MidCentral District Health Board

Minutes of the Quality & Excellence Advisory Committee meeting held on 25 July 2017 commencing at 9am in the Boardroom, MidCentral District Health Board

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PRESENT

Diane Anderson (Chair)
Karen Naylor (Deputy Chair)
Dot McKinnon (ex officio)
Barbara Robson
Dennis Emery
Cynric Temple-Camp

IN ATTENDANCE

Kathryn Cook, Chief Executive
Carolyn Donaldson, Committee Secretary
Craig Johnston, General Manager, Strategy, Planning & Performance
Gabrielle Scott, Executive Director, Allied Health
Kenneth Clark, Chief Medical Officer
Michele Coghlan, Acting Executive Director, Nursing & Midwifery
Neil Wanden, General Manager, Finance & Corporate Services
Stephanie Turner, General Manager, Maori & Pacific
Greig Russell, Principal Advisor to CEO
Lyn Horgan, Operations Director, Hospital Services
Chris Nolan, Service Director, Mental Health Services
Susan Murphy, Acting Director, Patient Safety & Clinical Effectiveness
Cushla Lucas, Service manager, Regional Cancer Treatment Service (part meeting)
Nicola Pereira, Paediatrician (part meeting)
Barry Keane, Nurse Director, Acting Mental Health
Wayne Blissett, Director, Maori Strategy, Support & Operations (part meeting)
Steve Tanner, Finance Manager, (part meeting)
Dennis Geddis, Communications Team Leader
Janice Wilson, Chief Executive Officer, Health Quality & Safety Commission (part meeting)
Richard Hamblin, Director of intelligence, Health Quality & Safety Commission (part meeting)

OTHER

Public (2)
Media: (1)

1 APOLOGIES

Apologies were received from Oriana Paewai and Michael Feyen.

2 LATE ITEMS

There were no late items.

3 CONFLICT AND/OR REGISTER OF INTERESTS UPDATE

3.1 Amendment 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

Karen Naylor declared a conflict with item 12, part 2, in terms of her role in Women's Health Service.

4 CLINICAL GOVERNANCE AND CONSUMER

4.1 Clinical Governance Framework Development

The importance of the Cognitive Institute's programme as the lead in the development of this framework and the appointment of the General Manager, Quality & Innovation were emphasized. A member expressed disappointment at the delay in getting this framework developed. The Chief Medical Officer noted the organisation currently had a clinical governance framework, but it did need improvement. The CEO noted that part of the new approach was to ensure there was a district-wide approach to clinical governance. Given the framework was refreshing a current one and improving it to be district-wide, the recommendation was amended.

It was recommended:

> *that the new timeframe of early 2018 for the commencement of the development of a refreshed district-wide Clinical Governance Framework be noted.*

4.2 Diabetes Specialist Service Configuration Project Recommendations

The Acting Executive Director, Nursing and Midwifery and Dr Nicola Pereira spoke to this report.

Diabetes has been increasing year on year. The paper reported there had been good investment in primary care, but investment in hospital based diabetes service capacity had reduced and was not keeping pace with the increase in demand. Dr Pereira covered the main issues raised by the project relating to people with diabetes in our region, eg access to insulin pumps by adults, an increasing rate of admissions,

average length of hospital stay, percentage of bed days, a pattern of declining practice standards, and capacity and service access issues. She went over the recommendations put forward by the project team.

The timeframe for implementation and whether or not additional resourcing was included in this year's budget was raised. Management advised an implementation plan would be developed. No additional resourcing had been budgeted. However poor care for patients translated into expensive care. If an investment was made in this service there should be a saving in patient care, eg shorter length of stay for patients, so the investment would pay for the improved service.

The lack of reference to Maori/Pacific and alternate families was raised. Dr Pereira advised the project team worked with an 'equity lens" so whilst no specific reference was made to Maori/Pacific people, they had been considered, especially given their high incidence for diabetes.

A member asked that in future when any declining practices or issues are identified, they must report to this Committee as soon as possible. The member was referring to the declining standards over the past eight years as noted in the diabetes report. There was also concern raised at the clinical risk to patients caused by the delays (up to two months) in clinical letters being received by their GPs from specialist services. This was seen as being a wider MCH issue than just the Diabetes Specialist Service.

The concept of integrating primary and secondary services was supported, but some concern was expressed in terms of capacity within primary care, their capability, skill, and resourcing to manage the extra demand. The CEO noted the project was about transforming the service and the way care was delivered, rather than just moving the service from secondary to primary.

Karen Naylor thought the recommendation was passive and suggested it be amended to: *that the committee supports the implementation of the recommendations* rather than just noting the recommendations.

The Chair said it was good to note the implementation plan was being developed. She imagined it would contain costs, timeframe, targets and measures and that it would be reported through to the committee. On that understanding, she supported the amended motion.

It was recommended that

> *The Committee support the implementation of the recommendations contained in the MidCentral Health Diabetes Specialist Services Configuration Project.* (Moved K Naylor/ Seconded B Robson).

5 PERFORMANCE REPORTING

5.1 Operational Report

The Operations Director Hospital Services presented this report.

Interviews for the positions of Acting Clinical Director, Medical Services and also Mental Health have been held and appointments should be made shortly. Advertising for the position of acting Clinical Director Surgical Services should occur shortly. These positions were "acting" for 6-12 months, as the cluster model was developed.

Consultation on the Horowhenua STAR 4 project has been extended slightly so the union partners have time to consider the proposal. It will probably be towards the end of August before it closes.

The CT work continues as planned. The building work has produced some minor issues as expected but they have been well managed. The Radiation Oncology National Plan 2017-2021 has been released by the Ministry of Health and is the second plan in this series. It looks at a number of indicators for meeting radiation oncology in NZ.

The plan to address arrears in Child & Adolescent Oral Health was progressing slowly, with a 4.8 per cent decrease since the December quarter. A member asked if management could advise how many bariatric patients there were per year at some stage. Clarification was also sought on how flexi beds operated. Management advised is a seasonal plan to adjust bed numbers during lower patient occupancy, eg during summer, with five beds being closed in Wards 25 and 26 and also STAR 2 during this time. However, there are physical non resourced beds in the hospital, which are used from time to time as flexi beds. A clinical decision was made to open these beds depending on demand and availability of bureau staff.

A member asked how people under 50 who had symptoms that could suggest bowel cancer were managed, and whether those referral were accepted. The Chief Medical Officer advised clinicians made decisions regarding care based on clinical need.

Dennis Emery asked if he could be connected to Te Hononga (Maori Cancer Advisory Group to the Local Cancer Network). The Service Manager, RCTS said she would arrange this. He also advised he was working with the programme Indigenous Spark, and wondered if he could meet with someone from Puhoro. He was informed by the General Manager, Maori & Pacific that Pae Ora was very involved with Puhoro. Pae Ora had just taken on regional responsibility to increase access to Puhoro and would connect him with leadership in the Puhoro Science Academy.

Management confirmed the Variance Response Management programme was in place across all clinical areas. The analysis of the data particularly from clinical settings will form part of the Local Data Council analysis of work that will be done at a local level. It will also be part of the work programme that will look hospital wide at the processes. Management also confirmed action was taken on VRM data. When warranted, action was escalated to the Duty Manager on Call. There were a number of protocols put in place to respond to changes in the VRM data. Management also advised MDHB's rating was around the middle in terms of the Safe Staffing Health Workplace Unit CCDM Standards.

The Committee was advised MDHB had hosted SSHW representatives at a workshop the previous week to specifically move MDHB towards the FTE calculations. It was hoped the calculations could be run across the nine inpatient areas in September. As

a result of this discussion, Management agreed to provide more information via a presentation on the programme in the near future so members understood the work and timeframes etc and how it was progressing.

A member commented on what he felt worked well in the organisation, eg projects that were led by SMOs with strong personalities. However, the Chief Medical Officer felt there was a weakness in investing in individual leadership to improve systems without considering how systems worked. Strong clinicians needed to enable other clinicians to do the work also, as an individual could not do it every day alone. Pressure points on hospital services currently were the volume and total patient flow through the organisation and the resulting demand on staff.

Advice has been received in relation to the Certification Audit, with another three years certification being awarded.

The Nurse Director, Mental Health reported on the recent older adult mental health project steering group benchmarking trip to Hawke's Bay DHB. He said there had been some good learnings from the visit, eg around specialist services, how referrals were managed, the relationship with mental health, and what was needed in order to have a strong out-reach service. He also noted that although Hawke's Bay identified as not having any inpatient beds, they did use some acute beds. The next workshop for this project was later today to continue the mapping process.

The Service Director, Mental Health & Addictions Service spoke to the mental health dashboard. The key pressure areas he highlighted were the increase in referrals in Horowhenua, demand on Ward 21, and the need to do the redevelopment. He advised a successful hui had been held, saying that working with those partners had an impact on managing services. The KPI 19 Post-discharge community care measure was discussed. The Service Director said the results were being monitored closely. The graphs showed the trends, which were analysed. The next report would provide a fuller narrative around the trends.

It was recommended:

that this report be noted.

At this point, the order paper was rearranged to receive the presentation from the Health Quality & Safety Commission.

8 INTEGRATION

8.1 Health Quality & Safety Commission report and presentation

Janice Wilson and Richard Hamblin joined the meeting to present the report.

Dr Wilson provided an overview of the Commission which was now in its 7th year. It was formed to have an overview of quality and safety in the health sector, and to work with the providers of the sector on quality improvement initiatives. The Commission had developed into two main hubs: a learning and improvement group, and an intelligence hub. There were four mortality review committees, and a 5th one was being announced later today.

Richard Hamblin outlined the development of the quality dashboard, which has around 150 measurements of health quality. They started putting together the quality and safety markers, and the patient experience survey and organised things into a better framework. The next version of the dashboard should be available to DHBs around February 2018. The aim then would be to update it every quarter. The long term aim was to make it publicly available from the website.

Mr Hamblin said help was required in respect of needing:

- Members from the community who were interested in this work
- People willing to review and comment
- Suggestions on how to link with local data, and how best to use it
- Knowing what support would be needed to make this work.

Issues covered in the general discussion included how various available information was best used, (eg the Commission's reports, Health Round Table reports, MDHB's own local data), the inclusion of ethnic data (Maori/Pacific in particular), and that the information must make sense to the public and the media. The website must be easy to negotiate.

It was recommended

that the Health Quality and Safety Commission report and presentation be noted.

6 MINUTES

It was recommended that

the minutes of the previous meeting held on 13 June 2017 be confirmed as a true and correct record.

6.1 Recommendations to Board

It was noted that the Board approved all recommendations contained in the minutes.

6.2 Matters Arising from the Minutes

A member referred to the CPHO presentation at the last meeting and *Manage My Health* which enables one to have electronic contact with their general practice team. After discussing this with his own GP the member had signed up to *Manage My Health* and encouraged his whanau to sign up. This service has a strong link to locality planning, particularly in relation to the new ways that general practice teams are meeting the needs of individuals and whanau.

7 COMMITTEE'S WORK PROGRAMME

Barbara Robson asked for the work programme to be updated to include a visit to Ward 21. She noted the request had been made previously when management had

advised this would occur during annual planning. However she asked it be added to the programme so it wasn't overlooked.

The Committee was asked for suggestions on how best to organise this and also the visit to the maternity ward area. It was agreed this should be arranged for the September board meeting day, and that committee members would be included in the arrangements.

The CEO also advised that the work programme should be from her.

It was recommended:

that progress against the 2017/18 work programme for 2017/18 be noted.

5.2 Ward 21 upgrade 'update' report for May 2017

The General Manager Finance & Corporate Support presented this report.

He said Destravis has been on site refreshing the Master Health Plan. This had a very long view to it. Ward 21's facility requirements were one of the significant issues involved in this planning. There were several options generated for Ward 21 at a conceptual level.

The next piece of work would bring together the thinking around a high level strategy, which would be refined into options. There would be some significant work required to refine the options in order to discuss their merits. Then they would be costed. The strategic business case would be presented to the Committee in September.

It was recommended

that the update on Ward 21 be noted.

9 LATE ITEMS

There were no late items.

10 DATE OF NEXT MEETING

5 September 2017

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 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 & Addictions Service Acute Care Continuum Development Plan	To protect personal privacy	9(2)(a)

Appreciation

The Chair noted that at the end of part 2 of the last meeting, a presentation had been made to a member of a Healthy Communities Advisory Committee whose term on the committee was finished. Unfortunately Duncan Scott's retirement was not also acknowledged. The Chair advised she and the CEO would visit Duncan and thank him for his contribution and time spent with this Committee.

Members agreed this action should be noted in the public section of the meeting as well.