

## MidCentral District Health Board

**Minutes of the Hospital Advisory Committee meeting held on 7 October 2008 commencing at 8.30 am in the Boardroom, MidCentral District Health Board**

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Lindsay Burnell (chair)  
Ann Chapman  
Jim Jefferies  
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)  
Nicholas Glubb, Group Manager, Child, Women, and Mental Health Services  
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  
Simon Floris, Planning & Performance Unit  
Kate Aplin, Project Manager, Child & Adolescent Oral Health Service Improvement Project (part meeting)  
Shirley-Anne Gardiner, Operations Manager  
Robyn Shaw, Elective Services Manager (part meeting)  
Denise Holcroft, Adolescent & Family Mental Health, Alcohol & Drugs Services Project Manager (part meeting)  
Communications Unit (1)  
Media (2)

### **1. APOLOGIES**

An apology was received from Jack Drummond and Richard Orzecki - As a candidate in the forthcoming general elections, Mr Orzecki was standing down from committee duties during October and November.

### **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.

## **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 2 September 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 from the minutes.

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

### **6.1. Investment in Child and Adolescent Oral Health Services Project**

#### **Investment in Child and Adolescent Oral Health Services Project**

There was considerable discussion on the paper seeking endorsement to progress the investment in the Child and Adolescent Oral Health Services Project in line with the business case approved by the Board in February 2008 but modified following negotiations with the Ministry of Health in June 2008 as highlighted in the paper under discussion.

The Ministry of Health (MoH) offer of September 2008 significantly improved the deficit position. The model of service delivery approved by the Hospital Advisory Committee and the Board had not been altered from the February paper. Management were confident the services could be delivered and that the identified benefits would be gained.

Issues discussed covered the following:

Size of the mobile units – the MCH proposal was for four 14.5m mobiles. In the last few days, the MoH had raised a concern that because there were only a few of the larger 14.5m mobiles required throughout the country, the cost had escalated and was unsustainable. The MoH were now looking at managing the procurement process in conjunction with DHBNZ to vary the design and enable them to be purchased for about the same cost. Management advised that other DHBs had also wanted the larger units but as they had significant funding issues, they had compromised on mobile size to reduce costs. MCH was in a better position with some room to negotiate. However, there had been an impact on MCH as a result of the other DHBs compromising and accepting smaller mobiles.

No fixed sites in Horowhenua or Tararua – Concern was expressed about this issue. The fixed sites were seen as a base from which to build relationships with the primary healthcare teams.

Volumes – a fuller analysis of the revised volumes across the different age bands and providers was sought. It was acknowledged that there was another provider of well child services, not dedicated oral health services, in the 0-2 age band, and concern was raised around funding if the other provider contributed to the revenue. Management advised there was a separate project and contract for the other provider and that the funding for the other provider was outside this project and was not included in this paper. However, Barbara Robson felt she did not have confidence in the figures provided and she requested further analysis of the information that had been provided to members. She wanted clarity as to what volumes belonged with each provider and what was in the business case. Ms Robson also expressed concern at the model of care for pre school children and how the proposed changes to the model would affect the overall 0-4 age group.

Community engagement – concern was expressed that there had not yet been engagement with the community regarding the proposal.

Workforce recruitment and retention – concern was expressed that the new model might impact on the recruitment and retention of staff who might not find it attractive working on mobile units. The impact of working from a mobile unit as opposed to a fixed location was appreciated by management, and was why flexibility in the mobile design that allowed for a staff discussion/meeting room had been preferred. There would be a change for staff with the proposed model. Management would work through the management of change process in consultation with staff and unions on a case by case basis. There was a range of ways that staff could work, for example not all of them wanted to work full time hours.

A staff survey had been done last year. 55% of the existing workforce would potentially have retired by year 3 of the project, so they would not be working from the mobiles. New graduates had been surveyed, and the only difficulty was space for family meetings. It was appreciated there were therapists who did not want to work on mobile units, which was one of the reasons for having some fixed clinics as well.

The new dental therapists would have dual scopes of practice, and concern was expressed that it was not known whether the therapists would like working on a mobile service.

Community engagement – There had been community stakeholder engagement early in the project ie more than 12 months ago . Further engagement was not scheduled until such time as the proposal had been accepted by the committee and board, at which time consideration would be given to determining the best sites for fixed clinics and the locations to be serviced by mobiles.

Volumes - Additional work had been done with the MoH around the population as a result of the new (2006) census figures. The change in volume figures from 38,912 in February to 37,112 in October was the result of that work. The business case was based on the 2001 census. The MoH accepted the population data used was appropriate and considered it fairly accurate. There was no certainty with the population predictions as it was not an exact science; however management were using census material predictions. There was some flexibility to adjust the volumes, if the population changed and there was a greater demand.

Appendix 2 – this section was different to the information presented in February 08. Management agreed, advising it was included as a reference point. Appendix 3 addressed the changes, with column D of appendix 3 showing the current financials upon which the MoH based its offer.

Longer term, the funding would be incorporated into the population based funding and would go direct to the DHB.

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Revenue – Concern was expressed that management had not shown the revenue was robust. Revenue would be determined by the volumes, so if the revenue was not close to or better than shown in the paper, then what was the sensitivity of that. Management acknowledged that this sensitivity analysis had not been done, but it could be.

Management advised in relation to timeliness, that MCH had acknowledged receipt of the Ministry's proposal, and informed the Ministry that MCH would respond following the October board meeting.

The discussion was summed up as follows:

- a. this proposal was a national model of care, not an MDHB model
- b. whilst there was endorsement for the model, it was not 100% supported by staff or committee members
- c. community engagement would be undertaken once the proposal and funding was approved
- d. revenue had been based on an assessment of volumes. Volumes had been determined by a different count (appointments versus completions) across different providers and without a sensitivity analysis. In addition, the figures used were different to the original figures as a result of more up to date data being available from census information.

The committee discussed the affect of delaying a decision until some additional information was provided. It was noted that the MoH was due to begin ordering the mobiles, and if MCH's requirements were not included in the bulk order, there would be an increased cost to MCH. The first order was being placed in December. The committee agreed that they would have to accept this risk.

After some discussion it was agreed the additional information would be circulated to members with a request that specific queries or feedback be provided to management as soon as possible. The paper would then be revised if necessary and re-presented to the November Hospital Advisory Committee meeting.

## **6.2. Update on Linear Accelerator Purchase**

It was recommended that

*this report be received*

## **6.3. Palmerston North Hospital Site Redevelopment update**

Members agreed that all capability and capacity should be utilised, subject to fulfilling clinical requirements and affordability.

It is recommended that

*this report be received*

## **6.4. Service Reconfiguration - Dermatology**

It was noted that only category 1 and 2 patients are seen at MidCentral Health. Routine referrals were managed by GPs. It was suggested MCH consider how support could be given to primary care in developing categories 3 and 4, and what other options might be available.

Management agreed with the suggestion, advising members a report would be provided in February/March 2009.

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It was recommended

*that the report be received*

## **6.5. Service Reconfiguration – Child Adolescence and Family**

It was noted that the business case for capital expenditure for the reconfiguration of Konini House, Community Village, would be presented to the December 2008 Hospital Advisory Committee meeting.

Management confirmed that the model of service delivery has been adapted to the New Zealand context. It was endorsed by the Werry Centre, and Te Rau Matatini the national Maori Mental Health workforce agency. Feedback from Te Rau Matatini confirmed the “Choice and Partnership Approach” was in line with Maori ways of working, and feedback from consumers was they felt the approach validated family involvement and inclusion in decision making.

It was noted that the reference to mobile clinics in section 4.2 of the report, referred to mobility for Palmerston North staff in terms of outreach clinics.

It was recommended

*that the report be received*

## **6.6. Women’s and Child Health Services, Whanganui and MidCentral District Health Board s - monthly update**

Management advised the Memorandum of Understanding was now back from the solicitors, and would now be progressed for the two CEOs’ consideration.

It was recommended

*that the report be received*

## **7. OPERATIONS REPORT**

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

### **7.1. Demand on services**

The recent very heavy demand on services across all specialties was raised. The various strategies being pursued, like the chronic disease management in the community and the PEDAL initiative, were acknowledged. However, members wondered if management should be looking ahead say three years, to see what the critical issues might be to give members some confidence for future service delivery. The Clinical Service Plan outlined the pathway forward, but the concern expressed was that it would not be implemented early enough to manage the increasing demand.

Management acknowledged the concern, and offered to update the bed number information contained in the plan, and include the information in the November workshop already

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arranged to discuss the medical administration unit and high dependency unit developments.

Another suggestion put forward related to the ambulatory care patients, and whether there were any changes that could be made in that area. Data would have to be gathered to show the type and number of patient seen by consultants, and whether the patient had been seen by a district nurse or other health provider that might have prevented them coming into hospital.

Dr Campbell joined the meeting.

**7.2. Finance Report**

The General Manager, Corporate Services, explained a number of the tables contained in the finance report.

Concern was expressed that although only two months had passed in the current financial year, the cost growth was significantly higher than inflation. This result was seen as a warning sign that escalating costs must be managed. A member made the comment that consideration would have to be given to rationing, as MCH could not do everything.

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**

4 November 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)