

MEETING DETAILS													
Time and Date	9:30am, Wednesday, 3 August 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 9:32am.</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>Dr Chris Chambers</td> <td>Dr Lester Levy</td> </tr> <tr> <td>Dr Lee Mathias</td> <td>Robyn Northey</td> </tr> <tr> <td>Gwen Tepania-Palmer (part)</td> <td>Ian Ward</td> </tr> <tr> <td>Associate Professor Anne Kolbe</td> <td></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 Taima Campbell – Executive Director Nursing Janice Mueller – Director Allied Health Ian Bell - Board Administrator</p> <p>Apologies</p> <p>Apologies had been received from Rob Cooper and Professor Iain Martin. Apologies for lateness were recorded for Lester Levy and Gwen Tepania-Palmer.</p>	Judith Bassett (Chair)	Jo Agnew	Peter Aitken	Susan Buckland	Dr Chris Chambers	Dr Lester Levy	Dr Lee Mathias	Robyn Northey	Gwen Tepania-Palmer (part)	Ian Ward	Associate Professor Anne Kolbe	
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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 6 JULY 2011												
	<p><u>Moved Lee Mathias; seconded Jo Agnew</u></p> <p><i>That the minutes of the Hospital Advisory Committee meeting held on 6 July 2011 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>												
4	ACTION POINTS 6 JULY 2011												
	The action points were noted.												
5.1	Operational Performance Report												
	The elective and six hour targets had good results in the final quarter. A more detailed review of performance to the end of year would come to the meeting next month. The electives were 40 positive for ADHB. A weekly snapshot of performance will be distributed to the Board.												

	<p>Lester Levy joined the meeting at 9:39am.</p> <p>The budgetary impact of electives is that if the target is not met there is a penalty, however they were not paid on the basis of WIES although WIES were used for electives for other DHBs. The actual number of patients waiting for First Specialist Assessment (FSA) was between 30 and 40 noting that the target is zero with work plans to achieve this for each service. It was suggested that there be a focus on a particular specialty or number of specialities each month.</p> <p>More proactive planning was being developed including managing variations to plan more effectively as demand is reasonably predictable. While the national target for FSA is 6 months ADHB would move to more clinically appropriate waiting times for each specialty noting that people wanted FSA diagnosis so they know and can then develop a clear plan of action. Ideally, there is an element of choice to be considered.</p> <p>It was noted that in the graph for elective WIES per month the budget in January was considerably higher than the actuals in that month and the Committee was advised that the budgeting for the coming year would reflect that past performance. The over-delivery in renal medicine included volumes that were expected to transfer back to Waitemata which had not occurred to plan. While haemodialysis demand was growing, there needed to be honest discussions with patients to consider alternatives, such as palliative care rather interventional care, as once started it is difficult to stop. There was evidence that for those over 60 the quality of life is not improved by dialysis although longevity is. There are national criteria to join the programme, so not all join. The Board is protected by those criteria. Pacific support staff are involved for Pacific. The increase in demand was not going to be limited by preventive measures and there needed to be a national discussion, where ADHB can take a lead, including empowering individuals and communities to be more engaged.</p> <p>The main drivers of cost for the year were outsourcing of clinical services to meet elective contracts, savings initiatives on direct treatment costs not met and additional staff costs. There had been repatriation of work in-house so the planned outsourcing would reduce and there was a lot of work around FTE planning service by service. Direct treatment costs planning in this year's budget was not as aggressive in relation to savings as the previous year.</p> <p>There were at least 100 MoH funding subcontracts.</p>
5.2	Health Target Updates
	<p>The Acute Patient Flow targets for combined as well as Adult and Children had met target and had stayed at the level for a number of months. Flows for July were approximately 90% with a very high volume of admitted patients, in some days reaching 100 rather than the expected 60, and all parts of the hospital had been opened to cope with some rescheduling of electives. Endeavours were being made to get outside hospital capacity to cater for surges. It was noted that in Horowhenua there was a trial with ambulances to get better integration with the primary sector to reduce numbers coming to hospital. The absolute numbers of people involved in variations between 90% and 95% were small i.e. in the vicinity of 4 or 5 patients. The introduction of a SMO to ED had made a considerable difference. Better Help for Smokers to Quit still had an issue of volumes, with work being done on having more information on discharge summaries and targeting different areas to capture data.</p>
5.3	HAC Risk Report
	<p>Software was being written to clear the backlog of unsigned histology reports and to have escalation to the appropriate director. Most of the reports would have been seen although they may not have been signed off.</p> <p>The Committee decided that the risk report should be held in public exclusion so that they could have a fuller discussion. Future reports would include moderate risks that were worsening and trends in complaints.</p>

5.4	Measures Work and the Pandit Model
	<p>Nigel Robertson and Justin Kennedy-Good were in attendance.</p> <p>There was a presentation on attempts to measure activity in operating theatres which would also run as a research project on the Pandit Model. The current state was monthly summaries of key measures including cancellations, session cancellations, late starts, FTE vacancies etc. and utilisation with a target between 85% and 90%. Some of the data from CRIS is not complete. One of the challenges was to capture overruns.</p> <p>Gwen Tepania-Palmer joined the meeting at 10:40am.</p> <p>An initiative was the development of a score card with a draft example. There were lost sessions at Level 8 because they were not booked noting that there were 20 steps to get a patient into an operating room. The “know how we are doing” is part of the Productive Operating Room project.</p> <p>The tool developed by Jaideep J. Pandit et. al. would be run as a research project and could measure if teams were slower or faster than expected. This would help to predict over runs and under runs so that lengths of sessions could be changed. At present surgery lists are only available at 2pm the day before. The Pandit trial would depend on getting data on how teams work, noting that ADHB is a teaching hospital, so that needed to be factored in, which may mean having teaching sessions and separate service sessions with the teaching one having one less list. Within the sector there was debate on productivity/efficiency and under utilisation of resources with having different length of sessions difficult to resource, a need to utilise capital effectively, mismatches of resources and public/private resources. The Committee thanked Nigel Robertson for the presentation.</p>
5.6	ADHB Surgical Briefing Paper
	<p>Ngaire Buchanan, Nigel Robertson, Justin Kennedy-Good and Ian Civil were in attendance. The paper gave an overview of the surgical pathways with a need for visibility of the whole pathway including capacity, timing etc. and a need to have visibility of lost lists which currently are viewed only for the previous week. It was a very comprehensive report and the three critical issues were information on the whole surgical process including visibility of demand coming in, a need to change the way operating rooms are managed with planning taking a three month view, utilisation of plant and visibility on costs. It was thought that e-referrals will help give visibility of demand from primary care. The Pandit model was supported, together with the need to have conversations to define the problems with clarity. The Committee asked for regular reports on lost lists with reasons.</p>
5.5	ADHB Mortality Review Project
	<p>This was to define what caused harm in hospitals with ADHB having a lower standardised ratio than the Health Roundtable hospitals with the 50 deaths being reviewed being a sample of the approximate 1,000 deaths each year to see what could be learnt and what were preventable factors. This would be compared with Health Roundtable data. If it was an expected death a review is not done unless there is a flagged issue or they are part of a clinical trial. Clinical Directors do communicate with families as to whether they have any questions as part of the bereavement process. The results of the project would be reported back.</p>
6.1	DAP Projects Report
	<p>A lot of projects were completed at year end, with a total of 40 in the financial year, and with a number carrying on to an amended future date. In the following month there would be a full review of projects for the year.</p>

	<p>Nurse Entry to Practice Programme</p>
	<p>Maori and Pacific applying for positions provides an opportunity to better reflect ADHB's population served, by recruiting appropriate numbers of Maori and Pacific. There were more Maori and Pacific in undergraduate programmes and new graduate programmes had been successful in retaining graduates. There was an intake in January but there is competition in the Auckland market. The first graduates from the Rangitahi programme are expected in December. Factors were that if this was the first place of employment there was greater chance of retention, schools were an opportunity to employ and the criteria had changed to recognise the need for Maori and Pacific, but this was still work in progress. This included changes around short listing and contract agreements with educational providers. An ethnicity question was being added to the application form, together with a question on skills including language with the ability to speak different languages an attribute. Questions will also included experience with community, church groups etc. There would be standardised interviews.</p> <p>It was proposed to apply the approach to other disciplines as well as nursing. It was also noted that there were more Maori and Pacific undertaking tertiary education with many of those being the first in their families to do this.</p> <p>The Committee endorsed approach outlined in the report.</p>
<p>8</p>	<p>GENERAL BUSINESS</p>
	<p>Physician Assistant</p> <p>This was a regional pilot which had been very positively received and would be extended by Health Workforce NZ.</p> <p>National Health Committee</p> <p>A work plan for the National Health Committee had been submitted to the Minister for approval. It had been done in a tight timeframe and would be provided to key stakeholders through their CEOs. Feedback on the work plan would be ranked to ensure that the sector, asking collectively, would be prioritised. Feedback would be required within five weeks with five weeks to aggregate the data. A small percentage of the Committee's work would be on new and emerging products and care to decide whether it should be adopted for New Zealand or not and a large percentage on models of care and changes required to get better returns on investments including a savings target.</p> <p>Auckland City Hospital</p> <p>A review was being done of ACH buildings' fitness for purpose with a number of external parties involved with an update next month through the Audit and Finance Committee and full report in November.</p>
	<p>NEXT MEETING</p>
	<p>The meeting closed at 12:18pm</p> <p>The next meeting is scheduled for 9:30am, Wednesday, 7 September 2011 A+ Trust Room Clinical Education Centre Level 5, Auckland City Hospital Grafton</p>
<p>CONFIRMED</p> <p>CHAIR: DATE:</p>	