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MidCentral District Health Board

Minutes of the Hospital Advisory Committee meeting held on 3 June 2008 commencing at 8.35 am in the Boardroom, MidCentral District Health Board

PRESENT

Jack Drummond
Lindsay Burnell
Ann Chapman
Jim Jefferies
Buster Kells
Stephen Paewai
Barbara Robson
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
Penny O'Leary, General Manager, RCTS, BSCC, Clinical Support Services
Jeff Small, Group Manager, Commercial Support (part meeting)
Anne Amoore, Group Manager Human Resources
Simon Floris, Manager, Management Accounting and Health Statistics
Robyn Shaw, Manager, Elective Services (part meeting)
Te Aira Henderson, Manager, Maori Health Service (part meeting)
Ian Ironside, Portfolio Manager, Secondary Care, Funding Division (part meeting)
Communications Unit (1)
Public (1) [part meeting]
Media (1)

1. APOLOGIES

An apology was received Jane Stojanovic.

The Chair read out a note from Ms Stojanovic advising she was sorry to be missing her last meeting of the Committee, that she had enjoyed her seven years on it and would miss the involvement with MidCentral Health. She wished members and staff very best wishes for the future.

The Chair acknowledged the sentiment. He also extended thanks to Mr Kells for the contribution he had made during the two terms he had been on the Committee.

2. LATE ITEMS

There were no late items.

6.6

3. CONFLICT AND/OR REGISTER OF INTERESTS

3.1. Amendments to the Register of Interests

Ms Robson advised her term as consumer representative on the National Collections Sub-Committee of the Health Information Strategy Action Committee was completed.

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

Jim Jefferies declared his interest in relation to item 7.7 "Increase in funding for elective services" advising he would not take part in any discussion on this matter. He was chairman of Aorangi Hospital Limited.

Dr Dummond advised an interest in the same item, as he was medical director of Waipuna Hospice. The Board Chair advised that general comments re the hospice would not be a problem in relation to this item.

4. MINUTES

4.1. Minutes

It was recommended:

> *that the minutes of the meeting held 6 May 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. OPERATIONS REPORT

The General Manager, MidCentral Health, presented her report.

6.1. Bed Day Usage

Management confirmed when calculating bed day usage, the number of beds taken into the calculations, was not changed unless the beds had been specifically closed and would not be reopened for some time.

6.2. Post Ponement of Elective Services

A member asked if it was known how often people arrived for an elective procedure only to find it had been postponed, as it was traumatic to arrive for surgery only to find it had been cancelled. Management agreed with this view.

6.3. Return to Nursing Course at UCOL

The Director of Nursing advised the delay in getting this course underway related to the time taken for the approval process to go through the Nursing Council approval mechanism.

6.4. Blockage – Ambulatory Care Centre

Members were advised that the last of the services to vacate the Ambulatory Care Centre during the sewage blockage, would move back into the Centre around 10 June.

6.5. Oral Health

Management confirmed the recently announced government budget had allocated some extra funding for oral health. The CEO advised the new money could be for operating costs, but he was waiting for further details of the allocation.

6.6. Finance Report

There was some discussion in relation to how national pricing was developed, and the difference between national prices and the level of cost growth. The General Manager, Corporate Services, advised he would be attending a two-day conference at the end of the week, to discuss national pricing issues.

Discussion on whether or not MCH was operating as efficiently as possible followed, with members agreeing the provider arm was not inefficient. However members agreed that MCH had to keep within the funding it was allocated and this seemed very difficult to achieve. The factors influencing this achievement were raised, for example compliance costs, the cost of new technology, pricing structure, funding level, supply costs, out-sourcing services. Other considerations included how the DHB allocated the funding it received between its various divisions, the possibility of rationalising services, and assessment of the deficit.

It was recommended

that the report be received.

7. STRATEGIC/SPECIAL ISSUES

7.1. Quarterly Quality update

The General Manager, MidCentral Health, advised the dates "July-September 2007" at the top of table 4 were incorrect. They should read "October-December 2007". The figures in the table were correct; it was merely the heading that was in error.

Optimising the Patient Journey

Members were advised that MCH had nominated itself to be a pilot site for the pilot programme being run from Counties Manukau DHB on "Optimising the Patient Journey". This project was one of five being run by the national Quality Improvement Committee.

It was recommended

that the report be received.

7.2. Quarterly Risk update

It was recommended

that the report be received.

6.8

7.3. Mental Health Staffing including FTEs and Internship update

It was recommended

that the report be received.

7.4. Secondary Care Plan (Cancer component) update

Management advised members that MCH was within the waiting list guidelines for Category C patients. Keeping within the guidelines had been possible because of the ability to send patients to Waikato and Australia for treatment.

The capacity of linear accelerator 2 (LA2) was less than the capacity of the other two accelerators because the type of patient going through the machine was more complex and usually required palliative treatment, which took longer to process.

The new bunker building project was proceeding to time and should be finished at the end of July. The "go live" date was not yet known.

It was further noted that the business case to replace the accelerator stated that the old accelerator would be kept running for six months after commissioning of the new machine, after which an evaluation would be done on the type of patients the machines could take and the affect on waiting times. There was some discussion on the reporting measurements, given the capacity of the machines (they could operate 24 hours per day) and the availability to staff them (generally 8 hours per day, five days per week). Given that MCH was currently sending patients to outside sources for treatment, an observation was made that it might reduce costs in the long term if the capacity was increased. It was recognised this could bring forward the date the machine would require replacing. Management advised each machine had a dedicated number of staff, and standards had been built around those figures. If the capacity of the machine was increased, there would need to be a corresponding increase in staffing numbers.

The comments regarding increasing the capacity were noted. Members also noted that the post event evaluation should cover such issues as well as efficiency gains resulting from the new machine and upgrading the old machines, and a recommendation regarding whether or not to retain the old machine.

Ms Robson asked if a future report could provide the proportion of colorectal patients presenting for treatment. Management agreed to provide this information.

It was recommended

that the report be received.

7.5. Liverpool Care of the Dying update

Media coverage of a recent court case involving the administration of morphine to a terminally ill patient that resulted in the death of the patient was noted, along with the comment that the community must have better access to palliative care. The incident did not occur in MCH's region.

It was recommended

that the report be received.

7.6. Improved Equity of Access to Elective Services

Management advised that a fully registered fourth urologist had been recruited, and would start with MCH in July.

The inability of MCH to arrange for sub-contracting work to local private provides at a price that would not increase the MCH deficit was briefly discussed. Management advised that a ministerial directive had been issued stating that work should not be contracted out at a price that was higher than the national case weight prices.

Management advised that compliance was achieved for the Elective Service Patient Flow Indicators (ESPIs) at the DHB level, but not at the service level for gynaecology, urology and ophthalmology (by one patient). Gynaecology and urology had been non compliant for four months, but work to become compliant was continuing.

The dilemma of either paying for some procedures to be done by a private provider thereby avoiding any penalties in terms of the early payment scheme, or not achieving compliance was raised. Management explained that the commitment thresholds were calculated on the number of patients treated in the previous six months. However, the complexity of the treatment could influence the score, eg four patients treated in four hours compared to one complex case treated in four hours. Patients were individually scored, and their score determined whether they met the commitment threshold. However, the commitment threshold was dependent on the number of patients treated over the past six months.

It was recommended

> *that the report be received.*

7.7. Increase in Funding for Elective Services

Mr Jefferies declared his interest in this item, as he was chairman of Aorangi Hospital Limited. He left the room for the discussion.

The Committee agreed that taking note of the ministerial directive around pricing, MCH's commitment to the public was that every opportunity was taken to do as much as possible for patients.

It was recommended

> *that elective services for the year ended 30 June 2009 be sub-contracted up to a total value of $3,787,652 (total amount to be determined by MCH provider capacity throughout the year), and*
>
> *that the General Manager, MidCentral Health, be authorised to undertake the sub-contracting process and sign all associated documents.*

7.8. Whanau Ora Service Review update

The "did not attend" (DNA) for Maori across the organisation for every specialty was just over 9%. Colposcopy was the worst area. Management were asked if the total DNA for the organisation, by ethnicity, could be provided. Whilst the split between initial appointment and follow-up appointment had not been done, a member wondered if the high rate of DNAs could be attributable to follow-up appointments rather than first-time appointments.

Discussion on the visit to Bay of Plenty DHB took place, highlighting the role of Te Pou Kokiri.

The number of staff identifying as Maori at MDHB was noted at 151. This number was seen as being under-representative given the total staff employed by MDHB was approximately 2,000.

The retirement of the Maori Chaplain, Reverend Kahu Durie in June, was noted. Members expressed their appreciation for the work she had done.

It was recommended

that the report be received.

7.9. Framework for the Continuum of Care update

Management updated the Committee on progress being made with the development of the nurse practitioner role. The Minister of Health met quarterly with the Nurse Practitioner Committee, and actively promoted the need for a nurse practitioner training programme, which he felt would assist with the workforce development programme.

The next area of focus for MCH was internal medicine and the emergency department, and developing advanced practice roles in these areas so that positions were available for staff to work to. However, MCH did not need any more nurse practitioners at the moment. Nurse practitioners supporting a one or two-doctor service could be the key to their future functioning.

An apprenticeship-type of scheme similar to the medical scheme would be helpful. MCH had therefore been thinking about a partnership approach with some of the lower North Island DHBs to support the development of nurse practitioners. Nurses worked right across the district wherever their participation was required. Training programmes ensured succession planning was in force.

The Committee asked Management to clarify the "tension" in relation to the medical management advice issue. Management explained that nurses were not allowed by law to prescribe medicines. However, advice was sometimes sought from nurse practitioners regarding medicines management. As the nurses were not legally able to prescribe, the inquirers were referred back to the prescribing general practitioners, and this had caused some tension.

It was recommended

that the report be received.

7.10. Workforce update

It was noted that when midwives came into New Zealand to work , they were required to spend 12 months working in the public sector before they could become a lead maternity carer (LMC). Management advised a lot of work was taking place in nationally relation to workforce planning for midwives, for example the Ministry of Health were in the process of

appointing a midwifery advisor and DHBNZ had a national project to better link regulatory and educational authorities, and so there was a better understanding and agreement as to how the syllabus should be structured.

It was recommended

that the report be received.

7.11. Financial Sustainability Programme update

The CEO commented that this report demonstrated there was no obvious areas where significant amounts of money could be saved, which he felt demonstrated MCH was an efficiently run organisation. There would be areas where some fine tuning could occur.

Members agreed with the CEO's comments and discussed how they saw the situation. One view was that either the prices being paid for secondary care services were falling behind but that if locum and supply costs could be controlled, it would go a long way towards reducing the deficit. However, the DHB had to continue with the primary healthcare model as well, so unless the funding model changed difficult choices would have to be made between continuing with the primary programme and putting more funding into the secondary model.

Another view put forward was that the issue related to costs and revenue, where the funding increased by only 3% but cost increases were much more than that.

A member felt it was difficult to make a judgement on the deficit because it was not clear whether the deficit was caused by inefficiency or high costs, and it was therefore too meaningless to quantify and make decisions on.

It was recommended

that the report be received.

7.12. DAP Initiatives update

It was recommended

that the report be received.

7.13. Non Financial Performance Indicator Report

It was recommended

that the report be received.

8. GOVERNANCE ISSUES

8.1. Work Plan for 2007/08

It was recommended

6.12

that the updated work programme for 2007/08 be noted.

9. LATE ITEMS

There were no late items.

10. DATE OF NEXT MEETING

3 June 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	Under negotiation	9(2)(j)
Financial Sustainability Programme	Commercially sensitive Subject of negotiations	9(2)(j)
Property Lease Agreements	Contract negotiations	9(2)(j)