

MidCentral District Health Board

Minutes of the Hospital Advisory Committee meeting held on 1 September 2009 commencing at 8.30 am in the Boardroom, MidCentral District Health Board

PRESENT

Jack Drummond (chair)	Richard Orzecki
Lindsay Burnell	Stephen Paewai
Ann Chapman	Barbara Robson
Cynric Temple-Camp	Kerry Simpson
Jim Jefferies	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, Director, Patient Safety & Clinical Effectiveness
 Nicholas Glubb, Operations Director, Specialist Community & Regional Services
 Lyn Horgan, Operations Director, Hospital Services
 Sue Wood, Director of Nursing
 Anne Amooore, Group Manager Human Resources
 Shirley-Anne Gardiner, Operations Manager MidCentral Health (part meeting)
 Simon Allan, Clinical Directors, Regional Cancer Treatment Service (part meeting)
 Nik Nedev, Medical Head, Radiation Oncology (part meeting)
 Chris Channing Manager, Planning & Performance Unit
 Catherine Marshall, Nurse Manager (part meeting)
 Communications (1)
 Media (2)

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

Richard Orzecki advised he had been appointed chairman of FoMANA Capital Limited. There was no direct relationship between this company and MidCentral District Health Board.

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

Richard Orzecki, Director of Horowhenua PHO and a member of RIMS GP Service: agenda item 6.2 Horowhenua Health Centre update. Stephen Paewai, part of item 15, Sentinel Events, in part 2 of the meeting, as he knew the party involved.

4. MINUTES

4.1. Minutes

It was recommended

that the minutes of the meeting held 4 August 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.

6. STRATEGIC / SPECIAL ISSUES

6.1. Strategic Development of Radiation Oncology Services

The Chairman welcomed Drs Simon Allan and Nik Nedev to the meeting.

Drs Allan and Nedev spoke to the report. Factors that had to be considered when developing the report included the region served and its demographics, the new political targets of four week wait times instead of six weeks, the age of the current machines, influences that can upset the service like down-time or surges in patient numbers, and therefore the need for some flexibility in capacity to deal with such issues. The paper had tried to deal with the acute issues and also the responsibilities for the sustainability of the machinery.

The difference in regional treatments was raised. It was noted that whilst reliable data was captured in terms of the number of patients treated, it was more difficult to be accurate in terms of the number of patients registered. For example, for various reasons patients from say Gisborne were not all captured, as often the election was made to have a mastectomy rather than travel a long distance and be away from home for up to five weeks. This type of decision impacted on the intervention rates.

Dr Allan said the service was aware of what was happening, and he did not feel there would be an excessive increase in intervention rates over the next 5-6 years. Dr Nedev agreed, saying there was nothing on the horizon that would dramatically change things.

Some patients were choosing to attend the newly established private radiotherapy clinic in Auckland, but at present there was a 10 week wait time for that service. There were limited patients who would make the choice of having this private treatment. One issue for radiation services in Auckland now, was workforce. There were limited experienced radiation therapy staff and many of them had moved to the private service, which did the easier procedures like breast and prostate cancers.

Diane Anderson joined the meeting.

The public service was then left with less experienced staff and the more difficult cases.

In response to a member's query as to whether the action suggested in the paper would enable the new four week wait time to be achieved by December 2010, Dr Nedev confirmed that was the intention of the paper. Additional machine capacity on an on-going basis was required in order to meet the new guidelines. The paper recommended the earlier replacement of one of the older machines, (due for replacement in 1½ years) by the end of this year, and then in another 1½ years time replacing LA2. That would mean the service had four good machines.

Currently there was movement in the public/private partnership model. A suggestion was made that perhaps it was time to have discussions with other entities to see if anyone was willing to purchase a linear accelerator thereby providing a service from a 4th machine. This could be done from our own site, in a similar way as the MRI had been set up. Dr Allan said there had been some preliminary thinking around that suggestion, but it had not progressed. The management team were encouraged to put forward as many options as possible to share with the committee. Then, if there were funding issues or other barriers, they could be identified.

A member asked if it was possible to future-proof capacity particularly in view of the public/private partnership situation. The member asked if some of the work could be done in private, eg the planning, with the radiation therapy work being done in public. Dr Nedev said the work could be split, but there would be workforce problems, as it would be the same people doing the planning work in both public and private, and there was only a limited number of people who could do the planning work. Once the planning work was disconnected with the treatment, particularly if there were big distances involved, then there could be problems, and he was not sure it was worthwhile.

The issue of how this planning fitted with the national situation was also raised, particularly in terms of the workforce. Dr Nedev acknowledged it would be difficult to resolve. Whilst there were sufficient radiation therapists being trained in New Zealand, they tended to leave the country. Dr Allan said the response to where we fitted nationally, would be looked at next year when developing the business case for the permanent 4th machine.

Dr Nedev advised that moving to a four week wait time, would require capacity. Ideally, LA3 should be replaced by the end of this year/beginning of next year, following which LA2 should be replaced. The MLC upgrade would probably be done by the end of this year.

It was agreed that when developing the business case, all parties should meet to discuss what was required before the case was developed.

The situation was summed up as an immediate along with a longer term problem, which had to be explored and which would require considerable funding. There could be a public/private relationship – but this required further investigation. The new guidelines would have to be met, and therefore more capacity was required.

It was recommended

that the report be received; and that

the programme objectives and proposed planning timetable be endorsed for further development

6.2. Horowhenua Health Centre update

Richard Orzecki's interest as Director of Horowhenua PHO and a member of RIMS GP Service was noted.

Ms Robson said she was very pleased to see the report. She felt it served as a useful benchmark, and she would like to see an annual reconciliation in order to keep an eye on the deficit. She noted the corporate overheads had not been included.

A concern was expressed in relation to the additional costs for MCH in providing space for the GPs, and whether the impact was being transparently recorded.

Management were now supported to look to the future and monitor performance against annual business plans and achieve the planned model of care. It was noted that the draft reconfiguration of treatment space to allow space to house GPs, nursing and administration staff, would require some investment.

It was recommended

that this report be received

6.3. Child & Adolescent Oral Health update

The engagement process was raised, and a request was made that the business case be placed as a separate item on the MDHB's website for easy access.

A member asked if access to staff facilities from mobile clinics during school holidays would be a problem. Management responded advising that it was anticipated clinics would not be sited at schools over holiday periods. Part of the engagement process would include discussions on issues like this. There was a standard lease document, drawn up by the Ministry that covered both fixed and mobile facilities. The mobile agreement covered items around ease of and safe access to facilities for staff and clients.

The proposal identified where workshops might be held, and letters have already gone out to the education sector regarding the plan for engagement with them. In terms of the wider community, it was envisaged school networks and advertisements would be used to invite people to attend the meetings. The school networks were the main client group, and using those contacts should assist in contacting the parties.

It was recommended

that this report be received

6.4. Dannevirke Outpatient Service Review

The communication surrounding this paper was discussed. The Manawatu Standard's editorial and article published on 31 August, stated the Tararua Mayor only found out about the paper when the media contacted her. Stephen Paewai said he had received a copy of the paper last week from Murray Georgel. He referred to the media articles, and also advised he understood a petition in Dannevirke for the reinstatement of the clinic service, was proceeding. He also said he felt it would have been useful to have a community representative on the review group, given the amount of public interest in this issue.

The CEO advised members that he had tried to contact the Mayor, MP, and Minister's office when the paper became available. He had left a message for the Mayor and also sent her an

electronic version of the paper on 28 August. He had subsequently spoken to her and she had confirmed she had received the paper. He offered to meet with her if she had any questions. Mr Georgel further advised that he and the Board Chairman were meeting the Mayor on 4 September as part of a regular meeting they had with the Mayor and CEO of each territorial authority.

The CEO referred to Mr Paewai's comment regarding community representation. He advised that following meetings held earlier in the year in relation to the original decision to close the clinics, Sharon Ward had been nominated as the community representative, and as a result, had been a member of the review group.

The CEO said it was a difficult situation in that the review had been requested and provided to the committee. It had been agreed there would be a meeting with the community. The difficulty was in reporting timelines.

Members agreed they had requested the report and therefore should receive it before it was discussed in the wider community. A meeting with the Mayor and community representatives would be held in the near future and will include key representatives from the Dannevirke community.

It was recommended

that this report be received

6.5. Workforce Reports

Whilst these reports were to provide members with information, it was agreed they would have a huge impact on the organisation. The five reports identified a need for a nationally coordinated approach across workforce training and funding. As a result, a separate national entity, the Clinical Training Agency Board, was to be established and led by Professor Des Gorman from the Health of the School of Medicine at the University of Auckland.

A national roadshow around all DHBs had been organised to provide an opportunity for medical staff and senior managers to discuss the report recommendations and provide feedback. Members were advised that if they had any major concerns or questions requiring more information, they should let management know.

The financial cost of implementing the suggested recommendations could not be determined at this stage, as the recommendations did not all line up. Nor was it yet determined where the ultimate responsibility for training would lie, and consequently any costs. Management would be watching developments.

Ian Wilson felt DHBNZ would consider the reports and potential key impacts for DHBs. A report would probably then be provided by DHBNZ outlining their findings. He suggested this could be a matter the CEO followed up on at a future CEO's meeting to see if that was the DHBNZ's intention.

It was recommended

that this report be received

6.6. DHB Hospital Benchmark information Report: January-March 2009

Average Length of Stay

The Director of Nursing commented on the average length of stay indicator. Many of MCH's patients were really sick. There was careful screening of patients to ensure all admissions were required. The case manager looked at patients who stayed in hospital more than 10 days to see if there was anything delaying discharge. There were a number of factors to be considered when looking at the average length of stay, including the large number of surgical work done by MCH for other DHBs, the motor vehicle accident patients who were brought to MCH rather than their own domicile and the age of the population served by MCH.

A major factor that influenced the average length of stay at MCH, was our policy of not discharging patients until they had their discharge summary completed. MCH considered it harmful for patients to go home without their discharge information.

The CEO commented that these were benchmark figures, which provided a starting point. He also advised a paper was being presented to the Community & Public Health Committee later in the day in relation to demand, how we look at it across the district, and its impact on hospital services. He suggested it could be a good paper for this Committee to receive for information purposes.

Diane Anderson left the meeting.

It was recommended

that this report be received

6.7. Non-Financial Performance Indicator Report including health targets and confirmation reporting for Quarter 4, 2008-09

The link between improved health outcomes as a result of reducing the radiation therapy wait times from 6 weeks to 4 weeks, and the cost of the investment required to achieve the additional capacity to achieve this result, was raised. Jim Jefferies said he would like to see an attempt to address the link of investment to health outcomes included in the forthcoming business case. Cynric Temple-Camp agreed, advising he had attended a presentation on the value of the outcome of earlier treatment. That presentation heard from consultants and included their comment that there had not been a big increase in health outcome compared to the investment made.

It was recommended

that this report be received

7. OPERATIONS REPORT

Medical Assessment & Planning Unit (MAPU)

Cynric Temple-Camp advised when he was in London recently he received feedback on a MAPU that had been established at Harrow. An issue faced by Harrow was inexperienced registrars, which had caused bed blocking as they did not move patients on. Consultants had

to be put in place to keep people moving. Management advised that was one of the issues they were currently considering.

Feedback on the new summary performance tables introduced into this month's operations report was requested. The following comments were noted:

- The quality of the comment was really important. The explanation relating to any variances was critical for understanding the impact on achieving targets and the year-end result, and what action was being taken.
- Interested in how MCH was tracking to the plan
- Was the surgical mix correct. Was MCH focussing on doing what was needed, and getting paid for the work.

Ann Chapman left the meeting.

Management commented that the clinicians prioritised the work, and fluctuations in surgical production were often to do with availability of staff rather than aspects of planned production.

Ann Chapman returned to the meeting.

Management advised that surgical procedures "washed up" against one another. The electives plan measured both case weights and also discharges, so that the focus was not just on orthopaedic joints at the expense of other procedures, and vice versa. One measure was the revenue earned and the second measure was the number of people treated. Both were important measures.

The issue of meeting time in relation to availability of the financial information was raised again. This impacted more on committee members than board members, as the committee members only attended committee meetings and did not receive board papers. As a result, Richard Orzecki felt the new tables had to be backed up with data showing whether or not MCH was on track, so the committee members understood where the organisation was heading. He did not get that feeling from the information in the current report. Ian Wilson supported the comments, and suggested a summary report setting out the current financial position and an indication looking forward, could provide some assurance.

Certification/accreditation

Members expressed congratulations on achieving certification, saying the work entailed in getting to this point was sometimes taken for granted.

Barbara Robson left the meeting.

Agenda Order

There was discussion regarding the order of agenda items, as some members felt it preferable to have the operations report at the beginning of the meeting. It was suggested to management that the actual operations report without its supporting appendices, could be brought back to the beginning of the agenda, and the statistical section left in its current position. It was suggested that greater emphasis be given to the impact of results.

Barbara Robson returned to the meeting.

It was agreed that the operations report should be at the beginning of the agenda papers. It was also noted that it would be useful to have reference in the report to any other critical papers for discussion in the strategic section.

It was recommended

that this report be received

8. GOVERNANCE ISSUES

8.1. 2009/10 Work Programme

It was noted that management had been asked to provide an update on the Dannevirke Outpatient Service Review once it was completed.

It was recommended

that the updated work programme for 2009/10 be noted.

9. LATE ITEMS

There were no late items.

10. DATE OF NEXT MEETING

6 October 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 : Further Management of Change and Service Reviews	To protect personal privacy Subject of negotiation	9(2)(a) 9(2)(j)
Strategic Development of Radiation Oncology Services	Subject of negotiation	9(2)(j)