MidCentral District Health Board

Minutes of the Hospital Advisory Committee meeting held on 29 April 2014 commencing at 8.45 am in Rooms A&B, Education Centre, MidCentral District Health Board

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Unconfirmed Minutes

PRESENT

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

In attendance
Lyn Horgan, Operations Director, Hospital Services
Mike Grant, General Manager, Planning & Support
Carolyn Donaldson, Committee Secretary

Diane Anderson, Board Member (part meeting)
Nicholas Glubb, Operations Director, Specialist Community & Regional Services
Muriel Hancock, Director, Patient Safety & Clinical Effectiveness
Michele Coghlan, Director of Nursing
Rodney Mackenzie, Manager, Business Support
Cushla Lucas, Service Manager, RCTS
Iona Bichan, Charge Nurse, Emergency Department
Digby Ngan Kee, Regional Clinical Director, Women's Health (part meeting)
John Manderson, Manager, Data Quality & Health Information (part meeting)
Kenneth Clark, Chief Medical Officer (part meeting)
Jill Matthews, Manager, Administration & Communications (part meeting)

Communications (1)
Media (1)

1. APOLOGIES

Apologies were received from Karen Naylor and Murray Georgel.

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

The following conflicts of interest were noted:

Duncan Scott declared a conflict in relation to item 7.1 and 7.2 - ultrasound services. These conflicts were due to his employment as general manager and company director of Broadway Radiology Limited.

Barbara Robson declared a conflict in relation to item 7.1, Regional Women's Health Service, due to her involvement as a consumer representative on the Maternity Information Systems Programme Steering Group.

6.7

As these papers did not require any decisions, there was no reason why the members should not participate in any discussion.

Cynric Temple-Camp declared a 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 18 March 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

There were no matters arising from the minutes.

6. WORK PROGRAMME

Members confirmed the most suitable time for their attendance at the Master Health Services Planning workshop scheduled for 1 August, was 4pm.

It was recommended

that the updated work programme for 2013/14 be noted.

7. STRATEGIC PLANNING

7.1 Regional Women's Health Service implementation report

Barbara Robson declared her conflict of interest in relation to the Maternity Clinical Information System.

In speaking to the paper, Management outlined progress made with implementing the Regional Women's Health Service, specifically covering the Maternity Clinical Information System and outreach clinics for Whanganui.

Good progress continues to be made internally with the information system. A project manager was in place, and systems were being readied for implementation. However MCH was dependent on the national systems also being ready in order for the local system to be implemented. Some further work on Clevermed's Cloud based system was required which will take the implementation date further into July.

The Maternity Clinical Information System was still being tested in the NZ maternity environment, as it was a UK model that was being adapted for NZ. Management were confident the DHB had the necessary expertise to implement it as external expertise had been brought in to help. It was noted the server for the NZ system was based in Christchurch, with backup in Dunedin.

The delay at the national level with establishing the interfaces between primary care systems and MCIS was a key issue, as primary data from GPs and midwives was required to be entered into the secondary system.

Ms Robson asked if MCH had committed to making the patient portal available as soon as possible, assuming implementation proceeded according to plan. Management advised this would depend on the extent the National Health IT Board was prepared to commit to its implementation.

In relation to the outreach clinics, Management advised they wanted to review all similar outreach areas, in order to ascertain an equitable arrangement. A member stated she considered improved access to outreach clinics in terms of the rural population, to be a

measure of the success of the service. Dr Ngan Kee clarified why it was important to have information on demographics before establishing outreach clinics.

Good governance structures were in place. Line meetings have been established. However, it was noted that better video conferencing facilities would facilitate communications and reduce travel involved in holding meetings.

Members were pleased to see the Maori Cultural Advisory Group had been established and that it had prepared a framework titled the "Tuia Framework". This framework has been endorsed by the Manawhenua Hauora and Hauora a Iwi boards. Management explained the advice contained in the Group's report would now be considered along with other priorities. The report contained a lot of aspirational suggestions for improving the health of Maori that had application across other services as well. This work was part of the implementation plan, and the governance group would incorporate what could be done across both DHBs.

Diane Anderson joined the meeting.

Another member said he had found the report encouraging. Work was proceeding in a considered manner and he felt reassured the end point would be reached.

Management explained SharePoint was a system for sharing information across a common framework, and would be available for both DHBs for RWHS before the end of June 2014.

In response to concern expressed about the lack of good conferencing facilities, Management advised MCH had made significant improvements with its video conferencing facilities, but there had been a huge growth in the use of systems, particularly priority areas. It would be good to see how access could be advanced and improved without unnecessary duplication of services. Dr Temple-Camp suggested some prioritisation for access to the facility might be useful, as he felt there were occasions when the room may be booked for a meeting rather than the use of the equipment.

Cynric Temple-Camp left the meeting briefly, then returned.

It was recommended

that the report be received

7.2 Update on ultrasound wait times

It was confirmed that ultrasound for women with symptoms of breast cancer would be seen by the Breast Screen service – this had been identified in the landscape report last year, and was part of an integrated pathway. It was resource intensive, and clinicians had agreed it was the appropriate way for the future. It was being put in place over time.

When the new sonographer arrives in July, this role will support all activity, including the obstetrics and gynaecology service. This will enable the O & G service to contribute to and benefit from the additional capability. A request for ongoing updates regarding this was made.

In relation to publicly funded private ultrasound, the DHB has access to external providers directly, and that has been useful on occasions. However, currently MCH was able to meet its timeframes for urgent and semi-urgent referrals. There was also engagement with Broadway Radiology around developing the workforce. It was commented that some other DHBs, eg Auckland, had developed a voucher system for use with private providers.

Management explained there was a checking process for patients who had been waiting longer than six months. The process was to confirm with the patient that the examination was still required rather than to decline patients who did not attain a certain threshold.

The clinical ultrasound governance group, which will involve Medical Imaging and Women's Health personnel, will report back to the umbrella group.

The Committee thanked Management for the positive progress made to date, noting they looked forward to ongoing updates through the monthly operations report.

6.a.9

It was recommended

that this report be received.

8. OPERATIONAL REPORTS

8.1 Provider Division Operating Report – November/December 2013

Hospital Operations Centre

The Hospital Operations Centre would have access to information from various sources across the organisation. There would be live information particularly around the flow into and out of the hospital. The information would be similar to that shown on the Hospital at a Glance (HaaG) screens in the wards.

World Down Syndrome Day

Management were congratulated on the World Down Syndrome Day event.

Influenza Vaccination Campaign 2014

Members were updated on progress with the influenza vaccination campaign. As at 17 April, 1,100 vaccinations or 34% of the DHB's staff had been vaccinated.

Consumer Engagement Indicator Survey

The Health Quality and Safety Commission has agreed that the disability question MCH had asked about, could be added into the survey questions possibly at no extra cost. Agreement with the provider was being finalised. A small working group has been set up to determine how the survey will be implemented.

The HQSC's preference that responses were made by email and the difficulties that would present for MCH, were noted.

Personnel Costs

It was noted that whilst a number of the collective agreements had expired, their expiry was not the reason why personnel costs were over budget.

Quality and Safety Markers

The decline in some of the quality markers was noted. The drop in the Central Line Acquired Bacteraemia result was due to some results not being recorded into the data collection system. MCH was very close to the target with the surgical site infection results. The drop in one of the surgical site infection results was due to orthopaedic surgeons using their preferred antibiotic rather than the nationally preferred one. Two or three other DHBs had this issue as well as MCH. The Chief Medical Officer is following this matter up with MCH staff. The recent appointment of Mr Chrisp to the position of Clinical Director, Surgical Services, would assist in resolving this matter.

Additional Colonoscopy Funding

Management advised additional funding had been approved for the total 110 colonoscopies applied for. Initially only 55 had been approved. A plan was in place to provide a service on Saturday mornings so that they were all completed by the end of June 2014.

The Director of Nursing commented on the initiative for nurses to perform some colonoscopies, advising Nursing was currently looking at how this could be developed over the next 5-10 years. The Chief Medical Officer said there was no doubt nurses were an effective part of the workforce, but there was some controversy over the cost effectiveness of nurse endoscopists. Any problem patients were referred back to doctors, so consideration had to be given to the cost implications of this, and to the numbers of nurses and doctors being trained. There was also potential for virtual colonographies, particularly where there

were high quality CT facilities. However, it was noted that where people were diagnosed with polyps, they would then need to have a colonoscopy to remove them.

Audiology Services

Consideration was being given to whether some of the audiology work could be done in the community.

Sleep Apnoea

Work was progressing on using some nursing workforce for this service, and an update could be available in the next operations report.

Patient Transport by Air Ambulance

Disappointment was expressed that the information provided for patient transport and accommodation had not been split to show MCH patient transfers of non-acute or semi-acute patients that do not require doctor escort, and medically supported patients transferred by a retrieval team.

Management advised that a manual exercise was undertaken to analyse activity since last July and provided the information verbally. There had been 72 external retrievals, 88 transfers using the contracted provider and a flight nurse, and 37 transfers using an external provider because MCH did not have a flight nurse available. Road transfers were in addition to these figures.

Management further advised the standard and complexity of transfer had increased in some situations. In terms of risk for the patient, it was no longer adequate for a flight nurse only to accompany some patients and this was now done by an appropriately skilled medical team.

The Committee was reminded that the logistics of sending an ICU specialist or registrar with a patient transferring by air was huge, as it included the necessity to back-fill for the staff which on occasions covered different shifts. Management were therefore aiming for a mix of retrieval and contracted provider transfer services.

It was noted that any flight costs for patients using the inter-district flow system, were invoiced as a separate process to the IDF system.

Management were requested to provide further information to show the breakdown in volumes and type of flight (retrieval or flight nurse) for the remainder of the calendar year.

It was recommended

that this report be received

9. LATE ITEMS

There were no late items.

10. DATE OF NEXT MEETING

10 June 2014

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)

6.11

Ambulatory Care Facility Review Report	Subject of commercial negotiations and negotiations with third parties	9(2)(j)
2014/15 Annual Planning	Under negotiation	9(2)(j)