

MidCentral District Health Board**Minutes of the Hospital Advisory Committee meeting held on 7 July 2009
commencing at 8.30 am in the Boardroom, MidCentral District Health
Board**

PRESENT

Jack Drummond (chair)
Lindsay Burnell
Ann Chapman
Richard Orzecki
Stephen Paewai

Barbara Robson
Kerry Simpson
Cynric Temple-Camp
Ian Wilson

In attendance

Mike Grant, Acting CEO
Lareen Cooper, General Manager, MidCentral Health
Stuart Wilson, General Manager Corporate Services
Carolyn Donaldson, Committee Secretary

Muriel Hanratty, Group Manager, ATR & Community Services (part meeting)
Nicholas Glubb, Group Manager, Child, Women, and Mental Health Services (part meeting)
Lyn Horgan, Group Manager, Medical Services (part meeting)
Sue Wood, Director of Nursing
Ngairé Smidt, Occupational Health Physician (part meeting)
Chris Channing, Manager Planning & Performance Unit
Ian Ironside, Funding Division (part meeting)
Lorraine Rees, Manager Infection Control (part meeting)
Rudyard Yap, Infectious Disease Physician (part meeting)

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**

Ian Wilson advised his term as chair and member of the Institute of Environmental Sciences and Research Limited had ended, and he was no longer involved with the organisation.

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

Conflicts of interest in relation to today's business were advised as follows:

Stephen Paewai – in relation to the Part 2 minutes - Sentinel and Significant Event update.

Barbara Robson - in relation to any items that referred to the Regional Clinical Service Plan as she was a consumer representative on RCSP Steering Group.

4. MINUTES

4.1. Minutes

It was recommended:

that the minutes of the meeting held 2 June 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. Capital Expenditure – Bed Replacement Programme

It was suggested a bed replacement programme should continually be in place, as the beds had a finite life and a cyclical programme would ensure they were updated regularly.

It was recommended

that approval be given for the purchase of 19 beds in 2008/2009 at a total cost of up to \$105,000 + GST.

7. OPERATIONS REPORT

The General Manager, MidCentral Health, advised Dr Rudyard Yap (Infectious Diseases Physician) and Lorraine Rees (Manager, Infection Control), would join the meeting at 9am to discuss the outbreak of norovirus and answer any questions for members.

The General Manager, MidCentral Health, spoke to her report.

Assistance to Whanganui DHB

It was noted that MidCentral Health (MCH) was currently helping Whanganui DHB with O&G calls. In particular, cover on a Tuesday for a 24 hour period on an ongoing basis. There were new staff coming on stream later in the year at Wanganui.

Regional Women's Health Service

The Committee was advised the position description for the project manager had been agreed. The Regional Clinical Director was working on recruitment of staff, and the mechanisms of joint appointments.

A second meeting of the two DHBs was planned for early August.

The General Manager, MidCentral Health, advised MCH had revised the revenue position over the last month, and that it was different to what was anticipated.

Electives and Acute Medical Assessment and Planning Unit (MAPU)

The opening date for the MAPU had been delayed a little. It was now anticipated this would be around 20 July as there was some building work required, eg in the door areas, and this had slightly delayed the opening.

The benefits of the MAPU were outlined for members, and included:

- : Ward 27 would be split into two groups, medical and surgical, with each group run as a separate unit within the ward.
- : Medical patients would not stay inappropriately in the Emergency Department (ED).
- : There would be a reduced average length of stay.
- : Patients in the MAPU would be seen first on the day for ward rounds and then teams would move from there. This should stop medical teams having to move around the hospital to see their patients.
- : Overnight patients from ED would be in one place. This should enable planning so that patients went to their home-based ward quicker, and enabling streamlined ward rounds.
- : The same documentation would be used in ED and MAPU.
- : Patients would have any radiological examinations needed before they went to MAPU.

Management advised there were other strategies as well, eg an antibiotic process in primary care, which should help reduce the number of people coming into hospital. This system involved the Pharmacy preparing an IV package that primary care used. There was a GP programme that GPs could access similar to the Post ED Assessment and Liaison (PEDAL) system, which had nursing and allied health support thereby taking some pressure off ED.

Management confirmed there would be reporting via new scorecard indicators plus narrative on progress or indications of slippage against targets.

Influenza A H1N1 Outbreak

Members were updated on this outbreak. All of NZ was now in the “manage it” phase. MDHB was the last DHB to move to this phase. The focus will now be on “influenza-like illness” rather than solely on H1N1 as routine swabbing would not now be done. This change also means that numbers reported would not now truly reflect all people who had the illness.

MidCentral DHB’s Emergency Operations Centre (EOC) was operating seven days a week. The web emergency operation centre enabled staff to do other work as well as the EOC work from the centre or remotely. MCH, public health and primary health were now incident centres, who reported through to the EOC, where the information was coordinated and sent to the Ministry. The Ministry would be tracking progress as this was a new virus and would also help the northern hemisphere as they go into winter.

S. 15
One focus was on keeping the influenza away from MCH as long as possible. Influenza assessment centres were now being set up in some of the larger cities. The trigger for setting them up was when the GPs could not cope with the volume of people presenting. A technical advisory group had been set up for MDHB. This group included key clinicians from across the board's district. This group would discuss and make decisions on clinical issues.

Diane Anderson arrived.

Resourcing the EOC was a challenge, as everyone was very busy. A "hot debrief" would be held on 14 July, that would incorporate a broad group of people and groups. This would record learnings to date and ensure information was not lost.

Two issues were raised by a member. They were sick leave policies, and non-compliant individuals. The member felt it was surprising that health workers did not believe in containment procedures like flu injections, as it left the organisation vulnerable. Management outlined MDHB's leave policy, including special employer related leave whereby staff were required to stay at home until they had been free from symptoms for 48 hours for norovirus. This leave was controlled by the Infection Control Team.

Norovirus Outbreak

Dr Yap and Ms Rees joined the meeting to discuss the recent (second) outbreak of norovirus. This virus was highly contagious and very difficult to confine to one area. A traffic light system was being used to manage once there was evidence of cross infection. If the virus spread to other wards, then those wards also went into the traffic light system. Staff were also unwell. National Ministry of Health guidelines were being used, as well as some guidance and support from Otago DHB, who had had a similar outbreak last year. Additional security staff had been put into some key areas to try and enforce compliance with hand washing. Public visiting had been limited, but would be relaxed later today. The hospital buildings were getting old (toilet blocks in particular). There was high occupancy, and once the gastro/norovirus was identified it was already spreading to other people. All gastroenteritis are treated the same. However, the mode of transmission of the H1N1 influenza was different. So far there was no evidence of the spread of the H1N1 influenza within the hospital. Guidelines for its management were beginning to be provided.

Education would be a key focus for the future. The other focus would be to maintain vigilance around care and cleaning of equipment. Over time equipment became tired and shabby, so replacement and cleaning of equipment were two areas to consider in moving forward. Another area for future consideration would be providing hand washing stations in buildings for visitors to use.

Dr Yap and Ms Rees left the meeting.

Electives Report

Private/public protocols have been agreed by Cabinet. These protocols will provide further opportunity to explore options should that be required during the year.

MCH was commencing new processes from this week around monitoring ESPIs for the new financial year, and working as a team more closely for production planning.

It was noted there was an expectation that in the new financial year, elective targets would be met, and Management outlined some of the strategies to ensure this occurred. The strategies

included such things as re-opening the Day of Surgery Area (DOSA) overnight for patients, thereby providing some additional beds and maximising the new beds' use.

Radiation Therapy Treatment Capacity

At the moment, there was no capacity to treat approximately 12 radiotherapy patients, and Management were looking at referring them to other centres in NZ. This situation had been caused by a surge in demand. LA2, the oldest machine, was noted as being very helpful. Linacs 1, 3 and 4 were being fully utilised each day. LA4 was treating 30 – 36 patients per day and working very well.

Members discussed the situation of having a regional centre that treated patients from other DHBs, but then had to refer patients to other DHBs at a cost because we were unable to treat them due to insufficient capacity. It was noted that if a change to current service provisions was required, it was necessary to go through a service change process.

Management advised that a paper due in September on development in radiation oncology would cover such issues including the need for additional linac machines, either in public or private.

Cataract Initiative

Management clarified that whilst the Ministry's emphasis was on cataracts, there had been a change in clinical practice. This meant that clinicians were providing avastin treatment, which prevented the loss of eye sight, rather than doing the numbers of cataract procedures expected.

Radiation Therapy Service

The issue of providing a regional service, and the government's recently announced public/private protocols, was raised again. It was suggested boundary issues could be reconsidered in view of the recent announcement and the opportunities provided from it. Management advised caution in relation to proposing changing boundaries for a regional service. Also, clinicians developed clinical relationships, which would be affected if boundaries were altered. There were also the relationships between chemotherapy and radiotherapy, as well as the non government organisations (NGOs) like the Cancer Society. A more appropriate opportunity could be between the cancer network, and strengthening relationships between neighbouring cancer centres. There was also the Regional Clinical Service Plan which was about relationships and looking at planned solutions to difficulties or over-demand.

The change in the radiation therapy treatment target from six weeks to four weeks next December was raised. It was suggested MCH should be looking at achieving the four week targets now and what prevented their achievement. The length of time envisaged to upgrade LA 1 was noted as being dependent on whether or not there would also be upgrades other than the MLC upgrade. A member asked if Siemens upgraded more than the MLC, was the additional work included in the original price or not. The member also asked what was happening to LA3 as Siemens said it was unsuitable for upgrading. The member expressed the view that the original business case for the linac was not robust enough to cover such issues.

Cynric Temple-Camp left the meeting.

5.17
The Acting CEO felt the issues raised by the member, would be covered in the paper being presented in September on radiation oncology developments. This paper should help clarify the future service development.

Lindsay Burnell returned to the meeting.

Cynric Temple-Camp returned to the meeting.

There was a brief discussion about the service received from Siemens and the time taken for the upgrade of the linac. A member felt there had been too many delays and downtimes, and that if the machines had been more reliable, the targets might have been met. It was agreed this issue should be discussed in part 2 of the meeting.

Nursing Excellence Awards 2009

The Committee asked that a letter of congratulations be sent to the winner of the Tracey McFarlane Clinical Excellence Award.

Child & Adolescent Oral Health Project

Ms Robson said that from her reading of the Ministry's response (appendix 7), while it confirmed operational funding would be built into the population based funding formula, there was no time given for that to happen. The Acting CEO confirmed the information was correct. He also clarified that the statement in the Ministry's letter about the future funding track (FFT) was consistent with the Ministry's current directives.

Finance Report

The General Manager Corporate Services referred the committee to the statement of financial performance comparison between the 2006 and 2009 years, pointing out the deficit growth and explaining this had occurred despite additional funding having been given to MCH at the end of each year so that MCH could start afresh. He went on to say, there was no additional funding available now, as all reserves had been used. MCH must control the cost grown, or the DHB would be in serious financial trouble. A similar position was evident from the statement of financial position, which showed the decline in equity and increase in bank assistance.

The General Manager, MidCentral Health, advised she had gone through things in some detail with the middle management team last week, to make sure everyone had a clear understanding of the situation and that MCH had to breakeven. There was allowance in this year's budget for capital expenditure, but it was being handled in a careful manner, being mindful of such things as the need to replace urgent breakdowns.

RECOMMENDATION

It is recommended that

this report be received

8. GOVERNANCE ISSUES

8.1. Work Plan for 2009/10

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

7 July 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 – : MECA accruals	Under negotiation	9(2)(j)