

<b>MEETING DETAILS</b>											
Time and Date	9:30am, Wednesday, 7 September 2011										
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton										
<b>1</b>	<b>ATTENDANCE AND APOLOGIES</b>										
	<p>The Chair declared the meeting open at 9:32am.</p> <p><b>Committee Members</b></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 Lester Levy</td> </tr> <tr> <td>Dr Lee Mathias</td> <td>Robyn Northey</td> </tr> <tr> <td>Gwen Tepania-Palmer</td> <td>Ian Ward</td> </tr> </table> <p>Associate Professor Anne Kolbe</p> <p><b>Management in Attendance</b></p> <p>Garry Smith - Chief Executive  Dr Denis Jury – Chief Planning and Funding Officer  Dr Margaret Wilsher – Chief Medical Officer  Brent Wiseman – Chief Financial Officer  Greg Balla – Director Performance and Innovation  Kristine Nicol – Professional Leader Allied Health  Margaret Dotchin – Nurse Director, Adult Health Services  Ian Bell - Board Administrator</p> <p><b>Apologies</b></p> <p>Apologies had been received from Dr Chris Chambers, Professor Iain Martin, Taima Campbell and Janice Mueller.</p> <p><u>Moved Jo Agnew; seconded Robyn Northey</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 Lester Levy	Dr Lee Mathias	Robyn Northey	Gwen Tepania-Palmer	Ian Ward
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<b>2</b>	<b>CONFLICTS OF INTEREST</b>										
	There were no declarations of conflicts of interest for any item on the agenda. Jo Agnew advised that she was Professional Teaching Fellow, School of Nursing.										
<b>3</b>	<b>CONFIRMATION OF MINUTES 3 AUGUST 2011</b>										
	<p>The Mortality Review Report would be provided in October. The Committee asked for a review of moderate risks and a report on complaint and compliment trends. They also asked for more information, including reasons, about the surgical lost lists and cancellations and patient DNAs and what was being done to improve..</p> <p><u>Moved Judith Bassett; seconded Susan Buckland</u></p> <p><i>That the minutes of the Hospital Advisory Committee meeting held on 3 August 2011 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>										

4	<b>ACTION POINTS 3 AUGUST 2011</b>
	All actions were covered in the report.
5.0	<b>Provider Operational Performance Report</b>
	<p>The report was for the first month of the new financial year and there had been coding pressures relating to the end of the previous financial year. Coding converts clinical activity into case weights which converts into the revenue stream. More complex cases take more time and involve more WIES and may take 3 months to be fully coded. While it is ideal to code at time of discharge, funding is bulk rather than on invoice. It was thought that ADHB coding was done well compared with other DHBs. The MoH target for electives was based on discharges, rather than WIES which were decreasing as electives went deeper into the population with less acuity and complexity. Employee numbers were down, although nurses were up, and the reduction in expenditure on clinical supplies partially reflected the reduced volumes.</p> <p>Some areas with less complexity have automated coding at time of discharge. Coding does not change cash flow, but only the final year end position and each month uncoded cases are not ignored but an estimate done. There had been significant improvements over the year, from 90% at month end to now 90% at 7 days. Real time coding helps with the prediction tool for readmissions and earlier planning. The real issue in a capitation system is cost control. Information from coding is being used for the daily and weekly reporting that is being implemented.</p> <p>ED performance was not able to sustain the 95% target with the acute demand and there needed to be proactive action to build a buffer in the hospital system, using better prediction tools. The target can be affected by as little as 5 people. Capacity outside hospital could be increased through the investment in after hours care centres and perhaps to have at least one rest home which could provide hospital level care, although in general, people were not turning up to ED inappropriately.</p> <p>A number of actions to improve prediction were being taken, such as looking at weather reports and virology in the community, as these affected respiratory and flu demands, particularly in older people. The predictive model would need to be tested. Other actions would be to incentivise Registrars to cover shifts, implement new ideas in General Medicine with a new Clinical Director appointed and working with primary care, St Johns and rest homes to develop the strategies to support and treat patients outside the hospital. It was important to keep staff focused on the target.</p> <p>For 80+ year olds, work was being done with St Johns, presently at the data collection stage, to understand what happened to these patients that they delivered to ED. There would be a report to the Committee within 2 - 3 months. There was also a review of people coming to Auckland rather than the other DHBs in the metro region. Clinicians supported the 6 hour target as it was good for patients.</p> <p>Electives had daily and weekly reporting, both retrospective and prospective. For July and 3 weeks in August there was an under delivery of 54 which had been rescheduled within the quarter and this number had now risen to 91 needing to be rescheduled in September. There were plans to close the gap by the end of the month, with plans in Paediatrics and Orthopaedics. Ophthalmology was over plan. General Surgery was a risk, but there would be some overs and unders, noting that, with January usually a reduced month, services needed to be ahead of targets in November. Orthopaedics and General Surgery were outsourcing now and not leaving the backlog to the new year. Greenlane was delivering to plan and continues to increase capacity as planned. Acutes and transplants can have a large effect on electives, so there was a need to get better understanding of their impact and the critical mass needed to maintain the targets. There was an annual production plan with daily, weekly and monthly reporting to get all connected and surgery planned 2 weeks ahead to ensure resources are coordinated. Orthopaedics had some 12 hour days built into their plans.</p> <p>The group service leaders are accountable for performance in the HSG model and the temporary Electives Project Director had been employed for the improvement initiative with his term extended to 30 September to embed the reporting, as well as predictive reporting, and delivery.</p>

	<p>There is a move to the Clinical Leadership model with 2 Director's of Performance for Child and Adults being recruited with ultimate accountability to the Chief Medical Officer and Director of Surgery. The Committee decided to report back to the Board their concerns for elective surgery and asked Management to have more focus on getting to the elective target and progressively removing impediments.</p> <p><u>Moved Judith Bassett; seconded Jo Agnew</u></p> <p><i>That the Hospital Advisory Committee records its serious concern at elective surgery performance.</i></p> <p><u>Carried</u></p> <p>Construction had started on the facilities for Ophthalmology and the service was going through a process improvement project under an enthusiastic Clinical Director.</p> <p>Reporting, including Waitemata, Counties Manukau and Northland as our biggest customers, was supported, as well as the top 3 and bottom 3 services. Ideally there should be no under or over delivery, so in reporting there needed to be words of explanation. The development of the reporting was a work in progress. Targets were an important tool and needed to be instilled into the layers of management, but a note of warning was made that it was key to have people engaged, as experience in the NHS had been some parts of the workforce being disengaged. Senior management needed to consider engagement issues and whether there was a need to change processes, rather than putting more pressure on existing practices.</p>
<b>6.1</b>	<b>DAP Projects Report</b>
	This was the first month of a new financial year. No issues reported.
<b>8.0</b>	<b>Health Quality and Safety Commission – Statement of Intent</b>
	This was for information only.

<b>11.0</b>	<b>Resolution to exclude the public from a meeting of the Hospital Advisory</b>										
<p><u>Moved Judith Bassett; seconded Jo Agnew</u></p> <p><i>That, in accordance with the provisions of Schedule 3, Clauses 32 and 33, of the New Zealand Public Health and Disability Act 2000, the public be excluded for consideration of Item 11</i></p> <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="199 504 1468 896"> <thead> <tr> <th data-bbox="199 504 614 638">General subject of each matter to be considered:</th> <th data-bbox="614 504 1053 638">Reason for passing this resolution in relation to each matter:</th> <th data-bbox="1053 504 1468 638">Ground(s) under clause 34 for the passing of this resolution:</th> </tr> </thead> <tbody> <tr> <td data-bbox="199 638 614 694">11.1 Risk Register</td> <td data-bbox="614 638 1053 694" rowspan="3">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="1053 638 1468 694" rowspan="3">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="199 694 614 795">11.2 General Medicine Service Excellence</td> </tr> <tr> <td data-bbox="199 795 614 896">11.3 NGO Audit Issues – Major Issues Status</td> </tr> </tbody> </table> <p><u>Carried</u></p> <p>Items discussed in public exclusion were the Risk Register, General Medicine Service Excellence and NGO audit issues.</p> <p><u>Moved Robyn Northey; 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 Risk Register	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 General Medicine Service Excellence	11.3 NGO Audit Issues – Major Issues Status
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<b>NEXT MEETING</b>											
<p>The meeting closed at 12:17pm</p> <p>The next meeting is scheduled for 9:30am, Wednesday, 5 October 2011 A+ Trust Room Clinical Education Centre Level 5, Auckland City Hospital Grafton</p>											
<p><b>CONFIRMED</b></p> <p><b>CHAIR:</b> <span style="float: right;"><b>DATE:</b></span></p>											