MidCentral District Health Board

Minutes of the Hospital Advisory Committee meeting held on 13 February 2012 commencing at 8.45 am in Rooms A/B, Education Centre,, MidCentral District Health Board

PRESENT

Jack Drummond (chair)
Lindsay Burnell
Kate Joblin
Richard Orzecki
Stephen Paewai
Barbara Robson
Phil Sunderland
Cynric Temple-Camp

In attendance

Murray Georgel, CEO
Mike Grant, General Manager, Planning & Support
Carolyn Donaldson, Committee Secretary

Unconfirmed Minutes

Diane Anderson, Board Member (part meeting)
Ann Chapman, Board Member (part meeting)
Pat Kelly, Board Member
Karen Naylor, Board Member (part meeting)
Nicholas Glubb, Operations Director, Specialist Community & Regional Services
Muriel Hanratty, Director, Patient Safety & Clinical Effectiveness (part meeting)
Lyn Horgan, Operations Director, Hospital Services
Dr Kenneth Clark, Chief Medical Officer (part meeting)
Chris Channing, Manager, Planning & Support Unit
Grant Jenson, Planning & Support Unit
Jill Matthews, Principal Admin Officer ((part meeting)
Dr Cheryl Benn, Midwifery Advisor, (part meeting)
Tracey Schiebli, General Manager, Whanganui DHB, (part meeting)
Hentie Cilliers, Regional General Manager, Human Resources
Doug McLean, centralAlliance, Women's and Children's Health Services, (part meeting)
Judy Boxall, Service Manager, (part meeting)
Communications (1)
Public/Staff (4)
Media (2)

1 APOLOGIES

Richard Orzecki apologised for leaving the meeting early.

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

Cynric Temple-Camp and Jack Drummond declared a conflict of interest with some of the cases mentioned in the confidential section of the operating report.

5-8

4 MINUTES

4.1 Minutes

It was recommended

that the minutes of the meeting held on 6 December 2011 be confirmed as a true and correct record.

4.2 Recommendations to Board

To note that the Board approved all recommendations contained in the minutes.

5 MATTERS ARISING FROM THE MINUTES

There were no matters arising from the minutes.

REARRANGEMENT OF MEETING ORDER

Members were advised that as guests were travelling from Wanganui to join the meeting at 10am, the agenda order would be slightly rearranged so that item 7 was taken at approximately 10am.

6 STRATEGIC/ANNUAL PLANNING

6.1 Child & Adolescent Oral Health Initiative – update 2

The significant issues being experienced during the transition would continue until the end of the next financial year when the project implementation should be complete. As a result, additional support was requested to support the service through until that time.

It was not envisaged that the delays in not achieving the agreed Ministry service delivery targets would result in a financial penalty. However, as the funding had been devolved to the DHB it might remain with the Funding Division depending on the wash up rules. The obligation was to make every effort to achieve the targets, as for any service.

Management agreed to provide more detail in the next update around the children who access the service and the level of success in getting children to attend clinics, ie the DNA rate.

It was noted the therapist assistant levels had been set when the business case was developed, and were the levels the Board had committed to long term. MCH believed it was necessary to support service delivery during the transition, and vital to maintain and manage the service. Once the new service configuration was fully implemented, the levels would be reviewed to see what was required to support productivity.

It was agreed there was a direct co-relation between increasing dental assistant numbers and increased productivity, eg for every additional assistant, there would be approximately 300 additional volumes per year. However, after careful consideration of the options, it was felt option 2 was prudent.

In terms of national comparisons, MCH tended to be achieving higher than some other DHBs in relation to adolescents; other DHBs were experiencing challenges in engaging with and in improving outcomes the Maori population, so they were similar to MCH in terms of achievement.

Management were asked to look at quantifying the risk in terms of Maori children not being seen, and to break down those accessing services to indentify the percentage of Maori, as there might need to be more communication with the community.

It was recommended that

- this report be received
- Option 2 (five additional Dental Assistants for 2012/2013) is incorporated in the 2012/2013 Annual Plan for MidCentral Health, at an additional cost of $187,730.

6.2 2011/12 Regional Services Plan Implementation – monthly update (Information item)

Disappointment was expressed that the multidisciplinary meetings were not happening as quickly as thought. If inter-DHB conferencing was available, patients could be dealt with quicker and it would save a lot of travel time for staff. Management understood a decision regarding this would be made shortly.

It was noted that although the regional boards meeting scheduled for 5 March was postponed, the regional work was still happening.

It was recommended

that this report be received

8. OPERATIONAL REPORT

Management advised the preliminary January result was available, and that MCH had kept up its good performance. There was a deficit for MCH of about $1.4m compared to a budgeted deficit of $1.9m.

Management clarified that the increased clinical trial costs were funded and the costs would balance out. The contract for the laboratory tests had been re-negotiated and costs would come back into line.

It was clarified that the job sizing exercise was to consider situations where staff had extra responsibilities and to adjust salary size accordingly.

Richard Orzecki left the meeting. Barbara Robson and Mike Grant left the meeting.

The Committee was updated in relation to recruitment of mental health clinicians, where two/three locums have been covering five vacant positions. MCH's personnel budget was based on being fully staffed, so a proportion of the additional mental health senior medical officer locum costs were the costs above what had been budgeted. MCH has been successful in recruiting three psychiatrists, with one starting this month.

Barbara Robson and Mike Grant returned to the meeting.

There was discussion on the information shown for elective surgery performance indicators 2 and 5 (ESPI 2 and ESPI 5). There had been considerable work and planning undertaken on achieving the ESPI results at zero, now that the former tolerance zone was being removed. It was noted that a third of the patients waiting for treatment had asked that their treatment be deferred as they would not available on the allocated date. However, these patient numbers were still included in the information reported. Most services had only small numbers of patients waiting for treatment. Management agreed to include a table that showed the information for all specialties.

The Committee were informed there had recently been a surge in patient numbers for radiation therapy. Management were asked to convey members' appreciation to staff for the effort and extra work done during this time to ensure the radiation therapy target was met.

Management agreed to provide a break down of the personnel costs by service.

It was noted that the Ministry will not be providing the diabetes annual reviews and management measures in the media in future, but that the results would be available via their website each quarter.

The issue of the bed day costs was raised, as a member felt they were very high at a time when MCH bed levels were as budgeted and occupancy in the medical wards was high. Management explained that since the establishment of the Medical Assessment and Planning Unit, Medicine kept within their bed allocation and rarely impacted on the surgical beds and that MCH budgeted for 85% bed occupancy.

It was recommended

that this report be received

7 CentralALLIANCE

In opening discussion on this topic, the Chairman confirmed all board members had speaking rights. There was no response to his question asking if any member of the public would like to comment.

7.1 Regional Women's Service – Proposal

An apology was received from Dr Digby Ngan Kee, Regional Clinical Director, Women's Health Service. Dr Ngan Kee asked that his letter of support be read out to the Committee. The CEO advised the letter had been read also to the Whanganui Hospital Advisory Committee and Community & Public Health Advisory Committee.

It was also noted that the business case, set out in the following paper, was contingent on the proposal.

Dr Kenneth Clark, Chief Medical Officer, MDHB, Dr Cheryl Benn, Midwifery Advisor, Nicholas Glubb, Operations Director, Specialist Community & Regional Services MDHB, and Tracey Schiebli, General Manager, Service and Business Planning Whanganui DHB, all spoke in support of the proposal outlining the background to it, the current situation, risk issues, and the necessity to develop a regional service to overcome the difficulties.

Dr Clark felt it was a tremendous opportunity to improve services. There would be a bigger population base, more opportunity for developing sub-specialty services and for the involvement of trainees in all levels across the sub-region. There would also be a flow-on effect into child health, theatre, surgical and anaesthetic capabilities. He said there would be challenges for the population, particularly those from Whanganui DHB, but if service changes were not made women and babies as well as the DHBs would be exposed to significant risk.

Dr Benn said the proposal would have a big impact on the midwifery services of both DHBs and that already there was concern that Wanganui women would want to use a MidCentral Lead Maternity Carer (LMC). This could over-load services in Palmerston North, so it would be a challenge to ensure the LMC service was retained in Wanganui as well as hospital staffing in both districts.

Mr Glubb confirmed the proposal was clinically led, and built on relationships developed over the past few years. Ms Schiebli felt it was a brave move by the Whanganui DHB management, but unless it was done in a planned way the women would not have a good service. She confirmed there would be discussions with the LMCs, as the proposal had to work for them.

The proposal was then discussed by members. The following comments were noted.

- The age of current Wanganui clinicians
- Locums were not the answer
- From a clinical point of view, the current situation was unsustainable and unacceptable
- Amazed to hear that Wanganui women were already thinking of using PN LMC – thought they would have used their own primary facility
- Primary care focus is positive, as women need care before and after the birth
- It would be good to get a break-down of intervention statistics historically so there was a better idea of the trends – both Wanganui and MidCentral, and Maori/Non-Maori
- Some women should be eligible for travel assistance
- Think more information is needed around safety
- A clear process for engagement and consultation will be necessary, and the process should be easy so people can make a contribution

- If further information was requested, every endeavour would be made to provide this to the boards when they discuss the issue next week; however it might not be possible to get everything requested in time to be included with agenda material
- Key aspect was safety: the chance of an acute serious event occurring was more common in a sub-group of women who would be identified during their normal pregnancy risk assessment. These women would deliver in the secondary centre, thereby reducing the risk. The key issue was for good antenatal risk assessments. It was essential there were good policies, decision making, communication, and transport mechanism that did not fail. Risk could not be eliminated; it could only be identified and addressed.
- Kaitaia was a good example of this model. The West Coast was a little different, in that there were at least 13 days a year when travel was impossible. So they still had to have an obstetric service. It was very difficult to sustain, as it was costly and relied on locums.
- Education and support would be needed for the midwives to enable them to become more confident. Rural midwives were the most experienced and confident with identifying these risks.
- New national referral guidelines were set in December last year. These guidelines looked at consultation with an obstetric specialist, so the GPs would be more involved. Some people would still decline to be transferred even after the risk had been identified. In those cases, the situation was documented.
- In some cases it would be difficult for families to follow the patient across, for various reasons.
- Another aspect was under current legislation, if labour had started the midwife could claim fees even if the birth had been going for only an hour, but if the patient is transferred across antenatally and the midwife did not follow the patient, then they could not access the fees.
- There are no GP LMCs and no obstetric LMCs in Wanganui.
- Primary maternity services needed to be available locally, similar to other primary health services
- Discussions had not yet been held with staff.
- If the proposed changes for Wanganui occurred, less staff would be required, but the staff currently in Wanganui were nearing retirement. Midwives would be needed in both districts.

Diane Anderson, board member, spoke in support of the proposal going forward to the next step, as she recognised the concerns for the viability of the service and the work that had gone into the proposal so far.

The Chairman advised Richard Orzecki asked that his support for the proposal be noted, as he had left the meeting during the discussion.

It was recommended

that the general direction set out in the for Regional Women's Health Service proposal be supported in principle, acknowledging the issues and keeping an open mind; and,

that public engagement and staff consultation on the proposal be undertaken, with the results reported back to the Board, and

that the committee notes the following:

- The proposal is conditional upon approval of the MidCentral DHB associated Capex Business Case,
- The proposal is also conditional upon the support of the Whanganui DHB
- a detailed Service Plan will be developed, outlining how the service will operate
- the final proposal and implementation plan will be reported to the Board in April 2012, and that a special board meeting be held on Tuesday, 24 April 2012 accordingly.

The Chairman asked that his vote in favour of the proposal be registered at the forthcoming board meeting, as he was not able to attend that meeting.

Phil Sunderland left the meeting.

7.2 Regional Women's Service – Maternity and Theatre Facility Development business case

Management advised the header section on alternate pages of this report were incorrect.

It was noted this business case was contingent upon the previous proposal.

Phil Sunderland returned to the meeting.

Management confirmed that there was no overall master site plan for the redevelopment of MidCentral Health yet. However, such planning was a number of years away, and the proposal put forward in this business case for additional theatre capacity, building alterations to the delivery suite and maternity ward, and the purchase of clinical equipment to provide the capacity required for implementing the Regional Women's Health Plan, would be useful for a number of years.

The issue of outsourcing work to the private hospitals was raised. This option had been considered, but it was not pursued given the recent experience of MCH doing the work in-house. The proposal under discussion was the preferred option. The issue was further clarified, with the suggestion made that if 300 elective cases could be sent to Wanganui, that would solve the theatre shortage issue at MCH. With regard to the modelling of additional elective surgery volumes, it was not certain that the year on year increases in elective surgery work would continue.

Management stated the paper did not address or consider capacity at Wanganui. It was understood that while150 procedures were recently accommodated in Wanganui, there was not sufficient capacity to support 10 sessions a week of additional elective work. Ms Schiebli advised that consideration needed to be given to more than just available theatre capacity and even if that were available, there would be other constraints to achieving that number of additional sessions. Dr Clark said there were other dynamics that occurred in the theatre setting that could not be put in the report, eg other specialty teams had to give way to acute obstetric cases. If another layer of obstetric emergencies were added, it would further change the dynamics for hospital patients. He added another issue was other regional dimensions like reconstructive breast surgery.

It was recommended

i. that approval in principle is given to the facility changes required to support the provision of a Regional Women's Health Service at Palmerston North Hospital at an estimated cost of $4.399m, subject to the support of both MidCentral and Whanganui DHBs' boards for the Regional Women's Health Service Proposal;

ii. that subject to (1) above, approval be given for the engagement of architectural, engineering and quantity surveyor building consultations to determine and cost a preferred operational and business location for a dedicated obstetric and acute gynaecology theatre at an estimated cost of up to $100,000, with the results to be reported back to the Board in April 2012;

iii that the Committee note that:

- the business case of $4.399m includes the $100,000 fees in 2. above, a dedicated obstetric and acute gynaecology theatre at an estimated capital cost of $3,735,000, building changes to the delivery suite and maternity ward an estimated capital cost of $340,000, together with estimated clinical and other capital equipment of $224,360;
- operating costs associated with these changes are estimated to be $1,146,898 and these have been incorporated in the separate Regional Women's Health Service Proposal;
- the increased theatre capacity will provide both for the projected increase in women's health volumes as a result of the Regional Women's Health Service

Proposal and growth in other elective surgical work – 25% RWHSP work/75% elective growth.

- a final business case will be submitted to the Board in April 2012.

9 GOVERNANCE ISSUES

9.1 Work Programme 2011/12

The CEO advised that the time allocated for a potential workshop on 24 April, would possibly be used for an additional board meeting to discuss the regional women's health service.

It was recommended

that this report be received

10 LATE ITEMS

There were no late items.

11 DATE OF NEXT MEETING

13 March 2012.

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: : Siemens Contract : Potential Serious / Sentinel Events / Complaints	 Subject to negotiation To protect personal privacy	 9(2)(j) 9(2)(a)
Contracts update	Subject of negotiation	9(2)(j)

Dr Drummond tendered his apology for the next meeting.