

MEETING DETAILS											
Time and Date	10:45am, Wednesday, 4 May 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 10:50am.</p> <p>Committee Members</p> <table border="0"> <tr> <td>Dr Chris Chambers (Chair)</td> <td>Peter Aitken</td> </tr> <tr> <td>Judith Bassett</td> <td>Susan Buckland</td> </tr> <tr> <td>Dr Lester Levy</td> <td>Dr Lee Mathias</td> </tr> <tr> <td>Robyn Northey</td> <td>Gwen Tepania-Palmer</td> </tr> <tr> <td>Ian Ward</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 was on leave of absence and apologies had been received from Jo Agnew and Professor Iain Martin.</p>	Dr Chris Chambers (Chair)	Peter Aitken	Judith Bassett	Susan Buckland	Dr Lester Levy	Dr Lee Mathias	Robyn Northey	Gwen Tepania-Palmer	Ian Ward	
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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 WEDNESDAY 6 APRIL 2011										
	<p>Moved Ian Ward, seconded Peter Aitken</p> <p>That the minutes of the Hospital Advisory Committee meeting held on 6 April 2011 be confirmed as a true and correct record.</p> <p>Carried</p> <p>There was a planned 35% increase in electives for the last six months of the financial year. Next year's production plan would have electives spread across the whole year with services to sign off on the plan which would be monitored and variances managed so production is expected to be more stable. Changes in the way electives are counted outside the PIMs operating theatre system will change statistics in 2 or 3 areas. This had been discussed with the National Health Board and accounts for about 1,500 discharges, and since the data was collected, another 300 cases.</p> <p>The recruitment process for the Level 2 clinical leadership roles for the HSGs has been completed with one exception. The Director for Women's HSG will be re-advertised and in the meantime the CMO is taking clinical accountability for the Women's HSG. The Level 3 Clinical Director review process will be completed this calendar year.</p>										

The overall focus was on elective delivery to get the revenue line, FTE management and direct treatment costs. GMs have put together detailed plans to get to FTE numbers for the start of the year and actions to control direct treatment costs. Electives do not include ACC which is a separate contract. There is an increased intervention rate for electives for our own population and for other DHBs and it is being monitored daily. ACC has started to use tighter criteria for intervention, so some patients may move back to the elective list. The tighter criteria may have an impact on health. All DHBs had raised this as an issue for a national impact analysis.

There were additional RMOs in general medicine with over appointment in anticipation of resignations. There were restrictions on allocating them different positions by the employment agreement. SMO vacancies were largely filled by locums and RMO roster gaps had settled down in general medicine. Issues in general medicine were the nature of the work, leadership and more interest in specialisation. Nursing FTEs in PICU and NICU were under resourced in the high acuity area so there is over staffing in other areas. PICU is being monitored as there is multiple ways into the Intensive care part of Starship.

A review of volumes going through areas is being undertaken and some FTE savings had not been delivered. In 2011/2012 there was a budgeted 2% increase in volume but this is to be offset by a 3% productivity gain. The Board was concerned at growth of FTEs since December and something radical needed to happen through a higher level of alertness and response before FTEs get out of control. The Board has not seen a visible cost saving plan and needs a detailed cost reduction plan. From July FTE reports would go to the Audit and Finance Committee every month.

A productivity of provider FTEs analysis based on revenue per FTE was tabled but was not considered very helpful. There was a need to match resources to activity with a fixed base and flexible base and a report on FTEs showing the base plus approvals for change e.g. ED, and the savings not achieved. It was noted in the earlier years that FTEs had increased by approximately 100 per annum but in the latter years that had reduced to 80 - 90.

Outsourcing to get the elective target was being managed and monitored closely with each of the teams reviewing where this can be pulled back. While there could be a push back on new technologies and innovative changes, to ration existing practices raised ethical issues. There had also been inadequate budgeting for direct treatment costs. Outsourcing to saving lives was appropriate and ADHB gets revenue on over-servicing its own population but not for IDFs. It was noted that hip replacement costs for ADHB were higher than the national price and overall for orthopaedics the two major centres of Canterbury and Auckland were above all others' costs. A service improvement project had been established to address minutes per operation benchmarking with the Health Roundtable. The first focus would be orthopaedics and then general surgery. There would also be surgeon comparisons although there needed to be care on quality, teaching and readmission but comparisons can be a way to change behaviour.

ESPI 2 and 5 were compliant but there was still some service workout plans to be developed. Detailed reports on work done for other DHBs were being distributed together with regular discussions with Waitemata. Ophthalmology will have a healthcare excellence project and for neurosurgery the elective uplift next year is very high.

5.2 Health Targets

Adult Acute Patient Flow had improved with good communication with orthopaedics and use of APU to move people out of ED. A short stay area was proposed for those needing surveillance. The Minister had commented on the improvement. It was noted that hip fractures in older people may be more a medical than orthopaedic issue.

It was expected the target for Improved Access to Elective Surgery would be met although this would be very tight. It was being monitored daily and there was good cooperation from services in doing extra hours, day and weekend work to reach target. The Greenlane Surgical Centre fit-out was excellent. The target this year had been increased by 12% as well as being asked to do 600 more for ADHB's population as the intervention rate was less than the national rate. The extras had been added in as part of the base for the next year which would be an 18% increase. This was being discussed with the National Board. It was noted that the intervention rates did not include private and if they were included Auckland would probably be above the national rate.

	<p>This was being discussed with the MoH. The cardiac and cardiology network had met and this body could be used vary the target for cardiac bypass surgery. It was expected to get a different target from the network with the MoH accepting that there was a shortage of patients. The waiting list line had been reduced from 80 - 40 for the rest of the year.</p>
6.1	DAP Projects Report
	<p>The Tamaki P2HC revised proposal was being finalised and would go to the Maori Health Advisory Committee in June.</p>
	GENERAL BUSINESS
	<p>AED and Radiology</p> <p>The improvements in ED were acknowledged and for radiology they had had 365 days of being within the waiting time target which was celebrated with a birthday cake. While project improvement was mostly provided by external people there was training of more internally and it was important to get clinical champions to get change. The Committee asked that there be a letter of congratulations to radiation therapists and the surgery teams.</p>
	NEXT MEETING
	<p>The meeting closed at 12:15pm</p> <p>The next meeting is scheduled for 10:45am, Wednesday, 1 June 2011 A+ Trust Room Clinical Education Centre Level 5, Auckland City Hospital Grafton</p>
CONFIRMED	
CHAIR:	DATE: