



# Auckland District Health Board Hospital Advisory Committee Minutes

<b>MEETING DETAILS</b>																	
Date and Time	10:45am, Wednesday, 6 May 2009																
Venue	A+ Trust Room, Clinical Education Centre, Level 5 Auckland City Hospital, Grafton																
<b>1</b>	<b>ATTENDANCE AND APOLOGIES</b>																
	<p><b>Board Members</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Dr Chris Chambers (Chair)</td> <td style="width: 50%;">Jo Agnew</td> </tr> <tr> <td>Susan Buckland</td> <td>Harry Burkhardt</td> </tr> <tr> <td>Dr Chris Chambers</td> <td>Rob Cooper</td> </tr> <tr> <td>Dr Brian Fergus</td> <td>Dr Ian Scott</td> </tr> <tr> <td>Pat Snedden</td> <td>Rt Hon Bob Tizard</td> </tr> <tr> <td>Seiuli Dr Juliet Walker</td> <td>Ian Ward</td> </tr> <tr> <td>Dr Rees Tapsell</td> <td>Farida Sultana</td> </tr> <tr> <td>Lynda Williams</td> <td></td> </tr> </table>	Dr Chris Chambers (Chair)	Jo Agnew	Susan Buckland	Harry Burkhardt	Dr Chris Chambers	Rob Cooper	Dr Brian Fergus	Dr Ian Scott	Pat Snedden	Rt Hon Bob Tizard	Seiuli Dr Juliet Walker	Ian Ward	Dr Rees Tapsell	Farida Sultana	Lynda Williams	
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	<p><b>Management in Attendance</b></p> <p>Garry Smith – Chief Executive            Dr David Sage – Chief Medical Officer            Brent Wiseman – Chief Financial Officer            Greg Balla – Director Performance &amp; Innovation            Clive Bensemman – Director Mental Health Services            Taima Campbell – Executive Director Nursing            Margaret Dotchin – Nurse Director            Fionnagh Dougan – GM Mental Health, Ambulatory, Cancer Blood Services            Dr Rick Franklin – Clinical Leader Ambulatory Services            Janice Mueller – Director Allied Health            Ian Bell – Board Administrator</p>																
	<p><b>Apologies</b></p> <p>The Chair declared the meeting open at 10:46am.            Apologies had been received from Associate Professor Anne Kolbe, Professor Iain Martin and Ngaire Buchanan, Kay Hyman and Margaret Wilsher. An apology for lateness was recorded for Harry Burkhardt.</p>																
<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 1 APRIL 2009</b>																
	<p><u>Moved Brian Fergus: seconded Susan Buckland</u></p> <p><i>That the minutes of the Hospital Advisory Committee meeting held on 1 April 2009 with amendments recording Rees Tapsell's apologies and total revenue for electives of \$20.8 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>																

<b>5</b>	<b>OPERATIONAL PERFORMANCE</b>
<b>5.1</b>	<b>Operational Summary Report</b>
	<p>Data presented to HAC showed the number of red alerts issued in Adult Health but not how long the alerts lasted.</p> <p>Management has responded to the capacity constraints until November in a number of ways including opening 12 beds in Day Stay and Support Building.</p> <p>The Six Hour ED Project is underway. There are constraints on outsourcing because of the need to find gaps in private lists. Another approach is considering at Waitakere Hospital and Saturday lists. There are still staffing constraints in Operating Rooms on Level 8, 8 nurse vacancies and four sicknesses.</p> <p>ESPIs are compliant and potential non compliance individual services have workout plans. Increasing acutes are impacting on electives. Lower level electives are outsourced so the impact is felt on the more complex electives. The previous electives forecast of a shortfall of 800 had further deteriorated to between 1500 and 1600. reflecting the overall capacity. Harry Burkhardt joined the meeting at 11:00am.</p> <p>Of the elective cancellations 130 were by surgeons and 106 by patients. The Committee asked for trends in cancellation of elective surgery to be plotted in categories i.e. by patient, by surgeon etc as the data does not show clearly the real impact of acutes on capacity if the non impact of cancellations is removed.</p> <p>It was noted that Medical and Community Services had a change in the way discharge numbers were counted so the comparison of data between years in the WIES table, 9 months to March 2009 in the financial report was not valid.</p>
<b>6</b>	<b>IMPROVEMENT ACTIVITIES</b>
<b>6.1</b>	<b>DAP Projects Report</b>
	<p>While there are no red projects there are a couple orange that are being monitored.</p> <p>The Cardiac Project is in the next years DAP though it started this year with an audit of waiting lists using an acuity tool. This has been used to reassess those waiting. Acuity will override waiting time with about 50 patients affected. The audit revealed problems in clinical practice when people stay in hospital versus those in the community with a higher acuity score. There is contracting out of services to private in Christchurch and Waikato as well as MercyAscot to help deliver additional services for those most at risk if they can travel. Resources in Australia were also being investigated. Process mapping of patient pathways is being undertaken with strong clinical support from the National Clinical Network meeting for the first time on 11 May at ADHB. This has MoH and the Minister's support. The clinical support from Paget Milsom and Peter Ruygrok was noted. With additional money for Cardiac bringing the level of acuity down there is a need to lift capacity.</p>
<b>7</b>	<b>HAC FINANCIAL REPORT</b>
	<p>The result for the month was \$1.5m favourable to budget however employee costs were expected to be higher as the MECA settlement came through and higher nurses FTE. The SMO job sizing exercise has a potential cost of \$5m per annum. Direct treatment costs are unfavourable due to higher drug and blood usage for hemophiliacs as well as outsourcing costs.</p> <p>Herceptin costs are recovered but work is still being undertaken with the MoH on not only recovering the cost of the drug but also the staff and associated administration costs and should total about \$900k per annum. ADHB had been advised that they would be paid to cover the total costs and the Committee asked that it be reported back if costs were to not be fully recovered.</p>

<b>8</b>	<b>PAPERS</b>
<b>8.3</b>	<p><b>Northern Regional Cancer &amp; Blood Service Waiting Times</b></p> <p>Richard Sullivan, Clinical Director Medical Oncology, Andrew MacCann, Consultant Radiation Oncology and Tim Hawkins, Clinical Director Haematology were in attendance. Work is being undertaken with the Decision Support Unit (DSU) on what is reported in terms of waiting times. It was noted that there are no reports on Bone Marrow transplant times. In the presented data, the graph 100% meant that treatment times were being met within the MoH target of 6 weeks. Other curves showed times being met between 80% and 90% of the time and for Category C Palliative (2 weeks) 75% to 80% of the time. Category B (2 weeks) was low and will not improve without improved planning with a model that be in place by the end of June. This would require a change in process and structure for radiation therapists and the union thought that the change was too quick and wanted it staged. The MoH Targets 2010 would reduce waiting times to 4 weeks from 6 weeks and it was expected that there was sufficient linear capacity if the private sector resource was included. A Wide Bore CT scanner replacement was being approved. The ratio of linacs to simulators was 3-1.</p> <p>With chemotherapy the space had improved as well as a number of process improvements which was contributing to reduced waiting times. Participation with the private sector will need to be managed and the risk would be if insurers change their policy requirements and so change access to private care. ADHB received about 2,500 new patients per year or 50 per week and the number in private was unknown. ADHB's budget was \$18m and that in the private sector thought to be about \$4m of which a lot related to unfunded drugs. The Cancer Registry was only a pathological registry and did not track progress of cancer so there needs to be investment to get a good data base of types of cancer and outcomes. This would require central direction. Garry Smith was on the National Cancer Group and data is a priority issue causing some frustration. Cancer is internationally measured by five year, 10 years survival data which is not available in NZ.</p> <p>Bone Marrow transplantation was a curative approach and demand was growing and projected to grow because indications have widened and apply to more cancers, better matching of donor/recipient and new technologies which meant that the treatment could be applied to people over 50. At present some people have to be sent to Christchurch. New Zealand intervention rates are half those of Australia with approximately 45 done at present, expected to grow to 65 and then 75 so within five years. Patients remain in hospital for a month so there is a need to expand bed capacity from 5 to 9 so space constraints will become apparent. All referrals are audited. Mortality on waiting lists is hard to measure. While there were no national guidelines the transplantation should be done within six weeks.</p> <p>The Committee asked that the number of patients waiting for bone marrow transplants and waiting times be advised. While ADHB was in a rationing process this curative treatment should not be rationed and a business case is being prepared. A quarter of the patients are funded by ADHB.</p>
<b>8.1</b>	<p><b>Elective Performance</b></p> <p>There were wash-up agreements with DHBs except Counties Manukau and if the MoH target are not met then revenue of \$4.3m was at risk. There was a general overall problem with capacity in the sector.</p>
<b>8.2</b>	<p><b>Electives to National Intervention Rates</b></p> <p>One of the points noted from the graph were that those above the national rate comparatively had better funding and are smaller non tertiary DHBs who are under financial pressure through PBF.</p>

<b>10</b>	<b>GENERAL BUSINESS</b>
	<p>There were two items referred by the Quality, Risk and Audit Committee.</p> <p><b>Risk Schedule - Operating room staff</b></p> <p>The nursing turnover was still a concern with 8 vacancies, 4 on sick leave and another indicating an intention to leave. Maternity leave and the staffing model of care in the operating rooms are also factors. Starship nursing resources were also of concern.</p> <p><b>Head and Neck</b></p> <p>A new specialist would commence in November and another specialist had returned although one remained on sick leave. More resources were being made available through nurse specialists and SMOs with support from Counties Manukau Plastics in the short term.</p>
	<b>NEXT MEETING</b>
	<p>The meeting closed at 12:34pm.</p> <p>The next scheduled meeting is schedule for:  10:45am, Wednesday, 3 June 2009  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>