MidCentral District Health Board

Minutes of the Hospital Advisory Committee meeting held on 10 June 2014 commencing 8.45 a.m. in the Board Room, MidCentral District Health Board

---

PRESENT

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

In attendance
Murray Georgel, CEO, MidCentral District Health Board
Mike Grant, General Manager, Planning & Support
Muriel Hancock, Director, Patient Safety & Clinical Effectiveness
Kay Nagy, Minute Taker

Lyn Horgan, Operations Director, Hospital Services
Nicholas Glubb, Operations Director, Specialist Community & Regional Services
Michele Coghlan, Director of Nursing
Vivienne Ayres, Manager, DHB Planning & Accountability (part meeting)
Jan Dewar, Nurse Director, Medicine, Surgery, Emergency Services (part meeting)
Robyn Williamson, Service Manager, Child Health & Women's Health
Carrie Naylor-Williams, Service Manager, Patient Flow (part meeting)
Sarah Donnelly, Service Manager, Medical & Surgical Wards & Emergency Department (part meeting)

Communications (1)
Media (1)

Barbara Robson welcomed everyone to the meeting with a special welcome to Kay Nagy, who was in attendance to take the minutes of the meeting, and to Lisa Knight, the new Health Reporter for the Manawatu Standard.

1. APOLOGIES

There were no apologies.

2. LATE ITEMS

There were no late items.

3. CONFLICT AND/OR REGISTER OF INTERESTS UPDATE

3.1 Amendments to the register of interests

There were no amendments to the register of interests.

5-6

3.2 Declaration of conflicts in relation to today's business

The following conflicts were noted;

Duncan Scott declared a conflict in relation to item 7.2 as there is reference to MRI, and the MRI contract is in Part 2 of the meeting (17. Quarterly Report Contracts).

Karen Naylor declared a conflict in relation to item 7.2 due to her involvement with Care Capacity Demand Model (CCDM).

Stephen Paewai declared a conflict in relation to items 7.2 and 7.6 as there is reference to the PHO, Mahi Tu Maia and the IFHC.

Cynric Temple-Camp declared a conflict in relation to item 15 in Part 2 in respect of the coronial cases.

Barbara Robson declared a conflict in relation to discussions within Part 1 and Part 2 of the meeting regarding the Maternity Clinical Information System Update.

Richard Orzecki declared a conflict in relation to the Reporting Framework as Chairman of Manawhenua Hauora and Enable NZ.

4. MINUTES

It was recommended

that the minutes of the meeting held on 29 April 2014 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

Sleep Apnoea
It was queried if there was to have been an update on Sleep Apnoea provided for this HAC meeting. It was advised that an update will be given at the next meeting.

6. WORK PROGRAMME

The Board has established a programme for 2014/15 and the work programme for HAC is part of that. Management will use this work programme as a base for reporting to the committee. There is a workshop after this meeting and another scheduled at the end of July 2014. The two workshops will assist with the preparation of an indicative business case to go to the Board meeting in August and committee members are invited to these workshops.

It was queried why there is a risk profile for Health Benefits Ltd (HBL). There are two risks, Finance, Procurement and Supply Chain, and Laundry and Food Services, that have been escalated to the Board more than they have been in the past – to ensure they get appropriate attention.

It was queried where the joint strategic plan for the centralAlliance fits within the framework. This is included in the work plan and went to CPHAC because it is about planning.

It was recommended

that this report be received.

7. STRATEGIC PLANNING

7.1 Regional Service Plan Implementation – Quarter 3, 2013/14

We are progressing well and almost 90% of the projects are on track. It was queried what is being done in order to try and increase the cardiac surgery and angiography intervention rates. This has been an issue for the Central Cardiology Network for most of the Central Region's DHBs. There have been workshops to look at the barriers to access and a workshop on strategic planning is being held so we can explore possible ways of improving access on a regional basis.

Development of the orthopaedic pathway (based on CCDHB's pathway) for the Central Region has been initiated with the clinical lead roles appointed and meetings are being held to discuss potential implementation and service delivery models. This will look at standardisation of how patients move through the system locally and regionally.

Rheumatic fever rates vary across the region, with MDHB categorised as a "low incidence DHB". MidCentral DHB's rate is very low so our Rheumatic Fever Plan is focused on monitoring and reporting.

It was recommended

that the report be received.

7.2 Secondary Care Update

Patient Flow/SSIED
Carrie Naylor-Williams has been appointed to the role of Service Manager, Patient Flow. We remain the lowest ranked DHB in the country for the Shorter Stays in Emergency Department (SSIED) health target but we are improving against this time last year. We are implementing a Hospital Operations Centre. There is still a lot of work to be done in terms of how staff work and communicate together, for example; changing the role of the Charge Nurses and greater expectations around their contribution to patient flow. The Emergency Department achieved 96% for SSIED in May for the patients solely managed within ED and this is a great achievement. Therefore, the focus sits with general medicine and surgery in order to meet the target for all patients presenting to ED. There is work under way to look at pathways to fast track clinically appropriate patients through ED. Currently we are undertaking some work around enabling us to get better live information on patient flow through the organisation and a business case around information/live data technology would be required to be developed for HAC.

ED presentations have increased consistent with national and international trends. The acuity of those presentations is in proportion with the presentations. It was queried why we have been unable to stem the flow of presentations to ED given our investment in primary care. It was advised that there has been an increase in presentations but the rate of increase has slowed down compared with previous years. Upon inquiry it was queried if there will be a Post Event Audit for the Hospital Operations Centre.

5.3

Patient Boards
This is a significant piece of work arising from Releasing Time to Care. An A3 sized, coloured copy of the board which will be above patient beds will be provided for the next HAC meeting. It was stated that this is an excellent initiative as the patient's family will be able to read the boards and notes to the healthcare team can also be added. No clinical information is written on the boards.

Endoscopy Services
A report on colonoscopy services was requested for the next HAC meeting so the committee has a better understanding of numbers as well as percentages and what it will take to meet and sustain the increasing targets that have been set.

Organised Acute Stroke Services
It was queried if Dr Anna Ranta is going to remain as the Lead of the Stroke Service across the region and management confirmed they believe this to be the case.

Theatre Utilisation/Productivity
Concern was expressed about the theatre cancellations. It was advised that we have done some comparative work across the six Central Region DHBs and MidCentral has one of the lower cancellation rates. It was queried if we are looking at any pathways to improve those rates. We are doing a number of things, i.e. ringing patients two days prior to surgery and the day before. There will still be patients who arrive who are too sick for their surgery and there will still be unexpected staff sick leave. However, we do try to minimise cancellations to the best of our ability.

Recovery at Home
It was queried what happens for people recovering at home because they are discharged back to primary care, including from private hospitals? How do these people impact on our hospital services? Patients are discharged from private hospitals to their GP and the GPs can then refer them to District Nursing. This doesn't impact on the discharging from our hospital.

School-Based Health Services
It was stated that Te Kura Kaupapa Maori o Te Rito is a total immersion school and, therefore, unless this service is delivered in te reo Maori, this could be difficult. It was advised that this issue is managed across a number of other schools.

Shared Care, Secondary Mental Health and Addiction Services and PHO
It is pleasing to note that the shared care model enables clients to rapidly re-enter secondary care, when required.

Supporting Parents in Need Multi Disciplinary Group
It is pleasing to see progress on this.

Cancer Services including Diagnostics
CCDHB are yet to confirm their future solution for their Medical Oncology patient management system. Most of the country has gone with MOSAIQ but CCDHB is still considering its approach. There would be benefits for all cancer centres to be on the same system. It was noted that when the National Tumour Standards are formally agreed and signed off, it is expected that the cancer care provided is provided in line with those standards.

Staffing
We have been successful in recruiting Radiologists. We now have a mix of full and part time Radiologists who are all permanent staff members.

It was recommended

that the report be received.

- Diane Anderson joined the meeting.

7.3 centralAlliance Strategy

This paper was developed as the result of the last centralAlliance workshop. There has been a slowing down of the work progress but this has not been because of the rewording of the Terms of Reference.

It was recommended

that the report be received.

7.4 2013/14 Annual Plan – centralAlliance Initiatives

It was queried if exploring opportunities to increase service sustainability and an outreach breast imaging site in Whanganui will impact on the medical imaging department at MidCentral. Management advised that BreastScreen Coast to Coast is essentially a separate service to the MCH Medical Imaging Department and that they did not foresee any significant negative impact as a result of the change.

It was recommended

that the report be received.

7.5 Update on the Indicative Business Case

It is proposed that a hybrid medical and surgical Acute Assessment Unit be established, with an increase from the current 17 medical beds to 25. It was stated that the additional eight beds will be the general surgical component of the Unit, allowing for a little bit of growth.

It was recommended

that the report be received.

7.5 Non-financial performance measures

Oral Health
There has been an issue identified nationally in relation to formaldehyde in the Oral Health caravans. Our caravans have been tested and two have come back positive, but at a low level. Over time we have had a number of our staff with some symptoms, mainly respiratory. This is a national issue and we are pursuing this with the manufacturers. In the interim we have opened a clinic in Levin which we closed last year to maintain capacity. Another couple of other options are also being looked at. The priority is the health and welfare of our staff and managing the manufacturer's response. This process is being managed through HBL.

5.10

Standardised intervention rates (SIRs)
MCH's SIR for cataract procedures as compared with the target intervention rate of 27.0 per 10,000 was queried. Members were referred back to Appendix 1 of the Secondary Care Update which shows that against the SIR for cataract procedures, MCH is nine behind the planned target of 510.

It was recommended

that the report be received.

7.7 Serious Adverse Event Management Overview

Management were congratulated on a good overview of these events. It was queried how we close the loop between ACC treatment injuries and this process. It was advised that the patients come in through a similar process – through the Chief Medical Officer's office, in terms of oversight, and through the Release of Patient Information office (because ACC may be looking for patient information) and we use this as a mechanism to identify anything that may be classified as 'adverse' and then follow our process. ACC offer presentations to all providers around ACC treatment injuries advising what treatment injuries are occurring, and what the numbers look like, and sometimes they provide case studies as well.

If there is a formal complaint around an adverse event there may be several agencies involved. Generally HDC will undertake their review first and then the Coroner as they may benefit from HDC's investigation. It was queried if we advise HDC if an adverse event occurs in order to give them a "heads up" before HDC might receive that complaint. We do not do this. Our initiative/aim is to work with the patient/family locally to try and resolve it. We may, however, work closely with the HDC advocacy service in terms of working towards resolution.

It was recommended

that the report be received.

8. OPERATIONAL REPORTS

8.1 Provider Division Operations Report, April 2014

The Year-to-Date result for the provider arm is adverse to budget. There has, therefore, been a real focus on this. It is important that we start the new financial year with the right budgets which are achievable. We are looking to be back on track for 1 July 2014. It was advised that when we do more electives, we do get paid for them, although it was noted that the extra revenue earned does not appear to fully cover the costs. We want to reduce or minimise month to month adverse variations, preferably making the variations positive. Management confirmed that additional cost has come about through full staffing. One initiative is trying to ensure we don't incur overtime, given the good staffing position overall.

Collective Employment Agreements
Some of these agreements are past their expiry dates and some of the people involved with those MECAs are feeling aggrieved that the MECA has not been settled. This appears to be the case with the administration/clerical/PSA MECAs. Therefore, we hope these agreements are resolved as soon as possible.

Patient's Place of Domicile
The complaint received regarding a patient's place of domicile has now been resolved. It has highlighted the importance of data quality and understanding, in particular, that when taking a patient's address we need to ensure it is correct and for rural addresses, this means the Rapid Number needs to be included. There is now an increased understanding of this across the organisation.

Patient Experience Survey
We are continuing with the implementation of the HQSC's patient experience survey – there is a focused effort to get it under way.

International Day of the Midwife/International Nurses Day
It was pleasing to note there was special focus on these days and there was some very positive feedback.

Nursing Professional Development and Recognition Programme (PDRP)
The uptake of the MidCentral programme has fallen from 60% to 42%. It was advised that it is probably time to refresh the programme as feedback indicates that the programme is very complex – other DHBs do not have the 'layers' we have. It is probably time to have a look at the programme in terms of making it regional and, therefore, this is being explored.

Nursing Recruitment & Nurse Entry to Practice Programme (NeTP)
At MidCentral Health we have 18 protected NeTP positions but we have currently employed 36 new graduates across the range of clinical services.

- Diane Anderson left the meeting.

Administration Appreciation Day
It is pleasing that there was recognition of the people who do a lot of work behind the scenes.

Sleep Apnoea – General Practice
This is a work in progress and an update is to be provided for the next HAC meeting.

- Digby Ngan-Kee joined the meeting.

First Specialist Assessment (FSA) – Declines
It was queried how the referrals that have been declined (currently sitting at 6.2%) compares to previous years. This information is to be provided for the next HAC meeting along with information on what advice/feedback is given to a patient's GP for ongoing management if they are declined an FSA.

It was recommended

that the report be received.

9. LATE ITEMS

There were no late items.

10. DATE OF NEXT MEETING

22 July 2014.

5.12

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)
Mental Health Update	To protect personal privacy	9(2)(a)
Quarterly Contracts report	Subject of negotiation	9(2)(j)
Maternity Clinical Information System update	Contractual negotiations	9(2)(j)