HOSPITAL ADVISORY COMMITTEE

MINUTES – PUBLIC - unconfirmed

Tuesday 26 May 2009
10.00am
Corporate Meeting Room 1
Base Hospital
David Street
New Plymouth

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

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

482.0 Declaration to Open Meeting
The meeting was opened at 10.00am with a karakia.

493.0 Apologies/Leave of Absence
Dan Devadhar, Grant Knuckey (Board members), Nic Boheimer (co-opted member)

Resolution
That the apologies be sustained.

Denness/Dunlop
Carried

484.0 Conflicts of Interest
The Register was circularised for updating by members, with the following amendment being declared:

Karen Eagles Resigned as Member of Waves Board April 2009

485.0 Presentation

485.1 Lean Thinking – The Stroke Pathway

Ms Farley introduced members of the Lean Thinking Project Team –
Warwick Gilchrist (Service Planner), Gillian Campbell (Manager Hawera Hospital), Mary Bird (Allied Health Co-ordinator), Wendy Langlands (Older Persons Health and Rehabilitation Manager), Perrin Aish (Clinical Nurse Manager – ED)
Lee McManus (Outpatient Service Manager) was also a member of the team.

Ms Farley advised that the Lean Thinking Project was aimed at improving productivity by improving workflow systems and procedures and was being undertaken as part of the Health Round Table. Six staff have learnt the principles of lean thinking which also provided a teaching tool to wider sector.

Background

- Lean thinking programme run by Health Round Table
- Places available for six from Taranaki DHB and representation provides good coverage across continuum of care
- Application of Toyota Production System of healthcare
- Lean Thinking is all about learning doing things better for patients

Key Objections From Staff

- Outlined some key objections put forward by staff –
- Not a manufacturer
- Health service is different to others
- Areas have different casemix – patients sicker and older
- Standardisation and pathways takes away autonomy

What is Lean Thinking

- Looking at better ways of doing things for patients in our care
- Getting people through the system in best way possible for the patient
- Locally Led
- Creating value and patient focused
- Empowering for staff to work in interests of the patient
- Continuing learning/continuing improvement
- Led by people on the floor. Staff empowered to do things better
- Time is the value outcome

Initial Focus

- Programme required to be chosen for the project.
- Chose ‘Strike Patient Journey’

Rationale

- Stroke pathway and services identified by GMs nationally as a priority for improvement
- Reviewed journey through hospital services for person who has had a stroke from ED to discharge and beyond from a patient perspective

- Clinicians very important driver and important that people realise that patient perspective can sometimes get lost but important that they are at the centre
- Needed to understand clearly the service delivery both from different perspectives – patient, family and staff

Process –

- Team looked at all areas
- Challenge with this particular pathway due to number of teams involved - Not a simple process
- Challenging but also means once tracking effectively can roll out across other areas and other pathways

Aims

- 100% patients present with stroke to be seen by stroke team within 6 hours
- Want to bring stroke team with appropriate expertise around that patient
- 100% patients present with stroke being admitted to designated stroke area which would be Ward 1 AT&R ward
- At present no formal policy around management of stroke patients.
- Based on review found met two of the six recommendations of the National Stroke Guidelines, they were multi-disciplinary team and treatment guidelines.
- Other guidelines are:
Employ Stroke Consultant
Employ Stroke Nurse
Dedicated acute beds
Dedicated rehab beds.
- Want to meet all recommendations if possible

Current Status

- Visual representation of pathway developed during three workshops
- Outlines steps in process and gives visual representation of what the pathway is like for a patient.
- Walked through steps identified
- During this process two additional steps found
- Noted – Acute Ward – ‘chaos’ because so much going on
- Ward 1 environment ‘messy’ – lots of people motion

Base Line Data

- A manual graph was designed and populated to measure what happens in real time for patients
- Outlined process in ED for treatment. Patient Triaged and generally speaking stroke patients seen within 10 minutes to half hour of presentation
- Data based on 20 stroke patients
- ED KPI – discharge from ED within 6 hrs
- Findings – 50% of patients in ED for longer than 6 hours

- Average length of stay 8.5 hours
- 80% patient group arrived in ED between 1200 and 2200
- Aim is for patients to go to Ward 1 – data indicated
    - 12 patients to Ward 5
    - One to HDU
    - One to Ward 4
    - Six to Ward 1
- 16% of total time in ED waiting to be seen by Emergency physicians
- 28% of total time waiting to see medics
- 23% of total time waiting for diagnostic CT treatment and decision to admit by medical team
- 33% total waiting time was waiting for an inpatient bed to be available
- 50% of patients with expected CVAs had a CT from Ed before admission to an inpatient ward
- Highlighted inconsistency around CT from ED and others that have CT later from Ward.
- Note undertook same process in Hawera – know that Hawera pathway is different

Revised Pathway – Way Forward

- Patients out of ED within 6 hours key performance indicator – nationally
- Want to get patient to place where can recover quickly. Key thing have to comply with Life After Stroke guidelines
- Six key objectives
- Meeting 2 currently
- Have to have Acute Beds
- Rehab Beds
- Stroke Consultant
- Stoke Nurse
- Intent of revised stroke pathway is to improve patient flow and mitigate waste identified in the current state

Value Stream Map – another set of workshops held and revised map

- Cut out 4 steps
- Proposed solution -
- all patients with stroke discharge from ED to a stroke team within 6 hours
- all stroke admissions receive acute and rehabilitation care in same geographical location , ie Ward 1 (unless patient transferred to ICU)
- Same multidisciplinary team will wrap themselves around patient for all phases of treatment

Hawera Hospital

- Stroke Pathway is Taranaki Wide proposal
- Realise current pathway for Hawera patients is different and dependent on day and time of presentation

- Acute pathway for stroke patients presenting to Hawera hospital will be developed to meet guidelines
- In future looking to be seen by stroke team early. Receive CT scan at base and then facilitate early return to Hawera for rehabilitation.
- Wherever possible rehabilitation will be provided from Hawera for south patients

Issues to be Resolved
- Bed Availability/Bed Blocks
- Discharge Planning
- Education of all staff to ensure awareness of revised process
- Staff – eg Allied Health/Nursing workload capacity

Ms Farley noted that the methodology of lean thinking can be applied to everything we do in the hospital. The aim is to reduce the time spent waiting between interventions for patients. The team gave excellent examples of how to improve processes and systems to achieve greater productivity and efficiency.

Discussion
In response to a question on the value of the lean thinking programme members of the team were very supportive advising that it gave them a different perspective and had enabled them to think differently and look for ways to improve systems and processes in their various areas to improve productivity and efficiency. It was also a tool which empowered staff to address issues at source.
The Committee questioned why the KPI of discharge from ED within 6 hours had been chosen instead of aiming for a lower time and therefore obtain greater value for money.
In response the team advised that the KPI had been chosen as this was accepted by staff as it was a Ministry requirement. It was highlighted that the goal was to continually improve systems and processes and it would be the intention to aim for a quicker response.
It was noted that discussions over the proposed solution to the pathway were required to be held with clinicians and there would also be tradeoffs required particularly with respect to what occurred when there were bed blockages. However, with the new facility there was the requirement to change how services were delivered and it was known that work arounds would be required in the current facility.

The Chairman thanked the team for the presentation and wished them every success in the implementation.

486.0 Minutes
Resolution
That the Hospital Advisory Committee resolve to accept the minutes of the meeting held on 28 April 2009 as a true and correct record.

Nager/Catt
Carried

487.0 Management Reports

487.1 General Manager Hospital Services

Ms Farley took report as read and highlighted

- Cardia Thoracic and Cardiology delivery – David Geddes, Chief Medical Advisor for Ministry of Health, and Brenda Wills, Elective Programme, had been engaged by Waikato to undertake a review of the service, had spent a day at the DHB meeting with management and clinicians, to obtain information for the regional report on how to improve the pathway for patients from Taranaki to receive cardiology services at Waikato.
- Increase in presentations to ED has an effect on the total operations and costs of the Hospital and work ongoing to try and find a solution.
- Almost completed price volume schedule for out patients and elective surgery The approval process will involve sign off by the clinical heads of department
- Highlighted graphs which indicated the increased activity in the hospital which was driving staff utilisation and created delays throughout the system.
- Noted that length of stay was not increasing but were trying to manage more people through existing resources.
- Graphs also indicated increased level of annual leave taken. The additional annual leave entitlement came into force during the year.
- Has been a corresponding reduction in sick leave.
- Pleased to be able to announce ambulance staff agreement ratified.
- Financial
- Revenue continued to track ahead particularly CTA Training Revenue
- ACC revenue under budget but recovering
- Average staff salary well in excess of budget and fluctuation on monthly basis has continued. Note five public holidays during the period
- Outsourced services over spent in area of locum staff. This will be felt this quarter as we have 10 vacancies this quarter. Engaging with RDA in how to manage this.

Discussion

Discussion took place around patient numbers and whether to address the bed blockage patients were sent home earlier than would normally be the case.

Ms Farley advised that the DHB did not discharge patients before clinically safe to discharge and a discharge plan for care at home was provided. There was a need however for discharge planning to occur earlier to reduce waiting times.

The Chairman referred to national reports which showed that Taranaki DHB had slightly longer average length of stay but comparatively the indicator that measures readmisson within 30 days is low compared with nationally.

Discussion took place around a perception by some that junior doctors received higher salaries at other DHBs and how this perception could be overcome.

Ms Farley advised that Junior Doctors payments were set under a national award so theoretically all junior doctors should receive the same level of payment, however with approximately 200 more junior doctor vacancies than doctors there was competition and a degree of variability around locum rates. The Chief Executive reinforced comments made by Ms Farley and advised that due to pressure to find locum cover there was a degree of local bargaining by doctors for increased levels of remuneration. Taranaki DHB did enjoy support from senior doctors to cover in certain circumstances. The commitment of DHBs and staff to honour national agreements varied across the country depending on local circumstances, but he endorsed the view that wherever possible national agreements should be honoured and the DHB would continue to encourage its colleagues to follow this line.

There was a general discussion around the volume of elective services undertaken over the year and whether this level would increase further particularly with the new facility and whether additional funding would be received.

Management advised that in the next financial year there was an expectation to increase elective volumes by 5% on 05/06 delivery and in out years to increase 3.28% per year. There was also the additional expectation to meet higher case mix discharge volumes, which would result in the DHB increasing discharge volumes by 4,000 discharges per year and this must be within a similar case mix to that already providing.

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

Denness/Nager
Carried

488.0 Other Business

488.1 Hawera ED

Ms Farley referred to a number of services reviews which were being undertaken around allied health, pharmacy, booking process etc.

A meeting had been held with the Hawera Steering Committee and local PHOs around ED services in Hawera and how services in Hawera could be developed in line with future directions and also aligned to link in with the new facility and models of care at Base.

These were always difficult conversations as doing things differently often created the perception that something was being taken away. One of the issues arising was the very low volumes of patients that come to the Hawera ED between 11pm and 7am (between 2 and 4 per night on average). One option is to run Hawera ED services from 11pm – 7am from the Ward as this would provide better staff utilisation and security. Absolute commitment is for emergency services to be continued to be available at Hawera but they would be provided in a different manner overnight to ensure better utilisation of resources.

The meeting had been reasonably supportive and further discussions on how services could be delivered differently would be on-going.

489.0 Next Meeting
The next meeting is scheduled to be held on Tuesday 30 June 2009 in Hawera.

490.0 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 11.20am to reconvene at 11.25am

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Chairman Date