Quality Accounts

A snapshot

of how we're doing

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Canterbury Health System Quality Accounts 2012-13

ISSN 2324-2043 (Print)
ISSN 2324-2051 (Online)

Disclaimer:

We have endeavoured to ensure that information in these Quality Accounts is accurate at the time of printing.

Welcome to our Quality Accounts

All those who work in the Canterbury Health System play a pivotal role in ensuring we deliver safe and high quality health services. We are all part of making the Canterbury Health System better for our people.

We are delighted to present the Canterbury Health System Quality Accounts as a snapshot of how our health system is meeting the health needs of our community.

Our vision is an integrated health system that keeps people healthy and well in their own homes by providing the right care and support, by the right person, at the right time, in the right place, with the right patient experience. The Quality Accounts show our progress in improving service delivery and health outcomes and highlight our successes, what we have learned, and our future improvement plans.

Health begins where we live, work, learn and play. Canterbury District Health Board's commitment to helping people stay well in the community means we partner with a range of other agencies to support healthy lifestyles.

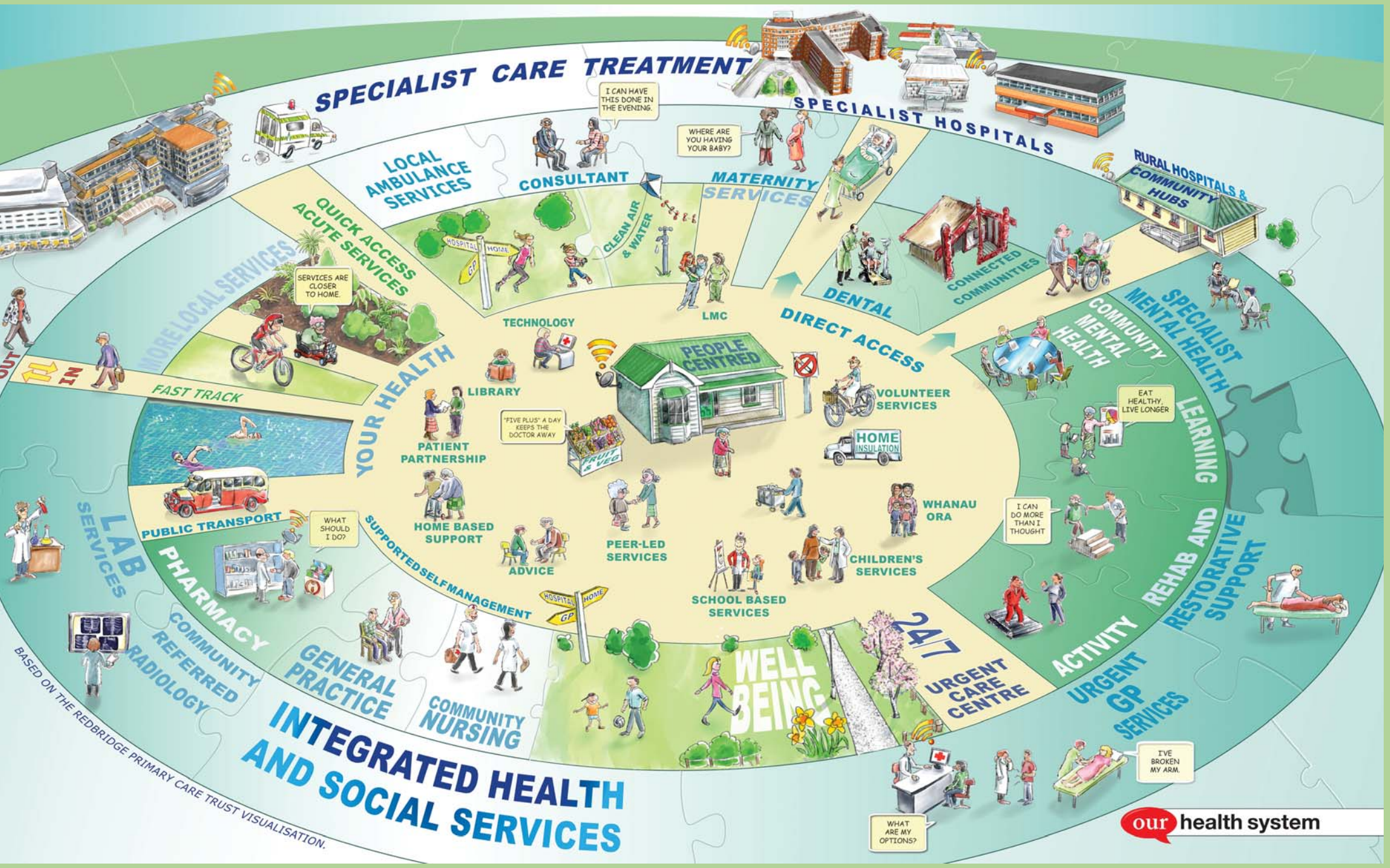
We continue to develop services in primary care and the community to support people to stay well and take increased responsibility for their own health. This helps free up our hospital-based services to provide the necessary acute and elective care, support people who require complex care and provide specialist advice to primary care providers.

All those who work in the Canterbury Health System play a pivotal role in ensuring we deliver safe and high quality health services. We are all part of making the Canterbury Health System better for our people.

We have every confidence the Canterbury Health System has the aptitude and drive to build on the successes captured in this set of Quality Accounts and continue to go from strength to strength through supporting a culture of continuous quality improvement and innovation.

David Meates
Chief Executive,
Canterbury DHB

Dr Daniel Williams
Chair,
Canterbury Clinical Board


SPECIALIST CARE TREATMENT
SPECIALIST HOSPITALS
RURAL HOSPITALS & COMMUNITY HUBS
LOCAL AMBULANCE SERVICES
CONSULTANT
MATERNITY SERVICES
I CAN HAVE THIS DONE IN THE EVENING.
WHERE ARE YOU HAVING YOUR BABY?
QUICK ACCESS ACUTE SERVICES
CLEAN AIR & WATER
HOSPITAL
HOME
GP
MORE LOCAL SERVICES
SERVICES ARE CLOSER TO HOME.
DENTAL
CONNECTED COMMUNITIES
SPECIALIST MENTAL HEALTH
COMMUNITY MENTAL HEALTH
LEARNING
REHAB AND RESTORATIVE SUPPORT
ACTIVITY
URGENT GP SERVICES
I'VE BROKEN MY ARM.
24/7 URGENT CARE CENTRE
WHAT ARE MY OPTIONS?
WELL BEING
COMMUNITY NURSING
GENERAL PRACTICE
COMMUNITY REFERRED RADIOLOGY
PHARMACY
LAB SERVICES
SUPPORTED SELF MANAGEMENT
WHAT SHOULD I DO?
PUBLIC TRANSPORT
FAST TRACK
IN
OUT
YOUR HEALTH
TECHNOLOGY
LMC
DIRECT ACCESS
PEOPLE CENTRED
LIBRARY
"FIVE PLUS" A DAY KEEPS THE DOCTOR AWAY
FRUIT & VEG
VOLUNTEER SERVICES
HOME INSULATION
PATIENT PARTNERSHIP
HOME BASED SUPPORT
ADVICE
PEER-LED SERVICES
SCHOOL BASED SERVICES
CHILDREN'S SERVICES
WHANAU ORA
EAT HEALTHY, LIVE LONGER
I CAN DO MORE THAN I THOUGHT
INTEGRATED HEALTH AND SOCIAL SERVICES
BASED ON THE REDBRIDGE PRIMARY CARE TRUST VISUALISATION.
our health system

The Canterbury way: A whole-of-system approach

For the Canterbury Health System, quality means delivering the right care and support, by the right person, at the right time, in the right place, with the right patient experience.

We have set a patient safety vision of 'zero harm' and we believe the key to achieving this and ensuring we deliver quality health services is to take a whole-of-system approach. It is not just about hospitals but about a whole system where all Canterbury health services work collaboratively to wrap care around people.

A large part of our success will rely on improving patient flow throughout the health system by ensuring pathways of care are aligned between our hospitals and the community. Improving patient information systems will enhance the sharing of information across community services, general practice teams and hospitals.

Since 2007 we have been collectively working to refocus the health system around the needs of people, removing traditional boundaries and barriers and improving outcomes for Canterbury's population. Partnerships and alliances now exist across the Canterbury Health System to enhance the way services are delivered and help us work towards our three strategic goals:

1. **People taking greater responsibility for their own health**

   The development of services to support people to stay well and take increased responsibility for their own health and wellbeing.

   Population health and prevention programmes ensure people are better protected from harm and are supported to maintain healthy lifestyles. Canterbury's earthquakes brought many challenges but also provided new opportunities to work with the wider community on things that affect our health such as housing, immunisation, smoking and alcohol.

   New Zealand is experiencing growth in long-term conditions such as respiratory disease, diabetes and heart (cardiovascular) disease. These conditions are major causes of poor health and account for a large number of visits to general practice teams and hospitals. We can expect the burden of long-term conditions to increase with our ageing population.

   Supporting people to make healthy choices will enable our population to attain a higher quality of life and avoid, delay or reduce the impact of long-term conditions on our health care services.

2. **People staying well in their own homes and communities**

   The development of primary care and community services that support people in a community-based setting and provide a point of ongoing continuity.

   Health professionals, including midwives, community nurses, social workers, physiotherapists, pharmacists, residential care providers, Māori and Pacific providers and community organisations all work in the community. For most people, their general practice team is their first point of contact with health services. Primary and community services can deliver services sooner and closer to home and help prevent disease and acute illness through education, screening, early detection and timely provision of treatment.

   Primary and community services have an important role ensuring long-term conditions are managed effectively and services are coordinated. They assist people to get back on their feet after illness and to remain as healthy and independent as possible. Primary and community services are vital, particularly in improving the management of care for people with long-term conditions and older people with more complex conditions. They work closely with hospital-based teams to make sure the right services are being provided by the right person, at the right time, in the right place, with the right patient experience.

3. **People receiving timely and appropriate complex care**

   Through the provision of complex care and support and specialist advice to primary care hospital-based specialist resources are freed up to be responsive to episodic events.

   Secondary-level hospital and specialist services meet people's complex health needs and support community-based care providers. By providing appropriate and timely access to high quality specialist hospital services, people's health outcomes and quality of life can be improved.

   Doctors, nurses and allied health professionals, along with patients and their families, make decisions regarding complex treatment and care. For those who need a higher level of care, timely access to high quality services can help improve health outcomes. However, not all decisions about care result in prolonging life but may focus on improving the patient's quality of life such as pain management or palliative services.

Shorter waiting times and fewer re-admissions are indicative of a well functioning system that matches capacity with demand by managing the flow of patients through services.

As providers of hospital and specialist services, district health boards (DHBs) are operating under increasing demand and workforce pressures. The expectations around reducing waiting times, coupled with financial challenges, mean DHBs need to develop innovative ways of treating more people and reducing waiting times with limited resources.

Our Quality Accounts

Developing a set of Quality Accounts was identified as a priority for the Canterbury District Health Board in 2011. In our 2011-12 Quality Accounts document we identified a number of priority areas of work:

- The consumer experience
- Reducing alcohol-related harm
- Managing influenza
- Managing avoidable hospital admissions
- Preventing patients in our hospitals being harmed
- Improving end of life care

Progress on these priority areas is included throughout this set of Quality Accounts (2012-13) or in the section entitled 'Summary and update on priorities identified for 2012-13. The only exception is the 'Zero harm from falls' spotlight area where the information has been split between 'Reducing avoidable hospital admissions' (community falls prevention) and 'Preventing patients in our hospitals being harmed' (inpatient falls prevention).

The 2012-13 Quality Accounts introduce some new spotlight areas:

- Responding to the needs of Māori and Pacific people
- Enhancing mental health and wellbeing
- Embracing quality improvement and innovation
- Transforming infrastructure and design

We are working towards measures for our new sections. Together, these ten spotlight areas along with our progress against the National Health Targets are designed to provide you with a snapshot of how we are doing and highlight some of our key areas of work.

A sub-group of the Canterbury Clinical Board oversaw the development of the 2012-13 Quality Accounts. Members included the Chair of the Clinical Board, the Medical Director Patient Safety, the Director for Quality and Patient Safety and representatives from the Executive Management Team, Planning and Funding, Community and Public Health, Primary Care, the Canterbury Clinical Network and the Canterbury DHB Consumer Council. This sub-group worked very closely with the Quality Accounts' working group to pull this document together and identify key information and relevant areas of work to highlight to the people of Canterbury.

The Quality Accounts are aligned with many of the Canterbury DHB's key accountability documents: the Annual Plan 2013-14, the Statement of Intent 2013-2016, and the Māori Health Plan 2013-14. All of these documents are available on the Canterbury DHB website www.cdhb.health.nz. The performance reporting against the service and financial performance goals outlined in these documents is presented publicly every quarter to the Canterbury DHB Board and annually in the Canterbury DHB's Annual Report (also available on Canterbury DHB's website www.cdhb.health.nz).

We want to hear from you

We will be publishing a set of Quality Accounts for the Canterbury Health System each year so your feedback is very important to us. This feedback will help us ensure the Quality Accounts provide relevant and useful information on the quality of health services being delivered in Canterbury.

You can let us know what you think by emailing qualityaccounts@cdhb.health.nz or write to Susan Wood, Director Quality and Patient Safety, Canterbury DHB, PO Box 1600, Christchurch.

This set of Quality Accounts and the 2011-12 Quality Accounts are available on the Canterbury DHB website, www.cdhb.health.nz, and in hard copy.


Improving consumer
experience

The Emotional Journey

The Emotional Journey initiative aimed to understand patients' view of their health care experience from an emotional viewpoint; to engage patients and their friends/relatives in various hospital contexts and to identify opportunities to inform future hospital design. The initiative involved interviewing 136 patients from general surgery, general medicine, orthopaedics and cardiology while they were in hospital or at their home.

Patients showed varying and changing emotional responses to being in hospital. In some cases this was a progression of emotional states ranging from shock through to acceptance and gratitude. Patients' emotional responses were generally linked to how emotionally prepared they were for hospital, the nature of their circumstance, the seriousness of their condition, their attitude/ personal philosophy and their life-stage.

Some patients appeared to struggle with the immediate disconnection from their day-to-day lives, displaying a sense of unease around being cast into a situation and system beyond their own control, whereas others were in a less traumatised, more reflective state – expressing a sense of acceptance and relief at having their medical needs met.

Some key themes emerged from the patient stories. Their feelings were triggered by their perception of staff and the service they received, by what was happening outside of hospital; the levels of communication and provision of information they experienced; and the hospital's physical environment.

Mrs Helen Campbell

The Emotional Journey initiative successfully engaged patients and helped us to understand, from an emotional viewpoint, their perspective of their health care experience. It also gave us the opportunity to identify key issues that should be considered in future hospital design.

Mrs Helen Campbell was part of the Emotional Journey initiative and kindly agreed to be filmed. She assisted us to understand the patients' view of health care from an emotional viewpoint. Her insightful feedback has set design challenges for our new hospital and continues to be a focus point for activities at our hospital Design Lab.

Helen's observations from an emotional angle have been humbling and incredibly valuable not only for the design process but also for training purposes. In allowing us to film her story, along with other patients and family members, she has directly challenged and instigated changes throughout the health system. Helen was delighted to be taken through the Design Lab to see how her input had affected ward design.

Improving consumer experience

Research shows us that better experiences, developing partnerships with patients, and patient and family centred care are linked to improved health, clinical, financial and service outcomes.

Background

Consumers have a unique perspective of health services and provide important information about the experience of care they receive. Research shows us that better experiences, developing partnerships with patients, and patient and family centred care are linked to improved health, clinical, financial and service outcomes.

We are continuously looking at ways of improving our services and the people who use those services are the best people to consult. We have a number of different ways of gathering feedback to help us "listen to the voice of the consumer". These include our website, surveys, focus groups, suggestion boxes, compliments or complaints and family meetings.

When a consumer's experience of our health services does not meet their expectations, we want to hear about it. We assist in a respectful manner with the fair and efficient resolution of complaints in accordance with The Code of Health and Disability Services Consumers' Rights (The Code of Rights).

The Canterbury DHB Consumer Council

The Canterbury DHB Consumer Council is another way we get feedback on how we can improve the consumer experience of our health care system. The Consumer Council's slogan is 'Nothing about us, without us', meaning that health care should always be planned with consumer involvement from the beginning.

The Council has 16 members whose interests include Māori health, Pacific health, mental health, people with long-term conditions, people with physical, intellectual and sensory disabilities, older people, family, child and youth health, rural communities, refugee and migrant communities, people with visual and hearing impairment and people with alcohol and other drug addictions.

Consumer Council members have diverse backgrounds, knowledge and skills and are all passionate about consumers being able to access the best possible care from the Canterbury Health System. Collectively they have a broad range of understanding and experience of how it feels to be a consumer and what consumers need. During the past year consumer input has helped develop The Shared Care Record View (eSCRV), an electronic patient information sharing system, and Advance Care Plans. They have also been involved with the Pulmonary Rehabilitation Working Group, and with the design forum of the new Burwood Health campus.

Council members sit on most of the Canterbury Clinical Network's Service Level Alliances and the Alliance Leadership Team. This enables

consumers to work in partnership with clinicians and health managers at a senior level, to influence the transformation of our health system. For more information about the Consumer Council visit the Canterbury DHB website at www.cdhb.health.nz and enter Consumer Council in the search box.

The Consumer Council is currently working on a guide for services on how best to ensure effective consumer participation. This will be available early next year. In the meantime requests for input into service development projects and health system process improvements can be made by contacting Wayne Turp, Project Specialist, CDHB, Email wayne.turp@cdhb.health.nz or telephone 03 364 4130.

Key focus areas

Partners in care projects

(Identified as a priority in the 11-12 Quality Accounts for 12-13)

This programme supports and enables patient and consumer engagement and participation across the health and disability sector. It aims to increase people's participation in decision-making about their own health and about the way health and disability services are delivered.

The Canterbury DHB initially identified four projects, and project teams were set up to include at least one consumer and one health professional. The teams attended a co-design of health services workshop and participated in online seminars and presentations until their projects were completed. Of the four projects identified, two were progressed.

1. Improving the Wellbeing Programme in Te Awakura (the Specialist Mental Health Acute Inpatient Service). The Wellbeing Programme project is part of the Direction for Change proposal in the adult services within the Specialist Mental Health Services. The working party designed a new inpatient therapeutic programme for the acute inpatient wards, to align with the new model of care and service delivery structure being introduced across the Adult Specialist Mental Health Service.

2. Promoting Consumer Focus Groups.[1] This project was a partnership with the Aged Residential Care Service Level Alliance to focus on improving delivery of respite care in Canterbury. It aimed to show how experience-based design can influence quality improvements to a health service. The initiative captured service users' experiences through focus groups, Likert scales[2] and questionnaires.

[1] A focus group is a group discussion that is organised to explore a specific set of issues. 'The group is focused in the sense that it involves some kind of collective activity such as viewing a film, examining a single health education message or simply debating a particular set of questions'. [Boulton, M. Challenge and Innovation. 1994. Chapter 10].

[2] This is a psychometric scale commonly involved in research that use questionnaires. The responses are scored along a range.

HealthInfo designed for patients and families

Designed especially for patients and their families/whānau, HealthInfo (www.healthinfo.co.nz) provides useful locally-approved information about health conditions, diagnosis, treatment, and referral options. HealthInfo business cards are now routinely handed to patients by many general practices, pharmacies and other health organisations. The health professional will write the search term in the space provided.

Website visits have increased by 380 percent over the past year. The focus over the next year will be on reviewing the website layout and design and improving the content.

Oncology Outreach Nursing Service

Cancer patients being treated with chemotherapy are at risk of complications from the treatment and may become high users of urgent hospital

services. The Canterbury Regional Cancer and Haematology Service, the Cancer Society and Southern Cancer Network identified that there was insufficient patient support during the high-risk period of active treatment. In January 2013 an Oncology Outreach Nursing Service was created.

The service is provided by a Clinical Nurse Specialist and Registered Nurse. The patient groups who are most likely to benefit from this follow-up service have been identified and include the elderly with gastrointestinal, head and neck cancers and complex cases with high needs.

Although the service is still in its infancy, it clearly supports the 'better sooner more convenient' philosophy in delivering patient-centred care. We believe this outreach service will reduce the use of urgent hospital services for these patients. Patients say they feel well supported and find the 'one person contact' gives continuity and is reassuring. Doctors are also providing direct referrals for patients who feel more comfortable with treatment if they have closer supervision from specialist nursing support.

"We believe this (oncology) outreach service will reduce the use of urgent hospital services for (cancer) patients."

Delivering antibiotics at home

The model of care for patients who require antibiotic injections at home for complex infections has been reviewed, resulting in enhanced delivery of this service within the Christchurch region. Nurse Maude, a home care provider and the Infectious Disease Department worked collaboratively on this review to ensure our service is aligned with best practice.

There are now several models available to suit individual needs at discharge including self administration, attending a community-based infusion centre, and home visits for patients who have mobility issues. This service can reduce the length of hospital stays by providing care at home or nearby. An average of 40 patients a day currently use this outreach service.

Welcoming sick children

The paediatric areas have just received a resource booklet for families with sick children. The Welcome Book was designed by the Child Health Family Advisory Council[3] in collaboration with the Charge Nurse Managers and other staff to provide practical information that sick children and their families may find useful when accessing Child Health inpatient/outpatient services.

A wide range of information can be found within the book, from car parking and nearby shopping facilities to encouraging families to know more about their children's illness and treatments. Some of the content is information that parents from the Child Health Family Advisory Council felt was not readily available but made a positive impact particularly during inpatient hospital stays. The Welcome Book is a great example of consumer engagement where health care providers partner with families to improve services and their health care experience.

[3] The Child Health Family Advisory Council is made up of parent volunteers who have experienced or are currently experiencing Child Health services, along with a number of Child Health staff.

Improving services for women in secure mental health care

Women's needs in secure mental health care can be vastly different from men's and it is important that our forensic services reflect these needs. The Canterbury Regional Forensic Psychiatric Service developed an audit tool for female service users which was subsequently used in all of New Zealand's five forensic services. The findings from these audits and focus groups identified strengths and opportunities to improve the existing service.

The audit confirmed there were gaps within the mixed framework of providing open and closed groups within the Canterbury Regional Forensic Psychiatric Service. Service improvements and changes for women accessing secure mental health care in Canterbury include developing open and closed group work, the closed Women and Relationships group, enhanced environments and women-only spaces.

A closed group manual for a 14-session therapeutic programme, 'Women and Relationships', was developed. Sessions focused on developing knowledge and awareness of relationships and associated themes such as loss, emotions, guilt, violence, trust, confidence building and coping strategies. A greater range of materials and resources is also available to women to complete valued roles such as pampering, self-care tasks, creative projects and cooking.

These women-only interventions are now firmly embedded in our inpatient therapeutic programmes. Female service users have acknowledged the effectiveness of these changes in enhancing their willingness to engage and talk more about their previous behaviours and offending: "I started to realise that if I made the effort and thought about who I wanted to be that I could change". The Closed Group Manual has been a valuable tool and has been shared nationally.

Measuring consumer/patient experiences

The Health Quality & Safety Commission (HQSC) is currently developing national indicators to improve consumer/patient care and experience on a national and local level. We provided feedback for the four patient experiences they recommended: communication, partnership, coordination and physical and emotional needs.

We also expressed our interest in assisting the HQSC with a pilot to test the draft tool that has been developed.

Priorities for the next 12 months

Consumer Experience Survey

Rollout of a consumer experience survey across the Canterbury DHB.

Health Passports

Health Passports are being introduced throughout New Zealand by the Health and Disability Commissioner. Educating the health workforce on the benefits of the passport will be a key area of work over the coming year. The Health Passport is designed to assist nursing, medical and support staff to understand the care, communication and support needs of people with disabilities. The passport belongs to the patient, is held and updated by them, and should be brought with them to hospital. Patients who will benefit most from completing a Health Passport are those who have difficulty communicating, people with dementia, and those who visit hospitals frequently. Passports are available from disability service providers/support groups, the Health & Disability Commissioner (0800112 233) or can be downloaded from www.hdc.org.nz.

Responding to the needs of Māori and Pacific people

An appetite for life

Appetite for Life (AFL) is a six-week interactive nutrition and physical activity programme within Canterbury. Information and tools are shared with participants, focusing on many small lifestyle changes that together add up to a big change in health. The emphasis on health gain rather than impossible weight loss goals allows people to lose weight slowly, maintain their weight loss and enjoy the process throughout.

AFL relies on facilitators trained in good nutrition, physical activity and cultural knowledge to present the programme in a way that is relevant to participants. Valuing participant experiences and incorporating their stories into the delivery of the programme is an important part of the process. The course is delivered with humour and uses the knowledge and experiences of the facilitators who can share some of their own whānau stories alongside the group participants.

Pegasus Pacific Health Manager and AFL facilitator Maria Pasene says “where we deliver, how we deliver, who delivers and in what way we deliver makes all the difference for our communities”.

“When a service is delivered in a community setting, where community norms and protocols dictate the manner in which we deliver and individual and group knowledge dictates what and how services are delivered, we know we are on the right track.”

Te Korimako, a division of Te Kakakura Health Services, is a kaupapa Māori residential care and supported access service for Takata Whairora, mental health consumers. The nine Māori male residents of Te Korimako aged between 20 and 50 have recently become AFL champion participants and advocates within their residential setting.

Wiremu, Te Korimako resident and participant in the AFL course, now understands his own eating habits and feels confident about making healthy choices when it comes to preparing and eating food.

“It’s been great to have more insight into what motivates me to eat so that I can practice mindful eating rather than just eating without thinking about what I’m doing.”

Maria Pasene adds “we all remember the loaf of white bread and butter on the table when we were young. It was the only way our parents could afford to fill our tummies, but now we know there are other ways to achieve fullness that also promote good health and wellbeing. It’s the sharing of these stories that we can all relate to that connects us and shows participants they are not alone in their experiences.”

Clinical Manager of Te Korimako Joy Drummond has been delighted with the results: “It has been great to see how this new knowledge has influenced the eating behaviour and choices that the guys now make in the house. They have

Wiremu, Te Korimako resident and a participant in the Appetite For Life course.

been able to support each other and share this knowledge with their extended whānau.”

The success of the AFL programme at Te Korimako relied on a familiar setting that allowed changes to be applied immediately to the home environment. The residents were proactive in requesting changes to more low fat, low salt and high fibre groceries in the house. The facilitator’s ability to see the immediate changes made in the shared residential setting made it possible to measure the course success and see long-term sustainable change in the home.

Responding to the needs of Māori and Pacific people

Background

Health inequalities are the differences in health status between different population groups that are unnecessary and avoidable. The Canterbury Health System is strongly committed to reducing health care inequalities and improving the overall health status of our more vulnerable populations in Canterbury, particularly Māori and Pacific people. There are many similarities between these two groups, yet some quite distinct differences.

Māori

In Canterbury, there are about 33,500 Māori enrolled with general practices, making up seven percent of the total population. Ngāi Tahu/Kāi Tahu is the most common iwi affiliation, although there are over 120 other iwi represented in the region. As a population group, Māori are a diverse, relatively young and growing population with numerous health inequalities across a wide range of disease areas, clinical settings and services. These inequalities persist even after factoring in poverty and education. As a high proportion of Māori access general practice services, understanding our Māori population is vital to be able to provide the best clinical care.

Pacific people

Like Māori, the Pacific population is youthful when compared with the non-Pacific population. There are an estimated 11,500 Pacific people in Canterbury including Samoans, Tongans, Cook Islanders, Fijians, Niueans, Tokelauans and Tuvaluans. Pacific people have poorer health status than the rest of the population and appear to have gained least from changes in primary care delivery.

Health indicators for life expectancy, avoidable mortality and hospitalisations suggest that health and disability services are not fully meeting the health needs of Pacific people. Socio-economic determinants also influence Pacific health status but cannot fully explain different outcomes from health care services. While the enrolment of Pacific people with mainstream primary health care services (82 percent) is good, this does not reflect the level of participation and engagement of Pacific people in primary health care and in the wider health service.

Key focus areas

There are many areas in which the health system can improve the health of its population. For Māori and Pacific peoples action is required to improve access, responsiveness and quality of care.

Whānau Ora

Whānau Ora is a Māori cultural concept that encompasses a wider and more holistic view of health than a focused clinical perspective. Health and wellbeing is described in the context of relationships, social environments and the wider determinants of health.

Whānau Ora is also an effective way primary care services can positively contribute towards improving health outcomes for Māori. It is essential to build on the integral strengths and assets of whānau and Māori communities and assess proposed interventions from a whānau, hapu, iwi and Māori communities' perspective.

General practices need to be supported to ensure their patients are cared for in a culturally appropriate way throughout their journey within the health system. Support for practices is available from Whānau Link, Partnership Community Workers and engagement with Māori providers like He Waka Tapu, Te Puawaitanga Ki Ōtautahi Trust, and Te Kakakura.

Te Kāhui o Papaki Kā Tai

Te Kāhui o Papaki Kā Tai is the Canterbury-wide Māori reference group with close links to primary care, the Canterbury DHB and the Canterbury Clinical Network District Alliance. The group provides leadership, advice and influence ensuring Māori health is consistently considered throughout the Canterbury Health System.

Earlier this year, members of Te Kāhui o Papaki Kā Tai along with Canterbury DHB planning and funding staff worked together for several months to develop the Canterbury Māori Health Framework – 'Kia whakakotahi te hoe o te waka' which means 'We paddle our waka as one'. This is a collective outcomes framework that acts as a basis for all organisational work plans; it identifies shared outcomes and priority areas for Māori health and encourages collective efforts across the Canterbury Health System. With this framework as a foundation for Māori health improvement, it is envisioned that we can reduce health inequalities by paddling our waka in unison in the same direction.

Pacific Workforce Development

These activities include developing a comprehensive cultural competency programme for primary health and the development and advancement of the Pacific health workforce through professional training, scholarships and leadership development and delivering specific education topics that relate to Pacific health needs in mainstream services.

Canterbury Pacific Heath Worker's Network

The Canterbury Pacific Heath Worker's Network was set up this year to meet identified training needs of Pacific heath professionals and provide an opportunity for Pacific health workers to network, share information and collaborate on projects. The group identified the topics and this year workshops were delivered by guest speakers and members of the network on health literacy, writing skills, project planning and evaluation and cultural competency.

Pacific Reference Group

The Pacific Reference Group is a Canterbury-wide group of clinicians, community representatives, Pacific health providers and Government. The group plays an advisory and advocacy role for health services developed for Pacific peoples in the Canterbury region. Pacific health progress is measured by quarterly updates and the annual updating of the Pacific Primary Care Report.

Pacific focus on health literacy

Health literacy is the capacity to obtain, process and understand basic health information and services to make informed and appropriate health decisions. We can improve health literacy and the health of Pacific people through community education, investing in professional development and advocating for the re-orientation of health services and policies. This year health literacy workshops have been held for the Partnership Primary Health Organisation Board, Christchurch Polytechnic Institute of Technology, Pacific Health Worker's Network, and Breast and Cervical Screening groups.

Measures

Performance against how well we are doing in primary care is monitored and delivered through the Primary Care Reference Groups and at a governance and operational level through the Primary Health Care Reports.

Māori Primary Health Care Report

The Māori Primary Health Care Report is a retrospective annual report of the Canterbury Primary Health Organisation (PHO) and provides a foundation for addressing how primary health care services could be improved to optimise health outcomes.

Figures 1 and 2 show that the make-up of the Māori enrolled population is quite different to the non-Māori enrolled population. The Māori enrolled population has a much larger percentage of people aged under 25; for example the 0-4 age group represents almost 12 percent of the total Māori enrolled population, but only about 6 percent of the total non-Māori enrolled population.

Pacific Primary Health Care Report

The Pacific Primary Health Care Report is the annual report of the primary health organisation's activities for Pacific people and provides a foundation for addressing how primary health care services could be improved to optimise their health outcomes.

The distribution of the Pacific peoples enrolled population (see Figures 3 and 4) is very similar to that of Māori and therefore quite different to the non-Pacific people enrolled population, in that there is also a much larger proportion aged under 25 than among non-Pacific people.

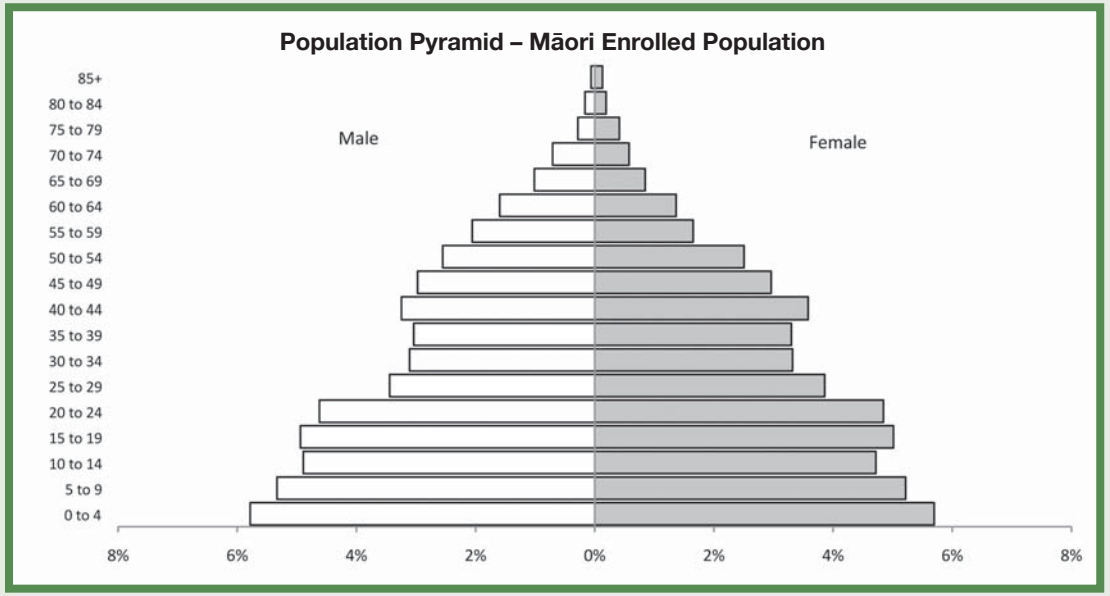


Figure 1: Population Pyramid – combined the Primary Health Organisation's Māori enrolled population in Canterbury – 2011-12 (based on Partnership Health Canterbury data)

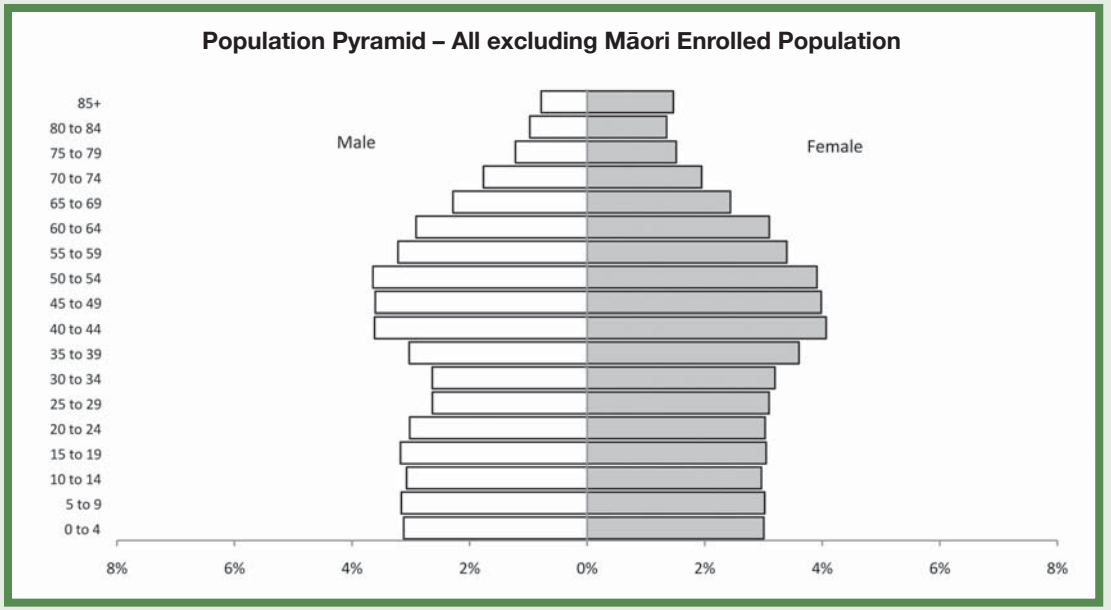


Figure 2: Population pyramid – combined the Primary Health Organisation's "other" enrolled population in Canterbury – 2011-12 (based on Partnership Health Canterbury data)

Summary

Access to health services is not just about the quality of services that a person receives but also whether they walk through the door. For Māori and Pacific populations this means those services need to be culturally competent and attend to their levels of health literacy.

Priorities for the next 12 months

Recommendations from the Māori and Pacific primary health care reports help inform strategies and activities for the following year with the following key priorities for 2013-14:

- An ongoing commitment to improve ethnicity data quality with the establishment of regular training for general practice to ensure that recording and collating data for iwi and different Pacific groups is accurate and consistent.
- Ongoing development of a programme that supports health professionals to provide culturally competent services.
- Completing a Pacific health framework.
- Continuing work on the priority areas of oral health, Human Papilloma Vaccine (HPV) programme, cervical screening and Before School Checks.

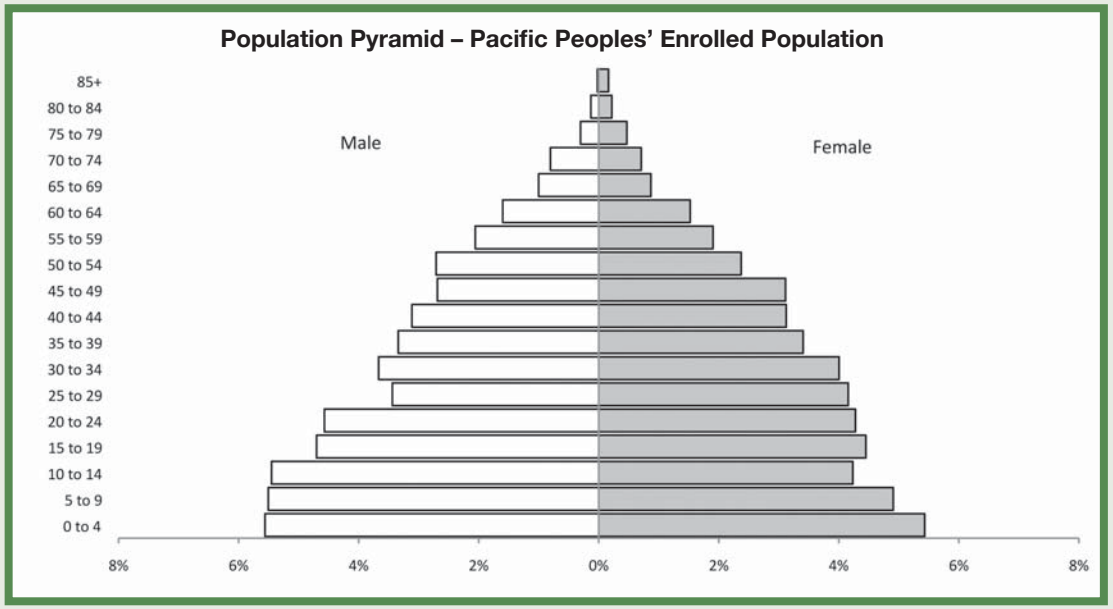


Figure 3: Population Pyramid – Pacific Peoples' enrolled population in Canterbury – 2011-12 (based on Partnership Health Canterbury data)

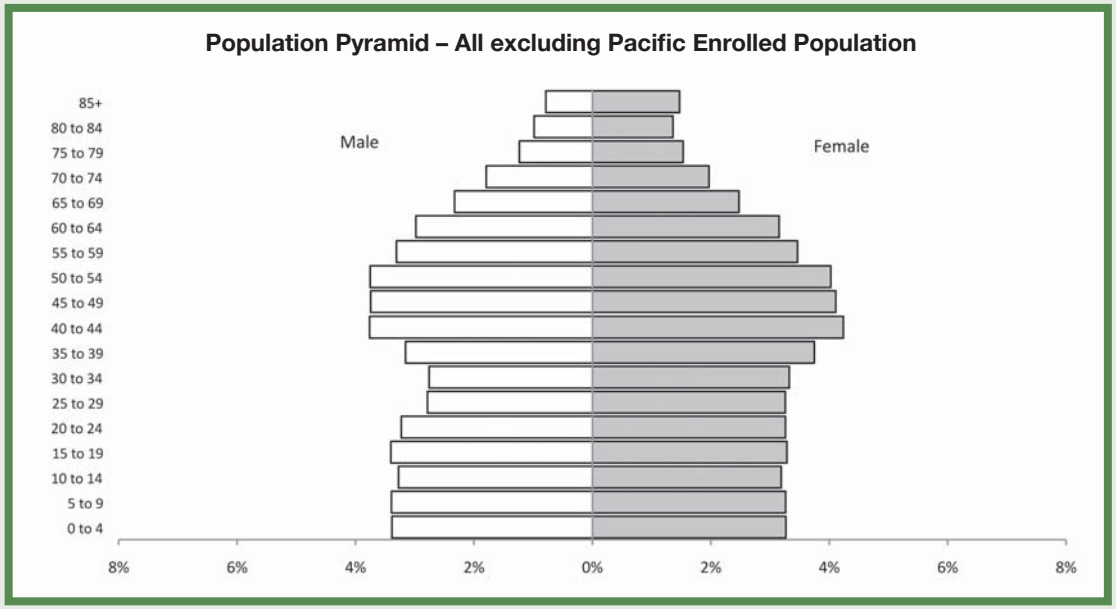


Figure 4: Population pyramid – 'Other' enrolled population in Canterbury – 2011-12 (based on Partnership Health Canterbury data)

Enhancing mental health and wellbeing

Working together to create better outcomes for consumers and families

Improving the way mental health clients access residential care was the objective behind the Residential Options Group (ROG). It was initially set up as an emergency measure after the February 2011 earthquake, but it proved so successful that it has been adopted longer term.

The group involves leaders from non-government organisations (NGOs), residential care providers, Specialist Mental Health Services and Planning and Funding, working together to receive referrals, to match people with the best service to meet their needs, and to maintain an overview of residential capacity across the Canterbury system.

Brad Macdonald, social worker/case manager for the south sector Community Mental Health Team, says case managers refer clients to ROG and the group meets weekly to discuss residential care options best suited to individual clients.

"ROG members are given enough time to familiarise themselves with the referral so they are well prepared with questions or thoughts. I find this element helpful. ROG is a good forum to talk directly to NGO providers together and allows for an efficient process, as all the relevant players are present. This saves time arranging separate meetings as we have in the past."

Brad also highlights the importance of maintaining high levels of consumer and family involvement and choice in this process. ROG can shed light on areas and other options available in the community, Brad says.

"If a residential placement has been declined, although it can be frustrating and require further discussion between the clinical team and ROG, it isn't always the end of the world. The group recommends alternatives in the community."

(ROG members) receive referrals, match people with the best service to meet their needs and maintain an overview of residential capacity.

Although a ROG referral takes time for the case manager to complete, it ensures decisions the group makes about eligibility for residential services are robust and based on quality information. After a referral is accepted the client is assigned a Residential Options Service Coordinator (ROSC).

"The coordinator provides continuity of care and works in with the various sector teams and NGOs to secure a successful placement. It is helpful, as they become very familiar with the key aspects of a person's care and can help with future placements."

The ROSC co-ordinates residential reviews every three months with residential staff and the case manager where goals are reviewed and clients are encouraged to achieve them.

"This enables a good forum for the client, family/whānau, NGO and Canterbury DHB staff to collaborate and address any issues/concerns and allows for cohesion," Brad says.

Enhancing mental health and wellbeing

Background

The mental health and wellbeing of Cantabrians has gained a significantly higher profile in the wake of the 2010-11 earthquakes. The challenges of the past three years have required mental health service providers to work harder and more creatively in a time of increased need and in the midst of challenging circumstances. The events have also reinforced the need for closer working relationships between Canterbury DHB Specialist Mental Health Services and the wider mental health sector to provide more seamless services to consumers and their families.

The Specialist Mental Health Service (SMHS) represents a large division of the Canterbury DHB and provides specialist mental health support in various settings across the spectrum of needs and age groups from children and youth to adults.

To respond effectively to the mental health needs of Cantabrians, SMHS works within the mental health system to:

- Remove traditional boundaries between providers, teams and care settings to achieve the best possible health outcomes for the consumer and their family/whānau.
- Develop systems which support and facilitate fast, efficient and thorough assessments to ensure consumers get what they need when they need it.
- Build upon existing strengths and working relationships between specialist mental health services, NGO services and other statutory organisations.
- Provide an increasingly mobile and technologically advanced service.
- Provide rapid, targeted support to consumers in their own homes and communities during times of greatest need and for as long as it is needed.
- Facilitate alternatives to inpatient care where possible.
- Work alongside consumers and their family/whānau on treatment goals which ensure the most socially inclusive and least restrictive journey towards discharge.

Key focus areas

Although there has been a notable increase in demand for SMHS services, waiting times have not increased significantly. Much of this is due to greater efficiencies in the system and an ability to take a whole-of-system approach to people's mental health needs. SMHS is committed to ensuring that consumers get what they need when they need it. This includes the reduction of time spent waiting and ensuring a smoother journey towards recovery and wellbeing.

The following initiatives aim to promote wellbeing in the wider community and to improve our responsiveness to the mental health needs of consumers.

All Right?

The All Right? campaign is a wellbeing campaign developed by the Mental Health Foundation and the Canterbury DHB under the umbrella of Healthy Christchurch. The campaign has been visible across Canterbury, including on billboards, buses, in newspapers and online.

All Right? aims to increase the mental health and wellbeing of the people of Canterbury after the Prime Minister's Scientific Advisor, Professor Peter Gluckman, highlighted the need to support the majority of the population post-earthquakes so that their own psychological resilience and coping mechanisms came to the fore.

Planning for the campaign began by sharing ideas about what messages might resonate with Cantabrians at this stage of the recovery. Local research and audience testing contributed to the campaign, including interviews with community leaders, focus groups and telephone surveys.

The key findings indicated that the way the earthquakes affected wellbeing was complex and diverse and that the secondary stressors of damaged homes, insurance wrangles, financial challenges and grief over the 'lost' Christchurch were taking their toll.

The 'All Right?' campaign is the start of a conversation about wellbeing in Canterbury. When talking about how we're doing, it's all right to answer 'No, I'm really not all right at the moment'. It's definitely all right to ask for help, and free help and support is still available to all Cantabrians through the Canterbury Support Line on 0800 777 846.

School-based Mental Health Team

This team was set up in June/July 2013 in response to an increased number of Christchurch school-aged children and youth accessing health services during the earthquake recovery phase. It is a unique service working very closely with the Ministry of Education (MOE), as part of a suite of Canterbury DHB and MOE initiatives to support children and young people in Canterbury.

The team currently consists of three clinical staff with an additional two staff coming on board soon. The team will work proactively to meet the needs of the schools so they can better support their students. To date 61 schools have expressed an interest in engaging with the team to address their needs, which range from monthly clinics through to much wider whole-of-school support. The team has been actively delivering programmes where there is urgent need.

Easier access to Specialist Services

Adults, children and adolescents services now have a single point of entry to make access to services easier. Alcohol and drug services operate a central coordination service with a central diary to coordinate referrals (including self-referrals) and allocate them to the most appropriate agency for assessment and follow-up.

Promoting access for Māori and Pacific consumers

There is strong evidence that people from Māori or Pacific backgrounds are less likely to access specialist mental health services than the rest of the population. Services need to respond to ensure that this inequity is addressed. A project has been developed to enable better access to specialist expertise for Tangata Whaiora and their whānau.

The project came about when the Kaupapa Māori and Pasifika NGO Collective met with senior leaders from Canterbury DHB Specialist Mental Health Services to discuss how to work more collaboratively and strengthen relationships, in order to provide best services for Tangata Whaiora and their whānau.

It was acknowledged that Kaupapa Māori and Pasifika people are reluctant to access specialist mental health services and that there are a range of Māori and Pacific community (NGO) mental health providers that are supporting Tangata Whaiora and whānau. It was agreed that an Adult Single Point of Entry (SPOE) outreach clinic could foster relationships and enable better access into SMHS. This approach could also deliver episodic specialist input into community care while maintaining the primary relationship and, therefore, support a whole-of-system approach.

Adult mental health services have been subject to rigorous review in recent years with the goal of developing a community-focused, integrated model of care.

The project ran for eight weeks with weekly outreach clinics held at a Kaupapa Māori venue. Four different community providers took part in the project, along with staff from SMHS.

While the project has yet to be formally evaluated, informal feedback has been very positive from both NGO and Specialist Mental Health providers. It has strengthened relationships and understanding between providers and offered Tangata Whaiora better access to specialist mental health services.

Changes to adult services

Adult mental health services have been subject to rigorous review in recent years with the goal of developing a community-focused, integrated model of care. Within the new model there will be single, integrated multidisciplinary teams functioning across outpatient and inpatient settings. The community focus is maintained regardless of care setting, which means that community outpatient teams become the point of continuity for the consumer, even if this involves episodic inpatient care or the involvement of more than one care agency.

Community services will work to a ‘hub and spokes’ model where there is an administrative ‘hub’ for community services based on the Hillmorton Hospital campus. Teams will work in a more flexible manner and have increased mobility so services can be provided in communities in convenient locations to facilitate choice and ease of access for consumers.

Significant progress has been made towards developing the service structures and leadership to reflect these changes and developments. Work on the administrative hub building for the adult community teams at Hillmorton is due to be completed at the end of December 2013. The acute inpatient wards at Hillmorton have been refitted and realigned so that there are four rather than three wards. Each ward interfaces fully with one of the corresponding community teams covering north, south, east and west Christchurch. This change supports the model of community-focused continuity of care across community and inpatient settings.

Access to other sources of support

Across the health system there is a focus on removing barriers to accessing services and reducing duplication and waiting times. In mental health this has been achieved by developing increasingly collaborative relationships between providers.

In response to an anticipated increase in demand for services following the February 2011 earthquake, a temporary change was made to the way people accessed residential and community support worker services. A separate needs assessment from the clinical team to determine eligibility for a service was replaced by a weekly NGO providers meeting and collectively allocating a provider to the referrals. The collaboration is referred to as Community Support Work Access Pathway (CAP).

Referral pathways for community support workers were also opened up so that they came directly from general practices. In July 2012 Community Support Work Access was broadened to include people over 65 years with mental illness not related to their age, and in February 2013 to include those with an alcohol or other drug problem. In April 2013 the CAP was placed on HealthPathways as a centralised referral point.

The success of the CAP and Residential Options Group developments has led to these initiatives becoming permanent features within the mental health system and provided learnings for other parts of the mental health service. NGOs and SMHS meet regularly. Combining knowledge and services has aided problem solving and improved service understanding.

Mobile Respite Service established

In May 2013, a new Mobile Respite Service was established to provide support in people's homes or other appropriate environments. This has coincided with the design of the HealthPathways site for adult mental health respite services. Once completed, all Adult Mental Health Respite Services will be available to general practice (currently only via SMHS).

These changes will mean:

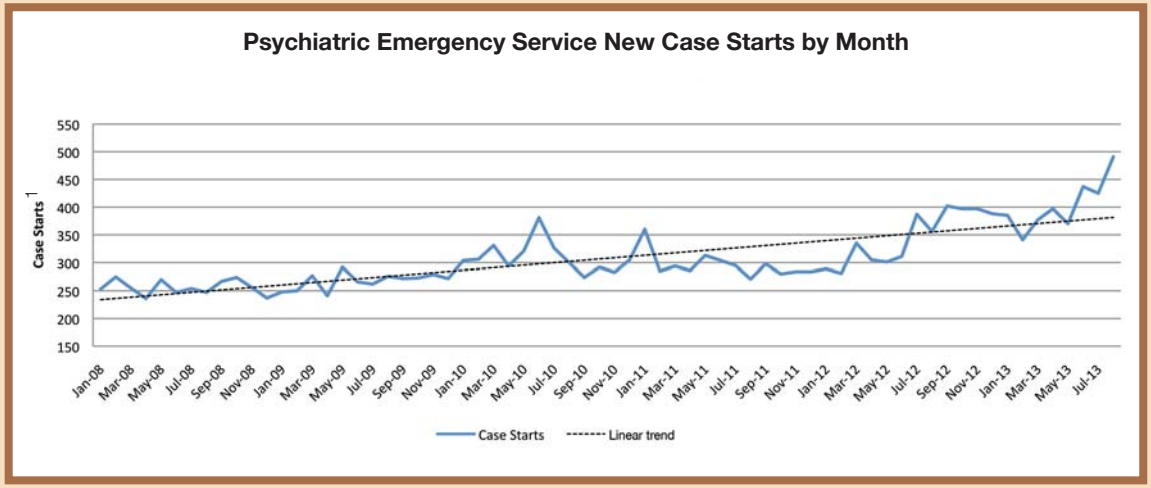
- Improved use of resources for those more acutely unwell, reducing the likelihood of a hospital admission.
- People can receive support in their own homes when an inpatient stay is not appropriate or practical for them e.g. parents with dependents.
- In the near future people can receive respite care as part of their overall recovery plan without duplication of assessment or delay in having eligibility confirmed.
- An increased capacity to support people in crisis in their own homes with clinical/non-clinical collaboration will provide a higher level of support than has been possible when working in separation.

In summary, the quality improvements have resulted in reduced duplication of assessment, reduced wait time, improved inter-sector relationships, shared planning and ability to respond to the needs of service users and their families.

Measures

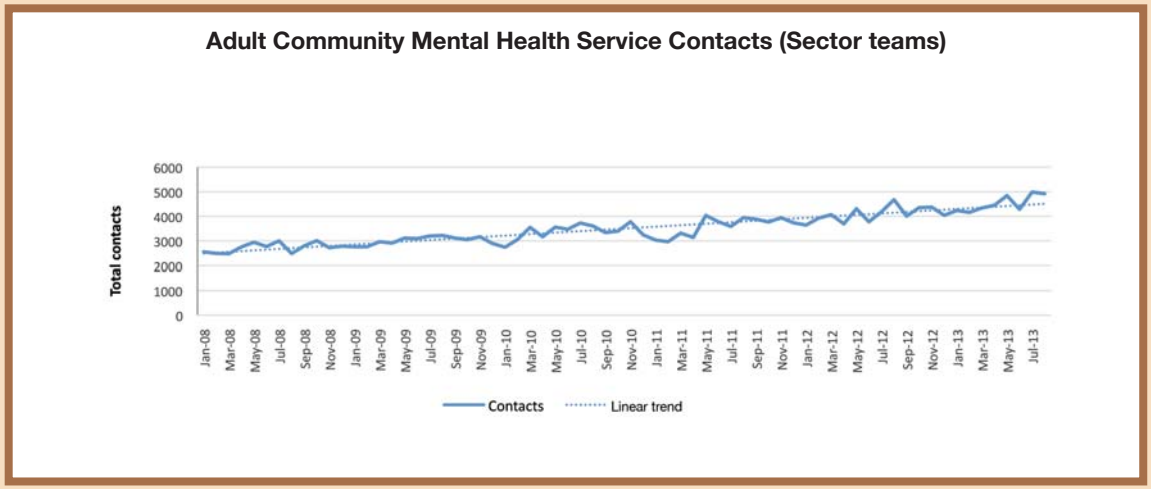
Improving access to services, inter-sector relationships and streamlining internal processes have all helped to effectively manage an increase in demand for mental health services and occupancy in post-earthquake Canterbury.

The graph on the right illustrates the continuing upward trend in the number of new cases seen by the Psychiatric Emergency Service since 2008.

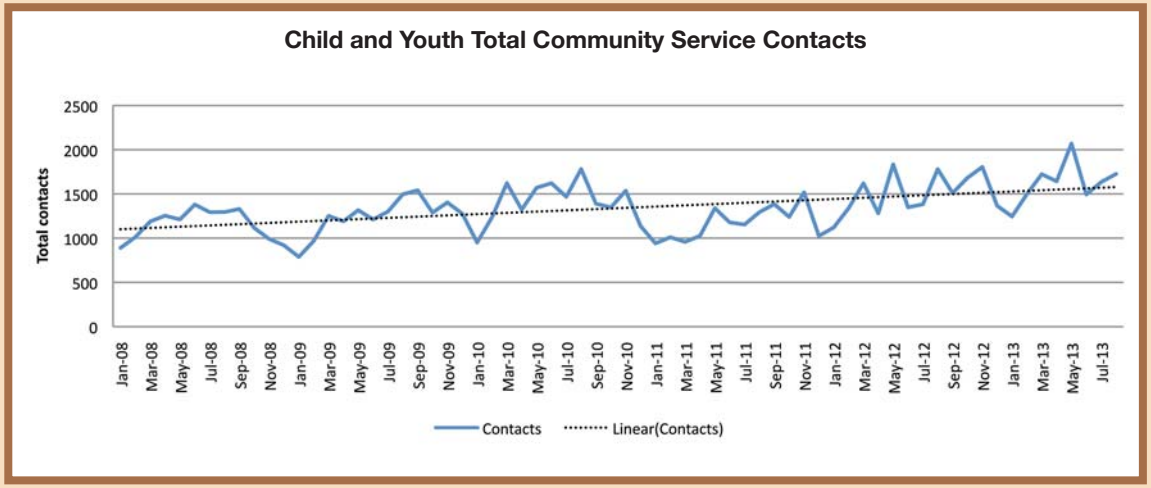


[1] Case Start describes the point at which a consumer has their first treatment contact with services.

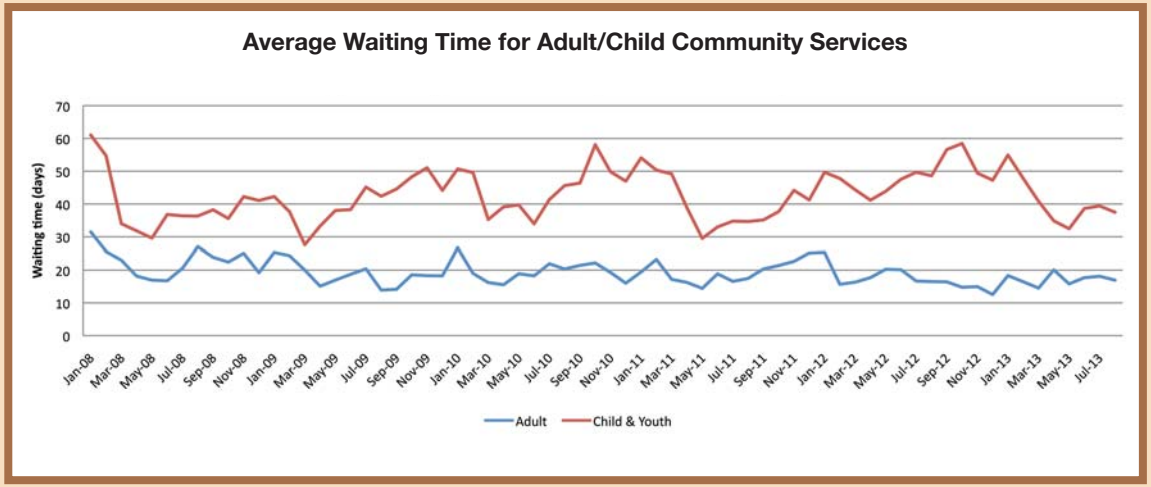
The upward trend is further reflected in the increase in contacts between adult community teams and consumers.



Child and Youth services have also witnessed an increase in contacts.



Despite the ongoing increase in demand, waiting times for Specialist Mental Health Services do not show the same degree of proportional increase. There has actually been a decrease in adult waiting times and only a small increase in waiting times for child and youth services.



Access to other sources of support Community Support Workers (CSW)

From 1 July 2012 to 30 June 2013 the following was achieved:

Period – Year	Number of referrals processed through Community Support Worker Access Pathway (CAP)
March 2011 – 28 February 2012	461
March 2012 – 28 February 2013	693
March 2013 – 26 July 2013 (year to date)	331 (at the current rate of referrals the total number for the full year will be about 1000)

- By 2012, 40 percent of referrals were from general practices and, in 2012, 280 more people received support from CSW.
- Wait times for allocating a CSW reduced from between four and six weeks to a maximum of seven days.
- Following removal of the separate needs assessment, 12 additional full time equivalent staff have been transferred from the Needs Assessment Service to CSW providers, supporting an additional 160 consumers at any one time. The fear that the capacity would be exhausted very quickly after broadening access has been unfounded. People are moving through the system in a more timely manner, accessing services earlier and without fear that they cannot access them again when needed.
- CAP has become a very productive group that identifies issues and trends and works with Canterbury DHB to find and be part of the solutions.

People are moving through the system in a more timely manner, accessing services earlier and without fear that they cannot access them again when needed.

Summary

The past three years have seen an increase in the sector-wide, unified approach to providing mental health care, treatment and support to Cantabrians during a very challenging period. Canterbury DHB Specialist Mental Health Services and NGO services have become increasingly responsive and flexible during a very challenging time. This report illustrates just some of the hard work and efforts of teams across the entire sector as they strive to promote and sustain good mental health and wellbeing in Canterbury.

Priorities for the next 12 months

- Completing the central hub building for adult community teams and the alignment of community teams with inpatient wards.
- Developing a crisis resolution function within adult community teams to provide a rapid response for people experiencing mental health crises.
- Further developing the infrastructural and technological requirements to provide a service which is increasingly mobile and responsive.
- Further developing and maintaining good working relationships between all providers of mental health support so they continue to work together with consumers and families towards mutually defined treatment goals.

Reducing alcohol-related harm

Canterbury's alcohol culture creates a heavy burden

The health resources devoted to caring for patients with alcohol-related conditions has grown steadily since the deregulation of the industry over a decade ago.

In July 2012, staff at Christchurch Hospital's Emergency Department (ED) set out to quantify that increase in alcohol-related harm. Their data showed that ACC funded injuries caused by excessive alcohol consumption has a big impact on ED's workload.

Alcohol-related presentations begin increasing at 8pm, peak between 2am and 3am, and do not reduce until after 6am. That amounts to 10 hours of increased demand on the ED every day. Not only does alcohol contribute to an increase in the number of episodes in ED during the night but these cases are typically far more disruptive and difficult to manage.

For most of the last 25 years ED Medical Specialist Dr Jan Bone has been working in emergency medicine and says that excessive alcohol is easily the worst drug problem the ED has to deal with.

"Almost all violence towards ED staff is related to excess alcohol. It causes so much of our work and negatively impacts on all aspects of our community. Patients and staff in ED are often

CDHB Alcohol Harm Coordinator Stuart Dodd, Emergency Department Medical Specialist Jan Bone and Sergeant Al Lawn.

abused by these patients and other patients wait for longer periods while we attempt to placate these abusive patients."

Dr Bone's colleague, Dr Scott Pearson, agrees that alcohol-affected patients have a huge impact on ED.

"Not only do ED staff have to contend with difficulties and risks of dealing with drunk patients, but other ED service users are also at risk. Other service users have to be around intoxicated patients, and their care is potentially compromised or delayed as staff are diverted to managing patients presenting with alcohol-related conditions," says Scott.

Dr Bone and Dr Pearson support the provisions in the proposed Christchurch City Council Local Alcohol Policy, including maximum trading hours for off-licensed premises such as supermarkets, bottle stores and grocery stores, and a 3am closing time for bars in the central city.

"About 50 percent of patients treated for facial fractures at Christchurch Hospital have been involved in incidents related to excess alcohol."

Mr Leslie Snape, Maxillofacial Surgeon

"Hospital and security staff have to deal with aggression, agitation and violent outbursts/bad behaviour most weekends and during the week because of alcohol."

Shaun Evans, CDHB Security Services Manager

"Nurses and other health staff are regularly verbally, and occasionally physically abused or threatened by intoxicated patients, making it difficult to assist with injuries. Sometimes people do not remember the things they say and do under the influence of alcohol, but we do. Mostly though we remember how sad and angry we are that so many of our people, and particularly our young people, continue to put their lives and futures at risk through excessive drinking behaviour."

Heather Gray, Director of Nursing, Christchurch Hospital

Reducing alcohol-related harm

Background

Reducing alcohol-related harm has remained an important priority for Canterbury DHB in the past year. In 2012, a DHB-commissioned economic analysis highlighted the financial impact of alcohol on the Canterbury Health System. A collaborative group across the DHB has developed a new alcohol reporting tool to analyse the distribution of alcohol-related inpatient data, inform the new alcohol strategy and suggest interventions to reduce alcohol-related harm in the region.

Data collected is already indicating that the burden of alcohol-related disease is not just related to intoxication and chronic heavy drinking but that a large proportion of the population drinks at a level that significantly increases the burden of chronic diseases such as cancers of the gut, hypertension and stroke.

Key focus areas

Local Alcohol Policies (LAPs)

These policies have the potential to significantly reduce the harm caused by alcohol through influencing the hours of sale, distribution and conditions under which alcohol licences are allocated. Key alcohol stakeholders across the DHB, and the Medical Officer of Health, played a key role in influencing the development of LAPs through deputations at the policy development stage and consultation submissions. Of the local authorities developing LAPs nationally, Christchurch City Council has shown strong leadership and an appreciation of the harm minimising goals of LAPs in the alcohol policies that it has consulted on.

Licensing enforcement

The good compliance of alcohol licensees across Canterbury is largely attributed to effective enforcement and the strong partnership working between DHB licensing and local authority enforcement staff and the Police. In June 2013 DHB liquor enforcement staff were given regulatory input into special and off-licenses. To manage this additional workload and keep their focus on effective compliance work, enforcement officers have developed a new risk assessment tool to identify and oversee the riskiest premises in the region.

Improved access to services

(Identified as a priority in the 11-12 Quality Accounts for 12-13)

Improving access to alcohol and other drug (AOD) services is a key priority for Canterbury DHB. In January 2012, a new Central Co-ordination Service was established to assist clients in accessing interventions and support. Increased investment in NGO community services has

provided for more staff, including medical staff, across the treatment system. It has also provided more community-based services and broadened their skill base. These changes have resulted in more clients engaging in the system.

The AOD system has implemented a number of initiatives to improve responsiveness to people engaged in the justice system, including an assessment service for people in prison, AOD training for probation staff, triage meetings at probation offices, a motivational group programme and ready access to all services. Future work will include AOD clinicians working within the Courts and increased support provided in North Canterbury.

Primary care data

(Identified as a priority in the 11-12 Quality Accounts for 12-13)

Pegasus Health is rolling out the Patient Dashboard software across its general practices. This application prompts practitioners to ask patients about their alcohol use and will encourage general practice teams to screen patients for alcohol misuse more frequently.

The Alcohol Harm Minimisation Advisory Group

The Alcohol Harm Minimisation Advisory Group was formed to develop a cross-sector response to reducing alcohol-related harm. The group has focused on understanding the impact of alcohol on health and, as that understanding grows, so does the response from the health system and other agencies.

The group has recently broadened its focus and membership to include the Police, Health Promotion Agency and Accident Compensation Corporation. The group continues to oversee the work programme of the Alcohol Harm Minimisation Co-ordinator that includes the DHB response to Local Alcohol Policies, co-ordinating the new alcohol strategy and enhancing alcohol identification across primary care and other settings.

Future work will include Alcohol and Other Drug clinicians working within the Courts and increased support provided in North Canterbury.

Measures

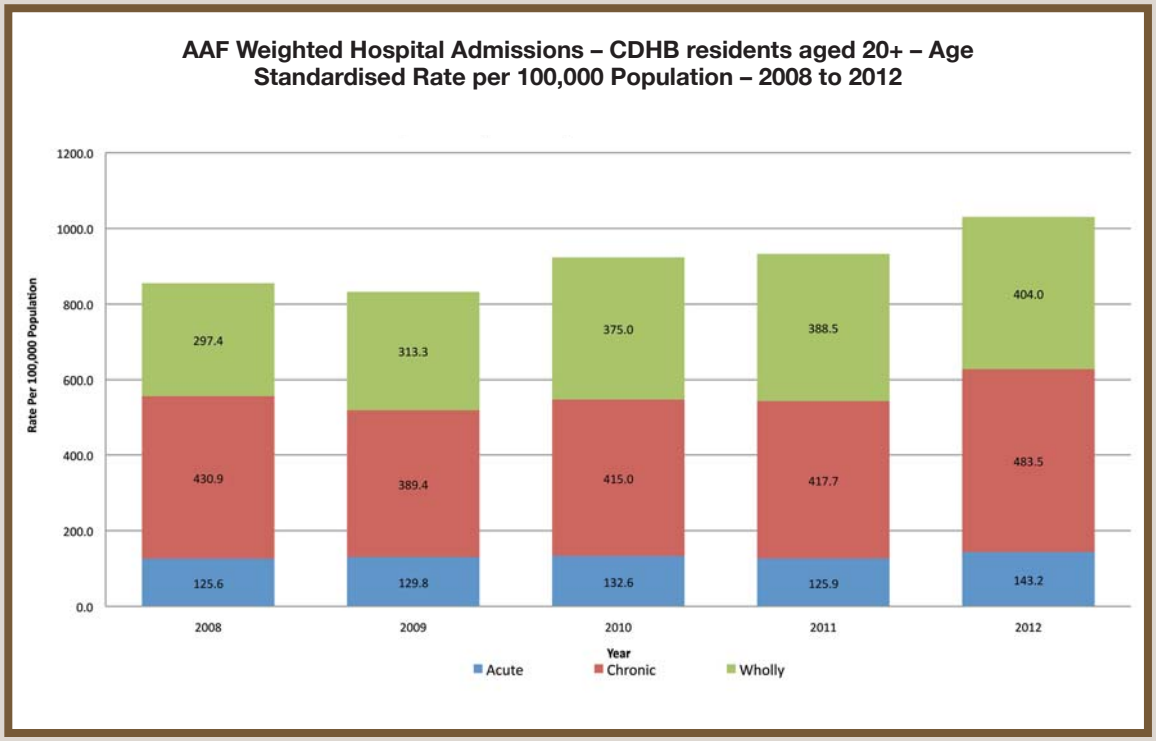
Many of the alcohol-related harm measures, such as relevant crime and health statistics, are also influenced by external factors such as the Canterbury earthquakes, operational practices and legislative changes.

Alcohol-related hospital admissions

(Identified as a priority in the 11-12 Quality Accounts for 12-13)

An alcohol reporting tool has been developed based on recording alcohol-related inpatient admissions and will give a strong indication of the impact of alcohol consumption on population health. Alcohol causes 60 separate health conditions. Using the Alcohol Attributable Fractions (AAFs) we can look at every alcohol-related hospital admission in Christchurch and get a reliable indication of the amount of alcohol-related harm experienced by that population.

The following graph displays alcohol's contribution to hospital admissions for all CDHB residents (data does not include ED admissions, which cannot be coded in this way). The main indicator is the rate of alcohol-related hospital admissions per 100,000 people per annum. The graph highlights that alcohol-related admissions are on the increase and this is mainly driven by increases in wholly attributable conditions (i.e. alcohol poisoning and conditions relating to alcohol dependence) and in chronic disease, such as hypertension, cancers of the gut and stroke.

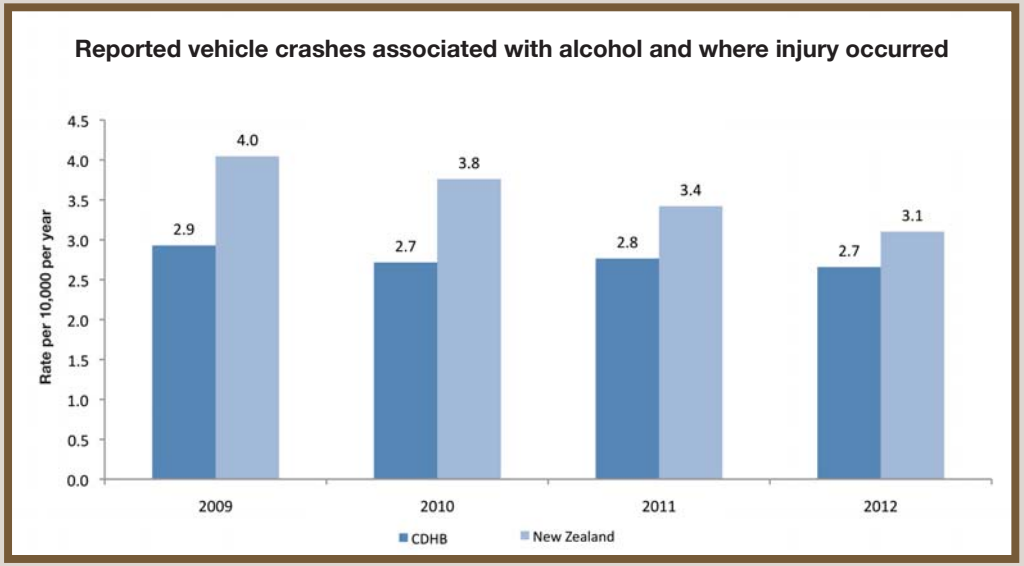


Controlled Purchase Operation compliance

Controlled Purchase Operations (CPOs) involve sending supervised volunteers (aged under 18) into alcohol retail premises to buy alcohol. Alcohol retailers fail to comply with the Sale of Liquor Act if they sell them alcohol. In 2012-13 140 premises underwent a CPO and 92 per cent of those were found to have complied with the Sale of Liquor Act.

Alcohol and Other Drug (AOD) involvement in road traffic accidents (RTAs)

Rates of road transport accidents in Canterbury have been consistently lower than in New Zealand as a whole. In part, this effect may be attributable to the condition of the roads in Canterbury as a result of the earthquakes.



Priorities for the next 12 months

- Canterbury DHB can focus on its commitment to develop an alcohol strategy now much of the development work around Local Alcohol Policies has been finalised. The alcohol reporting tool and other data sources will form a useful baseline for monitoring the future impact of the alcohol strategy going forward. We are anticipating a launch of the strategy in the first quarter of 2014.
- New self-care resources and alcohol screening tools will be developed to facilitate public engagement around hazardous alcohol consumption and raise awareness of the links between alcohol and chronic disease. Initially training will focus on staff working in primary care with plans to roll it out more widely.
- Canterbury DHB will continue working with stakeholders to further streamline processes that result in better access, engagement and outcomes across the alcohol and other drugs continuum.
- The impact of alcohol-related harm on ED services is better understood following the collection of a year of ED alcohol incidence data. A summer studentship project is being developed to help refine that data and calculate the cost of alcohol to the service. *(Identified as a priority in the 11-12 Quality Accounts for 12-13)*

Managing influenza

Canterbury dodges flu bullet

Cantabrians turned up to their family doctors in record numbers for flu vaccinations this year, helping us to “dodge” the flu bullet.

While there are always a lot of factors at play in reducing flu in our community, the numbers still speak volumes:

- 33 percent of under 18s vaccinated, twice the number achieved last year
- An estimated 74 percent of over 65s vaccinated; these are people who have probably had flu and are not keen to repeat the experience
- 76 percent of Canterbury DHB staff were vaccinated - a record number, protecting not only themselves and their families, but also the people they care for
- Only 119 hospital admissions for influenza-like illness to September 30 this year, compared with 477 last year

Dr Ramon Pink, Canterbury Medical Officer of Health, says the higher rates of vaccination are very encouraging because the more people who are immune in a community, the harder it is for the influenza virus to take hold.

“Babies and young children are very vulnerable and older children take it to school where it spreads very quickly to devastating effect. Nobody wants to nurse a sick child, knowing you could have prevented it.

People, especially those at greatest risk from influenza complications or those in contact with people who are at high risk from influenza, should get immunised as soon as the vaccine becomes available each March. For many people it’s free and in Canterbury, that will include under 18s for at least the next two years,” Dr Pink says.

Putting a vaccination reminder note on the calendar or the fridge for March next year is a great idea: “Even if you don’t consider yourself at risk, if not for yourself, do it for your family and community.”

Managing influenza

Background

Influenza can be a serious illness particularly for certain groups, including the elderly and the very young. The strategies to manage influenza each year include promoting the influenza vaccine and public health messages. In each region, the DHB funds immunisation through general practices, workplaces and institutions, conducts influenza-like illness surveillance as part of a national programme and develops and promotes public health messages. Primary care manages the immunisation strategy as well as the day-to-day management of patients with influenza. Admission to hospital is uncommon.

Key focus areas

Influenza immunisation programme

The Immunisation Service Level Alliance is responsible for overseeing the DHB influenza immunisation programme. A subgroup, the Canterbury Flu Working Group, develops recommendations on immunisation strategy including eligibility and delivery methods.

The influenza immunisation programme in Canterbury has been extended since 2011 to include those aged from six months to 17 years to reduce the potential health impact of substandard housing and overcrowding following the earthquakes.

In 2013, vaccination for this age group has been available in general practice and also offered in schools to all secondary school age children (year 7 to year 13). The school-based vaccination programme was delivered by Public Health Nurses and all secondary schools within Christchurch city were eligible.

Additionally vaccination was offered in paediatric wards, hospital outpatient departments and outreach immunisation services. Immunisation Coordinators and Primary Health Organisations worked closely with their general practice teams to provide immunisation information including advice, support and direction about the importance of the seasonal influenza programme. General practices were advised that immunisation is important not only for the subsidised groups but also for the whole community.

Promoting influenza vaccination

The Canterbury Health System's long-term goal is to normalise flu vaccination as part of people's preparations for a well winter. Market research carried out at the end of the 2012 flu season provided valuable insight into how to make the 2013 public flu vaccination campaign most effective. The research found that people who thought they might not need a flu shot understood that others around them were more vulnerable. They would be more likely to get a flu shot in order to help protect their family, whānau

and community. The ‘flu strong’ campaign voiced that simple message and used real people ‘just like us’ to be the face of flu strong.

Canterbury influenza-like illness surveillance programme

Each year, Community and Public Health (the public health division of the Canterbury DHB) conducts a Canterbury influenza-like illness surveillance programme to estimate the incidence of influenza in the community. The surveillance programme enables a reliable estimate of the incidence of influenza-like illness to be made. Results are updated weekly and sent to participating practices and other health and non-health organisations.

Weekly reports from Canterbury Health Laboratories

Canterbury Health Laboratories issues weekly reports on the numbers and types of respiratory viruses identified, including influenza. These reports help understand the underlying causes of winter illnesses and the types of influenza circulating in the community.

Canterbury Primary Response Group

The Canterbury Primary Response Group meets regularly to plan Canterbury’s response to influenza. The group has representatives from primary care (including general practice, community pharmacies and after-hours medical centres) and the Canterbury DHB. An initiative on this scale is unique to Canterbury.

Measures

The following measures represent both the effectiveness of promoting uptake of the influenza vaccine (vaccination coverage) and the impact of influenza on the health system and wider community. Many things beyond the influence of the health system will contribute to the burden of influenza in a given year, including the severity of the winter and how well matched the vaccine is to the prevailing strain of influenza. A record 207,860 influenza vaccinations have been distributed in Canterbury this year (enough to immunise 42 percent of the population).

Vaccination coverage of eligible people

Coverage rates in the Canterbury region continue to be higher than national average rates but remain lower than those achieved prior to 2011. In 2012, coverage for those aged 65+ in Canterbury (total population) was 70.8 percent, compared with 74.3 percent in 2010. The programme coverage goal for each of these years is 75 percent.

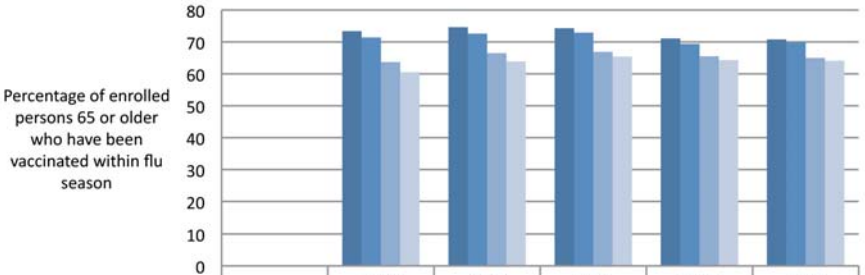
‘Flu strong” – real people with a simple message.

Vaccination coverage for under-18 year olds

Influenza vaccination for under-18 year olds started in 2011 and it has been recommended that they continue until 2015. The coverage target for under-18 year olds in 2011 was 30 percent and in 2012 and 2013 was 40 percent. These targets were based on international research on the benefits for the whole population of different levels of coverage in this age group. The overall coverage in 2012 was 18.5 percent of all eligible under-18 year olds, compared with 20.6 percent in 2011.

In 2013 an unprecedented 33 percent of under-18s have been vaccinated. The under-18 vaccination programme, combined with an outstanding performance from primary care, has no doubt contributed to this result. In terms of ethnicity, there was no statistically significant difference in uptake in schools for Māori and Pacific students (18.6 percent and 16.7 percent respectively) compared with non-Māori and non-Pacific students (17.8 percent and 17.9 percent). However, in primary care, Māori and Pacific (17.1 percent and 15.6 percent respectively) had a significantly lower uptake than non-Māori and non-Pacific (29.5 percent and 28.6 percent).

Canterbury 65+ Influenza Vaccination Coverage

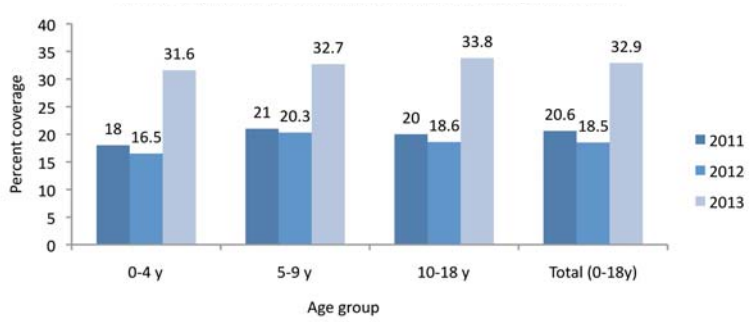


	2008	2009	2010	2011	2012
CDHB total population	73.4	74.6	74.3	71.1	70.8
CDHB high-need	71.4	72.6	72.9	69.4	69.9
National total population	63.7	66.5	66.9	65.5	65
National high need	60.5	63.9	65.4	64.3	64.1

Source: DHB Shared Service (2013). PHO Performance Programme Performance Results for Canterbury DHB as at December 31st 2012.

Notes: 'High-need' refers to those aged 65 and over who are of Māori or Pacific ethnicity and/or in deprivation deciles 9 or 10.

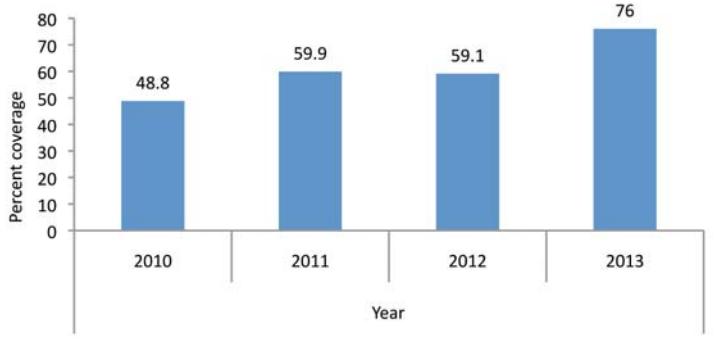
Canterbury under-18 Influenza Vaccination Coverage 2011-2013



Vaccination coverage for Canterbury District Health Board staff

Vaccinating Canterbury DHB staff is an important intervention to reduce the impact of influenza on the health system. The level of coverage across the Canterbury DHB in 2013 is substantially higher than in previous years and compares favourably both to other DHBs and to international experience.

CDHB Staff Vaccination Coverage



Source: CDHB Occupational Health Service

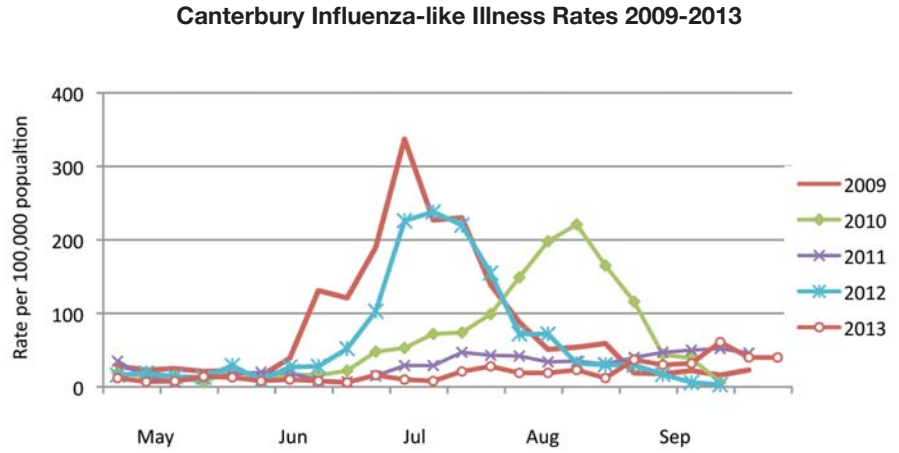
Notes: 2010 and 2011 percentages are for all staff (including students and contractors) at all CDHB sites.

2012 and 2013 percentages are for employees only (excluding students and contractors) at all CDHB sites.

In 2013 an unprecedented 33 percent of under-18s have been vaccinated.

Influenza-like illness rates in Canterbury

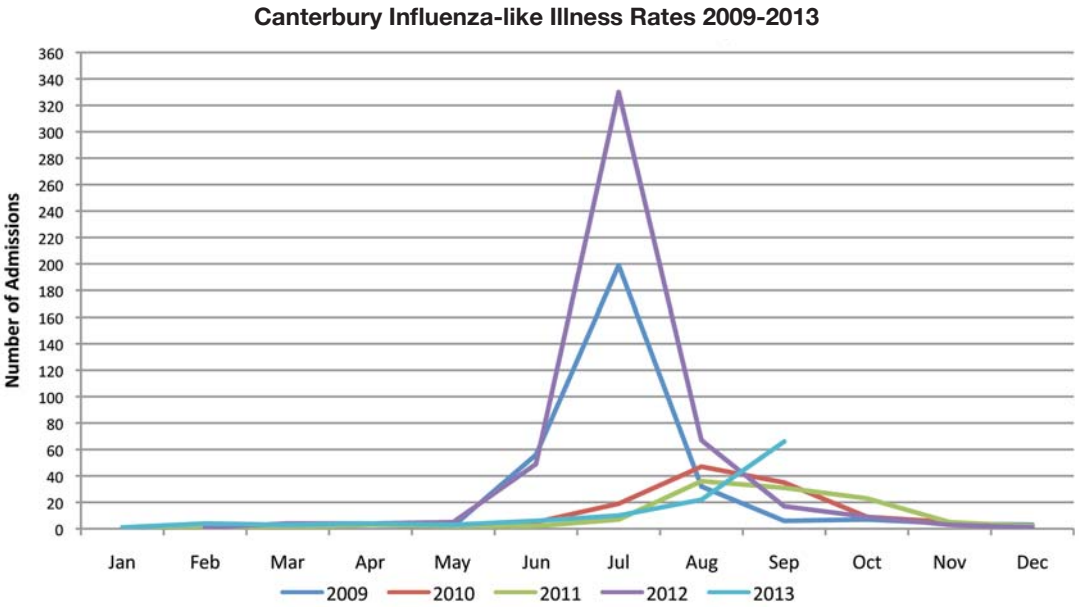
The year 2013 was a low incidence year for influenza-like illness with numbers increasing relatively late in the season. In contrast, the 2012 influenza-like illness rate increased markedly in early July, which was earlier than most years, and peaked at a rate similar to 2010.



Source: Community and Public Health, CDHB

Hospital admissions as a result of influenza

There were 490 admissions for influenza in 2012, which is more than in the pandemic year of 2009, when there were 315 admissions. The high number for 2012 was due in part to the prevailing strain of influenza having not circulated widely since 2007. In 2013 the number of admissions increased late in the season, but has remained low overall with 119 admissions by the end of September.



Summary

In 2013 overall influenza vaccination coverage for under-18 year olds was substantially higher than in previous years, although it remained below the 40 percent target. Coverage for the 65+ age group remains higher in Canterbury than nationally, but is below the target of 75 percent. The burden of influenza varies from year to year, with a lesser burden in 2013 than in most other years.

One of the priorities identified for 2012-13 was an evaluation of the 2012 under-18 vaccination programme. The key recommendations were that the vaccination should continue to be delivered in both primary care and schools; that improvements to data collection (especially to ethnicity data) should be made; and that the programme and associated media campaign should be evaluated again in 2013. A separate evaluation of the 2012 media campaign to promote flu vaccination influenced the development of this year's "flu strong" campaign, as described above.

Further priorities identified for 2012-13 were to align communicable disease surveillance and disease control guidelines across the South Island (this is currently on hold) and to pursue influenza vaccination and impact data by ethnicity. While some vaccination coverage and impact data are available by ethnicity, for example under-18 vaccination coverage, further work is required for this to be feasible for all measures.

Priorities for the next 12 months

- A follow-up evaluation of the 2013 under-18 vaccination programme is underway. As in 2012, the evaluation focuses on the overall uptake of the vaccine as well as patterns in uptake by setting type and population group. Key questions for the evaluation are what factors contribute to high uptake in different settings (secondary schools and general practices) and what factors contribute to greater equity of uptake (across different ethnic and socioeconomic groups).

- Primary care leaders are developing a strategy to enable general practitioners to improve the management of influenza in the community each winter. This strategy will assist patients to manage their illness responsibly without overloading the Emergency Department (ED) and help general practices to cope by using telephone advice, streaming patients, having clinics designated to see extra influenza patients, a voucher system for referral from the ED to these clinics, and reviewing medical centres' work practices to increase capacity as required.

- The Immunisation Service Level Alliance has identified the priority of improving targeting of the influenza immunisation programme to Māori and other ethnic groups.

Reducing avoidable hospital admissions

Improving medication management

In October 2011 Canterbury launched a free service to minimise medication-related adverse events to help people better manage their medications. The Medications Management Service (MMS) involves consultation with an accredited pharmacist, which can take place at people's local pharmacy or in their own homes. It is especially helpful for people who have multiple conditions, a complex list of medication or difficulty remembering to take medicines. Referrals can be made by hospital specialists, general practice, community providers, local pharmacies or the Community Rehabilitation Enablement and Support Team (CREST).

Canterbury Community Pharmacy Group (CCPG) programme facilitator Lisa Giles says users of the service are most commonly aged over 65 and referred to the service via CREST following time in hospital.

"After a referral has been made, a community pharmacist or one of the MMS mobile pharmacists will arrange the first of four meetings with the person that will take place over a period of 12 months," she says. "Ideally the consultation will be in the person's home, so the pharmacist can get a complete picture of how they are managing their medication."

Lisa says the pharmacist will talk through the medicines the person is taking and any issues they are experiencing with them. "They'll also take a look at the person's medicine cabinet, remove expired medicines or those that are no longer needed and find out whether the person is taking their medicine as prescribed. What people are supposed to be taking and what actually happens can vary for a wide range of reasons from forgetting to take their medicine at the right time, not being able to open a bottle or blister pack, or not knowing how to use an inhaler properly," she says.

Mobile pharmacist Melanie Gamble said that by visiting people at home the pharmacist can help to work out strategies that will fit the person's lifestyle and needs. "Involving families is also an important part of our work. Having a partner or other adult family member who understands what the person needs to do is especially helpful."

To date over 120 Canterbury pharmacists working for 61 pharmacies have completed the medication review training offered by the New Zealand College of Pharmacists and are now involved in the MMS. Three mobile pharmacists employed by CCPG also work for the service, making it the biggest programme of its kind in New Zealand. At the time of writing it was aiming to attract 97 referrals each week and had almost reached its goal with an overall total of 3000 referrals. "We just know that there are more people out there who could benefit from this service and we are working hard to let people know about it," Lisa says.

How could the MMS work for you?

Joe (not his real name) was admitted to hospital for an accidental overdose. Like many people with complex health conditions, he was on a number of medications and was struggling to keep track. When the MMS mobile pharmacist visited Joe at his home after being discharged from hospital, they found he was regularly taking three doses of his medication per day, rather than the prescribed two. He was also taking too high a dose of diuretic each evening that meant he had to get up to go to the toilet several times in the night. He said he was finding it hard to swallow some medication that came in large capsules as well as the eight paracetamol he needed to take each day. There was also surplus medication in his medicine cabinet, some stronger than the dose he was prescribed – a recipe for another overdose.

Joe's blister packs were changed so he could get a good night's rest – diuretics are now part of his morning medication. His GP modified his prescription to a medication that came in smaller, easier to swallow capsules. He really didn't need to take paracetamol regularly at all. Finally, the mobile pharmacist took medication that was surplus to requirements away, making his home safer.

Reducing avoidable hospital admissions

Background

The Canterbury Health System has taken up the challenge to work collaboratively to ensure we are delivering the right care and support, by the right person, at the right time, in the right place, with the right patient experience. Urgent or 'acute' demand for health care is a major source of pressure on the health system. Much of this demand is seen as avoidable, and not everyone who is acutely unwell needs hospital treatment. Many hospital admissions can be prevented by investing in services that help to keep people well or alternative care pathways that provide the right care sooner. Other services can support people to recover after a hospital admission or episode of illness, so that they don't become unwell again.

Canterbury's investment in community-based services is improving health outcomes and the patient experience because most people prefer to be treated in their own home or community. This approach has freed up hospital resources which can increase timely access to specialist care and the number of planned or 'elective' surgeries we deliver to our population. Canterbury's 'whole-of-system' approach to reducing acute and avoidable hospital admissions is already demonstrating positive results. We have the lowest rate of acute medical admissions of any large DHB and the second lowest rate of acute re-admissions of any DHB in the country, despite our ageing population.

Key focus areas

After-hours telephone triage service

Since 2005, the Canterbury DHB has been supporting a nurse-led telephone triage service. When people phone their general practice after hours, they receive one-to-one clinical advice from experienced registered nurses. These nurses support callers to make the best decision for their situation – looking after themselves at home, going to the after-hours surgery or travelling to the Emergency Department (ED). Calls are answered in the name of the practice, and the nurses can access patients' specialised care plans to provide individualised advice. Notes taken during calls are forwarded to the patient's general practice for follow-up.

Acute Demand Management Service

The Acute Demand Management Service (ADMS) supports people who are urgently unwell to avoid ED visits or hospital admission. Targeted services are delivered by general practice teams and community nurses including general practice consultations, practice-based observation, urgent home-based support (meals or equipment), acute community nursing, admission to community-based observation at the 24-Hour Surgery, rapid diagnostics and timely supported community discharges. Any health professional, including ambulance staff and ED clinicians, can refer patients to the ADMS for care.

Alternative ambulance pathways

During periods of very high demand (especially in winter), ambulance officers have worked with health professionals across the system to reduce pressure on the hospital by delivering patients who can be safely cared for in the community to their general practices or after-hours providers rather than automatically delivering them to ED. In July 2012, we introduced a new ambulance pathway specifically for people with Chronic Obstructive Pulmonary Disease. Ambulance officers now assess people based on agreed criteria and then arrange the most appropriate care for them, whether it is support at home with acute nursing, a visit to general practice or the 24-hour surgery, or a trip to ED.

Community-based Falls Prevention Programme

Falls are a major cause of avoidable hospitalisation in older people. Canterbury's Community-based Falls Prevention Programme, aimed at improving strength and balance, provides a range of home and community-based options for supporting older people to avoid falls. Community falls champions (physiotherapists or nurses) support frail elderly people in their own homes with a modified version of the Otago Exercise Programme. For more active older people, trained volunteers provide the 'Stay on Your Feet' Programme, either in people's own homes or in group settings in the community.

Community-based rehabilitation Service

The Community Rehabilitation Enablement and Support Team (CREST) supports older people to leave hospital sooner by wrapping a range of services around those who are medically stable but need a short period of intensive rehabilitation at home. The rehabilitation service helps people to avoid coming back into hospital by assisting their safe recovery. More recently, the team have begun taking direct referrals from general practices to support older people so they do not have to go to hospital.

Falls prevention in aged residential care

Research suggests that vitamin D supplementation for older people significantly reduces falls and serious harm from falls. In November 2012, we began working collaboratively with rest homes and general practice teams to ensure that 75 percent of rest home residents are receiving vitamin D supplements.

Falls are a major cause of avoidable hospitalisation in older people.

Measures

We expect to reduce the number of acute medical admissions in Canterbury and the rate of re-admissions to hospital after discharge by improving access to community-based services that keep people well, support them during an acute episode and help them to recover from illness or injury. As a result of this work, waiting times for treatment in our hospitals will decrease (including access to treatment in our ED for people who do need to be there). We will free up hospital services to deliver more planned surgery, to care for more complex patients and to provide specialist advice and support to primary and community care teams.

Access to acute care in the community

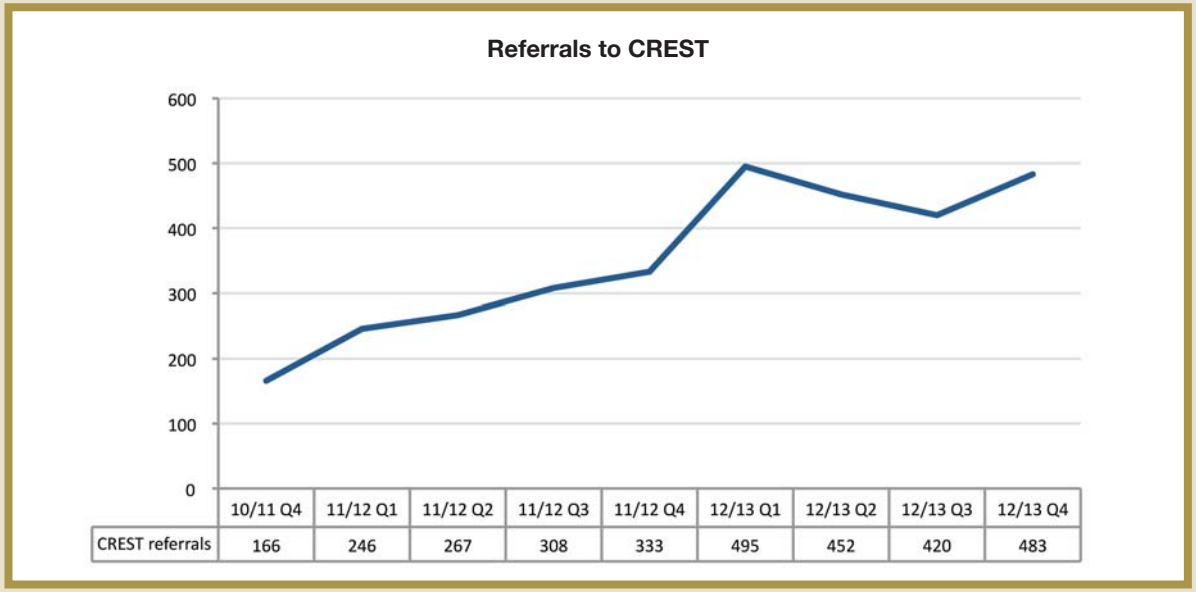
The Acute Demand Management Service continues to support an increasing number of people in their homes and communities rather than in our hospitals. In the year to June 2013, the service supported 25,374 people, which is over 5000 more than the previous year and well above our 2013 target of 18,000. Our aim is to support another 22,000 in the year to June 2014.

Access to community-based Falls Prevention Programme

The Falls Prevention Programme continues to support older people at risk of harm from falls by supporting people in their homes and providing exercise and education classes in community settings. In the year to June 2013, the programme supported 1613 people – twice our 2013 target of 800. The aim is to support another 1200 in the year to June 2014.

Access to CREST

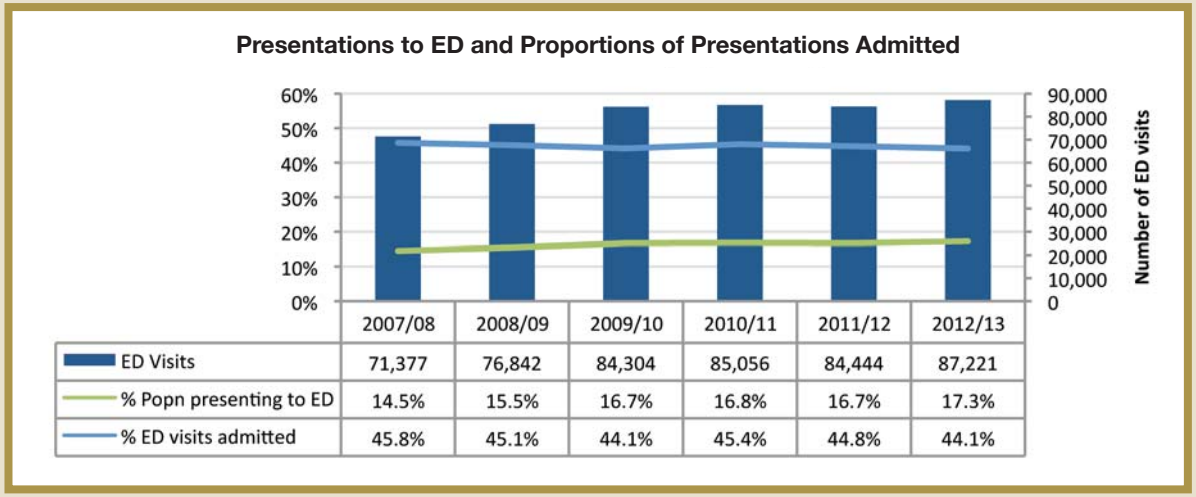
The CREST service continues to support an increasing number of older people in their homes and communities rather than in our hospitals. In the year to June 2013, the service supported 1850 people – up from 1154 in the year to June 2012 and well above our 2013 target of 1100 people. The aim is to support another 2200 in the year to June 2014.



	10/11 Q4	11/12 Q1	11/12 Q2	11/12 Q3	11/12 Q4	12/13 Q1	12/13 Q2	12/13 Q3	12/13 Q4
CREST referrals	166	246	267	308	333	495	452	420	483

People admitted or discharged from ED in under six hours

Two strategies improve performance against this measure: supporting people in the community and managing the flow of patients within the hospital to reduce the time people spend waiting for care. This measure is also a national health target, and Canterbury has consistently performed above the national average. In the final quarter of 2013 (April to June), we achieved the national target of 95 percent of people presenting at ED being admitted or discharged within six hours. The aim is to consistently achieve 95 percent or higher over the year to June 2014.



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
ED Visits	71,377	76,842	84,304	85,056	84,444	87,221
% Popn presenting to ED	14.5%	15.5%	16.7%	16.8%	16.7%	17.3%
% ED visits admitted	45.8%	45.1%	44.1%	45.4%	44.8%	44.1%

Reducing acute medical admissions

A reduction in the proportion of the population being acutely admitted to hospital can demonstrate earlier intervention and access to appropriate support in the community. Medical admissions are seen as more amenable to change than surgical admissions, and low acute medical admission rates reflect a high quality health system. Canterbury already has the lowest rate of acute medical admission of any large DHB in the country for patients of the same age. We achieved our goal in 2013 to maintain these low rates and plan to continue maintaining them in the coming year.

Reducing acute re-admissions

When people are discharged from hospital, it is important that they are well enough to leave and that the right supports are in place to help them to keep recovering in their own homes and communities. This way, their condition does not deteriorate and they are not re-admitted back into hospital. A low acute re-admission rate reflects a high quality health system where hospital and community-based health services work together to ensure people recover safely and stay well. Canterbury has maintained a lower acute re-admission rate than the national rate.

Summary

In 2013, our results have been very positive demonstrating increased access to services and improved outcomes for our population.

More vulnerable people have been supported in the community. Since 2008, over 95,000 people have been supported in the community by the Acute Demand Management Service. Our free Medications Management Service has enabled 2326 people to learn more about their medications from a pharmacist. In the first 11 months of establishing the alternative COPD ambulance pathway, 556 of the 1714 patients who called an ambulance were given care in the community instead of being transported to ED – that's one in every three people.

By helping people to better manage their long-term conditions, there have been fewer admissions to hospital. Dedicated acute demand liaison teams now have a strong presence within Christchurch Hospital, helping to identify patients who can be supported by community services on discharge. Backed by enhanced ADMS coordination, the liaison team is helping 60 to 70 patients a month move back to community-based care. In addition, in the 27 months since CREST began, over 3100 people have been supported on discharge from hospital. The service is still growing and now takes around 150 referrals each month from the hospital, ED and general practice.

The community-based falls champion model has continued to support an increasing number of people. In the 17 months since it began, 2350 people have been referred to the programme. There has also been a reduction (8.4 to 8.2 percent) in the population aged over 75 admitted to hospital as a result of a fall.

The goal of providing 75 percent of residents living in aged residential care with vitamin D was not quite met in the past year, but uptake has increased, with 73 percent of residents now receiving supplements. We will continue to strive to achieve 75 percent.

Priorities for the next 12 months

- Further development of community-based ADMS. Support 400 patients through the COPD ambulance referral pathway, provide 22,000 urgent care packages in the community and continue to promote general practice as people's first point of (phone) contact 24/7.
- Maintain the HealthPathways website to provide general practice with referral and best practice advice to support the management of their patients. Expand the HealthInfo website to provide people with the information they need to better manage their own health and stay well.
- Increase the visibility of key contributors to ED overcrowding (length of stay, wait times to be seen by inpatient doctors, frequent attendees and load on ED sections). Develop targeted responses, improve the flow of patients and reduce waiting times for treatment. Ensure 95 percent of people presenting at ED are admitted, discharged or transferred within six hours.
- Expand the CREST supported discharge services to support earlier discharge from hospital, and ensure older people discharged after a fall are referred to the Falls Prevention Programme. Provide 2200 people with support from CREST services upon discharge or direct general practice referral. Provide 1200 people with support through the community-based falls prevention programme.

Preventing patients in our hospitals being harmed

Enhancing care around caesarean section

When harm occurs to a patient an investigation is undertaken to establish causal factors and provide recommendations to prevent the incident occurring again. As part of a recommendation following an incident where unclear communication led to delays resulting in harm to a baby, a multidisciplinary working group was established. The aim of the group was to develop a classification system for caesarean section which leaves no room for misinterpretation of urgency and indicates the need of a neonatal specialist.

The following quality improvements were made:

- A guideline was developed to classify caesareans and communicate their urgency
- An Obstetric surgical safety checklist was developed
- An Obstetric emergency team was established
- An Obstetric emergency call system was developed
- Criteria for attendance of neonatal teams at births were developed
- Speaker phones were installed in Birthing Suite Operating Theatres so neonatal specialists could provide advice before arriving
- An iPhone was purchased for the Neonatal Associate Clinical Nurse Manager to communicate directly with the Specialist Neonatologist

In one month approximately 400 staff were educated on the improvements. Anecdotal evidence suggests that the language and culture around caesarean sections has changed rapidly to that of the new system. A survey of 120 staff confirmed that the majority agreed that the changes had been useful (94 percent) and that it was reassuring to know that a neonatal specialist had been called prior to the delivery of the baby (93 percent). Eighty six percent of staff said implementing the categorisation system clarified the urgency of performing the caesarean section, 69 percent felt it improved communication and 73 percent thought it was a safe and effective system.

Preventing patients in our hospitals being harmed

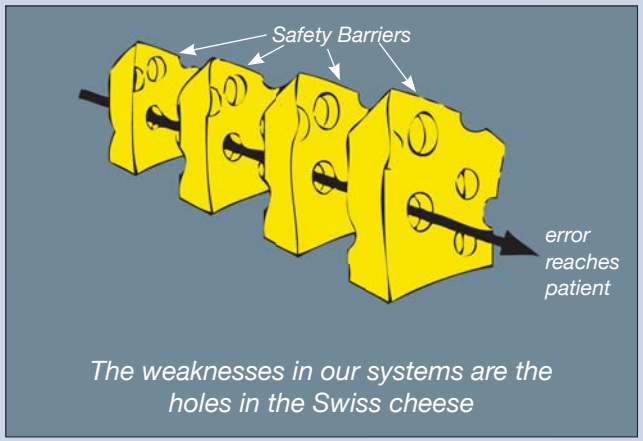
"So long as health care involves humans, it will never be free of errors. But it can be free of injury."

Don Berwick, Former President and CEO at Boston's Institute of Healthcare Improvement

Background

The Canterbury DHB has set itself a patient safety vision of zero harm and is focused on ensuring that the people using our services have a safe journey. While the safe patient journey and zero harm vision is always front-of-mind for our staff, it is acknowledged worldwide that people may be harmed as a result of receiving health care.

We know that people are fallible; with this in mind it is important to design 'safety barriers' into our systems. When harm does occur there are usually many contributing factors involved. The image of "Swiss cheese" is often used to help explain this. If, by some chance, all the weaknesses (holes) in the systems align, error can reach the patient and harm can occur.



The weaknesses in our systems are the holes in the Swiss cheese

By identifying problems and failures we can learn from them and introduce changes (safety barriers) to make our systems safer. These safety barriers can be engineered (e.g. alarms, automatic shutdowns, physical barriers), rely on people or depend on procedures and administrative controls.[1] One of the ways we are able to identify failures and problems with our systems is through reporting incidents. All staff are supported to actively report all incidents.

We also actively support open disclosure for all incidents. If harm does occur, our staff are required to speak to the patient and their family about what has happened. We will also share with the patient and family the outcome of the investigation into the event and the changes that have been recommended to prevent a similar event from happening.

Serious Adverse Event Report

The Serious Adverse Event Report, formerly known as the National Serious and Sentinel Events Report, is produced each year by the Health Quality and Safety Commission (HQSC). Serious adverse events are those where patient care has an unintended consequence resulting in either significant harm or death of a patient. The reports are released publicly and are available on the HQSC website at www.hqsc.govt.nz.

In addition to the national release by the HQSC every DHB is required to publish their own report on their websites. In 2010-11 the Canterbury

[1] Reason J. Human error: models and management. BMJ 2000;320:768-70.

DHB had 49 serious events, in 2011-12 there were 48 and in 2012-13 there were 47.

Key focus areas

Information on some of the key patient safety initiatives in our hospitals are included below. A number of these are also HQSC priority areas.

Zero harm from patient falls

(Identified as a priority in the 11-12 Quality Accounts for 12-13)

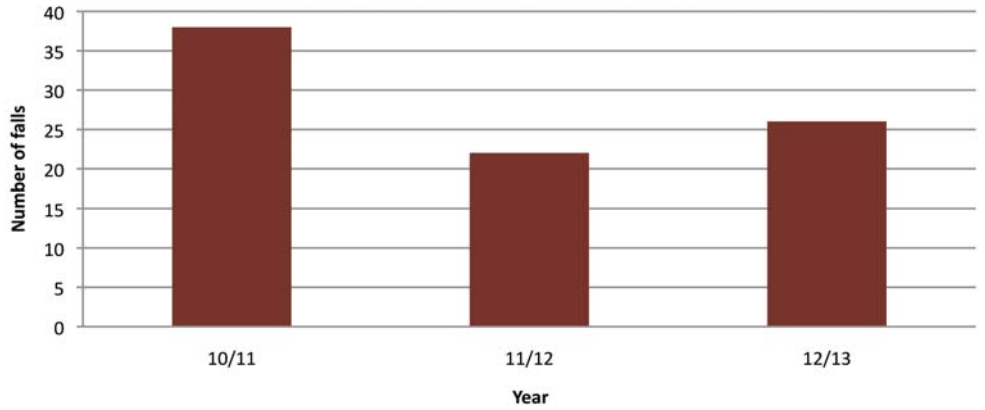
To move towards zero harm from falls[2] in the hospital setting, the Canterbury DHB is taking a multi-pronged approach focused on specific leadership and frontline actions. Initiatives include our annual Falls Awareness Campaign in April, (which the HQSC's Falls Prevention Programme also embraced in 2013), falls prevention Staff Self Learning packages, a ward-based Falls Audit Tool and the Canterbury DHB hospital falls study.

In October 2012 the findings from the Canterbury DHB hospital falls study were presented at the Australia and New Zealand Falls Prevention Society Conference. They reinforced the need to pay close attention to the specific falls risk for each elderly patient while they are in our care. In addition to addressing patient-specific factors, falls prevention by frontline staff is focused around five key actions (the essentials):

1. Asking the patient if they have suffered a fall at home over the last 12 months.
2. Assessing their risk of falling in a hospital environment.
3. Ensuring that appropriate falls risk management is in place for their hospital stay.
4. Discussing the findings and the prevention strategies with the person and their family.
5. Discussing with the person and their family falls prevention strategies for when they return home. This may involve referral to a Community Falls Champion.

Results of the data collected for the HQSC's quality and safety falls process markers confirmed that we are assessing our patients well. In 97 percent of the clinical records reviewed in an audit, there was evidence that a falls risk assessment had taken place and care plans

Serious & Sentinel Falls in Canterbury DHB hospitals 10/11 to 12/13



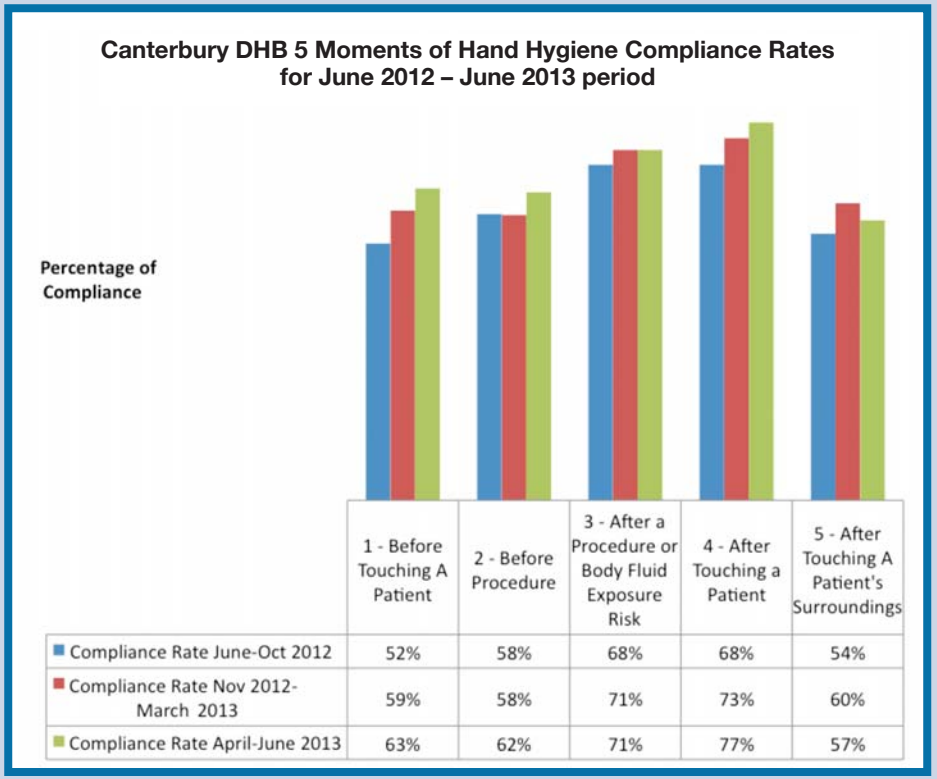
Source: Canterbury DHB Hospitals Serious & Sentinel Event Reports

Notes: A serious event is defined as one which has led to significant additional treatment. A sentinel event is life threatening or has led to an unexpected death or major loss of function.

[2] A patient fall is defined as an event which results in a person unintentionally coming to rest at a lower level.

reflected patients who had been identified at risk of falling while in hospital.

A range of falls prevention strategies implemented in our hospitals over recent years has contributed to a reduction in harm from falls in the elderly population. In the 2011-12 year we achieved a 42 percent reduction in serious harm falls in our hospitals compared with the 2010-11 year. Our goal for the 2012-13 year was to maintain this lower level of serious injury falls.



	1 - Before Touching A Patient	2 - Before Procedure	3 - After a Procedure or Body Fluid Exposure Risk	4 - After Touching a Patient	5 - After Touching A Patient's Surroundings
Compliance Rate June-Oct 2012	52%	58%	68%	68%	54%
Compliance Rate Nov 2012-March 2013	59%	58%	71%	73%	60%
Compliance Rate April-June 2013	63%	62%	71%	77%	57%

Reducing health care acquired infections

(Identified as a priority in the 11-12 Quality Accounts for 12-13)

Hand hygiene

Canterbury DHB started the National Hand Hygiene Programme in July 2012 and has completed the third audit period and the first full annual cycle. This programme promotes the 5 Moments for Hand Hygiene as the key opportunities that health care staff have to dramatically reduce the risk of spreading infection by cleaning their hands thoroughly.

The 5 Moments of Hand Hygiene are:

1. Before patient contact
2. Before a procedure
3. After a procedure or body fluid exposure risk
4. After patient contact
5. After contact with patient surroundings

Alcohol-based hand rub has been placed in all patient care areas. Posters reminding staff about hand hygiene and to inform patients about when they can expect hand hygiene to occur are on display. Staff education is ongoing and includes practical sessions together with an online e-learning tool on the Canterbury DHB's intranet.

The graph shows a breakdown of our compliance rates for each moment for the audits that took place between June 2012 and June 2013.

The national target for the overall hand hygiene compliance rate is 70 percent. Canterbury DHB's results from the third national audit period (1 April – 30 June 2013) showed our overall compliance rate was 67 percent. The overall national hand hygiene compliance rate for this period across all 20 DHBs was 70.5 percent. The results from this audit showed that the compliance with the 'before moments' 1 and 2 are still significantly lower than the 'after moments' 3 and 4. This highlights the need to target education on the importance of hand hygiene for patient safety rather than for the protection of health care workers, a trend that is also reflected nationally. This information is being used to inform our education programme.

Other activities are also being considered to help improve our compliance with the 5 Moments for Hand Hygiene:

- We already have hand hygiene champions who are actively involved in the promotion of the five moments of hand hygiene and we are now seeking hand hygiene opinion leaders. These opinion leaders would be health care colleagues who are highly influential and respected and are able to lead by example.
- We are considering making the e-learning education mandatory for all clinical staff with regular monitoring of completion rates.
- We are exploring approaches to engaging patients in hand hygiene improvement programmes.

These activities are supported by a public hand hygiene campaign at all Canterbury DHB hospital sites. This campaign focuses on the provision of hand hygiene stations and promotional banners which encourage visitors to clean their hands on entry to the hospital facilities.

Hand Hygiene New Zealand's national compliance report is available on their website: www.handhygiene.org.nz.

Central line associated blood infections

Around 50 percent of patients admitted to an Intensive Care Unit (ICU) will require a central venous catheter (a "drip" placed into a large vein). In 2011, 43 critically ill patients in ICUs across the country developed a central line associated bacteraemia (blood infection).

Once established, this bacteraemia can significantly increase the risk of death and can add between $20,000 and $50,000 to the cost of care. The measurement and prevention of central line associated bacteraemia has become one of the major quality targets for the critical care community. The end result will be safer patient care, shorter stays in ICUs and reduced costs.

Canterbury is one of the leading DHBs in the country in reducing bloodstream infections resulting from indwelling central venous catheters. By the end of June 2013 we had achieved 265 days without a central line associated bacteraemia. In the 2012-13 year we prevented seven central line associated bacteraemia in Christchurch Hospital's ICU.

Surgical Site Infections Surveillance Programme

Surgical site infections are the second most common health care associated infection after infections of the urinary tract. Auckland and Canterbury DHBs are jointly leading this initiative with a further six DHBs having been selected as development sites.

The programme began on 1 March 2013 with the initial focus on hip and knee joint replacement. The majority of the work that has taken place this year has focused on setting up work groups and collecting data. Three local champions have been appointed for the project, and the first report based on data collected during March and April 2013 is due to be released shortly. This is a three year project that will be expanded to include coronary artery bypass graft surgery and caesarean section in the near future.

Safe Surgery Checklist

(Identified as a priority in the 11-12 Quality Accounts for 12-13)

This checklist has been implemented in all our Canterbury DHB operating theatres and other locations where procedures are undertaken. It has three parts and is designed to ensure that the right operation is being performed on the right patient at the correct site or side of the patient. The checklist also assists with improving outcomes through promoting better communication and teamwork in the operating room.

The HQSC will monitor the percentage of operations where all three parts of the Safe Surgery Checklist are documented as being completed as one of their quality and safety indicators.

A selection of case notes for operations performed at Christchurch Hospital has been reviewed to find out how well this tool is being used. The results showed that in 40 percent of operations all three parts of the checklist were completed.

A significant amount of work has been undertaken to educate staff in the philosophy behind the checklist.

Reducing pressure injuries

(Identified as a priority in the 11-12 Quality Accounts for 12-13)

Although pressure injuries (also known as bed sores) are often not reported as serious events they can be regarded as a “slow killer”. This is despite it being accepted that 95 percent of pressure injuries can be prevented, especially in a hospital setting.

The Canterbury DHB has formed a project team to focus on reducing pressure injuries in our hospitals. A number of initiatives have been introduced including standardising tools and documentation across the hospitals. The new e-learning package has been expanded to cover pressure injury prevention and management and is applicable for staff across the continuum of care (community through to hospital). To date 84 nurses have completed the package since it was introduced at the end of July 2013.

An indicator report using data from clinical coding was developed to assist with the ongoing review and monitoring of pressure injuries. This report displays information as green, yellow or red traffic light indicators ward by ward, and includes any associated required actions.

Reducing medication incidents

(Identified as a priority in the 11-12 Quality Accounts for 12-13)

The use of medications always carries the risk of a side effect, allergy or other adverse event. In order to minimise this risk there are a number of initiatives within our hospitals focused on reducing the harm that results from the use of medications. These include:

Medicine Reconciliation

Medicine reconciliation involves obtaining the most accurate list of a patient's medicines, allergies and adverse drug reactions and comparing this with the prescribed medicines and documented allergies and adverse drug reactions. Any discrepancies are then documented and reconciled. Although primarily undertaken by pharmacists, medication reconciliation is promoted as being everybody's responsibility. Strong collaboration, communication and teamwork between medical, nursing, ambulance and pharmacy staff involved in the patient's care together with the patient, their carer and/or family is vital for its success. A prioritisation tool has been developed to help the pharmacy staff identify and target patients at admission most likely to benefit from pharmacy input. This has been rolled out across all of the adult Medical and Surgical wards at Christchurch Hospital, and within the Specialist Mental Health Services. There are also plans to roll this out for wards at Burwood Hospital.

National Medication Chart

This initiative aims to reduce medication errors by standardising the medication chart used in all hospitals nationwide. The National Medication Chart was introduced for trial in the surgical orthopaedic unit at Burwood Hospital towards the end of March 2012 and is still in use. In discussion with the HQSC it has been agreed that the National Medication Chart will not be rolled out throughout the Canterbury DHB, rather the focus will be on the introduction of an electronic medication prescribing system early in 2014 (further information on this is provided under the priorities for 2013-14).

Pharmacy staff in the Emergency Department

A pilot study trialling pharmacy staff (pharmacist and technician) working in the Emergency

Department (ED) was undertaken from January to June 2013. This resulted in a reduction of time for the patient to be seen by pharmacy staff and a reduction in time for a doctor to clerk the patient. In view of these positive findings the service is to be improved with a view to providing pharmacy input into patients being discharged home from the ED.

Reducing medication-related harm

In order to obtain a more accurate understanding of medication-related harm we are using the internationally validated "Trigger Tool" methodology. This involves screening a sample of 20 clinical records per month for a number of trigger words associated with a potential adverse drug (medication) event.

When an adverse event is identified it is graded for severity using an international grading system. Harm categories A-D are not reported, as although there was potential for harm, no harm occurred. Categories E-I cover events where some degree of harm was experienced by the patient, and are reported on below.

This Adverse Drug Event data focuses on adult medical and surgical admissions, and excludes psychiatric and maternity patients. The Canterbury Adverse Drug Event team works alongside our local Global Adult & Paediatrics Trigger Tool teams.

Canterbury DHB's overall adverse drug event rate since January 2010 is 25.5 adverse drug events per 100 admissions. This is in line with what is reported internationally.

Overall results from January 2010 to March 2013 are shown below:

Harm Category	% of events	Definition of event
E	64	An adverse event that may have contributed to temporary harm to the patient and required intervention by medical/nursing staff. E.g. prolonged nausea or constipation due to morphine-like medications.
F	31	An adverse event that may have contributed to temporary harm to the patient and either resulted in admission or prolonged the patient's hospital stay. E.g. falls in elderly patients receiving high-blood pressure medications.
G	0.3	An adverse event that may have contributed to permanent patient harm.
H	3.1	An adverse drug event that required intervention necessary to sustain life.
I	0.6	An adverse event that may have contributed to the patient's death.

The table shows that the majority of our adverse drug events (64 percent to date) have been temporary in nature with fewer than 4 percent of events (category G-I) resulting in a life-threatening situation or one where irreversible harm occurred to the patient. The details of our specific findings are reported to Clinical Leaders and provide information as to where best to focus safety improvement initiatives, to ensure that we continue to move towards our goal of zero harm.

Trigger Tool Programme

(Identified as a priority in the 11-12 Quality Accounts for 12-13)

In March 2012, Canterbury DHB joined the Institute for Healthcare Improvement Trigger Tool Programme. The programme ensures we continuously measure health care related patient harm and prioritise problem areas to respond to. Training was facilitated through the Health Roundtable. Trigger Tool methodology has been validated worldwide as a reliable mechanism for identifying the incidence and nature of health care adverse events (harm) and now complements our existing activities such as Incident Reporting, Complaints Review and implementing Health and Disability Commissioner and Coroner findings as a means of improving our health care system.

Nursing and medical reviewers form The Trigger Tool teams for adult and paediatric patient populations. Ten records of patients discharged from hospital are randomly selected and reviewed

fortnightly using 'trigger words' designed to identify those patients who may have been harmed in some way. Our Paediatric Service is the first in New Zealand to implement a Global Paediatric Trigger Tool. The Paediatric and Adult Trigger Tools supplement the already established Adverse Drug Events Trigger Tool programme. Data about patient harm is now being collected.

New electronic Clinical Incident Management System

(Identified as a priority in the 11-12 Quality Accounts for 12-13)

The move from a paper-based to an online incident reporting and management system was identified as one of the priority areas of work for the 2012-13 year. It has been agreed that all the South Island DHBs will use the same software. This important change will enhance our ability to achieve our vision of zero patient harm by facilitating both the reporting of incidents as well as improving the overall incident management process. This, together with an ability to interpret the accumulated data in greater detail, will assist us to manage risk more effectively. Testing is underway to ensure that the identified software will meet the requirements of our organisation as well as those of the other South Island DHBs.

Priorities for the next 12 months

- Continued focus on improving patient safety through reducing health care acquired infections, central line associated bacteraemia, pressure injuries, falls and medication errors.

- The development of the Electronic Medicines Management system (eMeds) as part of the South Island Alliance Information Technology plan developed in collaboration with the HQSC and the National IT Board. The development of eMeds will be clinically-led and will be an important area of work over the coming months. Canterbury DHB's business case has recently received final endorsement by the National Health IT Board. The project team and project board have been established and the recruitment of clinical leaders for nursing, medicine and pharmacy is underway.

Improving end of life care

Loving care at end of life

Judy Leonard is facing the end of her life with faith and an appreciation for the excellent care she has received in the Canterbury Health System over the past three years – in hospitals, community nursing and hospice. A former assistant Baptist Pastor and trained counsellor who emigrated to New Zealand from England 42 years ago, Judy has spent her working life helping others.

In November 2010 her life changed drastically when she was diagnosed with ovarian cancer and required major surgery.

“On Christmas Eve I started chemo at Christchurch Hospital. I was very, very sick and the care was absolutely fantastic. I was treated with love and kindness there and had a wonderful surgeon. A specialist nurse explained everything to me very clearly.” Judy received a peripherally inserted central catheter (PICC) line because staff were having trouble accessing her veins.

“This meant I needed a district nurse to call and clean it out and refresh it. That was my introduction to the community side of health care and it was very good.” Judy’s surgery and chemotherapy were successful and in June 2011 her surgeon pronounced her clear of cancer.

However 18 months later the cancer returned. “I didn’t want to hear that,” says Judy, who describes herself as a “young” 74 year old, “I would have liked a bit longer.” Judy became seriously ill and had to be stabilised in Christchurch Hospital before chemotherapy could be started. She was cared for at home by a Nurse Maude District Nurse and by the Nurse Maude Hospice Palliative Care Service. “They were extremely helpful getting my medications right and were very encouraging.”

In the last few weeks Judy’s health declined and she spent time in Nurse Maude’s Hospice, “where I received wonderful care”, before moving to the Nurse Maude Hospital where she remains. “It’s light and airy, the staff are very good and I have had excellent care. This is where I will probably die.” Judy says hers is an experience she would not want anyone to go through but there have been many “gifts” along the way. “I have been carried by the love of those who have cared for me and I have very much felt the presence of God. He has been with me through this journey. I know I am not alone.”

Improving end of life care

Background

End of life care is the provision of supportive and palliative care[1] in response to the assessed needs of the patient and family/whānau during the end of life phase. It focuses on preparing for an anticipated death and managing the end stage of a life-limiting or life-threatening condition. End of life care includes care around the time of death, and immediately afterwards. It enables the needs of both the person and the family/whānau to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support for the patient and family.

The end of life phase begins when it is recognised that death is imminent. It may be the judgement of the health/social care professional or the team responsible for the care of the patient, but it is often the patient or family who first recognise its beginning.[2] The end of life phase can also be regarded more broadly in order to ensure that symptom control, emotional and practical support and advance care planning are offered and available for individuals at such a time when you would not be surprised if they were to die within the next 12 months.

End of life care is the responsibility of everyone who works in health. It is provided by primary palliative care providers (hospital teams and wards, general practice teams, primary health organisations, community nurses, paediatric outreach nurses, aged residential care facilities, Māori health providers), by specialist palliative care services (hospices, specialist palliative care community teams and hospital palliative care teams) and by all health care workers who look after dying patients, whether or not their critical illness or death is anticipated.

It is vital that all health services and systems provide excellent care for dying patients and their loved ones. This is most likely to happen in an environment where the provision of high quality palliative and end of life care is a priority.

Key focus areas

Advance care planning

(Identified as a priority in the 11-12 Quality Accounts for 12-13)

Advance care planning is defined by the New Zealand Palliative Care Glossary as a process of discussion and shared planning for future health care. It focuses on the individual and involves both the person and the health care professionals

[1] Palliative Care is defined by the World Health Organisation as an approach that improves the quality of life of patients and their families facing problems associated with life-limiting or life-threatening conditions, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. World Health Organisation. (2002). National cancer control programmes, policies and managerial guidelines (2nd edn.). Geneva: World Health Organisation.

[2] The Palliative Care Council of New Zealand, Hospice New Zealand & the Ministry of Health. January 2012. New Zealand Palliative Care Glossary, 5.

responsible for their care. It may also involve the person's family/whānau and/or carers if that is the person's wish.

Advance care planning provides individuals with the opportunity to develop and express their preferences for care informed not only by their personal beliefs and values but also by an understanding of their current and anticipated future health status and the treatment and care options available. The specific directives within an advance care plan come into effect only when the patient is no longer competent.[3]

Palliative Care team members have been working with general practitioners (GPs) and hospital based health professionals to introduce a local framework and process for advance care planning that is in line with the National Advance Care Planning Cooperative. This has included the development of an advance care planning pathway on both HealthPathways and HealthInfo and a Canterbury DHB "My Advance Care Plan". This plan encourages the documentation of values, goals and preferences for care and treatment at the end of life. It also incorporates features consistent with an Advance Directive such as preferences regarding cardiopulmonary resuscitation. A programme of education and further development is ongoing.

[3] The Palliative Care Council of New Zealand, Hospice New Zealand & the Ministry of Health. January 2012. New Zealand Palliative Care Glossary, 35.

End of life care pathways

(Identified as a priority in the 11-12 Quality Accounts for 12-13)

Under the guidance of a designated Nurse Maude Liverpool Care Pathway facilitator, the Liverpool Care Pathway for the dying patient has been introduced into the Nurse Maude Hospice, many aged residential care facilities in Canterbury and a few acute care wards. There has been a very positive response with significant benefits realised around improving confidence in managing the many and varied issues facing dying patients and their families/whānau.

Despite the current phasing out of the Liverpool Care Pathway in the UK, the demonstrated advantages of this structured and evidence based framework will be retained in New Zealand. It will be modified to ensure that when it is used the plans are individualised to the patient's unique needs. The Canterbury DHB is fully engaged in this process and support for the pathway is ongoing.

Health Round Table – End of Life Care Project

(Identified as a priority in the 11-12 Quality Accounts for 12-13)

A delegation of Canterbury DHB representatives from palliative care and general practice have participated in two meetings in Australia where innovations in end of life care are shared, analysed and discussed. This commitment is ongoing and will help shape future developments in palliative and end of life care using highly detailed data that is comparable across services.

Canterbury Integrated Palliative Care Services

The Christchurch Hospital Palliative Care team and the Nurse Maude Hospice Palliative Care Service have been working more closely to create an integrated service with the focus on ensuring a seamless journey for palliative patients and their families. This united approach to education, support, service planning and regional development is being formalised in a strategy document. It has also been possible to align community and hospital information technology systems, resulting in more timely information sharing.

As part of the commitment to education, Palliative Care Master Classes at the Nurse Maude Hospice have been available for GPs to attend. The classes have been well attended and evaluated. Aged residential care facilities have been up-skilling staff by using the Hospice New Zealand Fundamentals package delivered by members of the Nurse Maude specialist palliative care team. Palliative Care Study Days for hospital based staff are conducted four times a year and are also very well attended.

The Hospice New Zealand Standards for Palliative Care have been introduced into the Nurse Maude Hospice Palliative Care Service and a peer review process conducted. This has been a positive experience for staff and will lead to improved outcomes for patients and families/whānau.

HealthPathways and HealthInfo

The palliative care pathway has been reviewed and an Advance Care Planning pathway and a Motor Neurone Disease pathway have been developed. These all have supporting patient information resources available on www.healthinfo.org.nz.

Measures

Coming up with measures for the quality of dying and end of life care is proving challenging and is a focus for the Health Round Table. It is important to consider what data is currently available and what further information/indicators may be useful to monitor progress. The Views of Informal Carers – Evaluation of Services survey may be one way to explore this. Work is also ongoing to ensure that information recorded about people receiving palliative care in hospital is accurate.

Priorities for the next 12 months

- Advance Care Planning: This is a major collaborative project supported by the Canterbury DHB and the Health of Older Persons South Island Alliance. Current work includes:
  - Regional primary education strategy targeting practice nurses, pharmacists and family care givers.
  - Ongoing education for health care workers.
  - Implementation of a pilot project for advance care planning facilitators.
  - Increasing the pool of advance care planning trained “champions” in primary, secondary and aged residential care.
  - Introducing and evaluating the electronic version of “My Advance Care Plan”.
- Health Round Table: Ongoing participation in the Health Round Table End of Life Care Project which covers issues such as advance care planning, end of life pathways, not for resuscitation orders, care planning and review, end of life care strategies, measurement and audits.
- VOICES (Views of Informal Carers – Evaluation of Services): The Christchurch Hospital Palliative Care service intends to undertake a VOICES survey along with two other main centres in New Zealand to obtain feedback from bereaved relatives and carers on the quality of care for cancer patients at the end of life. This survey is pending a decision on application for funding.
- Canterbury Integrated Palliative Care Services: The Strategic Plan 2013-15 will be available to inform future priorities and work within the Canterbury DHB and the wider region. There will be a strong focus on community engagement, education and improved communication with stakeholders.

Good end of life care a comfort

Grieving widower Roy is comforted by the knowledge that his wife was treated with empathy and dignity from when she was diagnosed with bone cancer until the day she passed away.

Jeanette died eight months ago at the “too young” age of 53, after an agonising four year battle, Roy says. The disease weakened her bones so much that she broke her hip three times. “In the last six months her bones started breaking. It was incredibly painful for her but she never complained.”

While the situation was not pleasant, the care she got in the Canterbury Health System was excellent, Roy says. “In a funny way it was a good experience; they couldn’t have treated us any better and cared for her with such respect.

Jeanette’s medication regime was regularly assessed to see if the management of her pain could be improved and Roy is impressed at the lengths the Palliative Care Team went to. “Even in hospital where she ended up, the team kept a watching brief on her. They would visit her in Intensive Care and talk to the other staff about her needs.” Jeanette knew she wasn’t going to get better but didn’t want to be reminded of that, Roy says.

“She was a wife, mother, aunty, sister and daughter and wanted to do those roles for as long as she could without being reminded that she was ill.” One of the best gifts the Palliative Care Team gave Jeanette and her family was ensuring she had the best quality of life that she could possibly have, Roy says.

Embracing quality improvement and innovation

Telehealth – closing the distance

Telehealth uses video conferencing technologies to deliver health-related services and information. We are increasingly using this technology to support clinical collaboration with West Coast DHB and other DHBs; to enhance local care skills; to improve access for patients who live remotely to be seen by their health professional and care teams; and to facilitate flexibility for the health workforce and the development of health care networks.

Telehealth has been used over the past year to assist in providing ongoing specialist clinical support, which is particularly important for the West Coast given their remote location. The ability to visually assess a patient via Telehealth enables our clinicians to provide specialist support around decision-making on assessment, treatment plans and acute admissions.

Telehealth is also used to improve patient discharge planning. Clinicians can hold discharge meetings with health professionals on the West Coast to reach a common understanding about continued care instead of sending a number of discharge and referral letters to different services. It has also increased the number of patients able to be seen by reducing the time health care providers spend travelling to visit patients.

Canterbury was the first DHB in New Zealand to use Telehealth as part of our patient retrieval service. This has meant that clinicians at Christchurch Hospital can assess a patient on the West Coast via Telehealth before they are retrieved. This enables a greater degree of support and clinical oversight to be provided by our specialists.

The Murphys' story

For the West Coast's Murphy family, having access to Telehealth became mission-critical when both daughters needed medical treatment at the same time.

Five year old Piper developed a serious condition while home on the West Coast. However, both parents were more than 200km away in Christchurch, supporting their youngest daughter Taysia through chemotherapy treatment.

Dr John Garrett says Piper had a condition known as haemolytic-uremic syndrome, which meant that she had to be transferred to Christchurch. "What we were able to do before we went and picked her up was to let her parents see her by video conference so they could see that she was doing fine, and they could understand why we needed to bring her to Christchurch."

Piper's mother Tash Murphy says that within minutes the family were at Christchurch Hospital on the Telehealth (system) talking to Piper. "We could comfort her and she got to talk to her dad and sister. If we didn't have Telehealth we would have had to make numerous trips to Christchurch before Taysia started her treatment to sign documents," Tash says. "Then when Piper fell ill to be told you need to hop on a plane and come and pick up your daughter and not even (having) seen her and talked to her… to be able to see her on the TV was just amazing."

Liaison Paediatrician for Canterbury and West Coast DHBs, Dr John Garrett, using Telehealth to help patients on the West Coast.

Canterbury and West Coast DHBs now have more than 60 Telehealth units bringing specialists closer to patients living outside the main centre. Aside from the obvious benefit to patients having access to these specialists closer to their homes, using this technology is also saving time.

Embracing quality improvement and innovation

Background

Canterbury's whole-of-system approach to health care ensures greater collaboration across the public, private and non-government sectors. In supporting clinical leadership across the system we ensure the message of innovation and quality improvement is reinforced and our workforce is provided the tools and support to make changes. The Canterbury Clinical Network District Alliance Leadership Team[1] and the Canterbury Clinical Board[2] are responsible for improving the way our system works, ensuring safe patient journeys across our health system and adopting a model for reducing harm in our hospitals and our community.

The following programmes have been designed to help people working in health develop skills and gain experience in quality improvement and "lean thinking":

- Xcelr8: Designed to develop our health systems leaders, it teaches tools and techniques for managing processes and resources more effectively. The programme empowers them to make positive improvements in the way we deliver our health services, with 558 participants since it was introduced.
- Particip8: Designed to rekindle people's passions for the system and empower them to make positive change. It is open to everyone working in the health system and focuses on tools and techniques that will help people participate in change – either by progressing their own ideas or supporting others. The tools focus on engagement, communication and empowerment, with 208 people participating since it began.
- Collabor8: Provides an introduction to the principles and tools of lean thinking, influencing change, culture and leadership, patient safety, personality styles and effective communication. The two day course has been completed by 384 people since it was introduced.

Peer groups review evidence

The Pegasus Small Group Education programme is another example of a programme designed to reduce unwarranted variation, promote the ethical use of limited resources and influence clinicians' behaviour. This programme is available to over 1000 Canterbury general practitioners, practice nurses and community pharmacists. Small peer groups are provided with a review of the evidence, example cases and feedback on

[1] The Canterbury Clinical Network (CCN) District Alliance is an alliance of Canterbury health professionals, including GPs, secondary care specialists, practice nurses, community nurses, physiotherapists, community pharmacists, Māori and Pacific health providers, PHOs, IPAs and the DHB. The CCN was established with the explicit inclusion of the DHB (as the funder) as a key partner to enable a 'whole-of-system' approach to service performance. The Alliance Leadership Team is the governing body for the CCN.

[2] The Canterbury Clinical Board has the overall responsibility for clinical governance over services that are provided or funded by Canterbury DHB.

individual prescribing and test ordering, for around six topics a year. Recent topics include multiple morbidities, dementia, cannabis, bronchiectasis and careful combinations (drug interactions). The programme is aimed at encouraging peer discussion and learning, particularly around topics where the best thing to do may be uncertain or different from common practice.

Encouraging and celebrating improvements and innovation

The annual Quality Improvement & Innovation Awards programme is another way we encourage and celebrate improvement projects across the Canterbury Health System. This programme has been well supported over the past nine years with 180 projects entered. The programme has evolved over time and includes a mentoring component that helps entrants prepare submissions and shows people how to make use of quality improvement methods in their project work to best demonstrate the impact of their initiatives.

Hub for health innovation

In late 2012, the Health Innovation Hub was launched, with Canterbury DHB as one of the four founding DHBs. The focus of the national health innovation hub is to facilitate ideas that both impact positively on health care and have commercial potential between the DHBs and the health innovation industry.

Contributing to regional innovation

Launched in 2012, the national health innovation hub and Via Innovations, our regional organisation are both supported by the Canterbury Development Corporation, universities and other tertiary providers. Clinicians now have improved opportunities to access innovation support through these regional and national networks, with the aim of accelerating interventions focused on improved patient outcomes and health system improvements.

Quality improvement and innovation in practice

The following projects will give you an idea of how people working in health have embraced collaboration, quality improvement and innovation.

Development of South Island position statements on tobacco and alcohol

Position statements are a formal statement of an organisation's stance on a key issue. As part of the South Island Public Health Partnership, analysts from both Community and Public Health and the Public Health Service of Southern DHB have worked together to write position statements focused on reducing harm from alcohol and tobacco. Each of these statements is supported by a background paper highlighting the New Zealand and international evidence. Both the alcohol and tobacco position statements have been adopted by all five South Island DHBs. This is a significant achievement made easier by greater collaboration as a result of the South Island Public Health Partnership (an initiative that aims to improve the efficiency and effectiveness of Public Health Services across the South Island).

The Wellbeing Game

The Wellbeing Game is part of the Wellbeing Campaign and is a free online game designed to make participants aware of how they support their own wellbeing. Participants record the activities that make them feel good and map them to one or more of the Five Winning Ways to Wellbeing: connect, be active, take notice, keep learning, and give. The game was developed by Community and Public Health, with support from the Mental Health Foundation. It is the first time the five ways to wellbeing have been brought to life in a game. The winning ways to wellbeing are based on United Kingdom research drawn from the inter-disciplinary work of more than 400 scientists from around the world.

A number of non-government organisations and some of our city's largest employers, including the Canterbury DHB, Air New Zealand, Christchurch City Council, CERA, IRD and Environment Canterbury, have embraced the game. The Wellbeing Game 2012 ran for a month (October-November), with 1096 people playing. An

evaluation found that a high proportion of those who played the game throughout the month felt that it contributed to greater awareness of how to improve their wellbeing. There was also a statistically significant increase in wellbeing scores for those who played throughout, although it can not be determined from the data to what extent this increase was due to the game.

Tracing communicable diseases

Case Contact and Tracing (version 2) (CCAT2) is an intranet-based database system developed by Community and Public Health to support the investigation and control of communicable disease outbreaks in the community. CCAT2 is linked to Community and Public Health's Healthscape system, and is accessed by Healthscape users who are taking part in cluster and contact tracing operations associated with outbreaks of communicable disease such as measles, non-seasonal influenza, campylobacteriosis, other forms of gastroenteritis, meningitis and hepatitis A.

CCAT2 provides a real-time "single source of truth" for staff working in rapidly changing communicable disease outbreak investigations. It has an easily adaptable user interface, which can be customised according to the specific needs of each outbreak without the intervention of information technology specialists. As information enters CCAT2, it is made directly available to analysts who can generate summary analysis reports, or drill down into detailed data as part of their investigation of the outbreak.

Last year, CCAT2 supported management and investigation of a large water-borne gastroenteritis outbreak. In 2013 CCAT2 has been used to coordinate data and reporting needs associated with a series of hepatitis A "clusters", and extended to direct data-capture of information from community vaccination clinics by Community and Public Health staff using tablet computers.

Promoting health in schools

A goal of the Health Promoting Schools Team at Community and Public Health is to promote health and wellbeing in the education sector. One way to achieve this is to promote student health leadership teams in the schools involved with Health Promoting Schools.

These teams attended a Student Health Teams' Forum at Community and Public Health in April this year. The forum enabled students to come together, think together, work together and to share their ideas about health issues identified within each school. The forum covered topics such as how to use basic logic in decision-making and develop a communication strategy to help them share health messages with students, parents, teachers and the wider school community. Teams learnt how to develop an action plan, focused on a health issue they had identified prior to the forum.

Both sessions were facilitated by the Christchurch East Student Council as part of their leadership development. Also present were principals, teachers and support staff who were very enthusiastic about the process. A follow-up forum is planned.

Sharing patient information

The Shared Care Record View (eSCRV) is a secure data repository for electronic patient information made available through Health Connect South, the Canterbury Health System's principal clinical information system. It provides Canterbury clinicians such as general practices, pharmacists and community nurses with secure access to the latest patient information, enabling them to deliver better and safer care. For example, pharmacists can find out about a person's allergies and current medications, and doctors and nurses can see scans and test results, or be alerted to a health condition that will influence care decisions. Shared Care Record View automatically includes hospital data and gathers data from pharmacies. Since September 2013, when the implementation of Shared Care view was completed, parts of patient records from general practices have been visible.

Shared Care Record View has worked particularly well for after-hours care facilities as clinicians have instant access to all the laboratory and imaging results, clinical correspondence from the hospital and the majority of general practice referral information. This enables the team to manage more complex patients having full and comprehensive access to previous problems, reducing the need for some Emergency Department (ED) admissions.

Website helps general practices

The HealthPathways website is the main source of information on Canterbury Health System services for general practice teams. It attracts about 6000 page views per day (over one million to date) and is a great example of how we collaborate to develop standard ways of working. It was developed by Canterbury Initiative work groups consisting of general practitioners, hospital clinicians, and other health professionals involved in the care of Canterbury patients. There are now over 540 clinical pathways and extended support information, facilitating consistency in the management of common conditions in general practice and the hospital system.

HealthPathways has been rolled out across the South Island. It is also being trialled in Hutt Valley, implemented in four health authority regions in Australia, and has commitments from a further seven Australian regions. This brings the total population whose care will be improved through its use to over 10 million.

Improving services for people suffering from eating disorders

A number of improvements have been introduced to the South Island Eating Disorders Service that will help people suffering from eating disorders and their families with their journey.

- **Support for families**
  A three session "tool kit" for carers provides information for families and carers on the best way to support their loved one and has been developed along with a tool kit for Māori family/whānau. Eating disorders have a significant impact on families and carers and the introduction of the Carer Tool Kit is designed to help them through this journey.

- **Development of The Maudsley Family based treatment for anorexia nervosa**
  The Maudsley Family based treatment programme has a 70 percent recovery rate for those under 19 who have had the illness for fewer than three years. The key to recovery from anorexia nervosa is early detection and treatment. It is a regional health initiative under the umbrella of the South Island Health Alliance.

South Island Eating Disorder Service Clinical Head, Rachel Lawson says ensuring the sustainability of the therapy model is now key. "We are excited by the good progress that has

been made in implementing Maudsley therapy across the South Island, but are mindful we need to keep training clinicians and supporting those who are trained.

"We have also been working with primary care to assist them to detect the illness early on and refer the service user to treatment. In Canterbury, HealthPathways has been extremely valuable in getting the message of early detection across to GPs, both via their education sessions and the development of a health pathway for eating disorders."

Supervision of the clinicians via telemedicine is being provided by the South Island Eating Disorders Service, the regional specialists based in Christchurch. Ms Lawson says it is positive that there is such strong regional support for the programme. "Although clinicians around the South Island can be isolated, the use of telemedicine has made the roll out and ongoing support for Maudsley therapy much easier."

The South Island Eating Disorders Service is also working with its district partners to identify alternative treatment pathways for those who do not manage to recover with Maudsley Family Based Treatment. The South Island Eating Disorders Inpatient unit in Christchurch has adapted its programme to meet the needs of these young people and their families before they return to their district to complete their treatment journey.

New Acute Medical Admission Unit

In June 2013, a new 36 bed Acute Medical Admission Unit (AMAU) was opened as part of the rebuild of Christchurch Hospital and reflects our focus on reducing the time people spend waiting. There are two acute general medical teams on duty within the unit every day, ensuring that patients are seen by a medical team as quickly as possible. After being assessed and treated, around a third of admitted patients are discharged directly from this unit to their homes or to other community care and support providers.

The AMAU provides comprehensive medical assessment and care, including access to multidisciplinary support from occupational therapists, physiotherapists, dieticians, speech and language therapist and social workers, to ensure that appropriate plans are quickly established to support a patient's return home.

Staff at the new Acute Medical Admission Unit (AMAU).

Nursing and medical staff within the unit work collaboratively with staff from many community-based services, such as the Acute Demand Service and the Community Rehabilitation Enablement Support Team (CREST), to ensure patients can access all the appropriate support they need upon discharge.

From September 2013, general practitioners will be able to refer patients who are considered to be stable directly to the AMAU, and will ensure that patients are seen by a general medical team quickly, without having to enter the hospital system via the ED. It is anticipated that the AMAU will further reduce the average length of time that patients who present with acute medical conditions will need to stay in hospital.

Improved capacity for MRI scanning

Canterbury Community Radiology (CCR) has acquired an off-site magnetic resonance scanner to increase the capacity for scanning MRI[3] outpatients and reduce the time people spend waiting. In addition to the people being scanned at Christchurch Hospital we are able to scan an extra 45 to 55 outpatients a week.

[3] Magnetic resonance imaging.

To further improve the throughput at CCR we are looking at optimising the protocols so that running a set of sequences takes less time. For patient safety reasons two staff are always present for MRI scanning and we asked technicians if they were interested in working different shifts to increase our capacity.

The technicians have also gained new skills with most undertaking IV cannulation training so they can start their own lines. All the technicians can administer contrast. This skill set has positively affected workflow at Christchurch Hospital and significantly reduced demands on nursing resources in the MRI Department. These changes have resulted in an increased capacity to between 65 and 75 patients per week on average, and we are continuing to work on improving our patient flow.

We are now able to take the time with our patients to ensure they are comfortable with the exam they are having, and yet still meet the needs of the community by not having a long wait list for MRI scans. Knowing we are meeting our targets also has a positive effect on staff morale as we know people are not getting 'lost in the system'.

Improving lung cancer patient journey

In response to patient feedback a project was initiated to improve communication between services (Respiratory, Cardiothoracic, General Surgery and Oncology) for those who required curative surgical treatment for lung cancer. The project introduced a range of changes, including greater use of multidisciplinary team meetings and improvements to documentation and discharge planning. A follow-up audit showed marked improvement in patient waiting times. Time from surgery to respiratory follow-up has increased from 52 to 82 percent of patients seen within one month. Annual audits are completed to maintain improvements.

Coming up Roses

Continence products are essential in health care, particularly for older people. They are absorbent products used for people with bowel and/or bladder incontinence. In 2010 the Canterbury DHB purchased half a million continence products that are destined for landfill, often triple bagged in plastic. The demand for continence products is expected to increase. By 2021 the number of people over 65 years old is forecast to rise to 18 percent of the Canterbury population.

The Coming up Roses project examined the feasibility of developing a new waste stream that segregated the continence product waste safely and sent it to be composted at Envirocomp a recognised continence product disposal company. This waste stream has not been developed in any DHB hospital in New Zealand or indeed any public hospital in the world. Participating in the Xcelr8 course was used as a platform to investigate this further.

A pilot was set up in one ward at The Princess Margaret Hospital. Initial data was collected on weights and costs, staff and patients were surveyed and the use of plastic in the process was also reviewed. Approximately 70 percent of the weight of the medical/infectious waste from the trial ward was soiled continence products, for which the Canterbury DHB paid by weight (79 cents/kg) for removal, processing and burial at special landfill. It was extrapolated from the initial trial data that this would add up to approximately 141,465 kgs of Canterbury DHB landfill waste per year. By diverting continence products from landfill to the composting waste stream 29 percent savings were made along with reducing the Canterbury DHB carbon footprint. In addition to the pilot determining that a new waste stream was achievable, making a sustainable choice was met with approval by both staff and patients who saw the project as 'doing the right thing'.

Following on from the pilot a four phase project plan was devised to roll out a composting waste stream for all continence products including nappies throughout all Canterbury DHB hospitals. The roll out commenced at Ashburton Hospital and Taurangi Home in November 2012 followed by Ward 3A and Ward 2B at The Princess Margaret Hospital in 2013. The project is currently in Phase 3 and is being re-evaluated to develop process models to allow roll out through clinical areas.

Transforming infrastructure and design

Transforming infrastructure and design

Background

The Canterbury Health System is undergoing one of the largest infrastructure repair and rebuild programmes in New Zealand history. The investment in new primary care facilities, ambulance facilities, rural hospitals, community services, pharmacies, dental, and key facilities such as after hours primary care and hospital rebuilds involves a whole of health facility redesign. This is a once in a lifetime opportunity to rethink the landscape of health care in Canterbury. We have a responsibility to all taxpayers to ensure that the rebuild is designed to meet future needs and will be sympathetic to rapidly changing service and population requirements.

In November 2012, the Canterbury DHB opened the Design Lab as a centre for user-based design to support the transformation activity of the Canterbury Health System. This 3000 square metre warehouse space enables patients, staff and key stakeholders to explore the intersection between service design, facility/structure design, technology and business process design. The facility provides space to build prototype design ideas. Ideas may involve full-scale facility mock-ups, where everyday activities can be simulated; patient and family experiences can be studied; and business processes can be developed.

The success of the Design Lab is directly linked to the ability to engage staff and patients to be part of the design process. Its purpose is to encourage disruptive thinking by users and workers of the health system, such that new ways of working are developed which inform the wider health system design process. Like all parts of the Canterbury Health System transformation story, the Design Lab operates in a partnership model between patients, staff, architects, designers, technology providers and equipment suppliers. It is a place to explore together the opportunities to enhance the experiences and needs of the users of the new physical health environments being designed across the health system.

Staff and patients are involved in the design process.

Key focus areas

The first year of the Design Lab commenced with Showcase, an interactive series of exhibits that explored the achievements of the Canterbury Health System, and the issues of an ageing population and workforce. It explored how we might redesign the health system for the changing population needs, and looked at how user-based design and rapid prototyping can empower patients and staff to be the architects of the rebuild. Over 3500 people from across the Canterbury Health System, including patient and consumer groups, visited Showcase. Everyone who came was exposed to the design activity of the Design Lab and, in particular, were given the opportunity to explore and feedback on a concept for a new multi-bedded space for Christchurch Hospital called the Ōtautahi Concept design.

In November 2012 a group of 16 clinical staff were given a design challenge to reinvent the Nightingale Ward. The concept behind this design challenge originated from an in-depth study in August 2012 of 138 patients. The team supported by the design company NBBJ explored design ideas from different sectors such as aircraft cabin design, campervans and hotel designs. These insights helped shape a variety of concepts but the team kept coming back to one design that best achieved the core design aims. Working with cardboard the team created a variety of different designs.

The Ōtautahi Concept was developed to provide equal access to natural light for all patients, to enable two-way visual contact between patient and staff and to enable both socialisation and visual separation between patients.

The resulting mock-up was tested in simulation exercises in January and February with staff and patients. It was further challenged in June 2013 in a two-week design session aimed at converting the Ōtautahi Concept into a floor plan for the new Christchurch Hospital ward design. This session, with architects, designers and over 30 staff and patient representatives, included a Burwood user-centric ward design process involving rapid prototyping techniques. It resulted in the conceptual ward configurations for both sites being created.

Key to the design at both Christchurch and Burwood hospitals has been the development by the Clinical Board of key design principles for facility designs.

Design principles

These design principles have been tailored to each site. For example ‘line of sight’ has a slightly different purpose and application between Burwood and Christchurch hospitals. At Burwood, where patients are being rehabilitated back to their place of residence and are typically spending almost 20 days in this environment, ‘line of sight’ means having patients visible in rehabilitation spaces; whilst in Christchurch Hospital being an acute high turnover environment it is about ‘line of sight’ to the bed.

In August a high fidelity version of the Ōtautahi Concept, designed by the Katoa Health Design group, was built. This was showcased on national television on the Campbell Live programme, and has inspired interest from around the world and within the business community.

This initial build is a test bed to simulate more real-world scenarios, and has been reviewed by a number of consumer groups including some of the 138 patients studied in August 2012. This was an opportunity for them to view their feedback and the impact they have had on the design process for the new Christchurch Hospital build.

Priorities for the next 12 months

The Design Lab is achieving its goals of engaging with staff and patient users, supporting disruptive thinking and developing ideas that change our thinking of future health environments. The interest and the desire to use this facility has broadened the engagement scope to include wider public sector design activity such as the Justice Precinct and the IRD design team.

From a health perspective the design of health hubs and integrated family health services is a priority along with supporting new outpatient facility design, theatres, the Intensive Care Unit and the Emergency Department. Investigating technology and how it can enable new work practices is a focus; and engaging with the public of Canterbury to be part of the design process remains a key goal. Using the high fidelity builds to explore and simulate patient experiences and undertake detailed design studies will be an ongoing activity.

Providing the Design Lab as an event space for staff and consumer groups, as a place to come and explore design and design needs is a pivotal function of the facility.

Delivering on the National Health Targets

Delivering on the national health targets

Background

The Health Targets are a set of national performance measures set by the Minister of Health for all DHBs.[1] While they capture only a small part of what is necessary and important to our community's health, they provide a focus for collective action and performance improvement. They also present a summary of performance across the continuum of care, from prevention and early intervention through to improved access to intensive treatment and support. In this sense, achievement of the Health Targets can be seen as a reflection of how well every level of the health system is working together to improve the health and wellbeing of our population.

Details on the actions we will take to deliver against the Health Targets can be found in the Canterbury DHB Annual Plan 2013-14, available on our website www.cdhb.health.nz.

Achievement of the Health Targets can be seen as a reflection of how well every level of the health system is working together to improve the health and wellbeing of our population.

[1] More information about the Health Targets can be found on the Ministry of Health's website: www.health.govt.nz/new-zealand-health-system/health-targets

Measures

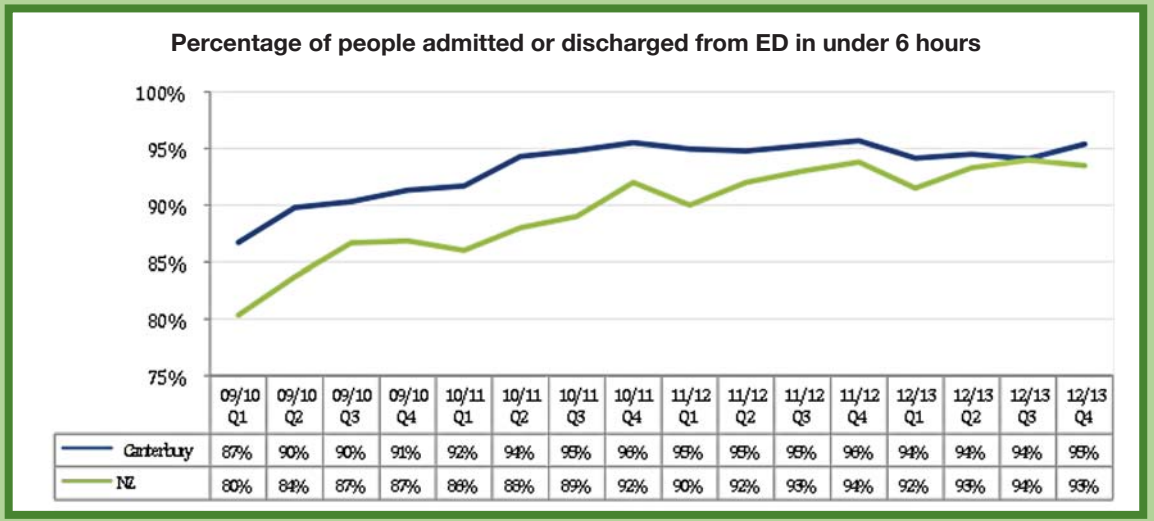
Shorter Stays in Emergency Departments ✔

Shorter stays in Emergency Departments (ED)

2012-13 National Target: 95 percent of patients attending ED will be admitted, discharged or transferred within six hours. Canterbury achieved the target of 95 percent.

2013-14 National Target: 95 percent of patients attending ED will continue to be admitted, discharged or transferred within six hours.

How are we tracking?



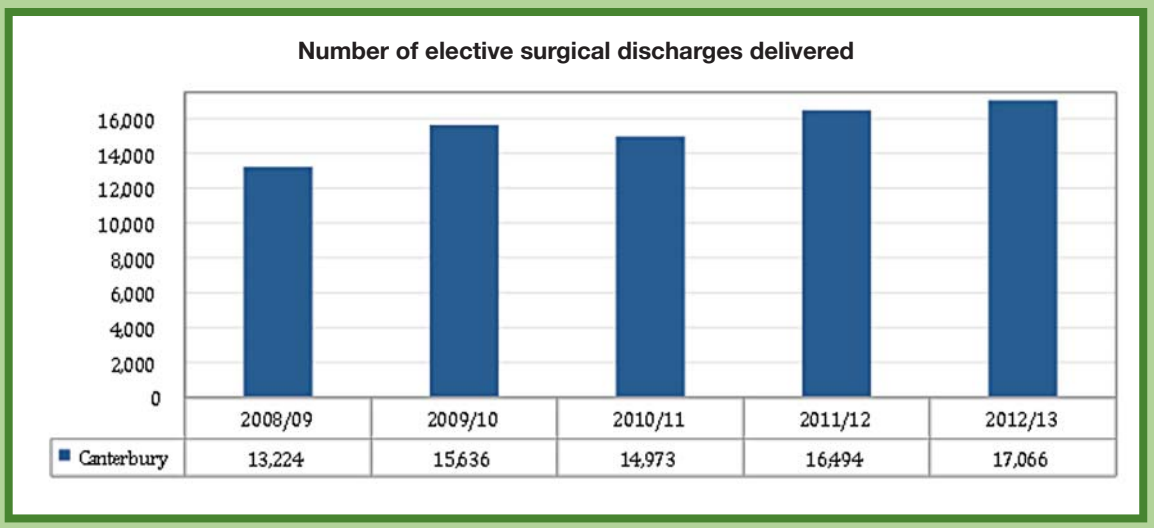
Improved Access to Elective Surgery ✔

Improved access to elective surgery

2012-13 National Target: 16,110 elective surgical discharges will be delivered. 17,066 elective surgical discharges were delivered to Cantabrians – surpassing the target.

2013-14 National Target: Canterbury will deliver 16,861 elective surgical discharges.

How are we tracking?

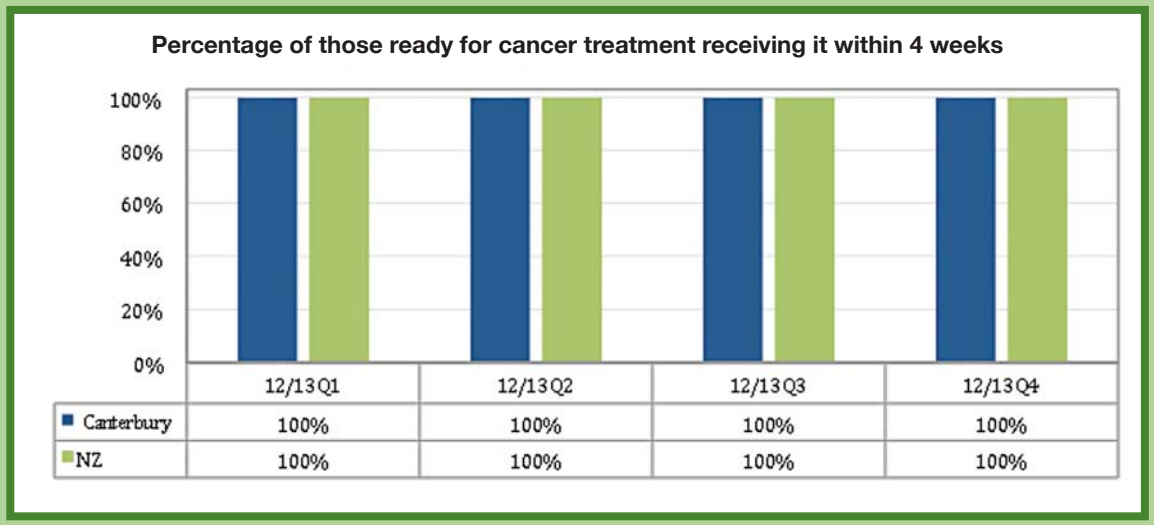


Shorter waits for cancer treatment

2012-13 National Target: 100 percent of patients ready for treatment will wait less than four weeks for radiotherapy or chemotherapy. Canterbury achieved the target of 100 percent.

2013-14 National Target: 100 percent of people ready for treatment will wait less than four weeks for radiotherapy or chemotherapy.

How are we tracking?



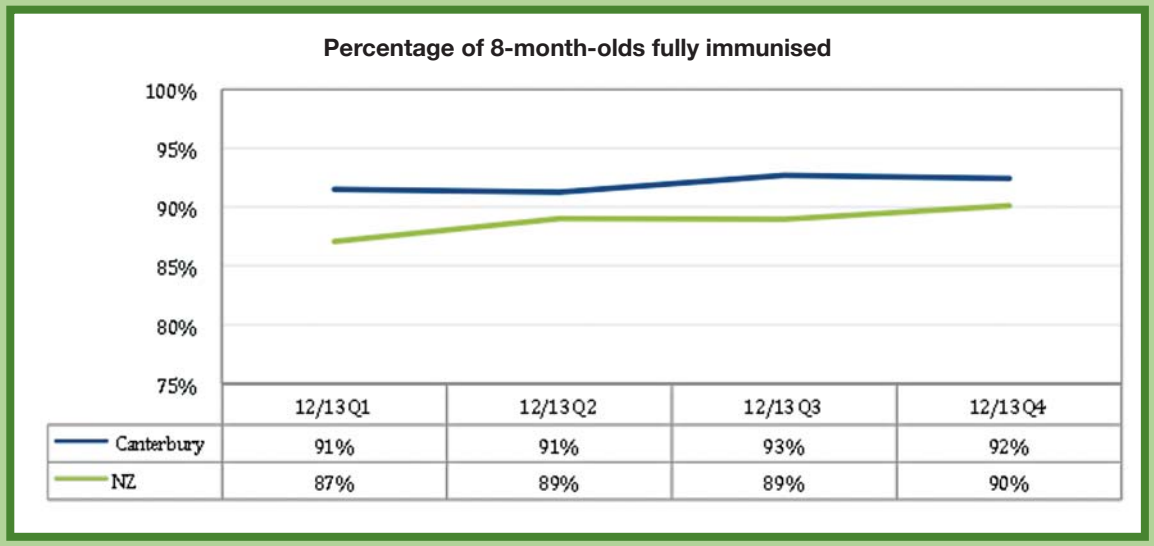
	12/13 Q1	12/13 Q2	12/13 Q3	12/13 Q4
Canterbury	100%	100%	100%	100%
NZ	100%	100%	100%	100%

Increased immunisation

2012-13 National Target: 85 percent of all eight-month-olds will be fully immunised. 92 percent of all eight-month-olds in Canterbury were fully immunised – surpassing the target.

2013-14 National Target: 90 percent of all eight-month-olds will be fully immunised.

How are we tracking?[2]



	12/13 Q1	12/13 Q2	12/13 Q3	12/13 Q4
Canterbury	91%	91%	93%	92%
NZ	87%	89%	89%	90%

[2] In 2012-13 the immunisation Health Target changed from two-year-olds to eight-month-olds, hence data is not available before 2012-13.

Better Help for Smokers to Quit

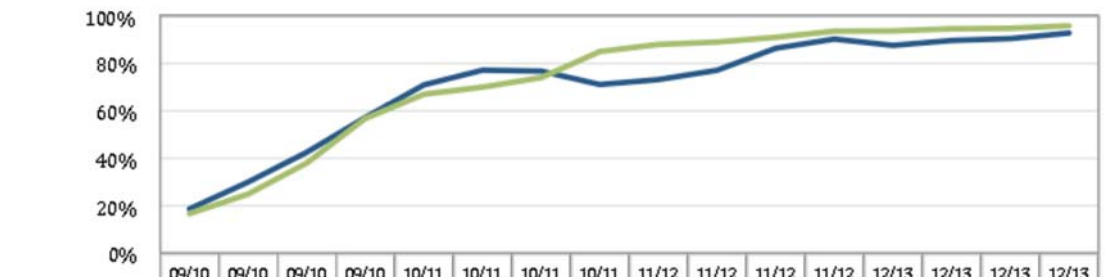
Better help for smokers to quit – secondary care

2012-13 National Target: 95 percent of hospitalised smokers are receiving advice and support to quit smoking. 93 percent of smokers hospitalised in Canterbury received advice and support to quit smoking – just 2 percent short of the target.

2013-14 National Target: 95 percent of hospitalised smokers will be offered brief advice and support to quit.

How are we tracking?

Percentage of hospitalised smokers offered quit advice and help



	09/10 Q1	09/10 Q2	09/10 Q3	09/10 Q4	10/11 Q1	10/11 Q2	10/11 Q3	10/11 Q4	11/12 Q1	11/12 Q2	11/12 Q3	11/12 Q4	12/13 Q1	12/13 Q2	12/13 Q3	12/13 Q4
Canterbury	19%	30%	43%	57%	71%	77%	77%	71%	73%	77%	86%	90%	88%	90%	90%	93%
NZ	17%	25%	38%	57%	67%	70%	74%	85%	88%	89%	91%	94%	94%	95%	95%	96%

Better Help for Smokers to Quit

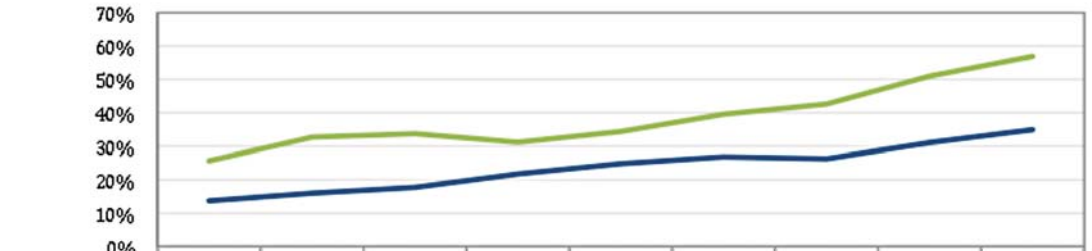
Better help for smokers to quit – primary care

2012-13 National Target: 90 percent of smokers seen in general practice will receive quit advice and support. 35 percent of smokers seen in Canterbury general practice received quit advice and support - a 10 percent on the previous year.

2013-14 National Target: 90 percent of smokers seen in general practice will be offered brief advice and support to quit smoking.

How are we tracking?

Percentage of smokers seen in general practice offered quit advice and help



	Yearto Jun 2011	Yearto Sep 2011	Yearto Dec 2011	Yearto Mar 2012	Yearto Jun 2012	Yearto Sep 2012	Yearto Dec 2012	Yearto Mar 2013	Yearto Jun 2013
Canterbury	14%	16%	18%	22%	25%	27%	28%	31%	35%
NZ	29%	33%	34%	31%	34%	40%	43%	51%	57%

Heart and Diabetes Checks

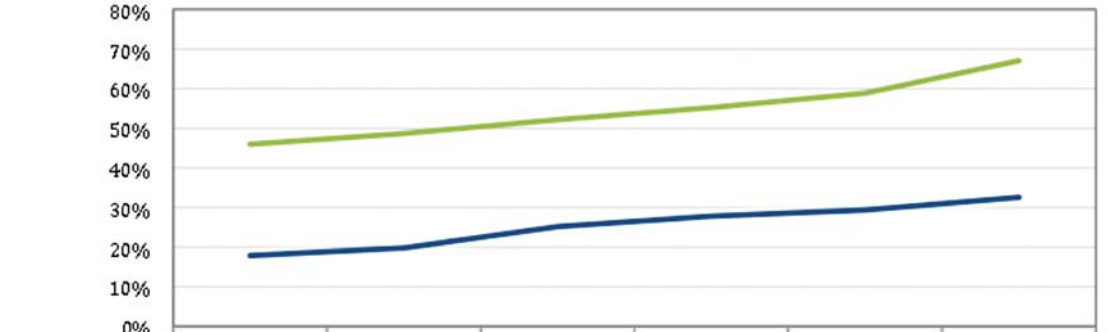
More heart and diabetes checks

2012-13 National Target: 75 percent of eligible people will have had their cardiovascular disease (CVD) risk assessed at least once in the past 5 years. 33 percent of eligible people in Canterbury had had their cardiovascular risk in the past 5 years – a 13 percent increase on the previous year.[3]

2013/14 National Target: 90 percent of eligible people will have their CVD risk assessed once every five years.

How are we tracking?

Percentage of eligible people having had a heart check in the past five years



	Mar 2012	Jun 2012	Sep 2012	Dec 2012	Mar 2013	Jun 2013
Canterbury	18%	20%	25%	28%	29%	33%
NZ	46%	49%	52%	55%	59%	67%

[3] Canterbury's largest Primary Health Organisation (PHO) (with over 75 percent of the enrolled population) adopted the national cardiovascular disease programme later than other PHOs around the country. This has an ongoing impact on Canterbury's result against this health target. The result is based on the proportion of the eligible population who have received a cardiovascular disease risk assessment anytime in the past.


MISSION

The right care and support, by the right person, at the right time, in the right place, with the right patient experience

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

www.cdhb.health.nz