# MidCentral District Health Board

## Minutes of the Hospital Advisory Committee meeting held on 21 July 2015 commencing at 8.45 am in the Boardroom, MidCentral District Health Board

Unconfirmed Minutes

**PRESENT**

Barbara Robson (Chair)
Lindsay Burnell
Kate Joblin
Karen Naylor
Phil Sunderland

**In attendance**
Mike Grant, General Manager, Clinical Services and Transformation
Carolyn Donaldson, Committee Secretary

Diane Anderson, Board Member, (part meeting)
Anne Amoore, Manager, Human Resources and Organisational Development
Barbara Ruby, Quality and Clinical Risk Coordinator
Chris Nolan, Service Director, Mental Health Service (part meeting)
Juliet Scott, Family Violence Intervention Coordinator (part meeting)
Karen Upston, Project Coordinator (part meeting)
Kenneth Clark, Chief Medical Officer (part meeting)
Lee Welch, Quality and Clinical Risk Coordinator
Leona Dann, Director of Midwifery (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
Nicholas Glubb, Operations Director, Specialist Community & Regional Services
Susan Murphy, Manager, Quality and Clinical Risk
Mr & Mrs Hume
Communications (1)
Media

### 1. APOLOGIES

Apologies were received from Duncan Scott and 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 to the register of interests.

#### 3.2 Declaration of conflicts in relation to today's business

Karen Naylor declared a conflict in relation to sections of the Workforce Strategy (item 7.1) and Operations Report (item 8) in terms of her role with the NZNO.

Barbara Robson declared a conflict in relation to paragraph 7.5 of the Operations Report (item 8) regarding any discussion on the Maternity Clinical Information System contained in any report due to her involvement as a consumer representative on the Maternity Information Systems Programme Steering Group.

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Phil Sunderland declared a conflict in relation to NZ Health Partnerships Limited, due to his directorship as the Board's representative for the central districts region.

## 4. MINUTES

It was recommended

> that the minutes of the meeting held on 9 June 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

*Quality Workshop* - There have been a few discussions concerning when this workshop should be held. The Chair advised she had also talked to the CEO about it, as the CEO had some ideas around a clinical governance framework. As a result a date for the workshop will be determined once the CEO has had a little more time to consider her ideas.

The Mental Health update would be provided next month.

It was recommended

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

## 7. STRATEGIC PLANNING

### 7.1 Workforce Strategy: Six Monthly update

The Manager, Human Resources and Organisational Development spoke to her report touching on the highlights of the past six months. The following points were raised by members.

*Vulnerable Children Act/Police Checks* – All new core workers working with children will undergo police checks as they are recruited. Current staff would be checked within the next year.

*Increasing Maori Workforce FTE* – the Maori Leadership Review contains a specific position around the workforce that would form part of recruitment strategies, along with current initiatives. MDHB also worked with national and regional organisations and local partners. Developing targets was suggested as a way to focus attention on achieving the goals and could form part of specifications for new positions.

*Team Development/Staff Safety Culture Survey* – the Committee is keen to see the evaluation of the Team Development Programme and how effective it has been, as well as the Cummunio report on the Staff Safety Culture Survey.

*Care Capacity Demand Programme* – Management were asked to provide information to the next meeting on how many wards have started this programme, how many have implemented it in full and an explanation of the programme. The information should provide an understanding on the twelve CCDM tools and the workshops, and how well targets were being achieved. The Acting CEO said this should come across in the evaluation report.

*Midwifery FTE* – the low vacancy rate was a percentage compared to the number of budgeted FTEs and did not split the result between midwives and the registered nurses who were also working in the area.

*Exit Interviews* – an employee will often provide negative feedback in an exit interview. Most of the time management were aware of the issue and were addressing it. Issues were escalated through the leadership teams.

It was recommended

that this report be received.

### 7.2 Annual Plan update - Patient Safety & Clinical Effectiveness

The Patient Safety and Clinical Effectiveness team members present were introduced to the Committee, and the role of the quality coordinator was explained.

The Chair commended the team on the excellent work being done.

Clarification on the certification process was given together with a number of explanations, eg what was required to have a corrective action down-graded; what the first corrective action *better match of staff resource to demand* meant; the date the certification occurred; and whether the survey scheduled for November 2015 would upgrade any recommendations or highlight new ones. Management advised that in the past, they had identified areas they felt were not doing so well, and the surveyors had provided recommendations which helped progress things.

The difference between the new accreditation model and the old accreditation model was explained. The new model was "whole of organisation" and contained criteria designed for the health setting. There were seven areas and it had a quite different approach compared to the old system. Further investment would be required to achieve the new model. The need for additional investment was queried, given the current heavy workload and investment in mental health. Management advised this was an overarching quality and culture change for the organisation and was related to the Baldridge criteria for performance excellence. It was not a duplication of investment.

*Skin integrity* – the Director of Nursing (DoN) advised the central region DoNs group was to form a central region plan to look at the top incident categories. Skin integrity would probably be the highest category. It was acknowledged that many patients obtained their injury in the community, so the project would include working with aged residential care partners and community teams. This work had started. It was also noted that work was taking place with MDHB's aged residential care partners and the community in other areas, eg congestive heart failure. It was almost impossible to quantify the cost of caring for patients with skin integrity issues, although there were generic costs that could be used for information purposes.

*Customer Relations* - The "Hello my name is" campaign was noted. There was no specific timeframe available as yet on the Real Time feedback survey. The various initiatives undertaken over the last year or so had freed up beds and reduced demands, and were now enabling staff to take leave, or attend workshops. Management was confident in terms of coping with sick leave. TrendCare data was reviewed on a weekly basis at a high level so management knew the demand to resources ratio.

*Food Contamination/Hawkes Bay DHB* – Management were not aware of any issues at MDHB relating to contamination of food in the organisation similar to those that had been raised by the Hawke's Bay DHB case, but offered to check and report back.

*Patient Handling* – Management described recently seeing a demonstration of hovercraft technology being used to lift 'individuals of size', suggesting it might be possible at some future stage to demonstrate it to board members.

It was recommended

that this report be received.

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### 7.3 Clinical Board Annual Report 2014/15

This item was deferred until Dr Clark joined the meeting.

## 8. OPERATIONAL REPORT

### 8.1 Provider Division Operating Report - May 2015

The June financial result was now available. While MCH was significantly favourable to budget for June , the year end position was still a deficit. Overall the DHB had a deficit of about $1.9m, which was an improvement on the forecast situation. Plans were in place to deliver to budget for 2015/16.

Issues briefly mentioned included the downward trend of acute surgical presentations from ED, over delivery of elective services, management of the measles outbreak, activation of the incident management team in response to flooding, and piloting of wireless in the Women's Health Unit.

*Annual Leave* – Concern was expressed at the amount of untaken leave, particularly where the leave was greater than two years' allocation. Management advised it had been difficult to take leave for many years. However this situation had changed over recent years and there was capacity now for leave to be granted. There might still be pockets where it was difficult, eg allied health. Rosters supported staff being able to take leave, and plans were in place to enable some nursing staff with significant leave hours, to take leave over the next three months. They would be replaced while on leave so there was no impact on other staff to cover for them.

A member said she would like to see a plan in place showing how the excess leave is being addressed. The member was concerned about staff buying out their leave as staff should be able to take their allocated leave when they wanted to. The Committee was looking for better visibility of annual leave on a regular basis, showing the progress being made. The Acting CEO suggested that an overarching plan for leave could be developed for the organisation.

*Road Patient Transfers* – Management confirmed the clinicians decided on the appropriate mode of patient transport, not management, and that there had not been any adverse consequences for any patients due to the mode of transport used. The Chair noted the YTD costs are well in excess of the annual budget.

*Midwifery update* – the Director of Midwifery advised a new charge midwife had just started in the position and that she came with a lot of experience.

*Mental Health update* - The Service Director, Mental Health Service, spoke to the update. He confirmed six clinical manager positions have now been filled, and applications closed on 17 July for the two remaining positions. The goal of 24 hour cover for the acute care team was reached at the end of June. The current acute care team had about 9 FTE, but was moving to approximately 12.

The summary document that would be presented at the next Committee meeting would report on progress against the recommendations of 'Phase one' of the mental health review project and becomes the reference document to ensure key elements from the recommendations are taken through to future planning in 'Phase two'. Some of the recommendations will require significant resource and time, and were usually a 2-5 year goal. The Older Adult Mental Health Service was the agreed way forward.

The Mental Health Service would be engaging more with consumer and family organisations and the community. There will be a memorandum of understanding covering the networks with the organisations. A member expressed concern in relation to consumer groups and their funding. The concern related to the potential for consumer groups funded by the DHB to be constrained with the input they may provide. and that management should also consider engaging with service users who aren't part of formally established/DHB funded groups. Management advised all the groups in the Consumer Engagement/Participation

project were funded by MDHB to some degree, however they also had access to alternative sources of funding.

Management reassured members, they recognised the consumer voice and family voice were very distinct voices. There were also links with a number of other smaller groups as part of the network. A member noted it should be remembered that not every family member was involved in a group. The Service Director acknowledged that, saying there had to be sensitivity to the uniqueness of the experience and ability to involve services. There will be more detail provided on Consumer Engagement in the next report.

*Housing* – the issue of housing and opportunities for further support has been raised with the NGO partners. Four extra places have been created, with the result that a place has been found for everyone looking for somewhere to live. There was currently a very low percentage of people being readmitted to Ward 21.

*Ward 21 business case* - The business case was an initial one, to identify options with sufficient background information for the Committee's consideration. The business case should be available for the next meeting.

It was recommended

that this report be received.

## 7.3 Clinical Board Annual Report 2014/15

Dr Clark spoke to this report, acknowledging the contribution made by Ann Podd who resigned earlier in the year. He noted Ann was still a member of the organisation's credentialing committee.

Issues discussed included an explanation of the Health Roundtable, an Australasian organisation, and its usefulness for comparing and contrasting data, and clinical audit activities. How clinical audit reports should be provided to a governance committee was under consideration. National discussions were taking place in terms of what level of information from the audits and their processes should be available to boards and the public in general, eg Official Information Act requests and the impact of the Ministry, Medical Council, Commission etc. Ownership of the data was an issue. The professional requirements for surgeons necessitate records being kept on their personal cases and audits. How that information was used within the organisation was a broader subject. Discussion touched on the Health Practitioners Competence Assurance Act and what audits were conducted under the protection of that Act.

It was recommended

that this report be received.

## 9. LATE ITEMS

There were no late items.

## 10. DATE OF NEXT MEETING

1 September 2015

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## 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:<br>: Potential Serious Adverse Events and Complaints | To protect personal privacy | 9(2)(a) |