MidCentral District Health Board

Minutes of the Hospital Advisory Committee meeting held on 17 July 2012 commencing at 8.45 am in the Board Room, MidCentral District Health Board

Unconfirmed Minutes

PRESENT

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

In attendance

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

Nicholas Glubb, Operations Director, Specialist Community & Regional Services
Lyn Horgan, Operations Director, Hospital Services
Anne Amoore, Manager, Human Resources
Chris Channing, Business Manager, Planning & Support
Susan Murphy, Manager, Quality & Clinical Risk
Robyn Shaw, Manager, Elective Services
Amanda Driffill, Service Manager, Medicine
Communications (1)
Public (1) – part meeting
Media (1)

1. APOLOGIES

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 to the register of interests.

3.2 Declaration of conflicts in relation to today's business

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

4. MINUTES

It was recommended

> that the minutes of the meeting held on 5 June 2012 be confirmed as a true and correct record.

6.7

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. STRATEGIC/ANNUAL PLANNING

6.1 MidCentral DHB's Workforce Strategy 2012-15

This report brings the workforce initiatives together into one document, and will be the reporting framework going forward. It outlined the major achievements made over the last six years, which have resulted in vacancy levels being at an all-time low.

The main risks for the DHB in terms of employment strategies were noted as being the areas that were difficult to recruit to particularly where there was a world-wide shortage, eg radiologists, while noting recent success in recruitment. Another challenge identified by a committee member, was the move, often by the best performing clinicians, into management. There was potential for this to happen in MCH in respect of the clinical director role, as the clinicians in that role did both clinical and management work.

The current move towards a regional and sub-regional approach will gradually see a change in the models of care. The kiwiana-themed migrants evening had been a very successful evening.

It was recommended

that this report be received

6.2 Clinical Board annual report – 2011/12

Protected Quality Assurance Activities (PQAA)

Management explained MCH previously had a number of PQAA activities, but the notice had lapsed. Services were now considering whether they wanted to renew the notice and have their activities protected from public release.

It was recommended

that this report be received

6.3 Improved Access to Elective Services update

The Committee was updated with end of year results. MCH finished the year with 353 discharges ahead of target and 180 cost weighted discharges behind. That was due to some under delivery, particularly in cardiothoracic cost weights. The Elective Service Performance Indicator targets had been achieved with no patients waiting greater than six months for a first specialist assessment or certainty of treatment. The patient focused booking initiative had also resulted in gains, with very low "did not attend" (DNA) rates in the services that were using the initiative.

Management advised the number of patients making up the percentages of the ENT DNA rate in table 3 was 16 DNA patients out of 180 new patients. The numbers for the colposcopy results were 7 DNA patients from a total of 50. A lot of work had been done to improve the DNA rates, with the Maori Health Unit particularly focusing on the DNA patients in colposcopy.

Management advised that under the patient focused booking system, very few patients required re-referral as a result of being removed from a waiting list. A response was usually received when the third letter was sent regarding an appointment and advising that the patient would be removed from the list if contact was not made.

The very good zero DNA rate for gastroenterology was noted.

The issue of appointments being cancelled a number of times was raised. The reasons for cancelling appointments were not usually advised to patients. These cancellations were not part of the 'did not attend' statistics.

There was some discussion on the cardiothoracic service from Capital & Coast DHB (CCDHB). Management reported that at a recent regional meeting, CCDHB advised they were now fully recruited. The cardiac cath laboratory was running full time and they expected to be able to see more patients. One barrier to accessing the system has been providing treadmill exercise testing. MCH's technicians have now attained qualifications enabling them to support ETT tests, and a second treadmill had been purchased. This should enable better identification of cardiac patients who required referral to CCDHB.

Clarification was sought in respect to access criteria for elective services. The criteria were around clinical appropriateness and patients with the greatest need / highest priority. A record was kept of any patients referred back to their GP, and there had not been an increase.

It was recommended

that this report be received

6.4 Regional Women's Health Service update

It was noted that this paper was also presented to Whanganui DHB who had agreed to it. The next step in forming a regional service was to draw up a development plan. It was recommended that a joint workshop for both boards and their Iwi partnership boards be held on 10 September to progress that work.

A member advised she understood the Ministry of Health would be conducting some reviews of some services as they were looking to make 10% savings over the next four years. As a result, the Boards should be mindful of possible changes. Management said they had not received any formal notification of this work yet.

It was recommended

that the report be received

6.5 2011/12 Regional Services Plan Implementation – monthly update

There was a brief discussion on home dialysis and the possibility of improving this service. Management noted there were inter-district flow implications to be considered.

A review of central regional patients showed that up to 30% of patients currently receiving in centre or satellite dialysis could be candidates for home dialysis. Management advised that some of these patients would need assistance to have the dialysis at home. MDHB had been working with Whanganui DHB looking at how the service could be increased. Some DHBs used trained carers to help patients at home, and MDHB was working through that model to see if it might work across the Wanganui/MidCentral region.

6.9

A member advised there was also a model being used in Auckland and Canterbury where patients were redirected to other GP services or nurses within practices or after hours facilities instead of the patient presenting at ED (primary options for acute care).

The Regional Services Plan had been approved by the DHBs and also signed by the Minister.

In terms of the 2012/13 plan, whilst it would be a continuation of current planning priorities, there would be some refinement and there was a clear demand for sub regional activity to be evidenced and doable. There was also the emerging shared services organisation for non-clinical activity.

It was recommended

that this report be received

7. OPERATIONAL REPORTS

7.1 Provider Division Operating Report – May 2012

It was noted that at the moment, EDs across the country were struggling with managing the impact of the winter flu. Management advised MCH had put a number of processes in place. One was the establishment of a patient flow coordinator in ED. That person will work with teams to manage patient flows to the wards. Beds had been flexed with four beds in the Medical and Assessment Planning Unit being opened and staffed, to relieve some of the pressure on patient flow.

It was noted that the timing for the shorter stays target in ED started when a patient's name was entered into the patient management system and finished when the clinician discharged the patient from ED.

Management was complimented on the good financial result.

It was recommended

that this report be received

8. GOVERNANCE ISSUES

8.1 2012/13 Reporting Framework

Members were reminded of the regional women's health service workshop scheduled for 10 September. They were also invited to the Treaty of Waitangi workshop on 7 August, following the next board meeting. This would be held in Feilding.

It was recommended

that the Committee's 2012/13 work programme be noted.

9. INFORMATION ONLY REPORTS

9.1 Update on implementation of the Cardiology Landscape Report and progress against Health target: Better Diabetes and Cardiovascular Services

It was recommended

that this report be received

9.2 Maori Health update

Richard Orzecki acknowledged the contribution made by the Shane Ruwhiu, the FD Maori Health Advisor, in reporting to Manawhenua Hauora. Shane had now resigned from the MDHB.

It was recommended

that this report be received

10. LATE ITEMS

There were no late items.

11. DATE OF NEXT MEETING

28 August 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 : Potential Serious / Sentinel Events / Complaints	To protect personal privacy	9(2)(a)