# AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora o Waitaha

**HOSPITAL ADVISORY COMMITTEE MEETING**
**to be held via Zoom**
**Thursday, 2 June 2022 commencing at 9:00am**

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| **Administration** | | | |
| | Apologies | | 9.00am |
| 1. | Conflict of Interest Register | | |
| 2. | Confirmation of Minutes – 3 February 2022 | | |
| 3. | Carried Forward / Action List Items | | |
| **Reports for Noting** | | | |
| 4. | Hospital Service Monitoring Report:<br>• Medical/Surgical; Women's & Children's Health; & Orthopaedics<br>ESPIs<br>• Specialist Mental Health Service<br>• Older Persons Health & Rehabilitation<br>• Rural Health Services<br>• Hospital Laboratories | Pauline Clark<br>*General Manager, Medical/ Surgical; Women's & Children's Health; & Orthopaedics*<br>Dr Greg Hamilton<br>*General Manager, Specialist Mental Health Services*<br>Kate Lopez<br>*Acting General Manager, Older Persons Health & Rehabilitation*<br>Berni Marra<br>*General Manager, Rural Health Services*<br>Gloria Crossley<br>*Interim General Manager, Laboratories* | 9.10-10.15am |
| 5. | Office of the Clinical Executive Update | Norma Campbell<br>Becky Hickmott<br>Dr Jacqui Lunday-Johnstone<br>*Clinical Executive Leads* | 10.15-10.30am |
| 6. | Resolution to Exclude the Public | | 10.30am |
| **ESTIMATED FINISH TIME** | | | **10.30am** |

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| | Information Items:<br>• Quality & Patient Safety Indicators – Level of Complaints<br>• 2022 Workplan | | |

# ATTENDANCE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

## HOSPITAL ADVISORY COMMITTEE MEMBERS

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

## Executive Support

(as required as per agenda)

Dr Peter Bramley – *Chief Executive*
James Allison – *Chief Digital Officer*
Norma Campbell – *Executive Director, Midwifery & Maternity Services*
Jo Domigan – *Interim Chief People Officer*
David Green – *Acting Executive Director, Finance & Corporate Services*
Becky Hickmott – *Executive Director of Nursing*
Dr Jacqui Lunday-Johnstone – *Executive Director of Allied Health, Scientific & Technical*
Tracey Maisey – *Executive Director, Planning Funding & Decision Support*
Hector Matthews – *Executive Director Maori & Pacific Health*
Tanya McCall – *Interim Executive Director, Community & Public Health*
Dr Rob Ojala – *Executive Director, Infrastructure*
Dr Helen Skinner – *Chief Medical Officer*
Karalyn Van Deursen – *Executive Director of Communications*

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

# COMMITTEE ATTENDANCE SCHEDULE 2022

Canterbury District Health Board
Te Poari Hauora ō Waitaha

| NAME | 03/02/22 (Zoom) | 07/04/22 (Cancelled) | 02/06/22 |
|---|---|---|---|
| Andrew Dickerson (Chair) | # | | |
| Naomi Marshall (Deputy Chair) | √ | | |
| Barry Bragg | # | | |
| Catherine Chu | ^ | | |
| James Gough | ^ | | |
| Jo Kane | √ | | |
| Ingrid Taylor | √ | | |
| Jan Edwards | √ | | |
| Dr Rochelle Phipps | √ | | |
| Michelle Turrall | 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)*

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| **Andrew Dickerson**<br>**Chair – HAC**<br>Board Member | **Canterbury Education and Research Trust for the Health of Older Persons** - Trustee<br>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.<br><br>**Canterbury Medical Research Foundation** - Member<br>Provides financial assistance for medical research in Canterbury. Recipients of financial assistance for research, education or training could include employees of the CDHB.<br><br>**Heritage NZ -** Member<br>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.<br><br>**Maia Health Foundation -** Trustee<br>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.<br><br>**NZ Association of Gerontology** - Member<br>Professional association that promotes the interests of older people and an understanding of ageing. |
| **Naomi Marshall**<br>**Deputy Chair - HAC**<br>Board Member | **College of Nurses Aotearoa NZ** – Member<br><br>**Riccarton Clinic & After Hours** – Employee<br>Employed as a Nurse. Riccarton Clinic & After Hours provides general practice and after-hours care. It is part privately and PHO funded. The PHO receives funding from the CDHB. |
| **Barry Bragg**<br>Board Member | **Air Rescue Services Limited** - Director<br>Subsidiary of the Canterbury West Coast Air Rescue Trust. Has gaming licenses with specified purpose of fundraising for air rescue services.<br><br>**Canterbury West Coast Air Rescue Trust** – Trustee<br>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.<br><br>**CMUA Project Delivery Limited** - Chair<br>100% owned by the Christchurch City Council and is responsible for the delivery of the Canterbury Multi-Use Arena project within agreed parameters.<br><br>**Farrell Construction Limited** - Shareholder<br>Farrell's Construction Limited is a commercial and light commercial construction company based in Christchurch. |

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| | **New Zealand Flying Doctor Service Trust** – Trustee<br>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.<br><br>**Ngai Tahu Farming** – Chairman<br>Farming interests in North Canterbury and Queenstown Lakes District and Forestry interests in Canterbury, West Coast and Otago regions.<br><br>**Paenga Kupenga Limited** – Chair<br>Commercial arm of Ngai Tuahuriri Runanga<br><br>**Quarry Capital Limited** – Director<br>Property syndication company based in Christchurch<br><br>**Stevenson Group Limited** – Deputy Chairman<br>Property interests in Auckland and mining interests on the West Coast.<br><br>**Venues Ōtautahi** - Advisor<br>A Christchurch City Council controlled organisation. Venues Ōtautahi is responsible for attracting, planning and delivering events for the Christchurch venues it owns, operates and manages.<br><br>**Verum Group Limited** – Director<br>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**<br>Board Member | **Christchurch City Council** – Councillor<br>Local Territorial Authority<br><br>**Riccarton Rotary Club** – Member<br><br>**The Canterbury Club** – Member |
| **Jan Edwards** | **Age Concern Canterbury** – Member<br><br>**Anglican Care** – Volunteer<br><br>**Neurological Foundation of NZ** - Member |
| **James Gough**<br>Board Member | **Amyes Road Limited** – Shareholder<br>Formally Gough Group/Gough Holdings Limited. Currently liquidating.<br><br>**Christchurch City Council** – Councillor<br>Local Territorial Authority. Includes appointment to Fendalton/Waimairi/ Harewood Community Board<br><br>**Christchurch City Holdings Limited (*CCHL*)** – Director<br>Holds and manages the Council's commercial interest in subsidiary companies.<br><br>**Civic Building Limited** – Chairman<br>Council Property Interests, JV with Ngai Tahu Property Limited. |

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| | **Gough Corporation Holdings Limited** – Director/Shareholder<br>Holdings company.<br><br>**Gough Property Corporation Limited** – Director/Shareholder<br>Manages property interests.<br><br>**Medical Kiwi Limited** – Independent Director<br>Research and distribution company of medicinal cannabis and other health related products.<br><br>**The Antony Gough Trust** – Trustee<br>Trust for Antony Thomas Gough<br><br>**The Russley Village Limited** – Shareholder<br>Retirement Village. Via the Antony Gough Trust<br><br>**The Terrace Car Park Limited** – (Alternate) Director<br>Property company – manages The Terrace car park<br><br>**The Terrace Christchurch Limited** – Director<br>Property company – manages The Terrace<br><br>**The Terrace On Avon Limited** – (Alternate) Director<br>Property company – manages The Terrace on Avon |
| **Jo Kane**<br>Board Member | **Christchurch Resettlement Services** - Member<br>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.<br><br>**HurriKane Consulting** – Project Management Partner/Consultant<br>A private consultancy in management, communication and project management. Any conflicts of interest that arise will be disclosed/advised.<br><br>**Latimer Community Housing Trust** – Project Manager<br>Delivers social housing in Christchurch for the vulnerable and elderly in the community.<br><br>**NZ Royal Humane Society** – Director<br>Provides an awards system for acts of bravery in New Zealand. It is not anticipated any conflicts of interest will arise. |
| **Dr Rochelle Phipps** | **Accident Compensation Corporation** – Medical Advisor<br>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.<br><br>**OraTaiao: New Zealand Climate & Health Council** – Founding Executive Board Member (no longer on executive)<br>The Council is a not-for-profit, politically non-partisan incorporated society and comprises health professionals in Aotearoa/New Zealand concerned with:<br>• the negative impacts of climate change on health;<br>• the health gains possible through strong, health-centred climate action;<br>• highlighting the impacts of climate change on those who already experience disadvantage or ill health (equity impacts); and<br>• reducing the health sector's contribution to climate change. |

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| | **Royal New Zealand College of General Practitioners** – Christchurch Fellow and Former Board Member<br>The RNZCGP is the professional body and postgraduate educational institute for general practitioners. |
| **Ingrid Taylor**<br>Board Member | **Loyal Canterbury Lodge (*LCL*) – Manchester Unity** – Trustee<br>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.<br><br>**Manchester Unity Welfare Homes Trust Board (*MUWHTB*)** – Trustee<br>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.<br><br>**Sir John and Ann Hansen's Family Trust** – Independent Trustee.<br><br>**Taylor Shaw** – Partner<br>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.<br><br>**The Youth Hub** – Trustee<br>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**<br>Manawhenua | **Canterbury Clinical Network (CCN) Maori Caucus** - Member<br><br>**Canterbury District Health Board** - Daughter employed as registered nurse.<br><br>**Christchurch PHO Ltd** – Director<br><br>**Christchurch PHO Trust** - Trustee<br><br>**Manawhenua ki Waitaha** – Board Member and Chair<br><br>**Oranga Tamariki – Iwi and Maori** – Senior Advisor<br><br>**Papakainga Hauora Komiti – Te Ngai Tuahuriri** – Co-Chair |
| **Sir John Hansen**<br>**Ex-Officio – HAC**<br>Chair CDHB | **Bone Marrow Cancer Trust** – Trustee<br><br>**Brackenridge Services Limited** - Director<br><br>**Canterbury Cricket Trust** - Member<br><br>**Christchurch Casino Charitable Trust** - Trustee<br><br>**Court of Appeal, Solomon Islands, Samoa and Vanuatu**<br><br>**Dot Kiwi** – Director and Shareholder |

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| | **Judicial Control Authority (*JCA*) for Racing** – Appeals Tribunal Member<br>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.<br><br>**Rulings Panel Gas Industry Co Ltd**<br><br>**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**<br>**Ex-Officio – HAC**<br>Deputy Chair, CDHB | **Pegasus Health Limited** – Sister and Daughter are Directors<br>Primary Health Organisation (*PHO*).<br><br>**Rawa Hohepa Limited** – Director<br>Family property company<br><br>**Sumner Health Centre** – Daughter is a General Practitioner (*GP*)<br>Doctor's clinic.<br><br>**Te Kura Taka Pini Limited** – General Manager<br><br>**The Royal New Zealand College of GPs** – Sister is an "appointed independent Director" College of GPs.<br><br>**Three Waters Governance Working Party** – Member<br>A Crown appointed taskforce of Mayors and iwi representatives to recommend a governance framework for the four proposed new Water Services Entities.<br><br>**Upoko Rawiri Te Maire Tau of Ngai Tuahuriri** - Husband |

**MINUTES – PUBLIC**

Canterbury District Health Board
Te Poari Hauora ō Waitaha

**DRAFT**
**MINUTES OF THE HOSPITAL ADVISORY COMMITTEE MEETING**
**held via Zoom**
**on Thursday, 3 February 2022, commencing at 9.00am**

## PRESENT
Naomi Marshall (Deputy Chair); Catherine Chu; Jan Edwards; James Gough; Jo Kane; Dr Rochelle Phipps; Ingrid Taylor; and Sir John Hansen (Ex-Officio).

## APOLOGIES
Apologies for absence were received and accepted from Andrew Dickerson; and Barry Bragg.
Apologies for early departure were received and accepted from James Gough (9.40am); and Catherine Chu (10.20am).
An apology for absence during the meeting was received and accepted from Sir John Hansen (9.30am to 9.45am).

## EXECUTIVE SUPPORT
Norma Campbell (Executive Director, Midwifery & Maternity Services); Dr Jacqui Lunday-Johnstone (Executive Director, Allied Health, Scientific & Technical); Dr Helen Skinner (Chief Medical Officer); and Anna Craw (Board Secretariat – Minute Taker).

## APOLOGIES
Dr Peter Bramley, Chief Executive; Becky Hickmott, Executive Director of Nursing; and Pauline Clark, General Manager, Medical/Surgical; Women's & Children's Health; & Orthopaedics.

## IN ATTENDANCE
Gloria Crossley, Interim General Manager, Laboratories
Dr Greg Hamilton, General Manager, Specialist Mental Health Services
Ralph La Salle, Senior Manager, Specialist Services & Non-Clinical Support
Allan Katzef, Finance Manager, Christchurch Campus
Kate Lopez, Acting General Manager, Older Persons Health & Rehabilitation
Berni Marra, General Manager, Rural Health Services

Naomi Marshall opened the meeting, welcoming those in attendance. Ms Marshall acknowledged the work to date of management and staff in preparedness for Omicron in the community.

## 1. INTEREST REGISTER

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

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

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

## 2. CONFIRMATION OF PREVIOUS MEETING MINUTES

**Resolution (01/22)**
(Moved: Naomi Marshall/Seconded: Jan Edwards – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 7 October 2021 be approved and adopted as a true and correct record."

## 3. CARRIED FORWARD / ACTION ITEMS

There were no carried forward / action items.

## 4. H&SS MONITORING REPORT

The Committee considered the Hospital and Specialist Services Monitoring Report for January 2022. The report was taken as read.

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

**Medical/Surgical; & Women's & Children's Health; & Orthopaedics – Allan Katzef, Finance Manager, Christchurch Campus**

- Pressure on the system is huge with staff absences and vacancies in a lot of areas, particularly in nursing. High sick leave over the Xmas/New Year period, which was a struggle to backfill.
- High numbers of ED attendances and acute presentations.
- Have had to defer some elective surgery. Almost caught up with cancelled surgery and outpatient appointments from August to October 2021. The team has done an incredible job to pull this back.

A member queried the plan for delivery of health services (business as usual and planned care) outside of Omicron. Dr Helen Skinner, Chief Medical Officer, advised there are multiple plans around a number of services that are under pressure, however, she stressed that all plans will be challenged as we move into Omicron.

The Committee requested an update be provided to the February Board meeting, providing transparency around system pressure points, plans in place to address these, and management of planned care wait times during the Omicron outbreak.

In response to a query about CDHB supporting Southern DHB neurosurgery elective cases, Ralph La Salle, Senior Manager, Specialist Services & Non-Clinical Support, confirmed that Southern DHB is covering the cost of what it takes to provide neurosurgery in Southern and anything CDHB does for Southern domiciled patients, Southern DHB is covering the cost.

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

- Demand – seasonal variation, with quite a significant drop off over the Xmas period. Staff go on holiday, but also consumers get different levels of support from their own community and families over the Xmas period.
- Changes in demand with COVID. Have had significant increases in three areas in particular:
  - Alcohol and Drug
  - CAF
  - Eating Disorders

  Both CAF and Eating Disorders, services amongst young people, are where there has been significant COVID growth, part of a worldwide phenomenon.

- Have had less growth in adults compared to other parts of NZ. This may be due to the Canterbury population having a history of dealing with difficult issues and disasters for an extended period of time.
- CAF volumes – there has been a decrease in the wait time for first face to face appointments.
- Staffing is a challenge. Each day we try to fill around 25 gaps in the roster, invariably through a range of mechanisms such as pool and agency staff, both of which dry up in January as people take holidays. Rely on filling gaps with the use of Allied Health Staff and also through overtime.
- The short staffing situation has been a long time in the making. NZ is the number one importer of overseas trained nurses, but none have come into SMHS since COVID. In addition, there are also a number of things that staff have left the service to do – for example: vaccination, testing, and other COVID work, as well as some of the community elements that have started, such as Te Tumu Waiora in primary care.

There was discussion around the presentation format for CAF data.

*Sir John Hansen left the meeting at 9.30am.*

A member queried how much the short staffing in SMHS has cost, over what it would cost if it was fully staffed. Dr Hamilton advised that the overtime spend for SMHS staff for the previous six months of the financial year (July to December 2021) was just under $2M. The member commented that it would be useful to have this data included in the report, so as to better understand the extent of the issue.

In response to a query around temporary capping of bed numbers to ensure safe environments for staff, Dr Hamilton advised of the following temporary soft caps on bed numbers:

- Psychiatric Services for Adults with an Intellectual Disability (*PSAID*). Capped at six, due to a reduction in demand over a number of years. Was previously ten.
- Te Whare Manaaki – medium secure acute forensic mental health service. Fifteen (15) beds, but is capped at 12. Probably the highest risk area in terms of access to services. The team has changed how it operates with a greater focus on flow through the system. We are moving people through from that service into a rehabilitation service more quickly to create some of the space. The risk sits with people potentially being in Corrections, needing our services, but not having access to a bed. That has always been a tension point, but that tension has got higher.

In response to a query, Dr Hamilton advised that the piece of work being taken control of is the "staffing mix". We will not get a whole lot of new Registered Nurses (*RNs*). He noted that whilst RNs are needed, and they need to be experienced so that they can direct and delegate, the mix of staff with both allied health and health care assistants is where the opportunity is.

*James Gough left the meeting at 9.40am.*

**Older Persons Health & Rehabilitation (*OPH&R*) Service – Kate Lopez, Acting General Manager**

- Significant focus on planning and contingency for Omicron.
- Workforce challenges across services - across both Burwood campus and the community components of the services. This is most notably in nursing.
- Care Capacity Demand Management Programme. A recent development is the early implementation of an ability for the nursing leadership team to manage and monitor nursing capacity versus patient demand at a glance. A new dashboard is being implemented and will support the team's ability to read the hospital at a glance and

understand what clinical areas are needing the support from a nursing resource perspective. Up until now this has been quite a manual process, so this is a positive step forward.

- Currently carrying 16 FTE vacancies from a nursing perspective.
- Recently taken on a number of new graduates.
- Kowhai Programme is providing potential to support the clinical areas. To date, in the first month of the programme, 100 hours have been contributed. The programme is receiving fantastic feedback and will be a critical resource going forward over the next couple of months.

*Sir John Hansen rejoined the meeting at 9.45am.*

Discussion took place around access to Dementia Hospital Level Care Facilities.

In response to a query about length of stay barriers and work to prevent hospital admission in the first place, Ms Lopez advised that while focus is on physical hospital beds, a fundamental part is to support people to remain in their own homes and to avoid admission. There is a lot of work going on in this space and will continue to be an area of focus, particularly as we go into the next few months, noting the hospital pressures we will be under.

Discussion took place about Aged Residential Care (*ARC*) in the Omicron environment. Ms Lopez commented that there is a lot of dialogue happening in this space, both at a regional and national level. Conversations are underway to agree a screening tool and framework for decision making. Strict protocols will be in place with regards to clinical assessment criteria, epidemiological assessment criteria, as well as stringent criteria as to when a test may or may not be required.

**Hospital Laboratories – Gloria Crossley, Interim General Manager, Laboratories**

- Acknowledged the efforts of the workforce.
- Projects running around the Laboratory space include:
  - The tearoom being moved to create room for a high volume molecular space, to better utilise what we have in the way of equipment. It will also be more secure for staff.
  - Stairwell 4 replacement, which is starting today.
  - The Ngāi Tahu carpark, which will begin soon.
- High volume chemistry instruments are largely in place. Working through some teething problems.
- Have a number of staff vacancies.
- Acknowledged the specific nature of the workforce and the need to work collaboratively with alliance partners.

**Rural Health Services – Berni Marra, General Manager, Rural Health Services**

- Now covering two primary health centres (Kaikoura and Chatham Islands), rural ARC services, Ashburton acute and inpatient space, and work in the Ashburton community.
- Pressure on dementia level care.
- Workforce challenges. Working strongly as a team around doing things differently. The ability to flex and focus is a strength in rural. Focusing on opportunities.
- Acute and inpatient flow remains busy, but admission rates are consistently dropping or remaining steady.

Discussion took place around the generalist nursing model introduced at Ashburton.

In response to a query around the increase in sick leave in rural areas, Ms Marra advised that rural has a proportionally older workforce. It is important to look at every opportunity to restrengthen, to share resources, and to work in a different way.

Ms Marra commented that she is working with Planning & Funding on equity of access for primary health care in Ashburton. There needs to be strong, resilient, primary care, so that people have access to care consistently, and that the acute space is for acute and not just a type of care that you get because you cannot get into primary care.

There was a request for additional information on people accessing services in the fast growing areas of Ashburton, Selwyn and Waimakariri.

The H&SS Monitoring report was noted.

## 5. OFFICE OF THE CLINICAL EXECUTIVE UPDATE

Norma Campbell, Executive Director, Midwifery & Maternity Services; Dr Jacqui Lunday-Johnstone, Executive Director, Allied Health, Scientific & Technical; and Dr Helen Skinner, Chief Medical Officer; presented the report. The following points were highlighted:

- Themes around models of care, sustainability, and the multi-disciplinary workforce.
- Working with clinical executive around an Emergency Clinical Governance Framework, so that when we are in this state of emergency we do not take our eye off the ball; we keep an eye on who is accessing services; that our most vulnerable are accessing; that we have metrics that we can look at each week to see that all the changes we are making are not disadvantaging anybody; and that when there is capacity that we are making sure that services are continuing.
- The clinical executive are working within their respective areas and across the whole system, ensuring they have full oversight of what everybody is up to and using opportunities that present themselves to look at doing things differently.
- A lot of work is happening around flow, particularly on Christchurch campus. Whilst Omicron is taking a huge amount of planning, it has galvanised the team to look at different ways of working. There is a huge amount of work here, but also a real opportunity for those models of care that we have been making inroads in, to move faster.

The Clinical Advisor Update was noted.

## 6. RESOLUTION TO EXCLUDE THE PUBLIC

**Resolution (02/22)**
(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 7 October 2021 | For the reasons set out in the previous Committee agenda. | |
| 2. | CEO Update *(if required)* | Protect information which is subject to an obligation of confidence.<br>To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).<br>Maintain legal professional privilege. | s 9(2)(ba)(i)<br><br>s 9(2)(j)<br><br>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."

*Catherine Chu left the meeting at 10.20am.*

## INFORMATION ITEMS

- 2022 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 10.20am.

Approved and adopted as a true and correct record:

_____ _____

Andrew Dickerson
Chairperson

Date of approval

# CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

## HOSPITAL ADVISORY COMMITTEE
## CARRIED FORWARD ITEMS AS AT 2 JUNE 2022

| DATE RAISED | ACTION | REFERRED TO | STATUS |
|---|---|---|---|

**There are no carried forward / action items**

# H&SS MONITORING REPORT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

**DATE:** **2 June 2022**

| Report Status – For: | Decision ☐ | Noting ☑ | Information ☐ |
|---|---|---|---|

## 1. ORIGIN OF THE REPORT

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

## 2. RECOMMENDATION

That the Committee:

i. notes the Hospital Advisory Committee Activity Report.

## 3. APPENDICES

Appendix 1: Hospital Advisory Committee Activity Report –May 2022

# Hospital Advisory Committee

# Hospital Activity Report

## May 2022

Based on the CDHB Outcomes Framework and Five Focus areas plus Specialist Mental Health and Canterbury Health Laboratories

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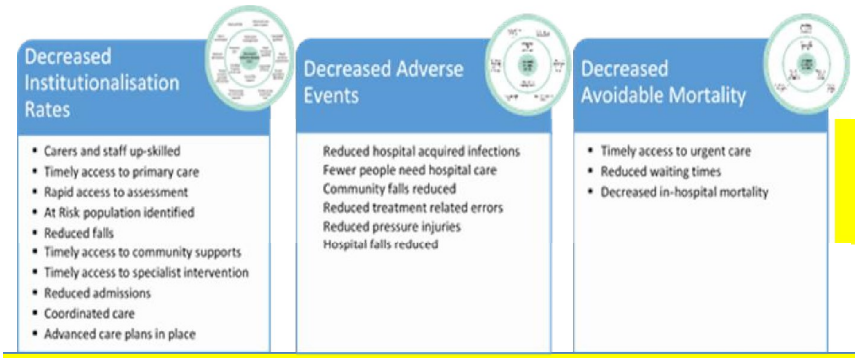
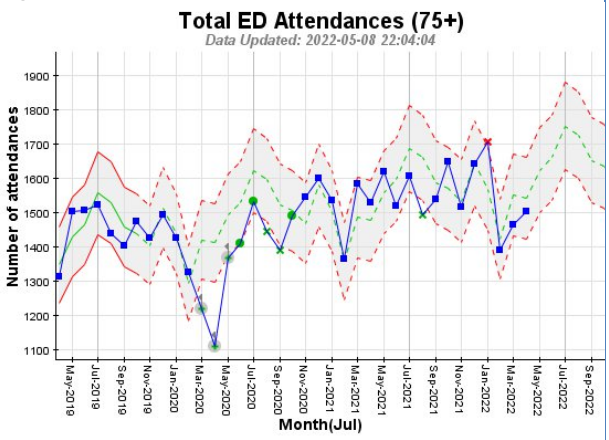


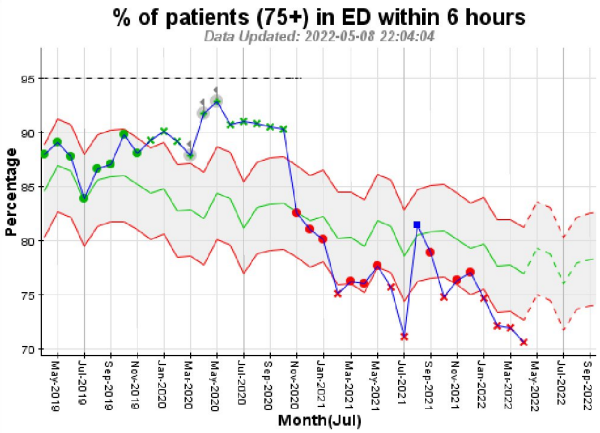

## *Outcome and Strategy Indicators*

*Figure 1.1*



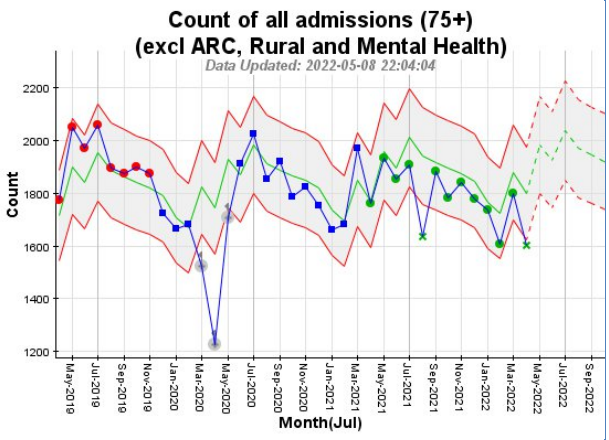

COVID 19 Alert Level restrictions led to a reduced number of ED attendances by people over 75 years throughout 2020 and in August 2021. The number of attendances has otherwise been increasing and within the forecast range although the recent Omicron outbreak suppressed activity in the community and ED presentations.

*Figure1.2*



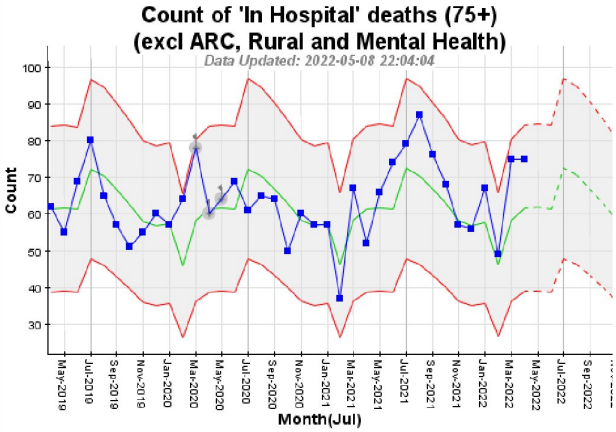

The additional processes required to assess for COVID-19 have affected the time that people spend in the department between February and April 2022.

*Figure 1.3*



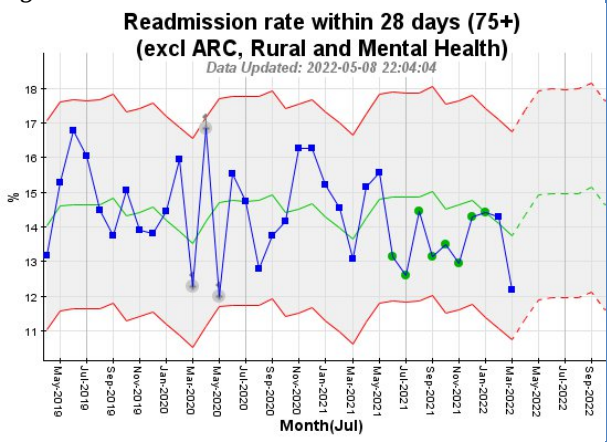

The number of older people admitted has reduced compared with the forecast values. All months since March 2021 have had less admissions less than the mid-point of the trend.

*Figure 1.4*



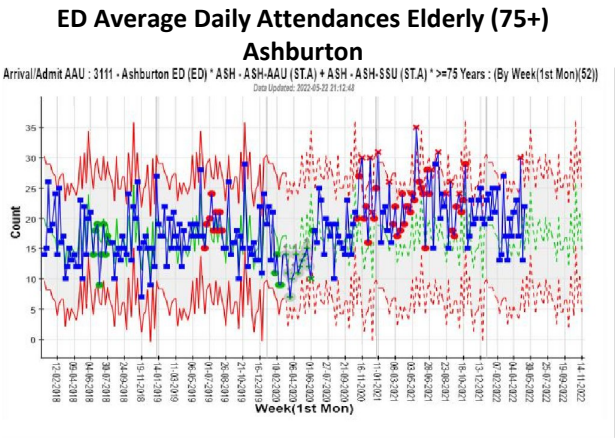

The number of in hospital deaths and mortality ratio by day of admission are within the upper extent of their forecast ranges.

*Figure 1.5*




Readmissions remain within the expected range.

*Figure 1.6*




Ashburton rate of attendances, 75+ age group, are within the expected range of forecast attendances.

*Achievements/Issues of Note*

## Older Persons Health and Rehabilitation (OPH&R)

**Supporting the wider health system – COVID19 response**

OPHR's contingency planning for and response to COVID19 took into account the likely need to provide support across the wider health system, for example aged residential care. During the course of the response to Omicron in our community, OPHR provided staff for redeployment in response to a total of 475 individual requests for staffing across the system. OPHR staff were deployed to Rapid Antigen Testing distribution centres, Community Based Assessment Centres, Te Nikau Hospital in Greymouth, Ashburton Hospital, aged residential care, Christchurch Hospital, Kaikoura, a Whanau Ora provider, CDHB Critical Services – Supply team, and primary care. These staff came from a range of roles across OPHR where activity was deprioritised to enable focus on critical areas of service delivery, or where reducing activity enabled better resilience against sickness absence, and release of staff to support other areas. We were also able to stand up and resource the Canterbury DHB's Remdesivir Clinic through this approach of deploying skilled nursing staff from other areas where activity had reduced.

**Community Dental Services**

93,783 children are enrolled with CDHB CDS for their oral health care across Canterbury and South Canterbury; with a further 100 (approx) children on the Chatham Islands. The age distribution is 38,909 preschool and 54,874 school age (to Yr8). From January 2022 as it became apparent that non-essential Community Dental Services would be suspended as part of the Canterbury DHB's response to Omicron in our community, planning began in order to mitigate the impact of the suspension of services on children.

From the beginning of Term 1 service delivery was primarily focused on treating children with identified oral health issues, rather than screening. Priority was given to children requiring treatment on permanent teeth and children living in high deprivation areas, given the latter historically have a higher caries risk. In addition, changes in how parents were notified of appointments were made at the Contact Centre and this reduced the number of non-attendances at booked appointments. The aim was to reduce the need for Relief of Pain clinics and the likely future demand for sedation and hospital dental services. Service delivery continued like this until the cessation of all non-essential CDS services on 10 March 2022.

Implementing this plan significantly reduced the number of children awaiting treatment. While operating only essential services, Triaging, and Relief of Pain clinics, this activity was focussed in low deprivation areas to provide better access for children and care givers who were more likely to have issues with transport.

In line with the CDHB's 'de-escalation plan', the service resumed 'business as usual' and redeployments from CDS across the system ceased for the beginning of Term 2 – May 2nd. Staff placements have since been increased in priority areas with the highest screening and treatment arrears, and we have commenced extended clinic hours through seeking expressions of interest for staff in working additional hours at different work times for a fixed period of time, with the aim of reducing screening and treatment arrears.

Children overdue for dental examinations (CDHB and SCDHB combined)

| | May-22 | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | # Enrolled | Screening Arrears | % Screening Arrears | Treatment Arrears | % Treatment Arrears | Total Arrears | % Total Arrears | COVID Days Closed |
| Pre-school | 39,368 | 10,736 | 27.3% | 91 | 0.2% | 10,827 | 27.5% | |
| 5yrs to Yr 8 | 55,049 | 16,986 | 30.9% | 1,048 | 1.9% | 18,034 | 32.8% | |
| **Arrears** | 94,417 | 27,722 | 29.4% | 1,139 | 1.2% | | | |
| **Total Arrears** | **94,417** | | | | | **28,861** | **30.6%** | **25 days** |

*(SOURCE: Titanium)*

Children overdue for dental examinations are referred to as being in "arrears" by the Community Dental Service. The most overdue for screening is currently 10 months; with the exception of children who have failed to attend. Some children despite multiple attempts (up to 8) to confirm treatment appointments have failed to attend, with the longest wait time from screening to treatment being 12 months. Changes to clinic hours should better facilitate access to treatment, and the service is confident that through working differently, and given the previous success in reducing arrears in 2021, children overdue for dental examinations will be reduced to 10% by the end of the 2022 school year.

Kowhai Programme

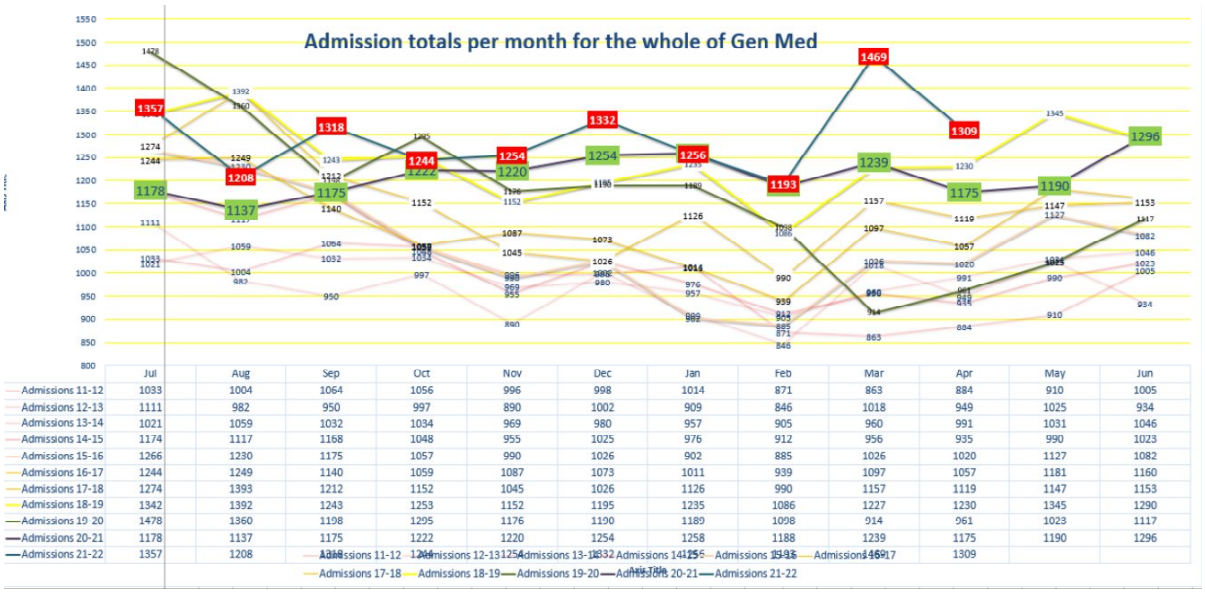
As previously reported, Older Persons Health and Rehabilitation were successful in applying for Ministry of Health DHB Sustainability Funding in late 2020, to support development and implementation of the Kōwhai Programme within OPH&R. The Kōwhai Programme is based on the 'Dementia and Delirium Care with Volunteers Programme', developed by the New South Wales Institute of Clinical Innovation, and aims to address the challenge of providing safe and compassionate support for patients with cognitive impairment in the inpatient environment, through implementation of a trained volunteer programme to provide meaningful engagement through a person-centred approach.

There was initial concern that the Kōwhai Programme might be disrupted by the response to Omicron in our community, changes in alert levels and our hospitals' response. However with visitor restrictions in place the Kōwhai Companions played a vital role in the COVID response at Burwood Hospital. Provision of one on one companionship for our more vulnerable patients when their whānau were not able to be there proved to be beneficial not only for patients, but whānau and of course the staff. From January to beginning of May the Kōwhai Companions provided 437 hours of one on one time for 72 different patients across all Older Persons Health wards.

Feedback from Kowhai Companions, patients, whānau, and staff is currently being collated as part of a three month review since going live, but the below feedback from a staff member is indicative of the general themes of staff feedback - improvement in mood and engagement, increased food and fluid intake, patients more settled and less anxious.

*"My patient this week was feeling tearful and missing time from her home and her family. Queried whether she might be depressed or whether this is reactive to her current circumstances. Kowhai Companion was right in there playing board games and cheered her up no end. Two things were achieved by this; it improved the patient experience with some enjoyable activities, and also addressed the cause of her mood disturbance, avoiding an increase in her antidepressants which would not have helped".*

As hoped, we are also seeing a wider impact from the programme; one of our Kowhai Companions has encouraged her employers to work towards being a 'Dementia Friendly' workplace: *"After being involved with Kowhai Companions I have engaged with the Senior management team at (my workplace) and we are currently looking at our processes and how we can be better business citizens for older people including looking at becoming a 'Dementia Friendly' business."*




| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Admissions 11-12 | 1033 | 1004 | 1064 | 1056 | 996 | 998 | 1014 | 871 | 863 | 884 | 910 | 1005 |
| Admissions 12-13 | 1111 | 982 | 950 | 997 | 890 | 1002 | 909 | 846 | 1018 | 949 | 1025 | 934 |
| Admissions 13-14 | 1021 | 1059 | 1032 | 1034 | 969 | 980 | 957 | 905 | 960 | 991 | 1031 | 1046 |
| Admissions 14-15 | 1174 | 1117 | 1168 | 1048 | 955 | 1025 | 976 | 912 | 956 | 935 | 990 | 1023 |
| Admissions 15-16 | 1266 | 1230 | 1175 | 1057 | 990 | 1026 | 902 | 885 | 1026 | 1020 | 1127 | 1082 |
| Admissions 16-17 | 1244 | 1249 | 1140 | 1059 | 1087 | 1073 | 1011 | 939 | 1097 | 1057 | 1181 | 1160 |
| Admissions 17-18 | 1274 | 1393 | 1212 | 1152 | 1045 | 1026 | 1126 | 990 | 1157 | 1119 | 1147 | 1153 |
| Admissions 18-19 | 1342 | 1392 | 1243 | 1253 | 1152 | 1195 | 1235 | 1086 | 1227 | 1230 | 1345 | 1290 |
| Admissions 19 20 | 1478 | 1360 | 1198 | 1295 | 1176 | 1190 | 1189 | 1098 | 914 | 961 | 1023 | 1117 |
| Admissions 20-21 | 1178 | 1137 | 1175 | 1222 | 1220 | 1254 | 1258 | 1188 | 1239 | 1175 | 1190 | 1296 |
| Admissions 21-22 | 1357 | 1208 | | | | | | | | 1309 | | |

- The number of people being cared for by General Medicine and occupying a hospital bed has shifted from being relatively low in the first half of April to extremely high in the second half of April and opening weeks of May
- The high inpatient volumes for General Medicine more typical of the majority of winter months, along with significant absences amongst nursing staff, have combined to put pressure on the campus and resulted in the decision to continue deferring some planned procedure activity
- All staff groups within the hospital have experienced constraints as a result of staff being ill, or isolating with and/or caring for family members, with COVID-19
- Services throughout the campus have worked together to fine tune the non-acute activity able to be provided on the campus on a daily basis, recognising both staff constraints due to sick leave and the prioritised care requirements of patients. Usual settings have been suspended to ensure that capacity has been shared to enable care to be provided to the patients that most needed it on the day
- Services outside of Christchurch Hospital have also felt the effects of the outbreak with community services (including CREST) and aged residential care often experiencing constraints on their capacity to accept patients when they are otherwise ready to be discharged from Christchurch Hospital
- While this has often delayed the ability for patients to be discharged from hospital on time, length of stay for medical patients has actually been lower than typical during the last two months. This has been partially due to the relatively short time spent in hospital by most COVID-19 positive patients (less than

2 days). However, the nature of the COVID-19 positive patient group has recently shifted noticeably to an older age group who are staying longer in hospital, significantly adding to bed availability pressure.

## Christchuch Campus

**Emergency Department Resident Medical Officer staffing**

- The Emergency Department Resident Medical Officer roster has stabilised with the addition of new Resident Medical Officer capacity for leave cover and implementation of a new roster pattern
- This time last year the department was unable, 72% of the time, to fill at least one Resident Medical Officer roster shift due to leave, sickness etc. This year the days with gaps have reduced to 14 – reducing the number of days that there is insufficient medical staffing to support patient flow
- The department characterises this progress as "outstanding"

**Infection Management Service**

- It can be very daunting for a patient to be discharged with six weeks of intravenous treatment ahead of them. Anything to mitigate this anxiety is useful
- The service has received patient education booklets for patients on Baxter pumps in Te Reo, Samoan and Chinese
- Feedback from patients in this early stage has been positive.

**Cardio-Respiratory Integrated Specialist Services (CRISS)**

- The team is working to ensure that its patients are ready for winter by providing influenza vaccines and back-pocket prescriptions. These actions have been shown to reduce hospitalisation for these cohorts
- The team is also attending relevant ward-based board meetings to support patients within its care to be discharged in a timely and safe manner.

**Allied Health Patient Flow Coordinators**

- A Physiotherapist and a Social Worker have been seconded as Allied Health Patient Flow Coordinators to contribute to patient flow initiatives at the Christchurch Hospital Campus
- The aim of these roles is to provide senior leadership to improve:
  - Efficient use of Allied Health resources with interdisciplinary ways of working
  - Consistency at ward board meetings to facilitate flow
  - Identification and utilisation of clinical criteria for discharge
  - Work towards solutions of barriers to discharge and patient flow in General Medicine.
- The key aims of the project are to:
  - Improve responsiveness of Allied Health to assessment and readiness for discharge
  - Reduce or eliminate the need for patients who are medically ready for discharge to wait for Allied Health input before discharge
  - Reduce length of stay
  - Improve documentation of clinical criteria for discharge and discharge summary advice.

**Strengthening Allied Health Decision Making at Front of House**

- The Ministry of Health has funded 1.4 full time equivalent 7- day Expert Occupational Therapists, 0.5 full time equivalent Hauora Māori for weekend cover and 1.4 full time equivalent Patient Flow Coordinator 7-day role
- Within three months of this pilot the project has been able to demonstrate that 65% of frail and elderly have been discharged due to having a dedicated Occupational Therapist resource based in the Emergency Department
- A dashboard has been developed with key data on the demographic, age and ethnicity of the patients. The Occupational Therapist is working at top of scope with an interdisciplinary approach with other Allied Health professionals.

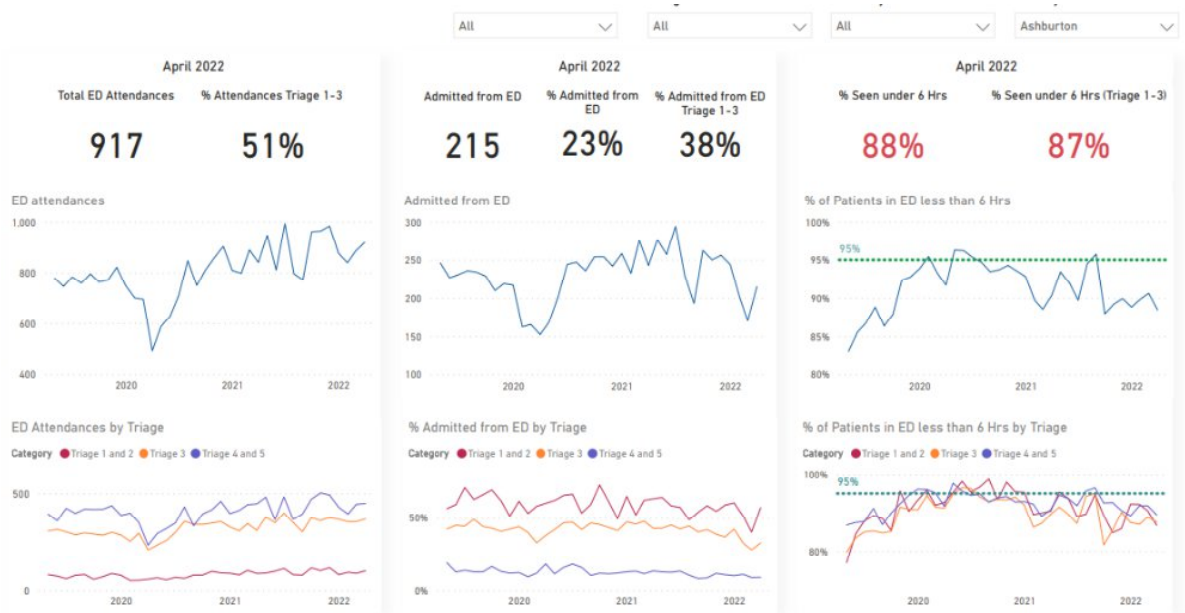
**Relocating Respiratory Physiotherapy outpatient activity**

- A project is underway with the primary goal of providing 70% of respiratory physiotherapy activity outside of a hospital setting
- This objective remains achievable though has been delayed due to staffing challenges, COVID-19 disruptions and subsequent facilities access
- Currently 40% of clinics are running off-site with 38% of appointments now offered in the community. This will increase to 55% of clinics by mid May 2022
- An additional facility is being sought to bring this up to the 70% target in the next three months
- Preliminary data demonstrate that the rate of non-attendance is approximately 35% lower in community clinics compared to hospital-based clinics
- Break-down of attendance by ethnicity is not yet available
- Initial patient reports have identified several patients attending community clinics who were unable or unwilling to access hospital-based clinics. A patient feedback survey is underway to identify further development of the model. Early feedback identifies easier location access, ease of parking, reduced transit time through facility and reduced exposure risk as the key highlights from the patient perspective.

## Ashburton Acute and Inpatient

The presentation and admission trend through the Acute Assessment Unit in Ashburton has been variable in numbers per day over recent months, but a consistent theme of low admission rate and high self-presentations. The facility has been operating with a merged single ward, operating with a 30-bed ward to enable a consolidated focus of both Nursing and Allied Health workforce.

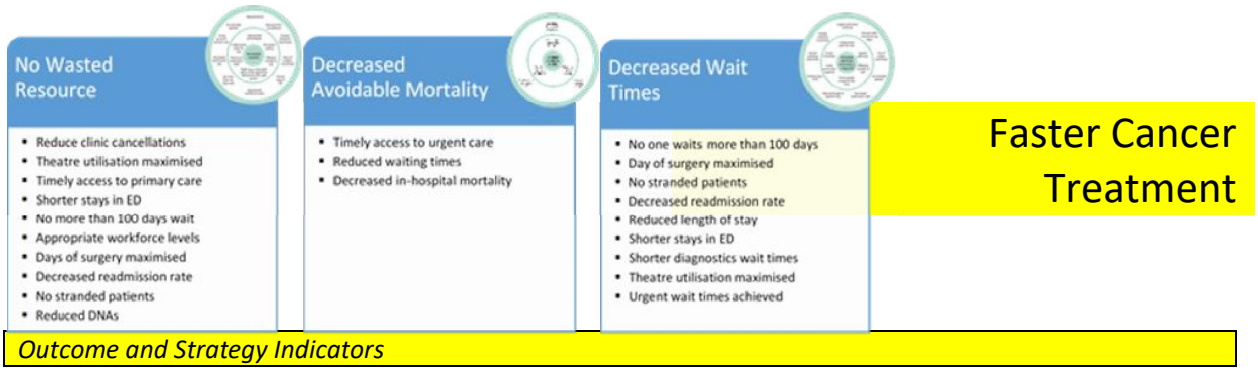
Whilst sickness continues to provide challenges in shift cover, this mitigation approach has enabled us to operate with minimal disruption and very few requests to the ECC staffing pool.




The graphs above demonstrate the dispersion of presentations by triage, highlighting that Triage 4 &5 continue to be the majority cohort presenting, but remain low in admission to the facility. Further work with the Hauora Hub and Health NZ frameworks reviewing After Hours care in rural communities will enable the team to focus on areas that reduce further the risk of admission, especially for our older population.

AAU and Inpatients is the single area focused on the Hospital/specialist service delivery, as reported through CDHB. The remaining areas of focus for the Rural Division have been focused on the primary and community service models distributed across the diverse geographic area from Kaikoura, Hurunui,

Waimakariri, Selwyn and Ashburton. A core focus during this period is how we can design and improve care in these local communities and enable our most vulnerable community members to remain in their home and reduce risk of admission. This will align with the Health NZ direction towards localities, with an adoption of rural community health hubs and collation of services with a Primary Community and Rural lens.




*Outcome and Strategy Indicators*

## Key Outcomes - Faster Cancer Treatment Targets (FCT)

Criteria for inclusion in the FCT measures include that the patient must be eligible for treatment in New Zealand for a new primary cancer i.e. not a recurrence or metastasis from a previously reported cancer, be 16 or older and have started their treatment in the public system.

Approximately two thirds of patients have surgery as their first treatment with approximately a quarter having radiation therapy and/or chemotherapy as their first treatment.

**62 Days Target.** This target measures the proportion of people who are referred with a high suspicion of cancer that receive their first treatment within 62 days.

In the three months to the end of April 2022 there were 159 records submitted by Canterbury District Health Board – slightly down on the 162 reported for the three months to the end of February.

Records of all patients whose treatment did not start within 62 days are reviewed and given a code reflecting the dominant reason for treatment delay. Canterbury District Health Board also does this for patients whose treatment did not meet the 31 days measure, although this is not required by the Ministry. The codes are:

1. Patient choice: e.g. the patient requested a delay until after a vacation or to have more time to consider options
2. Clinical considerations: includes delays due to extra tests being required for a definitive diagnosis, or where a patient has significant co-morbidities that need to be addressed before the start of their treatment. The delay, in these cases, is considered to be in the patient's best clinical interests
3. Capacity: this covers all other delays such as lack of theatre space, unavailability of key staff or process issues.

When calculating performance against this measure patient data where the 62 days target was missed through patient choice or for clinical considerations are excluded. Patients whose treatment was delayed through capacity, process issues or any other reason *are* included in compliance calculations.

Of the 32 patients whose treatment wasn't started within 62 days, 15 were due to patient choice or for clinical reasons and are therefore excluded by the Ministry in compliance calculations.

The remaining 17 patients where Canterbury District Health Board did not meet the 62 days target are included in compliance calculations. On this basis, 127 out of 144 eligible patients started their treatment within 62 days of referral - the compliance rate was 88.2 % meaning Canterbury District Health Board **did not meet** the 90% target.

The effects of COVID on the Canterbury District Health Board workforce likely contributed to this result. It is more than likely, however, that the CDHB's compliance percentage will change once the remaining patients who were treated in April are coded.


## 31 Days Performance Measure

The 31 days measure refers to the time from when a decision to treat is agreed between the patient and their clinician to provision of the first treatment.

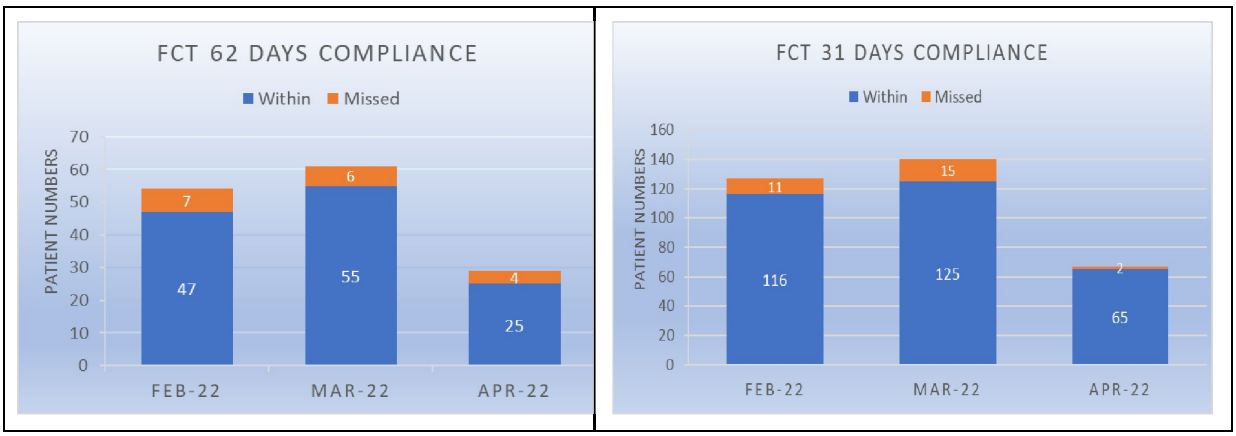
Canterbury District Health Board submitted 334 records in this three month period, down from 356 reported for the three months to the end of February. All patients whose treatment missed the 31 days target are included in the compliance calculation, there are no exceptions made for patient choice or clinical considerations. The threshold applied is 85%.

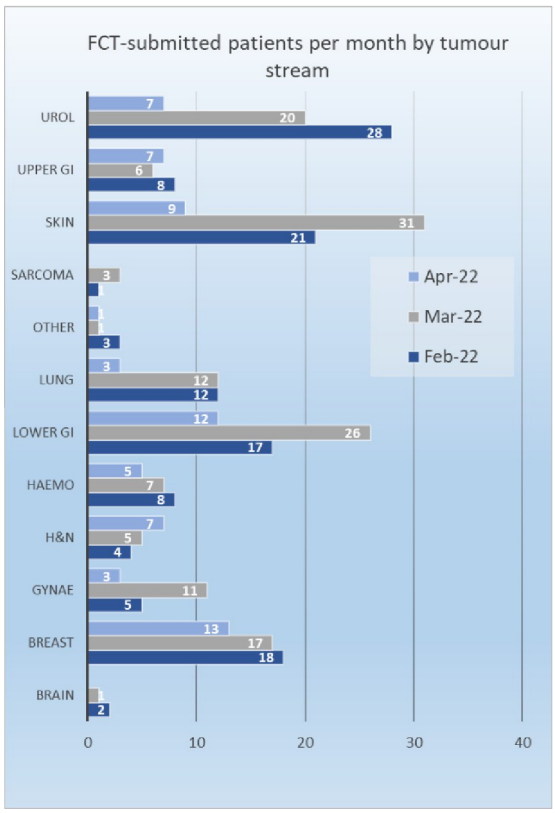
Canterbury District Health Board did not start treatment within 31 days for 28 patients out of the total of 334. For 18 of the 28 patients the target was missed by five days or less. Three patients were delayed for clinical reasons and one because the patient requested a delay.

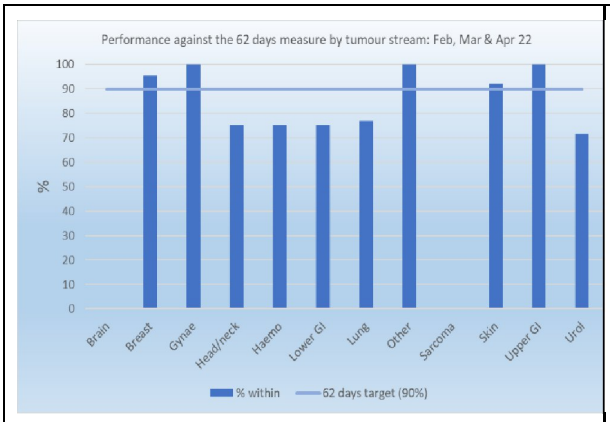
With 306 of the 334 (91.6%) eligible patients receiving their first treatment within 31 days from a decision to treat Canterbury District Health Board again met the 85% target.

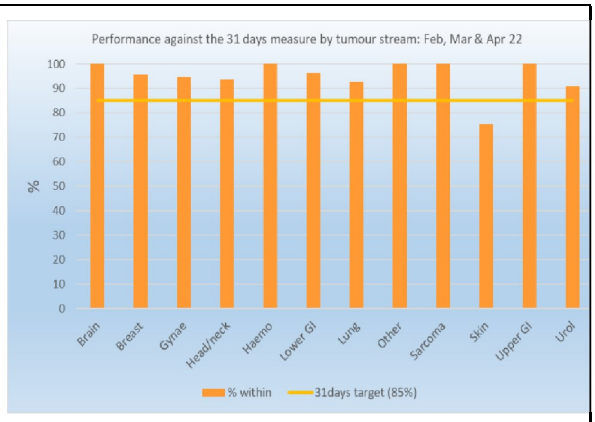
## FCT performance in CDHB

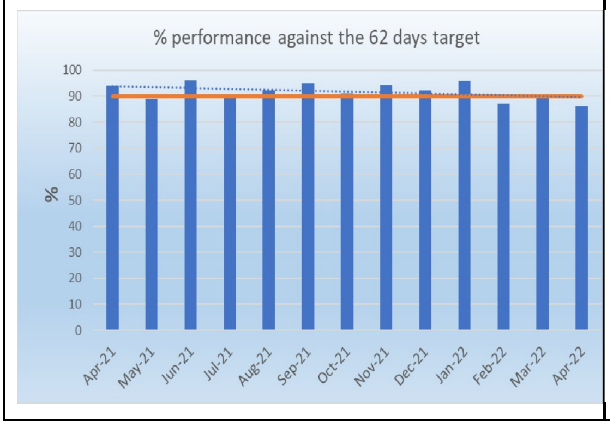
There is usually a dip in numbers in the last month reported which reflects the timing of when the report is compiled: this is governed by the reporting requirements of the Ministry. A significant number of the patients who have a first treatment date in the period each report covers will be awaiting coding and will be picked up in the following month's data extract.

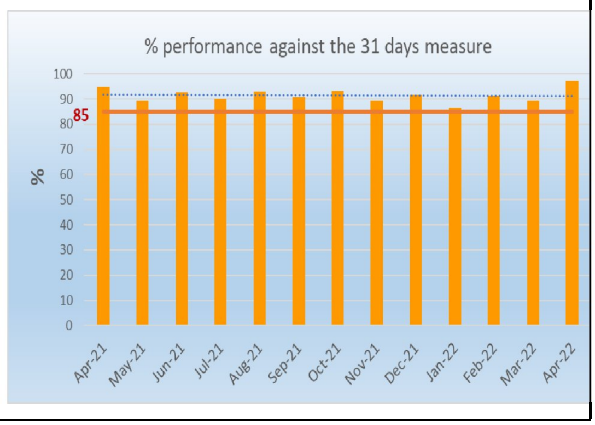



FCT-submitted patients per month by tumour stream
UROL
UPPER GI
SKIN
SARCOMA
OTHER
LUNG
LOWER GI
HAEMO
H&N
GYNAE
BREAST
BRAIN
Apr-22
Mar-22
Feb-22
0
10
20
30
40


Performance against the 62 days measure by tumour stream: Feb, Mar & Apr 22
%
Brain
Breast
Gynae
Head/neck
Haemo
Lower GI
Lung
Other
Sarcoma
Skin
Upper GI
Urol
% within
62 days target (90%)

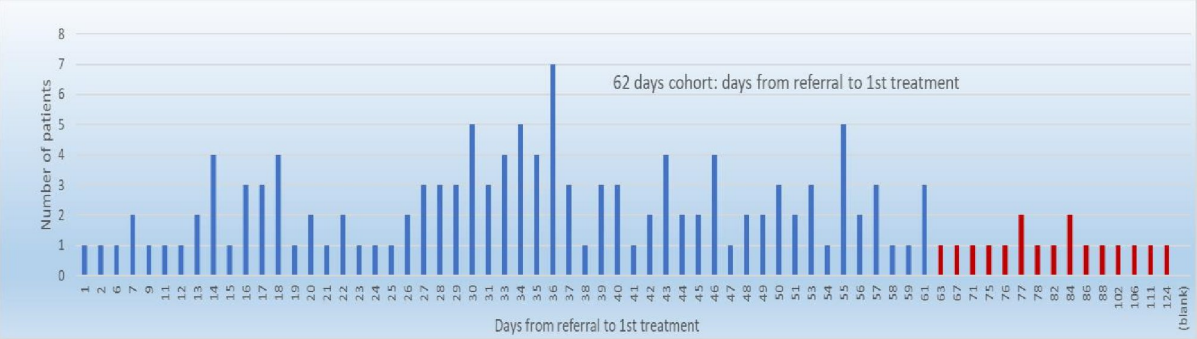

Performance against the 31 days measure by tumour stream: Feb, Mar & Apr 22
%
Brain
Breast
Gynae
Head/neck
Haemo
Lower GI
Lung
Other
Sarcoma
Skin
Upper GI
Urol
% within
31days target (85%)


% performance against the 62 days target
%
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22


% performance against the 31 days measure
85
%
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22

## Reviewing FCT performance

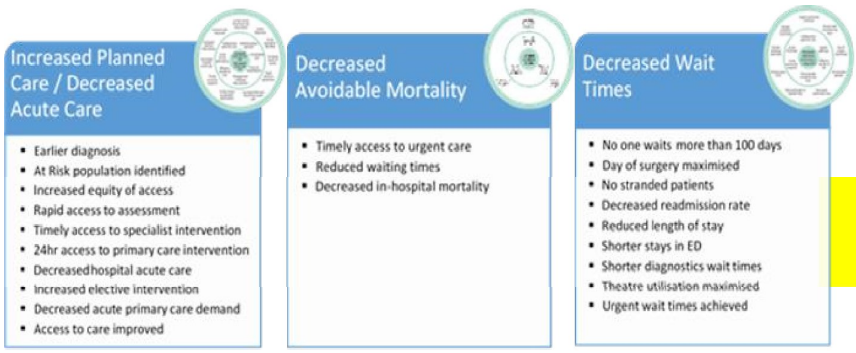
Each patient whose treatment did not meet either of both the 62 or 31 days targets is reviewed to see why. This is necessary in order to determine and assign a delay code, but where the delay seems unduly long a more in-depth check is performed. These cases are usually discussed with the relevant tumour stream Service Manager(s) to check whether any corrective action is required. The following graph shows the days waiting for each patient who met the 62 days criteria.




*Achievements/Issues of Note*

**Gastroenterology**

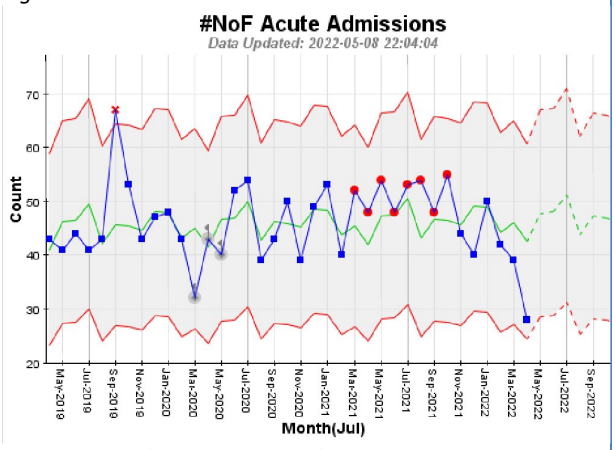
- The service has been managing a number of constraints throughout the period of the Omicron outbreak that have affected the number of gastroscopies and colonoscopies provided to patients
- Despite a severe shortage of reprocessing chemicals for seven weeks, the endoscopy unit continued to operate at 75% of normal capacity by using a Medivator reprocessing machine in ENT outpatients
  Since reprocessing chemicals arrived on 29th April, the endoscopy unit has returned to usual procedural numbers. Despite the chemical shortage the waitlist only increased by 200 patients during this timeframe
- There have been moderate issues with COVID sickness in both nursing and medical staff and these continue. These were responded to by team members being agile about their duties on any particular day
- Casual Senior Medical Officer capacity has been used to back fill planned leave
- Cancellations on the day of or the day before the procedure have been higher than usual as patients become infected or are caring for someone who is ill with COVID-19. The department is factoring in patient cancellation in patient booking to optimise use of capacity
- The service has also increased the number of patients and the age range of patients outsourced each week
- There are more symptomatic patients being outsourced to mitigate the clinical risk of missing a cancer
- Some routine patients are now being outsourced to South Canterbury District Health Board, (one endoscopy list per week)
- There have been several nursing resignations recently and the service is in the recruitment process.
- Transcription has been bought up to date with support from the General Surgery and Haematology teams
- Computed Tomography is looking to support the Gastroenterology waiting list reduction initiative, using faecal immunochemical testing (FIT) to identify low risk people to direct to computerised tomography colonography instead of staying in an endoscopy queue.




# Enhanced Recovery After Surgery (ERAS)

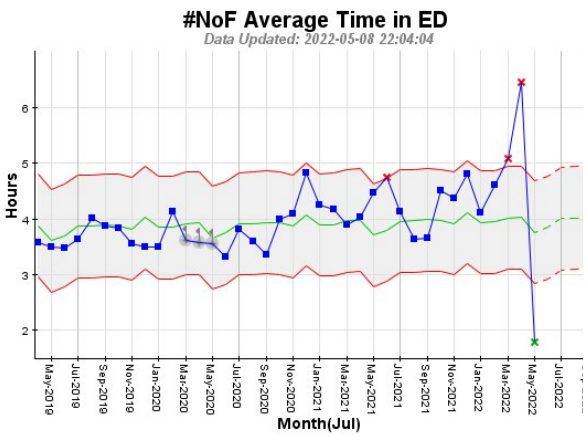
## *Outcome and Strategy Indicators – Fractured Neck of Femur (#NoF)*

*Figure 3.1:*



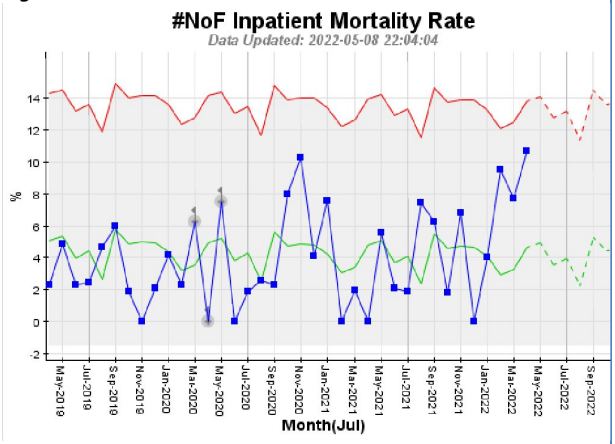

The number of admissions has fallen back to sit within the established range. The time taken to code discharges impacts the last two data points.

Figure 3.2:



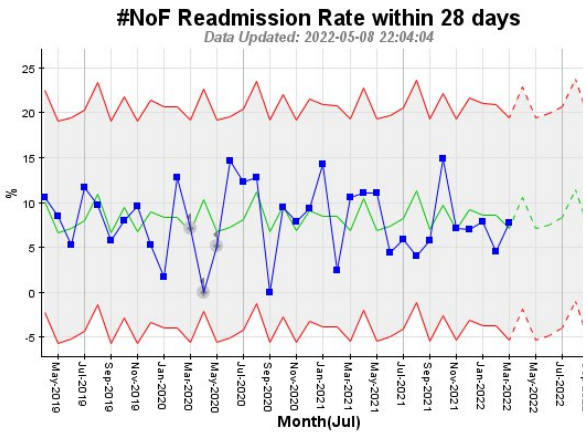

The additional processes required to assess for COVID-19 have affected the time that people spend in the department between February and April 2022.

*Figure 3.3:*

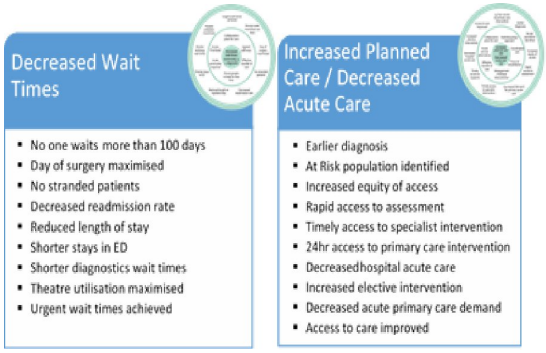



The #NoF inpatient mortality rate while variable is within the forecast range.

Figure 3.4




Readmissions continue to remain within the expected range.




# Elective Surgery Performance Indicators 100 Days

## Elective Services Performance Indicators

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

| | Apr | | May | | Jun | | Jul | | Aug | | Sep | | Oct | | Nov | | Dec | | Jan | | Feb | | Mar | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Imp. Req | Status % | Imp. Req | Status % | Imp. Req | Status % | Imp. Req | Status % | Imp. Req | Status % | Imp. Req | Status % | Imp. Req | Status % | Imp. Req | Status % | Imp. Req | Status % | Imp. Req | Status % | Imp. Req | Status % | Imp. Req | Status % |
| 1. DHB services that appropriately acknowledge and process patient referrals within the required timeframe. | 27 of 27 | 100.0 % | 27 of 27 | 100.0 % | 27 of 27 | 100.0 % | 27 of 27 | 100.0 % | 26 of 26 | 100.0 % | 27 of 27 | 100.0 % | 27 of 27 | 100.0 % | 27 of 27 | 100.0 % | 27 of 27 | 100.0 % | 27 of 27 | 100.0 % | 27 of 27 | 100.0 % | 27 of 27 | 100.0 % |
| 2. Patients waiting longer than four months for their first specialist assessment (FSA). | 1952 | 15.9% | 1694 | 14.1% | 1499 | 13.1% | 1578 | 13.6% | 1934 | 16.5% | 2304 | 20.5% | 2525 | 22.3% | 2463 | 22.3% | 2495 | 22.4% | 2813 | 24.3% | 2748 | 24.1% | 2861 | 26.1% |
| 3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT). | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| 5. Patients given a commitment to treatment but not treated within four months. | 1108 | 19.7% | 996 | 18.4% | 1011 | 18.4% | 1270 | 22.1% | 1417 | 24.0% | 1532 | 27.3% | 1714 | 30.7% | 1731 | 30.1% | 1939 | 32.2% | 2199 | 34.7% | 2302 | 36.8% | 2616 | 39.9% |
| 8. The proportion of patients treated who were prioritised using nationally recognised processes or tools. | 0 | 100.0 % | 0 | 100.0 % | 1 | 99.9% | 1 | 99.9% | 1 | 99.9% | 0 | 100.0 % | 0 | 100.0 % | 0 | 100.0 % | 0 | 100.0 % | 1 | 99.9% | 0 | 100.0 % | 0 | 100.0 % |

## Summary of ESPI 2 Performance - From Moh Final Summary March 2022 (published on 2 May 2022)

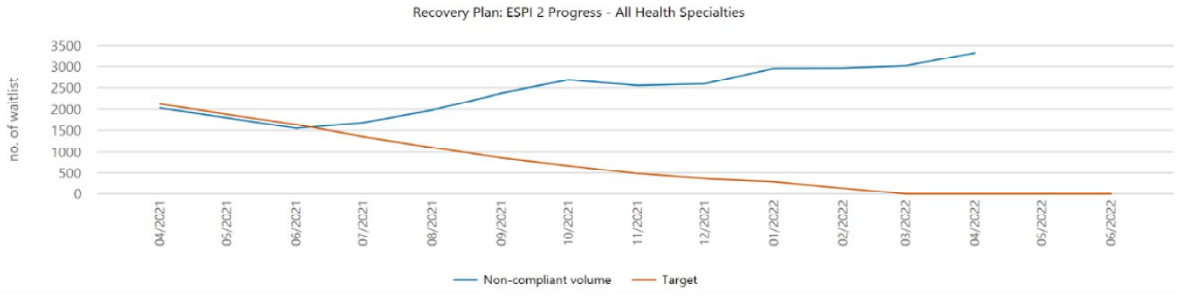
| | Jan-22 | | Feb-22 | | Mar-22 | |
|---|---|---|---|---|---|---|
| **ESPI 2 (FSA)** | Improvement required | Status% | Improvement required | Status% | Improvement required | Status% |
| Cardiothoracic Surgery | 1 | 5.6% | 1 | 4.5% | 2 | 14.3% |
| Ear, Nose and Throat | 332 | 27.3% | 274 | 23.3% | 202 | 19.0% |
| General Surgery | 168 | 18.4% | 178 | 17.4% | 225 | 21.5% |
| Gynaecology | 273 | 40.3% | 274 | 44.5% | 280 | 46.1% |
| Neurosurgery | 8 | 5.3% | 3 | 2.0% | 2 | 2.2% |
| Ophthalmology | 359 | 37.3% | 257 | 30.8% | 232 | 30.7% |
| Orthopaedics | 127 | 11.6% | 154 | 15.0% | 219 | 18.4% |
| Paediatric Surgery | 7 | 4.7% | 5 | 3.5% | 8 | 5.7% |
| Plastics | 66 | 21.0% | 75 | 23.2% | 69 | 26.8% |
| Thoracic | - | 0.0% | - | 0.0% | - | 0.0% |
| Urology | 27 | 4.3% | 36 | 5.4% | 22 | 4.3% |
| Vascular | 7 | 7.1% | 5 | 5.0% | 15 | 12.7% |
| Cardiology | 20 | 5.1% | 36 | 8.5% | 39 | 8.7% |
| Dermatology | 1 | 1.3% | 2 | 10.0% | 2 | 10.5% |
| Diabetes | 5 | 3.5% | 7 | 5.2% | 7 | 5.0% |

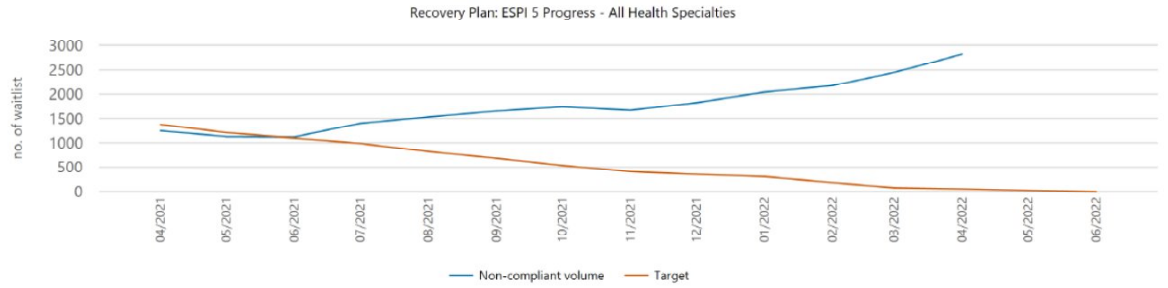
| | | | | | | |
|---|---|---|---|---|---|---|
| Endocrinology | 3 | 1.6% | 5 | 2.6% | 5 | 2.8% |
| Endoscopy | 859 | 48.0% | 874 | 47.9% | 924 | 50.7% |
| Gastroenterology | 42 | 13.0% | 32 | 11.5% | 31 | 12.8% |
| General Medicine | 35 | 18.2% | 38 | 18.4% | 48 | 28.1% |
| Haematology | 1 | 1.6% | 1 | 1.6% | 1 | 1.9% |
| Infectious Diseases | 1 | 10.0% | - | 0.0% | - | 0.0% |
| Neurology | 244 | 47.6% | 267 | 48.5% | 293 | 54.0% |
| Oncology | 4 | 1.3% | 3 | 1.1% | 3 | 1.5% |
| Paediatric Medicine | 132 | 24.4% | 112 | 22.0% | 106 | 20.5% |
| Pain | 1 | 100.0% | 1 | 50.0% | 1 | 100.0% |
| Renal Medicine | 15 | 20.8% | 24 | 32.4% | 24 | 30.0% |
| Respiratory | 44 | 12.6% | 67 | 20.6% | 68 | 21.3% |
| Rheumatology | 31 | **8.1%** | 17 | **4.1%** | 33 | **7.8%** |
| **Total** | **2,813** | **24.3%** | **2,748** | **24.1%** | **2,861** | **26.1%** |
| **ESPI 5 (Treatment)** | | | | | | |
| Cardiothoracic Surgery | 20 | 35.1% | 18 | 34.6% | 19 | 39.6% |
| Dental | 224 | 73.0% | 212 | 85.5% | 170 | 65.9% |
| Ear, Nose and Throat | 406 | 44.0% | 403 | 45.6% | 463 | 48.0% |
| General Surgery | 464 | 49.1% | 530 | 57.8% | 509 | 59.3% |
| Gynaecology | 56 | 18.4% | 60 | 20.5% | 84 | 22.1% |
| Neurosurgery | 1 | 2.6% | 1 | 3.0% | 2 | 5.9% |
| Ophthalmology | 307 | 41.0% | 297 | 39.9% | 347 | 46.0% |
| Orthopaedics | 137 | 18.3% | 172 | 23.7% | 256 | 30.4% |
| Paediatric Surgery | 27 | 23.1% | 30 | 25.6% | 52 | 41.6% |
| Plastics | 212 | 18.3% | 214 | 17.5% | 282 | 23.5% |
| Urology | 27 | 9.3% | 24 | 7.2% | 56 | 14.1% |
| Vascular | 124 | 54.6% | 140 | 60.1% | 146 | 59.3% |
| Cardiology | 194 | 41.0% | 201 | 44.9% | 230 | 51.7% |
| **Total** | **2,199** | **34.7%** | **2,302** | **36.8%** | **2,616** | **39.9%** |

Note - ESPI 5 figures and ESPI2 figures are taken from the MoH ESPI Finals report for March 2022, published 2 May 2022

The CDHB Improvement Action Plan is in place and focusses on CDHB achieving ESPI/Planned Care compliance in most services. At the 6th of May the overall target is not being met with 3,281 people waiting longer than 120 days for their **First Specialist Assessment.** None of the 27 specialty areas are meeting their recovery plan targets. The number of people waiting longer than 120 days decreased slightly during the week ending 6th May, prior to that it had increased week on week for six weeks.

When considering patient **waiting times for admission and treatment,** as at 6th May CDHB is not meeting the plan's targets. 2,735 people have waited longer than 120 days. One specialty area has no people waiting for longer than 120 days, none of the other 12 health specialties have not met their improvement targets. The number of people waiting longer than 120 days decreased slightly during both of the two weeks prior to 6th May, before that to that it had increased week on week for nine weeks.




*Achievements/Issues of Note*

**Neurosurgery**

- Work is ongoing to implement the single point of entry for referrals as part of the South Island Neurosurgery Service
- This currently involves stepping through triage and distribution of work and Information Technology flow.

**Virtual outpatient attendances**

- As a response to the Omicron outbreak, use of telehealth has increased to ensure provision of outpatient care continues
- During 2019, prior to the impact of COVID-19 in New Zealand, there were around 3,600 non-face to face outpatient events per month
- This has increased during lockdown periods before sinking back to a baseline level of around 5,000 to 6,000 per month
- During March 2022 more than 11,830 non-face to face appointments were provided. This is the third highest volume ever recorded and only slightly lower than in April and May 2020 (at 12,628 and 11,878)
- The Operational Improvement group has worked with some services to improve processes, making use of telehealth easier, however there is much more to be done in this area
- Despite the increased use of Telehealth, there were 1,093 less outpatient visits provided in March than during the same month in 2021 – incorporating 1,673 fewer new patient appointments.

**Allied Health - Expert Urogynaecology Physiotherapy**

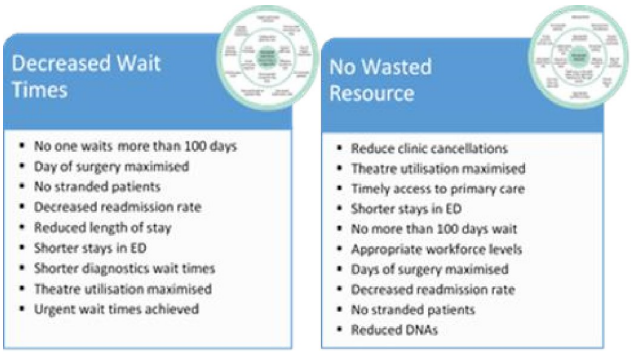
- The Ministry of Health has funded 0.7 full time equivalent Physiotherapist and 0.2 full time equivalent Administrator for 12 months for provision of a conservative approach to first line management of women referred for prolapse and incontinence, reducing referrals to Gynaecologists
- Most patients on the waitlist identified as appropriate for physiotherapy treatment have either had an initial assessment or have an appointment booked to meet their treat by date
- There are now just six patients waiting to be seen by a Senior Medical Officer beyond the 100 day treat by date. Only another nine patients require a Senior Medical Officer appointment
- The data continue to show that a third of referrals can be assessed by the Physiotherapist in person, a third require telephone triage; after a telephone triage 50% are happy to see a Physiotherapist for advice

and to trial a pessary. Some women happy to be discharged following an initial telephone appointment and advice

- A further three months of funding has been approved for this position to the end of June 2022.

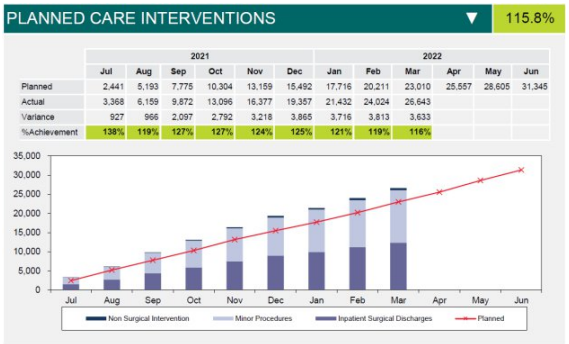
**Service improvement projects within the Eye Service,**

- The Eye department was successful at securing Service Improvement bids from the Ministry of Health focussing on sustainability and Improving did not attend rates within the service
- Implementation has been delayed due to the Omicron outbreak
- As a part of improving rates of attendances the service recruited a Māori Health worker during March. While there are no outcome results to report yet the department has noted that it has started to engage with its Māori patients and is learning a lot around what we need to do to improve our service for Māori
- As a part of the sustainability project, the service recruited two Ophthalmology assistants earlier in the year and training has started for two of our nurses to be upskilled in glaucoma. The department intends to open some nurse clinics in June once training has been completed which will improve the flow of patients being treated for glaucoma and relieve stress on Senior Medical Officer clinics.




# Theatre Capacity and Theatre Utilisation

- Canterbury District Health Board has an agreed phased schedule with the Ministry of Health for planned care delivery. As at year end Canterbury District Health Board's target is to deliver a total of 31,359 planned care interventions: made up of 19,614 surgical discharges, 11,409 minor procedures and 336 non-surgical interventions
- Reporting from the Ministry of Health to the end of March shows that provision of inpatient surgical discharges by Canterbury District Health Board was at 85.8% of target with provision of minor procedures in hospital and community settings well ahead (64%) of target



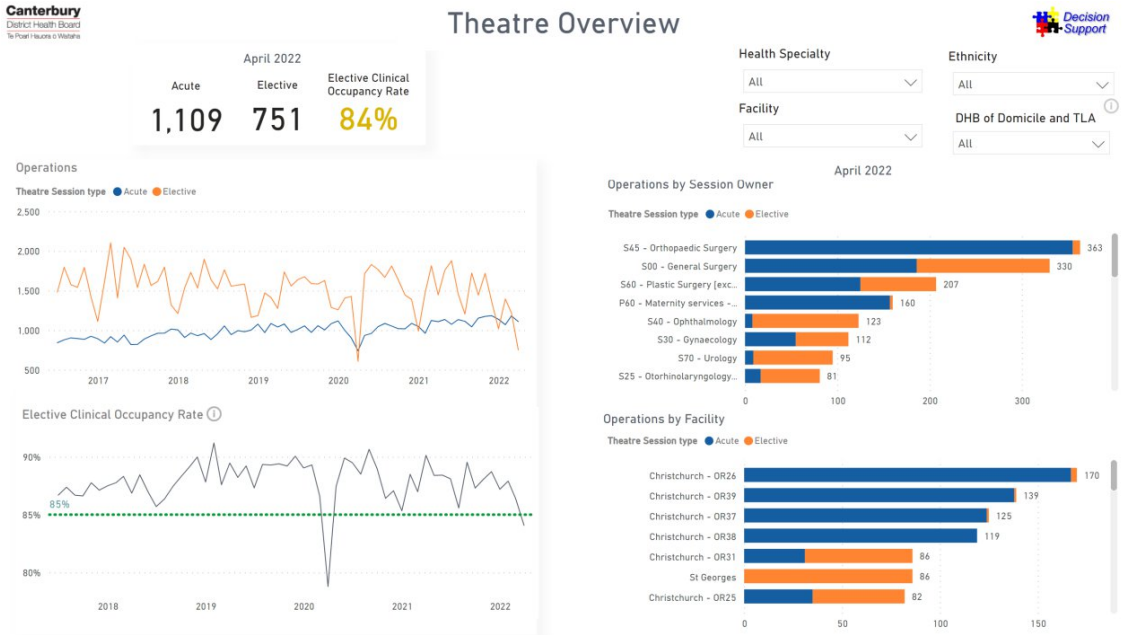

| | Interventions | | |
|---|---|---|---|
| | Plan | Actual | % |
| Non Surgical PUC with Surgical DRG | 625 | 599 | 95.8% |
| Surgical PUC | 13,780 | 11,761 | 85.3% |
| **Inpatient Surgical Discharges** | **14,405** | **12,360** | **85.8%** |
| Inpatient Minor Procedures | 1,101 | 1,717 | 155.9% |
| Outpatient Minor Procedures Hospital | 5,517 | 9,883 | 179.1% |
| Outpatient Minor Procedures Community | 1,744 | 2,120 | 121.6% |
| **Minor Procedures** | **8,362** | **13,720** | **164.1%** |
| **Non Surgical Interventions** | **243** | **563** | **231.7%** |
| **Total** | **23,010** | **26,643** | **115.8%** |

- **Internal reporting** show, 13,576 planned **inpatient surgical discharges** were provided – 2,760 less than the phased target of 16,327
- Within this, neither internal nor outsourced planned volumes have been delivered at the rates planned in the planned care dashboard. Arranged delivery is ahead of the phased plan
- Updated forecasts, showing the capability of existing internal schedules to deliver planned care outputs, are being developed from now until the end of June and then for the two halves of 2022/23 to help inform Perioperative Governance Group decision making
- At the end of April CDHB is exceeding target for minor procedures in hospital settings having delivered 1,871 as inpatients (633 ahead of target) and 10,823 as outpatients (4,466 ahead of target).

## Current theatre volumes

- Health System responses to COVID-19 have severely limited the capacity for planned operating. Surgical services have been prioritising acute activity to support patient flow and undertaking some planned care of surgical cases that meet the non-deferrable criteria
- Fewer acute and planned operations were provided at **Christchurch Hospital** in April 2022 than April 2021, with a total of 1,668 theatre events – this is 18% lower than in April 2021. During April 2022 there were 1,109 acute and 559 planned operations (vs 1,080 and 965 respectively in April 2021)
- The volume of operating at **Burwood** was 79% lower than in April 2021, with 55 operations provided during April 2022 and 266 in April 2021. During April 2022 there were no acute and 55 planned operations (vs 27 and 239 respectively in April 2021)

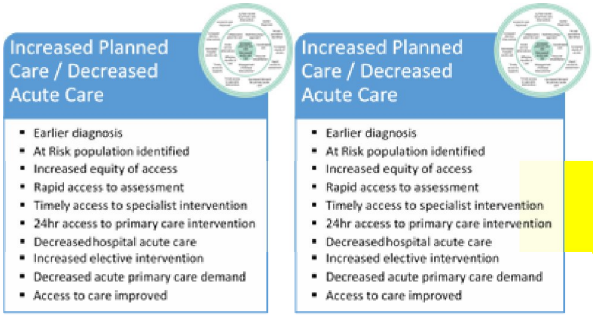
- A small volume of **outplacing** was carried out during April in mitigation of constraints across the campus. **Outsourced** operating has been lower than planned
- When **all operations** provided by or for Canterbury District Health Board (including in house, outsourced and outplaced) 1,860 operations were provided during April 2022 – 28% less than during April 2021. There were 2 more acute operations (0% increase) and 694 fewer planned operations (48% less)
- The Patient Information Care Systems shows that 12 booked surgical admissions were cancelled during April due to beds being unavailable, 178 due to pandemic and none due to theatre staffing.




*Achievements/Issues of Note*

**Effect of the Omicron outbreak on provision of planned care**

- All staff groups within the hospital have experienced constraints due to staff being ill, or isolating with and caring for family members, with COVID-19
- In addition to the resulting constraint on theatre and ward capacity there has been a high occupancy as a result of acute admissions, especially into medical services
- This has required a focus on acute and non-deferrable surgery. Ensuring that as much care is provided as possible to patients with the highest priority
- This has required flexibility, with many of the system's routines disrupted. One routine that has remained invaluable is the daily surgical huddle which sees senior clinicians and operational leaders engaging over how much, and which surgery will be provided each day
- Surgeons have shared lists and shown great flexibility to ensure that surgeon absences are filled by colleagues and do not result in wasted theatre capacity. All other work groups (nurses, anaesthetists, anaesthetic technicians, administrators and Resident Medical Officers) have shown similar flexibility in ensuring the system continues to hum.




# Mental Health Services

## Specialist Mental Health Services

This report highlights some of successes and challenges for Specialist Mental Health Services including demand growth and staffing pressures.

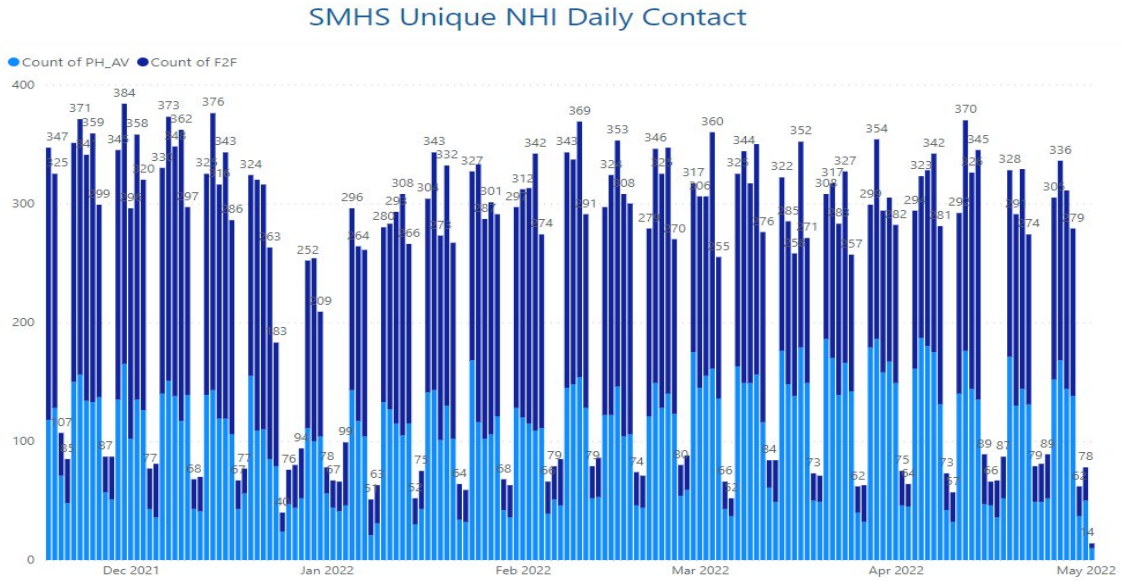
Specialist Mental health Services have had high numbers of staff who have been COVID positive with 65 people off at the peak. Currently the number COVID positive staff remains in the mid-30s. These gaps are occurring on top of chronic staffing shortages, however mitigations have ensured ongoing delivery of quality services to the people of Canterbury. Roster gaps are being managed by use of pool staff, some agency staff and significant overtime. The number of admissions has increased slightly since the omicron peak, however there is higher acuity among those in our services. The underlying population mental health needs will continue to be closely monitored. We are also coping with increased complexity of people being supported in the community

System integration (more so than in other DHBs) and innovation have helped mitigate demands however, mental health services remain under pressure.

## Demand – Community Services

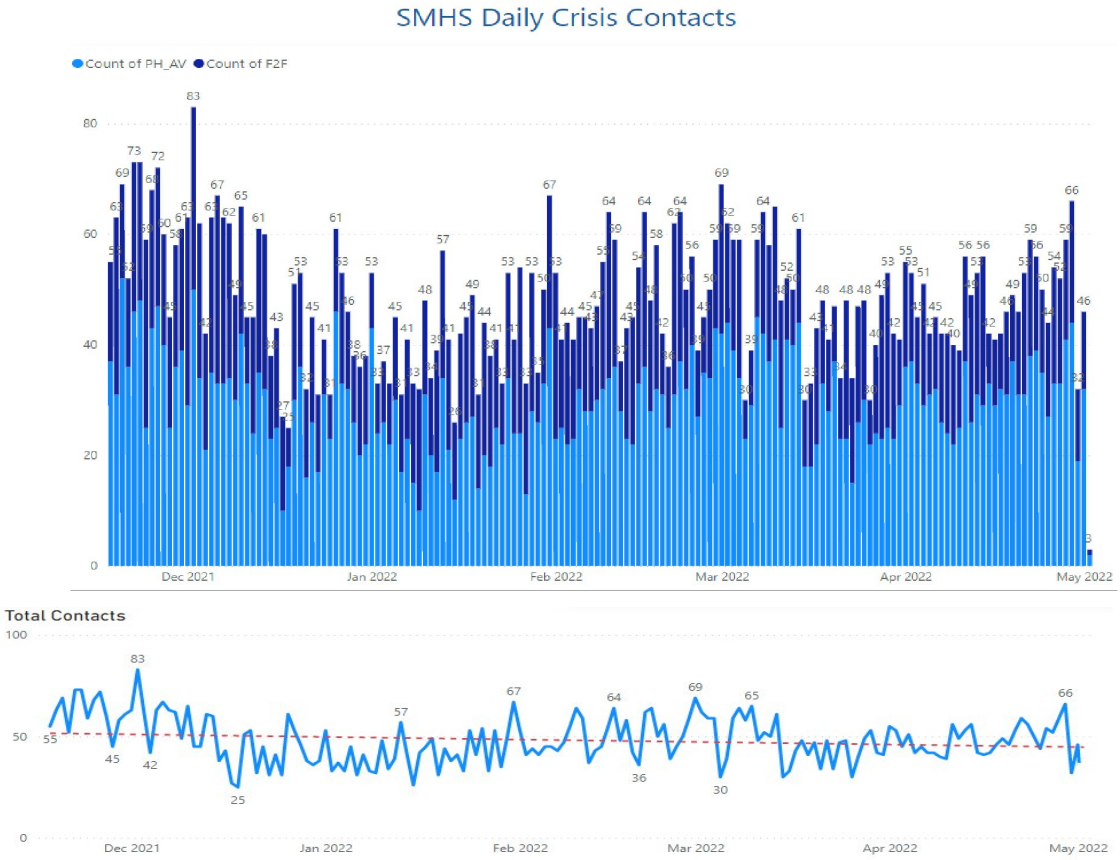
Specialist Mental Health Services continues to see an increase in demand for services, particularly in the Child, Adolescent and Family (CAF) Service, the Eating Disorders Service, and the Community Alcohol and Drug (CADS) Service.

Community outpatient services have continued to see people during omicron with a slight transfer of work to virtual modes to reduce to reduce the risk of COVID transmission.



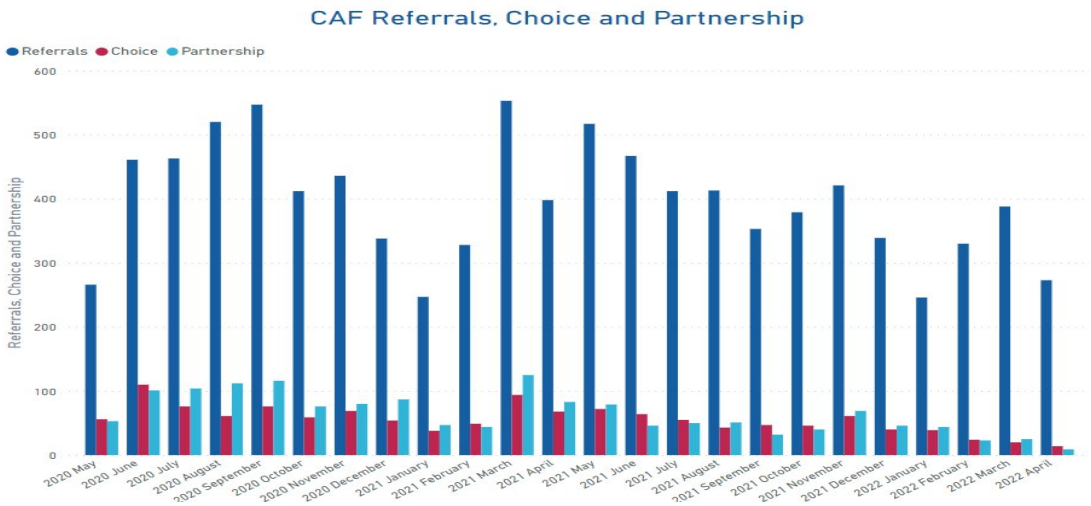
The number of people presenting to Crisis Resolution services has been similar during the omicron period to expected volumes. The disruption to mental health demand has been significantly less than during previous COVID waves.

**Crisis Contacts – daily**




## Child, Adolescent & Family Service

Referrals to the Child, Adolescent and Family Service have increased by 82% over the last two years.



Our Child, Adolescent and Family Service continue to work hard to address the growth in demand in their services. The goal of reducing wait times for first face-to-face appointment includes: one-on-one time slots devoted for General Practitioners to engage with a Psychiatrist to consider options for specific cases; information encouraging general practice to 'break' the privacy seal on HealthOne where appropriate to obtain relevant mental health information about a young person that can help general practice teams to manage that person; and ongoing engagement with School Guidance Counsellors to raise capacity and confidence and clarify referral pathways, including a hui with 65 School Guidance Counsellors. For young people and whanau waiting for appointments, one of our community partners (the Mental Health Education and Resource Centre – MHERC) are providing supportive online resources.

Average Wait Time in Days


The development of webinars have proven popular with teachers, School Guidance Counsellors and community health providers. Under the banner of 'Listening to Families' further expert online webinars are being developed with sponsorship by the Maia Foundation. These will provide the above audiences as well as family-whanau directly with information on emotional regulation, anxiety, suicide and refugee and migrant health.

## Eating Disorders Service

Referrals to the Eating Disorders Service have increased by 96% over the last two years. This problem has been nationally and internationally as an expanding area. The national development of supporting education materials by the Werry Centre is underway which our teams will utilise in their education work.

**Table one:** Eating Disorders Inpatient unit – C Ward

| Year | Unique NHI | Total open episodes |
|---|---|---|
| 2017 | 23 | 61 |
| 2018 | 51 | 64 |
| 2019 | 53 | 61 |
| 2020 | 43 | 50 |
| 2021 | 51 | 57 |

**Table two:** Outpatients – Eating Disorders Community Team

| Year | Unique NHI | Total open episodes |
|---|---|---|
| 2017 | 217 | 217 |
| 2018 | 308 | 315 |
| 2019 | 337 | 340 |
| 2020 | 390 | 394 |
| 2021 | 364 | 369 |

## Staffing

Specialist Mental Health Services have large numbers of vacancies particularly for inpatient nursing. The table below shows YTD the Division was 45.7 FTE under budget at the end of April 2022. This was lower than previous months but under-represents the shortfall as it includes overtime (paid at 1.5 and double time).

| Account Class | Apr-22 YTD FTE | Apr-22 YTD Budget FTE | YTD Variance | Overtime |
|---|---|---|---|---|
| Medical Employees | 98.60 | 102.35 | 3.75 | 1.17 |
| Nursing Employees | 595.78 | 622.99 | 27.20 | 20.57 |
| Allied Health Employees | 217.63 | 232.08 | 14.44 | 2.85 |
| Support Employees | 2.74 | 3.00 | 0.26 | 0.06 |
| Mgmt and Admin Employees | 95.15 | 95.22 | 0.07 | 0.28 |
| **EMPLOYEE EXPENSES** | **1,009.90** | **1,055.63** | **45.73** | **24.92** |

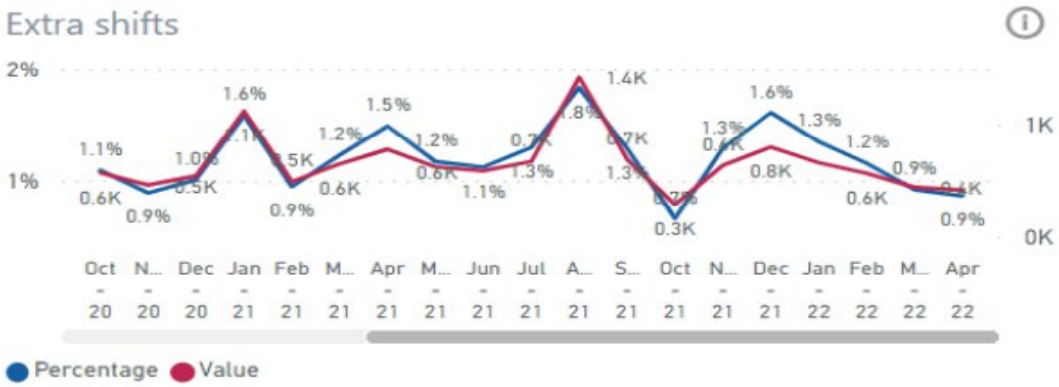
Roster gaps were reduced during the omicron wave due to the temporary closure of the Kennedy planned detox inpatient unit and the temporary merger of PSAID and Tupuna. This meant staff were able to be redeployed to cover gaps in other units. We also relied on casual pool or agency staff, allied health providing cross cover and leadership working on the floor, in many instances existing staff are committing to our consumers by working additional shifts to ensure basic care needs are met. We have now received some complaints from consumers that short staffing is affecting he activities they are able to do.

**Overtime:**

Total Overtime FTE is 24.92 YTD. Highest areas are:

- Forensic - 5.6 FTE
- Adult Community Teams which include Crisis Resolution – 4.3 FTE
- IDPH - 4.2 FTE
- Adult Acute – 6.1 FTE across all Adult Acute Inpatients

The graph below shows the value and percentage of extra shifts undertaken at Hillmorton and Princess Margaret Hospitals.

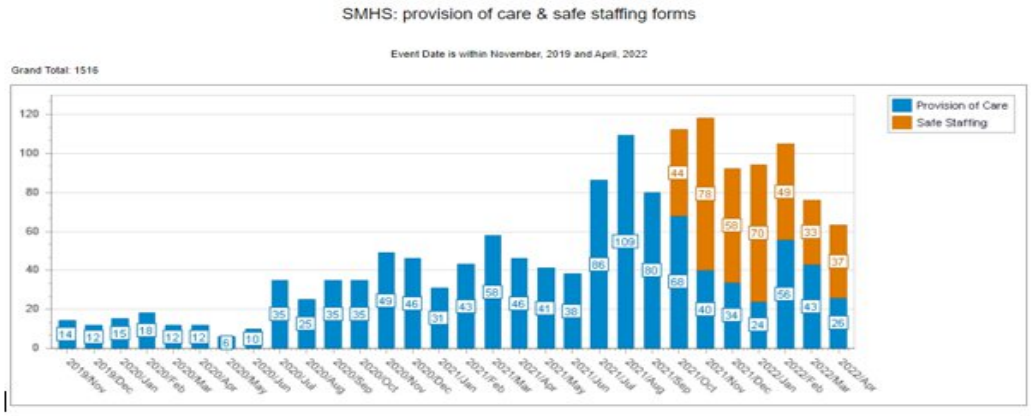



While this ensure consumers are provided with good care, working longer hours is not sustainable and puts our staff under pressure and can often flow on to increased sick leave.

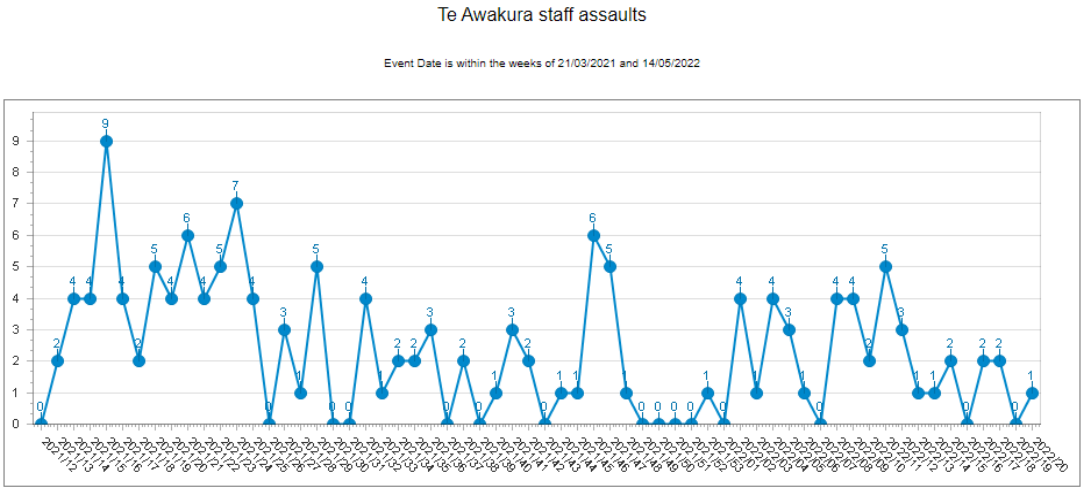
## Provision of Care

Safety 1st is Canterbury DHB's incident management system. Provision of Care forms are completed in Safety 1st by staff when a person's plan of care has not been followed as planned. The number of provision of care forms completed by staff increased markedly over 2021. Eighty six percent of provision of care forms completed by staff in Quarter 1 2021/22 related to insufficient staffing. In October 2021 'safe staffing' Safety 1st forms became available, and staff have been encouraged to use them to report staffing issues.

Number of Safety 1st Provision of Care forms completed (includes safer staffing)




We continue to closely monitor incidents and those resulting staff assaults. While rates have fallen over time there are still a number of assaults. While improved facilities will help to mitigate risks, these are a number of years away for our major areas of adult acute (Te Awakura - below) and Forensic services.



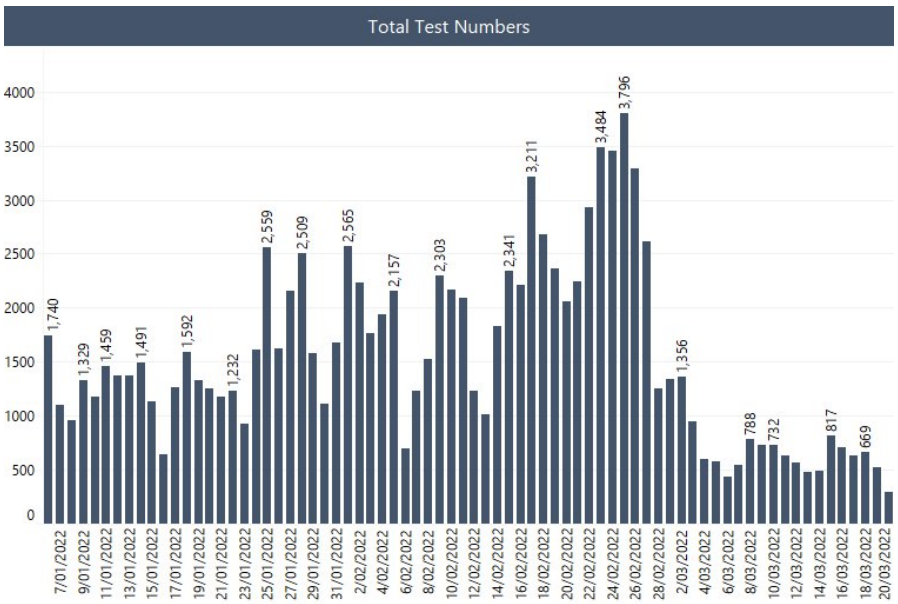

# Canterbury Health Laboratories

The DHBs are fortunate to have very supportive and responsive teams that continue to provide laboratory services at an extremely high standard and they are committed to continuing to do so. As a team we appreciate the support we have had from the Executive and the Board over recent times.

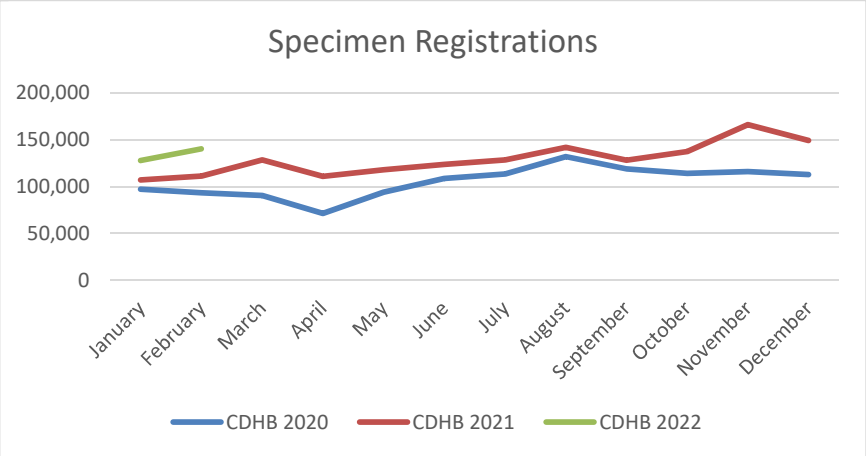
Please find my report below:

- The final stairway is undergoing its post-quake repairs and we have recently moved the tearoom to make way for the construction of the new High Volume Respiratory Molecular Suit. We also have the Energy Centre construction continuing and the Ngai Tahu carpark construction starting which puts the main CHL building in the centre of a large number of projects. Staff, equipment and the working environment are managing well with this level of upheaval.

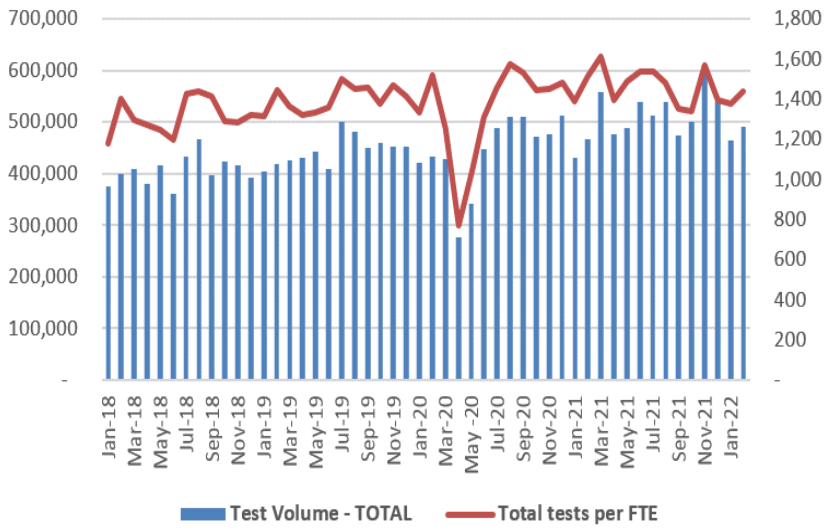
- Workload challenges for COVID testing have seen great fluctuations in the PCR swabs that required testing which is depicted in the below graph. Numbers have dropped considerably which is allowing for staff to catch up on other necessary work and the regular maintenance of equipment is able to occur. The test numbers are shown in the below graph:



Laboratory workload volumes across the DHB continue to grow as can be seen by the number of specimens that have been registered at the laboratory. The data is a three-year snapshot of registrations and depicts an ever-increasing workload. The volume may decrease slightly following the reduction of PCR testing, so this will be closely monitored.




The below graph shows the number of tests undertaken as well as the number per FTE within the laboratory. While the number of tests has not increased markedly the complexity of the tests and the time taken to do these has changed. Along with complexity there is also cost, as some of the new tests require very sophisticated equipment in their analysis.




Living Within Our Means

**The CDHB Statement of Financial Performance covers the following Hospital Services:**

# Canterbury District Health Board

## Statement of Financial Performance

### Hospital & Specialist Service Statement of Comprehensive Revenue and Expense
### For the 10 Months Ended 30 April 2022

| MONTH $'000 | | | | YEAR TO DATE $'000 | | |
|---|---|---|---|---|---|---|
| 21/22 Actual $'000 | 21/22 Budget $'000 | 21/22 Variance $'000 | | 21/22 Actual $'000 | 21/22 Budget $'000 | 21/22 Variance $'000 |
| | | | **Operating Revenue** | | | |
| 198 | 293 | (95) | From Funder Arm | 1,901 | 2,916 | (1,015) |
| 1,800 | 1,599 | 201 | MOH Revenue | 17,318 | 16,412 | 906 |
| 4,467 | 4,870 | (403) | Patient Related Revenue | 52,617 | 48,400 | 4,217 |
| 628 | 1,897 | (1,269) | Other Revenue | 30,651 | 18,956 | 11,695 |
| 7,093 | 8,659 | (1,566) | **TOTAL OPERATING REVENUE** | 102,487 | 86,684 | 15,803 |
| | | | **Operating Expenditure** | | | |
| | | | **Personnel Costs** | | | |
| 77,123 | 73,604 | (3,519) | Personnel Costs - CDHB Staff | 752,625 | 712,740 | (39,885) |
| 1,735 | 1,767 | 32 | Personnel Costs - Bureau & Contractors | 18,619 | 17,910 | (709) |
| 78,858 | 75,371 | (3,487) | **Total Personnel Costs** | 771,244 | 730,650 | (40,594) |
| 11,851 | 14,225 | 2,374 | Treatment Related Costs | 146,173 | 142,721 | (3,452) |
| 4,903 | 4,464 | (439) | Non Treatment Related Costs | 51,823 | 46,515 | (5,308) |
| 95,612 | 94,060 | (1,552) | **TOTAL OPERATING EXPENDITURE** | 969,240 | 919,886 | (49,354) |
| **(88,519)** | **(85,401)** | **(3,118)** | **OPERATING RESULTS BEFORE INTEREST AND DEPRECIATION** | **(866,753)** | **(833,202)** | **(33,551)** |
| | | | **Indirect Income** | | | |
| 1 | 1 | - | Donations & Trust Funds | 31 | 11 | 20 |
| **1** | **1** | **-** | **TOTAL INDIRECT INCOME** | **31** | **11** | **20** |
| | | | **Indirect Expenses** | | | |
| 7,092 | 6,509 | (583) | Depreciation | 65,285 | 65,042 | (243) |
| (8) | - | 8 | Net (Gain) Loss on Disposal of Fixed assets | 25 | - | (25) |
| **7,084** | **6,509** | **(575)** | **TOTAL INDIRECT EXPENSES** | **65,310** | **65,042** | **(268)** |
| **(95,602)** | **(91,909)** | **(3,693)** | **TOTAL SURPLUS / (DEFICIT)** | **(932,032)** | **(898,233)** | **(33,799)** |

Older Persons Health & Rehab
Women's & Children's Health
Mental Health

Medical & Surgical
Hospital Support & Labs
Facilities Management

## Achievements/Issues of Note

**ACC Revenue for the Christchurch Campus**

- The campus revenue team has been working solidly to maximise ACC revenue received by the campus. Huge gains were made in the first four months of the year which have been offset by reduced volumes, as a result of COVID-19 limitations in activity
- As at March 2022 an increased revenue (over budget) of $224,856 has been realised
- Lower revenue across February and March reflects the deferral of non-acute surgeries. These will still need to be provided thus the revenue will not be entirely lost.

**Anaesthesia**

- Breathing circuits – following a change in practice, anaesthesia is now replacing circuits weekly, rather than daily. This is expected to reduce the amount required by almost 50% with an anticipated savings of approx. $3,500 p.a
- During the first nine months, $12,600 in savings have been realised – likely contributed to by a reduction in activity as a result of COVID-19 restrictions.

**Cardiology**

- The service has moved to NZ HP contract pricing for consumables
- Projected savings for 2021/22 are $100k. There is a rebate opportunity if tier targets are met
- Cost reductions of $88,729 have been realised as at the end of March.

**Cardiothoracic Surgery**

- The service has stopped using the energy system. It was estimated this would lead to $40k savings over the year
- $29,997 savings have been realised at the end of March – on track.

**Cardiothoracic**

- The thoracic team has streamlined the choice of plates for rib fixation. The change in brand reduces the cost from $1,900 per plate to $700 each
- On average there are three plates used per case with around 10 cases are done every year and budgeted savings of $36,000 for the year.
- $27,000 savings have been realised at the end of March 2022 - on track.

**Diabetes**

- The service is sending all letters to general practices electronically to save paper, time printing and putting in envelopes and postage
- Estimated $4,800 for the year. Savings achieved have been lower than this with $1,024 savings to the end of March. Review of why savings predicted have not been realised with be undertaken in June
- The reduced savings will be contributed to by reductions in planned activity due to COVID-19.

**Emergency Department**

- In response to a recent audit, guidelines have been implemented to reduce the number of intravenous cannulations where venepuncture can be used as an alternative
- Insertion of IV cannula has dropped from 43% or patients to 29%. This is likely to result in approximately $15,000 net savings via cannulations per annum. Savings are being achieved by reducing time wasted placing and removing IV lines, reducing use of consumables (lines, dressings etc), and there is an improved patient experience (no unnecessary pain, phlebitis and infection)
- Cost reductions of $10,133 have been realised to the end of March.

**Gastroenterology**

- With the impending retirement of an existing staff member, the service reviewed the role responsible for identifying and monitoring outsourced Colonoscopy patients and reporting

- It was agreed that a senior nurse was not required for this task, which is better suited to an Administrator with estimated savings of approximately $20,000 per annum
- Cost reductions realised up to the end of March are $5,860.

**General Surgery**

- The service is sending all letters to General Practitioners electronically to save paper, time printing and putting in envelopes and postage
- Full year savings estimated at $4,800
- $2,575 in savings have been realised at the end of March. This is lower than estimate, likely due to reductions in planned surgery through the COVID-19 response.

**IDF Supplementary recharge for Bone Marrow Searches**

- Revenue for Bone Marrow searches that are not covered by inter-district flow charges has been pursued
- It was expected that this would increase revenue by $200,000 for the year. $198,875 increased revenue has been realised in the nine months to the end of March. Higher than budgeted.

**Maternity Ward – Bottle Project**

- A move from single use sterilised infant bottles and teats to reusable sanitisable bottles and teats
- Forecast to reduce costs by $43k for the year. Savings of $27,458 have been realised as at the end of March 2022.

**Maternity ward – Maternity Pad Substitution**

- Transition to a new brand of maternity pads was forecast to save $527 per month from November 2021
- Actual savings from that date have been $856 per month – totalling $4,280 at end of March.

**Medical records**

- Clinical Records has had a change in practice, positively impacting Iron mountain costs
- From 1st March 2021 scanning of Anaesthetic Records commenced, reducing the volume of records needing to be sent to the hospital. Once previous anaesthetic records have been scanned closed volumes of records do not need to be recalled from Iron Mountain. This has reduced the number of records retrieved from Iron Mountain and this reduction is expected to continue
- Budgeted reduction in cost was $50,000 for the year. This has been exceeded with $173,609 realised for the nine months to the end of March 2022. This is likely partially contributed to by the reduction in activity from COVID-19 restrictions.

**Neurology**

- Neurology has shifted to a cheaper brand of needles for electroencephalograms that will save around $157 per month
- $1,413 savings realised at the end of March – on track.

**Neurology**

- A complete audit of embolectomies was conducted by the Neurology Department and Clinical Coding. This identified an increase in the cost weight of 63.394 which is equivalent to $351,538. Those related to inter-district flow will contribute increased revenue
- $99,955 increased income achieved in first nine months of the year.

**Neurosurgery**

- Recovery of partial salary for a shared South Island Neurosurgery role - approximate recovery of around $40k is expected for the 2021/22 year
- Increased revenue realised to end of march of $33,525, on track
- Supplementary invoicing for Southern District Neurosurgical patient implants has come through in the April result.

**Occupational Therapy**

- The team now has well established practices for managing equipment returns

- Budgeted reduced costs for the full year are $100k with $72,643 realised during the first nine months of the financial year.

**Ophthalmology**

- Reviewing injection packs $14 per pack – approximate use of 200 per week. Current workings show that we can potentially reduce cost to approximately $8 per pack -with forecast reduction in costs of $62,400
- At the end of March 2022 $1,899 savings have been realised.

**Ophthalmology**

- Has reviewed the requirement for an anaesthetic before giving dilation drops. The service anticipates it can reduce its monthly order by up to 50% with estimated cost savings of $1k per month
- Reduction realised at end of March is $18,953.

**Orthopaedics**

- Elimination of orthopaedic planned surgery preoperative urine testing is forecast to save $25,933 for the year (1,270 joints @ $20.42 per test)
- $8,593 achieved in first 9 months of the year.

**Outreach rates**

- Hourly rate for Outreach staff has increased by approximately 2% - forecast to achieve an increase in annual income of $27,500
- This has been impacted by an inability to undertake the planned level of outreach work due to Omicron restrictions across the regions
- $11,162 realised in first nine months.

**Overseas chargeables**

- The campus is $1m unfavourable against budgeted revenue for overseas chargeable YTD April 22
- Comparing actual revenue, 20/21 was $2.022m YTD and 21/22 is $1.173m YTD
- The total value for April 22 was $82,657 – an increase on March's $15,668
- It is anticipated that revenue will increase with the further re-opening of the borders.

**Radiation Oncology**

- Savings on service agreement and repairs and maintenance are budgeted because Linacs T3 and T4 are under warranties which expire in Nov 21 and Apr 22 due to recent replacement
- Savings budgeted for the year are $401,780 and these have already been realised.

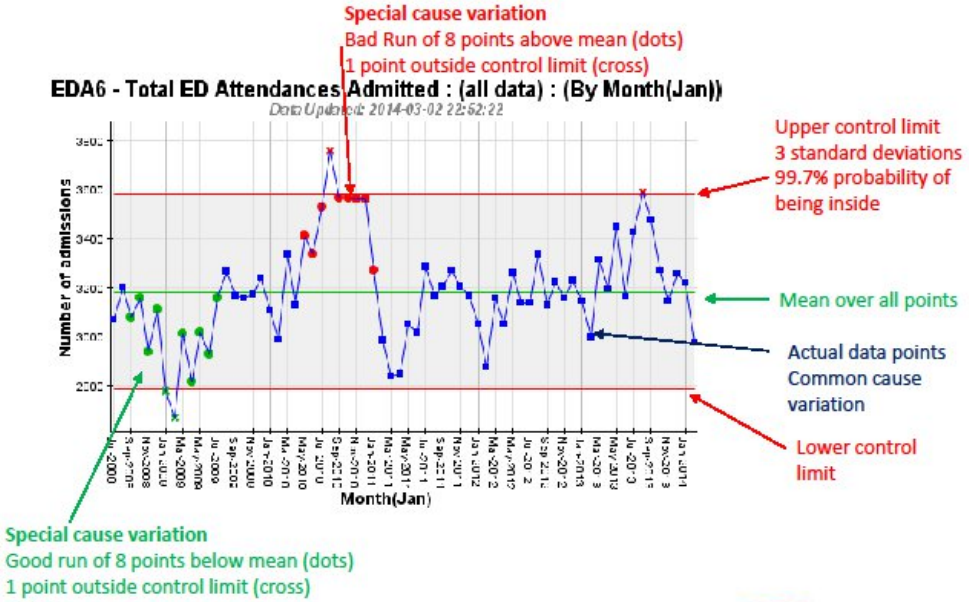
**Respiratory Outreach**

- Income from Edwards Lifesciences to cover afternoon Cardiac Rehab classes in the Salvation Army building has been increased by $6,500 - realised in January 2022 – meeting the annual forecast.

**RDST - Run changes**

- A new New Zealand Resident Doctor Association multi-employer collective agreement has recently been implemented. Among other changes it provided for pay increases and a changed salary calculation method to match the Specialty Trainees of New Zealand agreement
- The changes in the salary calculation method were required to fund the agreed pay increases meaning District Health Boards were under pressure to get the changes in place in time for the implementation date
- Three District Health Boards successfully achieved this, Canterbury was one of them
- This was the result of the dedication of a staff member who worked tirelessly to achieve this in time.

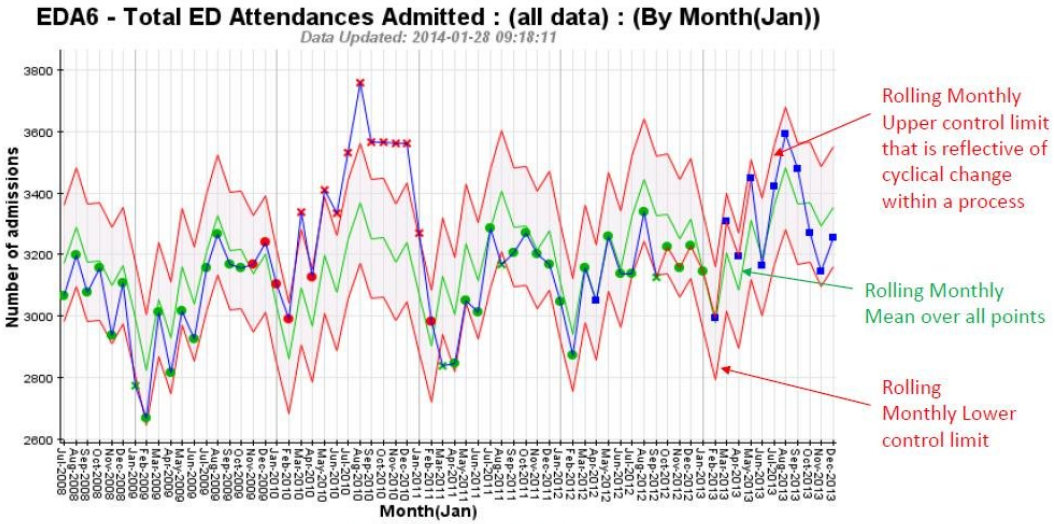
# SPC: How to Interpret a Control Chart




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

# OFFICE OF THE CLINICAL EXECUTIVE UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

**PREPARED BY:** **Office of the Clinical Executive**

**APPROVED BY:** **Norma Campbell, Executive Director, Midwifery & Maternity Services**
**Becky Hickmott, Executive Director, Nursing**
**Dr Jacqui Lunday-Johnstone, Executive Director, Allied Health, Scientific & Technical**

**DATE:** **2 June 2022**

| Report Status – For: | Decision ☐ | Noting ☑ | Information ☐ |
|---|---|---|---|

## 1. ORIGIN OF THE REPORT

The purpose of this report is to provide a summary of activity within the Office of the Clinical Executive.

## 2. RECOMMENDATION

That the Committee:

i. notes the update from the Office of the Clinical Executive.

## 3. DISCUSSION

### Midwifery & Maternity Service

- Continue to see high level of sickness in all areas of maternity – both Covid and non-Covid.
- Post 31 March, Annual Practicing Certificate (*APC*) date – a number of retirements across the system of midwives who had planned to retire 2020 and continued to work through pandemic and surge this year.
- Community units mostly staffed until sickness occurs.
- Christchurch Women's Hospital continues to have 23% vacancy, majority of which is midwifery.
- National Workstream looking at retention of midwives working in secondary/tertiary care facilities, midwifery pipeline which is not providing sufficient volume per annum. Looking at RNs who work in maternity now and educating to become midwives. Overseas and national recruitment for both filling current vacancy with overseas midwives, supplementing NZ numbers (used to be 50% of workforce pre-pandemic), and increasing student numbers particularly balancing current inequity of workforce composition.
- Working regionally on Kaiawhina/Kaimanaaki working in maternity from pregnancy through to five years – Whanau Ora model, cultural/parenting focus inside hospital and in community to support whānau.
- Opening of Oromairaki and closure of Lincoln Maternity on 31 May.
- Central City Birthing Unit continues to progress within timeframe.
- Chathams, Kaikoura, Ashburton units/services stable at present, but vulnerable with small workforces.

### Allied Health, Scientific and Technical

- AHST Workforce team supported ECC Staffing team and continuing to provide advisory support to System Wide Operations Centre (*SWOC*) Staffing team with 1000+ redeployed shifts for AHST staff since ECC stood up.

- Both Covid and non-Covid illnesses continuing to affect multiple areas of workforce.
- PSA Strike had a significant impact on the system from 8-23 May. Further strike action has been called off after a new offer made that the PSA are recommending members accept.
- Anaesthetic Technicians: multiple initiatives to support service underway and in collaboration with P&C, including:
  - Career framework;
  - Undergraduate pipeline planning; and
  - Linking in with SWOC staffing team to provide sector wide employment opportunities for students.
- 41 new AHST Staff commenced employment since 1 April – currently have 90 vacancies out to ad; and a further 40 that are either underway with the manager to discuss advertising, or the manager is not currently ready to advertise.

**Nursing**

- Hospital volumes remain high with high complexity reported across all sites.
- High nursing vacancies continue particularly in ARC, Mental Health and General Medicine. Overall nursing workforce challenges remain high compounded by Covid staff absences. Working closely with P&C on innovative ways we can use to attract and recruit more nurses and national DoNs sharing strategies and ideas.
- ECC staffing continues to support system flow through supporting nursing staffing requirements in ARC, Primary Health, Christchurch Campus, Burwood Campus and Specialist Mental Health.
- Children's Emergency Care centre is preparing for an opening late June as the challenges of winter begin to hit. Workforce is nearly recruited to and training is underway.
- CCDM Council is back underway. We are achieving now about 70% completion of the programme with the remaining ½ of the wards to complete FTE calculations by the end of February, noting that COVID and other challenges may somewhat impact on this. This will mean we will have completed our base FTE establishment for the future.
- Winter planning continues to progress and ongoing Return to Work and Winter Variance Staffing processes continue through the winter to support system flow. As part of the system flow governance focus on winter planning we are working closely with the following groups:
  - Hospital Flow
  - Urgent Care SLA
  - Community SLA
  - Community Hub
  - Primary Care leadership teams, PHO CEs
- Work is continuing on the process of redeployment of the MIQ nursing workforce.
- Further development work around refining and documenting our processing around Hospital Variance Response Management within our Care Capacity Demand Management framework continues.
- Expert advice was sought from Ian Sturgess, Francis Health Associate Medical Director with a site visit at the Hub, Christchurch and Burwood Campuses to assist in addressing bed capacity and patient flow challenges across the community and hospital system. Opportunities that were shared for discussion across the acute pathway were:
  - Focus on extending the Rapid Assessment & Treatment hours and earlier referral to inpatient services
  - An effective ED observations to prevent inpatient admission
  - An intake admitting process with continuity -Ambulatory Emergency Care + Short stay
  - Acute Frailty Process
  - Home wards and effective MDT working
  - Enhanced discharge to assess process (consolidation of community resource)

# RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

**DATE:** **2 June 2022**

| 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 item 1;

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

| | GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED | GROUND(S) FOR THE PASSING OF THIS RESOLUTION | REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9) |
|---|---|---|---|
| 1. | Confirmation of the minutes of the public excluded meeting of 3 February 2022 | For the reasons set out in the previous Committee agenda. | |

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

## 3. SUMMARY

The Act, Schedule 3, Clause 32 provides:

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

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

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

Clause 33 of the Act also further provides:

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

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

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

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

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

# QUALITY & PATIENT SAFETY INDICATORS – LEVEL OF COMPLAINTS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

**APPROVIED BY:** **Norma Campbell, Executive Director, Midwifery & Maternity Services**
**Becky Hickmott, Executive Director of Nursing**
**Dr Jacqui Lunday-Johnstone, Executive Director of Allied Health, Scientific & Technical**

**DATE:** **2 June 2022**

| 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 patient experience; feedback gained from surveys and the complaints system. This is a regular six-monthly report on the Committee's work plan providing latest monthly Patient Experience Feedback data and the current financial year complaint data.

## 2. DISCUSSION

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

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

## 3. APPENDICES

Appendix 1: Patient Experience – Survey Feedback, and Complaint Rates and Categories to March 2022

**APPENDIX 1**

## PATIENT EXPERIENCE: Survey Feedback

Every fortnight we invite patients who have spent at least one night in hospital to participate in our patient experience survey. An invitation to participate in the survey is delivered via email or a link in a text message. Taking part is voluntary. The survey asks patients to rate and comment on their experiences in four domain areas: communication, partnership, co-ordination and physical/emotional needs. Understanding how people experience healthcare gives us valuable insight. Feedback is used local teams to monitor care provided and assists us in identifying what went well, and what we can do better.

The CDHB Patient Experience Programme is inclusive of the Inpatient Survey (since 2014), Outpatient Survey (since 2018), Paediatric Child and Parent Survey (since March 2021). The availability of the Specialist Mental Health In and Outpatient Surveys is being promoted.

### Domain scores out of 10 for all surveys:

| Last 12 months | All Inpatients *Nr 5381* | Maori Inpatients *Nr 333* | All Outpatients *Nr 10953* | Maori Outpatients *Nr 537* | All Paeds *Nr 638* | Maori Paeds *Nr 111* |
|---|---|---|---|---|---|---|
| **Communication** | 8.7 | 8.5 | 9.1 | 8.9 | 8.8 | 8.3 |
| **Partnership** | 8.6 | 8.5 | 9.0 | 8.9 | 9.0 | 8.7 |
| **Coordination of care** | 8.5 | 8.3 | 8.7 | 8.5 | 8.6 | 8.1 |
| **Physical and emotional needs** | 8.7 | 8.5 | 9.0 | 8.7 | 9.4 | 9.0 |

The patient experience portal on the intranet enables staff to filter by service area, demographics, ethnicity and disability. In August 2019 the Washington scale health questions were introduced to enable comparison of experience with people with disability.

**APPENDIX 1**

| Location | Topic | Improvement Actions |
|---|---|---|
| Paediatric Inpatient Survey | Themes for improvement identified are around parent's access to meals and snacks, parking information, wait times, parents having to repeat same information to multiple staff, access to activities for Children and better TV options. | Changes progressing to ensure parents have better access to food are in place. Working on ensuring parents are well orientated to the care environments with this is being fed back through to the CNM's of the areas.<br>Play therapy team leader is drafting a leaflet that can be provided to parents/caregivers to be handed out to new admissions increasing awareness of what is available (i.e. activities) for children to have in their rooms.<br>Funding for TV options to be explored.<br>All appointment letters for elective admissions now include a QR code that links to the Child and Youth Health [Matatiki] website where parents can access information re parking options.<br>Options on how to improve response rate are being investigated. |
| SMHS Consumer Experience | Increase response rates.<br><br>Telehealth specific questions. | SMHS Consumer Experience Survey QR code pamphlets have gone live and are being included in inpatient discharge notes.<br><br>Telehealth questions being incorporated into the SMHS Outpatient Survey are now in the test environment. |
| Inpatients | Partnership<br>Medical team could not give time for when they would round. This meant that families were often not present and could not ask questions. Patients also reported that they often forgot what they had wanted to ask. | Creating of a new patient booklet setting expectations for the General Medicine Journey. This booklet has a space for patient and their family to write questions, so they are prepared when the medical team visits. It also contains other information regarding preparing for discharge. |
| Inpatients | Hand Hygiene<br>Enabling Hand Hygiene for those patients unable to independently mobilise to access | Following the successful trial at Burwood Hospital, Stroke Ward, the Hand Hygiene initiative, placing a 500ml bottle ABHR with table top holder on the bed side locker or table for |

**APPENDIX 1**

| | | |
|---|---|---|
| | facilities to clean/wash their hands has been an area of focus for improvement. | easy patient access, has been rolled out widely. Early results are encouraging with in the last fortnight 73 (83%) respondents answered 'yes' to the question 'if unable to walk unattended to the hand basin, when you needed to clean your hands, were you provided with a suitable alternative?' |

**COVID-19 Vaccination Experience** A consumer vaccination experience survey was instigated in August 2021.

Results to date indicate that 98 % of people (1402) say that their vaccination experience has been good or very good and a similar number said they were treated with respect throughout the process; 95% (1421) found that the clinic/site delivering the vaccine was easy to access; 92% (1410) said they received sufficient information before the appointment.
This survey is accessed by consumers scanning a QR code displayed at the vaccination site as well as hard copies being available at some sites. Along with the feedback that has been received from compliments/complaints and incidents, the survey feedback has been used to improve flow at mass vaccination sites especially for people experiencing a disability and improvements to the booking systems for those who require assistance.

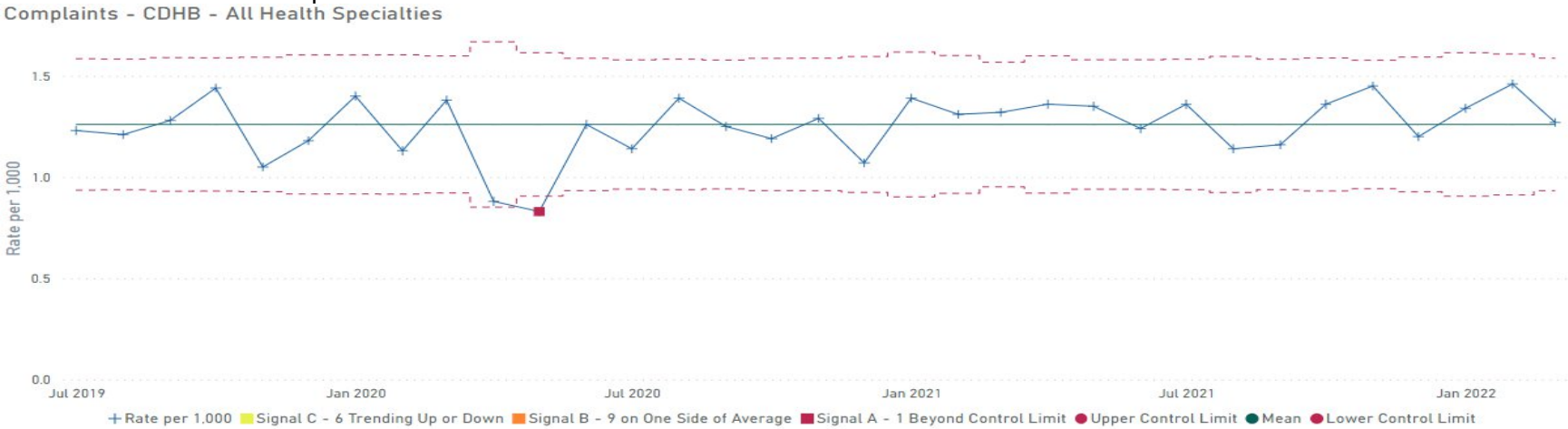
**APPENDIX 1**

## PATIENT EXPERIENCE: Complaints

**Definition:** Any expression of dissatisfaction with any aspect of a service which CDHB provide which has not been immediately resolved to the Complainants' satisfaction. This includes all Complaints relating to the quality of care of an individual Consumer and their rights under the Code of Rights. A Complaint may be received verbally, in writing, online via the website or through a third party (with the Consumer's knowledge and consent if that Consumer has capacity to make this choice) including an advocate.[1]

**Last 6 Months: F**rom October 2021 - March 2022, when looking at the 609,919 combined Canterbury District Health Board admissions, ED and outpatient attendances provided, 821 people made a complaint (ratio 1 complaint: 743).

**Outcome Indicator:** Complaints Rate[2]




*Complaints data for last 12 months:*

| | Apr-2021 | May-2021 | Jun-2021 | Jul-2021 | Aug-2021 | Sep-2021 | Oct-2021 | Nov-2021 | Dec-2021 | Jan-2022 | Feb-2022 | Mar-2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Numerator | 134 | 150 | 138 | 149 | 114 | 127 | 143 | 163 | 123 | 121 | 137 | 134 |
| Denominator | 98,585 | 110,967 | 110,855 | 109,168 | 100,432 | 109,181 | 105,059 | 112,634 | 102,380 | 90,415 | 93,692 | 105,739 |
| Rate per 1,000 | 1.36 | 1.35 | 1.24 | 1.36 | 1.14 | 1.16 | 1.36 | 1.45 | 1.20 | 1.34 | 1.46 | 1.27 |

[1] For full definition please refer to CDHB Consumer Complaints Management Policy (PPID 2400199)

**APPENDIX 1**

*Average for YTD and last 2 financial years:*

| | 2021/22 | 2020/21 | 2019/20 |
|---|---|---|---|
| Numerator | 1,211 | 1,620 | 1,419 |
| Denominator | 928,700 | 1,271,691 | 1,180,235 |
| Rate per 1,000 | 1.30 | 1.27 | 1.20 |

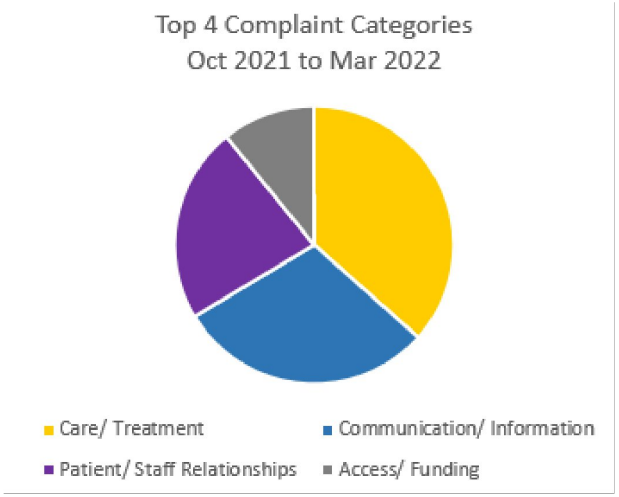
**Numerator:** Total number of complaints received in the period. (Excludes Corporate/MIQ, Community & Public Health and Canterbury Health Laboratories complaints)[3]

**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

*Note: The 2020 April/May result coincides with Lockdown.*

The top 4 complaint categories for the October 2021 to March 2022 period were:

1. Care/Treatment 390 (33%)
2. Communication/Information 317 (27%)
3. Patient/Staff Relationships 243 (21%)
4. Access /Funding 115 (10%)



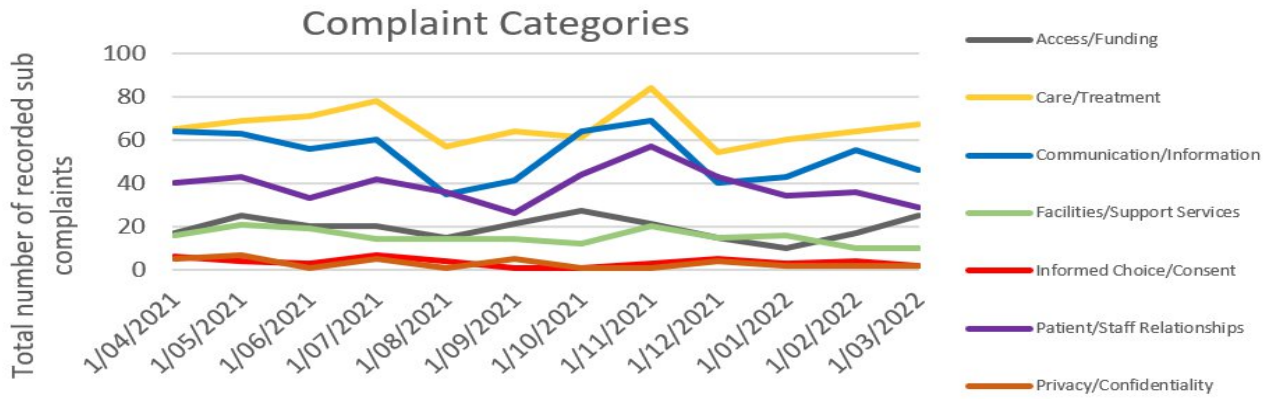

For the 2020/21 financial year the highest four categories of complaints were consistent with those reported above: Care/Treatment (671), Communication/Information (552), Patient/Staff Relationships (354) and Access and Funding (222).

A question was included in the Feedback database in March 2020 to capture if the complaint related to a Covid activity[4]. For the October 2021 to March 2022 period, 87 complaints have been recorded as Covid related.

[3] The HDC request types of 'Information Request Only' and 'Another Provider Information request' are excluded from the complaints rate numerator data.
[4] Complaints related to a Covid Activity are excluded from the Complaints numerator data.

**APPENDIX 1**

Breakdown of Complaints Categories October 2021 to March 2022:




| Start Date: 1/10/2021 | 1/10/2021 | 1/11/2021 | 1/12/2021 | 1/01/2022 | 1/02/2022 | 1/03/2022 |
|---|---|---|---|---|---|---|
| **Total Complaint Forms** | 144 | 166 | 124 | 121 | 137 | 134 |
| Total Number of Categories per complainee | | | | | | |
| 1 | 73 | 78 | 67 | 68 | 79 | 74 |
| 2 | 27 | 37 | 25 | 25 | 28 | 28 |
| 3 | 15 | 17 | 12 | 12 | 19 | 11 |
| 4 | 7 | 7 | 9 | 6 | 4 | 8 |
| >5 | 14 | 23 | 9 | 7 | 6 | 10 |
| Is this feedback related to COVID-19 activity? | 9 | 15 | 6 | 15 | 22 | 20 |
| Access/Funding | 27 | 21 | 15 | 10 | 17 | 25 |
| Care/Treatment | 61 | 84 | 54 | 60 | 64 | 67 |
| Communication/Information | 64 | 69 | 40 | 43 | 55 | 46 |
| Facilities/Support Services | 12 | 20 | 15 | 16 | 10 | 10 |
| Informed Choice/Consent | 1 | 3 | 5 | 3 | 4 | 2 |
| Patient/Staff Relationships | 44 | 57 | 43 | 34 | 36 | 29 |
| Privacy/Confidentiality | 1 | 1 | 4 | 2 | 2 | 2 |

*Note: The HDC request types of 'Information Request Only' and 'Another Provider Information request' are included in the Total Complaint Forms numbers above.*

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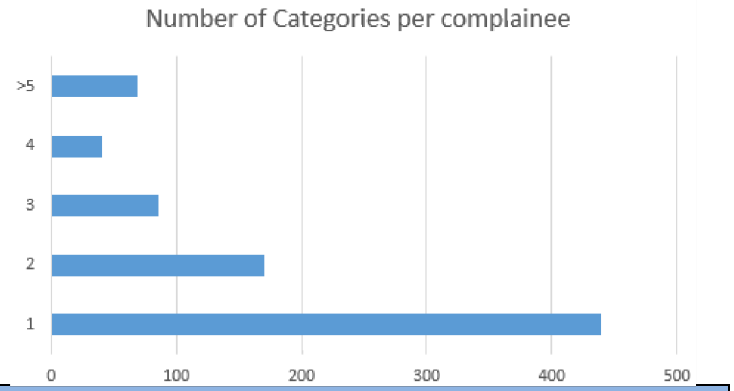
**APPENDIX 1**

When a complaint is lodged, there can be one or more categories covered. Just over half the complainants are concerned about one category such as communication/information, and just under a quarter complain about two.

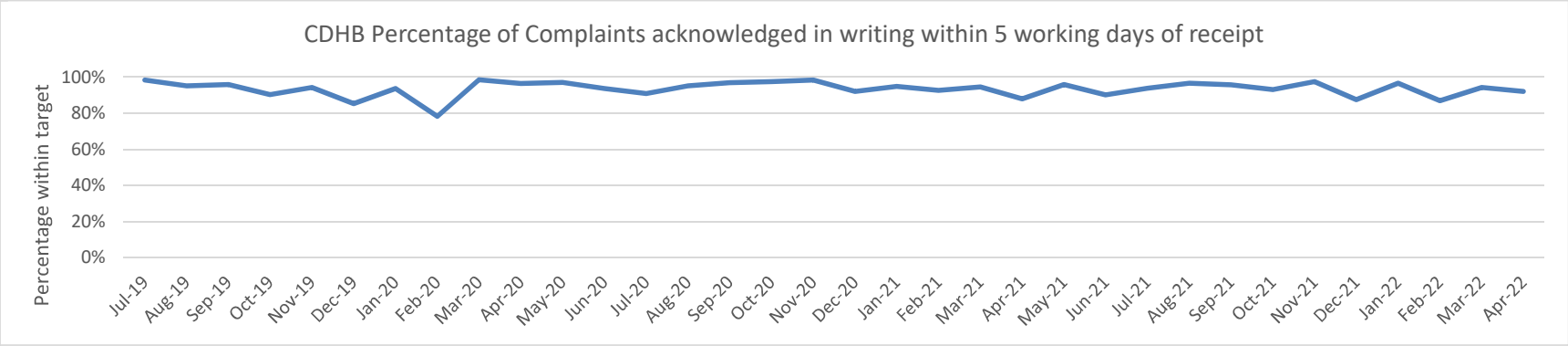



## Examples of Improvement Activity Related to Complaints Reviews

| Location | Complaint | Improvement Actions |
|---|---|---|
| **Partnership** | | |
| OPH&R | Excluded from being a support person for pre-op appointment. | Information provided about support people prior to appointments. |
| Christchurch Hospital | Family members denied due to Covid Visiting Restriction. | Guidance was reviewed to clarity Charge Nurses decision-making options for visiting. |
| **Facility/Environment** | | |
| Ashburton and Rural Health Services | Temperatures in Ward 2, uncomfortably hot over summer and cold over winter. | Iced water dispenser has been installed.<br>Fans ordered for each bed room to circulate the air.<br>Air temperatures monitored. |
| OPH&R | Only one room with a nappy change table and is also the breastfeeding room so if in use, no place to change a baby. | 3 breastfeeding / nappy change rooms available.<br>Notice at the carer's room to provide directions to alternative change table facilities.<br>Increase of additional formal signage in progress.<br>Staff reminded of the alternative change table facilities. |
| ED entrance | No 'drop kerb' close to the ED entrance making access very difficult for those with reduced mobility. | 'Drop kerb' installed. |
| ED Waiting room | Signage confusing. | Temporary and then final signage installed. |

**APPENDIX 1**

## 5-day Compliance[5]




*Data for last 12 months:*

| **All Facilities - CDHB** | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 |
| **Percentage of complaints acknowledged in writing within 5 working days of receipt** | | | | | | | | | | | | |
| Numerator | 111 | 142 | 129 | 138 | 115 | 137 | 136 | 159 | 106 | 116 | 114 | 117 |
| Denominator | 126 | 148 | 143 | 147 | 119 | 143 | 146 | 163 | 121 | 120 | 131 | 124 |
| Percentage within target | 88% | 96% | 90% | 94% | 97% | 96% | 93% | 98% | 88% | 97% | 87% | 94% |

*Average for YTD and last 2 financial years:*

| **Financial year:** | **2021/2022 (ytd)** | **2020/2021** | **2019/2020** |
|---|---|---|---|
| Numerator | 1138 | 1470 | 1256 |
| Denominator | 1214 | 1563 | 1362 |
| Percentage within target | 94% | 94% | 92% |

**Numerator:** Number of complaints acknowledged in writing within 5 working days, (excluding HDC/Privacy Commissioner/ Ombudsman/ Minister of Health Complaints)[6] within the period.

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

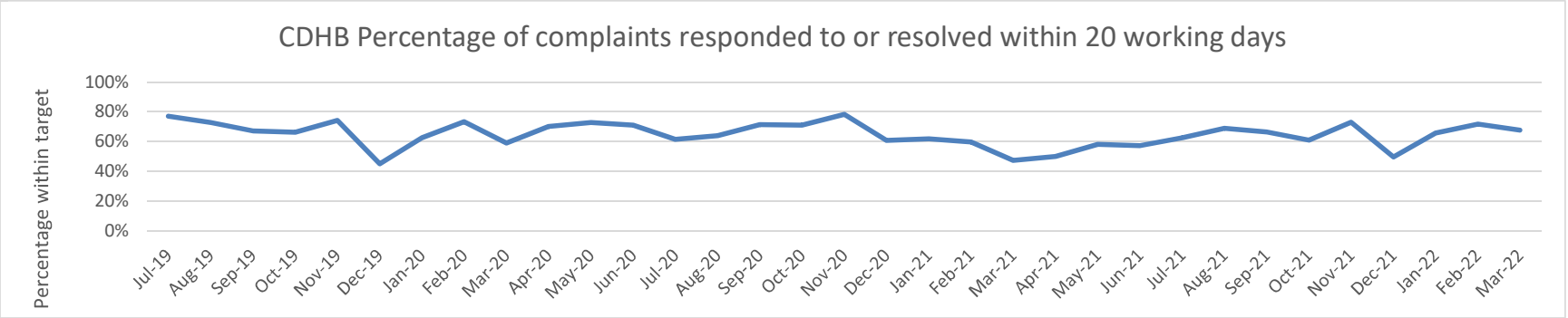
*Comments for six month reporting period:*

- The percentage of complaints acknowledged in writing within 5 working days varies below the expected level of 100%, with 94% achieved year to date.

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

**APPENDIX 1**

## 20-day Compliance[7]




*Data for last 12 months:*

| **All Facilities - CDHB** | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 |
| **Percentage of complaints responded to or resolved within 20 working days** | | | | | | | | | | | | |
| Numerator | 63 | 86 | 82 | 92 | 82 | 95 | 89 | 119 | 60 | 79 | 94 | 84 |
| Denominator | 126 | 148 | 143 | 147 | 119 | 143 | 146 | 163 | 121 | 120 | 131 | 124 |
| Percentage within target | 50% | 58% | 57% | 63% | 69% | 66% | 61% | 73% | 50% | 66% | 72% | 68% |

*Average for YTD and last 2 financial years:*

| **Financial year:** | **2021/2022 (ytd)** | **2020/2021** | **2019/2020** |
|---|---|---|---|
| Numerator | 794 | 962 | 913 |
| Denominator | 1214 | 1563 | 1356 |
| Percentage within target | 65% | 62% | 67% |

**Numerator:** Number of complaints resolved or responded to within 20 working days, (excluding HDC/Privacy Commissioner/ Ombudsman/Minister of Health Complaints)[8], within the period

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

*Comments for six month reporting period:*

- YTD 65% of complaints were responded to or resolved within 20 working days. Staff redeployment for Covid, covid leave and Customer Relations staff vacancies have impacted. Both OPH&R and SMHS have now been filled and staff are orientating.

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[7] All Facilities without date organisation notified unable to be recorded.

The percentage of complaints for the 5-day acknowledgment does not relate to the same complaint in the 20-day responses.

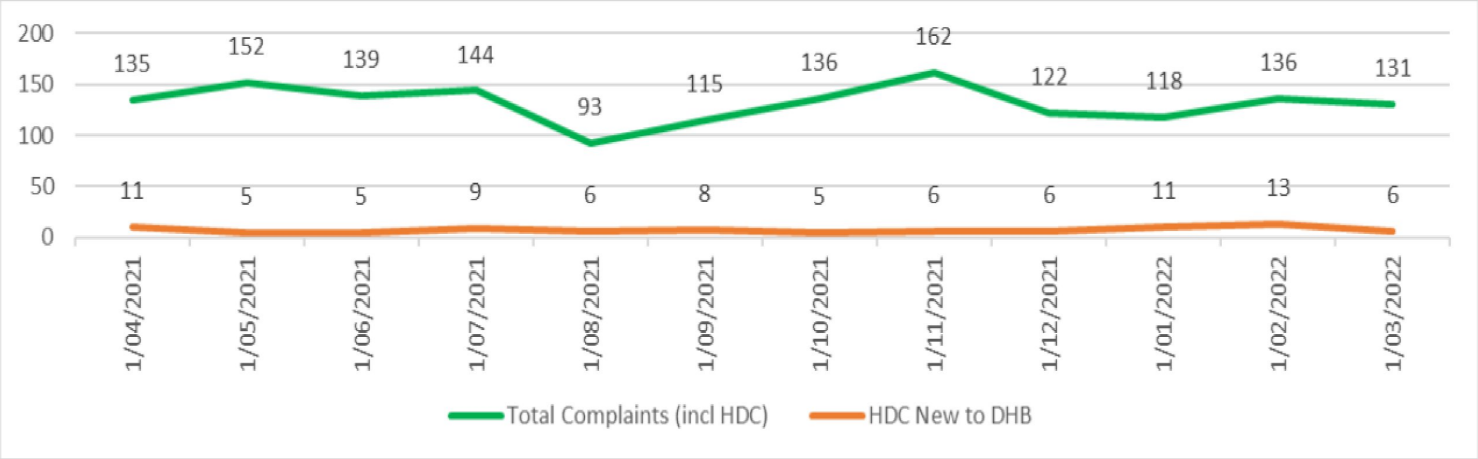
[8] HDC/Privacy Commissioner/Ombudsman/Minister of Health Complaints have different timeframes for responding and are excluded from this indicator.

**APPENDIX 1**

## Health and Disability Commissioner CDHB Complaints

The graph and table below show the number of Health and Disability Complaints as part of the Total Complaints.

### CDHB HDC Complaint Trend Report 1 October 2021 to 31 March 2022




### CDHB HDC Complaints breakdown

| Month | Oct 2021 | Nov 2021 | Dec 2021 | Jan 2022 | Feb 2022 | Mar 2022 |
|---|---|---|---|---|---|---|
| **HDC Complaint** | **10** | **12** | **7** | **11** | **17** | **13** |
| Existing DHB Complaint | 4 | 0 | 0 | 0 | 3 | 7 |
| HDC New to DHB | 5 | 6 | 6 | 11 | 13 | 6 |
| ***HDC Request Type Other*** | 1 | 3 | 1 | 0 | 0 | 0 |
| Information Request Only | 0 | 2 | 1 | 0 | 0 | 0 |
| Another Provider Information Request | 1 | 1 | 0 | 0 | 0 | 0 |
| **Total Complaints less HDC exclusions** | **143** | **163** | **123** | **121** | **137** | **134** |

# WORKPLAN FOR HAC 2022 *(WORKING DOCUMENT)*

| | 03 Feb 22 | 07 Apr 22 | 02 Jun 22 |
|---|---|---|---|
| **Standing Items** | Interest Register<br>Confirmation of Minutes | Meeting Cancelled | Interest Register<br>Confirmation of Minutes |
| **Standing Monitoring Reports** | H&SS Monitoring Report | | H&SS Monitoring Report |
| **Planned Items** | Office of the Clinical Executive Update | | Office of the Clinical Executive Update |
| **Presentations** | | | |
| **Governance & Secretariat Issues** | | | |
| **Information Items** | 2022 Workplan | | Quality & Patient Safety Indicators - Level of Complaints<br>2022 Workplan |
| | | | |
| **Public Excluded Items** | Confirmation of Minutes<br>CEO Update (as required) | | Confirmation of Minutes |