



HOSPITAL ADVISORY COMMITTEE

MINUTES – PUBLIC - Unconfirmed

Tuesday 26 June 2007

10.00am

Theatre Lounge

Community Centre

Albion Street

Hawera

Present

John Young (Chairman), Dan Devadhar, Jan Dunlop, Flora Gilkison (Board members), Brian Jeffares, John Doran (Co-opted members).

In Attendance

Peter Catt (Board Member), Joy Farley (General Manager Hospital Services), George Thomas (General Manager Finance & Corporate Services), Christine Henare (Chief Advisor Maori Health), Sue Carrington (Communication Advisor), Pamela Hikuroa (PA to Board)

396.0 Declaration to Open Meeting

The meeting was opened at 10.00am with a karakia.

397.0 Apologies

Hayden Wano, Kura Denness (Board members)

Tony Foulkes (Chief Executive)

Resolution

That the apologies be sustained.

*Gilkison/Dunlop
Carried*

398.0 Conflicts of Interest

No new interests were declared by committee members.

399.0 Public Comment

Ms Jenny Nager referred to the meeting held as part of the South Taranaki District Council Community Board meetings, wherein the Chairman and Chief Executive had allayed fears of the community over closure of the Hawera Hospital. However, Ms Nager advised that the real concern for the community was the gradual reduction in services provided and advised that this was not what the community wanted. It was felt that Hawera Hospital should be a vibrant asset not only for the people of South Taranaki but also for the province and therefore services needed to be maintained in Hawera.

340.0 Minutes

Resolution

That the Hospital Advisory Committee resolve to accept the Minutes of the meeting held on 29 May 2007 as a true and correct record.

Jeffares/Devadhar

Carried

340.1 Arising From Minutes

Dr Devadhar advised that he had received several complaints regarding the ambulance service and the delays being incurred.

The Chairman advised that this matter was included on the agenda and the General Manager Hospital Services would be providing a presentation.

340.1 Management Reports

340.1 General Manager Hospital Services

Ms Farley took report as read and reiterated the Chairman's comments that a presentation on the ambulance service would follow the report.

The following points were highlighted:

- Two main focus for month:
 - Development of business case for the redevelopment of facilities. The business case was due with the National Capital Committee by the end of August.
 - Impact of Industrial action which required considerable investment of time in the development of contingency plans, and although pleasing that none of the plans were required to be put into action their preparation took up a significant amount of time and effort.
- Seasonal impacts flowing through with general medicine significantly higher than the previous month.
- Orthopaedic and Cataract initiatives ahead of contract. Additional funding had been secured which will result in more operations being delivered than was budgeted at beginning of the year, which was a pleasing outcome for the community.
- Finance
- As previously signalled, outsourced services were coming under pressure and the result for the month had deteriorated. This was being driven by vacancies in the junior doctors' roster. Note however that this area was still significantly less than the same period last year.
- Forecast had been revised from a deficit of \$1.6m to a deficit of \$2.1m with the major reasons being:

- impact of employment of locums to cover junior doctor shortages.
- Seasonal influences with the possibility of the service coming under significant pressure over the next two months.
- Increase in provisions to recognise potential wage settlements currently under negotiation
- Major issue facing the service is the number of RMO vacancies which currently stood at six, but from 20 June will increase to eight out of a pool of 28 which is a significant percentage.
- There were also vacancies in the Emergency Department.
- Pleased to announce one of the new recruits for Hawera in-patient area joined the DHB this week.

Discussion

General discussion took place around the report.

A question was raised concerning the reduced general medical volumes and reasons for this. Ms Farley advised there were two main reasons, firstly Hawera Hospital had not had a full quota of doctors and therefore services were being matched to clinical support available. The gaps in resources had changed the ability of Hawera hospital to cater for some patients, however as had been advised several times clinical practice will inevitably drive what is catered for at Hawera Hospital and this matter had been discussed by the Hawera Steering Committee. Protocols were in place around what type of patients could be cared for at Hawera, but it still remained the discretion of the Doctors as to whether they would care for any particular patient. As clinical practice changed and as secondary services changes, it was likely that the casemix profile able to be accommodated at Hawera Hospital would also change.

The question on whether the monitored beds would be reopened at Hawera following the appointment of the new MOSS was raised. Ms Farley advised that the monitoring of patients at Hawera was determined by the above factors with medical and nursing staff taking into account whether the appropriate skills were available and in line with the appropriate clinical practice.

Reference was made to the newspaper report regarding ED departments and Ms Farley was requested to provide an explanation.

Ms Farley advised that the newspaper article followed a report issued by Tony Ryall, Opposition spokesman on Health. Approximately a year ago the Committee had been made aware of issues around data collection in ED in terms of what the data was telling us at both base and Hawera regarding triage categories and timeliness of treatment. The report indicates that most DHBs, whilst achieving Triage 1, were missing targets on categories 2 and 3. For TDHB we were close to the target in all areas. Ms Farley reported that she had every confidence that all patients, but particularly triage 1, 2 and 3 were being seen within the appropriate timeframes but there needed to be an improvement in how the data was captured for purposes of the benchmark report.

Considerable discussion took place around the junior doctor vacancies with Dr Doran, who is the supervisor of the junior doctors training programme,

gave an explanation of the problems currently being faced. He reported that there was a focus on trying to recruit more doctors from the UK on longer term contracts. However, to enable this to occur TDHB must ensure that it was able to meet the education requirements required of the UK programmes to enable the doctors to obtain registration. It was important to ensure that the resources required from TDHB were sufficient to enable these requirements to be met.

Management were also looking at ways of changing the runs to enable junior doctors to meet their training requirements but to also be able to provide cover.

The shortage of junior doctors was far worse than in previous years on a national basis.

Dr Devadhar noted that SouthCare Hawera seemed to be able to make appointments within a period of 6-9 months. Ms Farley advised that these appointments were not junior doctors but were General Practitioners or more senior doctors. The matter had been discussed with the Hawera Steering Committee particularly around the attractiveness of the positions for Hawera Hospital and one possible which is being discussed with SouthCare was the creation of a pool of doctors able to cover a number of areas. It was hoped that if this pool could be created the Hawera positions would be more attractive and increase future job opportunities.

Dr Devadhar requested clarification of the comments in the newspaper article around the occupation of the Hawera Hospital and the report that an injunction was in place regarding the sale of the surplus land.

Mr Thomas gave an explanation of the history around this matter, advising that the DHB had followed all requirements of the Crown such as land banking with the Office of Treaty Settlement. The land in question had been offered to Ngati Ruanui as part of the settlement process but had been declined. Following the process the DHB was now in a position to be able to sell the property. He advised that if people believe they have a right over the land they could apply to the Court for an injunction. At this stage the DHB was not aware of an injunction being issued and was proceeding with the sale process. The proceeds from the sale would come to the DHB for utilisation in health services.

Resolution

That the Hospital Advisory Committee note and receive the report.

*Gilkison/Dunlop
Carried*

340.2 Update Ambulance Service Issues – Presentation

Ms Farley gave a presentation outlining the issues facing the ambulance service which had been discussed at previous meetings.

The presentation gave background to the national decision to move to a central ambulance communications centre.

Issues –

- Noted that management had reviewed activity to date and proactively sought out issues

- Data collected from January to June – 4,058 calls to the centre and of that 64 issues were identified:
- Of the issues 50% incorrect dispatching decisions
- Of the issues 16% incorrect location and geo-verification
- Of the issues 13% paging errors
- Other reasons by volume –
- 4 customer service
- 4 routine patient transport ordering
- 3 ProQA determination
- 1 common location error

ProQA relates to the programme which determines the urgency of the case. A series of questions are asked and the responses determine the priority rating.

Key Issues

Met with ACP Director and Project Co-ordinator to discuss issues

- Mapping Address Verification – problems occurring around how locate and dispatch. Major issue which must be resolved.
- Impact of Mobile Data Terminals – the non-availability of the system has had an impact on the service. This matter is being worked on at present and the preferred option will be trialled in a number of areas to ensure that the system has been corrected. One of the terminals will be installed in Taranaki.
- Quality management systems – essential that the service learns from the mistakes. Centre now using some of our issues in their training.
- Cultural Differences – rural vs urban/centralised vs local.
- Resource management – Under local system managed resource proactively and manning was very lean. This leanness was acceptable when managing locally, but we become exposed when dealing with a centralised system. The same flexibility is not available.
- Expectations and perceptions of service level - our community has expectations which we had been able to meet, particularly around response times. In the past if an ambulance was available for priority 3 cases an ambulance would have been dispatched immediately. ACP agree with the DHB that with the implementation of the centralised comms function we should not accept any decline in service but the DHB will need to work with the local community outlining what is a reasonable response time.

Long Term:

- Need to work together and pleased with the response from the comms centre to the issues raised
- Very clear should not be change in service and they are committed to trying to make things right.
- Developed Action Plans
- Key themes –
- Quality management system – must close quality loop

- Mapping and address verification – correlation of mapping systems. Pleased to report that all three emergency services will be updating their systems shortly.
- Taranaki dispatch – agreed to review options around whether we could provide more support to dispatch functions. This would also involve training and how updates could be provided.
- Reviewing dispatch function.
- Mobile Data Terminals (MDTs) – hopeful that initiatives underway will address this matter in the near future.

Short Term

- Address immediate resource stress with an interim additional resource. Resource problem during the day due to staffing numbers. Focus area will be how to balance priority 1, 2 and 3 calls with more routine work.
- Two-thirds of ambulance calls are not emergencies
- Ambulance service suggested placing a PTS vehicle into New Plymouth. Likely to be operating between 8am to 8pm and would focus on routine transfers.
- Joint working party to consider single/double crew issues.
- This is a particular issue particularly in rural areas.
- Refining Complaints Process
- Important to support ambulance staff and for public to be aware of where responsibilities lie and that front line staff can focus on their core business which is attending to patients.
- Develop communication strategy around the ProQA tool – this will enable work with community groups around why the questions are being asked when calling for an ambulance and what are reasonable expectations around waiting times.
- Build relationships with the comms centre – need face to face contact

Current Situation

- Operator meetings have taken place
- Visit from Project Director and CEO ANZ to Taranaki has taken place and action plans agreed
- Progress has been made

Ms Farley advised that she was confident the aims and objectives of the comms project will eventuate and this confidence has been reinforced by the commitments given by the Project Director and CEO and the resources being contributed by the DHB towards achieving resolution to the issues. Ms Farley also advised that our own ambulance service had been involved in developing many of the plans for addressing this.

Dr Catt reiterated Ms Farley's comments advising that he had attended the meeting and was heartened by the approach being taken on the matter.

The Chairman thanked Ms Farley for the presentation noting the confidence being developed around the new system.

340.3 Chief Advisor Maori Health Report

Ms Henare thanked the committee for the opportunity to report advising that this was the first time a report had been presented to the Hospital Advisory committee. It was felt appropriate for a report to be provided in view of the DHB resources involved in hospital services and the responsibility of the service in delivering services to address Maori health inequalities.

Referred in particular to the graph which highlighted the referral patterns of Maori for Ischaemic Heart Disease, to appropriate secondary and tertiary interventions following referral from the primary or secondary sector. The research clearly showed the inequalities in Maori access to appropriate interventions. Discussions were currently underway with the Hospital Provider and Planning and Funding on ways to reverse the trend for Taranaki Maori.

Discussion took place on the report with Ms Farley advising that the project team would be looking at ethnicity data and stats around access to cardiology clinics and referrals and interventions which will provide information on the barriers which exist for Maori. She also advised that research published last year showed that even once admitted to secondary services Maori did not progress on to secondary and tertiary intervention and we needed to understand the reasons why this was the case. The results of this investigation would enable the findings to be applied across all services.

The Chairman thanked Ms Henare for the report and noted the focus on workforce development which was a key to ensuring greater participation in the health sector.

Resolution

That the Hospital Advisory Committee note and receive the report.

*Dunlop/Doran
Carried*

341.0 Work Programme 2006/07

Resolution

That the Hospital Advisory Committee note the updated workplan for 2006/07.

*Gilkison/Dunlop
Carried*

342.0 Next Meeting

The next meeting was scheduled to be held on Tuesday 31 July in New Plymouth.

Mr Jeffares tendered his apology for this meeting.

The Chairman notified that he may not be able to attend but would confirm.

343.0 Exclusion of Public

Resolution

That the Hospital Advisory Committee resolve to make this resolution in reliance on Schedule 4, clauses 34 and 35 of the New Zealand Public Health and Disability Act 2000 and the particular interest or interests protected by clause 34 Schedule 4 of that Act or section 5 or section 7 or section 9 of the Official Information Act 1982, as the case may require which would not be prejudiced by the holding of the whole or relevant part of the proceedings of the meeting in public are as follows:

- 1. To present Hospital Advisory Committee Minutes pursuant to an earlier resolution publicly excluding the item.*

*Gilkison/Devadhar
Carried*

The meeting adjourned at 11.45am to reconvene at 11.50am.

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Chairman

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Date