

AUCKLAND DISTRICT HEALTH BOARD

HOSPITAL ADVISORY COMMITTEE

Minutes of the Hospital Advisory Committee meeting
held on Thursday 7 June 2007 in the Marion Davis Library,
Building 43, Auckland City Hospital, Grafton
commencing at 11:00 am

1. ATTENDANCE AND APOLOGIES

Committee Members

Wayne Brown (Chair)	Ross Keenan
Harry Burkhardt	Dr Chris Chambers
Barry de Geest	Dr Virginia Hope
John Retimana	Dr Ian Scott
Associate Professor Pat Alley	Professor Iain Martin

Management in Attendance

Garry Smith – Chief Executive
Dr David Sage – Chief Medical Officer
Roger Jarrold – Chief Financial Officer
Dr Margaret Wilsher – Deputy Chief Medical Officer
Dr Nick Argyle – Clinical Director Mental Health
Taima Campbell – Executive Director Nursing
Margaret Dotchin – Nurse Director
Kay Hyman – General Manager Woman’s and Children’s Services
Vivian Rawlings – General Manager Human Resources Operations
Catherine Tracy – Service Manager Greenlane Health Services
Ian Bell – Board Administrator

Apologies

The Chair declared the meeting open at 11:05am.

Apologies had been received from Dr Di Nash and Ross Keenan had apologised for lateness.

2. CONFIRMATION OF MINUTES 3 MAY 2007

Moved Wayne Brown, seconded Virginia Hope

That the minutes of the Hospital Advisory Committee meeting held on 3 May 2007 be confirmed as a true and correct record.

Carried

4. CLINICAL DIRECTOR - ORTHOPAEDICS

Bruce Twaddle, Sandi Millner and Anthony Hardy were in attendance. Bruce Twaddle presented to the Committee. He covered the past giving the history of orthopaedics at

Auckland Public Hospital from 1991 when elective orthopaedics were subcontracted and performed at Northshore Hospital so that there was no interruption to the elective workflow. Auckland handled 90% acute orthopaedics, 20% complex cases and 15% tertiary referral work. Resources were a 54 bed unit with an average of 18 outliers per day meaning 72 beds were occupied.

Information from the trauma database 1995 to 2000 showed 8,436 trauma related admission of which 6,040 had orthopaedic injuries of which pelvic were 9.2%, compound fractures were 11% and multiply long bone fractures 2.6%.

Recommended guidelines were covered as well as delays from admission to surgery with major discrepancies between the recommended guidelines and current practice. What was done now were 20% of acute admissions out of zone, 42% of acute caseload, all the elective for ADHB with the joint replacement initiative providing additional workload moving to an extra 800 joints per annum.

In the future there would be the challenge of an ageing population with particular impact for women of osteoporotic fractures which would grow from a average of 31 beds occupied all year in 2006 to 62 beds to be occupied all year in 2025.

In response to questions, there was a reduced mortality rate if operated on within 48 hours with a reduced overall cost. There was a suggestion that the theatre should run 8:00am to 10:00pm with two nurse shifts. Garry Smith acknowledged that there had been a couple of models looked at in the previous OR Anaesthesia project and there was a need for surgery leadership so the signalled appointment of a Director of Surgery would be important. Workforce was a limiting factor and acutes had been higher than anticipated. Anthony Hardy commented that orthopaedics was not equal to joint replacements and this had been a lost sight of in the media and that there was scope to improve productivity with theatre utilisation from 3:00pm to 10:00pm.

There was some discussion on management of trauma across the Auckland isthmus with support from clinicians for one trauma centre supported, but separate from three step down services. This was noted to be raised regionally although it was also noted that Population Based Funding worked against creations of “centres of excellence”.

The Committee thanked the Clinical Directors for their presentation.

5. MANAGING ELIGIBILITY FOR FREE HEALTHCARE

Peter Le Cren, Legal Counsel, Medico-Legal was in attendance. The CMO advised that while there needed to be a policy and links to Immigration there needed to be exceptions where there was a public health risk or if non treatment would result in patients presenting acutely. While the status of eligibility would be checked through Financial Services there was still an obligation for front line staff to advise patients of a possibility of charge which complicated the situation. The Committee considered that reference should not be to “free healthcare” but to “publicly funded healthcare”. There were also now a pool of children who were not eligible for public funding with an estimate of 100 babies having gone through NICU that were not eligible. This changed criteria had been advised to pregnant women.

It was suggested that the Ministers of Health and Immigration be requested to attend a meeting to discuss the issue with background information being compiled on people that ADHB knows are not eligible to signify the size and complexity of the question. This was

amply demonstrated by the complex decision matrix contained in the draft policy. Other points raised were the possibility of treatment of ineligible patients being linked to foreign aid and whether not treating children would or could lead to long term adverse health affects.

6. PROVIDER SERVICES MONTHLY REPORT

The Committee was updated on Adult Services with average length of stay decreasing but also average WIES rates being significantly lower. There had been an independent review to improve clinical notes and coding. Efforts were being made to improve recruitment of clinical coders and having them work closer with clinical directors with more regular meetings. The interesting question of whether average WIES rates were increasing or decreasing with changes in the population was raised. It was noted that there was over performance to contract for cancer and blood services which were a regional service as against under performance in general medicine which may be more local population.

Also distributed was a paper on the relative cost structure between DHBs coming out of data for the national pricing programme. This showed that Auckland's costs looked much closer to those of other DHBs with comparatively larger increases in Waitemata and Counties Manukau. The lower average costs assisted in reducing the deficit.

The Committee was updated on the laboratory workers strike with the number 2 phase being to 11 June, number 3 phase 13-18 June, number 4 phase 24-25 June with tension becoming evident between union members and those working to keep production going. Phases 3 and 4 will bring reduced throughput to the hospital. The Chair noted that in the community laboratory contracting no patient had missed a test but the imposition of rolling strikes was having a large detrimental impact on patients. The Board supported management in talking direct to their staff which may require formal withdrawal from the MECA processes.

The Health and Disability Commissioner addressed to the nurses as part of International Nurses Day and their major part in ensuring patient safety was noted as was the implications of inter-district flow reductions to Counties Manukau District Health Board for hand surgery which demonstrated the potential to dilute a specialist service.

7. GENERAL BUSINESS

There were no items of general business.



8. NEXT MEETING

The meeting closed at 1:02pm.

The next meeting is scheduled for:
11.00 am, Thursday, 5 July 2007,
Marion Davis Library,
Building 43,
Auckland City Hospital
Grafton

CONFIRMED

CHAIR:

DATE:.....