MidCentral District Health Board

Minutes of the Hospital Advisory Committee meeting held on 2 February 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
Cynric Temple-Camp
Dennis Emery
Duncan Scott

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

Diane Anderson (part meeting)
Nadarajah Manoharan, Board Member
Oriana Paewai, Board Member
Ann Fowler, Team Leader, Occupational Health, (part meeting)
Anne Amoore, Manager, Human Resources & Organisational Development
Barbara Ruby, Quality & Clinical Risk Coordinator, (part meeting)
Chris Nolan, Service Director, Mental Health Service (part meeting)
Greig Russell, Medical Administration Trainee
Jill Matthews, Principal Administration Officer, (part meeting)
Kenneth Clark, Chief Medical Officer (part meeting)
Lee Welch, Quality & Clinical Risk Coordinator, (part meeting)
Lorraine Rees, Nurse Manager, Infection Prevention and Control, (part meeting)
Lyn Horgan, Operations Director, Hospital Services
Michele Coghlan, Director of Nursing
Muriel Hancock, Director, Patient Safety & Clinical Effectiveness
Neil Wanden, General Manager, Finance & Corporate Support
Nicholas Glubb, Operations Director, Specialist Community & Regional Services
Sande Ramage, Chaplain, (part meeting)
Stephanie Turner, Director of Maori Health & Disability
Susan Murphy, Manager, Quality & Clinical Risk, (part meeting)
Public (3)
Communications (1)
Media

WELCOME

A welcome was extended to Mr & Mrs Hume.

1. APOLOGIES

An apology for lateness was received from Kate Joblin.

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 the part 2 Operations Report and Women's Health reports, in terms of her role in the women's health service.

Duncan Scott declared a conflict in relation to a portion of part 2 Operations Report, in terms of the MRI contract held by his company.

The general declaration of a conflict of interest in relation to the part 2 Operations Report was noted for Cynric Temple-Camp due to his coronial duties.

4. MINUTES

It was recommended

> that the minutes of the meeting held on 24 November 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.

Kate Joblin joined the meeting.

6. WORK PROGRAMME

Members were advised that information in terms of timing for the planning workshop on 23 February, would be circulated once plans were finalised.

It was recommended

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

7. STRATEGIC PLANNING

7.1 Regional Service Plan Implementation – 2016/17 RSP Development Update

The announcement by the World Health Organisation that the spread of the Zika virus in the Americas was an "extraordinary event" that merited being declared an international emergency was raised in terms of any impact from it on the organisation and the region. Management advised it was too early yet to know, but there could be some impact from visitors from affected areas. The Public Health Unit works closely with the Ministry of Health and any information on the risk would be communicated in due course. An update on the issue would be provided to the next committee meeting.

It was recommended

> that this report be received.

7.2 Annual Plan Implementation - Patient Safety & Clinical Effectiveness, update 1

The Director, Patient Safety & Clinical Effectiveness, spoke to this report touching on the highlights. These included the Partners in Care Programme, generally referred to as Co-design, the inpatient experience survey ratings, the Open for Better Care campaign, the safe use of opioids in hospitals, hand hygiene, surveillance audit for certification against the Health and Disability Service Standards, and improvements related to family violence intervention.

Significant improvements have been made to the family violence intervention screening, but there were a few areas where improvements could be made, particularly in relation to documentation of the screening undertaken. Snapshot audits would be an ongoing annual requirement.

It was suggested it would be helpful for the Committee to receive a report on any work plan derived from the Privacy Self Assessment to be undertaken by the end of March 2016.

It was noted it would be some time before the organisation was paperless, and that off-site record storage would be required to accommodate clinical records for the foreseeable future. Management advised they had looked at adding scanned records to the clinical portal, but that capacity was limited at the moment. However as the move to electronic records progressed, this would change.

There was some discussion on the benefit of hearing about patient experiences, eg having patients attend board meetings to talk about their experience. This was already done by some DHBs including Whanganui. It was suggested MDHB could consider doing something similar in future.

A member expressed interest in hearing about the processes around medicines reconciliations, and reporting adverse medications events. Another member pointed out this was a major issue in all hospitals – eg was the incorrect prescribing due to the wrong drug or was the wrong amount of drug administered. Management acknowledged the issue, advising more analysis was required to understand the issues better. Management offered to provide an update on this, perhaps including a presentation to members.

The training and oversight provided when reviewing incidents was described. This year there would be an increased focus on reviewer training. Also, depending on the SAC rating of an incident, there is oversight by the Serious Adverse Event Governance Group. The Medications Advice and Policy Committee also ensured the right people were reviewing incidents.

The results of the measurement "Appropriate skin antisepsis in surgery using alcohol/ chlorhexidine or alcohol/ providone iodine" were discussed, as MDHB's result for the 2015 quarter 2 had dropped from 100% to 97%. Management advised there had been some inaccurate reporting so the process was being reviewed. Management felt the process had not been recorded accurately rather than not being done. Overall, all DHBs were performing really well.

The refreshed Health and Safety Statement was noted, as well as the forthcoming workshop (April) to discuss health and safety.

It was recommended

that this report be received.

7.3 Annual Plan Implementation - Workforce update 1

The Manager, Human Resources and Organisational Development spoke to this report, noting the key progress made. The next significant work would be to refresh the workforce strategy to support the strategic framework and cultural change.

It was recommended

that this report be received.

7.4 Annual Leave update

A member noted there were still high levels of accumulated leave, which was a high liability but more importantly staff should be able to take their leave. She felt the only progress being made was by the leave being bought out.

The issue was discussed with Management explaining staff were taking more leave now than previously, and were using up their current leave. It was the leave that had accumulated over three or more years that was proving difficult to shift. There were targets for staff to take their current year's leave and also have a plan for any leave balances in excess of two years. However, it was complex for some staff groups, eg clinicians, given the amount of medical and educational leave they were entitled to. A member suggested it might be helpful to look at other DHBs to see what they were doing about the issue.

It was recommended

that this report be received.

8. GOVERNANCE

8.1 Terms of Reference Review and Committee Structure

The Board Chairman spoke to this report. He felt it was timely that as governors, consideration was given to the board and committee structures to ensure support for the achievement of the revised strategic framework.

The report was considered. Mr Emery said he had some concerns about merging the Community and Public Health Advisory Committee with the Disability Support Advisory Committee. He also had some concerns for the Enable NZ Governance Group and the new Finance, Risk and Audit Committee. His concerns related to Maori disabled people if the committees were merged.

Mrs Robson was also concerned about the relative invisibility of disability. She said disabled people were very interested in how their health care services would be provided in hospital, and she wanted them to be well supported.

Other comments were:

- The Clinical Alliance was an excellent idea. It was difficult to get the right perspective on things, as no one person could do that – must have the structure right, so it was not a lobby group but was an advisory group.
- Financial and clinical imperatives must be aligned.
- Be good to strengthen and enable existing groups like the Clinical Leadership Council and the Consumer Advisory Panel to board level.
- The Hospital Advisory Committee needs to focus on both the financial and quality and safety aspects.
- The terms of reference for the proposed consumer alliance should be broader than just service co-design as there are consumer perspectives beyond service co-design that are important to consider.
- People with disabilities will still be heard provided the membership of the merged committee has someone on the committee who has a disability.

Members were asked to send their feedback on the proposals to Mr Sunderland.

It was recommended

that the report be received, and members' views on future committee structures and roles be provided to the Board Chair.

9. OPERATIONAL REPORT

9.1 Provider Division Operating Report - November/December 2015

The General Manager, Clinical Services and Transformation spoke to this report. Members were advised the January shorter stays in the Emergency Department target result for January was 95.3 per cent. Presentations to ED had not dropped as significantly as last year. However, the patient flow through the hospital was going well. There were a lot of initiatives occurring, eg reduction in the average length of stay in General Medicine has reduced compared to previous years, there was a different model of care, similar work was occurring in surgical services, eg the recovery after surgery work, there were better outcomes for patients from some of this work, and there were better ways of working in ED.

Management confirmed that under the funding rules, MCH was paid if the actual volumes were within 2% of target. However, the funds stayed within the Funding Division and therefore had no impact on the DHB's consolidated position. There were also other costs contributing to the current deficit eg locum costs, nursing overtime and double shift payments. The forecast to year-end would be looking for a monthly reduction of just over $100,000.

The key issues faced by Mental Health were noted by the Service Director, Mental Health and Addiction Services. The Service was very aware of the financial demands arising from the mental health service review. Recruitment was ongoing for senior medical officer cover, with the appointment of two staff, the possibility of a long term contract being extended, and the securing of consultant cover for other specialist services. As a result of these moves there had not been any loss of cover for the Service. Although double shifts were still an issue, they had not increased. However, as noted in the report, when the unit experienced clusters of admissions, often after hours, it drove requests for short notice additional resource such as double shifts and overtime.

The Committee was advised that Dr Adrian Lamballe has been appointed Clinical Director, Clinical Support Services.

It was recommended

that this report be received.

10. LATE ITEMS

There were no late items.

11. DATE OF NEXT MEETING

17 March 2016

12. 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)
Women's Health update	Subject of negotiations and to protect personal privacy	9(2)(a) and (j)
Quarterly Contracts update	Subject of negotiations	9(2)(j)
Annual Plan Process update – Funding Envelope 2016/17	Subject of negotiations	9(2)(j)