

**Minutes of the Hospital Advisory Committee meeting held on 5 October 2010  
commencing at 8.30 am in the Boardroom, MidCentral District Health Board**

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**PRESENT**

Jack Drummond (chair)  
Lindsay Burnell  
Jim Jefferies  
Barbara Robson  
David Warburton

Phil Sunderland  
Ann Chapman  
Cynric Temple-Camp  
Richard Orzecki  
Kerry Simpson

**In attendance**

Murray Georgel, CEO  
Mike Grant, Acting General Manager, Corporate Services  
Carolyn Donaldson, Committee Secretary

Diane Anderson, Board Member (part meeting)  
Nicholas Glubb, Operations Director, Specialist Community & Regional Services  
Muriel Hanratty, Director, Patient Safety & Clinical Effectiveness  
Lyn Horgan, Operations Director, Hospital Services  
Chris Channing, Manager, Planning & Performance Unit  
Ian Ironside, Funding Division (part meeting)  
Dr Anne Robertson, Medical Head, Sexual Health Unit (part meeting)  
Dr Phil Marshall, Clinical Director, CAOH Service (part meeting)  
Diana Macdonald, Project Manager, CAOH (part meeting)  
Communications (1)  
Media (1)

**1. APOLOGIES**

Apologies were received from Stephen Paewai.

**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 to the register.

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

Ann Chapman declared a possible conflict of interest in relation to item 7.1, Sexual Health Service Review.

**4. MINUTES**

**4.1. Minutes**

It was recommended

that the minutes of the meeting held on 7 September 2010 be confirmed as a true and correct record.

#### 4.2. Recommendations to Board

To note that the Board approved all recommendations contained in the minutes with the following exceptions:

- i. Diabetes Lifestyle Centre Service Reconfiguration – recommendation was held over until October/November.
- ii. Permanent Fourth Linac, Radiation Oncology – an additional point was added to the recommendation.

#### ***Diabetes Lifestyle Centre Service Reconfiguration***

Since the Hospital Advisory Committee's meeting on 7 September, the CEO had met with the Clinical Sponsors of the diabetes service reconfiguration project and with the senior clinical staff of the Diabetes Lifestyle Centre. They were developing a plan as to how they would re-prioritise services within available funding. This plan would also include the service and clinical measures for inclusion in the post event audit review.

A date of 15 October had been agreed with this team for completion of the plan. If possible, this date would be brought forward a few days to enable the plan to be included in the Board's papers for October 2010. If this was not possible, it would come forward in November.

The CEO had also received some questions of detail from Board Members and responses to these would be incorporated into the report.

As a consequence of the above, the Chairman determined that the recommendation regarding the Diabetes Lifestyle Centre, as contained in the Hospital Advisory Committee's minutes, would not be considered at the Board's meeting on 21 September. It would be held over and considered at the same time as the plan.

#### ***Permanent Fourth Linac – Radiation Oncology***

The recommendation was amended to read:

- Radiation Oncology progresses to a project for the purchase of fourth permanent Linac sited on the first floor adjacent to LA1, with a full business case to be presented for consideration in March 2011.
- **that the business case consider the option of increased hours of use of existing linacs together with the effect this would have on the timing of investment and replacement of linacs and the purchase of a fourth linac.**

The Board also identified other aspects to be addressed in the business case, including; competitive pricing in a "vendor lock" situation, public/private partnerships, horizon scan of new technology, and maximising revenue opportunities.

## **5. MATTERS ARISING FROM THE MINUTES**

Richard Orzecki noted that the minutes did not identify individual speakers, and he queried whether it was important to know who raised issues. The CEO advised the minute recording followed MDHB's policy and were not a transcript of everything stated.

## **6. OPERATIONS REPORT**

### **6.1. Actual to Budget trend**

Management explained the reason budgeted revenue for the next few months was lower than the actual revenue received for the last few months, was because it was determined by the number of productive days in a month. A lot of the revenue was budgeted according to expected throughput although there were other rates as well, eg flat rate, fixed amount for a service, or actual delivery and seasonal variations. The CEO noted that acute surgical services were still delivering lower than usual planned services due to a drop in demand. The money for this service remained with the Funding Division, and had not been passed over to MidCentral Health as a result. The budget figures were a cumulative result of the assumptions that had been built into the budgeting process. The CEO offered to provide more information on how the figures were determined if required.

### **6.2. Elective Case Weight Discharges**

Management said the elective case weight discharges (CWD) were over budget by 21 CWD as per the price volume schedule for the year. They included the local initiative work as well as any other inflow work done for other DHBs. The elective initiative involved MDHB work plus out-flow elective work done by Capital & Coast DHB for MDHB.

### **6.3. Variance Analysis**

Management advised that figure 2 (page 6.5) showed where the unfunded services were and their value at national prices compared to the total revenue received. They were largely in ED and medicine. This year, a new provision had been made for additional leave costs. If salaries increased, then it followed that when staff took their leave the cost of that leave would be at the new salary rate. The large negative variance showing in Hospital & Associated Services represented that new leave accrual. Staff were encouraged to take leave when possible, and some leave would probably be taken before any new increases became effective.

It was estimated that only 50% of the targeted \$1m additional revenue for Regional Cancer Treatment Service would be achieved in the current year. Funding Division are paying MidCentral Health at that level and endeavouring to secure that revenue from the contributing DHBs. It was anticipated that the full amount of additional revenue would be achieved in the 2011/12 year.

### **6.4. Recovery Programme – Financial Service Reviews**

Now that most of the financial service reviews were completed, the focus would be on implementing the recommendations arising from the reviews. A member suggested it would be helpful if some assumption of the contributions the various reviews have made to the recovery programme were available (bullet points would be sufficient). The hospital-wide projects for MRIs and clinical supplies related to ensuring the clinical supply usage and MRI referrals were appropriate. Also, the standardisation of the products would link into the work Materials Management were doing around national purchasing.

Cynric Temple-Camp declared a conflict of interest in relation to MRI referrals.

There was a brief discussion on MRIs, whether they could be done privately, and whether or not they were promoted as an avenue for additional revenue. The CEO advised this service did not belong to MDHB, but was owned by Broadway Radiology, who leased land from the Board for this service.

#### **6.5. Smoking Cessation Target**

Management advised a standard smoking cessation screening form was being finalised for printing and implementation. The form had been trialled and resulted in good feedback. The new forms would provide clinical staff with a standard way of documenting comments and the clinical coders a standard place to find the documentation. Use of the new form should see an improved result for this target. MDHB had been taking a broader view, using the project as an opportunity to promote smoking cessation in a range of ways rather than just focusing on numbers. The project was now moving into primary care.

#### **6.6. Shorter Stays in ED Target**

Management were working with the Central PHO and St John Ambulance Service to look at ED presentations, as MDHB could not support the growth on an ongoing basis.

#### **6.7. Elective Initiative**

The focus on recruiting anaesthetists was noted, with the improvement going from 12.8 FTEs in August 2010 to an anticipated level of 19.8 in March 2011. In addition, the Clinical Directors of Surgical Services and Anaesthetics were meeting regularly to look at leave and other issues, and to see how the shortfall in discharges could be made up and the elective targets maintained.

#### **6.8. Acute Surgical Services**

The reason for the downward trend in acute surgical work was not known, and Management were now considering that it might be a permanent trend. Most of the drop was in general surgery (such as appendixes, concussions, head injuries etc). There had been a major increase in elective work, and as part of the budget process for 2011/12 consideration was being given to what the anticipated volumes might be.

#### **6.9. Average Length of Stay**

It was noted that if a patient was transferred to another DHB, the patient was firstly discharged from MDHB and then admitted to the next DHB.

#### **6.10. Orthopaedic Volumes**

A focus last year was on case weights in all specialties, in order to ensure revenue was maximised. However, MCH was behind in orthopaedic volumes and was still a little behind this year. MCH was achieving the elective performance indicators and patients were being booked with certainty for treatment. They were not waiting beyond six months for their elective orthopaedic surgery.

#### **6.11. Radiation Therapy Wait Time Target**

The steps being taken to achieve the four week wait time target were outlined, with Management advising that as a result of that work, times should now reduce to the new targets in line with the December 2010 deadline.

### **6.12. Women's Surgical Services in Whanganui**

It was not known yet whether any women would take advantage of the offer to have their surgery performed in Whanganui. As women had taken the opportunity to use the Mobile surgical bus service in Dannevirke previously, it was anticipated some women would be keen to take up the offer to go to Whanganui. Information would be circulated to the women concerned that would include a profile on the clinicians, who underwent a common credentialling process to MCH clinicians.

### **6.13. Radiation Therapy – upgrade on Linear Accelerator machines**

It was suggested that good documentation quantifying the benefits received from the three linear accelerators should be maintained.

### **6.14. Bowel Screening Pilot Proposal**

It was recommended that Management consider the importance of benchmarking to show the impact of the screening and access to surgery, if this proposal was successful. It was further suggested that there should be some quality control for primary care around the communication and information provided to prospective participants in the programme. The reason for the suggestion was that the screening might not be as accurate as other screening tests, and people should be aware of that.

### **6.15. Linear Accelerator business case**

It was suggested that as part of the work on the business case for the new linear accelerator, some staff should go and look at a radiation oncology centre where the machines worked from 6am until 8pm and to get feedback on how it worked.

It was recommended

*that this paper be received*

## **7. STRATEGIC / SPECIAL ISSUES**

### **7.1. Sexual Health Service Review – Proposed Service Reconfiguration**

It was recommended

*that this report is received*

### **7.3 Service Configuration - Child Adolescent Oral Health Service**

The Committee was advised that the figure for the pre-school children in Tables 9 and 10 had been double counted, ie included in the regional figures and also in its own category. As a result, the total children enrolled should be 29,275, not 33,646.

After briefly introducing the proposal, the following issues were raised:

- could end up with more children travelling for dental care than originally proposed
- could not identify the “did not attend” figures associated with a community based approach

5.17

- if additional money became available for health then the clinics would be well placed to help the adult community
- More clarification was required around the volumes for completed treatments/client cases, which in the 2008 business case was stated as 37112. However, former spreadsheet information identified this 37,112 as appointments, not completed treatment /client cases. This should be clarified now, otherwise MCH might be asked to do additional volumes.
- Further information should be added to this report that goes back and reviews the volumes, and the revised operating performance is reconsidered.
- Concern at the \$480,000 funding shortfall as a result of an increase of 5,000 volumes, which would need to be funded from the population based funding, particularly at a time when services were being reviewed. Management advised the increase of volumes was always going to be an issue for the future. The business case forecast was based on what was identified for that period recognising that future growth and arrangements would be addressed via the population based funding. This was not a new issue.
- Concern at the 5,000 pre-school age volume – Management advised it was always intended to see this extra number of children. From a clinical perspective it was important to deliver some preventive measures early. The former service did not reach the pre-school population sufficiently well to enable a reduction in hospital presentations under general anaesthetic. The CAO service's aim was to reach the high risk children first, but ultimately it was intended to see all the children.
- The cost of this new service should be viewed as an investment for the future. The additional \$480,000 was part of that investment.

Management confirmed more information based on the concerns expressed during the above discussion, would be provided to members.

It was recommended that approval be given to the following changes in configuration:

- *replace one double chair fixed clinic in Palmerston North with one single chair fixed clinic in Dannevirke and one single chair fixed clinic in Levin*
- *replace one double chair mobile with two single chair mobiles*

## **8. GOVERNANCE ISSUES**

### **8.1. 2010/11 Work Programme**

It was noted that further information would be provided in line with the discussion on the Child Adolescent Oral Health Service topic in the earlier part of this meeting.

It was recommended

*that the Committee's 2010/11 work programme be noted.*

### **8.2. December 2010 meeting arrangements**

It was confirmed that the external committee members could join the December board meeting but they would not have voting rights.

It was recommended

*that the report be received and the amended meeting arrangements noted.*

**9. LATE ITEMS**

There were no late items.

**10. DATE OF NEXT MEETING**

2 November 2010

**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:

<i>Item</i>	<i>Reason</i>	<i>Reference</i>
"In Committee" minutes of the previous meeting	For reasons stated in the previous agenda	
Operations Report : Potential Sentinel/Serious Events and Complaints	To protect personal privacy	9(2)(a)
: MECA Negotiations	Industrial negotiations	9(2)(j)