AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Hospital Advisory Committee
Minutes

MEETING DETAILS	
Time and Date	10:45am, Wednesday, 2 March 2011
Venue	Sorrento in the Park, One Tree Hill Domain, Epsom

1 ATTENDANCE AND APOLOGIES

The Chair declared the meeting open at 10:47am.

Committee Members

Dr Chris Chambers (Chair)
Peter Aitken
Susan Buckland
Dr Lee Mathias
Gwen Tepania-Palmer
Associate Professor Anne Kolbe
Jo Agnew
Judith Bassett
Dr Lester Levy
Robyn Northey
Ian Ward
Professor Iain Martin

Management in Attendance

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
Aroha Haggie –Maori Health Gains Manager
Janice Mueller – Director Allied Health
Ian Bell - Board Administrator

Apologies

Apologies had been received from Rob Cooper and Ngaire Buchanan. An apology for lateness was recorded for Gwen Tepania-Palmer

2 CONFLICTS OF INTEREST

There were no declarations of conflicts of interest for any item on the agenda.

It was noted that Iain Martin was Chair of the Peri-Operative Mortality Review Committee and he undertook to talk on the operations of the committee in the third quarter of 2011.

3 CONFIRMATION OF MINUTES 2 FEBRUARY 2011

Moved Jo Agnew, seconded Ann Kolbe

That the minutes of the Hospital Advisory Committee meeting held on 2 February 2011 be confirmed as a true and correct record.

Carried

The membership of committees will be finalised by the Chair in the next few weeks.

4	**ACTION POINTS 2 FEBRUARY 2011**
	Financial Forecast This had been included in the Finance Committee papers. **Capacity** More work was being undertaken with Waitemata. Margaret Wilsher Chairs the regional planning of services and the regional service plan will come to the next meeting. It was noted that the University was going to increase their student numbers and so needed the regional service plan to plan their clinical education. The regional plan was based on "Do No Harm" addressing quality, having informed patients with advanced care planning, a focus on chronic care management of diabetes, CVD, cancer, and health of older people based on years to life, life to years and giving disadvantaged populations better access to care and treatment with specific deliverables in year one. This was an umbrella for ADHB's DAP.
7.1	**Electives and Elective Targets 2011/2012**
	Peter Lowry, Director of Elective Performance was in attendance and presented to the Committee. The Government's plan was to increase electives by 4,000 per annum which is an increase in excess of population growth. ADHB had been asked to increase their work the most with a projected 8% increase in 2011/2012. ADHB was at 94% and Waitemata at 92% of the equitable share so there is a need for considerable increase and this will be funded out of PBF. The drive for high targets and intervention rates were being discussed with the Ministry so that there is not an over investment which exceeds supply. ADHB undertook 40% of Waitemata's electives and a combined view should be taken. There needs to be clarity on accounting as this was an issue with elective work being done out of theatres and not being counted and accounting was required to see that ADHB's population had the right intervention rate at the national average: "if we fund it count it" no matter where it is done. ADHB did need to catch up from a historical low which raised the question of affordability and handling acute flows with funding through PBF. While the peak in 2010/2011 was being met in private there was planning and development of facilities now so that it did not occur in 2011/2012. This will involve the new plant at Greenlane, an investment in the productive operating theatre initiative and require a cultural shift to a big elective unit. The culture should be electives plus acutes rather than acutes plus electives. The Health Target Production Plan to 30 June 2011 showed that from the 500 unallocated volumes at 1 February this had been reduced to 116 at 1 March with planning service by service and would involve a 40% increase in production in the second six months compared with the first six months. The cultural change to move to Greenlane and the tension on the model that ADHB wished to run was not underestimated. The compliance risk to ESPI 5 had been addressed in February however it is non compliant for ESPI 2, patients waiting greater than 6 months for a first specialist appointment, which required a reduction of 250 patients. A number of strategies were being undertaken prioritising patients, looking at different pathways and daily and weekly monitoring. The responsibility was that of the clinical services and how information is presented was being reviewed to make it usable to assist decision making. The plan was to get to the elective target and be ESPI compliant.
	Meeting the Health Targets
	In ED there had been an analysis of activities to reach the six hour target with times to ED decision making having increased to 4 hours which was too long. More resources had been put into ED to lift performance i.e., bed management, nurse specialists and where there were breaches of times individuals were talked to. A dedicated acute surgical team for 7 days a week had been established. While there had been a step change in performance this had to be continuous and while there had been more resources the culture needed to change. It was noted that the new Director General was more engaged with health targets. It was suggested that the health target should be ADHB's target and not have an ADHB interim target.

5.1	**Operational Report**
	Financially there was a focus on managing of outsourcing, labour costs through leave management and direct treatment costs were subject to clinical scrutiny.
6.1	**DAP Projects Report**
	In relation to the strengthening clinical leadership model there was a question of building leadership across the region to lift clinical leadership and engagement with work being done with Health Workforce New Zealand and the Counties Manukau programme being very appealing. There was a question of how much to invest and priorities with a wide range of skill sets and engagement. It was noted that the annual review process can be negative.
	Networks
	The question of clinical practices and their impact on the bottom line was raised noting that clinical supplies are managed at the service level and that for changes of clinical practice there was the Clinical Practice Committee. ICD were driving costs through broadening their use. The Committee asked for a discussion on the impact of clinical networks, their governance, funding etc. both at the national and regional level. The regional cardiology network across the region was very powerful and the Northern Regional Health Plan was also an example of a living network.
	NEXT MEETING
	The meeting closed at 12:17pm The next meeting is scheduled for 10:45am, Wednesday, 6 April 2011 A+ Trust Room Clinical Education Centre Level 5, Auckland City Hospital Grafton

CONFIRMED

CHAIR: **DATE:**