MidCentral District Health Board

Minutes of the Hospital Advisory Committee meeting held on 5 May 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
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)
Muriel Hanratty, Group Manager, ATR & Community Services
Nicholas Glubb, Group Manager, Child, Women, and Mental Health Services
Penny O'Leary, Group Manager, RCTS, BreastScreening Coast to Coast, Clinical Services
Lyn Horgan, Group Manager, Medical Services
Sue Wood, Director of Nursing
Brett Sheehan, Group Manager, Surgical Services
Jeff Small, Group Manager, Commercial Support Services (part meeting)
Robyn Shaw, Project Manager Elective Services (part meeting)
Shirley-Anne Gardiner, Operations Manager (part meeting)
Dr Kenneth Clark, Medical Director (part meeting)
Denise Holcroft (Project Manager, part meeting)
Maggie Oulaghan (Business Leader, part meeting)
Shane Ruwhiu, Maori Health Advisor Funding Division (part meeting)
Communications Unit (1)
Media (1)
Public (1)

1. APOLOGIES

An apology was received from Kerry Simpson.

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.

6.1)

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

There were no conflicts of interest in relation to today's business.

4. MINUTES

4.1. Minutes

It was recommended:

> *that the minutes of the meeting held 7 April 2009 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 from the minutes.

Stephen Paewai joined the meeting.

6. STRATEGIC/SPECIAL ISSUES

6.1. Child Adolescent and Family Services Reconfiguration and Service Development Project

The Committee was advised that staff were very understanding of the issues concerning the delay in refurbishing the facilities, and had managed the situation with "work around" initiatives. The arrival of new staff had also been phased in order to relieve the pressure for space.

The Group Manager, Mental Health Service, clarified the reference that the service had fallen short in a long standing historical issue on the first page of the report. Mr Glubb advised that the Blueprint framework was developed at a national level, and MidCentral Health like many other DHBs had fallen short of the targets. This project was to support that initiative through planned growth.

It was recommended that

> *this report be received.*

6.2. Radiation Therapy Treatment Capacity Update

The Committee was advised that the linear accelerator supplier would be visiting MidCentral Health on 6 May to apply the software upgrade. They were confident that would resolve many of the issues. Members were also advised a MCH senior radiation therapist had recently visited a Korean site. A very comprehensive report was provided from that visit, giving confidence that the upgrade would resolve the majority of our issues. The Korean site was chosen because of its similarity to MCH. MCH was the 8th site to get this upgrade. If it was unsuccessful, Management would continue to work with the supplier to resolve any issues. It was noted that the upgrades to LA 1 and 3 were still to be done.

Lindsay Burnell joined the meeting.

In response to a query regarding the number of treatments LA4 could process, Management explained that the 8500 treatments in the business case for LA4, were based on a 10 hour day. An 8 hour day would see 7500 treatments. MCH continues to investigate the 10 hour day, but obviously has to work with employees.

A member commented that the complexity of cases also impacted on the number of treatments able to be done. As a result, it would be very hard if not impossible, to achieve the target, particularly if the old 4th liner accelerator was retired. He wondered if it should be retained, and further that MCH might need the four machines in future given the complexity of cases. Management advised they would be reviewing usage of the machines shortly as planned, and would factor the complexity of cases into the review. Understanding what the commitments were going to be over the next 10 years for the machines given the demand, would be difficult to work out, but Management were encouraged to give it a try.

Mr Wilson said the strategic discussions and the possible necessity to lift capacity would be impacted by the long term capital planning and also regional discussions around clinical services. He suggested the regional discussions should be held fairly soon as the time for replacement of the next machine would come around quickly.

Diane Anderson joined the meeting.

The Chairman said that the complexity of cases would probably mean a wider field of treatment was required. He felt there was going to be an increase in the complexity of treatment compared to past cases.

It was recommended that

this paper be received.

6.3. Feasibility Study re Molecular and digital Mammography Progress

Digital Mammography

Ms Robson felt this situation was similar to the linear accelerator case, where there was little choice but to provide the service. However, she felt it would be good when considering the business case, if the benefits could be quantified where possible so it was clear how the revised service would look and what the actual benefits were.

The chairman clarified the PET scanning process for members.

Management advised a few patients had travelled each year to Melbourne for PET treatment over the last five or six years. It was also confirmed that MCH met the cost for any patients referred for this treatment.

It was recommended that

this report be received.

6.4. Public Health Update

Stephen Paewai apologised but due to his late arrival, he had not declared a possible conflict of interest with this item as his wife was the Chairperson of Te Kura Kaupapa Maori o

Tamaki nui a Rua and he was a relief teacher. It was agreed that Mr Paewai remain in the meeting and participate in the general discussion as no decisions were to be made.

The low number of schools taking up the Health Promoting Schools Programme was noted, as was the demand and expectations on schools to participate in various activities. Management agreed stating the Public Health Service were trying to ensure things were done in a coordinated way as they appreciated the huge demand made of schools.

Richard Orzecki said he was on the Board of the NZ School Boards Association and also the Maori Board of Trustees. His comment was slightly different in that he wondered if the low response was due more to the large number of programmes available to schools, so they were selective in their choices.

Management advised there was some broader work being lead by the Funding Division around a district wide health promotion plan trying to bring some of these initiatives together.

It was recommended that

this report be received.

6.5. Determine Future Service Configuration to Ensure Clinical and Financial Sustainability of ATR Therapy Services and Dermatology

Ms Robson said she was not able to match up the available bed days as provided in the report with the price volume schedule in the current year or with the information in the monthly operations report. Management advised more beds had been occupied or utilised than funded for in the price volume schedule, which was why the figures did not match. More detail explaining how that worked would be provided in the next report to the Committee.

Mr Wilson sought reassurance that MidCentral were fully paid for services delivered via the Inter District Funding process and was it appropriate that MCH cared for patients from other DHBs. Whilst the number of psychogeriatric patients that MCH treated from neighbouring DHBs was not great, the level of expertise required to treat them was high. MCH felt it was worthwhile providing that service and supporting the other DHBs. Also, the continuing care facility for psychogeriatric patients was in our region, funded through the Funding Division, so if a person with high level complex needs from another DHB was placed in that facility it was highly likely MCH would be familiar with their needs. Once a person is placed in that facility regardless of their original DHB of domicile they will be admitted to MCH if requiring hospital care.

The difference in waiting times for ElderHealth and Rehab outpatient clinics was clarified for members. Management explained it was due to the difference in the size of the two services and therefore the number of Senior Medical Officers available. The Specialist Rehab service had only one full time and one part time senior medical officer. Patients also took longer in terms of initial and follow-up assessments, so it was a capacity issue. Patients could be seen urgently if there was that need.

Stephen Paewai noted that whilst most DHBs were investing in primary care strategies and chronic disease, much of that work focused on the disease state rather than a combination of disease states and the aging process and/or disability. He said he would like to think MCH considered both.

It was recommended that

this report be received.

6.6. Alignment of Service Needs and Development contained in the Clinical Service Plan with Revenue and costs

The Committee were advised that the Ministry were unable to provide further funding to the Regional Women's and Child Health Service initiative. This would be further discussed by both boards later this month. It was MCH's intention to spend the remaining seed funding and progress the initiative.

The Ministry had contributed $250,000. A further $175,000 was required from MidCentral District Health Board. It was noted the Whanganui DHB had approved funding only for this year, not beyond. This would be an issue to be discussed further at the centralAlliance sub-committee meetings.

The CEO advised that MDHB had supported this project knowing that the two boards would have to fund it. Members briefly discussed funding for new projects, noting it had not always been obvious over the years. However, in the current economic climate, care had to be taken to ensure only worthwhile achievable projects were pursued. In this instance, the Minister was taking a direct interest in how the two boards collaborated, and there was an expectation that this project would continue. The project had not been contingent on getting Ministry funding and the two boards now had to resolve the funding issue.

It was confirmed that the 22 beds in the project did not take into account the new beds being commissioned for surgical services.

The issue of acute and elective beds was raised, noting that the hospital had an obligation to take all acute patients who arrived. It was felt the level of acute beds was insufficient by 22 beds, and would not be resolved easily particularly given that people were now living longer than previously. The primary health strategies may slow down the rate of electives in a few years time, but they would not reduce them. Management advised they were working on strategies to manage the issues, eg a team was going to Christchurch to discuss and share ideas on 6 May. This visit would test MCH's assessments and provide the benefit of discussing and sharing ideas.

Management advised the Acute Medical Assessment Unit (AMAU) was progressing to plan. The General Medical Reconfiguration paper due next month would have information in it relating to the AMAU and update members on progress.

The General Manager, MidCentral Health said the discussion highlighted that both the regional initiative and the assessment unit were necessary projects that would come to fruition this year.

It was recommended that

this report be received.

6.7. Quarterly Elective Services Update

Lindsay Burnell left the meeting.

It was confirmed that the Elective Services Patient Flow Indicators (ESPIs) were compliant and funding would be resumed for the elective initiative specialties. Access to $1.4m ($350k x 4 months) of the total elective initiative funding for the year had been removed due to non-compliance with ESPIs.

Lindsay Burnell returned to the meeting.

Management confirmed the usual quarterly reporting on elective services would continue into the New Year, as the ESPIs had not changed. There would also be reporting against the Elective Service Plan. Measures were being developed for surgery as a result of the new plan, and the Committee were invited to put forward what they would like included in the reporting.

The style of reports presented to the Committee was raised, and Management were asked if the key information/measures/risk could be summarised at the front of the various reports, with the detailed information attached as appendices. The Committee advised that the section at the end of the operations report that responded to any questions raised by members at meetings was very helpful. When trialling new or innovative projects, it was good to report on how the project was working.

Management agreed to provide a high level template for reporting next month, given the significance of the work being undertaken regarding beds, the AMAU etc.

It was recommended that

> *this report be received.*

6.8. Improved Access to Palmerston North Hospital and Car Parking

Lindsay Burnell advised he could have a conflict of interest due to his involvement with the Horizons Regional Council.

Stephen Paewai said he appreciated what had been done particularly in terms of the golf cart/vehicle and the dedicated rural outpatient parks, given the closure of some rural clinics.

Clarification was sought in relation to the Church land. Management confirmed that the land developed by the Church and offered for staff leased parks, was separate from the proposal for a dedicated paid staff park at the hospital.

Management were asked that if any parking enforcement was required, it was done in a tasteful and sensitive manner. Management confirmed the enforcement was usually related to staff parking, and occurred after several warnings were given to the staff member.

A member queried whether, given that the establishment of a parking building was part of the overall redevelopment plan, could it be done first and maybe free up some land for the rest of the redevelopment. Management advised they were considering ideas such as a modular building concept that could be dismantled later and relocated if necessary.

The CEO noted that the paid car parking concept was being reviewed along with costings and revenue opportunities.

It was recommended that

this report be received.

6.9. InterRAI Business Case Update

It was recommended that

this report be received.

7. OPERATIONS REPORT

The General Manager, MidCentral Health, presented her report.

The General Manager advised the finalised details of the elective service plan would be sent to the Ministry on 8 May.

Norovirus Update

There had been a small return of the virus, but this now appeared to be finishing with no new symptoms in the last 24 hours.

Recruitment

Over the next few months, there would be only a few nursing vacancies.

Financial Report

The financial situation was disappointing, particularly as there were only a few months remaining in the year in which to reach the break-even target. The increase in FTE levels was noted. Management commented that the higher FTE level was difficult to manage. MCH was committed to the core work and several appointments were required. Some of the increased FTEs related to new work. Managers within the organisation were aware of the need to carefully consider whether re-appointments were necessary.

Diane Anderson left the meeting.

The General Manager, Corporate Services, spoke to the financial report, stating the 2009/10 year would be a greater challenge because the Funding Division had reduced the volumes they were able to purchase. It was noted that the terminology used in the finance report section should be amended to refer to un-funded over production.

There was considerable discussion on the situation of acutely unwell people arriving at hospital and requiring attention, which resulted in work being done for which there was no funding available. The issue of where the Board's funding should be directed was discussed, with the comment being made that perhaps the time had come for prioritisation by the Funding Division and overall the Board. If there was insufficient funding available from the Funding Division, then the Board had to make decisions about where funds should be allocated, eg whether some primary funding should be diverted to the provider arm. Otherwise, MCH might not be able to achieve its targets and goals. Pressure was being put

on hospital services at the moment from government, eg in emergency department and elective services, was noted.

The General Manager, MidCentral Health, advised MCH had looked at what services could be stopped due to the financial situation, but had not been able to find any obvious ones.

The CEO commented that the Board was aware of the situation, as most of the Committee's members were on the Board. Also, the recent District Annual Plan discussions had included discussion on the issue. The response from the Board had been that MCH had to live within the available funding and break-even, and also deliver as many services as possible.

This was confirmed as being the correct outcome from the District Annual Plan discussions. Ian Wilson felt that the discussions had to be related to the 2009/10 period now. If there was any chance that the provider arm would not reach its target in the District Annual Plan, then the Committee should be considering what services could not be produced.

A member felt the Board had not yet considered any service prioritisation, as the requirement to prioritise had not filtered through to that level. MDHB was not the only board with this problem, and the suggestion was made that perhaps boards should be sharing solutions across the sector.

The discussion came back to the point that there was only so much money available, and the organisation must live within their budget and change appropriately. If it was subsequently found that assumptions were not realistic, the Committee should be informed immediately. That was the basis on which the Board had accepted the 2009/10 budget. However, recognition should be given that there was risk involved.

Lindsay Burnell said he very uncomfortable with the budget, as he thought it too lean. He felt there were initiatives being undertaken in the primary sector that would not have any immediate impact for a number of years. However, Ann Chapman defended the primary initiatives saying they were critical to the long term health of the nation and had to be pursued.

Ian Wilson summed up the discussions saying the Committee had signed up to the divisional budget for MCH and presented it to the Board, saying it could be delivered. The Board accepted all the divisional budgets. He did not believe the break-even budgets could be changed now, so the Committee had to carefully monitor the situation. The Board should be immediately alerted to any issues. As the Committee felt there could be a high risk, the CEO should consider what this might mean in terms of his confidence for achieving the 2009/10 budget.

It was recommended

that this paper be received

8. GOVERNANCE ISSUES

8.1. Work Plan for 2008/09

It was recommended

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

9. LATE ITEMS

There were no late items.

6.24

10. DATE OF NEXT MEETING

2 June 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 and Significant Events update : MECA accruals	 To protect personal privacy Subject to negotiations	 9(2)(a) 9(2)(j)