

MEETING DETAILS													
Time and Date	10:45am, Wednesday, 6 April 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 10:48am.</p> <p>Committee Members</p> <table> <tr> <td>Dr Chris Chambers (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Peter Aitken</td> <td>Judith Bassett</td> </tr> <tr> <td>Susan Buckland</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> <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>Rob Cooper had been granted leave of absence and an apology had been received from Professor Iain Martin.</p> <p><u>Moved Robyn Northey; seconded Peter Aitken</u></p> <p><i>That the apologies be sustained.</i></p> <p><u>Carried</u></p>	Dr Chris Chambers (Chair)	Jo Agnew	Peter Aitken	Judith Bassett	Susan Buckland	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												
	There were no declarations of conflicts of interest for any item on the agenda.												
3	CONFIRMATION OF MINUTES 2 MARCH 2011												
	<p><u>Moved Jo Agnew, seconded Robyn Northey</u></p> <p><i>That the minutes of the Hospital Advisory Committee meeting held on 2 March 2011 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p> <p>The organisation was good at attending to acute demand but there needed to be a cultural change to apply the same attention to electives and not have cancellations with the need to increase electives by 35% in the second half of the year. This applied to planning of resources including conference leave, leave etc. to provide cover as is done for acute patient to ensure that production keeps going. This was also a matter of being respectful to patients and families with disruption to them if elective procedures are cancelled.</p>												

4	ACTION POINTS 2 MARCH 2011
	<p>Northern Region's Health Plan</p> <p>This had been lodged with the National Health Board and when finalised there will be discussions with the Medical School.</p> <p>Networks</p> <p>There are 4 cancer networks in New Zealand and through the Northern network came out favourably in a national evaluation. The networks connect hospice, NGOs, patient advocacy alongside the regional cancer service. The evaluation report is to be distributed. A paper on networks had been prepared by Chris Mules several years ago and this is also to be distributed.</p>
5.1	Operational Report
	<p>February production was on plan and acutes above plan. There is work on labour costs, which are a challenge due to the high acute demand being at the winter model level before winter, and also on direct treatment costs. Peter Lowry is manager of elective production. The reasons for the increased demand were multi-factorial, running above population growth, with the factors such as chronic conditions, trauma, etc. It is not thought that access to services for adults and children were affected by the economic conditions with presentations being appropriate.</p> <p>The FTEs above budget were a problem with the savings plans premised on FTE reductions. It was thought that the budget savings were overly ambitious and had lacked actions to deal with such factors as service creep, new treatments without due approval or change of treatment pathways and inputs and budgeting to do a certain number of procedures, which may be completed in the first six months. This then leaves a problem for the rest of the year. There were also questions of doing work for other populations rather than ADHB's. The information was available but it was important to get this to the right decision making point in the organisation.</p> <p>Occupancy of PICU was subject to fluctuations in numbers of long stay patients, not necessarily cardiac, and there was a need to support clinicians to protect scarce resources and not accept referrals if they are not clinically appropriate. The Board would provide that support to clinicians to be more mindful that it is not an open door and there was a need for consistent access and model of care across the country. In terms of these national services it was important to get the price right recognising the availability of a 24 hour service through top sliced funding.</p> <p>WIES were stable with a slight average decline. The throughput in CED was within a margin of error however there was more variation in the 6 hours target which needs more process improvement work. ESPIs are compliant but in areas where they were not there were workout plans for patients to be treated within six months, a buffer zone would be created by May and there was management of the front door for elective patients by going back to first specialists appointments for people in the pipeline. This would also require work with bookers and schedulers with referrers. Once on the waiting list there was a commitment to patients and families so there needed to be more thought about their being put on the list considering capacity, thresholds and whether patients were clinically ready.</p> <p>There were a number of challenges in General Medicine. It is not as attractive as a specialty to clinicians as it had been and faces increased work volumes and RMO and SMO roster gaps. It was subject to an improvement project and was being discussed with the University in terms of improving its academic attractiveness. There were different models in the USA.</p> <p>A new Nurse Director for Child Health had been appointed, being recruited from the UK, who would start in July which filled a management vacancy.</p> <p>A report on January to March quarter on the 6 hour performance in EDs was tabled with excellent performance in adults, however there was a need to get this sustainable, and decrease the variability of performance for children.</p>

5.2	Health Targets
	<p>There had been increased effort in February to engage all staff, and January to March there had been a 10% increase in presentations. Elective surgery performance to 30 June was being managed by Peter Lowry to drive elective performance with the clinical directors and while on target for the month of February it was slightly under target in March. There was a review of data to ensure that there was consistency of counting performance with other DHBs including records outside the PIMS operating theatre system.</p> <p>Smoking advice was being addressed in ED and APU but there was still work to ensure that it was coded into the records and seeking to engage RMOs more.</p> <p>Cardiac was a success and continued to perform well having ICU properly staffed and the right clinical leadership. This was a result of focus on an important department, investing in performance improvement and getting staff engagement through the Health Excellence programme.</p>
6.1	DAP Projects Report
	<p>The reporting allowed management to track commitments made in the Annual Plan and overall there was pleasing progress. The exceptions were noted.</p> <p>The HSG model was to have GMs supporting the clinical leadership in improvement roles. The job descriptions for clinical leadership at the Level 3 had been completed but had been dependent on having the Level 2s in place first.</p> <p>While there was a lot of literature on efficient occupancy of hospitals at 85% operating somewhere between that and 90% was thought to be efficient.</p> <p>The progress over the last five years to progress to clinical management was a major achievement and needed to be celebrated. With long term service planning there was a need to fit that with workforce planning which would require workforces being used more creatively to ensure plans can be effective. An example of the change was nurses in diabetes having prescribing rights. Further changes foreseen were pharmacist prescribing and changes coming from work areas rather than being imposed from the top.</p>
	NEXT MEETING
	<p>The meeting closed at 12:18pm</p> <p>The next meeting is scheduled for 10:45am, Wednesday, 4 May 2011 A+ Trust Room Clinical Education Centre Level 5, Auckland City Hospital Grafton</p>
<p>CONFIRMED</p> <p>CHAIR: DATE:</p>	