MidCentral District Health Board

Minutes of the Hospital Advisory Committee meeting held on 15 March 2016 commencing at 8.45 am in the Boardroom, MidCentral District Health Board

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PRESENT

Barbara Robson (Chair)
Lindsay Burnell
Kate Joblin
Karen Naylor
Phil Sunderland
Dennis Emery
Duncan Scott

In attendance
Kathryn Cook, CEO
Mike Grant, General Manager, Clinical Services and Transformation
Carolyn Donaldson, Committee Secretary

Diane Anderson, Board Member,
Nadarajah Manoharan, Board Member
Adrian Broad, Board Member, (part meeting)
Barry Keane, Nurse Director, Mental Health
Greig Russell, Medical Administration Trainee
Jan Dewar, Acting Director of Nursing
Janine Ingram, Project Manager, Mental Health (part meeting)
Lyn Horgan, Operations Director, Hospital Services
Muriel Hancock, Director, Patient Safety & Clinical Effectiveness
Neil Wanden, General Manager, Finance & Corporate Support
Nicholas Glubb, Operations Director, Specialist Community & Regional Services
Scott Crowley, Webmaster
Stephanie Turner, Director of Maori Health & Disability (part meeting)
Vivienne Ayres, Manager, DHB Planning and Accountability
Public (3)
Communications (1)
Media

The Chair advised Mrs Hume and Dr Manoharan wanted to speak to the committee. This would be done prior to the relevant agenda items.

1. APOLOGIES

An apology was received from Cynric Temple-Camp.

2. LATE ITEMS

There were no late items.

3. CONFLICT AND/OR REGISTER OF INTERESTS

3.1 Amendments to the register of interests

There were no amendments.

3.2 Declaration of conflicts in relation to today's business

Karen Naylor declared a conflict in relation to item 7.5, Maternity Review, in terms of her role in the women's health service.

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Duncan Scott declared a conflict in relation to the medical imaging update in item 8.1, Operations Report, in terms of the contract held by his company.

Barbara Robson declared a conflict in relation to the Maternity Clinical Information System in item 7.5, Maternity Review, in terms of her membership as a consumer representative on the Maternity Information Systems Programme Steering Group.

4. MINUTES

It was recommended

> that the minutes of the meeting held on 2 February 2015 be confirmed as a true and correct record.

4.1 Recommendations to Board

It was noted that the Board approved all recommendations contained in the minutes.

5. MATTERS ARISING FROM THE MINUTES

There were no matters arising from the minutes.

6. WORK PROGRAMME

It was recommended

> that the updated work programme for 2015/16 be noted.

7. STRATEGIC PLANNING

7.1 Regional Service Plan Implementation – 2015 Quarter 2 update

A member expressed concern regarding MidCentral Health's (MCH) cardiology service particularly in terms of transport and asked whether there were any benefits gained from the Regional Service Plan (RSP) initiatives. The member was informed that MCH provided separate cardiac road transport for patients being transferred to Wellington. Work within the cardiology service was ongoing. The Regional Cardiac Clinical Director recently visited to discuss what further work could be done here.

It was recommended

> that this report be received.

7.2 2016/17 Regional Service Plan – Development of Draft 1

It was recommended

> that this report be received.

7.3 Non Financial Monitoring Framework an Performance Measures – Quarter 2, 2015/16

A member referred to the increase in attendances at the Emergency Department, suggesting it would be interesting at some stage to have an understanding of what was driving the increase and how it was being managed. Management responded advising the number of GP consultations had recently declined, but the introduction of free consultations for under 13 year olds had seen an increase in these attendances after hours. This had displaced a group

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of the over 45 year old population to ED. It was felt that over time, the situation would flatten out. Another member said cost was also a factor.

It was noted that the sexual health service was doing well in relation to picking up family violence issues.

With regard to the arrears in the Child and Adolescent Oral Health Service, it was advised the longest waiting time was 6 months and there were 336 children in this group.

It was recommended

that this report be received.

7.4 Mental Health Service Reconfiguration update 3

Mrs Hume then spoke to the Committee. The main issues she covered were:

- Reporting on the DBT programme and its development
- Transparency of reporting - requesting that the reporting on the DBT programme to be in the public arena, as opposed to internal to the DHB (last reporting was in the workshop).

The Service Director, Mental Health and Addictions opened discussion on the report, noting some of the key activities:

- The clinical governance model was being further developed and the service is now engaging with teams in regular clinical governance forum.
- Employment of the outstanding consumer advisor roles and their strong representation on the executive and clinical management teams.
- Work continued on key focus areas identified. Pressure on over-utilisation in Ward 21 of existing resources was a key risk factor being monitored. There was a need to build up capacity along the acute continuum and support inpatient services.

In respect to DBT reporting, the programme was being reviewed, as advised at the last work shop where the update report had been presented. The current trend of training staff only to have them leave was not sustainable so a more sustainable model was being developed. At the moment there were about 12 people in the programme and six on the referral list. As noted there has been reduced uptake of referrals due to a limited capacity, as a result of the departure of key psychology staff. The service was recruiting to replace this staff.

With regard to DBT reporting data and narrative, Mr Nolan said this issue would be considered at a meeting later in the afternoon with Mr and Mrs Hume and the Mental Health Executive.

Concern was expressed at the occupancy demand at times on Ward 21. The Service Director advised there were some management strategies in place, but there were key element members should be aware of. As an example of key issues, there was 30 per cent increase in admissions in January. However the average length of stay decreased from the previous month, so occupancy was better managed managed with a reduced number of times the unit was over its bed state (about 6 times in January). The use of transition beds and the cooperation with community partners, and the added benefit of taking over STAR 1 unit who is now taking clients over 65 who were sometimes inappropriately placed in ward 21 had helped the situation. These developments are part of the service forward planning.

In terms of double shifts, an examination of the data has revealed that full double shifts are not necessarily occurring in the numbers presented in the graph and further work was being done to refine the reporting. When analysing the data more closely, it appears that of the total number of reported shifts, some shifts were only a few hours of additional time and not a full shift. There is an expected reduction in the next month, but . The service was also developing intensive and acute care pathways for ward 21 which would improve the standards of clinical service and bed management. The service was also working with Oranga Hinengaro as there are a number of Maori people who are referred to the service, highlighting the need to do better around cultural aspects of the service. The CCTV policy

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was another issue to be addressed. An updated policy was on the agenda for discussion this afternoon at the service's quality improvement forum, which Mr and Mrs Hume join as part of the service engagement with family input to improve services..

Reporting on involvement with community teams would be part of future reporting to the Committee. The main strategy was to make sure the service was outward looking, building relationships across the sector, and developing contacts. This was also work in progress.

The attendance at the various community and clinical governance meetings was raised, with the suggestion that participation should be included in future reporting as a key indicator. Mr Nolan agreed it was a good point. He said at the moment, all operational management meetings were well attended.

The readmission rate within 28 days and people being seen within seven days following discharge were issues. Work is being done to make the system more robust. The figures were being reviewed and outliers explained. An outlier is a client who may have highly individual circumstances and who therefore may require services which are beyond the normal or average service measures. Therefore we sometimes account for their data separately as including their activity in data may skew the overall report. For instance if one person in an inpatient setting accounts for 50% of reported incidents it may look like an overall increase in whole of inpatient incidents by a number of clients, unless we understand that the increase is due to one client and therefore needs to be understood in the context of their type of care. Or if a person or small group do not present to an appointment within the required timeframes (missing appointments due to ill health or medical admission to hospital) so not seen within the required timeframes. We still report on these individuals but note that they show as a variance on the overall report of data. The clarification about 'outliers' helps understand the total data by providing some context for variations.

Mr Emery expressed concern that not enough was being done for Maori people who had mental health issues. He said more work was required with services like Oranga Hinengaro. The Service Director indicated he was working on this issue, and was already in discussion with Oranga Hinengaro. The Director of Maori Health and Disability was also working on this matter and in the coming months would be reporting on it. The service agrees with the focus on the needs of Maori as a priority.

The clinical governance meetings with CAFs, AOD and Feilding community teams were noted, and a suggestion was made that some base line information would provide insight into these and the other community mental health services, so committee members better understood them and were able to question and monitor them. The General Manager Clinical Services and Transformation noted the recent workshop presentation set out what would be reported to the Committee by way of base line data across the service and also any emerging issues. A range of things were happening at an organisational level, eg refreshment of the strategic plan, a possible cluster arrangement for services, as well as focusing on Maori, community, the social sector and investment planning.

It was pleasing to note the successful approval of the Ward 21 unit as a training placement for registrars.

The commitment and effort being put into the Erica Hume implementation plan was noted.

Phase two of the review recommendations was considered. The primary mental health model of care was a critical part of the continuum of community services, but it was not working very well at the moment. A key service improvement goal was to update the model in partnership with the PHO, and progress to date was noted. Progress was heading in the right direction with good engagement taking place. Reporting on this work would continue.

A member referred to the non-financial performance quarterly report that had been considered earlier in the meeting, noting that shorter waits for non urgent mental health and addiction services for 0-19 year olds did not achieve the targets. The Service Director said although the missed target margin was low, that is one target missed by 0.5 %. he expected this to improve, There had been a number of staff movements, vacancies were being

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recruited to, an external review was planned of the CAF service, and demand had gone up by at least 50 per cent. So there was a lot of work going on with this service.

It was recommended

that this report be received.

7.5 Maternity Review update

Barbara Robson declared her conflict in terms of her membership as a consumer representative on the Maternity Information Systems Steering Group. This was noted. It was agreed it did not need any action on the part of the Committee.

Karen Naylor declared a conflict in terms of her role in the women's health service. Karen was excluded from the Board discussion on this subject prior to the report becoming a public document and as Karen worked in the service. However as the document was now public the Committee did not see any reason to preclude her from discussion.

Mr Manoharan was invited to speak to the Committee. Given he was a Board Member, it was suggested he could be part of the discussion. Diane Anderson was also invited to join the discussion but deferred to do so.

Before commencing discussion on the report, the Chair took the opportunity to express regret to the families who had experienced tragic outcomes.

The Chair said it was regrettable to be in this situation, particularly following the Mental Health Service Review. The Maternity Review identified issues that were damming and as the governing committee, the Hospital Advisory Committee must see they were resolved and ensure clinical governance was strengthened across the service and other hospital services. She said the Committee must ensure that reporting was meaningful and provided in a timely way so the Committee could more readily identify any problems and be sure action was taken to address them.

She referred to the Health Quality & Safety Commission booklet just circulated on guidance for board members, particularly regarding clinical governance.

Adrian Broad joined the meeting.

Mr Manoharan then spoke to members. He said situations like this were difficult for staff. However they should be able to bring forward any concerns to management without fear of victimisation, and he felt the organisational culture had to be improved in this respect.

The CEO commented that one of the key areas of focus in the revised strategic plan was the development of culture and the four areas associated with it. There would be a significant cultural change programme.

Committee members also conveyed their regret to the families, and endorsed the various comments expressed regarding the situation.

Karen Naylor also supported commissioning the review, saying the outcome highlighted a number of areas to be addressed. However she urged caution saying care should be taken not to automatically draw links or assumptions to each outcome in a clinical sense. Members had not seen the Root Cause Analysis reports or recommendations from them, and they should not make assumptions that the outcomes were as a result of deficiencies in the service. There would always be negative outcomes in any service, and there was always an opportunity to improve services.

Mr Emery suggested there should be Iwi representation on the steering group. Mr Burnell suggested Information Systems should also be represented.

Members were advised recruitment to the clinical directorship should be underway shortly. It would be advertised both internally and externally.

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The Memorandum of Understanding that was developed between the two DHBs would need to be robust and provide a good service for the women of both DHBs. It would come under the auspices of the centralAlliance, who would maintain oversight.

A member suggested patient focused bookings as being more convenient for mothers with young families.

Kate Joblin reported on decisions made at last week's Whanganui board meeting including the Regional Women's Health Service being redesigned with the respective CEOs reporting back on this by July, the importance of a strong Memorandum of Understanding, management aspects of developing a collaborative framework for monitoring and reporting, and keeping a close eye on developments.

The General Manager, Clinical Services and Transformation, clarified that the steering group membership would have an independent view through input from an independent midwife. There was also a general acceptance within the service that an independent external appointment would be made to the clinical director role. The model of care would be sufficiently developed that the clinical director would have to have congruence with that model of care. The acting charge midwife was new to the service and therefore could be perceived as independent.

In relation to the information system, the General Manager Clinical Services and Transformation said the view was that it did not require a separate work programme, but possibly required greater visibility, transparency of issues, and resolution pathways. The National Health Information Technology Board was leading this work. He was happy to add it to the work programme though.

Mr Grant also clarified the Maternity Clinical Information System was implemented by MDHB as the early adopters of a system that was evolving. The adoption of the system was a work in progress from the National Health IT Board perspective, which was probably a little different to how MDHB usually implemented IS systems.

It was recommended that

> that this report be received, and it be noted that six-weekly updates against the maternity services health work programme will be provided to the Hospital Advisory Committee, and
>
> that the current arrangements with Whanganui DHB for the Regional Women's Health Service be replaced by an explicit memorandum of understanding that will detail the clinical integration and collaboration for our women's services going forward, for implementation before 1 July 2016.

8. OPERATIONAL REPORTS

8.1 Provider Division Operating Report - January 2016

The General Manager, Clinical Services and Transformation spoke to this report.

It was noted that the internal audit programme being completed this year would include clinical governance. It would be reported through to the Finance and Risk Advisory Committee.

In response to a query regarding any emerging themes from complaints, the Director, Patient Safety & Clinical Effectiveness advised detailed reporting occurred via the six monthly reports. However at a high level, staff communication could be a common thread.

The increase in readmission rates was noted. Management advised they had not drilled down into these figures, but re-presentations to ED had just been done.

The Operations Director, Hospital Services advised the Elective Services Performance Indicators (ESPIs) were now compliant. Further consideration was required around leave planning and managing workloads, particularly in areas like ENT which had got behind over the Christmas holiday period due to leave arrangements.

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It was recommended

that this report be received.

9. LATE ITEMS

There were no late items.

10. DATE OF NEXT MEETING

26 April 2016

11. EXCLUSION OF PUBLIC

It was recommended

that the public be excluded from this meeting in accordance with the Official Information Act 1992, section 9 for the following items for the reasons stated:

Item	*Reason*	*Reference*
"In Committee" minutes of the previous meeting	For reasons stated in the previous agenda	
Operations Report: : Potential Serious Adverse Events and Complaints	To protect personal privacy	9(2)(a)
2016/17 Draft Annual Plan	Subject of negotiations	9(2)(j)

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