

<b>MEETING DETAILS</b>									
Time and Date	10:45am, Wednesday, 7 October 2009								
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton								
<b>1</b>	<b>ATTENDANCE AND APOLOGIES</b>								
	<p><b>Committee Members</b></p> <table> <tr> <td>Harry Burkhardt (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Susan Buckland</td> <td>Dr Brian Fergus</td> </tr> <tr> <td>Dr Ian Scott</td> <td>Rt Hon Bob Tizard</td> </tr> <tr> <td>Ian Ward</td> <td>Lynda Williams</td> </tr> </table> <p><b>Management in Attendance</b></p> <p>Garry Smith - Chief Executive  Dr Margaret Wilsher – Acting Chief Medical Officer  Brent Wiseman - Chief Financial Officer  Dr Richard Aickin – Clinical Director Child Services  Ngairé Buchanan - General Manager Operations  Margaret Dotchin - Nurse Director  Fionnagh Dougan - GM Mental Health, Ambulatory, Cancer Blood Services  Kay Hyman - General Manager Women’s and Children’s Services  Janice Mueller - Director Allied Health  Vivienne Rawlings – GM Human Resources  Ian Bell - Board Administrator</p> <p><b>Apologies</b></p> <p>The Chair declared the meeting open at 10:47am.</p> <p>Apologies had been received from Chris Chambers, Rob Cooper, Pat Snedden, Juliet Walker, Anne Kolbe, Iain Martin and David Sage.</p>	Harry Burkhardt (Chair)	Jo Agnew	Susan Buckland	Dr Brian Fergus	Dr Ian Scott	Rt Hon Bob Tizard	Ian Ward	Lynda Williams
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<b>2</b>	<b>CONFLICTS OF INTEREST</b>								
	There were no declarations of conflicts of interest for any items on the agenda.								
<b>3</b>	<b>CONFIRMATION OF MINUTES 2 SEPTEMBER 2009</b>								
	<p><u>Moved Ian Ward; seconded Lynda Williams</u></p> <p><i>That the minutes of the Hospital Advisory Committee meeting held on 2 September 2009 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p> <p>The downward trend in women choosing the 52 week treatment of herceptin continued.</p>								
	<b>Presentations</b>								
	<p><b>Cardiac Surgery</b></p> <p>Padget Milsom, Clinical Director, CTSU, Anna MacGregor, Nurse Manager, CVICU and Daniel Hunt, Project Manager, Cardiac Service Improvement project were in attendance. The waiting list of over 250 a year ago had been reduced with the lowest being 52 but would rise to 75 as the lists</p>								

are refreshed every Wednesday. Of the 126 patients outside the timeframes at the time that the MoH reviewed the list in May all are treated now except 5. There are different categories of urgency in the waiting list being acute 6 weeks, 12 weeks and 26 weeks. Outsourcing and weekend work provided scope for handling the variations in the waiting list. The Cardiac Service Improvement project ran a project dashboard showing throughput targets, waiting list projections and key indicators. There had been increased throughput and increased quality through the project running 10 work streams. This gave greater visibility of what was going on, what was coming, maintaining pathways, leadership who can make decisions and clinical reporting. They had now achieved a waiting list that could be controlled. Length of stay was 5 1/2 days and it was aimed to bring this down. While outsourcing had stopped, the partnership with those providers was essential. The 80 waiting list aim was based on 18 patients per week for an average of 4 1/2 weeks.

Anna MacGregor had been in the ICU for 6 months and for the last 3 months they had had full FTE. Retention of staff was good, there was an up-skilling education team providing coaching, there was a waiting list of staff wanting to come back and a pool wanting ICU experience. Reduced infection rates and increased throughput had been achieved. There were regular bed meetings for Level 4 so that all knew what was going on and all working as a service not as individuals.

The team was congratulated on the successful progress.

**Women’s Health**

Denys Court, Clinical Leader Woman’s Health; Jenny McDougall, Clinical Director Obstetrics; Anne Yates, Midwifery Leader and Kirsty Walsh, Service Manager Woman’s Health were in attendance. Denys Court presented to the Committee giving the context of a section 88 notice for primary maternity services and the unique public/private care dichotomy of unrestricted access to a publicly funded facility. The service benchmarked with institutions in Australasia. The code of rights stated that there needs to be informed choice and informed consent. There were approximately 7,500 births per year with approximately 70% coming from the Auckland District area and 60% being managed by independent midwives and private obstetricians. In this area there was little room to influence quality. Older women chose more private care. With ages over 35 there is more risk and maternal age had been progressively increasing.

Instruments for change included data and benchmarking, clinical governance including audit and publishing results from leader institutions. To effect change it was important to have early advice particularly after a first caesarean section. There was also a focus on reducing induction rates. The challenges from Professor David Elwood at the National Woman’s Annual Clinical Report day were to reduce induction rates, reduce anaesthesia rates and caesarean rates. There were a number of quality initiatives including family violence screening, security of babies in the hospital and medication safety.

While there was a lack of influence over the LMC audit and policy stances could influence and the unit tried to lead by example. In the multi disciplinary team to do nothing was not an option and changes were being made to have an impact on unnecessary caesarean with a focus on having less intervention. The Minister of Health could influence policy through the MoH. As there is only a national access agreement it was difficult for ADHB to use the access agreement as a means of influence. The recommendation of the Committee to the Board was that the Executive Team explore options for developing a policy to prevent the performance of caesarean sections which do not meet recognised medical criteria and which carry significant risk to both mother and child.

The Chair noted that the Annual Report Day was refreshingly honest.

**4 ACTION POINTS 2 SEPTEMBER 2009**

The graph of costs to revenue had been checked. The data on Maori being treated in cardiac surgery would be going to the Maori Health Advisory Committee. While 15% of cardiac surgery was done for Maori the issue was rather getting access into cardiology.

<b>5</b>	<b>OPERATIONAL PERFORMANCE</b>
<b>5.1</b>	<b>Operational Summary Report</b>
	Since the report was developed there had been a further 600 WIES split 50% between acute and elective. Cardiac outsourcing had ceased 3 weeks ago. The Committee asked that WIES change by service be included to track why, while discharges were going up, WIES were going down overall.
<b>5.2</b>	<b>The Patient Journey and Key Service Improvement Projects</b>
	<p>The improvement projects were going extremely well. There were two steering groups for the 6 Hour projects for AED and CED as this is where practices will need to change and there was a pleasing response throughout the hospital to the projects. To reduce waiting times for early hour admissions was difficult with staffing restraints due to MECA restrictions and a limited number of rosters at that period and having high utilisation of beds with discharges not being able to be done until the next day. While there were some nurse discharges it required confidence between medical and nursing staff and within the One Hour project there was pre-discharge so there would not be delays and there was a work stream looking at what was coming into the hospital. With the new beds opening in November these would be used to lower the occupancy rate to 90%. The Committee asked why there had been an increase in cancellations due to normal bed availability from 20 electives to 35 electives. A simulator was being added to improve access to CT scanning. The Waitemata DHB had approved their renal business case and this together with the elective unit needed to be escalated for regional discussion as they concerned regional services.</p> <p>The matter of the previous taxi rank in Park Road was raised.</p>
<b>5.3</b>	<b>Operational indicators Exception Report</b>
	There was high occupancy at Te Whetu Tawera which created high risk. There was a waiting list and this was trying to be understood with also a need to look at long stay patients. While the access rate to mental health was going up admission rates are falling.
<b>6</b>	<b>IMPROVEMENT ACTIVITIES</b>
	The improvement activities were noted.
<b>9</b>	<b>GENERAL BUSINESS</b>
	There were no items of general business.
	<b>NEXT MEETING</b>
	<p>The meeting closed at 12:27pm.</p> <p>The next meeting is scheduled for 10:45am, Wednesday 4 November 2009 A+ Trust Room Clinical Education Centre Level 5 Auckland City Hospital Grafton</p>
<b>CONFIRMED</b>	
<b>CHAIR:</b>	<b>DATE:</b>