

<b>MEETING DETAILS</b>															
Time and Date	10:45am, Wednesday, 2 December 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>Dr Chris Chambers (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Susan Buckland</td> <td>Harry Burkhardt</td> </tr> <tr> <td>Rob Cooper</td> <td>Dr Brian Fergus</td> </tr> <tr> <td>Dr Ian Scott</td> <td>Pat Snedden</td> </tr> <tr> <td>Rt Hon Bob Tizard</td> <td>Seiuli Dr Juliet Walker</td> </tr> <tr> <td>Ian Ward</td> <td>Assoc Prof Anne Kolbe</td> </tr> <tr> <td>Farida Sultana</td> <td>Lynda Williams</td> </tr> </table> <p><b>Management in Attendance</b></p> <p>Garry Smith - Chief Executive  Dr Denis Jury – Chief Planning &amp; Funding Officer  Dr David Sage –Chief Medical Officer  Brent Wiseman - Chief Financial Officer  Greg Balla – Director Performance and Innovation  Ngaire Buchanan - General Manager Operations  Taima Campbell – Executive Director Nursing  Margaret Dotchin - Nurse Director  Fionnagh Dougan - GM Mental Health, Ambulatory, Cancer and Blood Services  Dr Rick Franklin – Clinical Leader Ambulatory Services  Kay Hyman - General Manager Women’s and Children’s Services  Chris Morgan – Manager, Material Management  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 10:45am.  An apology had been received from Professor Iain Martin.</p>	Dr Chris Chambers (Chair)	Jo Agnew	Susan Buckland	Harry Burkhardt	Rob Cooper	Dr Brian Fergus	Dr Ian Scott	Pat Snedden	Rt Hon Bob Tizard	Seiuli Dr Juliet Walker	Ian Ward	Assoc Prof Anne Kolbe	Farida Sultana	Lynda Williams
Dr Chris Chambers (Chair)	Jo Agnew														
Susan Buckland	Harry Burkhardt														
Rob Cooper	Dr Brian Fergus														
Dr Ian Scott	Pat Snedden														
Rt Hon Bob Tizard	Seiuli Dr Juliet Walker														
Ian Ward	Assoc Prof Anne Kolbe														
Farida Sultana	Lynda Williams														
<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 4 NOVEMBER 2009</b>														
	<p><u>Moved Pat Snedden; seconded Jo Agnew</u></p> <p><i>That the minutes of the Hospital Advisory Committee meeting held on 4 November 2009 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p> <p>Patients awaiting surgery are rung to determine if they were still healthy but this may still need clinical input. The major reason for late cancellations is still the patient being unfit for surgery.</p>														

4	<b>ACTION POINTS 4 NOVEMBER 2009</b>
	<p><b>Regional Plastic Services</b> The update is still to be done and a written answer will be provided.</p> <p><b>Pricing Maternity Services</b> This was work in progress unpicking some of the funding to provide for the equitable distribution of funds based on case mix with the external provider.</p>
5.1	<b>Operational Summary Report</b>
	<p>Sales of services are 90% related to laboratory services. It had been a good month however with employee costs, although FTE numbers were higher the cost was on budget, and there was a MECA payment coming up in December. There will need to be savings outside employee costs. There is a review of high cost treatments under the Concord project and other specific areas are being reviewed where there could be savings.</p> <p>Each week there is a review of all patients with stays over 10 days and daily patient flows in Starship. While long stays are identified manually an IT solution is being sought. One of the issues was transfer of people out to other DHBs and while delays are charged for, it is difficult to get payment. Direct treatment costs were over budget \$1.3m for the month and \$5.6m year to date partly due to a change of product for angio patients. Outsourcing is being reviewed for the total year end together with revenue particularly related to orthopaedics which has volume increases. There was still some delays in operating rooms due to volume and there is not enough capacity for acutes, nor the best configuration with sessions running over as well. While the additional day clinic at Greenlane would assist, that move may not address orthopaedic use of operating rooms and general operating room overall utilisation. There is some concern that ACC changes may impact on ADHB.</p> <p>The WIES for October reflected the improved coding although since month end there was additional 341 WIES catch-up of which half were acute and half elective and, of the elective, half for ADHBs population.</p> <p>While FTE numbers were over, the average rate is lower, but the payment set for December will put pressure on later in the year so there is a phasing issue. The vacancies in both anaesthetists and anaesthetic technicians was being addressed by trying to increase training in the region and, while private practice had not trained technicians in the past they were commencing to do some training. This would take 1-2 years to resolve so those trained in the UK were being considered.</p>
5.2	<b>Operational Indicator Exception Report</b>
	There were no exceptions. The confidence intervals and trend lines are reviewed regularly.
6.1	<b>DAP Projects Report</b>
	Projects are generally going well with improved discharge planning and time of discharge being addressed through a multi discipline team and piloted in Ward 68. The nurse led discharge would be re-launched as this had lapsed due to a lack of good planning. Discharge planning commences at time of admission. Phase 3 of cardiac services planning was being done to increase rates of intervention by 20% over 2-3 years by lowering the threshold of entry to increase the volume of patients receiving care. Intervention rates are compared internationally.
6.2	<b>The Patient Journey and Key Service Improvement Projects</b>
	The current statistics for the 6 hour target for both Adult ED and Children's ED both included short stay patients which will be excluded so Children's ED will be up to target. Within the project there was a need to change practices and there was good engagement of clinicians in the team but a need to work with many more clinicians. There was also some measurement improvement in that short stays were not captured correctly in the system with a focus on improving data collection at time of admission.

7.1	<p><b>Advanced Care Planning</b></p>
	<p>Barry Snow, Clinical Leader of the Concord project, Ian Dittmer, Clinical Director Renal and Ann O'Callaghan, Clinical Director Palliative Care were in attendance. The project was about the Right Amount of Care. While 85% of people die after chronic illness, not a sudden event, half were not in a position to make their own decisions and families had a low understanding of options. With this uncertainty there was a tendency for doctors to treat with vigour and keep patients alive where this may cause suffering. Austin Health in Melbourne has a programme on respecting patient choices which was best practice as, if, the choices are known they can be respected. In evaluating that programme 90% requested no life prolonging measures with 80% requesting symptom and pain management.</p> <p>The Counties Manukau initiative objectives, booklet and documentation was provided. It was important that there was communication with secondary care to ensure that the Advance Care Plan was available in the right place.</p> <p>The ADHB plan was to collaborate with Counties Manukau to ensure regional consistency and to start with the renal dialysis service as that disease progression is reasonably predicible with certain groups having much shorter life expectancy. They did require an Advance Care Plan as it was a dramatic step to stop dialysis and this needed to come from the patient. There were also meetings with Waitemata and Procure to get regional processes coordinated. Of the 500 patients on dialysis half were from Waitemata which would be transferred back over a couple of years and half were ADHB which was expected to grow to approximately 300.</p> <p>It was noted that this was about dignity of people, not money, and that in the last 5 years there was a growing awareness of what people want and the ability to have early conversations required doctors to be trained to have those conversations. The best place for an Advanced Care Plan to reside was with the patient's GP.</p> <p>The Committee noted that with Maori there were occasions to use Te Reo and they accepted death as a natural part of life. Older immigrants may not wish to have these conversations based on religious or cultural beliefs. It was important that communications were in the right cultural setting and context.</p> <p>There had been good discussion on the rebalancing between a curative approach and care.</p>
6.2	<p><b>The Patient Journey and Key Service Improvement Projects (continued)</b></p>
	<p>There was a team working on the Greenlane Surgical Unit facilities and workforce and the impact on current infrastructure of shifting volumes to Greenlane. There was logistics in getting the design signoff by clinicians however the Council had agreed to a process to get the building consents with the intention to start construction over the Christmas break.</p> <p>The Releasing Time to Care project is in the listening stage to understand the issues and get the objectives, workforce, training, patient flow and discharge right including looking at the role of specialists. While there were no solutions yet a patient journey approach was being taken. Stakeholders were being consulted as there was a need for cultural change away from specialists.</p> <p>Intervention rates against the agreed, relatively low, national target were 116%. The target set by the MoH associated with extra funding to achieve intervention rates for ADHB's population was however a struggle to meet. It was noted that major DHBs sat at the bottom of the rates which may be due to the funding model being used. ADHB will be able to increase intervention rates over time as part of the Greenlane Surgical Unit business case to reach the national average, noting however that there were higher rates of private work in Auckland so care needed to be taken in interpreting the intervention rates.</p> <p>The DNA rates were impacting on the cardiac intervention rates particularly for Maori and the Chair undertook to provide what Counties Manukau had done to improve rates.</p> <p>There had been a break down at a time when a linear accelerator was decommissioned which impacted on cancer waiting times. There were meetings to complete the Radiation Strategic Plan for the region. The Committee acknowledged the changed practices of staff providing flexibility and them taking a "can do" approach. There would be a presentation on cancer waiting times in</p>

	<p>February.</p> <p>Community Laboratory services had taken a lot of time of the Chair in the past month. A new CEO had been appointed at Labtests and there had been significant staff changes since. The issue was still to get clinician confidence which would be difficult and take time to achieve. The QSTAT had been replaced by a Quality Improvement Team and there was still a high level of DHB scrutiny. A number of processes were underway with a conclusion expected by mid December leading up to the IANZ audit. While the KPIs were being achieved the clinical relationship and output from the laboratory was not. While the interface with the public was improving the main issue was the clinical interface with DHBs surveying GPs and midwives and keeping close to the GP community. It was noted that there would always be slight differences between laboratories in terms of ranges so results were not incorrect but different. The outcome in December would be based on evidence with a range of options going forward. The Chair of the Governance Group, Pat Snedden would be reporting to all 3 Boards.</p>
<b>9</b>	<b>GENERAL BUSINESS</b>
	<p>A request concerning management of staff in a high stress environment had been raised and this was referred to the next Quality, Risk and Audit Committee.</p>
	<b>NEXT MEETING</b>
	<p>The meeting closed at 1:10pm.</p> <p>The next meeting is scheduled for  10:45am, Wednesday, 3 February 2010  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>	