

MEETING DETAILS													
Time and Date	9:30am, Wednesday, 5 October 2011												
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton												
1	ATTENDANCE AND APOLOGIES												
	<p>The Chair declared the meeting open at 9:31am.</p> <p>Committee Members</p> <table> <tr> <td>Judith Bassett (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Peter Aitken</td> <td>Susan Buckland</td> </tr> <tr> <td>Rob Cooper</td> <td>Dr Chris Chambers</td> </tr> <tr> <td>Dr Lester Levy</td> <td>Dr Lee Mathias</td> </tr> <tr> <td>Robyn Northey</td> <td>Gwen Tepania-Palmer</td> </tr> <tr> <td>Ian Ward</td> <td>Associate Professor Anne Kolbe</td> </tr> </table> <p>Management in Attendance</p> <p>Garry Smith - Chief Executive Dr Margaret Wilsher – Chief Medical Officer Brent Wiseman – Chief Financial Officer Greg Balla – Director Performance and Innovation Ngaire Buchanan – General Manager Operations Taima Campbell – Executive Director of Nursing Janice Mueller – Executive Director of Allied Health, Scientific and Technical Ian Bell - Board Administrator</p> <p>Apologies</p> <p>Apologies for lateness were recorded for Rob Cooper and Gwen Tepania-Palmer.</p> <p><u>Moved Lee Mathias, seconded Peter Aitken</u></p> <p><i>That the apologies be sustained.</i></p> <p><u>Carried</u></p>	Judith Bassett (Chair)	Jo Agnew	Peter Aitken	Susan Buckland	Rob Cooper	Dr Chris Chambers	Dr Lester Levy	Dr Lee Mathias	Robyn Northey	Gwen Tepania-Palmer	Ian Ward	Associate Professor Anne Kolbe
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2	CONFLICTS OF INTEREST												
	<p>There were no declarations of conflicts of interest for any item on the agenda. The Board Administrator had been notified of changes to the interests register by Lee Mathias and Robyn Northey.</p>												
3	CONFIRMATION OF MINUTES 7 SEPTEMBER 2011												
	<p>The report on where patients 80+ year old transported by St Johns go will be made once the data is analysed. Automated coding at time of discharge for less complex cases will be applied to those from external DHBs.</p> <p><u>Moved Jo Agnew; seconded Robyn Northey</u></p> <p><i>That the minutes of the Hospital Advisory Committee meeting held on 7 September 2011 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>												

4	ACTION POINTS 7 SEPTEMBER 2011
	<p>The statutory definitions of the Hospital Advisory Committee and the Community and Public Health Advisory Committee did not support the HSG philosophy which was to look at the whole continuum of care including activity outside of hospital that had effects on the hospital e.g. diabetes, POAC etc.</p>
5.1	Operational Performance Report
	<p>The results were reasonable for the month and year to date but there are still challenges to work through. An updated Flash Report was tabled. The tables on Maori and Pacific acute data were roughly in line with their percentage of population although there was a caution that the data was variable. The development of the data and graphs is an evolutionary process.</p> <p>Production for the quarter would be at 100% with outsourcing being brought forward to achieve this. Going forward there were plans service by service to achieve sustainability. A capacity gap in orthopaedics has been identified.</p> <p>The aim of having zero patients waiting over six months for elective procedures had identified risk areas. Information was supplied on reasons for cancellations, with orthopaedics having experienced the most. They are also disproportionately impacted by acutes, although cancellations were reducing. There was a capacity gap and with that service being asked to increase production 30% year on year there needed to be better planning tools to align resources.</p> <p>ESPI and health targets are not related. There is a need for the rate of FSA and procedures to align i.e. with increased targets there needs to be an increase in FSAs to get the throughput. This requires realignment of resources. The institution of buffers was to provide for contingencies and unforeseen situations. Each service was looking at the gaps and the need to outsource, which came from a total outsource pool, with outsourcing brought forward to be on track for the first quarter. Patient and Operational Demand Plans (POP) were used to match resources to what was needed to be delivered, with this being on a daily, weekly, monthly basis which was helping to achieve the cultural shift needed to deliver to the plan.</p> <p>Gwen Tepania-Palmer joined the meeting at 10:05am.</p> <p>Resolution of the production issues would take time, but the mechanisms are there. Cancer had demonstrated that if shorter times are demanded they can be achieved. It was noted that ADHB served a wider population than just its own.</p> <p>The committee acknowledged that it was the patient's prerogative to cancel. This may be the right outcome for the patient although it may conflict with efficient production. It was also noted that there was some patient responsibility as they are using a community funded resource. . Cancellations are managed in some areas by over booking where there are higher cancellation rates, and standby lists are also used. The key was to avoid wasting surgical resources..</p> <p>Rob Cooper joined the meeting at 10:20am.</p> <p>Lists are negotiated and worked to finishing, either early or late. Work was being undertaken to try and predict peaks to smooth production, as high demand days do cause bed blockages and across all areas to make the system more robust. Improvements required attention to detail, and discipline. The visual aid of a "Green Shirt" being a person to go to was noted. Some areas are affected by staffing but the main driver is volume demand.</p> <p>The number of child acute patients waiting 12 hours or more had diminished significantly by changes in practice. Cardiac bypass surgery waiting lists were subject to huge variation in referrals, for example surges after well attended conferences to catch up. A predictive line of cardiac waiting lists were requested to be included in the graph. The goal was to have 81 patients on the list to achieve the most efficiency. It was noted that 1100 people had been given quit advice relating to smoking.</p>

9.1	<p>Resolution to Exclude the public from a meeting of the Hospital Advisory Meeting</p>											
	<p><u>Moved Judith Bassett; seconded Anne Kolbe</u></p> <p><i>That the exclusion of the public from the relevant part of the meeting is necessary to enable the Board to deliberate in private on a decision or recommendation as to whether any of the grounds in paragraphs (a) to (d) of clause 32 of Schedule 3 of the Act are established in relation to all or any part of the meeting.</i></p> <p><i>THAT the public be excluded from the following part of the proceedings of this meeting, namely consideration of items 9 of the Agenda.</i></p> <hr/> <p><i>The general subject of the matters to be considered while the public is excluded, the reason for passing this resolution in relation to each matter, and the specific grounds under the above clause for the passing of this resolution are as follows:</i></p> <table border="1" data-bbox="199 694 1356 1243"> <thead> <tr> <th data-bbox="199 694 582 817">General subject of each matter to be considered:</th> <th data-bbox="582 694 981 817">Reason for passing this resolution in relation to each matter:</th> <th data-bbox="981 694 1356 817">Ground(s) under clause 34 for the passing of this resolution:</th> </tr> </thead> <tbody> <tr> <td data-bbox="199 817 582 907">11.1 Confidential HAC Minutes 7 September 2011</td> <td data-bbox="582 817 981 907" rowspan="6">To enable the Board to carry on without prejudice or disadvantage commercial activities and negotiations: Official Information Act 1982 s.9(2)(i) and s.9(2)(j)</td> <td data-bbox="981 817 1356 907" rowspan="6">That the public conduct of the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under s 9 of the Official Information Act 1982.</td> </tr> <tr> <td data-bbox="199 907 582 952">11.2 Risk</td> </tr> <tr> <td data-bbox="199 952 582 996">11.3 Quality</td> </tr> <tr> <td data-bbox="199 996 582 1041">11.4 Productivity Report</td> </tr> <tr> <td data-bbox="199 1041 582 1086">11.5 Global Trigger Tool and Mortality Review</td> </tr> <tr> <td data-bbox="199 1086 582 1243">11.6 Performance Improvement Activities – Financial Impact</td> </tr> </tbody> </table> <p><u>Carried</u></p> <p>Items discussed in public exclusion were the risk register, quality, productivity report, global trigger tool and mortality review and the financial impact of performance improvement activities.</p> <p><u>Moved Jo Agnew; seconded Lee Mathias</u></p> <p><i>That the meeting resume in public.</i></p> <p><u>Carried</u></p>	General subject of each matter to be considered:	Reason for passing this resolution in relation to each matter:	Ground(s) under clause 34 for the passing of this resolution:	11.1 Confidential HAC Minutes 7 September 2011	To enable the Board to carry on without prejudice or disadvantage commercial activities and negotiations: Official Information Act 1982 s.9(2)(i) and s.9(2)(j)	That the public conduct of the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under s 9 of the Official Information Act 1982.	11.2 Risk	11.3 Quality	11.4 Productivity Report	11.5 Global Trigger Tool and Mortality Review	11.6 Performance Improvement Activities – Financial Impact
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	<p>NEXT MEETING</p>											
	<p>The meeting closed at 12:13pm</p> <p>The next meeting is scheduled for 9:30am, Wednesday, 2 November 2011 A+ Trust Room, Clinical Education Centre Level 5, Auckland City Hospital, Grafton</p>											
	<p>CONFIRMED</p> <p>CHAIR: DATE:</p>											