Distribution:
Committee Members:
E Borrows, Chairman
K Eagles, Deputy Chairman
A Ballantyne,
M Bourke
P Catt
K Denness,
F Gilkison,
B Jeffares
P Lockett
A Rumball
P Moeahu (Co-opted member)
C Tuuta

Management:
CEO
GM Finance & Corporate Services
GM Hospital Services
GM Planning & Funding & Population Health
Chief Advisor Maori Health
Chief Medical Advisor
Nursing Director
GM HR & Organisational Development
Quality Risk Manager
Management Accountant
PA to Board
Advisors:
S Carrington, Media Advisor
P Franklin, Legal Advisor
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Health Centres – Stratford, Patea, Opunake, Mokau
Base Hospital Library
Hawera Hospital Library
Tui Ora Limited
Corporate Reception

TARANAKI DISTRICT HEALTH BOARD

AGENDA

HOSPITAL ADVISORY COMMITTEE

ORDINARY MEETING

OPEN

Thursday 8 March 2012
10am

Corporate Meeting Room 1
Taranaki Base Hospital
David Street
New Plymouth

HOSPITAL ADVISORY COMMITTEE

MEETING AGENDA

Thursday 8 March 2012
10 am

Corporate Meeting Room 1 Base Hospital
David Street
New Plymouth

1. Declaration to Open Meeting

2. Apologies Tony Foulkes

3. Conflicts of Interest

4. Public Comment

5. Minutes

5.1 Minutes of meeting held 9 February 2012 Pages 1 - 6

Resolution

That the Hospital Advisory Committee resolve to accept the minutes of the meeting held 9 February 2012 as a true and correct record.

6. Arising From Minutes

7. Chairman's Report

8. Management Reports

8.1 General Manager Hospital Services and attachments. Pages 7 - 14

Resolution

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

9. Other Business

10. Next Meeting

5 April 2012 in New Plymouth

HOSPITAL ADVISORY COMMITTEE

MINUTES – PUBLIC - unconfirmed

Tuesday 9 February 2012
10 am
Corporate Meeting Room 1
Base Hospital
David Street
New Plymouth

Present:
Ella Borrows (Chair), Alex Ballantyne, Kura Denness, Flora Gilkison, Brian Jeffares, Pauline Lockett, Alison Rumball (Board Members), Peter Moeahu (Co-opted member), Peter Catt and Mary Bourke (ex-officio)

In Attendance:
George Thomas (General Manager Finance & Corporate Services), Rosemary Clements (General Manager Hospital & Specialist Services), Gavin Woolley (General Manager Human Resources & Organisational Development), Anne Kemp (Quality & Risk Manager), Katherine Fraser-Chapple (Management Accountant), Ngawai Henare (Chief Advisor Maori Health), Ramon Tito (Kaumatua), Sue Carrington (Media Advisor), Jenny McLennan (PA to Chief Executive)

Lee McManus - Clinical Services Manager (Surgical)
Leigh Cleland - Clinical Services Manager (Maternal / Child Health)
Gloria Crossley - Clinical Services Manager (Allied Health)
Gillian Campbell - Clinical Services Manager (Medical)
Wendy Langlands - Clinical Services Manager (Older Peoples Health / Mental Health)
Hester Swart - Clinical Director for Mental Health

705.0 Declaration to Open Meeting
The Board Chair, Miss Bourke opened and commenced proceedings in the absence of Mrs Borrows who had advised that she would be late.

706.0 Apologies
Apologies were received and noted from Ms Tuuta, Mrs Eagles and Mr Foulkes, and for lateness from Mrs Borrows.

707.0 Conflict of Interest
The Register was circulated to members for signing.

708.0 Minutes of Previous Meeting

Resolution

That the Hospital Advisory Committee resolve to accept the minutes of the meeting held on8 December 2011

Catt/Jeffares
Carried

709.0 Chair's Report

As there were no items to report from the Chair Mr Moeahu took the opportunity to comment on the excellent service he had recently received when he had attended the pre-admission ward. All staff involved had provided an excellent professional service and Mr Moeahu asked if this message could be conveyed back to staff.

710.0 General Manager Hospital & Specialist Services Report

The General Manager Hospital & Specialist Services took the report as read noting the following:

Ward occupancy higher than expected with a busy New Year/ Christmas period. No wards had closed over this period which was usual practice.

TDHB Provider results for the month of December was $220k worse than the budgeted deficit of $619k.

An additional $75k was likely to be incurred by year end to ensure delivery of elective volumes required to meet compliance targets for 2011/12.

Overall casemix was 2% ahead of plan for December and 3% above year to date.

December FSA delivery was slightly less than plan with position moved from 13% ahead to 10%.

Hawera ED presentations slightly less than same period in previous year.

Base Hospital ED presentations in accordance with historic trends with greater than average patient numbers.

ED Waiting times Health results lower than six hour target.

In response to a question raised by Mr Moeahu on initiatives and saving programmes , Mr Thomas advised that there were a number of initiatives targeted across the sector, both locally and nationally that were yet to be fully realised and that timing issues did contribute to delay in any savings that may be incurred.

Mrs Borrows joined the meeting.

Mrs Clements introduced members of the Hospital & Specialist Services management team:
Lee McManus - Clinical Services Manager (Surgical)
Leigh Cleland - Clinical Services Manager (Maternal / Child Health)
Gloria Crossley - Clinical Services Manager (Allied Health)
Gillian Campbell - Clinical Services Manager (Medical)
Wendy Langlands - Clinical Services Manager (Older Peoples Health / Mental Health)

Hester Swart - Clinical Director for Mental Health

Each manager introduced themselves and provided a briefing on their respective services and outlined significant pieces of work that were underway.

Discussion

Mr Moeahu re-iterated the non-realised savings yet to be achieved and questioned whether there was a systematic failure within the system that doesn't allow for the achievement of a balanced budget even though the deficit was small compared to the overall budget.

Ms Lockett questioned whether reports were available at Board level that would provide alignment with budgets at unit/service level and associated variances to budget.

Mr Thomas advised that such reports were available and noted that the focus should be on the actual expenditure as current monitoring practices provides reasons for expenditure beyond budgets.

Miss Bourke noted that it was a governance responsibility to ensure understanding of reasons behind budget variances.

Ms Lockett also noted that those responsible for their respective areas would have been involved in setting the budgets and questioned where the accountability rested.

Mrs Clements advised that Service Managers had responsibility in the setting of budgets and their respective Unit Managers reported monthly on budget variances which in turn were reported back via the Service Managers. Mrs Clements added that variances were for services that were provided above and beyond expected levels and that this was reflected at DHBs throughout the country.

Mr Thomas advised that the health sector was in a transition period and that while significant changes were underway results would not materialise overnight.

Dr Gilkison noted that while the combined provider/funder financial results were generally able to meet the consolidated budget questioned why budgets were not set inline with actual costs against the level of service provided. Dr Gilkison added that a 'no tolerance' of variance to budget could be considered as a governance decision to ensure budget management.

Dr Catt advised that services were not able to be cut unless that had been identified in the Annual Plan and that the savings from South Taranaki reconfiguration had not materialised as had been indicated in the Annual Plan.

Mrs Rumball supported the concerns raised by members.

Ms Denness acknowledged that while services could not be cut without prior notification, she referred to the provision of uncontracted services that continued to be provided simply because they have been provided in the past.

In response to discussions Miss Bourke indicated that it would be appropriate for the issues raised to be discussed at the Strategic Planning workshop.

710.1 Financial Report for Hospital & Specialist Services for the month ending 31 December 2011

Mrs Fraser-Chapple took the report as read and was available to respond to any questions:

Discussion

On referring to the report Dr Gilkison noted that the report did not provide information that was easily understood and that there was a need to provide more trend results against cost centres, adding that the report was not a true governance report.

Miss Bourke suggested that Dr Gilkison, Ms Lockett and Ms Denness meet with the Mr Thomas and Mrs Fraser-Chapple and GM – Hospital Services to confirm the information that is required for presentation to the committee. It was noted that this would be arranged before the next committee meeting and that all members would be advised of the meeting time so they could attend also.

Resolution

That the group comprising of Dr Gilkison, Ms Lockett and Ms Denness be charged with the responsibility of meeting with the financial team to determine financial reporting requirements.

Bourke/Rumball
Carried

Discussion cont'd

Dr Gilkison questioned the Hospital & Specialist Services management structure noting that the number of direct reports to the General Manager and that best practice was considered to be 6-8. The low number of men was also noted.

Mr Woolley advised that the structure demonstrated the clinical partnership approach and this would provide the opportunity for the growth of strong clinical leadership. It was also noted that the appointments made demonstrated internal professional development within the organisation.

710.2 Human Resources and Organisation Development Report for October – December 2011

Mr Woolley took the report as read and was available for questions:

Discussion

Ms Denness referred to the provision of similar information in the previous report provided and requested that more specific details be included in future report.

710.3 Maori Health Report

Ms Henare spoke to her report noting:

That while the Maori Health operates on a small budget achievements of the unit were significant noting the positive engagement with the new hospital management team which provided the opportunity for more focus on specific initiatives.

Discussions underway with the Emergency Department to locate a Kaimahi Hauora to increase the support available to patients and whanau presenting to the department.

Discussions

Mr Ballantyne questioned whether the Kaiawhina involvement had led to a change in DNA's. Ms Henare advised that while there had initially been some positive results, with the additional effort underway new reasons for not attending continued to emerge. The increased focus on community health service utilisation meant an increase in associated DNA's.

Ms Henare advised that the Whanau Ora HNA was to be submitted to the Board at its March meeting.

Ms Denness noted that the He Ritenga: Treaty of Waitangi Principles Audit final report was yet to be received.

710.4 Quality & Risk Report for October, November and December 2011

Mrs Kemp took her report as read and highlighted the following points:

69% of complaints were considered closed within the Ministry timeframe.

Taranaki DHB had performed well in the recently released report from HDC.

Significant savings had been incurred through the ACC partnership programme.

Discussion

Mr Moeahu questioned the level of complaints against the number of compliments received. Mrs Kemp noted that of the 745 comments received in the Patient Satisfaction Survey 64% represented compliments and 36% represented complaints.

Mr Ballantyne noted the rating of hospital food quality and was advised that the standard of food was always closely monitored with ongoing discussion with the supplier.

Dr Gilkison questioned the infection control results and whether there was a mechanism to compare results with like sized DHBs. Mrs Kemp advised that had previously been reported via DHBNZ and that comparable results may be available in the future through the Quality & Safety Commission.

Resolution

That the Hospital Advisory Committee receive and note the Management Reports and attachments.

Catt/Bourke
Carried

Dr Gilkison, Ms Denness and Ms Lockett voted against the motion advising that to vote for the receipt of the reports indicates acceptance of the financial results.

…….. ……

Chairman Date

TDHB Hospital Advisory Committee Task List as at 8 December 2011						
Action No	**Date Raised**	**Action Description**	**Status**	**Assigned**	**Due Date**	**Updates**
~~9~~	~~9 February 12~~	~~**Financial Group Meeting** – meeting of sub group to discuss financial reporting requirements~~	~~Held~~	~~PA to CE to arrange~~	~~8 March 12~~	~~Meeting held 28 Feb 12~~
8	6 October 11	**New Facilities –** Consideration of acknowledging former Chairman		Chair	2013	

TO	CEO and Hospital Advisory Committee
FROM	Acting General Manager Hospital & Specialist Services
DATE	27 February 2012
SUBJECT	Exception Report for January 2012

TARANAKI DISTRICT HEALTH BOARD

MEMORANDUM

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1 OVERVIEW

This report provides an overview for the Hospital Advisory Committee (HAC) of hospital activity for January 2012.

Bed occupancy and patient turnover in the adult surgical and medical wards was lower than the December period. The orthopaedic ward however was significantly affected by the increased trauma during January and occupancy remained over 80% for this area.

Mental Health was extremely busy in January, with an occupancy of 99% in TPW. There were a high number of patients requiring constants and this had a direct impact on staffing resource.

1.1 Financial Comment

The Provider financial result for the month of January was $556K worse than the budgeted deficit of $794K. This was made up of revenue $156K below budget and expenditure $400K higher than budget.

For the year to date the Provider deficit is $4.01M, $2.3M worse than budgeted. Contributing to this is reduced revenue from ACC ($694 below budget) and higher than expected costs in Personnel ($1.05M), Clinical Supplies ($700K), and Infrastructure ($910K).

Year to date Personnel costs are higher than budget primary in clinical and associated services including Nursing ($382K) and Allied Health ($447K).

Medical staff costs are significantly below budget ($705K and 7 FTE), however this relates to vacancies and is partially off set by the use of additional locum staffing.

Clinical supply costs remain higher than budget relating to demand earlier in the year, and the variance is expected to trend downwards as the year progresses.

Infrastructure and Non-Clinical costs have been impacted by high facility and transportation costs. An increasing variance to budget relates to unrealised savings initiatives that were budgeted in the second half of the year.

2 ACTIVITY

DHB Funded Activity

2.1 Casemix and Non Casemix Activity

2.1.1 Casemix Delivery for 2011/12

Overall casemix delivery was 14% ahead of plan for January (169 cwd) and was 2% above year to date (195 cwd). January discharges were ahead of last year (98) and caseweight ahead at (199 cwd). We are meeting current targets in most specialties with significant focus on meeting the new July 1 ESPI requirements. Surgery is responsible for the majority of over-delivery, particularly in General Surgery and Orthopaedics.

2.1.2 Specialty breakdown

Acute delivery

January was busy with acute delivery, particularly during the New Year shutdown. The resulting higher than expected occupancy in acute wards needed to be carefully managed. Increased acute volumes can negatively impact on our ability to deliver elective cases, predominantly due to cancellations and bed shortages. Significant effort is ongoing to ensure this risk is minimised.

Elective delivery

ENT, Orthopaedics and General Surgery were responsible for most of January's elective over delivery. This is good news in relation to our ability to meet new Ministry targets and wait times by 30 June 2012. The additional procedures being performed are reducing the waiting lists significantly and we are on track to be compliant by the end of the financial year. Detailed analysis of the waiting lists is occurring weekly and Clinical Leaders are focussed on achieving the targets.

2.2 Outpatient FSA Delivery for 2011/12

Medical First Specialist Assessments (FSA)

Clinical Nurse Specialist roles are having a significant impact on the follow up waitlists and are enabling physicians to increase FSAs. All medical specialties continue to develop plans to ensure compliance with the 6 month target.

Surgical First Specialist Assessments (FSA)

Surgical FSA delivery continues positively in most specialties with January delivery slightly ahead of plan. Work with specialities continues to enable achieving compliance with the 6 month target.

2.3 ACC

ACC revenue is below target across most contracts. This is impacting on the overall financial position, however we are currently reviewing how we deliver ACC contracts and considering options, including viability .

2.4 Inpatient Delivery

The inpatient areas experienced higher than predicted activity during the beginning of the month. Wards 3 and 4 were particularly busy with the acute workload in General Surgery and Orthopaedics previously noted. Specialist areas (NNU, ICU and Paeds) were not as affected, nor was the medical ward.

2.4.1 Hawera Inpatient Ward

January occupancy was higher than in December 2011 with an average of 10.7 patients per day, compared to 9.3 patients per day in December. January was 10% lower than January 2011.

2.5 Emergency Departments

The activity across both Base Hospital and Hawera Hospital Emergency Departments for January was lower than the average presentations for 2011. BED presentations for January 2012 were 4% lower than January 2011, and HED 5.7% lower.

Hawera ED

HED had an average number of triage 2 and 3 presentations but the reduction in attendances overall was due to the reduction in the volume of lower acuity (triage 4 & 5) patients.

Base ED

Over the past 6 months, higher acuity presentations to the BED have plateaued after a significant period of increases in this area, however triage 4 & 5 volumes are now showing an increasing trend.

2.6 Mental Health

A very busy month for the acute inpatient mental health ward.

Te Puna Waiora occupancy for January was 99%.

Te Whare Whakauhuru - (4 bed residential facility for high and complex MH cases) occupancy was 97.6%.

3 PROJECT UPDATES

The Productive Operating Theatre (T-POT)

In September 2011 Taranaki District Health Board made two applications for funding to the Ministry of Health Elective Services Productivity and Workforce Programme for the introduction of The Productive Operating Theatre (T-POT) programme and a whole of system Pre-Admission project.

The Ministry of Health has now approved both Initiatives and has allocated funding to support their implementation. This is now well underway.

The programme is a licensed United Kingdom National Health Service (NHS) initiative that the Ministry of Health has introduced to 12 New Zealand District Health Boards.

The programme steering group and facilitator are in place. The first part of the programme is to hold workshops on 23 March 2012 that will establish a shared vision for the programme. This workshop will involve as many of the members of the peri-operative staff as possible.

A presentation will also be made to the TDHB Board in March 2012 as part of the programme of implementation.

Pre-admission project.
The Purpose of the Pre-Admission Pathway initiative is to deliver:

Appropriately Prepared Patients
on
Appropriately Prepared Lists
with
Appropriate Information

To achieve this Taranaki DHB intends to take a "whole of system" patient centred approach to the pre-assessment pathway for all surgical procedures delivered by the DHB. Effectively this will transform the patient pathway for all surgical patients - with the reduction in identified bottlenecks and resource wastage - supported by the introduction of standardised processes – and continuous small scale, staff driven improvements.

Taranaki DHB intends to utilise this initiative to provide the foundation for long term sustainable service transformation in this area.

Hospital Dental Unit Refit
The Taranaki DHB Hospital Dental Unit has been fully renovated over the Christmas period. This refit is designed to ensure that the Dental Unit is operating in an environment that is appropriate and meets all current and likely future service requirements. This is the first substantial change to this service area since the 1990's. Improvements include a revised instrument re-processing area and upgrade to the patient reception area, as well as clinical equipment and surgery rooms.

Enhanced Recovery after Surgery (ERAS)
TDHB General Surgery department is engaging with other Midland Regional DHBs to implement the ERAS programme for Colo-rectal Surgery. This will initially be piloted in Waikato and BOP, then a supported roll out to Lakes, Taranaki and Tairawhiti. Major colorectal surgery is associated with considerable morbidity and a prolonged recovery process. ERAS methodology has been shown to reduce post-operative complications and reduces hospital length of stay. This programme focuses on a co-ordinated multi-disciplinary approach and will require leadership and governance from key stakeholders.

Releasing time to care (RTTC)
RTTC continues in Wards 3, 4 and ICU with a fourth ward commencing soon. Staff report ongoing satisfaction with gains experienced. The Well Organised Ward (WOW) module has been particularly successful for efficiency gains.

Midland Regional Trauma Network
TDHB continues to participate in the development of a regional trauma system designed to deliver the best care and outcomes for trauma patients and their families. Locally a trauma team has been developed and scenario training commenced. Data collection is ongoing and reports are being structured to inform local decision making.

PLANNING UPDATES

Smokefree Health Target: 90.53% of admitted patients who smoke were offered advice regarding smoking cessation. This is an upward movement toward achieving this target after compliance with this reduced last quarter. Education to all areas continues.

Interventional radiology: we continue to utilise Braemar Hospital in Waikato for our interventional work. This transition has been smooth, however we are strongly supporting Fulford in their recruitment process for a Interventional Radiologist.

ED Health Target: January 2012 showed slight improvement with the ED Health Target. The ability to have patients discharged or admitted within 6 hours remains a key focus while ensuring quality care is provided.

The below initiatives to improve the 6 hour target result continue:

- 'Medical Patient Acute Pathway' project. This project continues with targeting of a number of small incremental issues to improve discharge planning. Planning for potential significant pathway changes continue to be researched and evaluated across the medical continuum.
- Feasibility for a Emergency Observation Unit has been completed and is recommended for the Base ED to improve quality of patient care for patients requiring extended periods of observation/treatment within the ED setting. A 4 bed unit is proposed.
- Proposal for a nurse led minor injuries unit is underway. This will be a CNS led service with oversight from senior emergency department medical staff
- The # NOF pathway pilot continues.

Project Maunga
Construction of the new Acute Services Block (ASB) is proceeding on time and with largely minimal impact on other areas of the hospital. We also continue to plan for the introduction of electronic prescribing and other elements of the e-pharmacy project into the hospital prior to the move into the new ASB. This process is being held back by delays with the development, refinement and integration of the software programmes by external parties that is required to implement the e-pharmacy package. This is unfortunate as it impacts negatively on the amount of time available to us to implement these significant changes to work practice in a timely manner. Regardless of this, we are proceeding with trials of mobile workstation options and PC types to find the most appropriate equipment to support our clinical staff when the software is ready for implementation.

There is also ongoing work occurring to finalise equipment requirements for the new ASB and an in-depth gap analysis is nearly complete looking at what equipment can be transferred from the existing wards/departments and what needs to be purchased as new equipment. User Groups are closely involved in this process.

There is regular liaison occurring between HIQ representatives and hospital operations to ensure the IT requirements for the future are accommodated, including e-pharmacy, development of an electronic patient whiteboard, identification of nurse call system requirements, and integration of all devices with the hospital's patient management system. This includes the architecture necessary to support this enhanced electronic capability.

Preliminary discussions have already occurred to begin planning for the migration into the new hospital in July 2013.

Steve Berendsen has now been seconded full-time to work on the Project and provide Hospital Services oversight to all aspects of the project.

Older Peoples Health

Project Splice

- Full implementation of the InterRAI (international residential assessment instrument) is expected to be in place from 1 July 2012.
- Progress continues in the creation of a Single Point of Entry within the Older Persons Specialist Services which undertakes triage and screening for clients requiring further assessment designated either 'non complex' or 'complex'.
- Good progress is being made around the shift from a non clinical NASC function focused on 'support needs assessment' to a clinical care management model embedded into specialist services but with locality links to general practice. Seven new Care Manager roles are being recruited, with each Care Manager expected to be assigned to specific local GP practice enrolled populations using the interRAI HC tool.

Enhanced Intermediate Care Service

- This is a new development which is being led by our ICATT (Intermediate Care Assessment and Treatment Team) within Older Peoples Health Services. A Request for Proposal process to tender for a suitable residential care provider has recently closed. This service is intended to provide a residential care based Service for Older People who would otherwise face an extended length of stay in acute inpatient services or long term residential care. The aim is to facilitate the transition from hospital to home, and/or from medical dependence to optimal functional ability, where the objectives of care are not primarily medical, the service user's discharge destination is anticipated and a clinical outcome of recovery (or restoration of health) is appropriate. The service will normally be delivered within a maximum of 6 weeks with some service users requiring as little as 1 - 2 weeks. Length of stay in the service will be under continual review by the TDHB Intermediate Care Assessment & Treatment Team (ICATT).
- We expect to implement this new service at the end of April 2012.

4 GENERAL

TDHB continues to achieve elective delivery targets despite a very busy month for acutes. Clinical teams are focused on achieving compliance for the new ESPI requirements in force 1 July 2012 and are working closely with the Elective management team to ensure this occurs.

Agreement has been achieved on local delivery targets for 2012/2013 year, focussing on areas of regional and national concern, i.e. Cardiology.

The Ministry of Health has advised further indicators to be introduced, related to Endoscopy, Cardiac Intervention and Radiology (CT and MRI) waiting times. These indicators are now being consulted on with a view to being implemented by June 2015. THDB is currently reviewing these to determine our ability to comply and where we will need to focus our resources.

RECOMMENDATION

That the Hospital Services Reports for the month of January 2012 be noted and received.

Lee McManus
Acting General Manager
Hospital & Specialist Services