

Hospital Advisory Committee Minutes

MEETING DETAILS													
Time and Date	10:45am, Wednesday, 7 April 2010												
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton												
1	ATTENDANCE AND APOLOGIES												
	<p>Committee Members</p> <table> <tr> <td>Dr Chris Chambers (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Susan Buckland</td> <td>Rob Cooper</td> </tr> <tr> <td>Dr Brian Fergus</td> <td>Dr Ian Scott</td> </tr> <tr> <td>Pat Snedden</td> <td>Rt Hon Bob Tizard</td> </tr> <tr> <td>Seiuli Dr Juliet Walker</td> <td>Ian Ward</td> </tr> <tr> <td>Associate Professor Anne Kolbe</td> <td>Lynda Williams</td> </tr> </table> <p>Management in Attendance</p> <p>Garry Smith - Chief Executive Dr Denis Jury – Chief Planning & Funding Officer Brent Wiseman - Chief Financial Officer Greg Balla – Director of Performance & Innovation Ngairie Buchanan – General Manager Operations Margaret Dotchin - Nurse Director Fionnagh Dougan – GM Mental Health, Ambulatory, Cancer & Blood Services Aroha Haggie – Maori Health Gain Manager Chris Morgan - Manager Materials Management Vivienne Rawlings – General Manager Human Resources Ian Bell - Board Administrator</p> <p>Apologies</p> <p>The Chair declared the meeting open at 10:55am.</p> <p>Apologies had been received from Harry Burkhardt, Professor Iain Martin, Farida Sultana, David Sage and Kay Hyman.</p>	Dr Chris Chambers (Chair)	Jo Agnew	Susan Buckland	Rob Cooper	Dr Brian Fergus	Dr Ian Scott	Pat Snedden	Rt Hon Bob Tizard	Seiuli Dr Juliet Walker	Ian Ward	Associate Professor Anne Kolbe	Lynda Williams
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2	CONFLICTS OF INTEREST												
	There were no declarations of conflicts of interest for any item on the agenda.												
3	CONFIRMATION OF MINUTES 3 MARCH 2010												
	<p>Margaret Wilsher was developing a Research Strategic Plan noting Professor Martin's comment about the need to be a vibrant research organisation. This would provide a more intentional relationship between ADHB and the University. Tony O'Connor would be contributing.</p> <p>The Committee was advised that Professor Richard Reznick was undergoing a review of the University as to the structure of a Clinical Education Board in the Clinical School which would look at the interrelationship with the DHB. Research was the only flexible revenue stream for the University.</p> <p>It was suggested that there be a discussion on where ADHB sat as a University teaching hospital at the Strategic Planning Day.</p>												

	<p><u>Moved Pat Snedden seconded Lynda Williams</u></p> <p><i>That the minutes of the Hospital Advisory Committee meeting held on 3 March 2010 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>
<p>7.1</p>	<p>Adult Acute Flow Project</p>
	<p>Margaret Dotchin; Tim Parke, Clinical Director Adult ED; Mark Gardener, Senior Physician championing the flow through ED project; Charlotte Porter, Charge Nurse Ward 68, a General Medical ward; and Tim Denison, Improvement Specialist presented to the Committee.</p> <p>The project was being undertaken as, had been advised at previous meetings, it was estimated that 38 patients per annum died due to delays and the 6 hour target set by the Minister was in fact good care as it is best to move people on and not have ED as a warehouse. Progress was being measured and there had been genuine improvement. Approximately 35% of patients are discharged direct from ED and do not move into the hospital system. Getting improvement in times waiting for a bed was slow progress due to the need to have the hospital working better. The project was coming to a turning point where there could be improvements to target or it could plateau or even fall. It was about not having electives interfere with acutes as while electives are planned there is not planning for acutes.</p> <p>The solutions were outlined being recognising short stay at Emergency Medicine with these patients to be accounted separately from the 6 hour data, increased staffing with now a full compliment of RMOs and increased SMO input which provided more supervision and earlier decision making. Further improvements were access to investigations with 24 hour access to CT and faster radiology, improved efficiency by reducing occupancy which created more space to see patients, more liaison with APU and education to have more engagement by everyone. The work stream on ward admissions, the one hour work stream, had improved the time between bed request to admission from an average of 7.5 hours to 4.4 hours. Causes of delay were bed blockages and high occupancy, problems with weekend discharge and delays in discharge. Improvement activities were a daily rapid round of 15 minutes which covers every patient, day of discharge logistics, improved weekend discharge and re-launching of nurse facilitated discharges. There was daily bed management communication. Further beds had been opened in November with a further increase in January.</p> <p>In managing acute flows senior medical staff had more understanding when real examples were provided. There was a need to have beds empty and not filled with electives. There were measurable KPIs and there was an aim to get planned discharge date estimates 90% correct. Planning acutes can be very predictive and the Greenlane surgical unit will assist. There was also a project to focus on General Medicine to get a cultural change and conversation with the private sector.</p> <p>It was noted that Primary Care would not make a difference to the 6 hour target, the target was realistic but hard and Counties Manukau was compliant. Primary Care could improve discharge although it was noted that again this was run as a 5 day service rather than 7 day service. It was noted that hospitals were for sick people and provided a critical mass of skills where as it would be uncertain whether Primary Care could provide that critical mass.</p> <p>The Chair thanked the presenters.</p>
<p>7.2</p>	<p>Maori DNA Rates</p>
	<p>Linda Thompson, Manager Clinical and Projects Maori Health; John Paterson, Manager Provider Arm Services Maori Health; and Leigh Cleland, Manager Greenlane Clinical Centre presented to the Committee as they had to the Maori Health Advisory Committee.</p> <p>Information was provided that showed Maori DNA rates had decreased 1% from 2006 – 2008 and by another 1% 2008 – 2009 but still remains highest along with Pacific DNA. The Maori DNA rate of 10% was the lowest DNA amongst DHBs and complies with the Health Roundtable range of 5% - 10%. It was noted that 47% of DNAs were from outside ADHB. To address the problem six specialities had been targeted and of note was the 94% DNA for the 0 – 15 year olds audiology</p>

	<p>clinics which may be due to their dependence on people to bring them.</p> <p>Initiatives being undertaken were flyers to all patients, invitations to make appointments at times which suited them, a child play area, texting etc. It was suggested that mobile audiology may improve the low rate for children and it was noted that once the issues were identified and resources applied good results could be obtained. Recommendations would be going to the Clinical Board.</p>
5.1	Operational Summary Report and Financials
	<p>The financials were favourable with a lot of savings being made, not in FTE but in other ways. The MRI donation was expected in May. How to report on productivity was being reviewed.</p> <p>With radiation therapy it was known that there would be noncompliance for Quarter 2 and Quarter 3. Planning time was being reduced from 15 days to 8 days and there were discussions with AOR who were willing to flexed capacity over the next year. With the existing MECA there were constraints on radiation therapists outside hours work and there also needed to be a skill mix with ADHB having more less skilled.</p> <p>Cardiology was experiencing difficulties with the RT strike and Lab strike so there was some outsourcing. The Minister had been advised early and was concerned at getting back to the 81 waiting which at present sat at 84. The overall contract number for the year will be delivered and there is an aim to get a lower waiting list to provide a buffer to cover unforeseen circumstances. Arrangements with private providers for both radiology and cardiology were being reviewed to get better planning rather than stop/start arrangements.</p> <p>Radiation was reliant on having workforce issues resolved and getting the planned replacement machine. There was still a commitment to get to a target of 4 weeks by December 2010.</p> <p>The Government objectives were immovable in these areas so there may be a need to move resources from other areas whilst still achieving breakeven. If priorities shifted resources had to shifted. The improvement projects were being undertaken although there may be some time to get their benefits coming through.</p>
9	GENERAL BUSINESS
	The Auckland City Hospital Car Park had been delayed with changes at the national level in the approval system and Capital Committee.
	NEXT MEETING
	<p>The meeting closed at 12:50pm.</p> <p>The next meeting is scheduled for 10:45am, Wednesday, 5 May 2010 A+ Trust Room Clinical Education Centre Level 5 Auckland City Hospital Grafton</p>
CONFIRMED	
CHAIR:	DATE: