**MidCentral District Health Board**

**Minutes of the Hospital Advisory Committee meeting held on 7 September 2010 commencing at 8.30 am in the Boardroom, MidCentral District Health Board**

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**PRESENT**

Lindsay Burnell (chair)
Jim Jefferies
Stephen Paewai
Barbara Robson
David Warburton
Phil Sunderland
Ann Chapman
Cynric Temple-Camp
Richard Orzecki
Kerry Simpson

**In attendance**
Murray Georgel, CEO
Mike Grant, Acting General Manager, Corporate Services
Carolyn Donaldson, Committee Secretary

Diane Anderson, Board Member
Nicholas Glubb, Operations Director, Specialist Community & Regional Services
Muriel Hanratty, Director, Patient Safety & Clinical Effectiveness
Lyn Horgan, Director, Hospital Services
Sue Wood, Director of Nursing
Chris Channing, Manager, Planning & Performance Unit
Maggie Oulaghan, Business Manager (part meeting)
Ian Ironside, Funding Division (part meeting)
Dr Bart Baker, Clinical Director, Regional Cancer Treatment Service (part meeting)
Dr Nik Nedev, Medical Head, Radiation Oncology (part meeting)
Cushla Lucas, Service manager, Radiation Oncology (part meeting)
Communications (1)
Media (1)
Staff and public (10) – part meeting

## 1. APOLOGIES

Apologies were received from Jack Drummond.

## 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.

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

There were no conflicts of interest.

5·10

*Rearrangement of Order Paper*

The Chair advised two people had been granted permission to speak to the Committee in relation to the Diabetes Service Review paper (item 7.3). He proposed the speakers should be heard prior to item 6, and that item 7.3 be moved up the order paper to follow item 6. This action was agreed to by members.

## 4. MINUTES

### 4.1. Minutes

It was recommended

> *that the minutes of the meeting held on 3 August 2010 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

### 5.1. Industrial Action

An update on industrial action being taken by the Medical Radiation Technologists was requested. Management advised the industrial action had commenced this morning. From the point of view of service delivery, all planned activity, clinical procedures etc that relied on radiology backup had been postponed and where appropriate substitutions had been made. There was a small number of non-union staff available to support acute and urgent care, and backup arrangements had been made with Broadway Radiology along with appropriate systems and processes.

**PUBLIC SPEAKERS**

Kathy Scott (Secretary of Diabetes NZ Manawatu) and Professor Nan Kinross spoke to the meeting. The following points were noted:

*Kathy Scott*

: Concerned at services being trimmed
: There never was any duplication of services
: Diabetes is increasing so fail to see how cutting services will reduce costs
: Reducing staff will impact on service provision
: Need to prevent problems like kidney failure, strokes, amputations etc
: What services will not be delivered as a result of staff reduction
: If there is no duplication of services, why should there be a reduction in staff?

*Nan Kinross*

: Question of partnership and self management
: Diabetics must learn how to self-manage very successfully
: Challenge the skills in relation to those in the community from a community based practitioner point of view
: The MCH Diabetes Lifestyle Centre should offer training courses in the community

: The partnership between those who have diabetes and those who advise them should be highly developed. This has not yet happened in the community. It should so that diabetics could successfully self-manage their diabetes.
: The rural communities need rural solutions.
: Seamless integration of services – this is only possible if all health professionals have a mutually agreed goal.
: Recommendation for some means of measuring the effects over the next few years of any reduction made, and also whether or not the skills of people working in the community could be improved.

The Chair invited anyone else in the audience to speak if they so desired.

*Rosemairi Knowles, Dietitian*
: When the PHO started, strict guidelines were put in place to ensure the Diabetes Lifestyle Centre did complex patients and the PHO managed the less complex patients.
: Report does not mention how a seamless service would work.
: If staff numbers are reduced, how could MCH support the PHO and also provide training.

No clarification questions were asked by the Committee.

## 6. OPERATIONS REPORT

### 6.1. Total personnel and outsourced personnel costs

Noted that the last part of the second sentence under this heading should read "....from staff **salary** increases in the year."

Management clarified what was meant by the statement "the below budget cost had provided an opportunity to cover unbudgeted leave accrual costs", advising that although provision was made for all leave costs on the balance sheet, any future salary changes would increase that liability. Therefore a provision had been made this year to cover additional leave accrual costs resulting from salary changes.

Phil Sunderland advised he had recently received a letter from the Minister congratulating us on the improvement in most of the health targets areas, but particularly the shorter waits for cancer treatment target. However the Minister still wanted us to meet planned elective service levels and other health targets like shorter stays in emergency departments.

### 6.2. Recovery Programme

Management clarified the "actual and identified savings" term, advising it meant savings had been identified and made, as well as savings had been identified but not yet achieved.

Management also clarified that the $3.5m savings from the financial service reviews (actual and identified) was for this year and was built into budgets, and it represented savings made so far towards the $6m required to be made for this year. In addition to the review savings there were also reduced costs arising from renegotiated contracts.

### 6.3. Emergency Department

The resignation of the Clinical Director, Emergency Department (ED) was noted. Management assured members that the department would continue its work and was committed to achieving the health targets. ED had responsibility for its own patients, but the Medical Heads and Clinical Directors of other services had responsibility for their own patients. Achieving the targets was an

organisational responsibility. Management advised the six-monthly update for hospital services was due in November, and this could include information on the split between ED's responsibility compared to other services.

### 6.4. Emergency Assistance to Christchurch following recent earthquakes

Management advised that no request had been made for assistance yet, only a request to consider what help could be provided, possibility in health protection services.

### 6.5. Radiation Oncology

A member referred to the proposal later in the order paper regarding replacing the oldest linear accelerator, and said the clinical justification for such a decision had not been clear to date. The member felt the Committee should know what clinical gains would be achieved and the number of people that would benefit from those gains, given the financial cost involved in replacing the machine and the Minister's directive to shorten wait times. The CEO clarified that the proposal to replace the linac was not entirely driven by the wait time change to four weeks, but was also related to the age of the machine. The CEO recalled the RCTS Medical Head had informed the Committee that the four week wait time was not necessarily determined on any clinical benefit.

It was recommended

*that this paper be received*

## 7. STRATEGIC / SPECIAL ISSUES

### 7.3 Diabetes Service Review – Proposed Service Reconfiguration

There was a full discussion on this review. The following points were noted:

- The 1.0 FTE nursing position was originally funded by a service level agreement, to provide backfill cover for training diabetes nurses in primary health. That contract had now ceased and there was no revenue to cover the position. In future, as new nurses in primary were employed, some of their training would be provided by primary health.
- Management advised over-production would be managed either by referring appropriate patients back to the primary provider or by adjusting volumes via the price/volume schedule negotiations. The additional medical FTE would see the FSA patients, but the appointee would also be working in General Medicine and would prioritise in-patient referrals as appropriate.
- Was sufficient being done for diabetes prevention and treatment in the wider public sector, particularly in relation to helping people self manage their diabetes.
- There needed to be closer integration of primary and secondary services.
- There was no clinical impact analysis of removing the 1.0 FTE nursing component. Management advised work had been done around volumes and capacity of nurses. The assessment was made that with this reduction there would be no change to contracted volumes. The non-funded work would have to be realigned.
- Diabetes was one of the Board's ten priorities for the organisation. The Board had made a significant investment in both primary and secondary diabetic services, but there might be an opportunity to further integrate primary and secondary services.
- In response to a request, the Acting General Manager Corporate Services gave a brief update on primary healthcare chronic health care status.
- A suggestion was made that through the Board, the CPHAC could be asked to identify and report on issues in relation to the community/secondary interface and the ability to fund further development outside the current strict contractual responsibilities. This could be done via an amendment to the proposal recommendation.

- It was suggested that the recommendation be amended, and that the Hospital Advisory Committee recommend to the Board a review of the wider investment in diabetic care in the region with particular consideration to integrating primary and secondary care.
- The option of delaying the decision was considered but not supported.
- A suggestion was made that the post audit review be done sooner than 2011 to see how the education and self-management aspects were coping. Mike Grant advised it was the responsibility of the PHOs to ensure that their diabetic nurses and other nurses were receiving the necessary support and development to meet their proficiency levels. The secondary service commitment had come to its natural conclusion. If there was further education required, it was the PHOs' responsibility to make that investment.

The following amended recommendation was put to the meeting:

It was recommended that:

- *MidCentral Health align its Diabetes Service outpatient volumes to contract level*
- *recognising the non-continuation of the service level agreement, the nursing levels be reduced by 1.0 FTE*
- *administration levels be reduced by 0.50 FTE*
- *the reconfiguration of the Diabetes Service provide financial benefits of no less than $100,000*
- *a review be undertaken of the wider investment in diabetic care in the region with particular consideration to integration of primary and secondary care*
- *a post event audit review of the Diabetes Service reconfiguration be conducted by August 2011.*

Barbara Robson voted against the recommendation. Ms Robson said she would like to know what was included and excluded in the post event audit as it should not be too narrow – there were impacts other than financial savings that should be audited.

The public and visiting Diabetes Lifestyle Centre and associated staff left the meeting, which then briefly adjourned.

## 7.1. Hospital Benchmarking Information report

It was recommended that:

*this report be received*

## 7.2. Non financial performance indicators (copy for information only)

The ambulatory sensitive (avoidable) hospital admission results were noted, and it was agreed that if this trend held, then some analysis should be undertaken to see if there was an explanation.

It was recommended that:

*this report be received*

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### 7.4. Permanent Fourth Linac – Radiation Oncology

The paper on a permanent fourth linear accelerator for Radiation Oncology was discussed and the following points were noted:

- If MDHB wanted to provide tertiary regional services, then planning for the replacement of the oldest linac machine must be done
- The RCTS provided a positive contribution to the organisation.
- Prices for treatment were determined nationally. Revenue received from other DHBs was based on volumes of two years ago with a small adjustment for volume increases. However, there was an issue with this pricing methodology.
- The old machine was fully depreciated, so the replacement would result in an increase in costs.
- Buying another machine would be an investment to provide capacity for the future.
- MCH needed to create a surplus to fund future investment.
- While it would be useful to look at what MDHB's long term strategy was for regional cancer services, there appeared to be little option but to proceed with this development.
- It would be helpful to have a clinical justification regarding the 4 – 6 weeks wait times.
- MCH was on target to achieve the 4 week wait time target in December 2010, and the various measures that had been put in place to achieve that target were included in the discussion paper.
- A request that the post event audit include the outcome of the efficiencies gained from the integration of the three machines.
- Management should look at pricing and funding options including partnerships and alliances, and the best way to fund the purchase. The government has stated any capital expenditure over $25m should be considered in terms of funding alliances.
- Income should be generated by the service as there was a need to replace machinery and equipment and there were also risks that should be covered.
- Whilst increasing the hours the machine was used was an option, this should not be done at the moment. There was competition for staff, and it would probably be better to consider this option once we had established a centre of excellence.
- Previous papers had considered the overall strategic development of the service and there was no doubt that MidCentral Health needed to maintain and develop a RCTS.

It was noted that the paper presented to the Committee was the first stage to discuss whether there was a need to replace the machine. The issues raised would be included in the business case that would be developed for presentation in March 2011.

It was recommended that:

*Radiation Oncology progresses to a project for the purchase of fourth permanent Linac sited on the first floor adjacent to LA1, with a full business case to be presented for consideration in March 2011.*

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## 8. GOVERNANCE ISSUES

### 8.4. 2010/11 Work Programme

*Earthquake – Christchurch*

A member asked how quickly MDHB would be able to mobilise if assistance was requested to help with the earthquake damage in Christchurch, and whether Management had considered this as part of the risk management processes. Management advised some work had just been commissioned with Ernst & Young in relation to the Business Continuity/IT Disaster Recovery, and that the report would be presented to the Group Audit Committee in due course.

It was recommended

> *that the Committee's 2010/11 work programme be noted.*

## 9. LATE ITEMS

There were no late items.

## 10. DATE OF NEXT MEETING

5 October 2010

## 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<br>: Potential Sentinel/Serious Events and Complaints | To protect personal privacy | 9(2)(a) |
| Permanent Fourth Linac – Radiation oncology | Financial contain commercially sensitive information | 9(s)(j) |