MidCentral District Health Board

Minutes of the Hospital Advisory Committee meeting held on 9 June 2015 commencing at 8.45 am in the Boardroom, MidCentral District Health Board

PRESENT

Barbara Robson (Chair)
Lindsay Burnell
Kate Joblin
Karen Naylor
Phil Sunderland
Duncan Scott
Cynric Temple-Camp

In attendance
Mike Grant, Interim General Manager, MidCentral Health & Support
Kathryn Cook, CEO
Carolyn Donaldson, Committee Secretary

Diane Anderson, Board Member, (part meeting)
Barbara Cameron, Board Member, (part meeting)
Anne Amoore, Manager, Human Resources and Organisational Development
Lyn Horgan, Operations Director, Hospital Services
Nicholas Glubb, Operations Director, Specialist Community & Regional Services
Muriel Hancock, Director, Patient Safety & Clinical Effectiveness
Jill Matthews, Principal Administration Officer
Vivienne Ayres, Manager, DHB Planning and Accountability
Syed Ahmer, Clinical Director, Mental Health Service
Chris Nolan, Service Director, Mental Health Service
Janine Ingram, Project Management Team, Mental Health Services (part meeting)
Carrie Naylor-Williams, Service Manager
Chris Simpson, Service Manager
Amanda Driffill, Service Manager
Barry Keane, Nurse Director
Jan Dewar, Nurse Director
Leona Dann, Director of Midwifery (part meeting)
Cushla Lucas, Service Manager, RCTS (part meeting)
Mr & Mrs Hume
Communications (1)
Media (1)
Public (1 - part meeting)

In opening the meeting, the Chair extended a warm welcome to the new Chief Executive Officer, Kathryn Cook.

1. APOLOGIES

An apology was received from Richard Orzecki.

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.

17

3.2 Declaration of conflicts in relation to today's business

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.

Karen Naylor declared a conflict in relation to the Secondary Care update section 5.1.3 Care Capacity Demand Model, in terms of her role with the NZNO.

Barbara Robson declared a conflict in relation to 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.

Duncan Scott declared a conflict in relation to the Contracts update in part 2, due to his employment with Broadway Radiology Limited.

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

4. MINUTES

It was recommended

that the minutes of the meeting held on 28 April 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

Karen Naylor referred to the minutes, section 7.2, Mental Health Review update 6 "Performance Reporting" and the reference to overtime. The concern she raised at the last meeting related to the staffing levels and whether they were adequate. She said the reason for relating it to the overtime was because she would have expected that an increase in staffing would have had a corresponding decrease in staffing levels, and she was asking were they adequate given the overtime levels had not shifted. She did not feel her concern had been fully captured in the minutes.

Kate Joblin also noted that the request to address the committee by Nadarajah Manoharan had described Mr Manoharan as a member of the public and she felt the minutes should have mentioned that he was a board member. Mr Sunderland said that whilst Mr Manoharan had addressed the committee as a member of the public, in the circumstances it could have been recorded that he was a board member who spoke as a member of the public.

6. WORK PROGRAMME

A member commented that a lot of issues were very repetitive in reports, eg waiting times in the emergency department. Whilst all the issues came from different perspectives, he wondered if they could be combined into one report. The Chair advised she had already discussed the issue with management. The level of duplication had been reduced in some areas, but some reports, eg the performance monitoring report, was an accountability document and was included for members' information and transparency.

The CEO referred members to the joint workshop with Whanganui DHB regarding the centralAlliance Strategic Plan. This workshop would be held on 26 June at the Marton Golf Club, 1-3pm.

The Chair advised of an issue regarding parking for the shuttle transport vehicles at the hospital front door, advising the Feilding Shuttle organisers would be contacting the Board to see if anything could be done to improve the situation.

It was recommended

that the updated work programme for 2014/15 be noted.

The Chair advised that given the importance of the Mental Health Review update which included the finalised longitudinal clinical review report into the care of Erica Hume, she would change the agenda order so that this item was discussed next.

7. STRATEGIC PLANNING

7.4 Mental Health Review – update 7

The Chair opened the discussion by expressing gratitude to Mr & Mrs Hume on their decision to make the longitudinal report available to the committee and the public. She said the report was excellent and that the author, Dr Margaret Aimer, should be thanked for it, and that Mrs Hume's decision to provide Erica's diary to Dr Aimer should also be commended.

Management spoke to the update, noting the longitudinal report's recommendations focused on a better experience for patients and families, the development of more robust multidisciplinary processes and therapies and ensuring there would be robust mechanisms in place to evaluate them. The recommendations for systemic improvement were consistent with the recommendations from last year's review. The Clinical Director, Mental Health & Addiction Services advised he had met Mr & Mrs Hume to discuss the report findings, and that the recommendations would be incorporated into the work plan as a separate action plan. The Service Director noted there were clearly identified goals to improve the service.

The report was then discussed by members with the following comments being noted:

Erica's name should be included on the action plan. This had been done now following feedback from Mr & Mrs Hume.

Kate Joblin felt the report was a leader and asked the CEO if she could reflect on her experience of similar reports. The CEO said having a report such as this available in the public arena was standard in many of the health systems she had worked with. She also felt having such a report available across the organisation was invaluable from a cultural, clinical governance and leadership perspective.

The CEO said she would discuss the continuing involvement of Mr & Mrs Hume when she met them the following day. Management would then look at an overarching framework for reporting back to the Committee.

Management noted that sustaining any changes made was important and had to be enduring to create a successful service. The service was identifying themes and future plans that would enable suitable development which would be monitored to ensure the achievements were ongoing. One of the challenges would be to implement all the recommendations so that people knew what to expect and feel when entering the service, and at some point there would have to be a move to business as usual.

None of the services were provided in isolation, and consideration would be given to the whole system so there were no blockages, eg housing shortages.

Management noted that changes to the threshold for people requiring assistance had now been made, and if someone was receiving care in another DHB they would get it at MDHB, at least for a few months. An issue currently being worked on was the entry system. Until that work was completed, staff had been told that no one individual could turn down a referral. Any referral should be considered by the multi-disciplinary team before decisions were made.

Dr Temple-Camp agreed with the comment on the quality of the notes. Clinical notes were required, often urgently, and by all services not just mental health. He felt the implementation of the electronic clinical record should be done as quickly as possible. The

19

recommendation regarding collaborative note writing in order to keep documented records accurate and meaningful to consumers, families and staff was noted. Management advised actions were being developed for recommendation 9. The consumer advisory group referred to in recommendation 7 was already in existence within the community, and would be identified appropriately.

Mr Sunderland felt the report was very salutary. He was comforted that the external systematic review was done early and a work programme developed. The recommendations from the longitudinal review which were targeted to a real event, would give confidence that the service was on the right track.

The recommendations regarding clinical notes and documentation would be cascaded through various forums to ensure staff were reminded of the importance of accurate notes. The Mental Health & Addiction Service had now started putting records on the clinical portal, and in a few months all retrospective records would be added. Eventually all records would be electronic.

Mr and Mrs Hume were then invited to address the Committee.

Mr Hume said the reason they were still involved with the Board was to see changes were made. They wanted to move on and not look back at the past and what had happened, but they wanted to ensure nothing similar happened again.

The Committee then discussed the remainder of the update.

The Operations Director, Specialist Community & Regional Services, noted the key updates since the last report included the recruitment to eight clinical manager positions, and the expansion of the Review Project Board to include additional representation for phase two of the review.

The Chair expressed uneasiness in moving to three-monthly reporting at Hospital Advisory Committee meetings. She suggested that a brief update be provided via the operational report at the intervening HAC meetings. She felt phase two was large and there were still some things to be done in phase one, as well as the recommendations arising from the longitudinal report on Erica Hume. Management were comfortable with this suggestion.

Management referred to the ongoing work, advising they had started approaching other DHBs in relation to pathways between services. Mr Sunderland advised he and the CEO had met with a number of local authority people, during which there had been discussion regarding housing. The discussions with the PN City Council had been positive.

The Mental Health Emergency Team, to be known as the Acute Care Team, will take some time to implement fully. At this stage it was planned to commence 24 hour emergency service provision by the end of June 2015. Management agreed that the Project Team would review the timeframe, given there was further recruitment required to the team, and report back to the next Committee meeting.

Clarification on the next steps in relation to housing was provided. The meeting with the Mayor covered the potential for a forum to be run by the city where the issues on housing could be discussed. The Mayor undertook to discuss this further with his CEO. Mr Sunderland agreed to follow up on this with the Mayor.

Developing a connected network across the district was a priority for the next phase in the development plan. Mental health care was 85% community based, with only a small amount of hospital activity, in terms of client numbers. The first part of this development would involve mapping out the range of services that were linked and funded, and identifying any gaps. The initial steps apart from mapping services would be to engage with current clinical networks and look at sector wide broad bases. It was a large amount of work but it was essential for the future. The Chair felt the terms of reference should include reference to quality, culture and effectiveness.

In relation to consumer groups, contact with existing groups in the community would be made, as it was important not to establish or capture artificial consumer voices.

Whilst the next steps were set out, the Chair asked that information on the services provided regionally to be provided for completeness. She felt the Committee should decide what they wanted to be reported back to them with regards to performance monitoring. She suggested a workshop be held to determine this. Management suggested the operational update could provide a dashboard as an appendix, providing the measures previously committed to.

The average length of stay (ALOS) and readmissions was discussed. The ALOS was higher than the national average, and was a risk the service was trying to address. Beds had to be found for new admissions noting there could be as many as six admissions a day. However there were fewer beds available as some patients stayed up to three months due to lack of suitable accommodation in the community. This affected the ALOS results.

The Chair referred to the use of CCTV, asking what happened to the tapes and what policies there were relating to their storage and availability following an incident. She requested this information be provided in the next update.

It was recommended

that this report be received.

Barbara Cameron joined the meeting.

7.1 Secondary Care update

In response to a question regarding the difference the establishment of the cancer nurse coordinators had made, management advised a national evaluation had been undertaken recently. The results were not yet available. The main focus of the coordinators has been around the patient experience from the suspicion of cancer through to treatment, with a streamlining of the process for patients resulting in fewer gaps in their care.

Multidisciplinary meetings are a large part of the work, and have increased in number. They are considered clinically important. There is a regional information systems suite which enables an electronic link between MDHB and Whanganui DHB. MDHB is fortunate as their oncologists travel to other regions, and can undertake this work when they are at the other DHBs.

The Neurology Service strives to cover after-hours thrombolysis service for stroke patients, but this is seen as unsustainable long term. After hours cover by neurologists for the management of stroke patients is also being addressed by the Regional Stroke Network and consideration of additional FTE to support this has been discussed.

The stroke network is also looking at regional thrombolysis support through tele-networking. This is a similar process to that which was undertaken between MidCentral Health and Wishaw Hospital in Scotland. This pilot was completed late last year.

The CEO advised she was the regional executive lead for the Stroke Services Clinical Network and would be able to contribute to any future discussions on this issue.

Management were asked if MCH's endoscopy services were at capacity with regard to diagnostic wait times for colonoscopy, and what did management plan to when/if colorectal screening was implemented. Management agreed this would be an issue and MDHB, Whanganui and Hawkes Bay DHBs have been looking at gastroenterology service capacity to see how it might move forward. A report on it would be going to the Ministry. It will probably require additional funding if the screening programme proceeds, but any such service was a long way off at this stage.

It was recommended

that this report be received.

7.2 2014/15 Annual Plan – centralAlliance: initiative – update 2

It was noted the September update for the Regional Women's Health Service would include information around the sub-specialities and the Tuia Framework. The Maori Health Directors from both MidCentral and Whanganui DHBs were supportive of this work.

21

It was recommended

that this report be received.

7.3 Regional Services Plan Implementation – update, Quarter 3, 2014/15

Management advised the information pertaining to volumes of service utilisation in the table on page 7.73 for the Youth forensic project and Maternal mental health service, although correct, were in the wrong boxes, and should be swapped around.

The CEO advised she was the regional executive lead for the Regional Health Informatics Programme (RHIP).

With respect to the RHIP and the involvement of and commitment to future funding by 3D, (3D is made up of the three lower North Island DHBs) management advised there is a process in place to look at ensuring there is a common end point, and that there are pathways which will enable progress to the end point. There is a piece of independent work being undertaken to enable MDHB to look at some of those pathways and whether or not there are different pathways to the regional informatics programme. It was hoped this work would be completed within four weeks.

It was recommended

that this report be received.

7.5 Non-financial Monitoring Framework and Performance Measures – Report for Quarter 3, 2014/15

It was noted that this report was an accountability document for the Ministry and was presented for transparency.

It was recommended

that this report be received.

8 OPERATIONAL REPORT

8.1 Provider Division Operating Report - April 2015

Clarification was sought on what was meant by the sentence in the first paragraph of the financial section, page 8.3, *Bringing costs within the MH services in line with costs across NZ will be a focus over coming months.* The Operations Director explained this related to moving to full recruitment of employed senior medical officers, rather than the number of locums currently used, managing capacity and patient flow through Ward 21, and undertaking a careful review of skill mix and FTE in and across the service.

The staff survey results were presented at a high level recently. The response rate was 39%, with about 3,300 comments. These were being analysed. The comments were positive. There would be some things to address, so once analysed a programme would be developed. This would probably be a continuation of the current work underway from the last survey. The final report was expected mid July.

The Nurse Director, Service Development had been appointed recently. She would be looking at the Professional Development and Recognition Programme, and the Nurse Entry to Practice Programme.

Karen Naylor declared a conflict in relation to section 5.1.3 Care Capacity Demand Model and the Collective Employment Agreement section, in terms of her role with the NZNO.

The Chair asked that the tables in appendix 7 on transport and accommodation should include the table showing details on flights made each month. She was concerned about any

trends that may be emerging with both road and air ambulance services that the Board should be considering.

Karen Naylor referred to the annual leave in excess of two years. She asked Management what plan was in place to reduce this; if an update was available on the progress that had been made; and the expected timeframe to achieve the target. Management advised it will take some time to reduce the excess leave balances. Since last October there had been a drop in this measurement, particularly for nursing staff. For the first time and as a result of the improvement in patient flows, there was some flexibility that provided an opportunity for staff to take this leave through winter, and Management were confident the target would be achieved, but it would take some time.

It was recommended

that this report be received.

9 LATE ITEMS

There were no late items.

10 DATE OF NEXT MEETING

21 July 2015

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)
Quarter Report – Contracts	Subject to negotiation	9(2)(j)