

## MidCentral District Health Board

### Minutes of the Hospital Advisory Committee meeting held on 2 September 2008 commencing at 8.30 am in the Boardroom, MidCentral District Health Board

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Lindsay Burnell (chair)  
 Jack Drummond  
 Ann Chapman  
 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)  
 Sue Wood, Director of Nursing  
 Muriel Hanratty, Group Manager, ATR & Community Services  
 Penny O'Leary, Group Manager, RCTS/BreastScreening/Clinical Services  
 Brett Sheehan, Group Manager, Surgical Services  
 Lyn Horgan, Group Manager, Medical Services  
 Vivienne Ayres and Simon Floris, Planning & Performance Unit  
 Communications Unit (1)  
 Media (1)

#### **CHAIR**

Members were advised that as the Chair was unwell, the Deputy Chair Mr Burnell, would lead the meeting.

#### **WELCOME**

A warm welcome was extended to Richard Orzecki, the newly appointed committee member.

#### **1. APOLOGIES**

An apology was received from Jim Jefferies.

#### **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. Richard Orzecki advised his register of interests was being prepared for Management, and he outlined them for members.

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

There were no declarations of conflict in relation to today's business.

### **4. MINUTES**

#### **4.1. Minutes**

It was recommended:

*that the minutes of the meeting held 5 August 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**

Management were asked if the additional information provided to members following the last meeting regarding:

1. Lease option considered by the project team
2. Electronic health records

would be made available for the public. Management agreed this could be done.

### **6. STRATEGIC/SPECIAL ISSUES**

#### **6.1. Child & Adolescent Oral Health update**

In response to a query, Management advised the adjustment to the business case following updated information being provided to the Ministry's Technical Review Panel, would result in a slight decrease in costs. This was because the price for the mobile units had now been confirmed. The business case had contained estimated costs. Management confirmed the programme could still be run within budget with the new figures.

It was recommended

that this report be received

#### **6.2. BreastScreening Services update**

It was noted that the mobile unit had visited the Levin region after 30 June, so the Horowhenua figures would have changed now.

Members discussed the advertising for this service. Management advised the publicity/health promotion was done nationally or by word of mouth. There were Maori and Pacific Island health promoters who also advertised the services available, including the age group covered by the scheme.

A member noted there was currently no waiting list for new women in the region, but other areas did have a waiting list, and that at least one other area was not taking new women. Management acknowledged this fact and pointed out that MidCentral Health had good equipment and a stable workforce, which helped with throughput.

It was recommended

that this report be received

### **6.3. Secondary Care Component of the Cancer Control Plan update**

In response to a query regarding the low utilisation of LA 2, Management advised it was because LA2 was the oldest machine, and used for certain case-mixes only.

It was recommended

that this report be received

### **6.4. Renal Service Plan update**

The benefits for both the patient and the organisation in having a kidney transplant were discussed. At the current time, approximately 12 patients were on the waiting list for a kidney transplant at Capital & Coast DHB. It took about a year to prepare patients for these transplants. Management advised there was a national donor pool for cross matching patients, but most of the MCH patients were waiting for a live donor transplant as they had a close relative/friend who was prepared to donate their kidney.

Management were encouraged to explore any possible transplant options available, given the obvious benefits of the transplants to both the patient and organisation, and to report back at a later date on their findings. Management noted the suggestion, advising they could respond in the "committee responses" section of the operations report setting out what transplant options were available in New Zealand and overseas.

It was noted that renal services at MCH have adopted the Liverpool Care of the Dying pathway. As a result, there was an integrated multi-disciplinary approach to renal services that worked in conjunction with the palliative care team.

Management outlined the strategies for managing the impact of chronic diseases including the diabetes and cardiovascular disease state plans. There was also community support eg support for GPs to manage their renal patients and establish data bases, and support from a nephrologist who was helping GPs with early intervention, thus enabling patients to remain in the community and slow the progression of people requiring dialysis.

The number of Wanganui patients requiring emergency dialysis was noted with concern. Management advised a second nephrologist would be arriving in October 2008, and there was strong interest from a locum currently working with MidCentral Health. Once the second nephrologist commenced, outpatient clinics would be scheduled at Levin and Wanganui, and this would provide better access for patients.

Barbara Robson congratulated MCH on the good relationship it had with the Palmerston North Kidney Support Group. Ms Robson advised new kidney support groups had just been started in Wanganui and Levin, which would also be helpful.

The CEO noted that the renal report under discussion had been developed leading on from prior reports/plans, and commented that the committee's discussion was a reminder to management that new committee/board members should have been provided with supporting historical information. He referred specifically to the renal service plan, stating the current report showed the progress since the service plan had been completed. He said a copy of the renal service plan would be provided to the new members.

It was recommended

that this report be received

### **6.5. Feasibility study re capacity to provide additional elective services**

Management advised that over the last week or so, the hospital had been at full capacity. As a result, MCH had utilised the services of the two local private hospitals to accommodate patients who needed to be in a hospital bed but did not need acute care. This had involved between 3-6 patients. The patients who were moved to the private facilities, had treatment/management plans and dedicated senior medical officers looking after them. It was noted that as the hospital was so full, no elective surgery had been possible during this time. Management also acknowledged the tremendous work being done by the district nursing teams and hospital-in-the-home teams, looking after patients in the community during this busy period.

The Committee queried whether there should be more beds at Palmerston North Hospital. Management advised the Clinical Service Plan had identified MCH required more beds over the next few years in order to meet and grow demand. In the interim, the management team had been working on medical assessment and high dependency models, and a report on this work would be brought to the Committee over the next few months. This work would link in with the facility review.

It was recommended

that this report be received

### **6.6. Quarterly Quality Report**

It was noted that overall, the number of complaints appeared to have increased. Management explained there was a good process in place around the patient's arrival at the front desk. There was a notice at the door, advising the capacity of the hospital. The triage nurses managed patients very well, but it was very difficult to give patients an idea on how long they might have to wait. This depended on what the clinicians were doing at the time, eg the clinician might be in the operating theatre in which case s/he would not be available until the surgery was completed. Management advised Compass Health had set up an 0800 number to develop a priority list of people who did not have a GP but who urgently required one.

In relation to improving the safety and quality of medicines management, a member wondered if there was some interim work that could be done particularly if a consumer focus group was established to collect more targeted information. It was suggested that high medication users could be encouraged to carry their own list of medications. The member also expressed personal concern at the robustness of the certification processes for rest homes.

A member raised the issue of the antibiotic monitoring project and asked whether potential savings from processes implemented could be identified. The savings that could be achieved by ensuring that all people moved from intravenous antibiotics to oral antibiotics at the appropriate time were identified in the pilot as approximately \$30,000 per year.

It was recommended

that this report be received

### **6.7. Clinical Risk Report**

It was recommended

that this report be received

### **6.8. DHB Hospital Benchmark Information Report**

Management advised members that a telephone survey was recently completed of a sample group of 40 patients recorded as Did Not Attend (DNA). Particular attention was paid to the response related to transport. Of the 42 surveyed, 30 respondents had no problem with transport, a further 10 respondents did experience problems for a number of reasons. These included requiring a driver, unable to attend on specific days or for particular reasons, unable to drive and forgot to cancel, missed the bus, and petrol cost. These reasons were similar to those given during a 2003 survey.

Members commented they had looked carefully at the results for both MidCentral DHB and Whanganui DHB, given the closer relationship that was developing between the two boards.

As members were aware, MCH's Infection Control Team reported monthly on the bacteraemia rate. They had not found any reason for variations.

Strategies were constantly being considered to improve performance. Recently the Canterbury DHB had visited to discuss their "Hospital in the Night" initiative. Another project MCH would be involved in was the Quality Improvement Committee's project sponsored by Counties Manukau DHB – Optimising the Patient's Journey (OPJ).

It was recommended

that this report be received

### **6.9. Non Financial Performance Indicator Report**

Richard Orzecki endorsed the initial rating of "outstanding" given for the indicator measuring local Iwi/Maori engagement and participation in DHB decision-making, and the development of strategies and plans for Maori health gain.

It was recommended

that this paper be received

## **7. OPERATIONS REPORT**

The General Manager, MidCentral Health, presented her operations report.

### **7.1. Horowhenua District Council**

The General Manager advised that she and the CEO had recently attended a meeting of the Horowhenua District Council Joint Transport and Health Services Subcommittee. They had enjoyed meeting with the Subcommittee, and felt the visit had been very worthwhile. The General Manager and the Group Manager Surgical Services had also recently met with the Horowhenua Mayor and other parties to discuss topics of mutual interest.

## **7.2. Scorecard**

Management referred to the scorecard appendix 1, which was in a slightly different format to previous reports. The General Manager advised some of the results in the tables were on a “rolling twelve months cycle”, and not a year-to-date cycle. This would be made clearer in the next report.

A request was made to see if Management could provide either colour copies of some of the reports so that variations stood out better, or highlight the variations in some other manner, as this would help members focus on the specific variation areas.

It was noted that the targets in the scorecard were mostly MCH targets and expectations, and that some of them were included in national reporting. Targets had been avoided on a national basis for most of the indicators.

## **7.3. Shortage of Physiotherapists**

Management advised they were trying very hard to recruit physiotherapists. The shortage was now being felt by neighbouring DHBs as well. A few physiotherapy assistants who were waiting on registration had recently been employed by MCH, and it was hoped they would stay with MCH.

## **7.4. Accredited Equipment Assessments**

Management advised the increased demand for accredited equipment assessments was from the over 65 years age group.

## **7.5. Nursing Staff**

Management confirmed that MCH employed approximately 50-60 new graduate nursing students each year. There was no shortage of supply, as about 100 nurses graduated. The students underwent a six week programme prior to going out onto the wards. They did not do night duty during the first year. There were three educators looking after them.

Management advised MCH participated with UCOL’s training programmes for nurses wanting to return to work, by providing clinical placement for nurses. MCH also considered the overseas nurses graduating from training programmes that UCOL ran for these people each year.

## **7.6. Finance Report**

The General Manager, Corporate Services, explained the table in paragraph 2.2. This table set out the revenue and expenditure of each service line, prior to applying the service level agreement (SLA) adjustments. The table highlighted the difficulties of managing throughput to the levels the Funding Division purchased.

The acute demand had to be managed as well as possible so that the elective work could also be done. Various strategies were employed, eg supporting people to stay at home, this had been extended to supporting GPs to manage their demand. The surgical team took every opportunity to do elective work, eg day-stay surgery, and sub-contracting work.

Management also pointed out that each month had different influences and spikes, but it was unlikely there would be twelve months of very high demand. The SLA was based on the expected annual results. Although it was not known what the demand would be, acute patients had to be treated.

As noted earlier in the meeting, the Clinical Service Plan had identified a need for more resourced beds. This determination had been made with the knowledge of the work being undertaken in the primary sector, and the demographics of the ageing population. Jack Drummond said he would be interested in the morbidity of patients who could not have their elective surgery and could not work. This was noted. Dr Drummond said the need to increase the number of beds was a high priority. Management acknowledged Dr Drummond's comments, advising a lot of work was currently being done in relation to bed management and to see how the high dependency unit and medical assessment unit could be rearranged. This work would be presented to members once it was completed.

It was recommended

that this report 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.

## **10. DATE OF NEXT MEETING**

7 October 2008

## **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 - Resident Medical Officers negotiations and MECA accruals	Industrial negotiations	9(2)(j)