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MidCentral District Health Board

Minutes of the Hospital Advisory Committee meeting held on 3 February 2009 commencing at 8.30 am in the Boardroom, MidCentral District Health Board

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Jack Drummond (chair)
Lindsay Burnell
Ann Chapman
Jim Jefferies
Richard Orzecki
Stephen Paewai
Barbara Robson
Kerry Simpson
Cynric Temple-Camp
Ian Wilson

In attendance
Murray Georgel, CEO
Lareen Cooper, General Manager, MidCentral Health
Stuart Wilson, General Manager Corporate Services
Carolyn Donaldson, Committee Secretary

Diane Anderson, Board Member (part meeting)
Graeme Campbell, Board Member (part meeting)
Ormond Stock, Board Member (part meeting)
Dr Kenneth Clark, Medical Director (part meeting)
Nicholas Glubb, Group Manager, Child, Women, and Mental Health Services
Brett Sheehan, Group Manager, Surgical Services
Lyn Horgan, Group Manager, Medical Services
Jeff Small, Group Manager Commercial Support Services (part meeting)
Penny O'Leary, Group Manager, RCTS, BreastScreening Coast to Coast, Clinical Services
Muriel Hanratty, Group Manager, ATR & Community Services
Simon Floris, Planning & Performance Unit
Shirley-Anne Gardiner, Operations Manager
Robyn Shaw, Manager Elective Services (part meeting)
Vivienne Ayres, Planning & Performance Unit (part meeting)
Ian Ironside, Portfolio Manager Secondary Care, Funding Division (part meeting)
Brad Grimmer, Senior Portfolio Manager Health of Older Persons, Funding Division
Chris Simpson, Service Leader (part meeting)
Communications Unit (1)
Media (1)

Opening

In opening the meeting, the Chair referred to recent media publicity quoting his comment "bugger the budget" and said that whilst that applied in some instances, the opposite was that the "cake was finite" and that to give priority to some things at a cost may result in curtailment of other services. He asked the clarification of his view be included for completeness.

1. APOLOGIES

There were no apologies.

2. LATE ITEMS

There were no late items.

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3. CONFLICT AND/OR REGISTER OF INTERESTS

3.1. Amendments to the Register of Interests

There were no amendments.

3.2. Declaration of conflicts in relation to today's business

Jim Jefferies declared his conflict it item 6.7, Elective Services throughput and impact of ESPI non-compliance, due to his involvement with Aorangi Hospital Limited.

4. MINUTES

4.1. Minutes

It was recommended:

> *that the minutes of the meeting held 2 December 2008 be confirmed as a true and correct record.*

4.2. Recommendations to Board

The Committee noted that the Board approved all recommendations contained in the minutes.

5. MATTERS ARISING FROM THE MINUTES

There were no matters arising.

6. STRATEGIC/SPECIAL ISSUES

6.1. Palmerston North Hospital Site Redevelopment update

It was noted that the site redevelopment planning had been rescheduled due to financial constraints.

Some concern that the rescheduling might compromise future development was expressed, but management reassured members that there was no intention to deviate from the Clinical Service Plan. The Clinical Service Plan would provide clinical and patient flow benefits but not financial benefits.

Members discussed a number of issues currently facing management in respect to the financial situation, including the capital expenditure process, the risk of doing an inadequate job if the original timelines were kept, the financial impact of delaying the redevelopment and the choices to be made in order to keep within the financial boundaries.

It was recommended that

> *this report be received.*

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6.2. Regional Women & Child Health Services update

Management advised that they would be reporting back to both Whanganui and MidCentral DHBs with a recommendation on how the costs of this initiative should be allocated.

It was recommended that

this report be received.

6.3. InterRAI business case update

Management advised that the process for implementation of InterRAI is being strongly prescribed by the Ministry, so that a consistent approach is achieved locally, regionally and nationally. At an individual DHB level, it is difficult to identify what the direct costs will be as some common issues will be addressed regionally and therefore costed on a pro rated basis.

Management also advised that since writing the paper, the Ministry has advised the project would comprise only two of the basic modules. The model that has been dropped is the community health assessment module. The indicative MOH funding contribution to each DHB has not been reduced. There is a strong degree of support amongst the central DHBs to move on this project.

Members commented that although it was good to have a national approach, correct intervention was still essential eg a 90 year old person would probably prefer to be showered in the middle of the day when it was warmer, rather than early in the morning at a time to suit a computer schedule.

It was recommended that

this report be received for information.

6.4. Ministry of Health feedback on DHB performance: Assessment of 2007/08 fourth quarter and annual performance

It was recommended that

this report be received.

6.5. DHB Hospital Benchmark Information Report, July-September 2008

Members discussed the various factors influencing the average length of stay statistic, noting one of the key reasons for wanting to keep length of stay to a minimum was to free up beds. It was noted that the Minister had just released a paper seeking submissions on an initiative to reduce waiting times in emergency departments to six hours. Members also briefly discussed triage times, the measurement criteria and whether the results were comparable.

The CEO responded to the discussion, reminding members that this was a benchmarking report. It was largely raw data, but provided an opportunity for similar sized DHBs to compare results. However, the results should not be considered in isolation.

It was recommended that

this report be received.

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6.6. Elective Services update

The orthopaedic initiative volume for the year was 433 joints, which equated to nine per week. MidCentral Health is not achieving this goal and is behind by 94 procedures at the end of the second quarter. The steps being taken to achieve the contract volumes were outlined and included out sourcing work to the private sector. The private providers were progressing well in achieving the volumes approved for out sourcing so far, and had indicated they had further capacity. If work continued at the same rate and if the private providers could double their volume, then between 250-300 joints could be done by the end of the financial year.

There was some discussion in relation to whether neighbouring DHBs had capacity to assist. Management advised that surgeons and the NZ Orthopaedic Association resisted the movement of patients between DHBs as they felt it clinically inappropriate to so manage patients whose long term care would need to be provided close to home.

Further discussion covered issues like forward planning and the danger of focussing heavily on compliance for elective services at the cost of other service provision.

It was recommended that

this report be received.

6.7. Elective Services throughput and impact of ESPI non-compliance

Jim Jefferies had declared his interest in this topic, and refrained from taking part in the discussion.

Management advised a careful monitoring process was in place to ensure all information was collected in relation to elective service work.

Following the increase in elective targets late in the budget process, a decision was made to utilise all capacity available to deliver elective services and thereby gain access to the elective funding. Additional work was outsourced to private providers to support MCH. It was noted there were a number of scenarios when determining the value of work.

The risks of not achieving compliance were discussed, including spending funding on additional out sourcing work to achieve only the base volumes, which would mean the cost was incurred without additional revenue.

The Ministry had written advising of the suspension of access to funding for the additional elective work due to non compliance. The CEO outlined the response from Management, which asked for tolerance from the Ministry because of the confusion over the interpretation of the rules. MCH had been recording information and forwarding it to the Ministry who accepted it, for some time. A change in senior staff at the Ministry resulted in them advising MCH that MCH had been incorrectly recording information. Whilst changes had been made, they were unable to be done quickly enough.

Management also commented that the amount of elective work available this year had increased, and whilst it might not be possible to do it all, other services had been delivered which were unfunded.

Other comments included reference to the ability to manage and plan for capacity to meet demand; roll out of the "lean thinking" concept via the "optimising the patient's journey" programme; acute medical demand; spot contracting some elective surgery; amount of

elective volumes purchased by MCH; and a suggestion that a "free thinking" opportunity/ workshop be arranged sometime to explore ideas and innovative thinking.

It was recommended that

this report be received.

6.8. Radiation Therapy Wait Times

Currently there were 202 patients in total waiting for radiation therapy. Eighteen had been waiting longer than six weeks, which is the health target. Planning had been put in place following the December meeting and Management were confident the new accelerator would be fully functioning by now. However that had not happened.

Members were updated on the background and progress to commissioning the new linear accelerator (LA4).

At the time of purchase the software was not differentiated into network or stand-alone. MCH believed they were purchasing networked software – the supplier suggested that MCH buy a fully integrated network system that was clinically acceptable. There was never mention of stand-alone software in the purchase agreement.

The networked software had not been officially released to other Artiste owners. The Radiation Therapy Department (Medical Head and Treatment Supervisor) believed that network bugs and all, the software was more acceptable than the stand-alone system as it was clinically safer and was the platform for moving forward.

Networked software was logistically frustrating but not clinically frustrating nor unsafe. Using the stand-alone was equivalent to using a PC. That is, if the system failed, the PC would automatically turn off.

Management were informed that Melbourne would not have the same capacity over Christmas, due to limited accommodation. Arrangements were made to use the Waikato facility for 12 weeks, but this on its own would not achieve compliance with the targets.

It was not known yet, whether all the strategies that had been put in place would be sufficient to meet the targets. This would be clearer once the new machine was functioning fully. There were a lot of variables, and the situation was being continually monitored. Out-sourced services would continue to be offered to patients, and "at risk" patients were receiving immediate care. Management's best guess for getting back on target was between two and three months.

It was recommended that

i) That outsourced services are utilised to supplement Radiation Oncology's capacity to meet demand thus reducing waiting times, and that this is funded through identified savings across MidCentral Health.

ii) Wait times together with the management strategies are reported monthly to the Hospital Advisory Committee, and that

iii) This report be received.

6.9. Financial Action Plan

It was recommended that

this paper be received.

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7. OPERATIONS REPORT

The General Manager, MidCentral Health, presented her report.

In speaking to her report, the General Manager referred to the over production against contracted patient caseweight volumes, advising that choices would have to be made in order to bring production back to contracted volumes.

The Medical Director advised that despite recent media publicity, MidCentral Health was in the best "health" he had seen for a number of years. The quality of care and morale of staff was consistently better than it had been for the last five years. The organisation was incredibly complex and although clinician involvement was required to make difficult decisions, he was concerned about the impact of those decisions in terms of the organisation. What to do to avoid weakening the organisation was being considered, as the ripple effect of any change on another part of the organisation was huge.

It was recommended

> that this paper be received

8. GOVERNANCE ISSUES

8.1. Work Plan for 2008/09

A member requested that the workplan be amended to include an update in the operating report on the recent Civil Aviation Authority and single engine helicopter pad issue.

It was recommended

> that the updated work programme for 2008/09 be noted.

9. LATE ITEMS

There were no late items.

10. DATE OF NEXT MEETING

3 March 2009

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 – : Sentinel Events update : MECA accruals	 To protect personal privacy Subject to negotiation	 9(2)(a) 9(2)(j)
Radiation Therapy Wait Times	Commercially sensitive information	9(2)(j)
Financial Action Plan	Subject to negotiation	9(2)(j)