MidCentral District Health Board

Minutes of the Hospital Advisory Committee meeting held on 24 November 2015 commencing at 8.45 am in the Boardroom, MidCentral District Health Board

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PRESENT

Barbara Robson (Chair)
Lindsay Burnell
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

Ann Chapman (part meeting)
Nadarajah Manoharan, Board Member
Amanda Driffill, Service Manager, Medical Subspecialties (part meeting)
Anne Amoore, Manager, Human Resources & Organisational Development
Barbara Ruby, Quality & Clinical Risk Coordinator
Carrie Naylor-Williams, Service Manager Patient Flow (part meeting)
Chris Nolan, Service Director, Mental Health Service (part meeting)
Chris Simpson, Service Manager, Sub-Specialties, Peri-operative/Anaesthetic/ICU Services (part meeting)
Cushla Lucas, Service Manager, RCTS (part meeting)
Di Orange, Team Leader, Radiology (part meeting)
Greig Russell, Medical Administration Trainee
Janine Ingram, Project Manager, Mental Health (part meeting)
Lee Welch, Quality & Clinical Risk Coordinator
Leona Dann, Director of Midwifery (part meeting)
Lyn Horgan, Operations Director, Hospital Services
Maggie Oulaghan, Business Manager (part meeting)
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
Robyn Shaw, Service Manager, Electives (part meeting)
Sarah Donnelly, Service Manager, Medical & Surgical Wards and Emergency Department (part meeting)
Stephanie Turner, Director of Maori Health & Disability
Syed Ahmer, Clinical Director, Mental Health & Addiction Service (part meeting)
Vivienne Ayres, Manager, DHB Planning and Accountability
Wayne Blisset, Maori Health & Disability
Mr & Mrs Hume
Communications (1)
Media

WELCOME

A welcome was extended to Mr & Mrs Hume.

1. APOLOGIES

Unconfirmed minutes

An apology 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 section of the Operations Report, item 14, in terms of her role in the women's health service.

Duncan Scott declared a conflict in relation to the Regional Service Plan, Radiology Information System, in terms of the MRI contract held by his company.

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

The Chair advised Mrs Hume had asked to address members.

Mrs Hume spoke to the meeting. The main points mentioned were:

- Dialectial behaviour therapies (DBT) reporting (database and reporting update/identification of ongoing quarterly timeframes for reporting this data)
- Erica's action plan (the action plan report didn't meet their expectations; feedback on what should be included in this plan was not included; specific expectations for outcomes or timeframes).
- A request that the reporting keep to the original template to allow comparative tracking.

The General Manager, Clinical Services and Transformation responded, thanking them for raising the issues, and for partnering with MidCentral Health on what was a very difficult journey. He advised the issues relating to the DBT database and reporting would be covered at the workshop being held following this meeting. The other issues raised would be covered at a meeting scheduled for later in the afternoon between Mr & Mrs Hume, and the Clinical and Service Directors, Mental Health & Addiction Services. The CEO acknowledged the concerns expressed, and said that going forward an opportunity to see information relating to Erica's action plan would be provided to Mr & Mrs Hume before it was made public. This had not occurred this time, for which she apologised.

4. MINUTES

It was recommended

> that the minutes of the meeting held on 13 October 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

Unconfirmed minutes

It was recommended

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

The order paper was rearranged, so that the Mental Health Service update was discussed next.

6.4 Mental Health Service – Update 2

The Chair expressed concern about phase 2, noting that a lot of progress had been made and staff were to be commended for their hard work to make improvements, however she did not feel she had an insight into the care provided in the community – what had changed since the review, how were things measured etc. The Clinical Director, Mental Health & Addiction Service, advised this information was available, but the Committee needed to clarify what sort of data they wanted to see. He agreed the information had not yet been provided to members. The General Manager, Clinical Services and Transformation, said the request was very similar to that expressed by Gloria Johnson back in February at an earlier workshop, who had asked "how would the committee know and be confident, that the service was providing optimum care for patients and families". The Service Director Mental Health & Addiction Service, confirmed the issues raised relating to reporting, particularly around the clinical review of Erica Hume, and processes by which there would be input into the formulation of reporting, would be discussed at the workshop following this meeting. The workshop would also discuss the concerns raised about community services. The discussion would look at the total picture, how it works and what improvements can be made in future.

The Service Director Mental Health & Addiction Service then went through the report, commenting on the key initiatives. Following the Mental Health Advisory Group forum last week, there was now a plan to progress a gap analysis and work with the community to cover a variety of issues. The report indicated working with PHO partners and practices to include a primary mental health model. Other options being considered included development of a paper for redesigning the unit. This would be a considerable challenge. The report commented on the over-utilisation of the unit, double shifts, and overtime. Future reporting would provide some clarity on issues and better data.

Mr Emery noted that 17 percent of the MCH population were Iwi Maori. He said the report was very light on reference to Iwi Maori, and he wanted to see more involvement in future reports. Management advised this would happen in terms of Maori Mental Health and the consumer engagement with Mana o Te Tangata Trust (previously Journeys to Wellbeing), and there was a specific item on this matter on the workshop agenda.

The Chair referred to the Partners in Recovery forum held earlier in November, and asked if it would be possible to have a brief summary report of the key themes that came out of it, for the next meeting. Management agreed adding there was a considerable amount of work being done around the outcomes from the meeting, and that a report was being written.

The work of the Director of Area Mental Health Services was acknowledged.

The Service Director Mental Health & Addiction Service said he hoped to present more detail about where improvements were being made at the forthcoming workshop. Considerable work had been undertaken to ensure the HAC report and relevant data was clear and understandable and work will be ongoing to ensure that data represented in the report was accurate and timely. The issue of over utilisation of capacity and double shifts in ward 21 would be discussed as well at the workshop. A project has commenced which aims to improve the match of resource to demand including rostering improvements and staffing levels. One of the learnings was that the necessity for double shifts had stabilised but not decreased. Consideration was being given to residential placements, and how a patient changed from being an inpatient to being an outpatient and required services. Dr Ahmer advised on the structure used at Hawkes Bay DHB. Whilst MDHB's arrangement was similar, it did not have transitional sub acute beds for use for people being discharged. Lindsay Burnell left the meeting.

Unconfirmed minutes

There was discussion on some of the issues relating to patient flow, which could not work without networking. Residential care could be a "log jam" which created issues. A more effective service coordination process was needed within the district that was both mental health and aged residential care focused. This would provide a seamless flow for patients post discharge from the ward.

Lindsay Burnell returned to the meeting.

There was discussion on the graphs in the appendices. In response to a query about why there was a spike on certain days, management advised it could be for a number of reasons, eg the condition of patients.

Mrs Naylor expressed concern at not seeing any improvement in the number of double shifts and overtime. The Service Director Mental Health & Addiction Service said this issue was a top priority along with managing the over-utilisation of the unit. He outlined the work being done including recruitment, rostering, managing the over-utilisation, and unexpected staff absences. It was important to recruit staff above the requirement for the funded 24 beds. Members were referred to the information on page 104 of the report, which covered bed state, (funded and unfunded,) and occupancy.

Management advised they would provide more information in relation to recommendations 4 and 5 of the key actions arising from the longitudinal clinical review of the care of Erica Hume.

Management also commented on the recent surveillance audit. There were no new corrective actions for mental health. Two previous ones remain at a low level as they require a bit more work. Overall, the result of the audit was positive.

It was recommended

> that this report be received.

7. STRATEGIC PLANNING

7.1 Regional Service Plan Implementation – Update Quarter 1, 2015/16

Mr Emery advised a Maori Caucus Board had been formed to work with Hospice NZ in relation to palliative care.

The low MDHB figures for accessing maternal mental healthcare were noted. Management felt it was related to data collection in terms of the low starting point of nurses who provide the service and the collection of the data to maternal mental health. This issue would be resolved.

It was recommended

> that this report be received.

7.2 Development of the 2016/17 Regional Service Plan – approach and timeline/16

It was advised the possibility of establishing a regional residential maternal mental health service, similar to those in Auckland and Christchurch, was not being considered.

It was recommended

> that this report be received.

7.3 Secondary Care initiatives update

It was noted that although the heart failure patient case review and management service being established was based at Kauri Health Care, the service would be progressively rolled

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out across all the Integrated Family Health Centres. This would cover up to 80 percent of the population.

The need for further education in supporting clinicians to capture all eligible patients with a high suspicion of cancer, when triaging referrals for the faster cancer treatment initiative was noted. MDHB wanted to move to a more effective approach, for example a reduction in patients presenting with first symptoms of cancer through the Emergency Department, noting that patients can enter the system in a number of ways.

Mr Sunderland advised he had just received the latest Health Target results, which were good for MDHB.

Members were advised a business case was to be presented to the Minister shortly, looking at rolling out a bowel screening programme possibly in 2017.

Dr Temple-Camp left the meeting.

Management were commended on this report, which members felt provided good information for them.

It was recommended

> that this report be received.

7.4 Non-financial Performance Measures for quarter ended September 2015

It was noted there were a number of changes to the performance measures and reporting deliverables this year, in addition to increases in target values for several of the performance measures.

Issues with data quality, particularly mental health data held by the Ministry of Health, were noted.

Dr Temple-Camp returned.

It was recommended

> that this report be received.

7.5 Evaluation of MidCentral District Health Board's Team Development Programme

It was recommended

> that this report be received.

8. OPERATIONAL REPORT

8.1 Provider Division Operating Report - September/October 2015

The committee was updated on the recent certification audit visit, which was very positive. Nine of the previous 30 actions have been closed, leaving 21 corrective actions. There are no high priority actions. The final report was expected in 4-5 weeks.

The General Manager, Clinical Services and Transformation then spoke to the financial section of the report, noting there was a deficit of $300,000 for the month, which was a variance of $800,000 to budget. Good work was continuing in terms of working on a new financial forecast for year end. However, it will be January/February before any improvement in the financial situation is seen.

The Manager, Human Resources and Development, advised that while overall there was a reduction in the "over two years" leave balances from July figures, that was mainly due to

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leave buy-out and termination balances. The accrued annual leave in most months was higher than the leave being taken. A more detailed analysis of annual leave accruals, annual leave taken, and the financial impact will be provided to the next meeting. This would include the detail of the calculations (maths detail). A member expressed her concern that there was not any progress being made in reducing the outstanding leave balance, and suggested long service leave should probably be included in the reporting. The CEO assured members that every staff member with excess leave was required to have a plan in place to reduce it.

Management advised they had received good feedback from patients and families on last week's patient safety initiative.

Management confirmed that as far as was currently known, the national mental health serious adverse events report would be a separate report again this year. It was not known when it would be published.

The reducing average length of stay was noted, with a suggestion it would be good to keep an eye on readmission rates.

Ann Chapman arrived.

It was noted that the number of new patients waiting >4 months in urology as at October 2015, (figure 1, page 226), should be 2, not 30.

It was recommended

that this report be received.

9. LATE ITEMS

There were no late items.

10. DATE OF NEXT MEETING

2 February 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 Annual Plan Development: Update and Assumptions	Subject of negotiations	9(2)(j)

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