HOSPITAL ADVISORY COMMITTEE

MINUTES – PUBLIC - unconfirmed

Tuesday 30 June 2009
10.00am
Theatre Lounge
Community Centre
Albion Street
Hawera

Present:
Peter Catt (Chairman), Karen Eagles, Jenny Nager, Grant Knuckey, John Young (ex officio), (Board members), Jan Dunlop, Peter Moeahu (co-opted members)

In Attendance:
Alex Ballantyne, Flora Gilkison (Board member)
Tony Foulkes (Chief Executive), Joy Farley (General Manager Hospital Services), Sandra Boardman (General Manager Planning, Funding & Population Health), Sue Carrington (Media Advisor), Pamela Hikuroa (PA to Board)

491.0 Declaration to Open Meeting
The meeting was opened at 10.00am.

492.0 Apologies/Leave of Absence
Dan Devadhar, Kura Denness, (Board members), Nic Boheimer, Brian Jeffares (co-opted member)

Resolution
That the apologies be sustained.

Nager/Dunlop
Carried

493.0 Conflicts of Interest
The Register was circularised for updating by members, with no new interested being declared.

494.0 Minutes

Resolution

That the Hospital Advisory Committee resolve to accept the minutes of the meeting held on 26 May 2009 as a true and correct record.

Dunlop/Nager
Carried

495.0 Management Reports

495.1 General Manager Hospital Services

The Chairman advised that the presentation on Hawera Hospital would be made as part of Ms Farley's report.

Ms Farley took report as read and highlighted the following:

- Draft report on Waikato Cardio Thoracic Volumes had been circulated to clinicians for feedback. Anticipated that the final report would provide an action plan to be put in place across the Midland region. Expect final report would be available towards end of August.
- Acute Services – difficulty in past years around acute medicine however this year acute surgery posing the real difficulty. Acute delivery 12% ahead of contract mainly in orthopaedics.
- Increased numbers of patients presenting to Base Emergency Department while Emergency Department in Hawera has remained static. Undertaking work as part of acute pathway to define role of ED. Paper out for feedback across clinical groups once confirmed view model of care and role of ED at base.
- Theatre volumes continuing to climb very much linked to the acute surgical activity.
- Bed occupancy FTE elevated around specialling, this has been an issue over the past two years. Have engaged with Nurses Union around how look at specialling and commenced joint piece of work on how to do differently going forward.
- Financial – Total deficit $6.9 million which includes extraordinary expense around asset revaluation, net of this deficit $5.6 million which is negative to budget by $2.4 million.
- Revenue continues to be ahead
- Operating costs – Main areas of concern are FTE personnel, out sourced services and whilst have retained some control over locums in the third quarter have 10 RMO vacancies. Fully staffed for 4th quarter.
- Continuing to prioritise elective activity but this does impact on FTEs.
- Increasing annual leave, changes to Holidays Act and MECA provides additional leave across clinical FTE which has impacted on operating costs.
- Clinical Supplies- pharmaceuticals overspent almost all around oncology drugs
- Forecast remains unchanged.
- Renal services continues to be delivered with support from Counties Manukau DHB. Recruitment looking positive.

- Some discussions have been held with Stratford Health Trust around how develop services on the Stratford site. At very preliminary stage and will be subject to feedback.
- Reviews underway – Allied Health and Pharmacy - looking at costs of those services and how deliver across province. Also reviewing booking process and role design.
- For all reviews Hawera Hospital included, looking at province wide not just base or Hawera.

Discussion
Questions were raised regarding the possibility of increasing renal services at Hawera. Ms Farley advised that outpatient clinics are held in Hawera and the possibility of providing haemo dialysis was being investigated in terms of the models of care for Hawera moving forward.
Committee members noted that ACC revenue remained below budget with Ms Farley advising that there had been a $120K improvement over last month and she was hopeful that the position would continue to improve.
Further clarification was sought over the elective services and impact of the current position on finances. Ms Farley advised that the provider was currently ahead of contract for elective services which had an impact on FTEs and consumables but noted that the decision had been taken to run ahead of contract due to difficulties in achieving the cardio thoracic volumes.
Mrs Boardman advised that from the overall DHB perspective the elective services plan required the delivery of all extra volumes and as Waikato were running behind with cardio thoracic if Taranaki DHB failed to meet plan for electives funding would not be provided by the Ministry. As a result the funder had requested the provider to over-deliver on the contract and the funder would recompense the over delivery at the end of the year, from the funding retrieved from Waikato for the under-delivery.
It was noted that there were additional costs being faced by the provider due to the impact of swine flu and seasonal flu as all patients coming to the hospital with flu symptoms were being treated as contagious with involved additional costs.
Committee members noted that 935 (triage 4,5) people had attended Hawera Emergency Department in May and questioned whether there was a breakdown of the time of day of attendance and whether those presenting could have been serviced by their general practitioner.
Ms Farley advised that a breakdown of times of attendance was known and that predominantly those attending were for GP type ailments. She advised that the attendance curve at Hawera was completely different to that at Base, with the major numbers in Hawera presenting from 10am through to approximately 7-8pm whereas at Base presentations were more pronounced towards the end of the day. Ms Farley noted however that triage was only an indicator of acuity but generally speaking triage 4 and 5 were less acute patients who were not in imminent danger. The issues facing South Taranaki over after hours care have triggered the work being undertaken by the provider to see what we as a hospital can do to assist.

Presentation – Hawera Hospital Vision for Future
Ms Farley introduced Gillian Campbell, Manager of the Hawera Hospital.

Context
Ms Farley advised that this work was part of the reviews being undertaken around acute pathway, maternity, oral health, theatre capacity.
As all are aware with the facility redevelopment at Base it was absolutely essential that it the planning took into account the needs of the total province and all of the groups involved in the planning of the new facility have Hawera or Rural representation.
A series of reviews were being undertaken around processes - looking at Allied Health, Pharmacy, booking system because as we know next year we are heading into a very difficult funding situation because we will not be getting funding increases relative to other DHBs because relatively static Taranaki has a declining population. The Hospital is currently running a deficit for the year of approximately $6.2m which has to be supported by the wider DHB. It is clearly the responsibility of the hospital to sort out its affairs because we are spending more than we are provided for by the funder.
Also, the hospital has to look to do things differently because of technology changes, clinical practice changes and if we are to spend more on new procedures etc then we have to do things differently and this is the basis for the service reviews. The reviews are being undertaken across the DHB and Hawera Hospital has also undertaken a review in its own right on how they will work in the future to be able to undertake additional services to meet the needs of the population.
The presentation has been given to a number of forums, is available on the intranet and is presented for information.

Presentation -
In November 2008 undertook a review – Hawera Vision for the Future
Steering Group established – wide representation –
Staff, clinical representatives, Hawera Hospital management, community representatives, Maori representative.
Community representative was appointed by the Hawera Community Committee.

Key considerations –
Service consolidation at Hawera Hospital

- 6 years operating at new site
- changed delivery model for ED from GP/AH back to ‘pure’ ED
- gradual lowering of acuity with increase length of stay in the in patient unit
- difficulties with workforce retention and recruitment
- changing health service delivery due to new technologies and changes in clinical practice
- changing South Taranaki demographics – aging population
- Planning for new facility at base with models of care with link to base projects around:
    - Acute pathway

- Maternity
- Oral health

Initial consultation

- Initial question to staff and stakeholders – ‘What should we be dong in Hawera Hospital into the future?”
- Think about what should be doing in the future, concentrate around making sure best practice, what is best for patient and what is best from medical point of view. Anything decided in Hawera needed to be sustainable could not be stop gap solution this is what do and last for 12 months and then find another solution.
- strongly felt needed to be sustainable offering what new care is needed
- Stakeholder meetings significant amount of data analysis try and work out what Hawera Hospital was currently doing
- Lot of people think know but actually was to try and get concrete scope of what doing
- Look at what other rural hospitals doing huge number around country all work in significantly different ways
- Hard to compare because different models and different populations and different demographics
- What other innovative things people doing.

Took summary back to steering group to consider
Decided where to go
Key messages
Need 24 hour ED service

- Change of GP After hours/ED combined service to pure ED model has not changed pattern of presentations
- Volumes at night remain low (0-7 presentations per night) with at least 50% being considered low acuity
- Concerns about patients transferred for specialist consult (medicine/surgical) who are then transferred back to Hawera ED without a treatment plan – results in multiple transfers

Hawera In-Patient Unit (HIP)

- Aging population as result rehab services strong but need to make sure develop further to reflect population
- Length of stay is increasing for general medicine – reflective of aging population
- 24% of patients admitted to HIP transferred to base or other hospitals for admission or investigation
- lower threshold for admission to HIP and lot of people commented around easier to admit to ward than necessarily try and sort out with community services, admit and then work out how to get people back home safely.

Other Points

- Opportunity for tele-medicine – use of new technologies
- Video conferencing, patient consultants, consultations specialists at secondary or tertiary hospital and link up by video support staff when require advice
- General statements made around quality of what do and consistency of what do in Hawera
- One thing noted out of this work need to have clear pathways make sure whatever developed patients accessing best care at right time
- We are rural, small hospital and part of delivering good services means being flexible - cannot forget that as get more structure around what do.
- Specific clinical leadership for Hawera tend to pull senior doctors on to committees and report through to HoD having some leadership from rural point of view.
- Most in patient and ED focus of everyone however, do need to consider outpatient services - must not forget hospital/community linkage.

Priorities

Develop the service delivery model for HIP and ED

1. Alternate model to deliver ED service at night
   Current number of patients attending resources deployed are not sustainable
   2 nurses ED each night Dr employed into ED and then fully staffed ward

2. Inter Hospital Transfers – do have patients go between New Plymouth and Hawera ED No formalised process in terms of getting patients retrieved. Need to ensure get unwell patient through to New Plymouth as quickly and safely as possible.

3. Implement Point of Care Testing (POCT) - Technologies being able to do blood tests at the bedside and result available in 15 minutes.
   Laboratory services exceptionally busy huge number of call outs and that impacts on Laboratory service down line.
   With staffing contracts if do not have a 9 hour break do not come in the next day
   Looking at how we can use technologies to delivery service.

4. Implement ICATT - Part of service package around looking at how facilitate discharge for patients to the community

5. Centralise booking process – Hawera outpatient bookings part of that review

6. Introduce Telemedicine Telepaeds – very good quality video link

Discussed priorities and what next step.
Steering group after very robust debate and discussion came up with options:

Emergency Department
General consensus still needed to make sure deliver emergency service 24 hours per day.
However could we do it a better way at night and that is where discussion was held around collocating ED service into HIP having all resources in one area
Currently struggle with nursing levels, vacancy levels, struggle in terms of skill mix and having to staff two areas, stretches the resources.
If going to go down and look at collocating and have same volume of patients coming through then need to make sure good acute pathway. This needs to link in with the work being undertaken at Base.
Co-located inpatient ward during hours of 2300 – 0700
Ward has beds and physical capacity to accommodate demands of inpatient and emergency service.
Develop an acute pathway between Hawera and base ED
Develop Clinical pathways for care
Development of new roles eg nurse only consults, case management, clinical nurse specialist

HIP
Provide 2 Assessment Beds –
To be used overnight for ED and day procedures, eg transfusions/infusions
Will reduce administrative work involved where currently patient admitted to ward for transfusions etc.

HIP – 4 Short Stay Beds
24 hours for assessment and planning
Will again reduce administrative work
Enable better care for patient

HIP Long Stay Beds (14)
Rehabilitation focus
Direct admission criteria to be developed
Ensure patient receives best care and tidy up transfers between Hawera and Base. If patient needs more investigations or specialist consults arrange all to be done and then facilitate return to Hawera

This is proposed model.
Considerable consultation undertaken with staff and have gone out to community groups. Feedback on proposed model due 8 July.
Aware that there will be issues with intoxicated patients etc and need to ensure escalation plan in place where necessary.
Feedback is to the stakeholder group as from a public perspective the service around ED will not change.

Discussion
A full discussion took place around the presentation with the committee supportive of the approach.
Questions were raised around ability to manage the transfers through to Base and availability of nursing staff for this function.
In response Ms Campbell advised that currently transfer were being undertaken and in fact 25% of people in the Ward go through to Base for tests etc. On average 60-70 transfers from Hawera to Base per month. Intention is to ensure people are transferred as quickly and safely as possible rather than waiting in the Ward for a number of days.
With respect to a doctor being available for ED overnight the current situation would continue.
Questions were raised around maternity services with the committee being advised that the current maternity beds (4) were not considered as part of HIP and there was no change in this area.
Discussion took place around GP after hours service and what was the GP's responsibility in this area.
Mrs Boardman advised that GPs were required to have after hours arrangements in place and this could be provided by one:one face to face, eg Dr Blayney practice, whilst other practices nominated Accident and Medical Centres in New Plymouth as their after hours provider, or used a telephone triage system.
This resulted in patients presenting at ED, as is the case at Base and other DHBs, but the Provider was not compensated for this service and it was not possible to clawback funding from GPs.
The DHB was currently trialling an enhanced healthline telephone triage service as part of a national pilot where the patient would receive advice and if part of the advice was to see a GP an appointment could be made.
Ms Farley advised that the concern for patients presenting at Hawera was that many were using the ED service as their GP not just out of hours, and from a health outcome point of view this was not good for their long term health as ED was not set up to deliver that sort of care.
The Hospital had a very good relationship with the local primary services and was looking at how could work together to support general practice in the region. It was essential that all health services work together to deliver services required within the funding package and to provide career development opportunities for the health sector.

Further discussion took place around the maternity review with Ms Farley advising that recommendations would be forthcoming in the near future.
In response to questions around the Minister's announcement of additional funding for training of midwives and obstetrics for GPs, the Committee was advised that at this stage no specific details had been received.
Mrs Boardman advised that midwifery courses were running in Taranaki for 12 months jointly with AUT Auckland which would hopefully benefit recruitment of midwives longer term.
This was a very important issue with the rural services in Stratford and Hawera being built on the loyal and hard working midwives who were now

nearing retirement age and finding replacements would be extremely difficult. It was essential that discussions on this issue be undertaken while the midwives were still in employment to enable a way forward for the future to be determined.

Resolution
That the Hospital Advisory Committee note and receive the report and attachments.

Eagles/Knuckey
Carried

495.0 Other Business
495.1 Family Violence Presentation
Ms Farley advised that following the audit of the programme the presentation would be provided and this was likely to be around August/September.

495.2 Institutional Racism
Mr Moeahu referred to the report form the Otago University regarding research into Institutional Racism in the Health Sector and also the public statement by the Associate Minister of Health concerning the matter.
He suggested that it may be opportune for the DHB to consider the issue and for example, whether a Human Rights Commission audit of the processes would help.
Mr Foulkes advised that the issue was noted and suggested that this was something which would reflect on and could perhaps be a topic of further discussion with Te Whare Punanga Korero as appropriate.
Ms Farley also advised that along with the Chief Maori Health Advisor a work plan for the hospital provider and Maori Directorate was being built and one of the areas being looked at was the outcome for Maori in the secondary system and whether they received the same level of interventions or same care pathways as non-Maori. The Department of Cardiology had been approached to see if they would consider looking at this question as there were clear defined targets if you are diagnosed with a certain set of symptoms and therefore could be measured. The Department was keen to work directly with the Maori health team on this matter.

Mr Young commended Mr Moeahu for raising the topic and felt that it is a challenge for the DHB to ensure that we create an environment where there is equality of health and a lot of work has been done by our staff in this area. With reference to the Beryl Report on the Maori Economy in Taranaki Mr Young felt that what would help this issue to the greatest extent would be the far greater participation by Maori in our workforce.
Mr Young was not necessarily sure whether an audit would help in this process but he knew there was an earnest desire within the organisation to ensure that Maori get the same sort of service as everyone else in the community.
Dr Catt agreed with the comments made and congratulated Ms Farley and Ms Henare on the planning for a review of processes in cardiology.
Mr Knuckey was of the view that a review of services could be helpful. With respect to Maori workforce the sector did not have the resources to go out

and recruit. They had a very good understanding of the makeup of the community and the levels of achievement but did not have the people to go and recruit and market the health sector as being where long term well paid jobs were available which would keep those families in the community and help the whole economic development of Taranaki.

496.0 Next Meeting

The next meeting is scheduled to be held on 28 July 2009 in New Plymouth.

Mr Young, Chairman Taranaki DHB thanked the people of Hawera for attending the meeting, as it was important for the community to be aware of the number of highly skilled and dedicated people working in the interests of Taranaki in the health area and their presence indicated an interest and gave encouragement to the Board and staff.

497.0 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 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.*

Nager/Dunlop
Carried

The meeting adjourned at 11.35am to reconvene at 12 noon.

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Chairman Date