20	√			
James Gough		* 16/04/20	√			
Naomi Marshall	* 25/02/20		√			
Ingrid Taylor	* 25/02/20		√			
Wendy Dallas-Katoa	√	** 01/06/2020				
Jan Edwards	√		√			
Dr Rochelle Phipps	√		√			
Trevor Read	√	** 01/06/2020				
Michelle Turrall		* 01/06/20	x			
Sir John Hansen (ex-officio)	√		√			
Gabrielle Huria (ex-officio)	x		√			

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

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

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

Andrew Dickerson **Chair – HAC** Board Member	**Canterbury Health Care of the Elderly Education Trust** - Chair Promotes and supports teaching and research in the care of older people. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Canterbury Medical Research Foundation** - Member Provides financial assistance for medical research in Canterbury. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Heritage NZ -** Member Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance and Heritage NZ has already been involved with CDHB buildings. **Maia Health Foundation -** Trustee Is a charitable trust established to support health care in the CDHB area. Current projects include fundraising for a rooftop helipad and enhancements to the children's wards at Christchurch Hospital. **NZ Association of Gerontology** - Member Professional association that promotes the interests of older people and an understanding of ageing.
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. **Farrell Construction Limited** - Shareholder Farrell's Construction Limited is a commercial and light commercial construction company based in Christchurch. **New Zealand Flying Doctor Service Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB. **Ngai Tahu Farming** – Chairman Farming interests in North Canterbury and Queenstown Lakes District and Forestry interests in Canterbury, West Coast and Otago regions. **Paenga Kupenga Limited** – Chair Commercial arm of Ngai Tuahuriri Runanga **Quarry Capital Limited** – Director Property syndication company based in Christchurch **Stevenson Group Limited** – Deputy Chairman Property interests in Auckland and mining interests on the West Coast. **Verum Group Limited** – Director Verum Group Limited provides air quality testing and asbestos sampling and analysis services; methamphetamine contamination testing; dust; gas and noise workplace monitoring services in New Zealand. There is the potential for future work with the CDHB.
Catherine Chu	**Christchurch City Council** – Councillor Local Territorial Authority **Riccarton Rotary Club** – Member **The Canterbury Club** – Member
Jan Edwards	**Age Concern Canterbury** – Member **Anglican Care** - Volunteer
James Gough	**Amyes Road Limited** – Shareholder Formally Gough Group/Gough Holdings Limited. Currently liquidating. **Christchurch City Council** – Councillor Local Territorial Authority. Includes appointment to Fendalton/Waimairi/ Harewood Community Board **Christchurch City Holdings Limited (*CCHL*)** – Director Holds and manages the Council's commercial interest in subsidiary companies. **Civic Building Limited** – Chairman Council Property Interests, JV with Ngai Tahu Property Limited. **Countrywide Residential (2018) Limited** – Director/Shareholder Residential Property Development

	Gough Corporation Holdings Limited – Director/Shareholder Holdings company. **Gough Property Corporation Limited** – Director/Shareholder Manages property interests. **The Antony Gough Trust** – Trustee Trust for Antony Thomas Gough **The McLean Institute Trust** – Trustee Trust for the McLean Institute **The Russley Village Limited** – Shareholder Retirement Village. Via the Antony Gough Trust **The Terrace Car Park Limited** – (Alternate) Director Property company – manages The Terrace car park (under construction) **The Terrace On Avon Limited** – (Alternate) Director Property company – manages The Terrace.
Naomi Marshall Board Member	**Riccarton Clinic & After Hours** – Employee Employed as a Nurse. Riccarton Clinic & After Hours provides general practice and after-hours care. It is part privately and PHO funded. The PHO receives funding from the CDHB.
Dr Rochelle Phipps	**Accident Compensation Corporation** – Medical Advisor ACC is a Crown entity responsible for administering NZ's universal no-fault accidental injury scheme. As a Medical Advisor, I analyse and interpret medical information and make recommendations to improve rehabilitation outcomes for ACC customers. **OraTaiao: New Zealand Climate & Health Council** – Founding Executive Board Member (no longer on executive) The Council is a not-for-profit, politically non-partisan incorporated society and comprises health professionals in Aotearoa/New Zealand concerned with: • the negative impacts of climate change on health; • the health gains possible through strong, health-centred climate action; • highlighting the impacts of climate change on those who already experience disadvantage or ill health (equity impacts); and • reducing the health sector's contribution to climate change. **Royal New Zealand College of General Practitioners** – Christchurch Fellow and Former Board Member The RNZCGP is the professional body and postgraduate educational institute for general practitioners.
Ingrid Taylor Board Member	**Loyal Canterbury Lodge (*LCL*) – Manchester Unity** – Trustee LCL is a friendly society, administering funds for the benefit of members and often makes charitable donations. One of the recipients of such a donation may have an association with the CDHB. **Manchester Unity Welfare Homes Trust Board (*MUWHTB*)** – Trustee MUWHTB is a charitable Trust providing financial assistance to organisations in Canterbury associated with the care and assistance of older persons. Recipients of financial assistance may have an association with the CDHB.

	Sir John and Ann Hansen's Family Trust – Independent Trustee. **Taylor Shaw** – Partner Taylor Shaw has clients that are employed by the CDHB or may have contracts for services with the CDHB that may mean a conflict or potential conflict may arise from time to time. Such conflicts of interest will need to be addressed at the appropriate time. • I / Taylor Shaw have acted as solicitor for Bill Tate and family. **The Youth Hub** – Trustee The Youth Hub is a charitable Trust established to provide residential and social services for the Youth of Canterbury, including services for mental health and medical care that may include involvement with the CDHB.
Michelle Turrall Manawhenua	**To be advised.**
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 **Judicial Control Authority (*JCA*) for Racing** – Appeals Tribunal Member The JCA is an independent statutory authority constituted under the Racing Act. The JCA ensures that judicial and appeal proceedings in thoroughbred and harness racing are heard and decided fairly, professionally, efficiently and in a consistent and cost effective manner. **Ministry Primary Industries, Costs Review Independent Panel** **Rulings Panel Gas Industry Co Ltd** **Sir John and Ann Hansen's Family Trust** – Ingrid Taylor sits as independent Trustee; and provides legal services to the Trust and to Sir John and Ann Hansen.
Gabrielle Huria **Ex-Officio – HAC** Deputy Chair, CDHB	**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*). **Rawa Hohepa Limited** – Director Family property company **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 via Zoom
on Thursday, 4 June 2020, commencing at 9.00am

PRESENT

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

APOLOGIES

Apologies for absence were received and accepted from Sally Buck; and Andrew Brant (Board Clinical Advisor).

EXECUTIVE SUPPORT

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

EXECUTIVE APOLOGIES

David Meates for lateness (9.17am).

IN ATTENDANCE

Pauline Clark, General Manager, Medical/Surgical & Women's & Children's Health
Dan Coward, General Manager, Older Persons, Orthopaedics and 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
Ralph La Salle, Team Leader, Secondary Care

Andrew Dickerson, HAC Chair, opened the meeting. He welcomed new members to the Committee: Michelle Turrall as the new Manawhenua representative and two new Board members, Catherine Chu and James Gough. He noted the reappointment of external Committee members Jan Edwards and Dr Rochelle Phipps for a further three year term and took the opportunity to acknowledge the contribution of external Committee members whose terms concluded on 31 May 2020: Wendy Dallas-Katoa (Manawhenua representative) and Trevor Read.

Mr Dickerson acknowledged the contribution of everyone throughout what has been a public health emergency; across our hospital services, public health services, and laboratory services. He acknowledged that New Zealand's response has been comparatively very good and Canterbury's response has also been very good. He noted that it is not over yet and we cannot afford to be complacent.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register

Barry Bragg advised that he has been appointed as Chair of Paenga Kupenga Limited, the commercial arm of Ngai Tuahuriri Runanga, effective 1 July 2020.

There were no other additions/alterations.

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

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

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (04/20)
(Moved: Barry Bragg/Seconded: Jan Edwards – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 30 January 2020 be approved and adopted as a true and correct record, subject to correction of the BMI figure stated on page 5 of the minutes from '60+' to '40-45'."

3. CARRIED FORWARD / ACTION ITEMS

Item 3 – ED attendances for over 75s
Carolyn Gullery, Executive Director, Planning Funding & Decision Support, advised that analysis is being done around the over 75s. A new programme has been put in place for age residential care. She noted that we learnt during the COVID-19 response that access to afterhours general practice was variable in age residential care. From this we have built a new model platformed off the 24 hour surgery and our acute demand model, to provide better access both virtually and also through direct house calls for age residential care, to see if we can moderate back the over 75s presentations. Will be able to report back in a couple of months on the impact of the new model.

Ms Gullery further noted that during lockdown, we managed to accelerate rapidly our advance care planning. This was a targeted and focused approach for elderly people and also people with longstanding chronic conditions. Almost quadrupled the number of advance care plans and acute care plans that were undertaken or refreshed while general practice was in lockdown.

Item 4 – ESPI process, including prioritisation process and recovery plan
Ms Gullery noted that Ralph La Salle would be presenting to today's meeting on how we will deliver recovery for planned care. Further comment would be given during this item.

Item 5 – Bariatric Pathway
Status to be corrected to a report for the 6 August 2020 meeting.

The carried forward action items were noted.

The meeting moved to Item 5.

5. ELECTIVE SURGERY RECOVERY PLAN (PRESENTATION)

Ms Gullery introduced Ralph La Salle, Team Leader, Secondary Care, who is managing the elective surgery recovery plan.

Mr La Salle thanked the Committee for the opportunity to present and noted that he was presenting on behalf of everyone who had given him support and guidance while this plan was developed and was presenting on behalf of the front liners who brought all of this to life. Mr La Salle noted that whilst he walked alongside of these people during this journey he had been inspired by their ability to share their strength and unity of purpose, despite not always knowing what was going to come next. Mr La Salle shared a proverb with the Committee: "there is food

at the end of my hands" – referring to the ability to use the skills and resources we have to create success and be responsible for those resources and capabilities.

Mr La Salle's presentation covered the following:

- Managing clinical risk at restart
- Planned care:
  - Phased approach to surgery
  - Results
  - COVID capacity reduction
- Radiology restart:
  - Facility constraints
  - COVID constraints
- Oncology:
  - Medical oncology – pharmaceutical cancer treatments (*PCT*); clinics; facilities issues, MDMs; and inpatients
  - Radiation oncology – LINACs
  - Outreach
  - Wins & Learnings

Ms Gullery noted that as part of the whole recovery procedure, we are running through not only the new referrals into the system, but will be reviewing the referrals that got paused in the system and also looking at all of our long waits so we can make sure we get people back into the system with clinical priority. Addressing particularly issues of equity where the response of the system has not been appropriate. We have done some analysis to make sure that our Maori, Pacifica and Asian populations were not adversely affected any more than the whole population was affected by the pause. What we are seeing at the moment is that the reduction in access to our hospital based systems was similar across ethnicities, with the exception of Asian, which saw a significantly higher reduction, but the recovery has been slower for Maori and Pacifica. Will be addressing this directly through the work we are doing with primary care to ensure the right patients get back through the system faster. Ms Gullery advised it is about being deliberate about access, timing, transport and taking a proactive approach when people do not attend. There is a lot of work to go on in this space, but we are in a better position now than a year ago in terms of data analysis and also in terms of virtual models.

There was a query around cancer patients waiting for diagnostics. Ms Gullery advised that non-deferrable surgery went ahead. We are currently looking into issues around the diagnostic end, but it was noted that all radiology has been caught up on. Ms Gullery noted that the biggest concern, given the rate of cancer in Canterbury is higher than the rest of the country, is how many people did not present to their general practice. This is what we saw post the earthquakes – when people were identified with cancer they were further through, so were more complex and at a more invasive level because they had not stepped into the health system earlier. The 30 to 50% reduction in general practice attendance will be one of the biggest risks for us.

There was discussion around the impact of capacity reduction and what will occur when we shift to Level 1. Mr La Salle advised we are still working through what Level 1 will mean for us. Mr Meates advised that theatre throughput will struggle to get back to what it was pre-COVID-19 and that is simply due to physical issues, but it will reduce from the 13%. There are processes being worked through to remap and mitigate the impacts of that. He advised that the other issue is the six and five bedded rooms across Parkside and Riverside. Dealing with these, we will lose about 66 beds, not including another 15 that sit in the current ED component, where we cannot achieve a one metre separation on a good day. Clinical standards and protocols are being revisited in terms of how we manage complex respiratory cases in particular in very confined spaces that are contrary to what would be seen as good practice. Capacity issues will remain an ongoing part of our landscape.

In response to a query about theatre capacity nationally, Mr La Salle noted that theatre constraint has hit Canterbury more than other areas. For Canterbury we have indicated this will likely mean more outsourcing, at least until we get into Hagley where we will have more resource. Mr Meates advised that across all of the larger DHBs there are significant challenges with both catch-up and how that will be delivered out over the next 12-18 months. For smaller DHBs it is less of an issue purely and simply due to the type of cases they are doing and the capacity that sits in those areas. Ms Gullery advised that Canterbury has the advantage that due to our longstanding theatre capacity restraint our way of working with the private sector is well embedded. Work undertaken during the lockdown to cement that process means that we are better positioned than most other DHBs to use the private sector as part of our recovery.

The meeting moved to Item 4.

4. COVID-19 UPDATE

Sue Nightingale, Chief Medical Officer, presented the report which provided an update on CDHB's response to COVID-19. She also provided a presentation on the function of the Emergency Co-ordination Centre (*ECC*) and observations on the response.

Ms Nightingale noted that questions had been asked as to what we were doing when the hospitals were quiet during the COVID-19 response. She noted that just because we did not have a huge influx of COIVD-19 patients, this did not mean we could not plan for them. There was a phenomenal amount of organising that went on. We had to assume that we would be inundated with cases, as was seen in the United States for example, so that led to a wide range of activities for every single service in order to plan for care safely.

The ECC presentation covered the following:

- A brief overview of work as Incident Controller in the Emergency Coordination Centre and priorities through the COVID-19 response.
- Operational response plan objectives.
- Sites / Services
- How priorities are changing and will change as we transition to the new normal – accelerating the future.
- Key learnings and observations.
- Changes that have occurred through the COVID-19 response that if retained or adapted would accelerate the transformation of our system.

There was a query about concerns raised when it first became apparent that we may be looking at a global pandemic rather than an isolated incident in China, about intensive care bed capacity across the country. Ms Nightingale noted there is a national group looking at ICU capacity. Locally, we were trying to move into Hagley early, but also had the ability to expand Wards 10 and 11. We have the ability to ramp up if we have to, but there remains the potential to be overwhelmed.

There was a comment that as a system there was a huge amount of planning, we were not really tested, and when it comes down to it it will be the public health system that will safeguard the hospitals from being overwhelmed.

Laboratory services were commended for their work during the COIVD-19 response. Ms Nightingale noted it was important to recognise that Labs work, in the same way as Community and Public Health's work, is not done with respect to the COIVD-19 response – this will be ongoing. Ms Nightingale also took the opportunity to acknowledge the work of

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the Infection, Prevention and Control Team, who have been phenomenal in their advice and support to the whole of the health system, not just our hospitals.

There was acknowledgement of the people who pulled together the daily situation reports, both DHB and Ministry of Health staff. The information received was succinct, timely and useful.

There was a query around accelerating the future and what this will mean. Mr Meates advised that some of these elements are already emerging. A wide range of things have been identified through the ECC framework. We are looking to cohort into and leverage off existing infrastructures in the Canterbury health system – moving from emergency response to accelerating our future component. Some are simple and clear cut, whilst other elements need to be worked through to ensure we reach the right outcome. The challenge that all health systems have – there is a window of opportunity – the longer it goes on without embedding the changes, the likelihood of losing the opportunity gets higher.

The COIVD-19 Update report was noted.

The meeting moved to Item 6.

6. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (05/20)
(Moved: Naomi Marshall/Seconded: Jan Edwards – carried)

"That the Committee:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of the minutes of the public excluded meeting of 30 January 2020.	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."

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There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 10.30am.

Approved and adopted as a true and correct record:

_____ _____

Andrew Dickerson
Chairperson

Date of approval

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HAC MEETING 4 JUNE 2020 – MEETING ACTION NOTES

Item No	Item	Action Points	Staff
	Apologies	Sally Buck and Andrew Brant – for absence David Meates for lateness	Anna Craw
1.	Interest Register	Barry Bragg – addition – Chair of Paenga Kupenga Limited	Anna Craw
2.	Minutes – 30 January 2020	Adopted – subject to clarifying correct BMI figure on page 5. *Barry Bragg / Jan Edwards*	Anna Craw
3.	Carried Forward Items	• ED attendances for over 75s – report to 6 Aug 20 meeting • Bariatric Pathway – correct status to a report for the 6 Aug 20 meeting	Carolyn Gullery Carolyn Gullery / Anna Craw
4.	COVID-19 Update	Nil	
5.	Elective Surgery Recovery Plan	Nil	
6.	Resolution PX	Adopted *Naomi Marshall / /Jan Edwards*	Anna Craw
	Info Items	Nil	

Distribution List:
Carolyn Gullery

CC: Regan Nolan

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE
CARRIED FORWARD ITEMS AS AT 6 AUGUST 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. TBC: Report to 3 December 2020 meeting.
2.	5 Dec 2019	Faster Cancer Treatment	Carolyn Gullery	Today's Agenda – Item 8.
3.	30 Jan 2020	ED Presentations – Over 75 Years Old – Analysis Paper.	Carolyn Gullery	Today's Agenda – Item 7.
4.	30 Jan 2020	South Island Bariatric Surgery Service – Summary 2019/20	Carolyn Gullery	Today's Agenda – Item 9.
5.	30 Jan 2020	SMHS – Management of Children and Addressing Gaps	Barbara Wilson	Today's Agenda – Item 5.
6.	30 Jan 2020	Chatham Islands	Carolyn Gullery	Report to 1 October 2020 meeting.
7.	30 Jan 2020	Emergency Department Presentation – Hagley migration transfer and change of model.	Pauline Clark	TBA

MATERNITY ASSESSMENT UNIT – 9 MONTH UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **Pauline Clark, GM Christchurch Campus**
Norma Campbell, Director of Midwifery

APPROVED BY: **Mary Gordon, Executive Director of Nursing**

DATE: **6 August 2020**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This paper provides a nine month overview of the newly established Maternity Assessment Unit (*MAU*). It provides a summary of outcomes to date and an outline of next steps for the development of the unit.

The MAU was established in August 2019 with the purpose of being able to redirect as clinically appropriate antenatal activity to a dedicated assessment space. The initial goal being able to improve flow and redirect a quantum of antenatal attendances per month from the Birthing Suite environment, thus creating more capacity within Birthing Suite to deal with intrapartum care and acute presentations. This also brought Christchurch Women's Hospital (*CWH*) into a more nationally and internationally consistent model with a clearer pathway for presentation, assessment and treatment as required.

2. RECOMMENDATION

That the Committee:

i. notes the paper and outcome update of MAU; and
ii. notes the need to progress combining unplanned and planned antenatal activity in the same physical space.

3. SUMMARY

The MAU has seen positive results within the last nine months since establishment. The following is a summary of outcomes to date:

- Approximately 206 antenatal assessments per month have been taken off Birthing Suite.
- There are approximately 152 less women attending Birthing Suite for assessment per month – so antenatal assessment workload decreases for staff in this area.
- The average wait time for women having antenatal assessments has reduced by 47% (three hours 30 minutes to one hour 52 minutes). Previously, some women were waiting on Birthing Suite for up to seven hours for assessment.
- The MAU is costing less to run with fewer staff rostered than had previously been forecasted prior to implementation. Staffing numbers have been continually refined throughout the last nine months.
- There has been no additional cost to Birthing Suite for consumables (MAU consumables come from Birthing Suite).

- Overall, Lead Maternity Carers (*LMCs*) are more satisfied with the MAU than the previous Birthing Suite process.
- Consumer feedback has highlighted that women are happy with the care they receive through the MAU.
- The MAU is completely midwifery led.
- Medical staff feedback is highly supportive of this unit and the positive impact this has on the birthing suite workload.

4. DISCUSSION

Key Changes That Have Occurred Within the Previous Nine Months Since MAU Implementation

- **Birthing Suite Activity Change**: MAU takes an average of 206 antenatal attendances per month off the Birthing Suite. Approximately 189 of these attendances are acute and 17 are planned. An average of 52 women per month from the 206 get referred onto Birthing Suite and approximately six will be admitted onto the maternity ward directly. If the unit is ever closed for a day (due to unforeseen circumstances) there is a substantive workload that is pushed back to Birthing Suite and comments from medical staff as to the negative impact if there is a closure.
- **Key MAU Activity**: the following key reasons for referral are now seen in the MAU and not on Birthing Suite:
    - reduced or no fetal movements
    - abdominal pain
    - pre-eclampsia assessment
    - antepartum haemorrhage
    - threatened pre-term labour
    - abnormal scan
    - planned DAU/ANC assessment
    - rupture of membranes
    - latent phase
    - fall or minor trauma
    - other.
- **Improved Patient Flow:** There has been a significant reduction in overall wait time for women accessing antenatal assessments through the MAU. This in turn has had a positive impact on patient flow.
- Pre-MAU the average length of stay was three hours 30 minutes on Birthing Suite.
- The current average length of stay through MAU is now one hour 52 minutes.
- This has meant an average reduction in wait time of one hour 38 minutes for women accessing antenatal assessments, or 47% reduction in wait time from MAU commencement.
- **LMC Satisfaction**: Overwhelming feedback from LMCs is the positive impact the MAU has had on their ability to cut down wait times for both them and their women. LMCs have noted the improved communication process/feedback loop from the MAU regarding their women, and the streamlined assessment process this unit offers. Specific feedback from LMCs is included below:
    - "Fabulous staff and service, best initiative the CDHB have devised and instigated for past 20 years I've worked as an LMC."
    - "So appreciate this valuable service."
    - "I have felt supported and have experienced good communications each time I have had to use the MAU. I very much value the time that the senior midwife on staff has to

discuss my client, assessments and possible scenarios when I have need of this. The midwives who staff this unit are fabulous, thanks team."

- "As a LMC I have found MAU space highly valuable – amazing for timely assessments".

- **Midwifery Led Process**: The unit is midwifery-led and staffed, which has freed up the workforce capacity within the obstetric RMO/SMO workforce in not having to do the initial attendance/work up for antenatal women. Midwives work at the top of their scope and there has been positive feedback from both the midwifery and the medical workforce. Midwives working within the MAU have commented on the immense satisfaction at being able to work in such an autonomous way, in a midwifery led unit.
- **Staffing Requirements**: Initially the MAU was scoped to allow two midwives on a morning shift and two on an afternoon shift. This has been revised and there is now one midwife on the morning, one on the afternoon, with a swing shift that suits the workload. The initial Hospital Aide cover is not required and there is a ward clerk for six hours on each shift. Overall this means that there is less FTE being used to run the MAU than was originally estimated.
- **Admissions to Maternity Ward**: On average six women per month are admitted from MAU to the Maternity Ward directly.
- **Consumer Satisfaction**: There has been overwhelming supportive feedback from consumers regarding the MAU. The only negative feedback thus far has been regarding the beds being uncomfortable and how hot the rooms get. The following feedback has been received from consumers:
  - Nice and quiet compared to the old observation unit.
  - Thank you for absolutely amazing care.
  - The care was really good and timely.
  - Thank you for making a scary experience calming. Really helped my nerves.
  - Thank you so much. Very informative and I felt respected.
  - So lovely and friendly and no waiting to be seen!
  - Friendly staff, great team of midwives.
  - Great people, amazing experience and great service.

5. CONCLUSION

Next Steps for Development

- Maintain the MAU as a unit.
- Expand the functionality to include Day Assessment Unit (*DAU*) activity and essentially have both planned and unplanned antenatal assessments in one space. This to be renamed Antenatal Assessment.
- Note the potential changes to greater primary assessments within the community (clinics now established at Lincoln and Rangiora, during COVID-19) with the Women's Outpatient Clinic realignment work, including greater use of telehealth from rural units (ie. Ashburton, Kaikoura and West Coast).
- Review what component of women could potentially have planned care (i.e. twice daily CTGs) through the MAU, rather than be admitted onto the Maternity Ward as an inpatient admission.
- Review what space may be required to be occupied to maintain MAU functionality, if the current Parkside location requires vacating.
- Note the current Misoprostol for Induction of Labour Project and the potential for a cohort of women to start their induction of labour (*IOL*) on MAU with the new regime. The MAU must be within the CWH footprint for this to occur.

H&SS MONITORING REPORT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

APPROVED BY: **Justine White, Executive Director, Finance & Corporate Services**

DATE: **6 August 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:

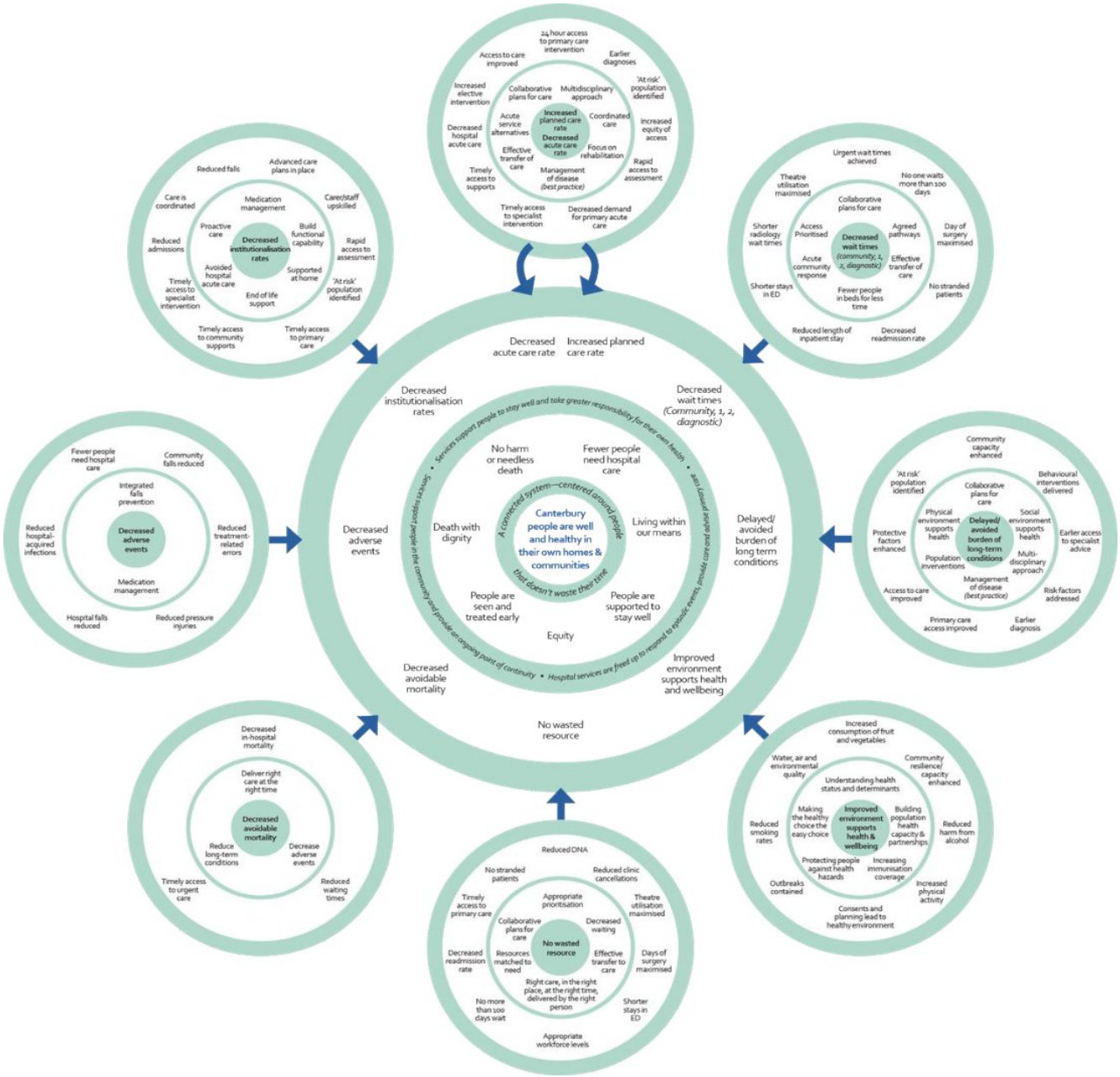
i. notes the Hospital Advisory Committee Activity Report.

3. APPENDICES

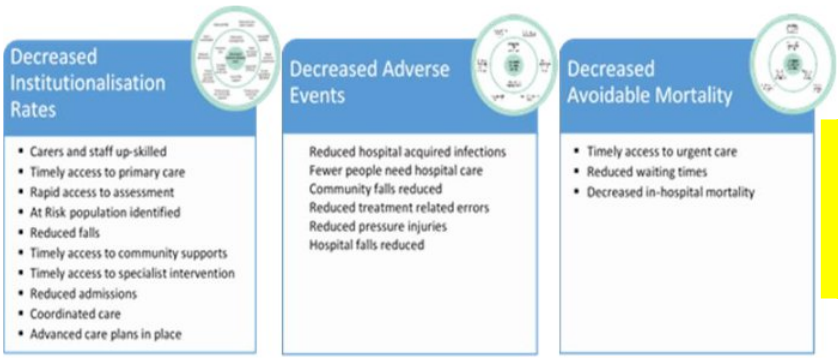
Appendix 1: Hospital Advisory Committee Activity Report –July 2020

Hospital Advisory Committee

Activity Report

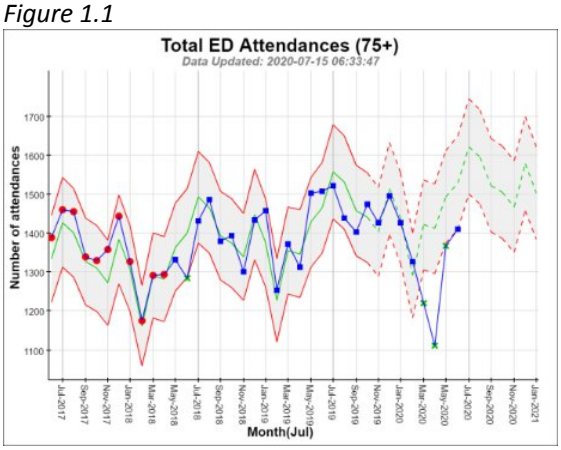


July 2020



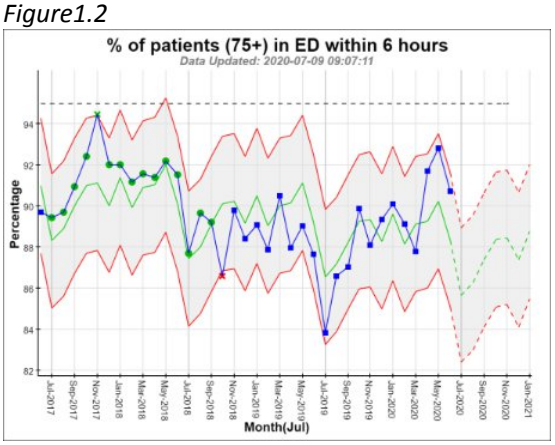
Outcome and Strategy Indicators

Figure 1.1



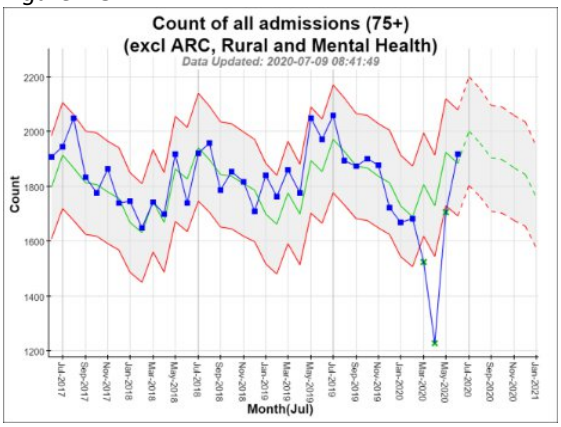
Covid 19 Alert Level restrictions led to a reduced number of ED attendances in March and April, increasing towards previously forecast levels in May – but remaining lower than recent trends would indicate.

Figure1.2



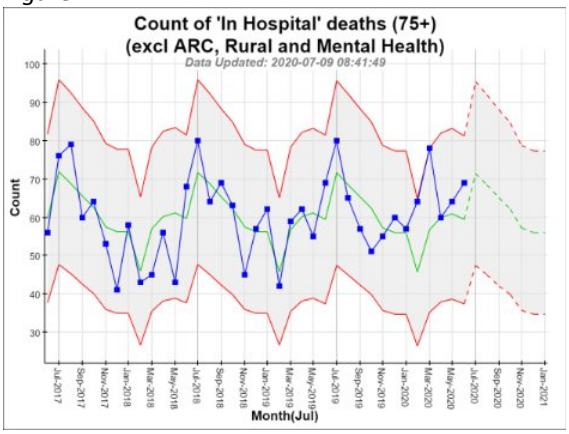
The reduced volumes have led to a faster turnaround in ED with more than 90% of older patients leaving ED within six hours during the past three months.

Figure 1.3



The number of older people admitted is generally within the forecast range but was reduced during the COVID lockdown period.

Figure 1.4



The rate of in hospital deaths against admissions was higher than forecast in March, reaching a rate not seen since winter 2014. Exploration of data has not explained this. Since then the monthly rate has fallen back to within forecast range and is following the ongoing reducing trend.

Figure 1.5

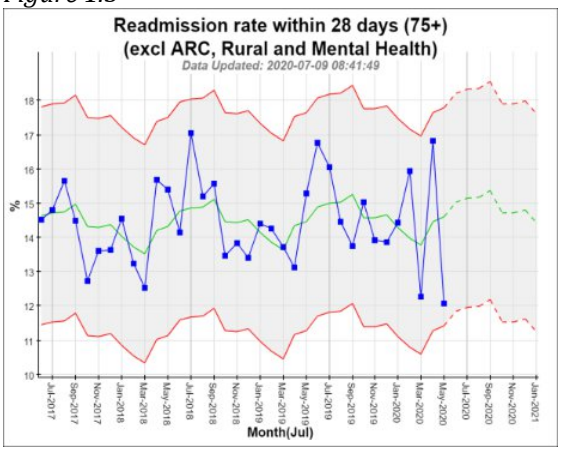
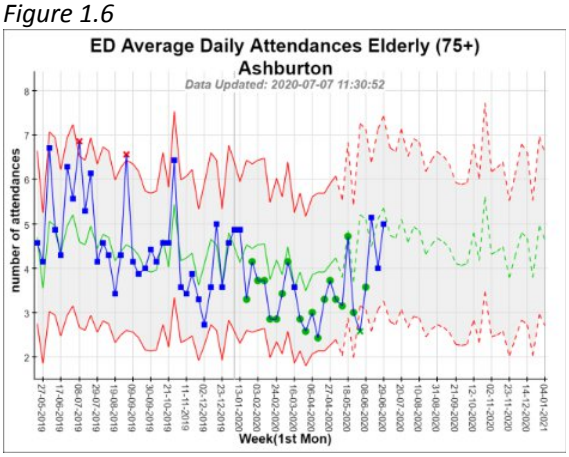


Figure 1.6



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

Achievements/Issues of Note

Ashburton Health Services

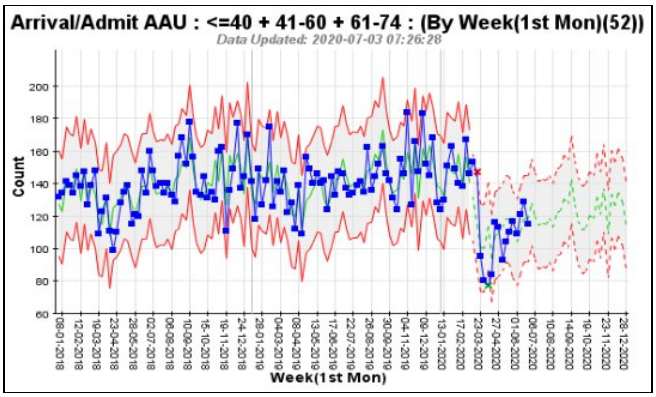
Following the COVID-19 level 4 response and instigation of multiple digital health service delivery models that have maintained with the reinstatement of level 1, the Ashburton Health Service leadership team has monitored the flow of older persons through the hospital.

Community narrative has indicated on one hand a fear from our older persons community that would suggest a drop in our presentation rate, with the counter concern that the outcome from our needs assessment reviews for community services have created increased risk of hospitalisation for older people and what balance measure is being reviewed. Working with the Planning and Funding SFN team, we have confirmed that the attendance of over 75 years old at Ashburton AAU has returned to a similar level as pre-Covid 19, about 32 to 35 attendances per week. You will note this is reflected in *Figure 1.6* above, however we are continuing to run below the mean.

However, the wider data indicates a 20% reduction of the demand for children and adults. This reflects approximately 20 attendances less per week, the current weekly pattern range between 110-120 attendances, compared to previous 130 to 150. Noting that the Community Based Assessment Centre (CBAC) has continued to operate throughout this time, with a closure date on the 17th July we requested further information on the presentation rate to this facility. The CBAC is on the campus of the Ashburton Hospital and as a community would not be identified as a separate organisation or approach to that of the hospital. We noted that the Ashburton CBAC reported a higher rate of presentations than city counter parts and potentially many of the adult winter respiratory presentations previously seen in AAU have been addressed through this model.

Through our Service Level Alliance, we have asked for the corresponding presentation rates to primary care, so that we may consider as a wider system the older persons current pattern in accessing care and if we need to revisit any specific area. The overall pattern of presentations for those under 75 has dropped significantly, reflected in the table below. We have presented this information to our SLA partners opening a discussion regarding access to health care overall and if in fact the new models of digitally delivered care has enabled community to access primary care more than previously reported.

*Figure 1. AAU Arrival/Admit **under 75 years** old weekly pattern*

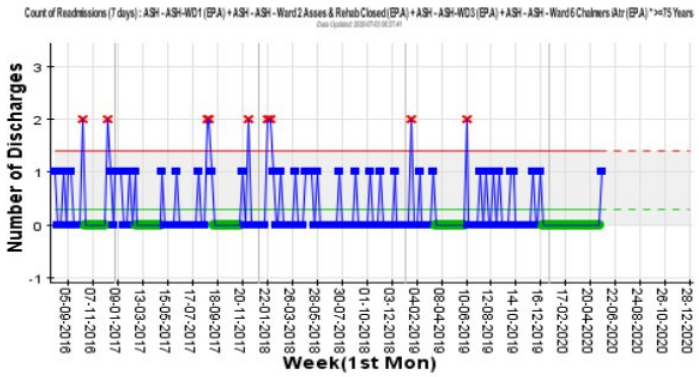


Readmission

Readmissions of over 75 years old within 28 days for the year 2020 (6 Jan) to date is about 11%.

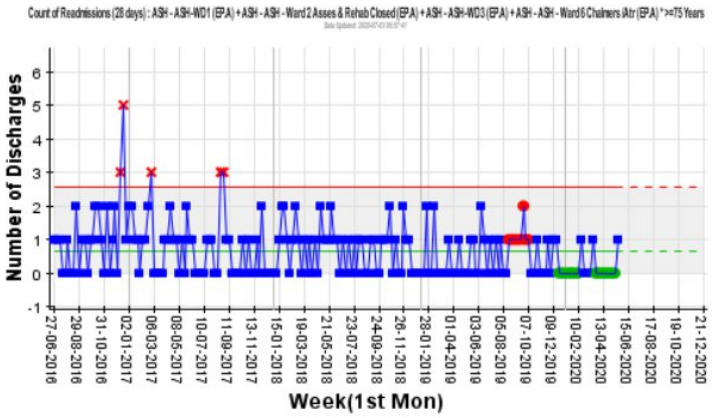
1. Within 7 days of Discharge of patient went through Ashburton Facility

Of patients admitted to Ashburton Hospital shows that during 2020 only one patient was readmitted within 7 days of discharge from any CDHB hospital.



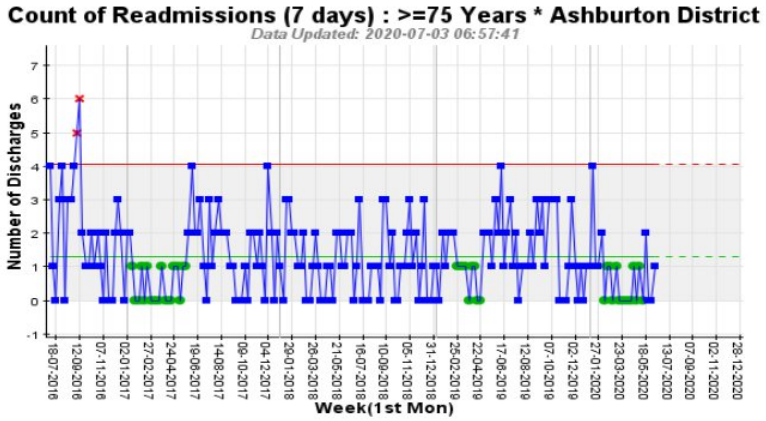
2. Within 28 days of Discharge went through Ashburton Facility

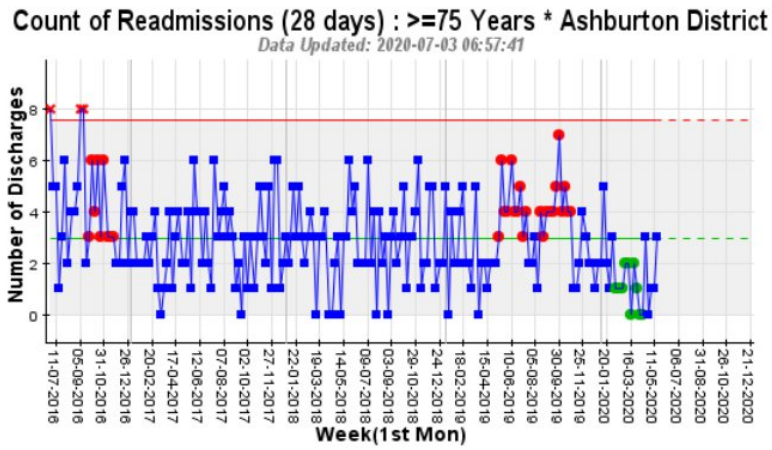
Of patients admitted to Ashburton Hospital the information below shows that during 2020 3 patients was readmitted within 28 days of discharge from any CDHB hospital.



3. Readmission |People with Domicile at Ashburton

Confirming that Ashburton domiciled readmissions are not occurring to the Christchurch based facilities, the following data set was reviewed.





Ashburton rates of ED (AAU) presentation are higher when comparing to overall rate within Canterbury:

- 139 People attending AAU per 1000 enrolled population within the Practice.
- 186 AAU Attendances Rate of presentation per 1000 enrolled population, noting the difference as people may have more than one attendance during the period.

Rate per 1000 enrol population period 28 April 2020 to 03 July 2020 (Level 3 onwards)

After Level 4, the total attendance between 28 April to 03 July 2020 was 264 attendances.

The average rate for the period:

- 75 People attending ED per 1000 enrolled population within the Practice.
- 93 ED Attendances Rate of presentation per 1000 enrolled population, noting the difference as people may have more than one attendance during the period.

The data indicates variability across the Practice size by comparison to the enrolled population per practice, with some visible outliers. However, when comparing by Emergency Attendances rate, the higher rate may imply a different need within each individual as they may present to the emergency department more frequently.

Further detailed analysis was provided by Decision Support Unit for discussion, the inference at this point is we need to continue to monitor and explore any trends across the wider system of health care presentation, with an open discussion to alternate models of service delivery and early intervention emphasising restorative care practice, balancing an appropriate acute care response model that mitigates unnecessary demand on tertiary level services.

Older Persons Health Inpatients Patient Flow

With increased inpatient demand post Covid, the service has re-focused on managing patient flow. Post a review of demand Winter Flex staffing for this year did not proceed, reducing available beds by 24 across the service compared to this time last year. Demand has been highly driven from a Surgical and Orthopaedic perspective during the month which continues.

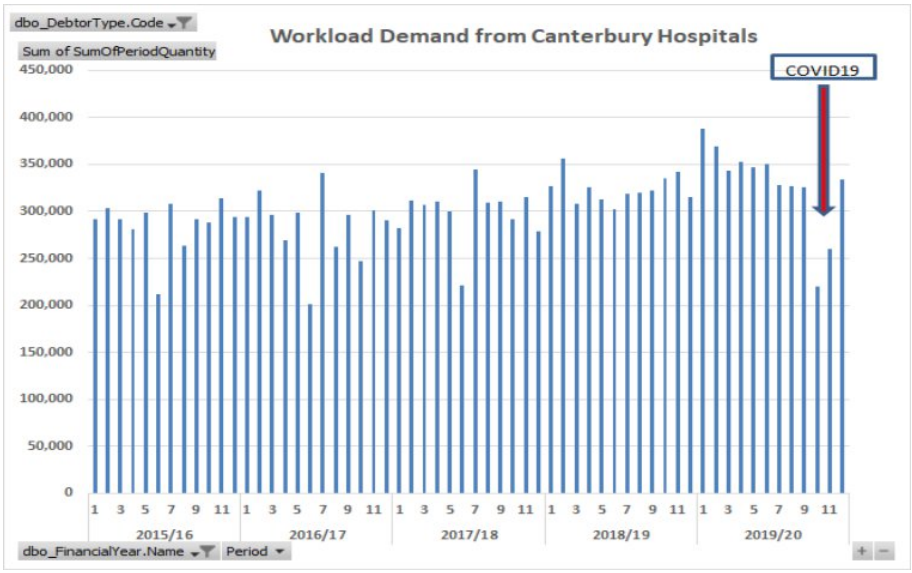
Initiates to support patient flow included: Development of Afternoon' Huddles', focused on ensuring all activities for discharge are complete or underway to minimise on the day last minute changes to discharge plans. Focus on bringing forward actions and tasks to support morning discharges the following day. This then supports forward booking of Christchurch transfers in the morning supporting the OPH team to undertake appropriate assessments on the day of transfer, improving overall patient planning and flow. This has reduced the number of changes to discharges on the day of planned discharge. Morning Board Rounds – renewed focus on these from the senior nursing team to support appropriate planning for the day. Reviewing pattern of Monday discharges to see what could be moved forward to the Friday before the weekend to improve weekend patient flow. Close liaison with Christchurch Hospital to support forward planning with planned discharges form the coming week.

Floor Line Beds Trial in Older Persons Health Wards

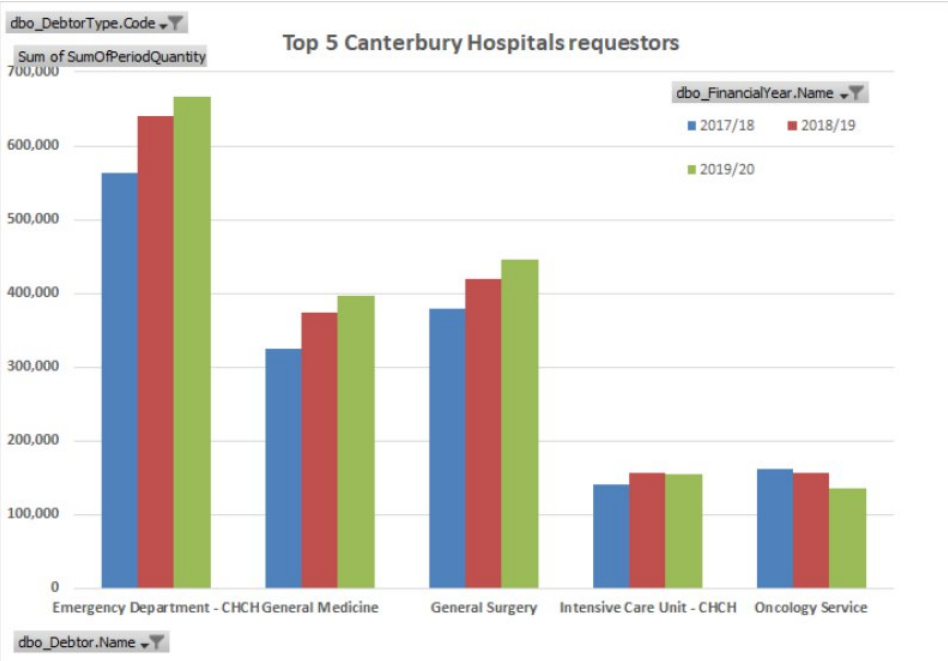
A trial of Floor Line Beds using low beds has commenced on two of the Older Persons Health Wards. Currently hospital aides are utilised for close observation overnight. As a way of addressing this demand, a review of this system has been undertaken to determine if there is a more effective solution. The key to reducing the number of patients requiring for overnight close observation may be using a combination of floor beds and intentional rounding. The intent of this trial is to determine whether the use of floor beds has the potential to reduce falls including injurious, which would in turn allow more appropriate use of our close observation hospital aide resources.

CHL pathology service activity report for services provided to all Canterbury Hospital requestors

Total 4 million tests performed for Canterbury Hospitals in FY 2019/20. Overall increase in demand was consistent in 18/19 and 19/20 at 8% (before adjusting for COVID 19 demand drop, which is now recovering).
Please note increase in June 2020 is already consistent with growth in previous years.



Test request changes from Top 5 Canterbury Hospital requesters over the last 3 years



TOP 15 Canterbury Hospitals Requestors – Annual Pathology Tests Workload

Department	2015/16	2016/17	2017/18	2018/19	2019/20
Emergency Department - CHCH	472,995	507,441	563,383	640,998	666,419
General Surgery	359,663	330,469	379,982	419,500	445,905
General Medicine	329,544	338,095	325,303	373,844	396,813
Oncology Service	186,339	170,089	162,320	155,827	136,232
Clinical Haematology	159,057	150,615	138,488	142,835	162,931
Nephrology	151,402	146,068	133,944	139,592	133,566
Cardiology	139,392	137,226	131,536	117,037	116,715
Orthopaedic Department	126,612	138,171	136,204	139,899	148,958
Medical - AT & R	118,410	103,023	109,888	121,412	101,302
Gastroenterology	117,929	109,978	99,739	122,667	136,083
Cardiothoracic Surgery	100,647	98,246	61,126	54,040	62,070
Ashburton & Community Health Services	82,205	85,296	93,320	95,017	89,171
Intensive Care Unit - CHCH	78,950	91,332	141,682	157,153	155,031
Children's Haematology Oncology Centre	78,423	78,442	67,070	68,265	82,029
Paediatrics	59,251	57,834	64,134	75,880	86,184
Total TOP 20 requestors	**2,560,819**	**2,542,325**	**2,608,119**	**2,823,966**	**2,919,409**
Total Workload for Canterbury Hospitals	**3,439,202**	**3,419,437**	**3,585,535**	**3,889,082**	**3,944,683**
% of TOP 20	**74%**	**74%**	**73%**	**73%**	**74%**

Improving safety of Heparin administration

- Unfractionated heparin is an anticoagulant medication. Correct dosing is essential to ensure that patients do not suffer from either clots or bleeding.
- The previous unfractionated heparin form was consistently contributing to errors amongst users. This was highlighted via multiple Safety 1st incident reports
- The prescribing template has been updated and audit results reflect the new template reduces the risk of medication errors. This is supported by reduced incident reports.

Infectious Diseases team and COVID-19

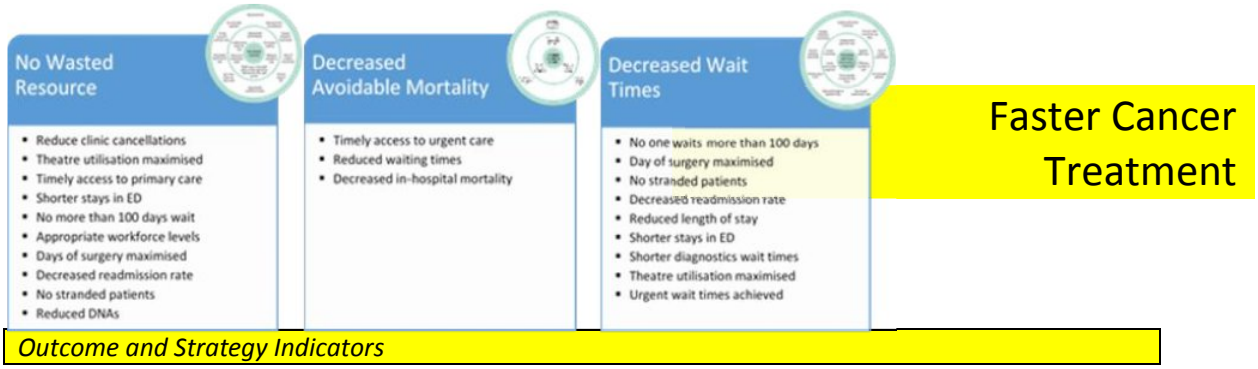
- The Infectious Diseases (ID) team has been integral to the CDHB response to COVID-19 and that has been the major focus for the team in the first half of 2020. The ID team has worked closely with colleagues in Microbiology, Infection Prevention and Control and Public Health as well as the Christchurch Hospital and Canterbury Health Board emergency management structures.
- The work required has involved the team heavily in writing patient admission, assessment, testing and management pathways as well as deciding what personal protective equipment needed to be worn in different situations.
- This included liaison with every department to tailor advice to their patient population and management pathways. Significant time was spent providing education to departments and different occupational groups.
- The ID team also provided advice (and continues to do so) to local Aged Residential Care facilities and there is continued support for the quarantine facilities.

Home Intravenous (IV) Antibiotic (AB) Service

- The Home Intravenous Antibiotic Service at Christchurch Hospital provides quality care for patients with complex infections who need prolonged courses of intravenous antimicrobials as well as enable patients to be supported to return home rather than endure a lengthy hospital stay.
- On average 30 patients are being provided with care with each patient receiving on average 20 days of Home intravenous antibiotic treatment. This comprises approximately 2/3 of their intravenous treatment course and saves well over 8,000 inpatient bed days each year.
- Since 2014 we have routinely pre-emptively consulted on all patients with *S. aureus* bacteraemia in the Christchurch Hospitals Campus and institute a bundle of care aimed to improve the management of these patients.
- An audit of this bundle of care demonstrates lower rates of relapse (1.3% versus 7.4%) since the Home IV AB Service introduced this bundle, leading to lower rates of re-admissions and lower morbidity for patients.

Recent Hand Hygiene audit achievement Christchurch Hospital

- Audit results from March to June 2020 show an 84% achievement rate in Christchurch Hospital (this is an improvement on previous results) with 91% in Christchurch Women's against a national target of 80%.
- Christchurch Hospital exceeded the CDHB target of 85% for three of the five 'moments' and Christchurch Women's exceeded the CDHB target for four of the five moments. Moment five remains the challenge across most areas which relates to after touching a patient's surroundings.



Key Outcomes - Faster Cancer Treatment Targets (FCT)

62 Day Target. In the three months to the end of May, of the 180 records submitted by Canterbury District Health Board 46 patients missed the 62 days target, 39 did so through patient choice or clinical reasons and are therefore excluded from consideration. With 7 of the 141 included patients missing the 62 days target our compliance rate was 95%, meeting the 90% target.

31 Day Performance Measure. Of 341 records towards the 31-day measure 306 (90%) eligible patients received their first treatment within 31 days from a decision to treat, meeting the 85% target. Of the 35 patients who missed the 31 day target, 10 missed it by five days or less and 7 through patient choice or clinical considerations.

The impact of Covid 19

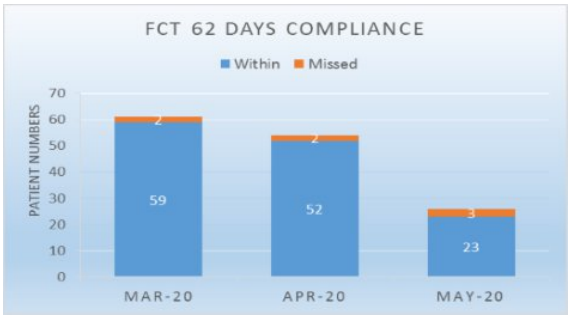
On March 23rd New Zealand moved from Alert Level 2 to Alert level 3 and within a few days to Alert Level 4. In the same period last year, we submitted 298 records so despite being in lockdown the number of patients who started their treatment (341) was significantly higher.

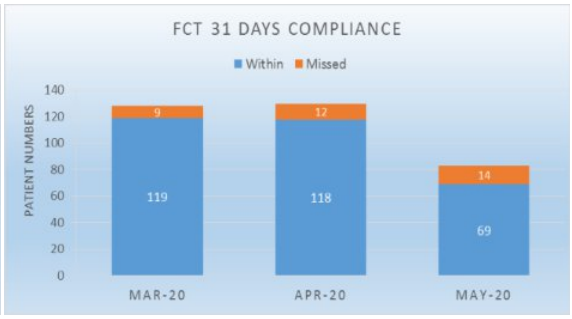
In May, performance against the 62 and 31 days targets dipped slightly below the compliance thresholds. It is too early to say if this is a true reflection of performance in May as there would have been some patients who were still awaiting coding at the time the report was prepared. This is why we always report a 3 month period as it gives a more accurate picture of performance: the MOH actually calculates FCT compliance on a six-month rolling average.

Alongside this a significant reduction in the number of new cancer cases registered occurred during the March – May 2020 period compared with 2019. During that period in 2019 there were 770 new cases registered in Canterbury and in 2020 there were 446 – a reduction of 324 (42% less). The South Island region saw a reduction of 804 registrations, 45% less than 2020. It is expected that these cases will be diagnosed and registered in months that follow.

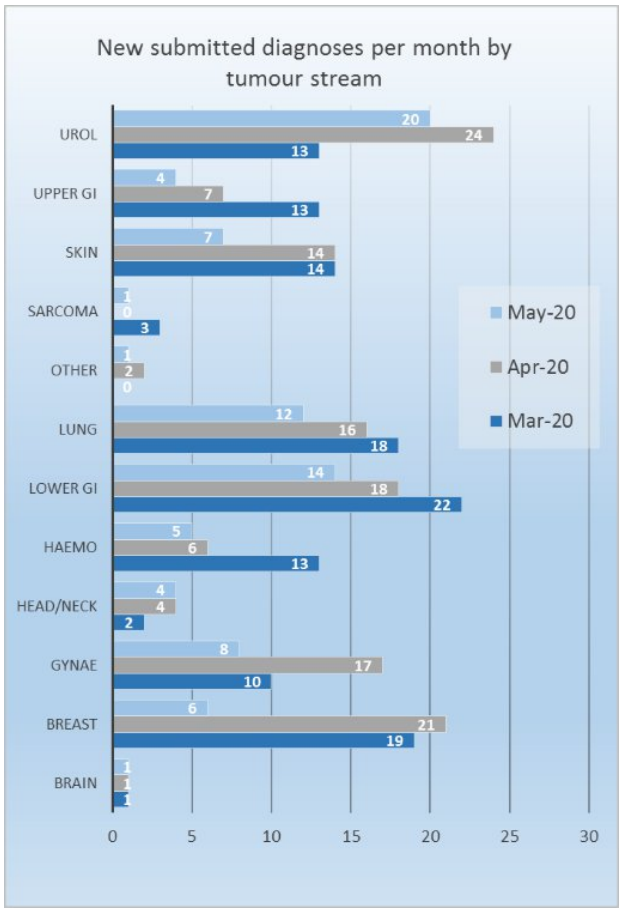
FCT performance in CDHB

The dip in numbers in the last month of every report (May 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.


FCT 62 DAYS COMPLIANCE
Within
Missed
PATIENT NUMBERS
70
60
50
40
30
20
10
0
59
2
52
2
23
3
MAR-20
APR-20
MAY-20


FCT 31 DAYS COMPLIANCE
Within
Missed
PATIENT NUMBERS
140
120
100
80
60
40
20
0
119
9
118
12
69
14
MAR-20
APR-20
MAY-20


Compliance with targets
(90% for 62 days and 85% for 31 days)
100.0
95.0
90.0
85.0
80.0
75.0
70.0
%
Mar-20
Apr-20
May-20
62 days
31 days
85%
90%


New submitted diagnoses per month by tumour stream
UROL
20
24
13
UPPER GI
4
7
13
SKIN
7
14
14
SARCOMA
1
0
3
OTHER
1
2
0
LUNG
12
16
18
LOWER GI
14
18
22
HAEMO
5
6
13
HEAD/NECK
4
4
2
GYNAE
8
17
10
BREAST
6
21
19
BRAIN
1
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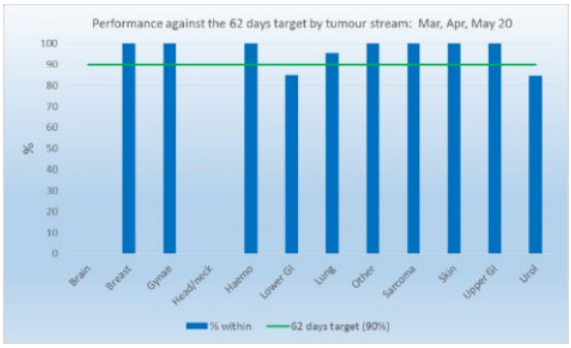
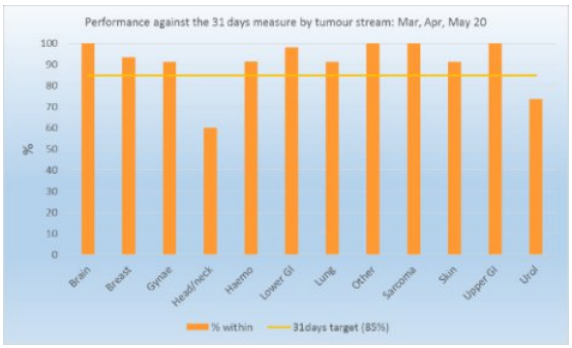
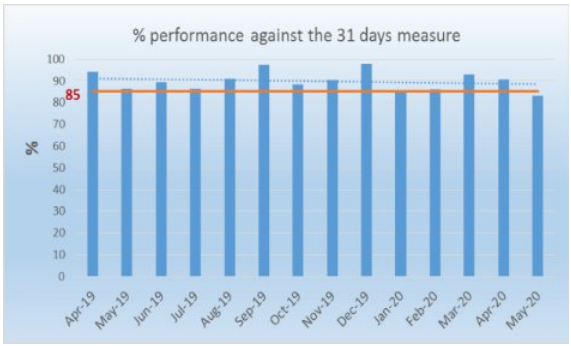
May-20
Apr-20
Mar-20
0
5
10
15
20
25
30





Note: One head and neck tumour stream patient and no brain/CNS patients met the 62 days criteria in this period.



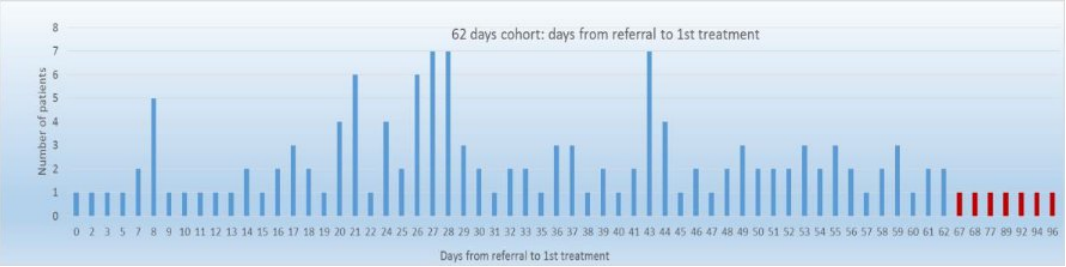
Patients who miss the targets

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: 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 who 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

I Pads improve productivity for Cancer Nurse Coordinators

- Cancer Nurse Coordinators work across specific tumour streams, engaging with patients throughout their journeys in various settings to ensure that the journey throughout multiple services is as smooth and timely as possible.
- The introduction of five iPads has significantly improved and enhanced productivity and efficiency of Cancer Nurse Coordinators allowing work to be done while waiting. An unintended positive consequence is that iPads proved useful during COVID-19 lockdown to enable distancing and remote attendance at meetings.

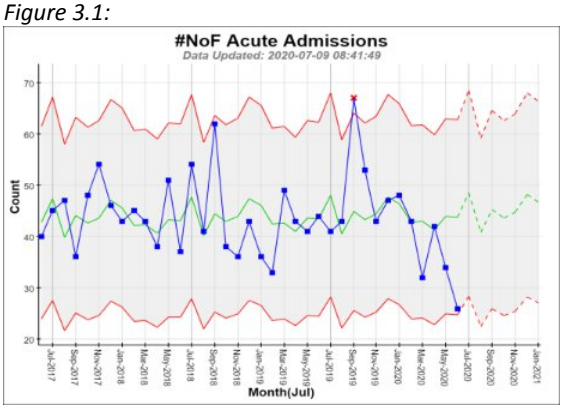
New Patient Transfer Document to replace faxing

- In collaboration with Health Connect South and St George's a new Patient Transfer Document has been developed to replace faxing.
- The new template is used to record information for patients being transferred to CDHB via the Emergency Department from St George's Cancer Care Centre.
- It avoids the privacy risks associated with use of fax and ensures that clinical information is immediately available wherever it is required in the Canterbury Health System. Both expediting and supporting safe care.

Enhanced Recovery After Surgery (ERAS)

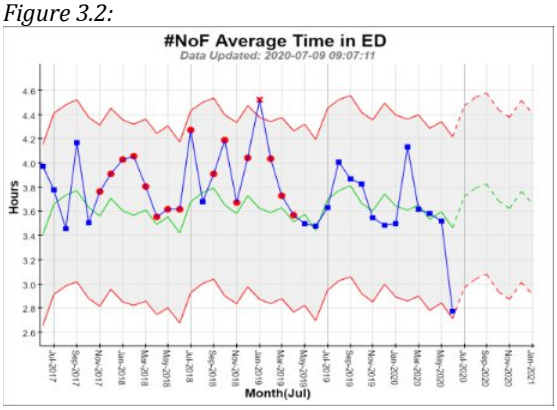
Outcome and Strategy Indicators – Fractured Neck of Femur (#NoF)

Figure 3.1:



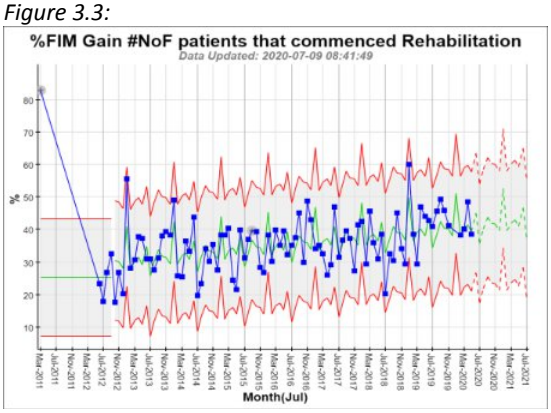
Coding delay impacts the latest data point. Admissions are generally following the expected mean count.

Figure 3.2:



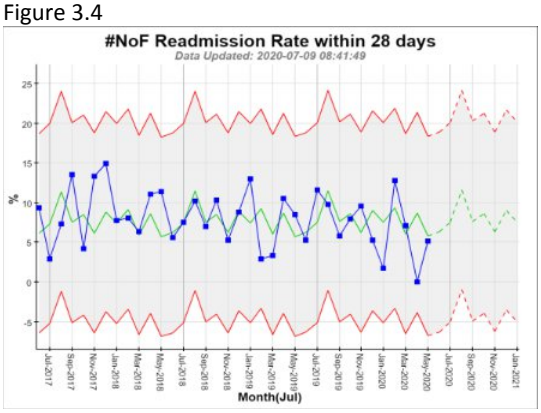
Coding delay impacts the latest data point.

Figure 3.3:



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

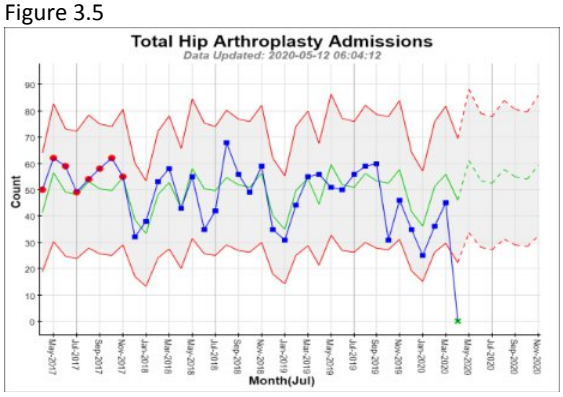
Figure 3.4



Readmissions continue to remain within expected mean values.

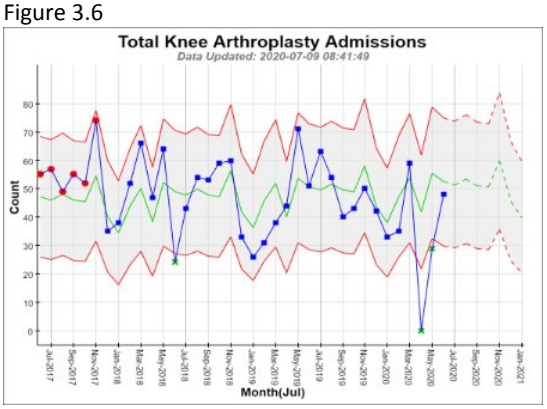
Outcome and Strategy Indicators – Elective Total Hip Replacement(THR) and Knee Replacement(TKR)

Figure 3.5



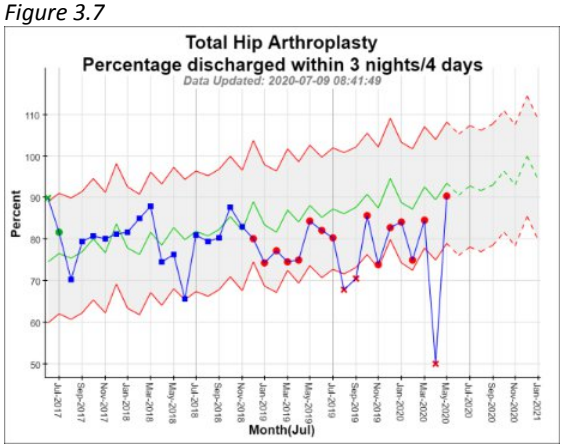
Admissions are trending within the expected range. April shows no record of planned admissions in line with NZ Covid 19 Alert Level 4 restrictions

Figure 3.6



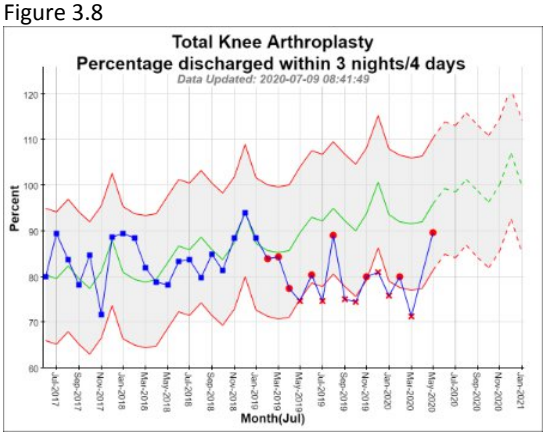
Admissions are trending within expected range. April shows no record of planned admissions in line with NZ Covid 19 Alert Level 4 restrictions

Figure 3.7



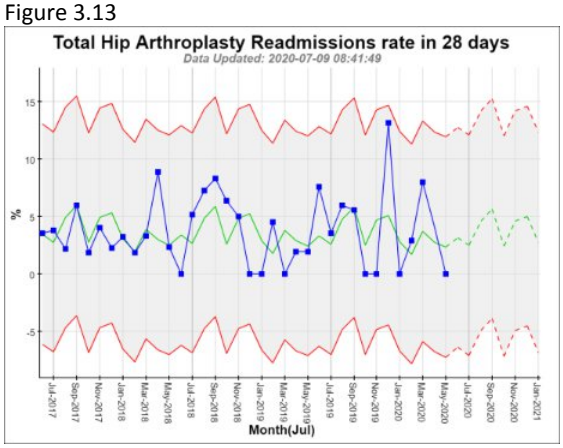
The percentage of patients clinically safe to be discharged is within 3 nights/ 4 days is trending below the expected percentage.

Figure 3.8



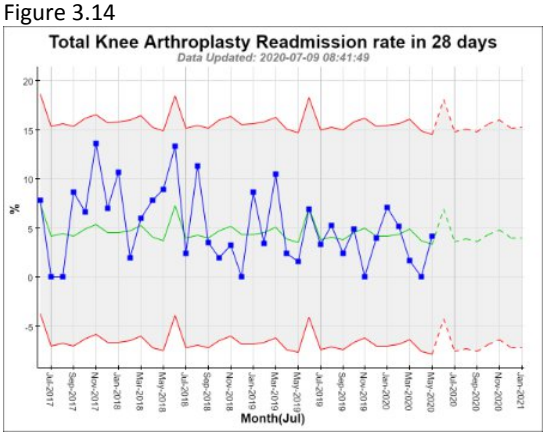
The percentage of patients clinically safe to be discharged is within 3 nights/ 4 days is trending below the expected range.

Figure 3.13

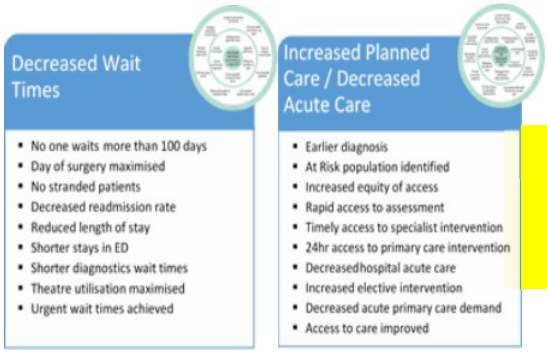


Readmission rates remain a low percentage.

Figure 3.14



Readmission rates are maintaining within tolerances.



Elective Surgery Performance Indicators 100 Days

Achievements/Issues of Note

Collaborative Care in Managing Patients with Rheumatic Fever

- Rheumatic Fever disproportionately affects Maori and Pacific Island People. It is a complex condition that may have significant health consequences for patients if not managed effectively and management involves care from several specialties.
- In 2019 a “One Stop Shop” multidisciplinary clinic for Rheumatic Fever patients established also included a Cardiology review and Echocardiography. This provides a single point of healthcare contact for our patients who would otherwise need to come to several separate appointments.
- High attendance rates at the clinic and feedback from patients is that the “One Stop Shop” clinic is highly appreciated. It has minimised the risk of wasted resource due to patients not attending appointments and ensured improved rates of contact with consumers who to date have presented the health system with some challenges in staying connected and engaged with them.

Improving Hepatitis B immunisation coverage

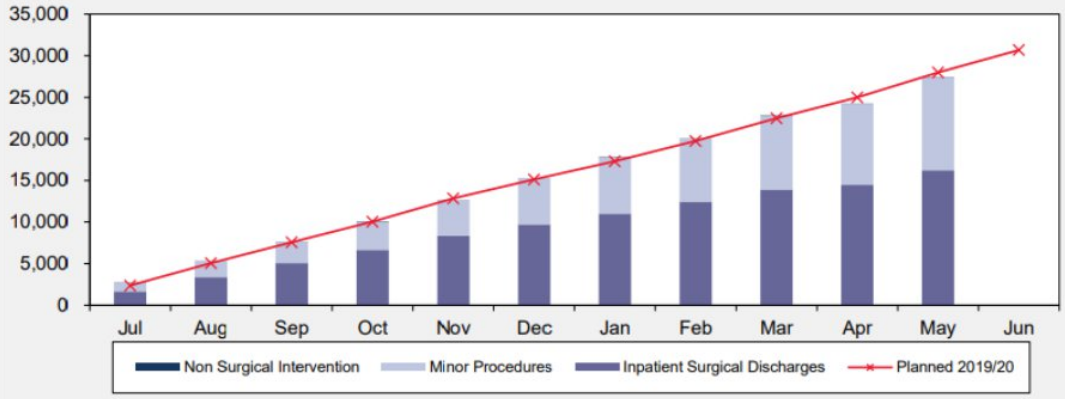
- A Clinical Nurse Specialist from the Infectious Diseases team is working alongside staff at the Hepatitis C Community clinic in a nurse led initiative to offer an onsite vaccination clinic.
- This free clinic removes many barriers for users and has resulted in improved vaccine coverage within an at-risk population as well as opportunities for education of patients.

•

- 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.
- Ministry of Health reporting is available until the end of May. It shows that prior to the COVID lockdown period Canterbury District Health Board was ahead of its planned care target. During the lockdown period non-essential planned care was deferred creating a deficit against target. During May this deficit was reduced.

PLANNED CARE INTERVENTIONS ▲ **98.1%**

	2019						2020					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Planned	2,381	5,065	7,579	10,044	12,847	15,130	17,305	19,751	22,496	24,993	27,982	30,675
Actual	2,732	5,287	7,619	10,070	12,627	15,225	17,884	20,054	22,795	24,256	27,462	
Variance	351	222	40	26	-220	95	579	303	299	-737	-520	
%Achievement	115%	104%	101%	100%	98%	101%	103%	102%	101%	97%	98%	



- **Internal reporting** shows that total volumes delivered were ahead of target at the year's end, with 30,962 episodes counted against a target of 30,675.
- Planned inpatient discharges were ahead of target at the end of February. By the end of the year we had provided 18,010 planned inpatient surgical discharges, 1,172 or 6.1%, less than the phased target of 19,182.
- At the end of June we had provided 12,915 minor procedures, 1,530 more than our target of 11,385. 8,792 of these were provided in a hospital setting (either inpatient or outpatient) – 203 fewer than planned. 4,123 carried out in the community – 1,733 more than planned.

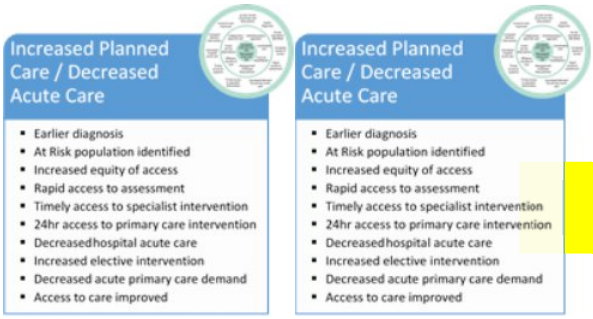
- The final component added to this year's planned procedure target is the provision of publicly funded procedures and non-surgical intervention in community settings. This is an area in which Canterbury has led the country. Provision of data from primary care to the Ministry of Health's National Minimum Dataset collection is being worked on so that these volumes are counted. At this point 37 interventions have been counted against a plan of 108.

Current theatre volumes

- The number of events in Christchurch and Burwood theatres is back at forecast levels and has been since early and mid may respectively.
- The number of operations carried out for CDHB patients in private hospitals was close to the upper level of the forecast range during both May and June.

Perioperative nursing staff.

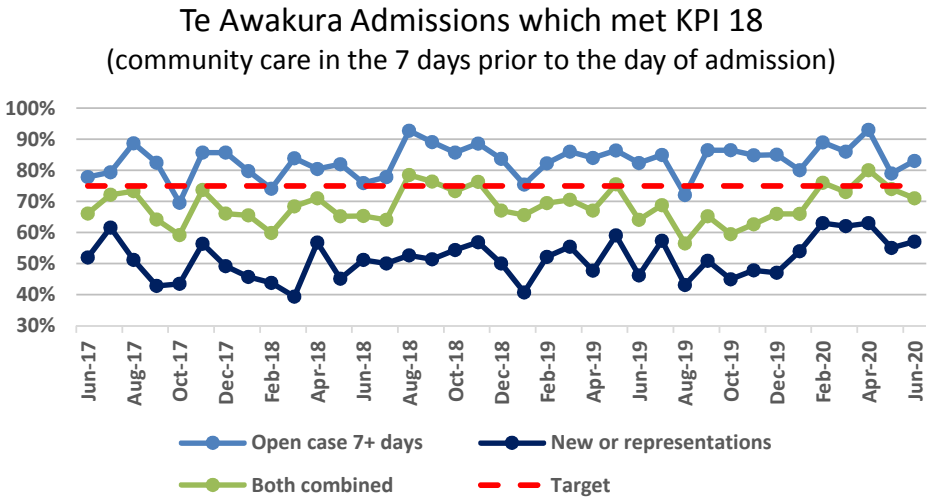
- Perioperative nursing resource that was employed in anticipation of Hagley theatres coming on line is being allocated to other areas, including provision of support at quarantine hotels
- Christchurch Hospital perioperative nursing staff are also working in outplaced sessions in the private sector to support provision of planned care to our patients.



Mental Health Services

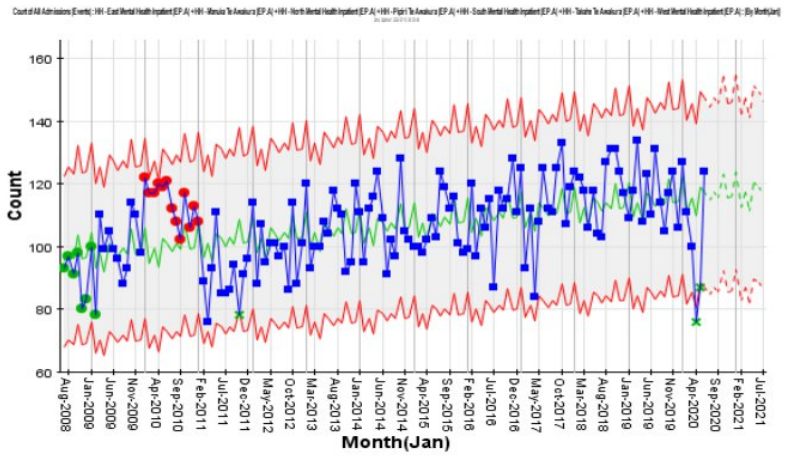
Adult Services-Inpatient demand and flow

Our goal is to support consumers within a community context and avoid inpatient admission wherever possible. KPI 18 is a consumer engagement measure and identifies the percentage of consumers in contact with community mental health services prior to an acute inpatient admission. In May 2020, 75% 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 June 2020, the figure was 71%. The most common reason for non-engagement prior to admission is first presentations requiring hospital admissions.

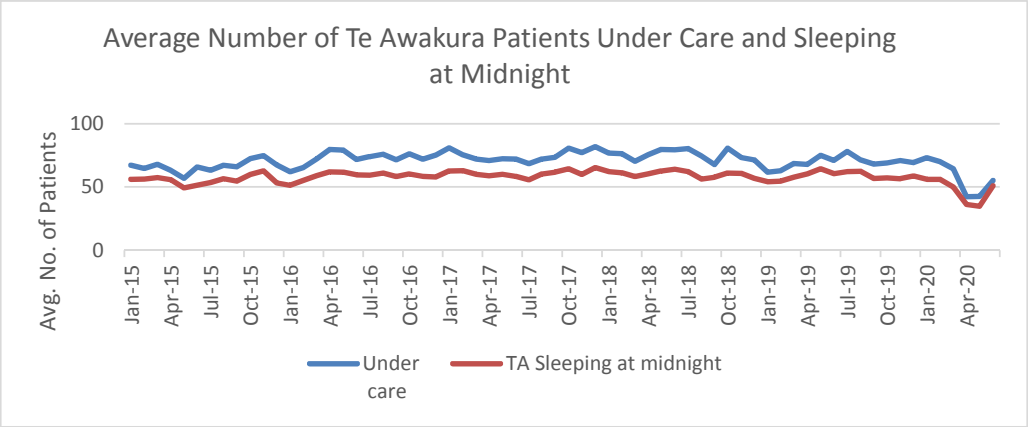


Our COVID-19 response plan required us to build capacity within the inpatient environment to manage potential infection and mitigate risks related to staffing capacity. To enable this, the threshold for admission to the adult acute unit was raised and crisis admissions (a brief pro-active intervention to manage risk factors during an immediate crisis) were limited. The impact on admissions, the number of people under care and the occupancy can be seen in the following graphs.

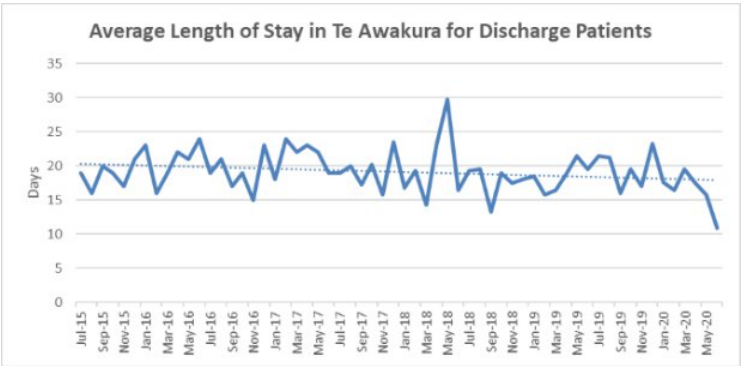
The average number of consumers under care in the 64-bed Te Awakura facility was 43 in May 2020 and 55 in June 2020. Occupancy was 54% May 2020 and 79% in June 2020.



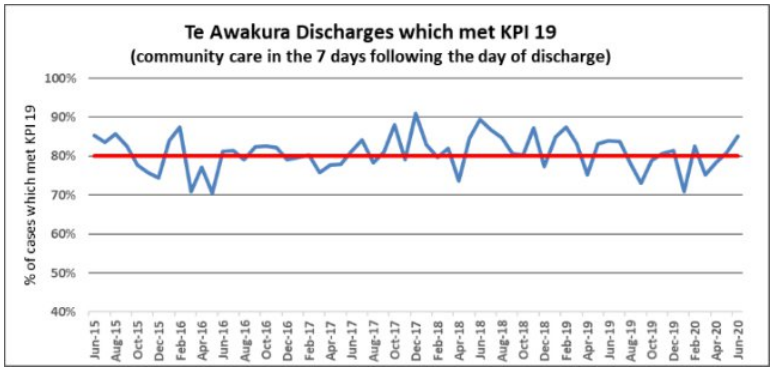
Monthly view of a count of admissions to Te Awakura



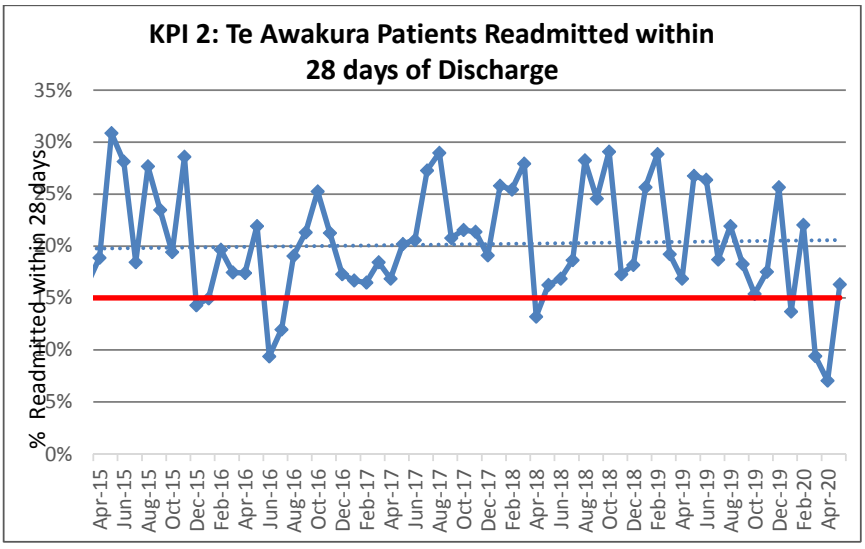
We continue to monitor length of stays as this can be an indicator for demand, acuity, complexity, accessibility and appropriateness of community-based support options. The average length of stay for consumers discharged from Te Awakura was 16 days for May 2020 and 11 days for June 2020. The low length of stay in May and June are directly related to an increase in crisis admissions, which are generally only for 24-72hrs. As at 13 June 2020, 35 acute inpatient beds were occupied by people who have been in the service for 16 days or longer, two had been in the service for 3 months or longer, one had been in the service for six months or longer and one person has been in the unit for more than a year. Work is underway, led by Planning and Funding, to provide additional community-based resources for this 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 seven days post discharge. In May 2020 80.9% of consumers discharged from Te Awakura received a community care follow-up within seven days of discharge, and so met KPI 19. For June 2020 the figure was 85.2%. We pro-actively review the cases not seen within seven days to identify any barriers to follow up. The key reasons are consumers decline follow up or are difficult to engage, or people have moved out of area.

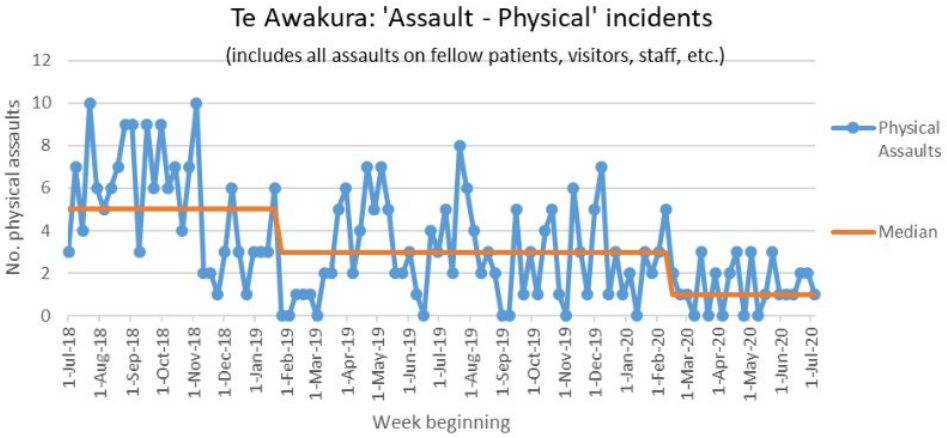


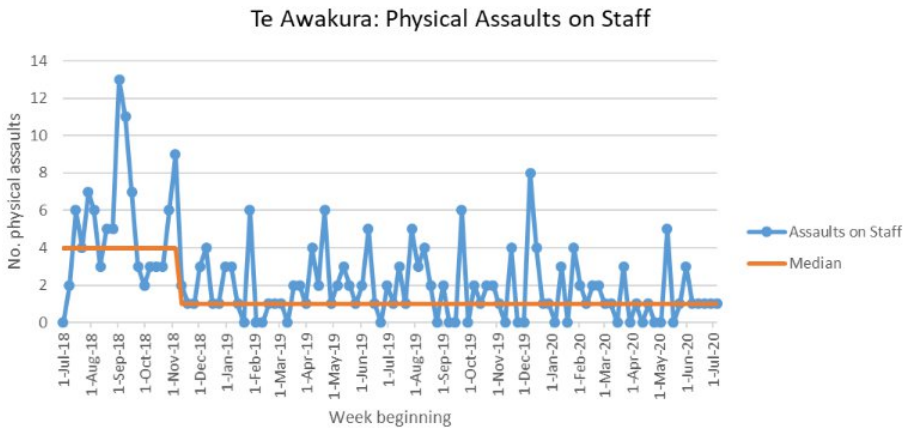
The graph below shows the readmission rate within 28 days of discharge. Of the 128 Te Awakura consumers discharged in April 2020, 7%, were readmitted within 28 days. This low figure could be attributed to COVID 19. In May 2020 of the 92 Te Awakura consumers discharged 16.3% were readmitted within 28 days.



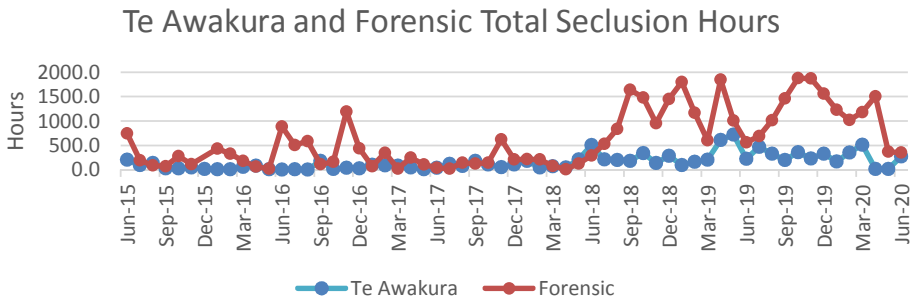
Adult Services – Safer for All

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 several serious assaults resulting in harm to staff and other consumers. Initiatives have been implemented within this environment and there has been a noticeable reduction in incidents of violence and aggression which has been sustained





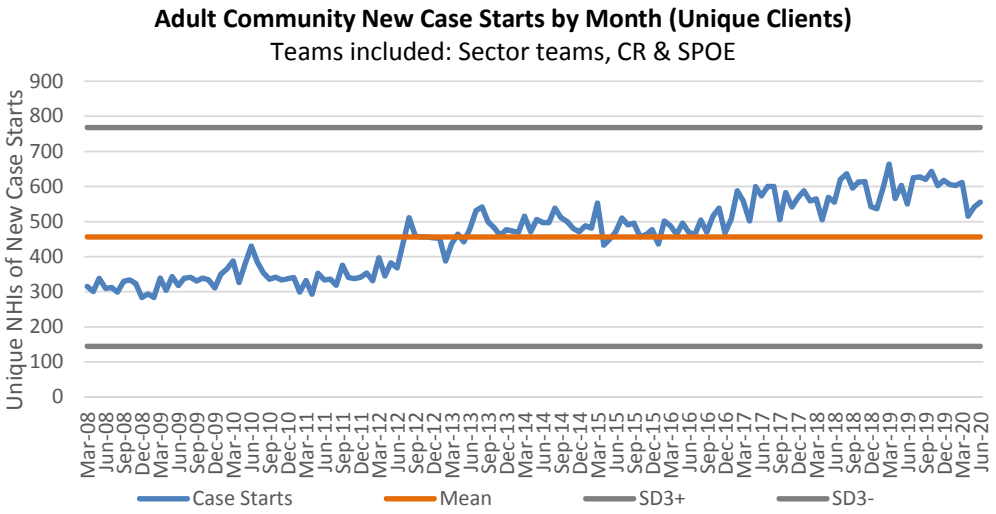
The focus of the Safer for All working group is now on the use of seclusion which has increased since mid-2018. In the Forensic Service the environment has a significant impact on the use of seclusion because there are limited spaces to manage multiple high-risk consumers and maintain a safe environment for all. In recent months staff have been working on initiatives to try and reduce the use seclusion within the unit



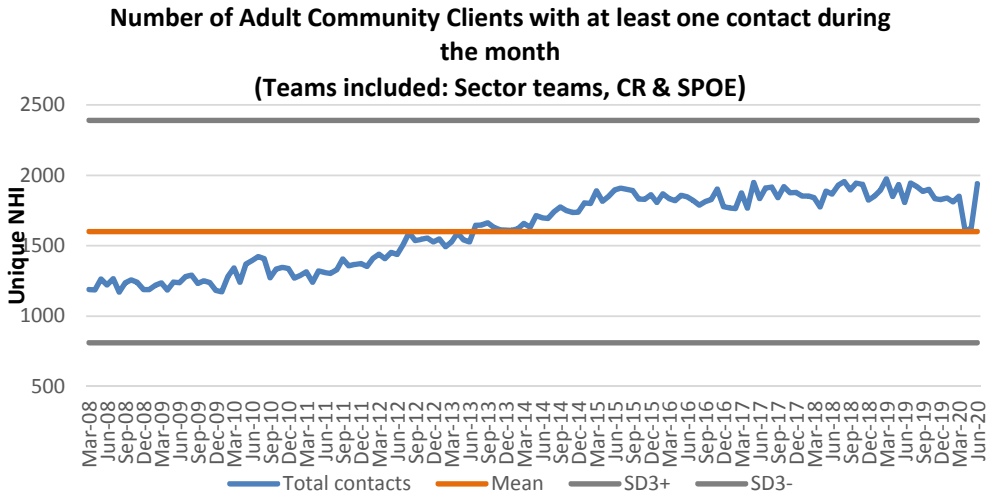
In May 2020, three consumers experienced seclusion for a total of 14.7 hours in the acute adult inpatient service, Te Awakura. In June 2020 there were 11 consumers secluded for a total of 268.4 hours. The service reports they have cared for several unwell consumers during June, including some impacted by methamphetamine use. They had seen a significant drop in consumers affected by methamphetamine during the COVID-19 lockdown period due to limited supply. In the Forensic Service four consumers experienced seclusion for a total of 367.9 hours in May 2020, and in June 2020, four consumers experienced seclusion for a total of 348.2 hours.

Adult Services – Community demand

New cases were created for 541 individual adults (unique NHIs) in May 2020 and 555 in June 2020. Demand dropped during the COVID-19 lockdown but is returning to normal levels.



In May 2020 there was at least one contact recorded for 1622 unique adult community mental health consumers and 1940 in June 2020.



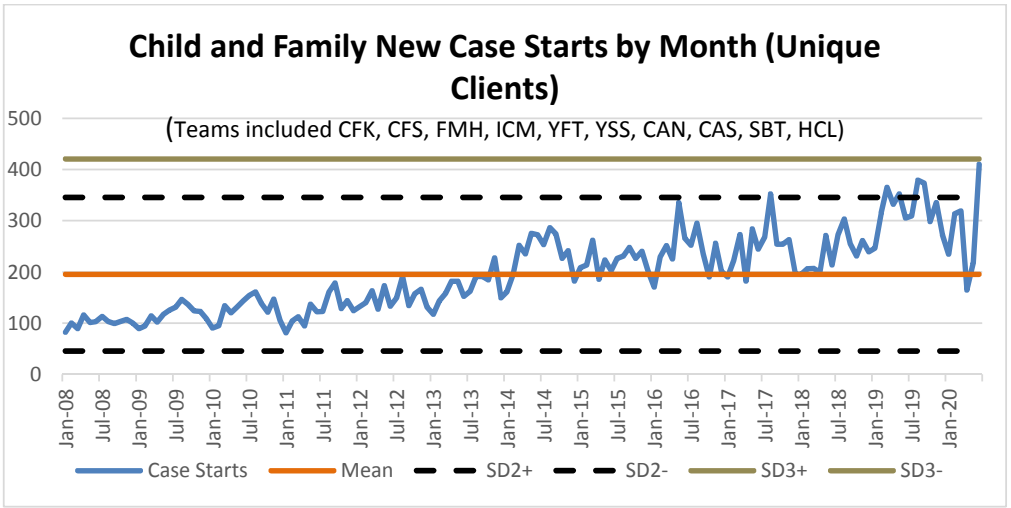
Child and Youth Service:

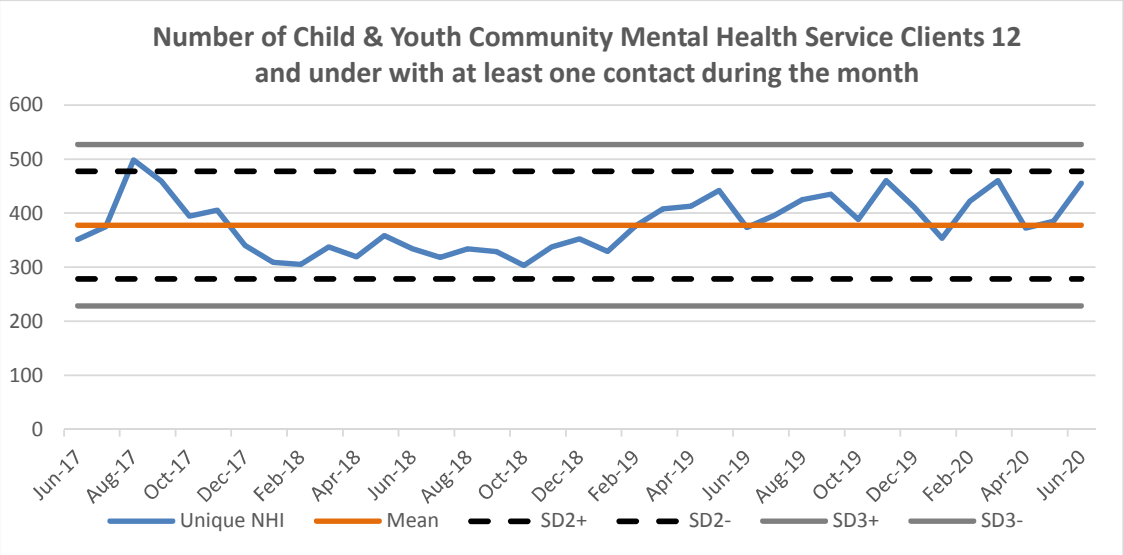
The Child, Adolescent and Family Community Services (CAF) service continues to experience high demand for services resulting in significant wait-times for treatment. To manage this:

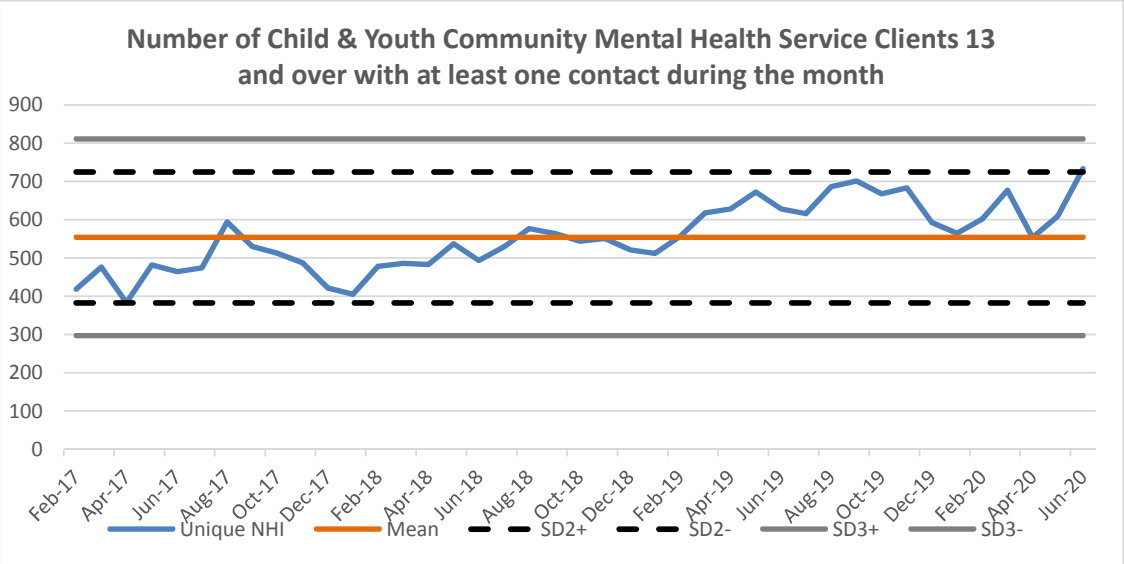
- Internal staffing numbers have been directed to key areas including the Access team (referral, advice and triage and the emergency function) and the two general outpatient teams.
- High clinical demand requires CAF to focus treatment on individuals with serious or acute mental health concerns and key treatment modalities. A review of referral criteria, along with a redefining of specialist core work has occurred to provide staff with clear expectations regarding referral criteria, active assessment, treatment, review and discharge processes. Gaps identified through this process have been communicated to Planning and Funding.
- The Access team is now providing enhanced triaging/ advice to reduce the number of people referred whose treatment can be provided by community services; directing assessment and treatment resources to those who require a specialist intervention; providing short term assessment and treatment for people who present in crisis; and providing urgent assessment and brief intervention or follow up before transferring people back to the community to continue treatment.
- There is an overall increase in complexity of presentations because of Adverse Childhood Events (ACE's). This includes trauma, displacement, poverty, housing, intergenerational trauma, parents with mental illness, substance abuse, parents with AOD issues, resulting development disorders, adverse effects of social media, bullying. People accepted for treatment are triaged by clinicians to determine clinical priority and acuity.
- Referrals for ADHD diagnostic work accounts for more than half of referrals to CAF. Delays can occur with progressing these referrals to assessment due to dependency on schools and families to return psychometric testing required by clinicians.
- There is parental and sector pressure to accept all referrals compounded by challenges for CAF to discharge patients due to lack of community support services and ongoing demand from the community sector for support and education to enable transition from CAF services.

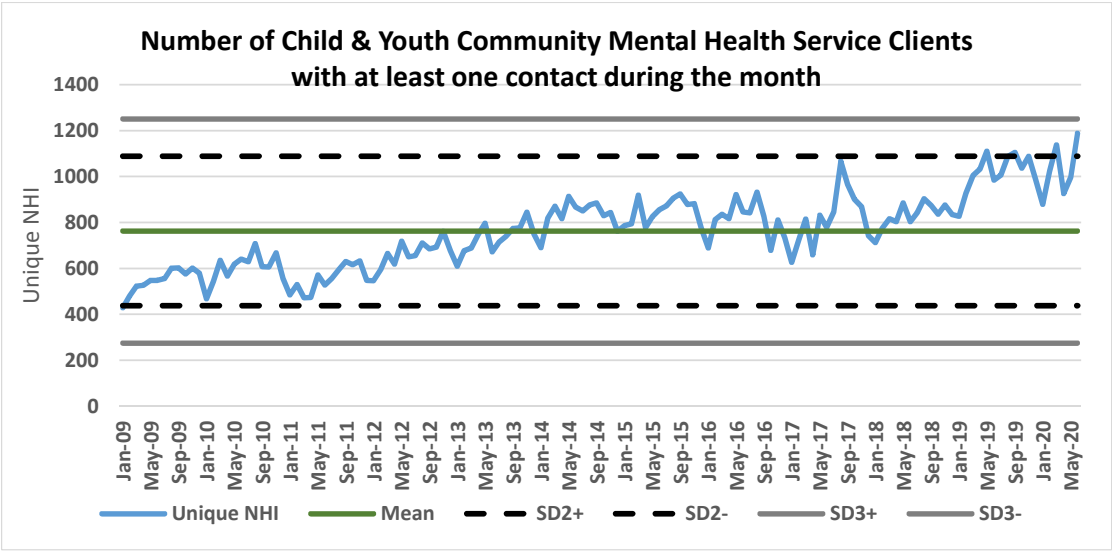
Child and Youth Services demand data

New cases were created for 230 children and adolescents (unique NHIs) in May 2020 and 424 in June 2020. There were 994 unique patients with at least one contact during the month of May 2020 and in June 2020 there were 1188.




Number of Child & Youth Community Mental Health Service Clients 12 and under with at least one contact during the month
600
500
400
300
200
100
0
Jun-17
Aug-17
Oct-17
Dec-17
Feb-18
Apr-18
Jun-18
Aug-18
Oct-18
Dec-18
Feb-19
Apr-19
Jun-19
Aug-19
Oct-19
Dec-19
Feb-20
Apr-20
Jun-20
Unique NHI
Mean
SD2+
SD2-
SD3+
SD3-


Number of Child & Youth Community Mental Health Service Clients 13 and over with at least one contact during the month
900
800
700
600
500
400
300
200
100
0
Feb-17
Apr-17
Jun-17
Aug-17
Oct-17
Dec-17
Feb-18
Apr-18
Jun-18
Aug-18
Oct-18
Dec-18
Feb-19
Apr-19
Jun-19
Aug-19
Oct-19
Dec-19
Feb-20
Apr-20
Jun-20
Unique NHI
Mean
SD2+
SD2-
SD3+
SD3-


Number of Child & Youth Community Mental Health Service Clients with at least one contact during the month
Unique NHI
1400
1200
1000
800
600
400
200
0
Jan-09
May-09
Sep-09
Jan-10
May-10
Sep-10
Jan-11
May-11
Sep-11
Jan-12
May-12
Sep-12
Jan-13
May-13
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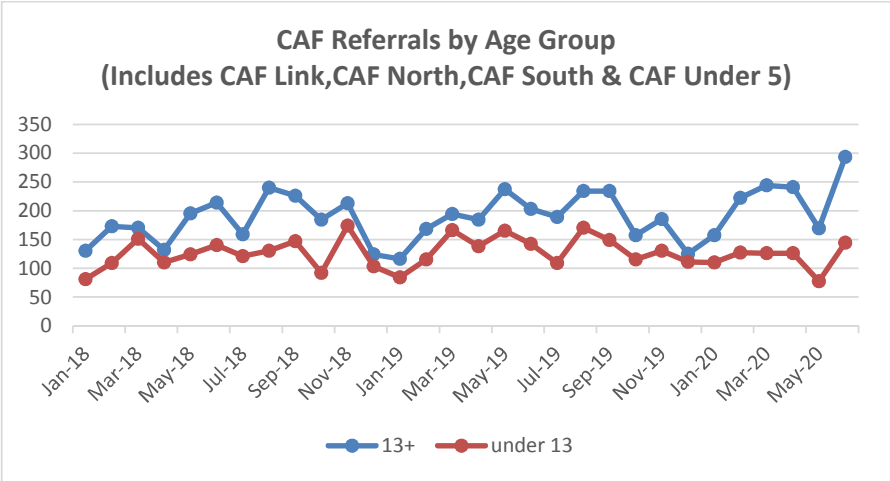
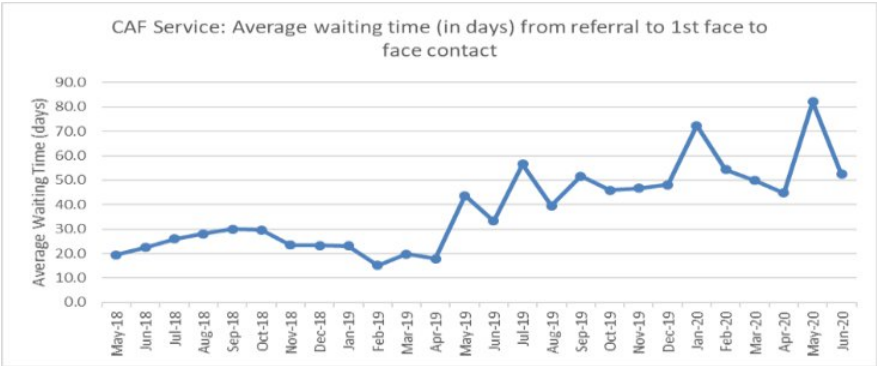
Jan-16
May-16
Sep-16
Jan-17
May-17
Sep-17
Jan-18
May-18
Sep-18
Jan-19
May-19
Sep-19
Jan-20
May-20
Unique NHI
Mean
SD2+
SD2-
SD3+
SD3-

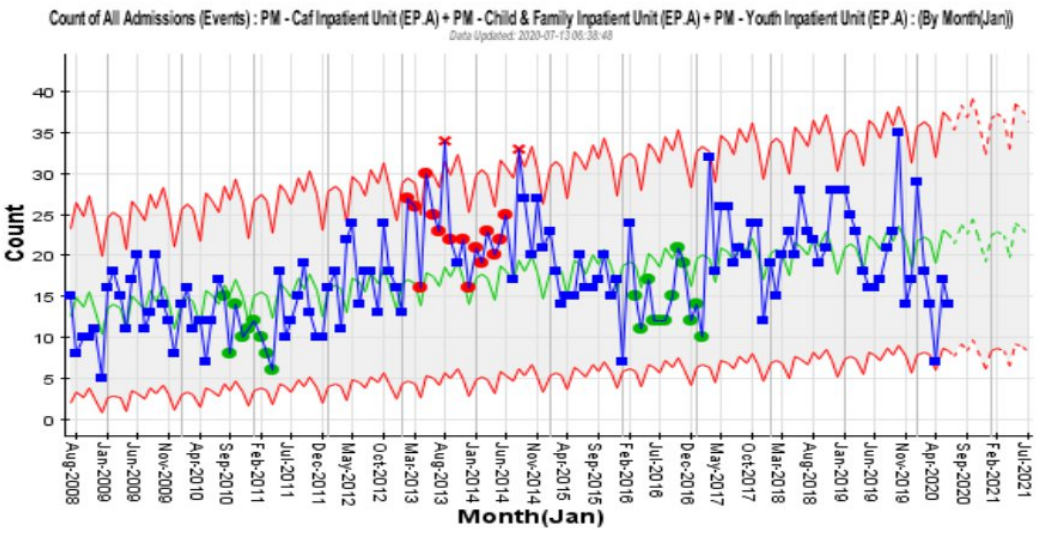
There has been a marked increase in referrals to CAF services in June 2020.

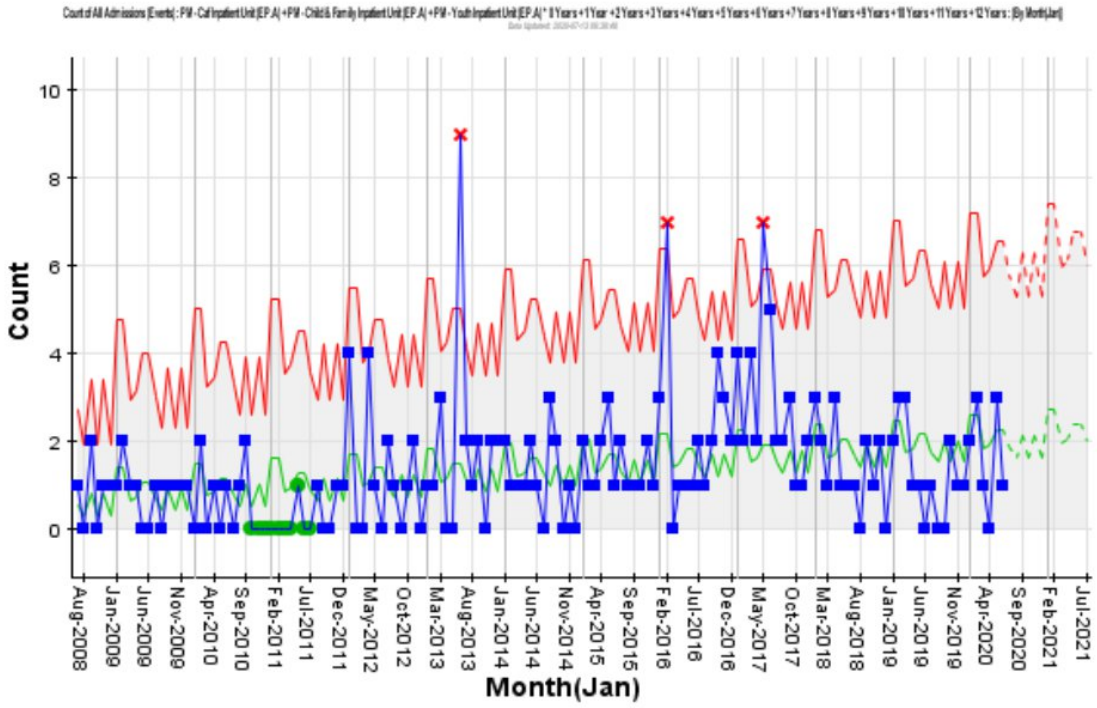


Wait time to first contact has reduced significantly following the realignment of the Access team, however wait time to first face to face contact and engagement in treatment remains of concern (82 days in May 2020 and 52 days in June 2020).

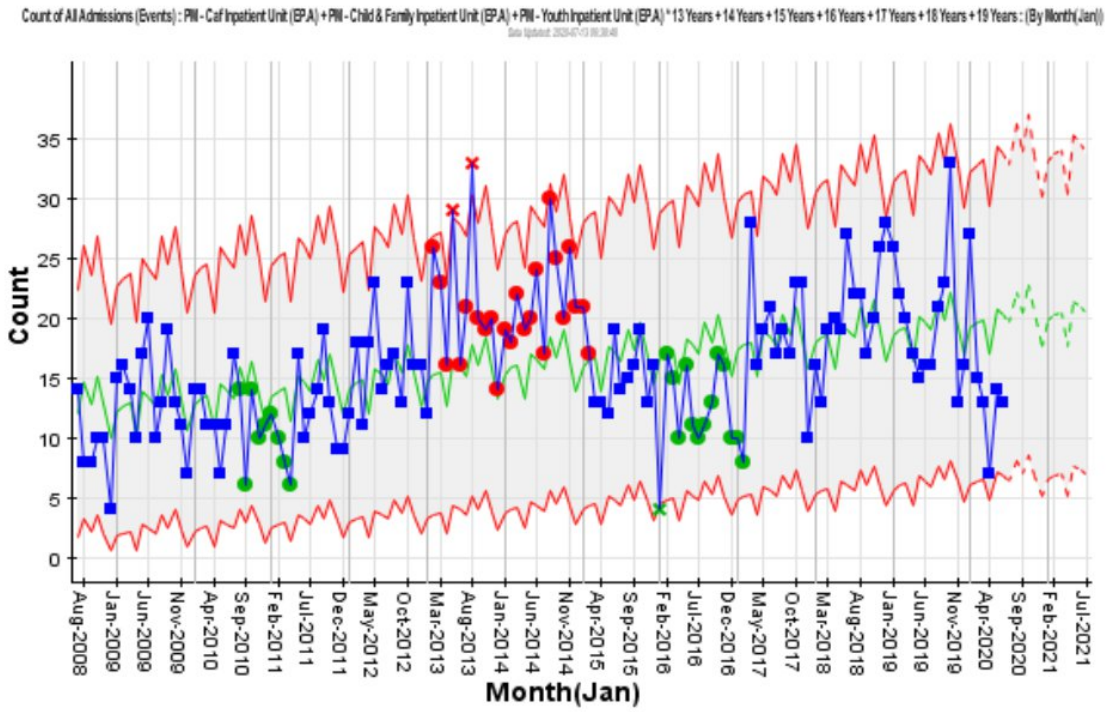


The number of admissions to the Child and Adolescent Unit and its predecessors, has shown a steady increase over time, particularly for adolescents, however this trend has been interrupted by a COVID-19 related drop in April-May.



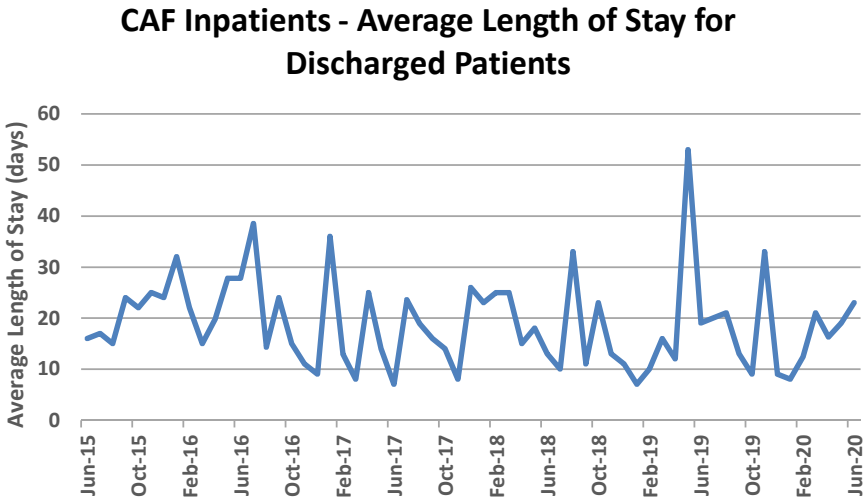


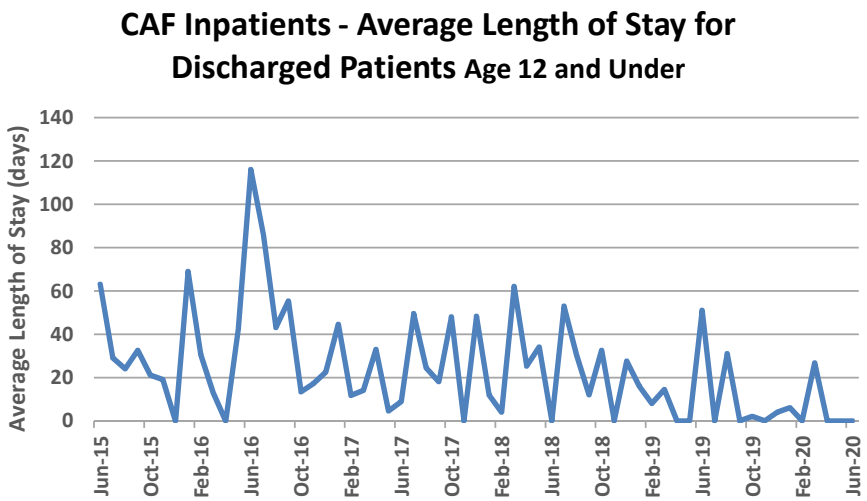
All admissions by month 12 years and under

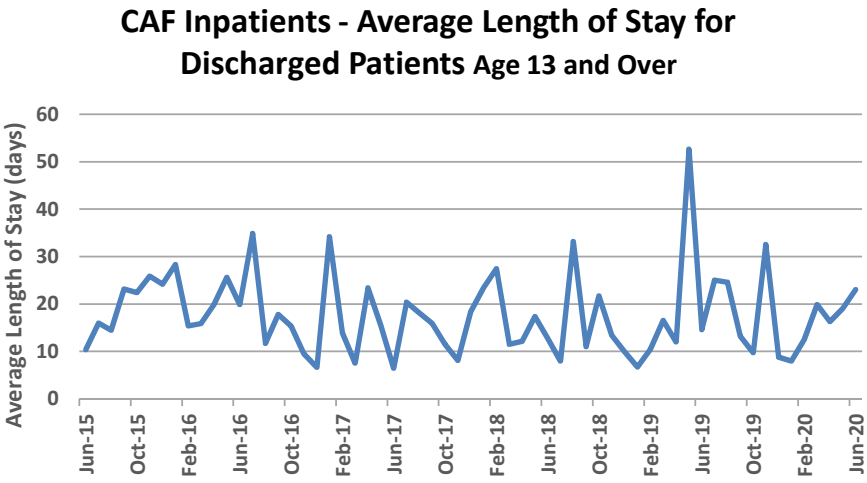


All admissions by month 13 years and over

The average length of stay for discharged inpatients was 19 days for May 2020 and 23 days for June 2020.





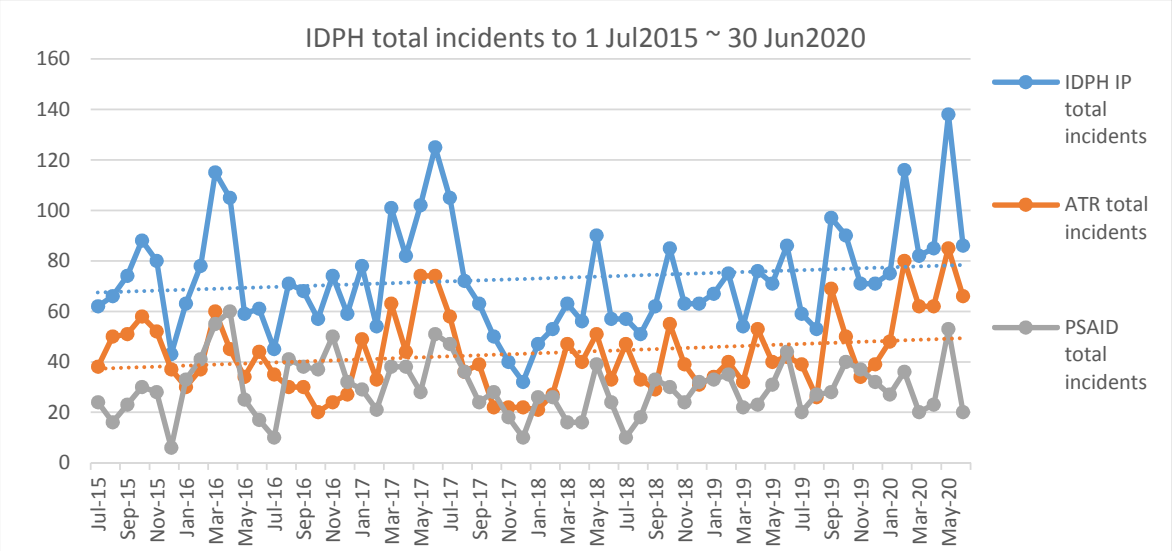


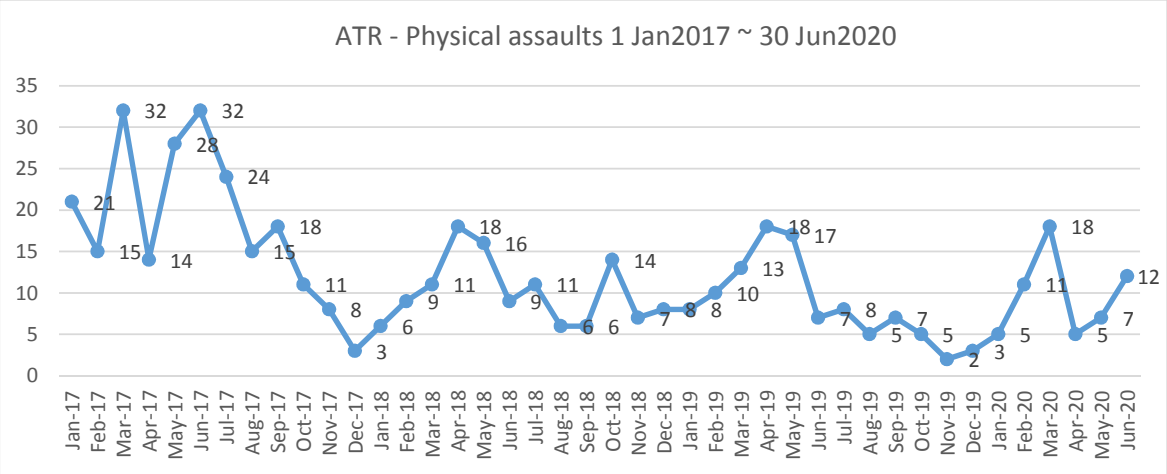
Intellectually Disabled Persons Health Service

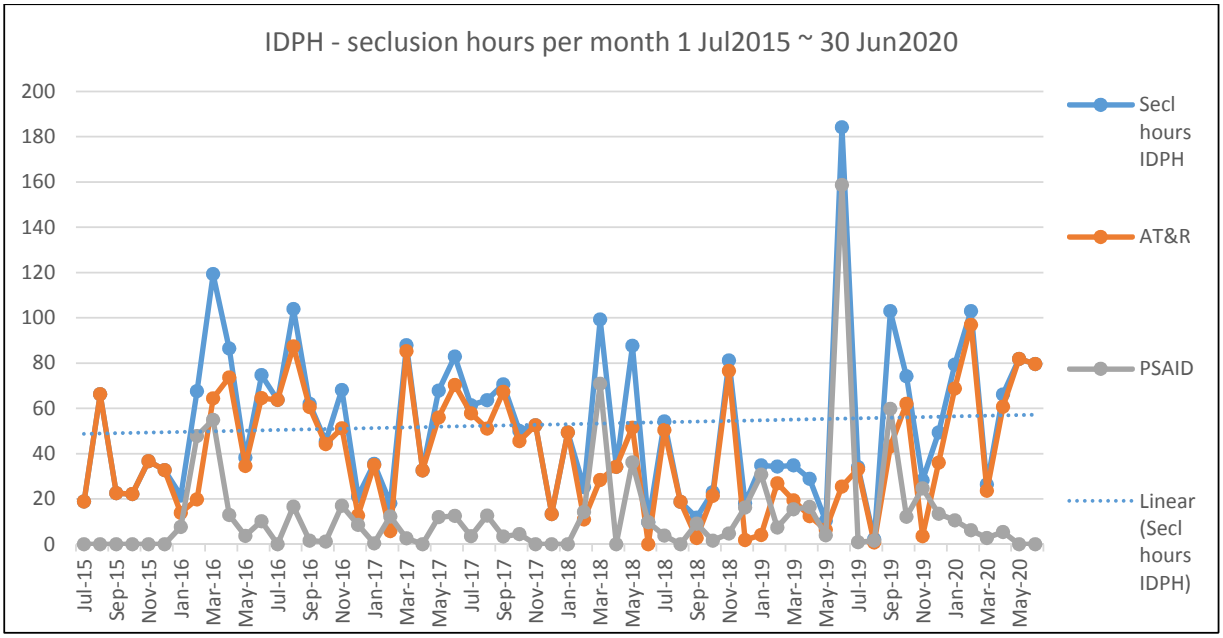
The IDPH Service inpatient units comprise a secure unit, Assessment, Treatment and Rehabilitation (AT&R), currently operating as a 6-bed unit and a 15-bed dual disability unit, Psychiatric Service for Adults with Intellectual Disability (PSAID) within the Aroha Pai building, Hillmorton Hospital.

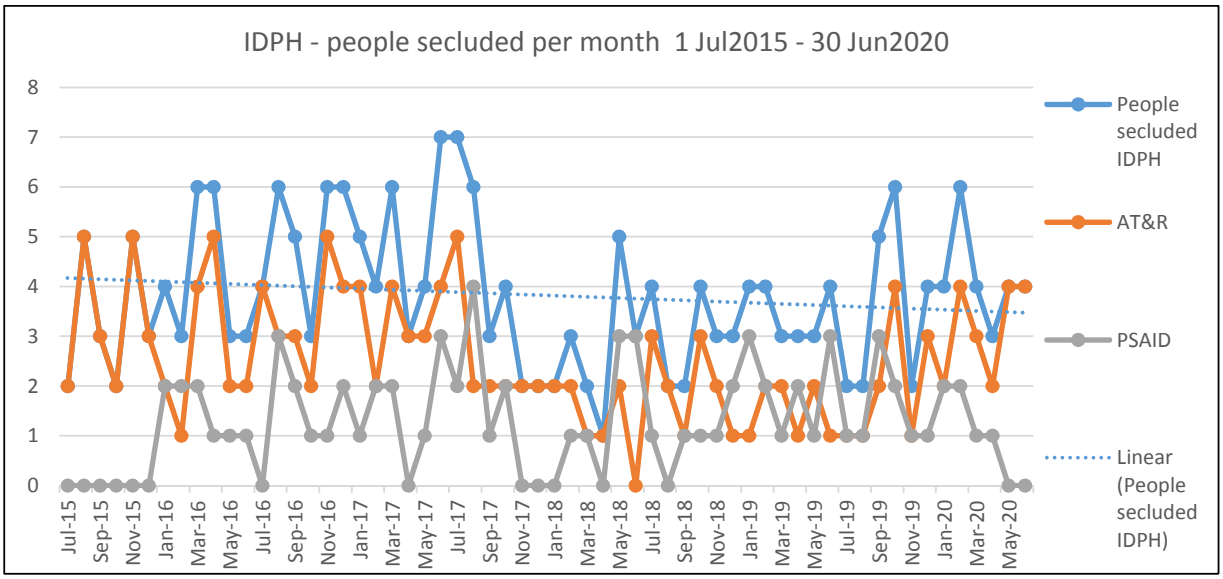
The Assessment, Treatment & Rehabilitation Unit building footprint is currently being extended to include four separate apartments for individuals who require this level of care environment and is due to be completed in late 2020.

Interim internal modifications include two internal annex areas both of which resulted in a reduction in physical assaults and the requirement for seclusion for several months, however in February and May 2020 there has been increased inter-peer conflict, with contributing factors including the admission of a new female inpatient and limitations of external activities due to COVID 19.






IDPH - seclusion hours per month 1 Jul2015 ~ 30 Jun2020
200
180
160
140
120
100
80
60
40
20
0
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Jul-18
Sep-18
Nov-18
Jan-19
Mar-19
May-19
Jul-19
Sep-19
Nov-19
Jan-20
Mar-20
May-20
Secl hours IDPH
AT&R
PSAID
Linear (Secl hours IDPH)


IDPH - people secluded per month 1 Jul2015 - 30 Jun2020
8
7
6
5
4
3
2
1
0
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Jul-18
Sep-18
Nov-18
Jan-19
Mar-19
May-19
Jul-19
Sep-19
Nov-19
Jan-20
Mar-20
May-20
People secluded IDPH
AT&R
PSAID
Linear (People secluded IDPH)

Living within our means

Living within our Means, including No Wasted Resource

Financial Performance

Canterbury District Health Board

Statement of Financial Performance

Hospital & Specialist Service Statement of Comprehensive Revenue and Expense
For the 12 Months Ended 30 June 2020

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				
237	451	388	(151)	From Funder Arm	5,412	5,420	5,595	(183)
1,870	1,764	1,996	(126)	MOH Revenue	21,118	19,156	18,683	2,435
4,993	4,374	4,398	595	Patient Related Revenue	52,786	54,083	51,128	1,658
4,535	2,120	1,564	2,971	Other Revenue	24,922	22,195	18,653	6,269
11,635	8,709	8,346	3,289	**TOTAL OPERATING REVENUE**	104,238	100,854	94,059	10,179
				Operating Expenditure				
				Personnel Costs				
69,918	67,623	61,120	(8,798)	Personnel Costs - CDHB Staff	794,034	787,931	735,965	(58,069)
1,972	1,947	2,355	383	Personnel Costs - Bureau & Contractors	25,161	23,010	23,625	(1,536)
71,890	69,570	63,475	(8,415)	**Total Personnel Costs**	819,195	810,941	759,590	(59,605)
13,575	14,143	11,671	(1,904)	Treatment Related Costs	151,590	157,874	150,355	(1,235)
4,713	4,502	3,812	(901)	Non Treatment Related Costs	48,826	44,315	43,527	(5,299)
90,178	88,215	78,958	(11,220)	**TOTAL OPERATING EXPENDITURE**	1,019,611	1,013,130	953,472	(66,139)
(78,543)	**(79,506)**	**(70,612)**	**(7,931)**	**OPERATING RESULTS BEFORE INTEREST AND DEPRECIATION**	**(915,373)**	**(912,276)**	**(859,413)**	**(55,960)**
				Indirect Income				
166	1	5	161	Donations & Trust Funds	329	19	15	314
-	-	-	-	Gain on Disposal of Assets	-	-	-	-
166	**1**	**5**	**161**	**TOTAL INDIRECT INCOME**	**329**	**19**	**15**	**314**
				Indirect Expenses				
3,059	4,315	1,976	(1,083)	Depreciation	32,519	43,762	21,840	(10,679)
(13)	(1)	6	19	Loss on Disposal of Assets	10	(8)	3	(7)
3,046	**4,314**	**1,982**	**(1,064)**	**TOTAL INDIRECT EXPENSES**	**32,529**	**43,754**	**21,843**	**(10,686)**
(81,423)	**(83,819)**	**(72,589)**	**(8,834)**	**TOTAL SURPLUS / (DEFICIT)**	**(947,573)**	**(956,011)**	**(881,241)**	**(66,332)**

Achievements/Issues of Note

Improving care for ventilated patients requiring emergency hyperbaric oxygen therapy

- Hyperbaric oxygen is standard of care treatment for decompression sickness and cerebral gas embolism. Severe cases are commonly ventilated and require ICU-level care. The Christchurch Hyperbaric Medicine Unit is the only in NZ with ventilated patient capability.
- Simulation training generally requires prohibitively expensive mannequins, and time out of the workplace to attend a formal simulation centre which is challenging when most employees are part time.
- The Hyperbaric Medicine Unit team has developed its own approach. A dressmaker's mannequin was sourced for less than $100, a modified ventilator test lung fitted into the chest cavity and IV access, catheter and arterial lines were fitted to the mannequin using expired kits.
- Feedback following several recent challenging intubated cases reflects increased team confidence and satisfaction in managing ventilated hyperbaric cases, all as a result of a near zero spend on simulation equipment.

Improvements in the care of neonatal intensive care patients

- Neonatal Discharge /Outreach Team Leader role has been increased from 0.4 FTE to 1.0 FTE for a twelve-month trial period. After six months it has generated significant improvement in the care of the unit's patients.
- Interventions developed include:
    - Development of specific discharge/outreach criteria
    - Earlier engagement with more families, identifying babies suitable for early discharge.
    - Identifying and managing potential issues sooner, averting delayed discharges.
    - Greater support in establishing oral feeding and educating parents to enable them to enterally feed their babies at home.
    - Provision of wider staff education into discharge processes/planning.
    - Increased opportunity/time to engage with Lead Maternity Carers and other community providers further supporting families in their home.
    - Establishment of Outreach nurse led clinics at Rangiora, Burwood and Ashburton.
- This has led to a reduced average length of stay by two days – resulting in 202 cot days saved in the last six months. The cot days saved have created capacity and therefore led to a reduction of in-utero transfers to other DHB's from 18 mothers between Oct 2018 and April 2019 to three mothers in the Oct 2019-April 2020 period.
- Nurse led clinics have resulted in reduced travel time and costs for outreach staff and enhanced accessibility for families.
- Earlier discharge of babies has not resulted in increased hospital readmissions.

Maternity Assessment Unit – nine months post implementation

- The unit was established in August to redirect clinically appropriate antenatal activity to a dedicated assessment space, improving flow and moving a significant volume of antenatal attendances, per month from the Birthing Suite environment. This was done to create more capacity within Birthing Suite to deal with intrapartum care and acute presentations.
- In the nine months since establishment a positive impact has been demonstrated.
- Approximately 206 antenatal assessments, provided to 152 women, per month have been shifted from the Birthing Suite.
- The average wait time for women having antenatal assessments has reduced by 47% from three and a half hours to less than two hours. Prior to the unit's establishment, some women were waiting on Birthing Suite for up to seven hours for assessment.
- The cost of running the unit is less than forecast. Staffing numbers have been continually refined throughout the last nine months.

- Consumer feedback has highlighted women are happy with the care they receive through the unit.
- The unit is midwife led. Medical staff feedback is highly supportive of this unit, releasing them to undertake other clinical duties such as in the birthing suite where interaction with women can be less hurried and thus more satisfactory for all involved.
- The implementation of this unit was presented to the Executive Management Team on 15th July where approval has been given for planning to occur towards the next phase of the units development to further improve benefits to patients while reducing costs to the system.

Discontinuation of use of heparinised saline for flushing central lines in Child Health

- Transitioning from the use of heparinised saline to flush central venous access devices in adults prompted a review of practice in child health. It was found that there is no proven benefit in using heparinised saline.
- Accordingly, Child Health is transitioning to the use of saline for this purpose, saving approximately $100K per year.

Reduction in the use of burettes for intravenous infusions in Child Health

- Improvements in pump technology provide free flow protection and practice guidelines have enabled a decision to confine use of burettes to cases where they are needed for the dilution and delivery of some medicines.
- This has reduced the cost of 90% of infusion setups by $5 each, saving approximately $18,000 a year

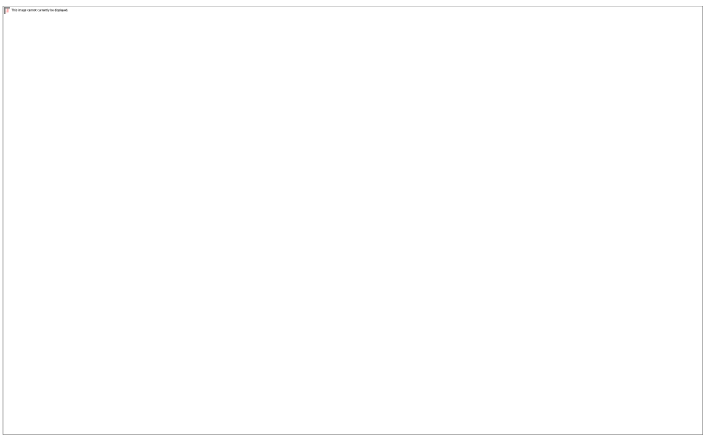
Change in after-hours arrangement for front of house Social Workers

- In March 2020 changes were made to the delivery of Social Work services in the Emergency Department, Acute Medical Assessment Unit and Intensive Care Unit.
- Previously, daytime services were provided up until 4pm and a ten-hour overnight shift started at 9:30pm. Late afternoon and evening care was provided on an on-call basis.
- This way of arranging our workforce led to a series of problems:
    - People's stay in the Emergency Department was extended as it would take staff between 15 and 60 minutes to arrive with the patient after being called in.
    - Patients were being admitted for social reasons due to the barrier to access to social work created by the on-call arrangements
    - Providing evening call in work on top of a full day's work caused staff to become very tired, with many becoming unavailable for call due to medical reasons.
    - The expense of providing evening work on a call out basis was being exacerbated by a year on year increase in demand for social work care.
    - Having a single person on front of house night shift was insufficient on the busiest nights of the week.
- Rosters have now been re-arranged for the 60 social workers (53 FTE) working on the Christchurch Campus to improve front of house services.
- This gives onsite provision of social work care at these front door units on a 24/7 basis. Three shifts have been put in place: a day shift, two people on late shift running between 1:30 and 10:30pm and a night shift (with two people on the busiest nights of the week). This provides adequate cover for the busy afternoon period and lighter staffing during the morning when demand is the lowest.
- This new approach has improved the timeliness of the Social Work response to patients and families needing social work care, has improved working conditions for team members and has reduced the cost of this team by $10k per month – twice that forecast – by reducing on call and overtime costs.

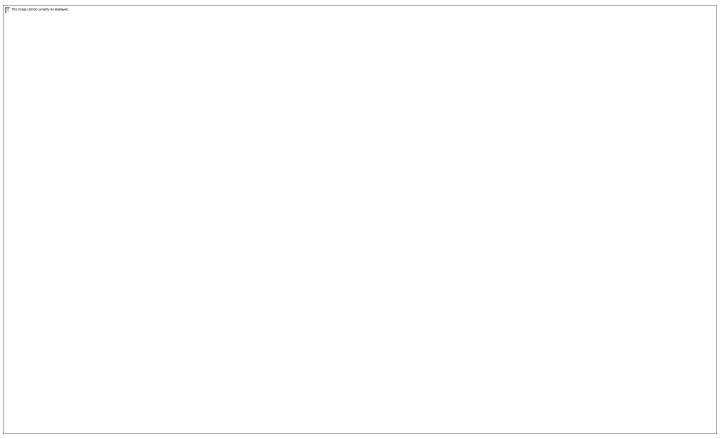
Leave care showing results on the Christchurch Campus

- People leaders working on the campus have been working with employees who have long leave balances to significantly reduce these balances.
- A clear process has been developed and communicated and tools provided. Accountabilities for process and achievement targets have been clearly set.
- The processes in place are showing results. The proportion of staff with annual leave balances ≤20 days within Med Surg is 2% higher at the end of May 2020 than in June 2019 and sits at 65.9%. Alongside this the proportion of staff taking ≤10 days sick leave in the last year has grown by 2.4% to 72.4%, meaning that there is a lower proportion of staff taking >10 days sick leave.
- The proportion of staff in Women's and Children's with annual leave balances ≤20 days has grown by 3.3% to 70.9% and those who have taken ≤10 days sick leave in the year has grown by 0.3% to 78.3%.

Med Surg:



Women's & Children's



Gastrointestinal Endoscopy Unit

- In December 2019 the Gastrointestinal Endoscopy Unit relocated the storeroom during the reprocessing project and implemented a compactor shelving storage system.
- As part of this process, complete stock management transitioned from the endoscopy nursing and Health Care Assistant team to a combined system, whereby the Supply Department manages regular stock items using a barcode system.
- Despite some initial glitches during the COVID-19 lockdown period stock levels have reduced from $530k in 2019 to $466k in 2020.

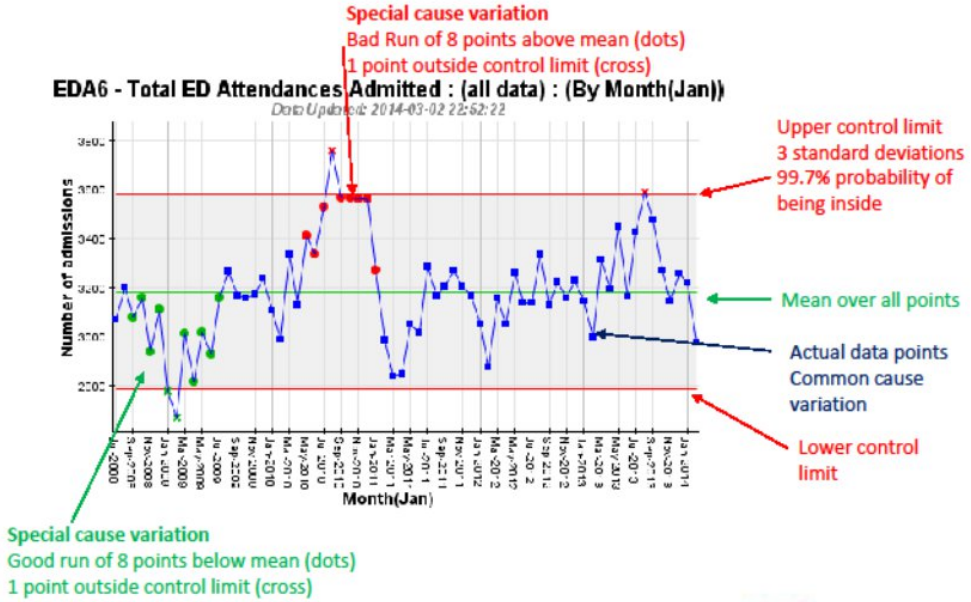
Radiology Stocktakes

- Stock management in the Radiology Department has been progressively improved over recent years because of an increasingly strong partnership between the Supply and Radiology departments.
- Alongside this a Hospital Aide has been dedicated to stock management and the stock requirements of Interventional Radiology.
- These changes have meant that while $2,000,000 of consignment and DHB stock items were held at the 2019/20 stock take, only $856 worth of items needed to be written off (0.04% of total holdings).

Community Dental Service Consumables

The service is working through their consumables list to identify opportunities for cost savings. Fluoride varnish is applied to children's teeth to as part of treatment plans to prevent tooth decay. The service has reviewed and reinforced the Clinical criteria for its use which has resulted in savings of approx. $25k over last financial year and moved to a new supplier with an estimated annual saving of $22k for coming years.

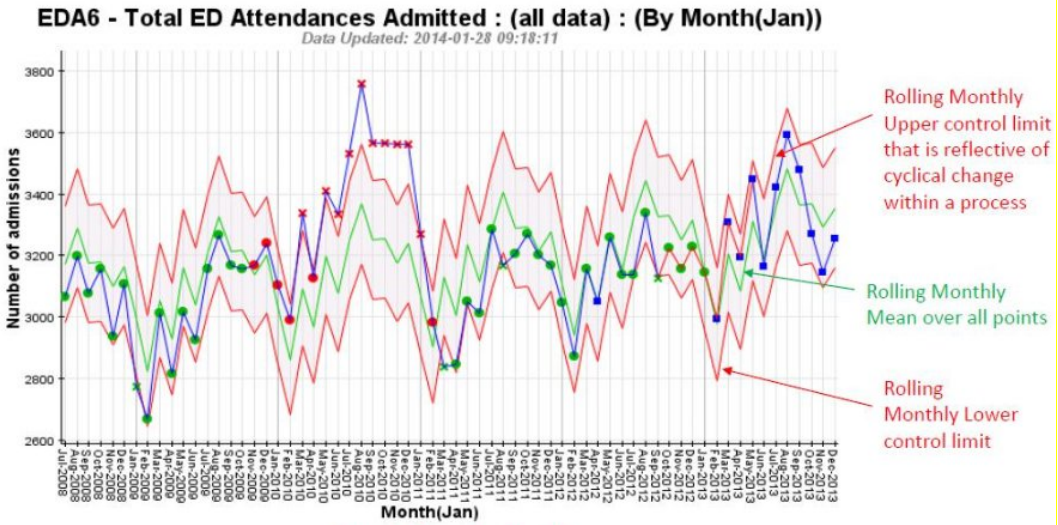
SPC: How to Interpret a Control Chart



sfn signals from noise

make it better

SPC: How to Interpret Cyclical and Trended Data



Criteria for a Cyclical Process:

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

sfn signals from noise

make it better

CLINICAL ADVISOR UPDATE – NURSING

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NOTES ONLY PAGE

ED PRESENTATIONS – OVER 75 YEARS OLD – ANALYSIS PAPER

Canterbury District Health Board
Te Poari Hauora o Waitaha

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

PREPARED BY: **Soledad Labbe-Hubbard, Information Analyst**

APPROVED BY: **Carolyn Gullery, Executive Director Planning Funding & Decision Support**

DATE: **6 August 2020**

Report Status – For:	Decision	☐	Noting	☑	Information	☐

1. ORIGIN OF THE REPORT

The purpose of this report is to provide the Committee with further information and analysis of the ED presentations for 75+ patients.

2. RECOMMENDATION

That the Committee:

i. notes the ED Presentations – Over 75 Years Old – Analysis paper.

3. SUMMARY

Since 2016, Canterbury has experienced increasing single and repeat presentations to the emergency department for people over the age of 75. The number of repeat presentations has increased by 17% over this time. This is a concerning trend as Canterbury grapples with limited bed capacity, as this cohort has a high probability of admission to hospital from ED with stays of 2-4 days.

Further analysis and work with primary, aged care and secondary care is underway to determine the reasons for the increasing presentation with a view to ensuring the right supports are in place to minimise avoidable presentations or admissions.

4. APPENDICES

Appendix 1: Emergency Attendances for over 75 Years Old

Emergency Attendances for people 75 and over

Background

Population (75+)

- The 2020-21 Ministry of Health funded population estimate for people aged 75 and over is 40,300. This is made up of 17,500 (43%) males and 22,800 (57%) females.

Growth of ED attendances

- Canterbury experienced 5% of growth in ED attendances for this cohort between March 2019 and March 2020. This is the equivalent of an extra 832 emergency department attendances during the period (see table 2).
- Over the past four years, there has been an average increase of 800 additional emergency attendances per annum. Growth between March 2017 (14,740) and March 2020 (17,173) was 17%.
- The rate per 1,000 population attending ED has also increased by 10% in the past five years. This is despite an increasing older population with ED attendances growing by twice as much as the 75+ population over this time.

Emergency attendances January to July 2020 (75+)

- In 2020, 6,094 people have attended ED with 8,634 attendances. The average age of these attendees is 83 years, 52% are between 75 and 84 years old. Fifteen percent of all attendances are by 75 years old and over.
- About 23% of attendances are accident related, this proportion has not changed over the years. Monthly ED attendances from Age Residential Care, are monitored to identify the drivers for attendance as well as the hours of the day that attendances tend to occur.
- Work has also commenced to identify and understand our pre-frail cohort, with a view to preventing ED presentations and admissions to hospital in the long run.

ED attendance trends

- In 2020, 4,451 people (44%) attended ED only once within 365 days, 26% of people re-presented within 60 days of ED departure and 30% re-presented between 61 days and one year.
- Between March 2017 to March 2020, there was a 20% growth of people attending two or more time to ED within a year, compared to 12% of growth to single attendances.
- During the COVID lockdown period, the volume of attendance and frequency reduced by nearly 50%.

Emergency Attendance Medical and Accident over 75 years old

Growth for this current year and last 4 years

Accumulative view of Emergency Attendances by Representation frequency last 365 days

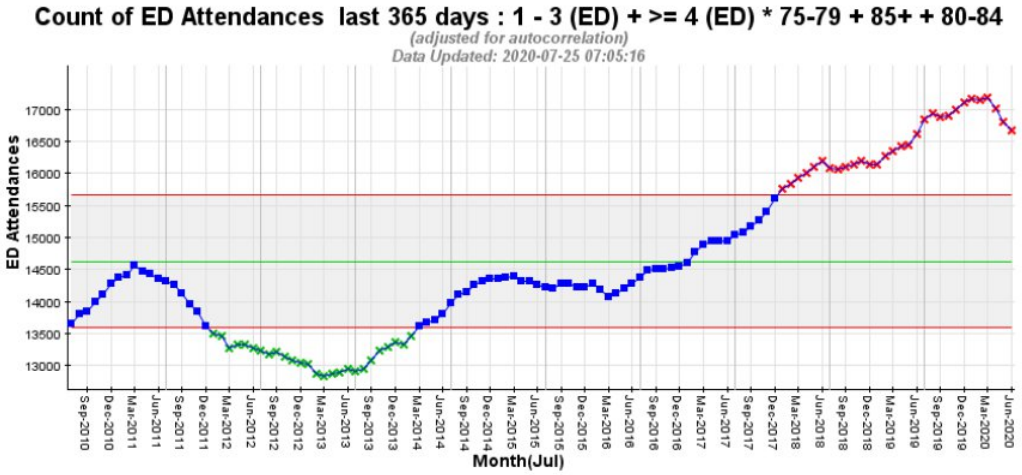


Figure 1. All presentations to ED within last 365 days (accumulative graph of the last 12 months)

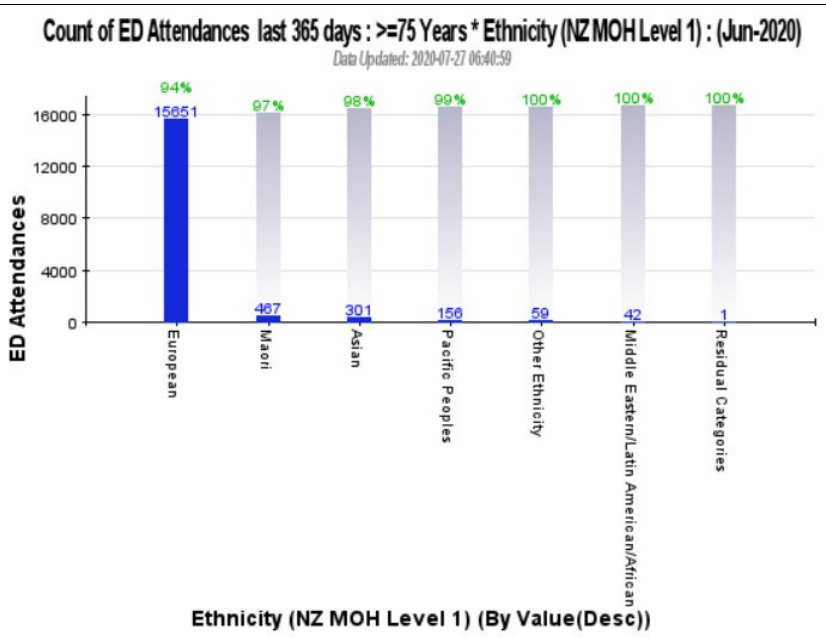
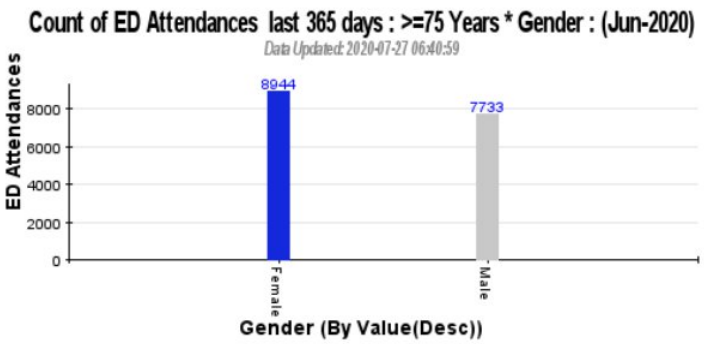
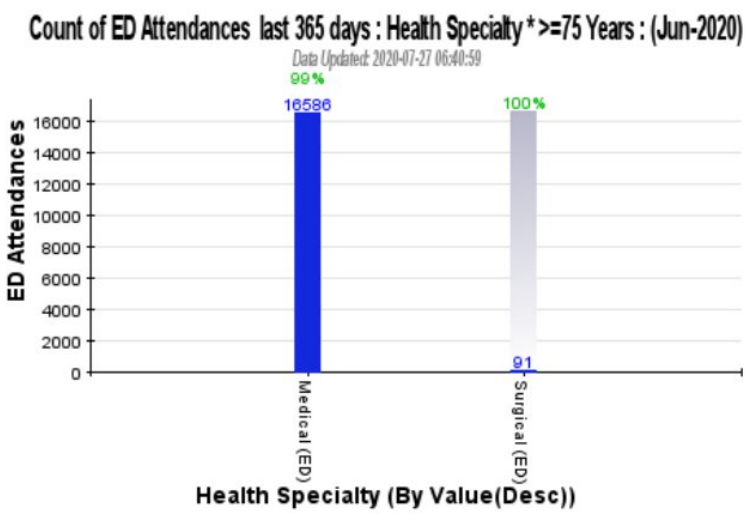
From September 2010 to March 2011 presentations increased through the earthquake period tapering off until March 2014. From June 2016 2016 presentations have been increasing dramatically. From March 2017 to March 2020 the rate of people with more than one presentation increased by 20%, the rate of those who presented only once increased by 6% over the same period. The Canterbury's ED growth is increasing not only by overall volume but as a rate per capita as well. As shown in table 2 below, Canterbury's ED attendance rate for the 75+ cohort has grown steadily since 2015/16. In the past five years the 75+ population increased by 12% and the number of attendances increased by 24% over the same period. The rate increased from 400 to 441 per 1,000 population (10%).

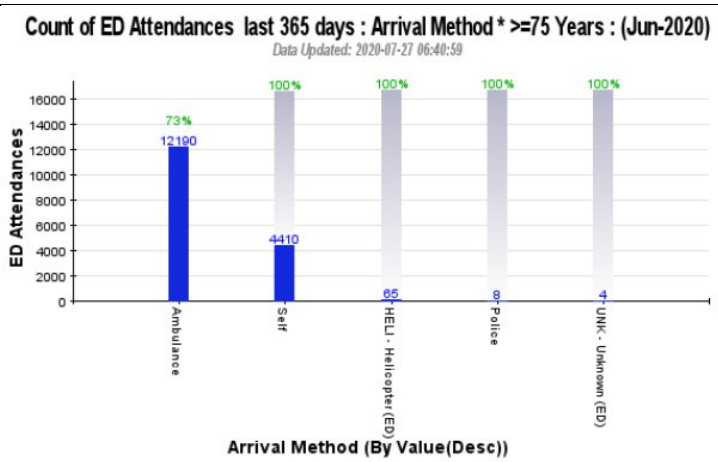
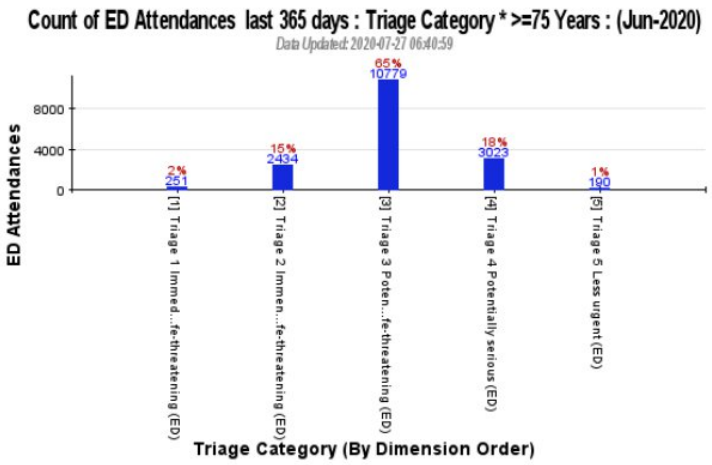
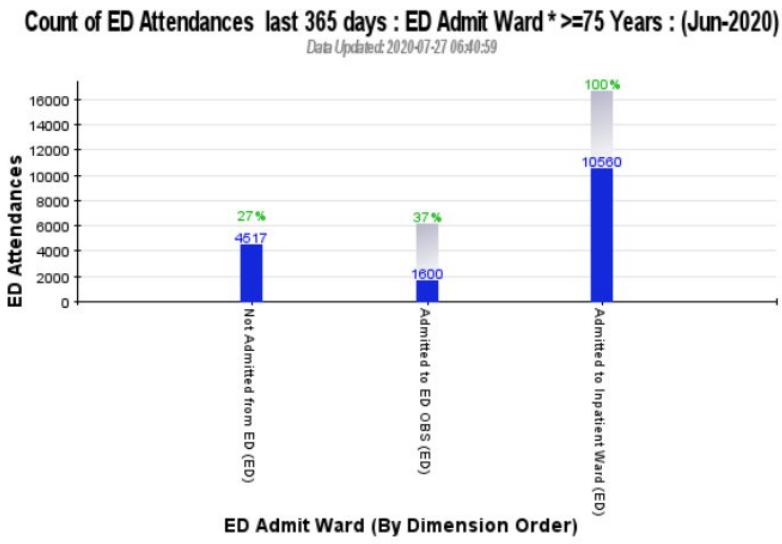
Why is examination of this cohort so important?

While total volumes of ED presentations for other age groups are increasing as well, 73% of the over 75 age cohort typically present by ambulance and require medical rather than surgical support. 81% of these presentations are at triage levels 1 to 3[1] and 64% of those presentations are admitted to hospital. Once admitted this group will normally stay between 2 and 4 days. With limited bed resources and especially during high occupancy times, the DHB needs to look at all options to minimise additional bed requirements where possible. Other population cohorts are generally single presentations and do not contribute as significant a probability of bed usage as those over the age of 75.

[1] Triage 1 - Immediately life-threatening, Triage 2 - Imminently life-threatening, or important time-critical, Triage 3 - Potentially life-threatening, potential adverse outcomes from delay > 30 min, or severe discomfort or distress

Some background of the cohort for context (period 01 June 2019 to 01 June 2020)

Ethnicity	
Gender	
Specialty	

Arrival Method	
Triage Category	
Where do they go? 64% are admitted to hospital (excl. those admitted to Emergency Observation 10%)	

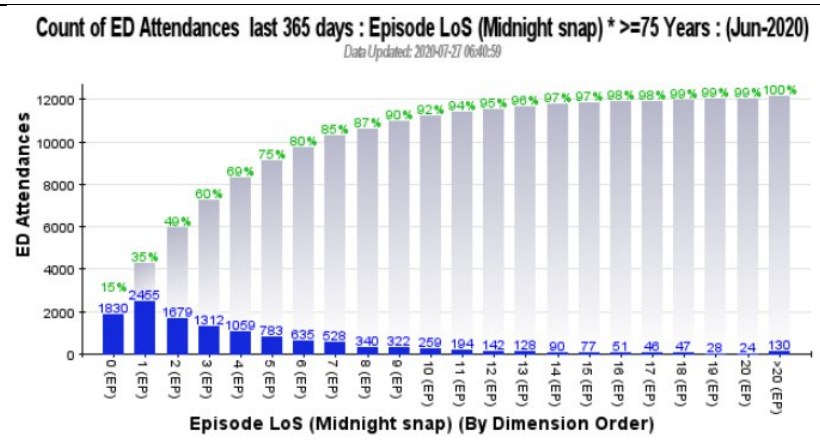
Once admitted – how long do they stay? Average 2-4 day LOS	

Figure 2 – Background of over 75 cohort presenting to ED

Table 1. 75+ ED Attendances (ED att.) Accumulative

Financial Year	Funded Population	ED att. Total	Rate Per 1,000	Change %	Single ED att.	Change%	2 or more ED att.	Change%
FY 10/11	32725	14459	441.8		6848		7611	
FY 11/12	32325	13144	406.6	-9%	6128	-11%	7016	-8%
FY 12/13	32435	12710	391.9	-3%	5996	-2%	6714	-4%
FY 13/14	32940	13463	408.7	6%	6291	5%	7172	7%
FY 14/15	33630	14280	424.6	6%	6681	6%	7599	6%
FY 15/16	34740	13905	400.3	-3%	6495	-3%	7410	-2%
FY 16/17	35960	14740	409.9	6%	6853	6%	7887	6%
FY 17/18	36850	15927	432.2	8%	7269	6%	8658	10%
FY 18/19	37790	16341	432.4	3%	7301	0%	9040	4%
FY 19/20	38940	17173	441.0	5%	7705	6%	9468	5%
Avr. compound growth per year (2017 to 2020)				4%		3%		5%
March 17 to March 20				17%		12%		20%
2015/16 to 2019/20	12%	24%	10%					

Emergency attendances period January 2020 to 16 July 2020

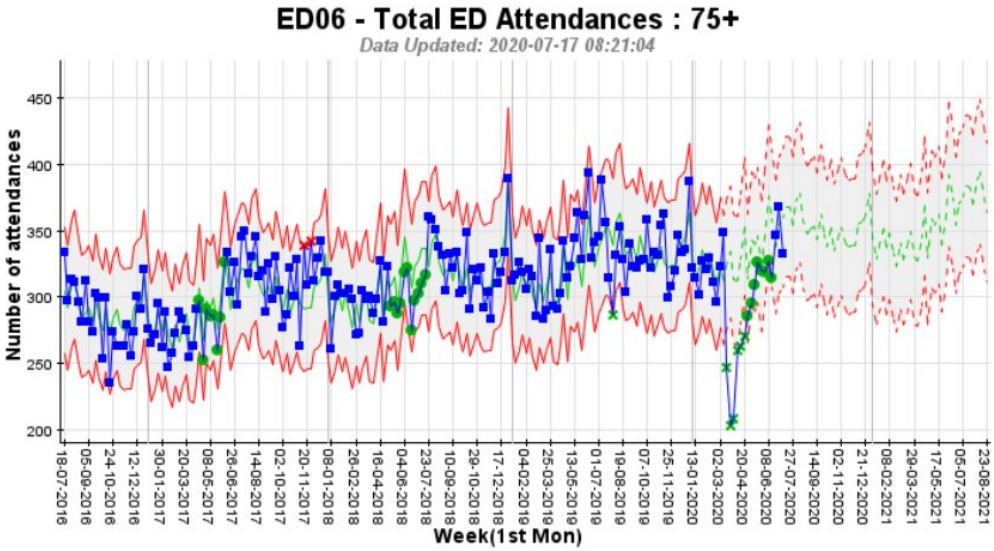


Figure 3. Weekly attendances last 4 years weekly pattern

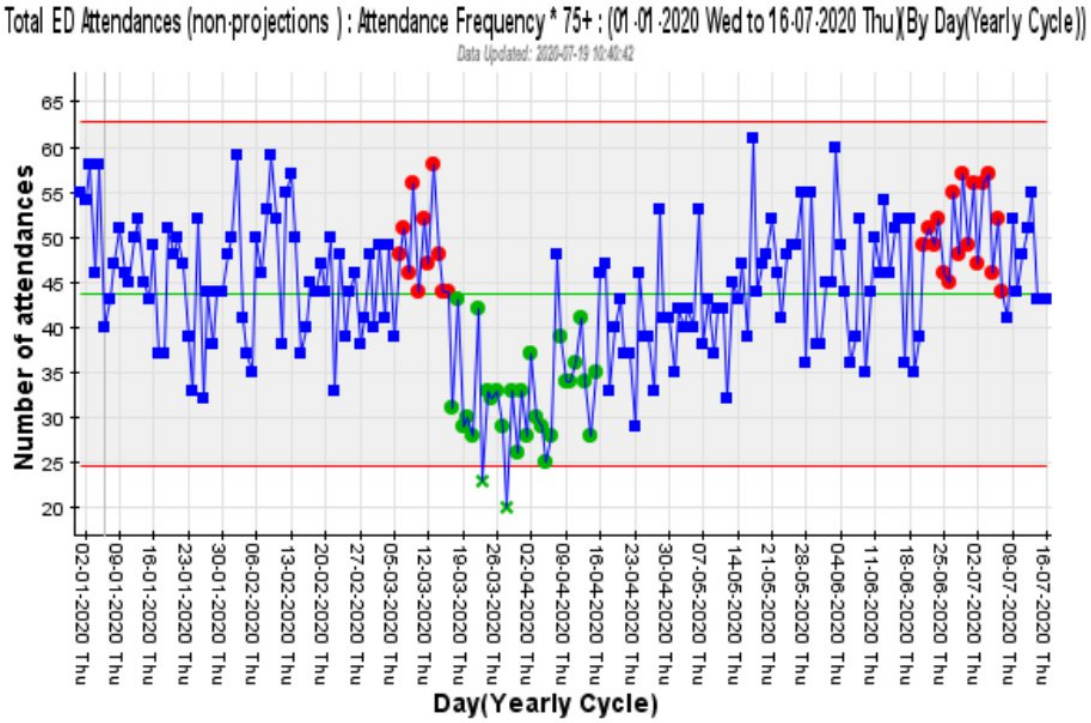


Figure 4. Daily pattern January to 16 July 2020.

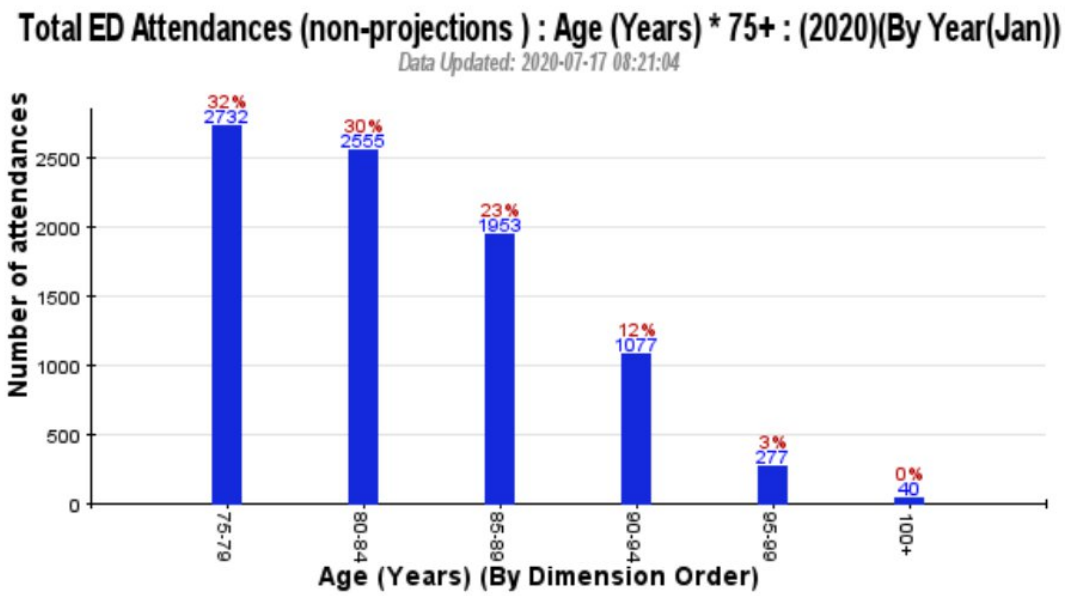


Figure 5. Age distribution Period January 2020 to 16 July 2020

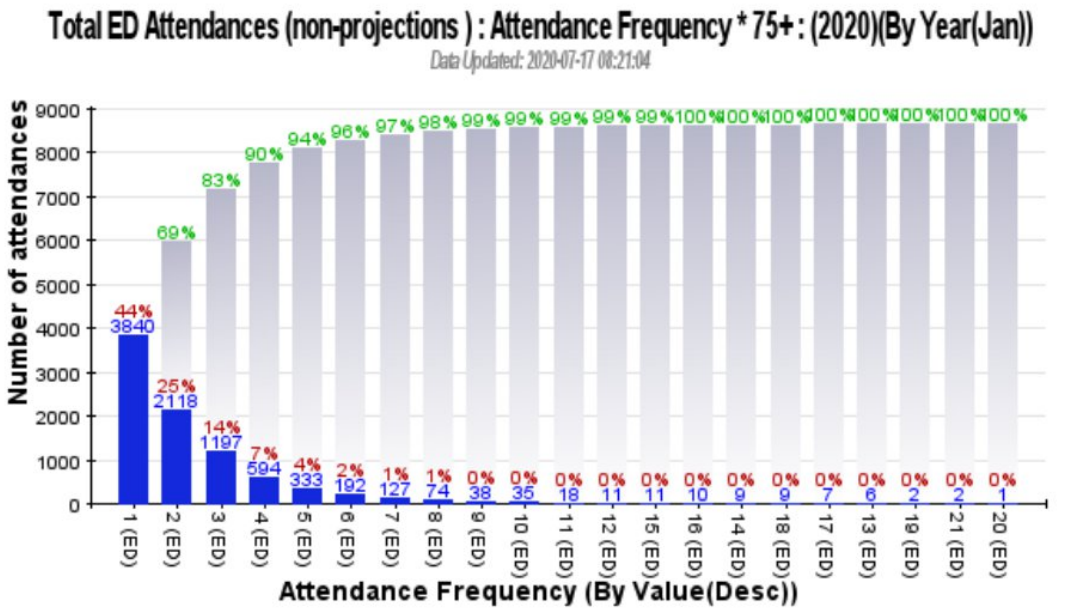


Figure 6. Frequency of ED presentation within 365 days | period Jan to Jul

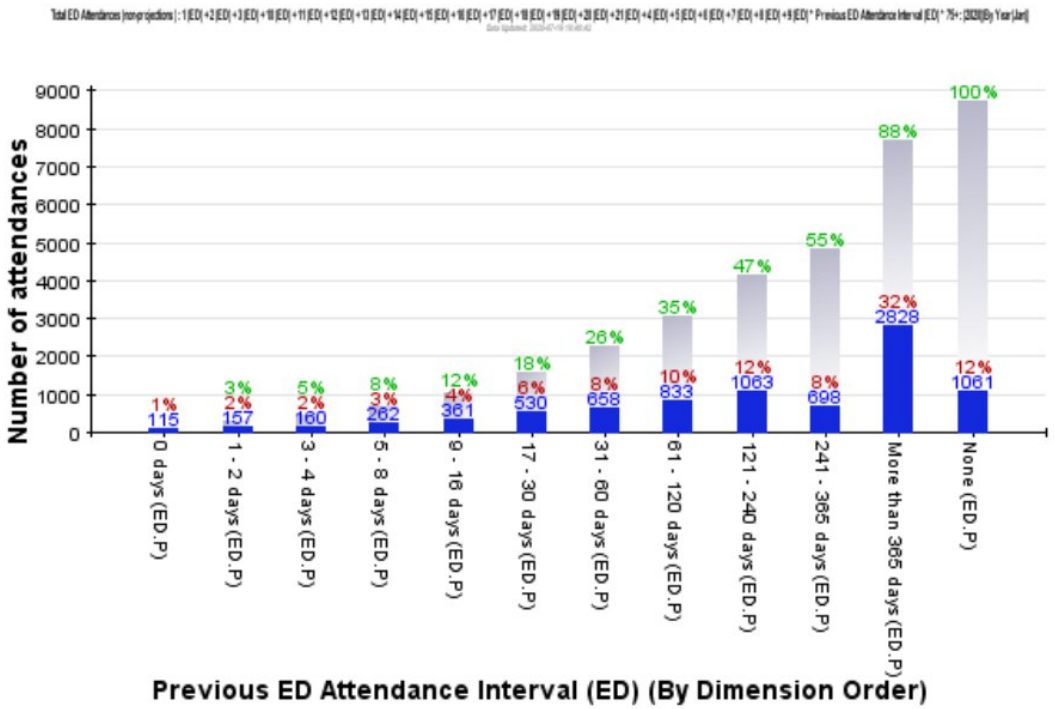


Figure 7. Interval of Emergency Attendance January to July 2020

Medical | Accidents

23% of attendances are accident related, this proportion has not changed over the years.

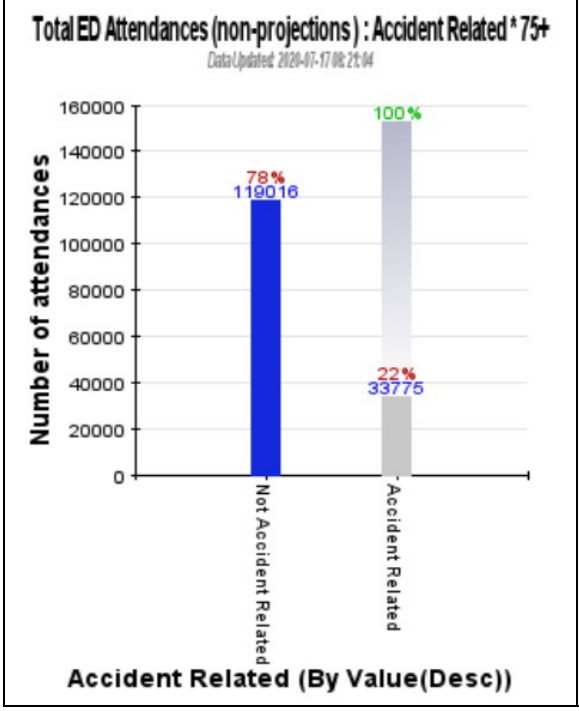
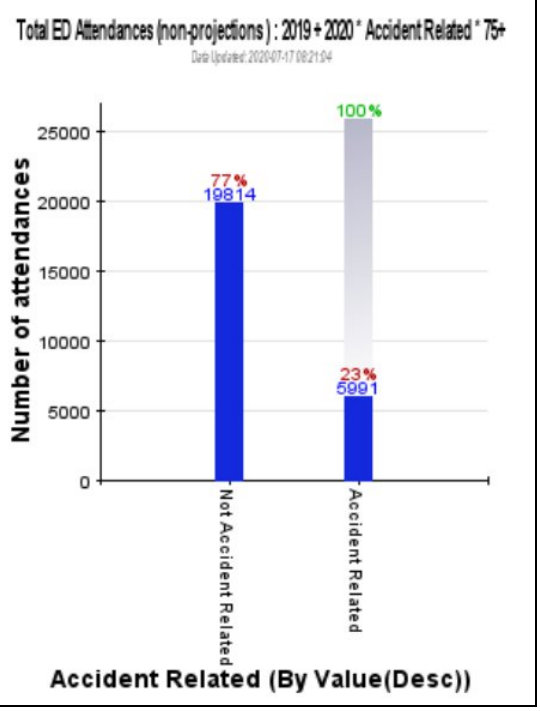
10 Years view	Last 18 moths
	

Figure 8. Accident versus non-accident ED attendance rates

Rate per Enrolled population *period January 2020 to 16 July 2020*

The funnel plot graph portraits the average of emergency attendances across the enrolled population. It shows an average rate of 18.2 ED presentation per General Practice. The graph indicates that there are 16 out of 117 General practice have rate above the average.

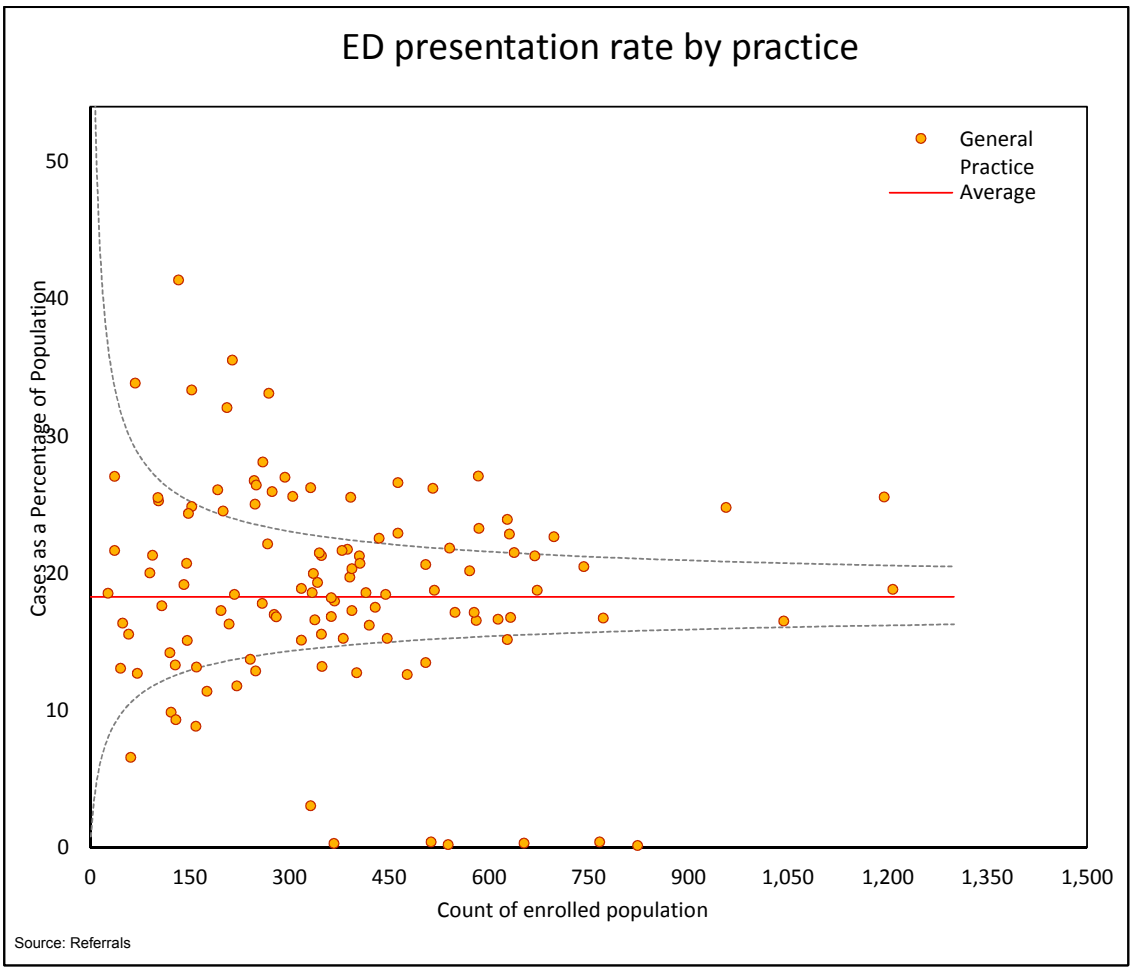


Figure 9. Representation of Emergency Attendances by Enrolled Population within each General Practice

FASTER CANCER TREATMENT

Canterbury District Health Board
Te Poari Hauora o Waitaha

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

PREPARED BY: **Andy MacKnelly, Portfolio Manager Secondary Care**

APPROVED BY: **Carolyn Gullery, Executive Director Planning Funding & Decision Support**

DATE: **6 August 2020**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

The purpose of this report is to provide the Committee with insight into the DHB's Faster Cancer Treatment (*FCT*) processes and provide additional information as requested by the Committee in regard to the 62-day pathway and patient outcomes.

2. RECOMMENDATION

That the Committee:

i. notes the Faster Cancer Treatment report.

3. SUMMARY

The main mechanisms by which the DHB measures its cancer service performance are the 31- and 62-day cancer treatment pathways. While these measures work effectively to track patient progress from referral to treatment they do not provide insight regarding access to the service, equity status or treatment outcomes.

Overall Canterbury's FCT performance remains among the highest in the country, but further analysis is needed to identify where there may be barriers to access. National data shows there are significant complicating factors for effective diagnosis and treatment of Māori, however, co-morbidities such as hypertension and diabetes play an important role. Early engagement with primary care services and support remains a key challenge to addressing the overall equity gap for Māori and non-Māori.

4. DISCUSSION

A detailed analysis of our FCT performance by ethnicity is limited by the relatively small numbers of patients diagnosed with certain cancers: the numbers are not statistically viable. Nevertheless the CDHB is committed to improving equity of outcomes and has implemented several initiatives to help us achieve our goals.

5. CONCLUSION

The CDHB continues to meet FCT performance measures and is actively looking at ways to improve equity throughout our cancer treatment pathways.

6. APPENDICES

Appendix 1: Faster Cancer Treatment briefing for HAC Aug 2020

Faster Cancer Treatment: Briefing paper

Background

What is Faster Cancer Treatment (FCT)?

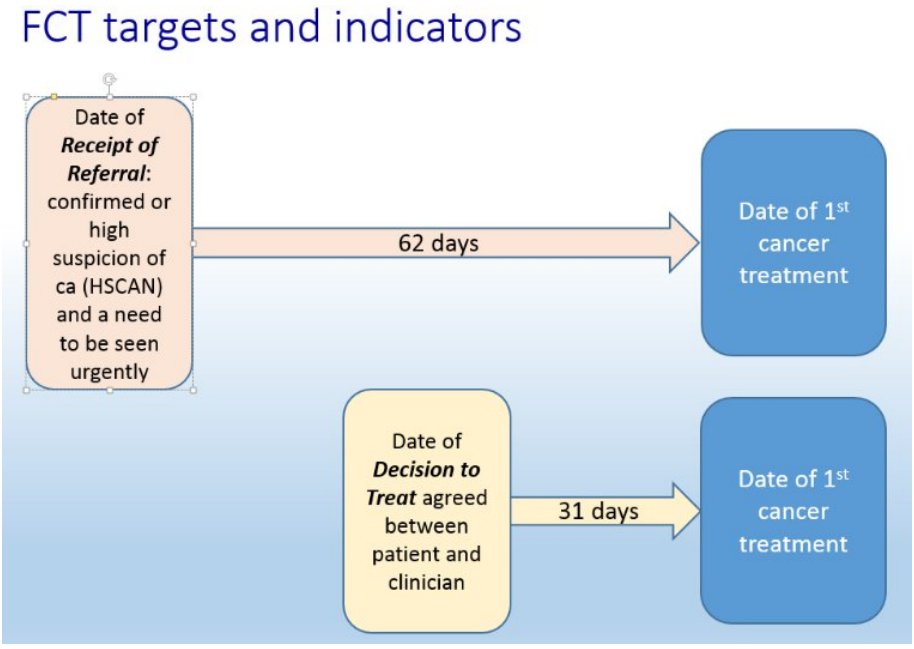
FCT is a government-led initiative based on similar programmes in the UK and Canada. Eligible patients triaged as having a high suspicion of cancer (**HSCAN**) and who need to be seen urgently[1] should wait no more than 62 days from when their referral is received by the hospital to the date of their first treatment.

Not all patients are eligible for inclusion in FCT statistics. The patient must have started their treatment in the public sector, be over 16, and eligible for NZ health-care. The patient must also be diagnosed with a new primary tumour, i.e. not a recurrence or metastasis of a previously reported cancer[2].

The 62 day and 31 day pathways

Eligible patients triaged as having a high suspicion of cancer (or a confirmed cancer diagnosis by biopsy) and a need to be seen urgently are included in the 62 days cohort.

Many patients are diagnosed with a cancer but were not triaged as having a high suspicion of cancer or who do not need to be seen urgently will not be included in the 62 days cohort, but they are measured against the 31 day standard. These patients are simply required to have their first treatment within 31 days from the date a decision to treat is made, whether that is surgery, radiation therapy, chemotherapy, or some other treatment. A full list of treatment types is provided below.



[1] Urgent is considered to be those people that need to be seen within 2 weeks.
[2] Some types of cancer are excluded from the FCT methodology

Reasons for missing the targets

When patients miss the 62 day target the Ministry requires DHBs to provide a reason. DHBs must use one of three delay codes.

Delay code 1: Patient choice: e.g. the patient requested a delay in treatment.

Delay code 2: Clinical considerations: there may be good clinical reasons why a patient can't start their treatment within the target times. For example, they may have other co-morbidities which need to be assessed and resolved before their cancer treatment can start.

Delay code 3: Capacity constraints: this covers everything else, including delays in diagnosis, time lost when patients are referred between departments and/or DHBs, lack of available theatre space, process issues and availability of staff. It is this category where we look for service improvements as the other two categories are in the patients' best interests.

Patients with a delay code of 1 or 2 are excluded by the Ministry from compliance calculations.

What do we do when patients don't meet the target?

In Canterbury we consider that by putting the patient at the centre of what we do and arranging services accordingly then compliance with the FCT targets will follow. Therefore, each patient who did not meet the target is investigated to determine why. If it was through patient choice or clinical considerations, then normally no further detailed analysis is necessary because these delays are either respecting the patient's right to choose or in the patient's interest.

Service improvement efforts are focused on patients who are delayed for other reasons. Analysis is usually done on a service-wide perspective to see if there are identifiable trends. An example would be a recent project which reviewed the treatment pathway for patients with a cancer of the head and neck across DHBs. By reviewing the whole pathway, it becomes easier to see where efficiencies can be made.

DHB Performance

Reflecting the size of our population and our role as a tertiary hospital in the South Island, Canterbury often reports the largest number of patients seen in the country. Canterbury has consistently met the FCT 62 and 31 days targets for several years now which is a strength for the Canterbury population as well as other SI DHBs. (See figures 1 and 2 below – excerpts from Southern Cancer Network FCT Dashboard results as of 05/05/2020

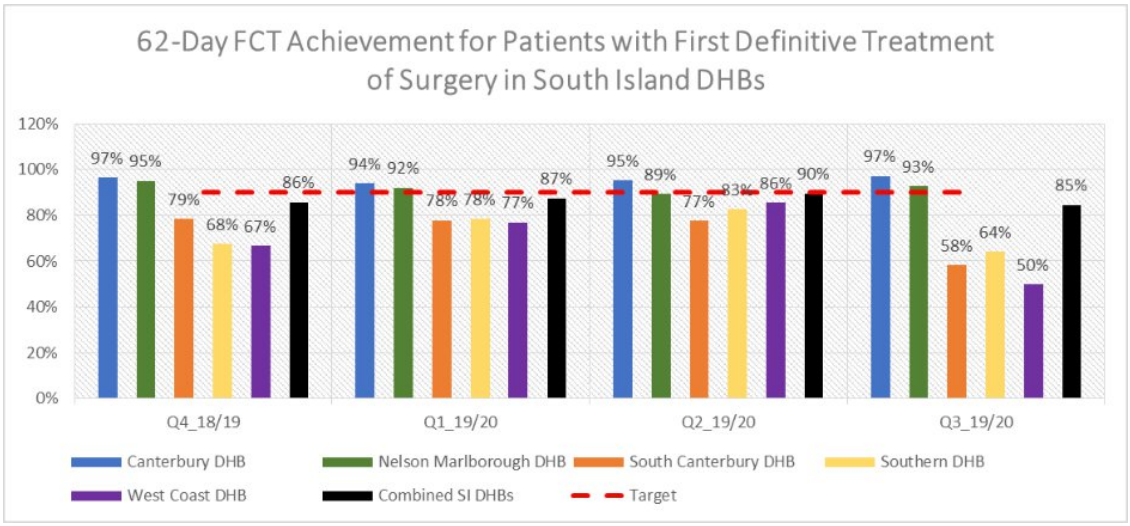


Figure 1 – 62-day FCT achievement

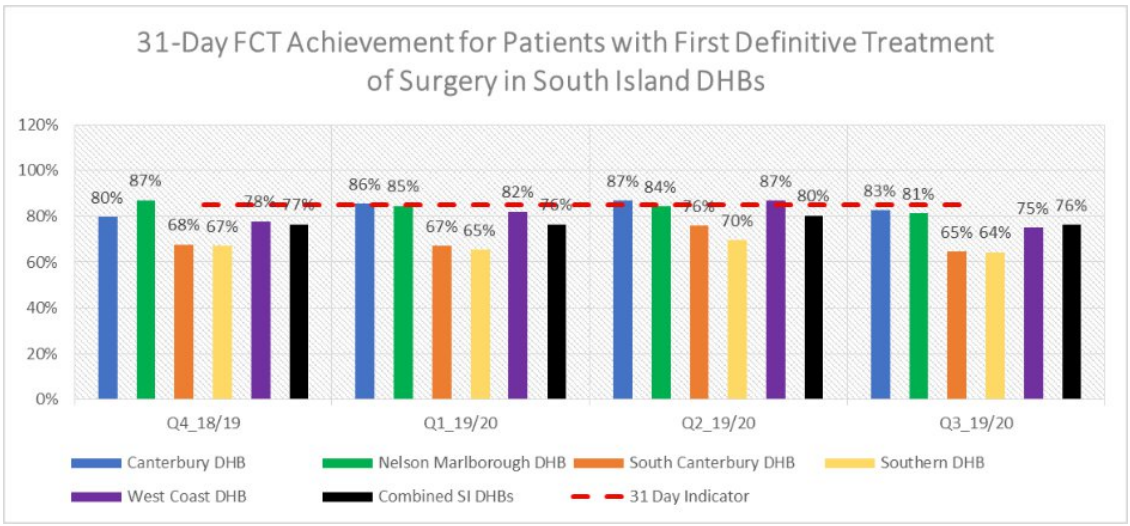


Figure 2 – 31-day FCT achievement

Faster Cancer Treatment During COVID-19

The regular FCT report to HAC shows that once again the CDHB met the FCT targets for both 62 and 31 days cohorts.

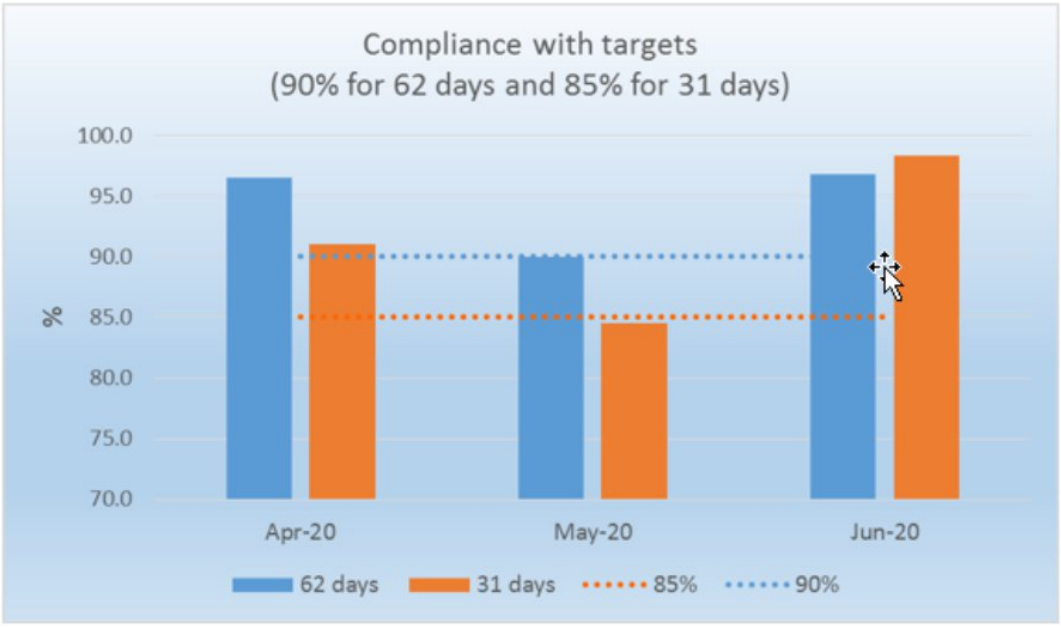
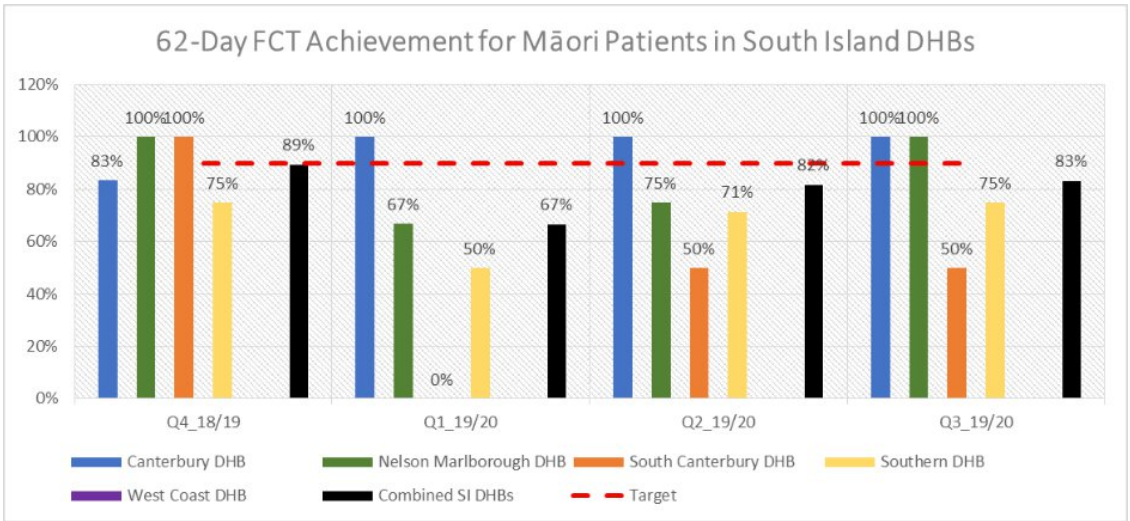


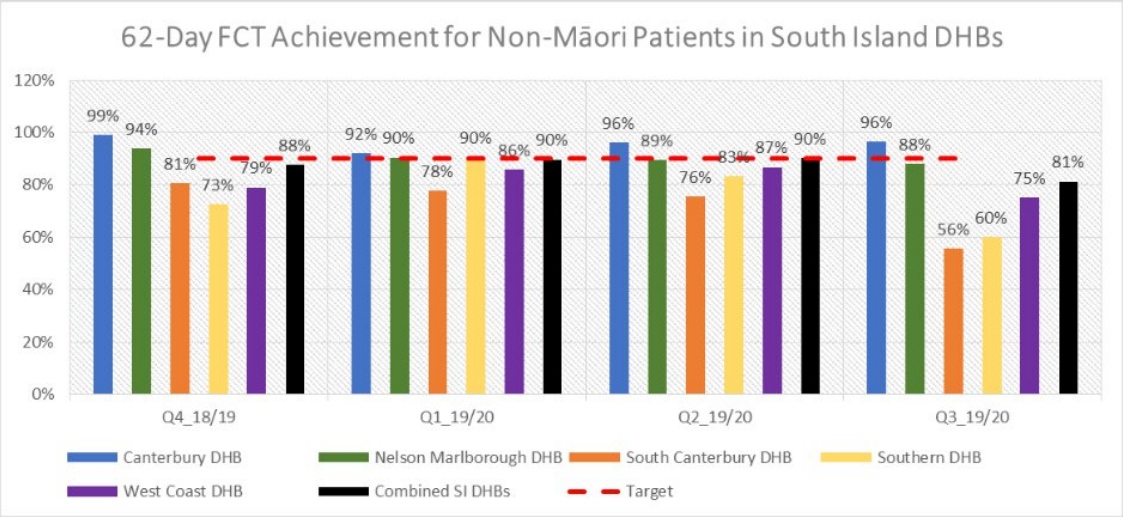
Figure 3 – most recent quarter performance (Q4) for CDHB – included as part of HAC Report – Aug 20

A total of 33 patients from the 62-day cohort experienced delays due to COVID. Seven of these went on to miss the target, five of which were because of clinical considerations leaving two patients who may have missed the target because of delays caused by COVID.

FCT data by ethnicity

Canterbury DHB continues to ramp up its ability to provide analysis by ethnicity in house. We participate in the South Island FCT Leads group with Southern Cancer Network and have been working with them to better understand our ethnicity information. Some of what is known is shown below.





The above charts show there is a small percentage gap to close at CDHB and further analysis is continuing because percentages do not accurately portray when there are small numbers of people involved. In some cases, the difference is one patient.

Each breach for Maori patients is mapped across a time line to indicate where delays occurred and to be used for process improvement. The total Maori breaches for the SI for Q3 19/20 = 7 patients' performance.

First Treatment

The following table shows the 1st treatment patients received for their cancer; many go on and have more than one type, for example surgery then radiation therapy. Between March 2019 and March 2020, 14 people declined treatment, of these none were Māori.

Treatment types	Asian	European	Maori	Other	Pacific	Total
Chemotherapy	11	166	12	3	3	195
Clinical trial	-	3	1	-	-	4
Concurrent radiation	4	50	5	1	-	60
Non-intervention	1	16	1	-	-	18
Palliative care	5	55	3	-	3	66
Patient died	-	4	-	-	-	4
Radiation	4	178	13	1	2	198
Person Refused treatment	-	13	-	-	1	14
Surgery	37	770	54	3	11	875
Targeted therapy	1	67	5	1	1	75
Not recorded	1	-	-	-	-	1
Total	**64**	**1322**	**94**	**9**	**21**	**1510**

SOUTH ISLAND BARIATRIC SURGERY SERVICE – SUMMARY 2019/20

Canterbury District Health Board
Te Poari Hauora o Waitaha

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

PREPARED BY: **Gill Fowler, Service Development Manager**
Ralph La Salle, Team Leader, Planning & Funding

APPROVED BY: **Carolyn Gullery, Executive Director, Planning Funding & Decision Support**

DATE: **6 August 2020**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

The purpose of this report is to provide the Committee with a service summary of the South Island Bariatric Surgery Service for 19/20 along with plans for the upcoming 20/21 year.

2. RECOMMENDATION

That the Committee:

i. notes the South Island Bariatric Surgery Service – Summary 2019/20 paper.

3. SUMMARY

CDHB continued to provide Bariatric surgery as a part of the South Island Bariatric Service during the 19/20 year. 49 patients received surgery during 19/20 out of the planned 68 cases. Under-delivery was due to the delay in approval of additional cases over the 18/19 period and the COVID response. Funding for cases not completed during 19/20 will be requested from the Government's Catch Up funding allocation.

For 20/21, CDHB will provide 34 of the 68 cases planned and its share of any catch up cases allocated.

4. APPENDICES

Appendix 1: South Island Bariatric Surgery Service – Summary 2019/20

South Island Bariatric Surgery Service – Summary 2019/20 Page 1

Introduction

The South Island Bariatric Service incorporates all South Island DHBs. Canterbury DHB is the contract holder on behalf of the South Island DHBs with St George's Hospital and is allocated half of the nominated volume per annum and Southern DHB also provides bariatric surgeries internally and is allocated the other half of the SI volume of cases.

A Clinical Priority Assessment Criteria (CPAC) scoring tool is used to prioritise referrals. There is a single wait list for all South Island prioritised referrals. A South Island Selection Committee meets during the year to make the final selection of referrals to go through to surgery. The Selection Committee has an independent chair until June 2021.

Clinicians value the regional approach based on both the patient's ability to benefit and the wider benefit to the whole South Island with the highest clinical need cases going first regardless of location. Clinicians benefit from the peer support for difficult clinical decisions and want to continue with this model of service

Summary - 2019/20

49 cases were completed across the South Island DHBs (Fig 1) – this was under-delivery against 68 planned cases.

Fig 1. 2019/20 cases completed by DHB

2019/20	BARIATRIC CASES COMPLETED				
CDHB	SDHB	NMDHB	SCDHB	WCDHB	IDF
22	19	5	1	1	1

Fig 2. 2019/20 cases by ethnicity

Ethnicity	Number
Cook Island Maori	1
New Zealand European	38
New Zealand Maori	6
Tongan	1
Samoan	3
TOTAL	**49**

The reason for under-delivery was two-fold. There was a delay in approval of the extra 10 case volume (from 58 to 68 cases) across the DHBs which meant the extra 10 cases were pending for the first six months. With the lockdown and COVID response, bariatric surgery was paused during March through early May. May and June saw some catch-up occurring. The balance not completed in 19/20 (19) will be requested from the new Government allocation of catch-up funding.

Plans for 2020/21

1. Canterbury DHB General Surgery department continues to host the South Island Bariatric Surgery Service and notes that:
   - a SMO continues to triage the bariatric referrals using the CPAC scoring tool;
   - clinics are arranged to see patients who meet the threshold prior to the quarterly Selection Committee meetings; and

- the department enjoys a positive working relationship with Christchurch Weight Loss which manages the wrap around services e.g. patient education and nutritional support prior to surgery.

2. There has been a theatre capacity issue in Southern DHB with only one surgeon – a second surgeon commenced during the 2019/20 which ensured they maximised their sessions and provides the additional capacity ongoing.

3. A new surgeon in Nelson Marlborough DHB means First Specialist Assessments can be seen there – which is better for the patient and frees some clinic time in the CDHB General Surgery department. At this stage there is no intention to do bariatric surgery in Nelson Marlborough DHB.

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

APPROVIED BY: **Justine White, Executive Director, Finance & Corporate Services**

DATE: **6 August 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, 2 and 3;

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of the minutes of the public excluded meeting of 4 June 2020	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)
3.	CDHB Planned Care Plan 2020/21 and CDHB Improvement Action Plan 2020/21	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s 9(2)(j)

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

3. SUMMARY

The Act, Schedule 3, Clause 32 provides:

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

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

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

Clause 33 of the Act also further provides:

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

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

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

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

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

QUALITY AND PATIENT SAFETY INDICATORS – LEVEL OF COMPLAINTS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **Irena de Rooy, Quality & Patient Safety Manager**
Susan Wood, Director, Quality & Patient Safety

APPROVED BY: **Mary Gordon, Executive Director of Nursing**

DATE: **6 August 2020**

Report Status – For:	Decision ☐	Noting ☐	Information ☑

1. ORIGIN OF THE REPORT

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

2. DISCUSSION

Attached (Appendix 1) is a report outlining the "All Hospitals Complaint Rate" expressed by rate of 1000 contacts for the period November 2019 – June 2020, as well as a 12-month overview of the complaints categories and compliance timeframes.

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

Canterbury DHB has implemented the South Island Electronic Consumer Feedback Module in Safety 1st. From 1 December 2017, all hospital feedback data is entered into Safety 1st. This module includes compliments, complaints and suggestions, and has been in use in other DHBs since 2015. It provides more visibility of data, including HDC complaints, as well as easier analysis of trends to identify themes. The Canterbury DHB Complaints Policy and associated documentation was reviewed and issued in January 2019.

Complaints data is reported as part of the Patient Experience and Harm Indicator Report and monitored by the Clinical Governance Group; Serious Incident Review Committee; the General Managers Group; and the Quality, Finance, Audit and Risk Committee.

3. APPENDICES

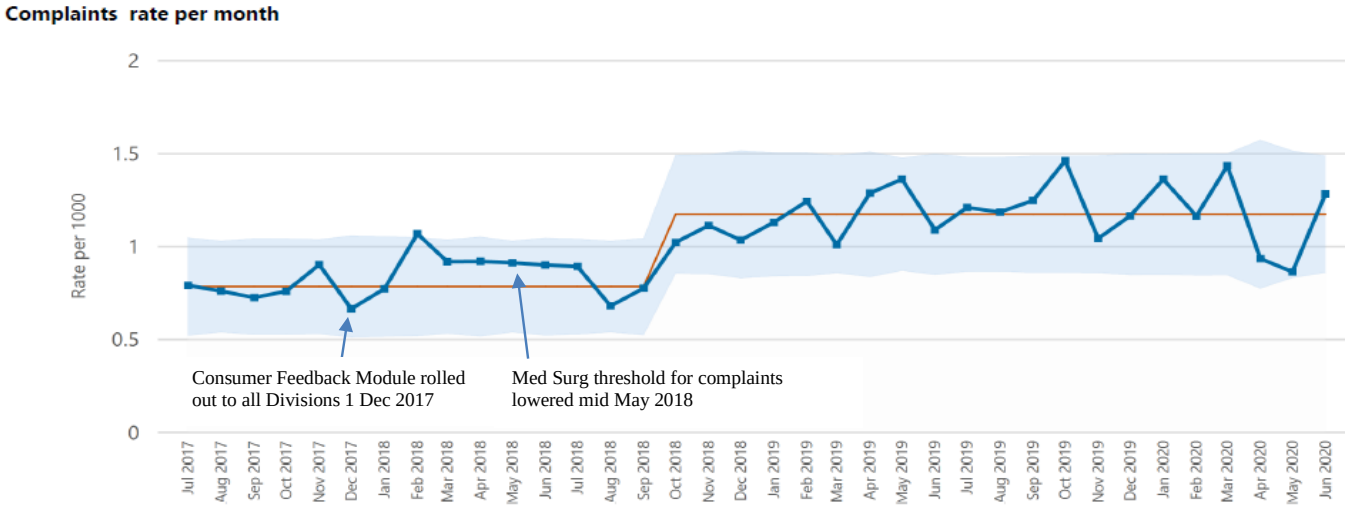
Appendix 1: CDHB Complaint Rate and Categories to October 2019

APPENDIX 1

PATIENT EXPERIENCE: COMPLAINTS

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

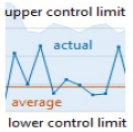
Outcome Indicator: **All Hospitals Complaints Rate**



Numerator: Total number of complaints received in the period.

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

Calculated as a rate per 1,000



Data for 2019/2020 year to date:

Complaints - Complaints

2019/20													2018/19	2017/18
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YTD	YTD
135	133	134	157	111	116	136	115	142	62	78	138	1,457	1,292	1,066
111,603	112,217	107,388	107,445	106,357	99,571	99,880	98,797	99,015	66,315	90,310	107,526	1,206,424	1,233,084	1,265,760
1.21	1.19	1.25	1.46	1.04	1.16	1.36	1.16	1.43	0.93	0.86	1.28	1.21	1.05	0.84

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

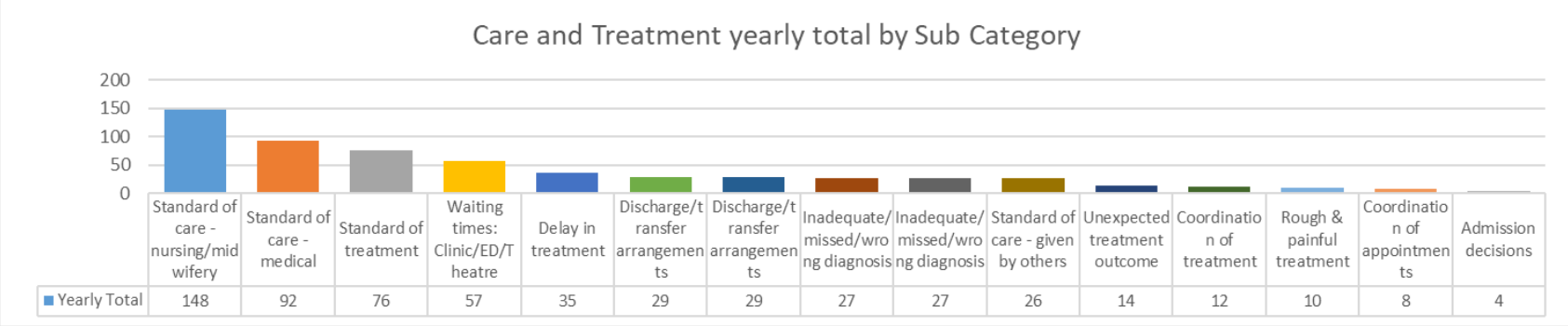
Comments for seven month reporting period of November 2019 to June 2020

- There is a decrease in number of complaints reported in April and May 2020.
- The majority of complaints between November 2019 and June 2020 relate generally to 1 category
- The top category for the November 2019 to June 2020 period was Care/Treatment (347), followed by Access /Funding (142), then Communication/Information (135), followed closely by Patient/Staff Relationships (130).

Care and treatment Subcategories (last 12 months)

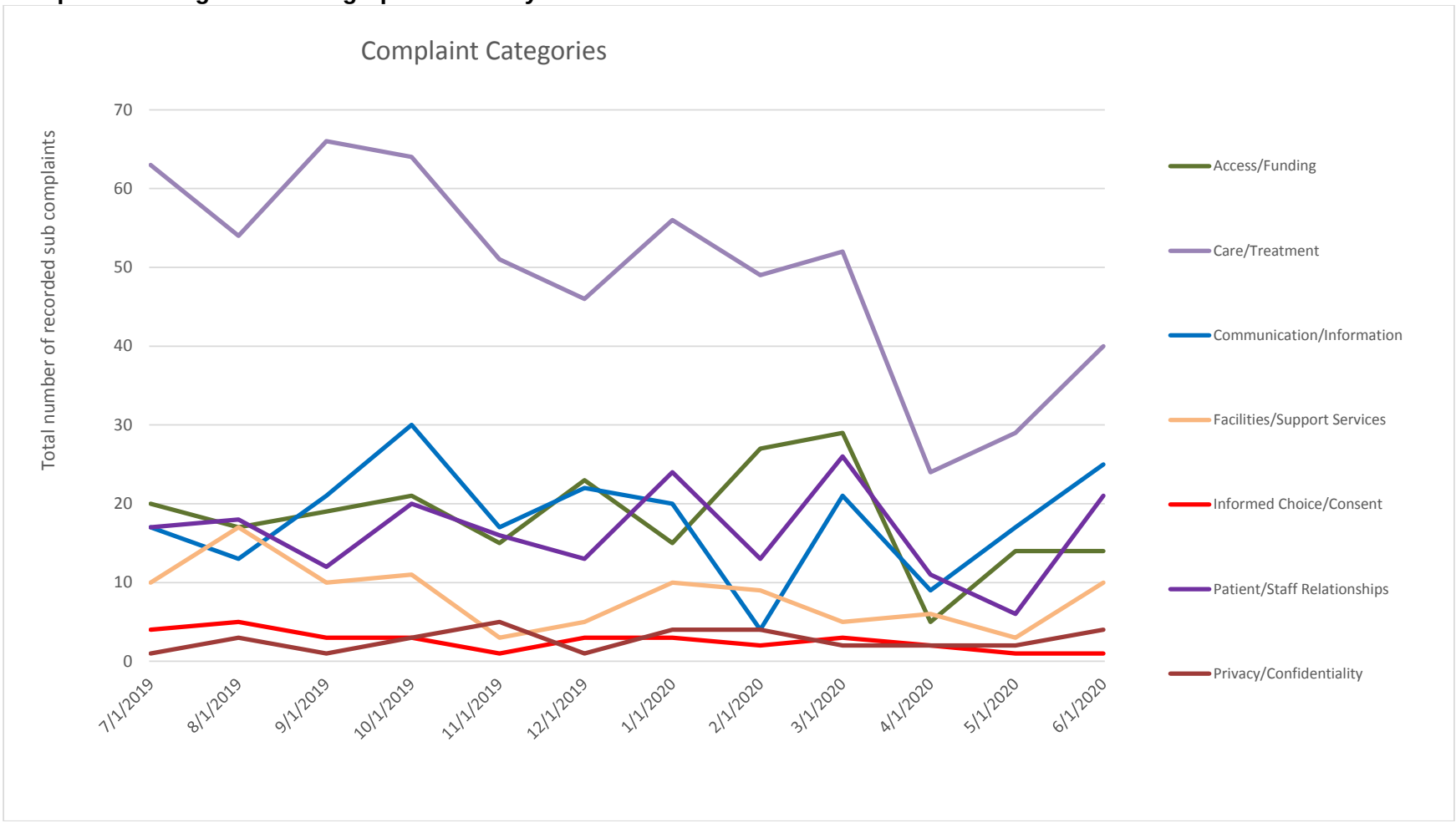
Breakdown of Complaints Categories [1] from 1 July 2019 to 30 June 2020:

Start Date: 1/07/2019	1/07/2019	1/08/2019	1/09/2019	1/10/2019	1/11/2019	1/12/2019	1/01/2020	1/02/2020	1/03/2020	1/04/2020	1/05/2020	1/06/2020	TOTAL
Total Complaint Forms	132	127	132	152	108	113	132	108	138	59	72	115	***1388***
Total Number of Categories per complainee													
1	21	35	22	28	23	27	21	29	27	13	20	37	***303***
2	31	35	24	30	16	22	31	27	28	9	17	35	***305***
3	22	24	32	27	14	30	42	23	30	12	10	24	***290***
4	19	11	15	14	12	10	15	10	22	10	10	6	***154***
>5	39	22	39	53	43	24	23	19	31	15	15	13	***336***
Access/Funding	20	17	19	21	15	23	15	27	29	5	14	14	***219***
Care/Treatment	63	54	66	64	51	46	56	49	52	24	29	40	***594***
Communication/Information	17	13	21	30	17	22	20	4	21	9	17	25	***216***
Facilities/Support Services	10	17	10	11	3	5	10	9	5	6	3	10	***99***
Informed Choice/Consent	4	5	3	3	1	3	3	2	3	2	1	1	***31***
Patient/Staff Relationships	17	18	12	20	16	13	24	13	26	11	6	21	***197***
Privacy/Confidentiality	1	3	1	3	5	1	4	4	2	2	2	4	***32***



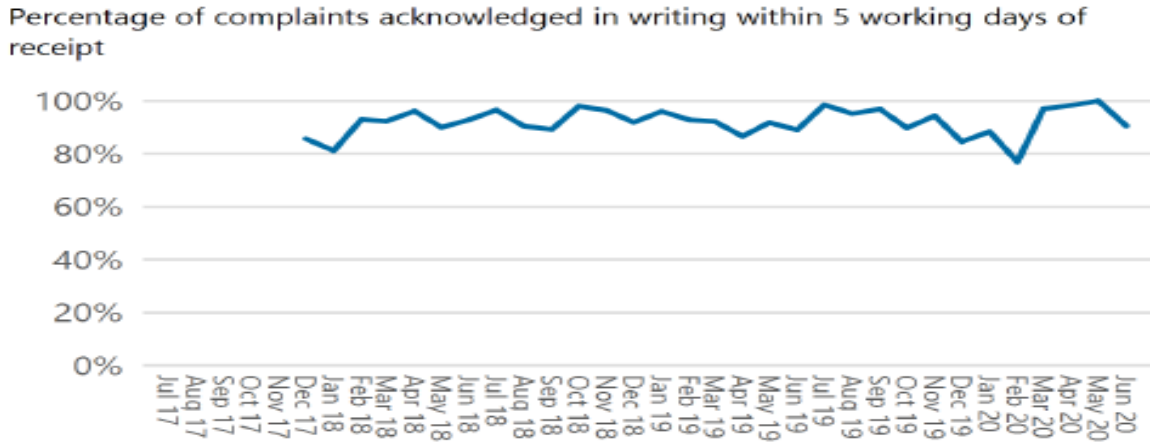
[1] The Breakdown of Complaints Categories data is refreshed monthly, reports are generated in the first week following the close of the month – hence the 'Total Complaints Forms' numbers may differ to the complaints numerator data as this is refreshed weekly.

Complaints Categories trend graphs for 1 July 2019 to 30 June 2020:



The implementation of the consumer feedback module on Safety1st has enabled monitoring of the 5 and 20 day compliance timeframes as per Complaints Policy.

5 day Compliance[2]



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

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

Data for 2019/2020 year to date:

Complaints Percentage - Percentage of complaints

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

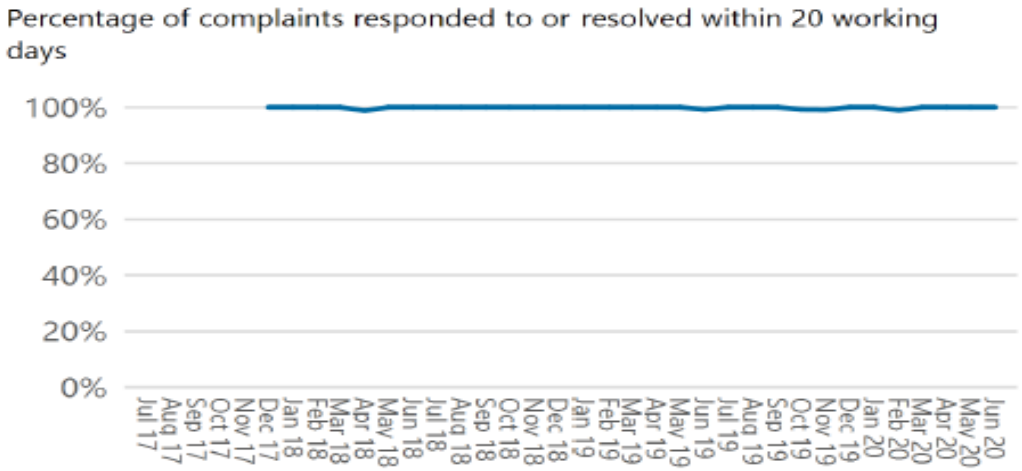
Measure	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
Numerator	129	118	122	132	99	93	114	80	128	57	69	115	1256
Denominator	131	124	126	147	105	110	129	104	132	58	69	127	1362
Percentage	98%	95%	97%	90%	94%	85%	88%	77%	97%	98%	100%	91%	92%

Comments for seven month reporting period of November 2019 to June 2020

- The percentage of complaints acknowledged in writing within 5 working days varies below the expected level of 100%, with the 100% only being achieved for the month of May 2020. Following investigation, it was noted that due to staff leave the 100% compliance is not consistently achieved.

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

20 day Compliance[4]



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

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

Data for 2019/2020 year to date:

Percentage of complaints responded to or resolved within 20 working days

Measure	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
Numerator	135	99	105	129	115	107	96	93	102	84	67	91	1223
Denominator	135	99	105	130	116	107	96	94	102	84	67	91	1226
Percentage	100%	100%	100%	99%	99%	100%	100%	99%	100%	100%	100%	100%	100%

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

Comments for seven month reporting period of November 2019 to June 2020

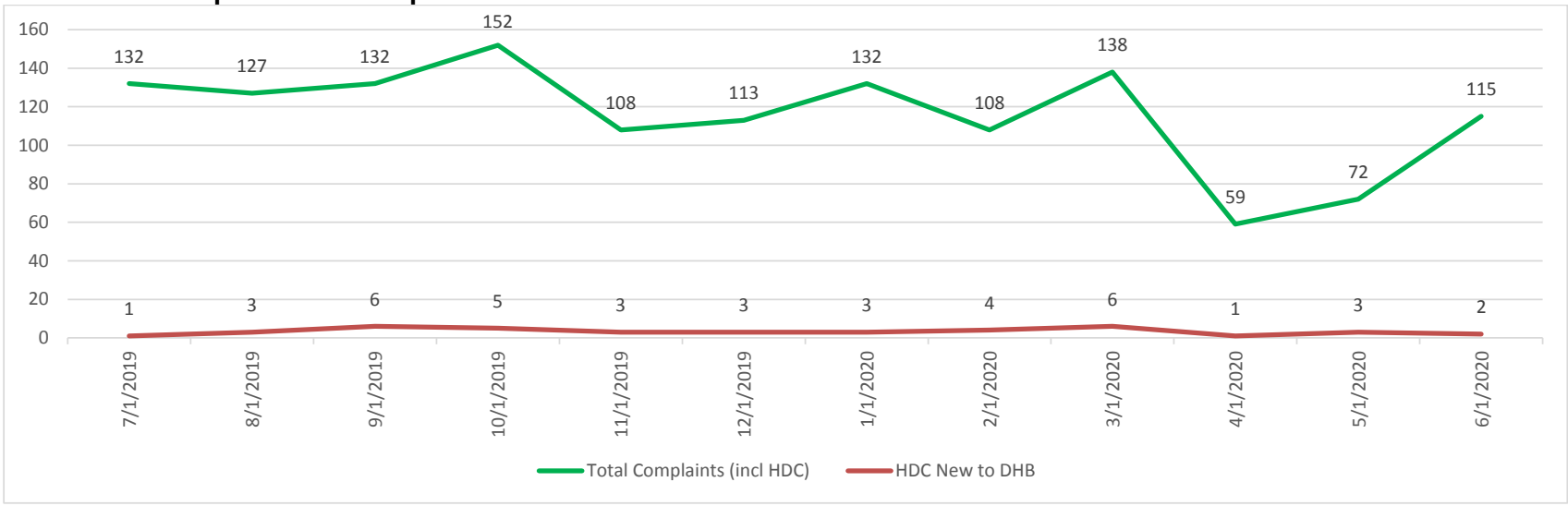
100% of complaints were responded to or resolved within 20 working days during the last seven months, with the exception of November 2019 and February 2020 when 99% was achieved.

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

Health and Disability Commissioner CDHB Complaints: Trend Reports

Start Date: 1/07/2019	1/07/2019	1/08/2019	1/09/2019	1/10/2019	1/11/2019	1/12/2019	1/01/2020	1/02/2020	1/03/2020	1/04/2020	1/05/2020	1/06/2020	TOTAL
Total Complaint Forms	132	127	132	152	108	113	132	108	138	59	72	115	***1388***
HDC Complaint	**1**	**3**	**6**	**5**	**3**	**3**	**3**	**4**	**6**	**1**	**3**	**2**	***40***
Existing DHB Complaint	0	0	0	0	0	0	0	0	0	0	0	0	***0***
HDC New to DHB	1	3	6	5	3	3	3	4	6	1	3	2	***40***
HDC Request Type Other	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	***1***
Information Request Only	0	0	0	0	0	0	0	0	0	0	0	0	***0***
Another Provider Information Request	0	0	0	0	0	0	0	0	0	0	1	0	***1***

CDHB HDC Complaint Trend Reports 1 June 2019 to 30 June 2020:



Complaints to Health and Disability Commissioner involving District Health Boards

This report details the trends in complaints received by the HDC about DHBs between 1 July and 31 December 2019. The total number of complaints received about care provided by DHBs varies quarter to quarter.

Number of Complaints received in the last five years

	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17	Jan–Jun 18	Jul–Dec 18	Jan–Jun 19	Average of last 4 6-month periods	Jul–Dec 19
Number of complaints	389	422	383	386	477	439	450	442	427	**440**	**472**

National Rate of complaints received in last five years by HDC[6]

	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17	Jan–Jun 18	Jul–Dec 18	Jan–Jun 19[2]	Average of last 4 6-month periods	Jul–Dec 19
Rate per 100,000 discharges	84.60	87.57	81.44	78.79	99.08	88.23	93.80	88.47	87.97	**89.62**	**94.16**

The national rate of complaints received during Jul–Dec 2019 (94.16) shows a 5% increase on the average rate of complaints received for the previous four periods. The trends in complaints remain similar to what has been seen in previous six-month periods, with surgery being the most common service type complained about and missed/incorrect/delayed diagnosis being the most common primary issue.

Access to services continues to be an issue seen in complaints to HDC about DHB services, featuring in around a quarter of all complaints about DHBs. Inadequate prioritisation systems, where patients are not prioritised according to clinical risk, and poor communication with consumers, are a common feature of investigations by the HDC Office into treatment delays.

As can be seen in the table below, Canterbury DHB's complaint rate for Jul–Dec 2019 (78.78) is similar to the average rate of complaints received for the previous four periods. Similar to what was seen in the last period, mental health services (37.8%) was the most commonly complained about service type at Canterbury DHB in Jul–Dec 2019. Canterbury DHB again received a higher proportion of complaints about mental health services in this period than was seen nationally across all DHBs (25%). Canterbury DHB received a lower proportion of complaints about maternity services (6.7%) in Jul–Dec 2019 than was seen in the previous period (11.9%).

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

Similar to national trends, on analysis of all issues identified in complaints about Canterbury DHB, the most common complaint issue categories were about care/treatment (present for 78% of complaints), communication (present for 78% of complaints), and consent/information (present for 22% of complaints).

On analysis of all specific issues raised in complaints about Canterbury DHB, the most common issues were:

- Inadequate/inappropriate clinical treatment (51%)
- Failure to communicate effectively with consumer (49%)
- Inadequate/inappropriate examination/assessment (24%)
- Disrespectful manner/attitude (22%)
- Failure to communicate effectively with family (22%)

This is broadly similar to what was seen in the last period for Canterbury DHB.

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	Meeting Cancelled	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes
Standing Monitoring Reports	H&SS Monitoring Report			H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report
Planned Items	Clinical Advisor Update – Nursing		COVID-19 Update	Clinical Advisor Update – Nursing Maternity Assessment Unit – 9 Month Update ED Presentations – Over 75 Years Old – Analysis Paper Faster Cancer Treatment South Island Bariatric Surgery Service – Summary 2019/20	Clinical Advisor Update – Allied Health Care Capacity Demand Management Update	Clinical Advisor Update – Medical 2020 Winter Planning Review
Presentations	Department of Anaesthesia		Elective Surgery Recovery Plan			
Governance & Secretariat Issues	2020 Workplan					
Information Items			HAC Terms of Reference - Amended 2020 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 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) CDHB Planned Care Plan 2020/21 and CDHB Improvement Action Plan 2020/21	CEO Update (as required)	CEO Update (as required)