MINISTRY OF HEALTH
INFORMATION BRIEFING DOCUMENT

Cliff # 956388

PREPARED FOR: Graham Whitmarsh, Deputy Minister,
- **FOR INFORMATION**

TITLE: Burnaby Hospital Situation Analysis Update

PURPOSE: To provide an update of Burnaby Hospital Situation Analysis in response to release of the *My Burnaby Hospital Citizen Report*.

BACKGROUND:
The My Burnaby Hospital Community Consultation committee collected community input on Burnaby Hospital (BH) issues from May to October 2012. It publicly released its findings in a Citizen Report on November 29, 2012.

The Citizen Report highlights a number of issues, including a perceived lack of resources relative to other Fraser Health Authority (FHA) facilities, inadequate emergency department (ED) facilities, mismanagement of urgent safety requirements, allocation of operating room (OR) time and aging physical infrastructure. The report blames FHA for many of the issues and makes several comparisons to resources allotted to other FHA facilities.

In a separate initiative, the Ministry of Health (the Ministry), in cooperation with FHA, undertook a focused look at issues at BH in October and November of 2012. This resulted from concerns raised by BH physicians to the Minister of Health during a site visit in September 2012. The process is described in Appendix A.

The focused look (situation analysis) consisted of key informant interviews and two focus groups with BH physicians and staff. Both the interviews and the focus groups were led by Ms. Lillian Bayne. Ms. Bayne and Ministry staff toured the hospital before the focus groups.

Key informant interviews identified the most pressing problems at BH as the perception that BH was not given its fair share of resources, and the perceived lack of local autonomy to make routine decisions. Other major issues were the allocation of OR time, and dealing with an aging physical structure.

Senior FHA staff, Ms. Bayne and Ministry staff debriefed following the second focus group to discuss actions for addressing the identified issues. FHA has developed a summary of the issues and associated action items from the situation analysis (Appendix B). Key Actions are:

1. Enhanced site leadership.
2. Increased coordination and resources on the community side.
3. Minor renovations to the ED and ambulatory/GI unit which should be financed from FHA working capital (approx. $1.5 million each for short run solutions). FHA has not committed to these renovations but has provided cost information.

4. Process improvements to enhance communications and physician engagement.

In terms of site leadership, FHA has announced that there will be one Executive Director, Ms. Cathie Heritage, in charge of the site (she was previously site lead). Ms. Heritage was present during the tour and debrief and is working to strengthen the local Multidisciplinary Health Care Committee, which is charged with resolving site issues.

DISCUSSION:

During the situation analysis, the Ministry found BH staff to be committed to doing what they can with a dated physical structure. For example, since June, BH is the only facility in FHA to meet the target of 80 percent of admitted ED patients transferred to an inpatient bed within 10 hours. An extensive tour revealed a clean facility, with committed staff, where space is used as efficiently as possible.

S13

FHA will provide a monthly report of progress against the plan in Appendix B and update during regularly scheduled bi-weekly teleconferences. An update will be provided to Ministry executive monthly.

FINANCIAL IMPLICATIONS:

S17

ADVICE:

S13

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Date:	December 7, 2012
File:	L:\HAD General\Briefing Notes\2012\HPS\956388 Burnaby Situation Analysis update - approved by Barbara Korabek Dec 21, 2012.doc

APPENDIX A

BRITISH COLUMBIA

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OCT 0 1 2012

Dr. Nigel Murray
President and Chief Executive Officer
Fraser Health Authority
Suite 400 Central City Tower
13450 – 102 Ave
Surrey BC V3T 0H1

Dear Dr. ~~Murray~~ Nigel:

As I am sure you are aware, Honourable Dr. Margaret MacDiarmid, Minister of Health recently visited Burnaby Hospital. During that visit, she was alerted to a number of issues by the medical team. In addition over the last few weeks her office has received a number of correspondence from physicians from Burnaby and individuals with concerns. As a result, Minister MacDiarmid has asked Ministry of Health staff to follow up with physicians and others to better ascertain what the issues are and what, if any, follow up actions might be appropriate. To this end, we have asked Ms. Lillian Bayne to lead two focus groups of Burnaby Hospital staff. We will also be requesting background information and potentially a meeting from your leadership team to help us move as expeditiously and thoughtfully as possible. To the best of our knowledge, the issues are independent of those identified by Dr. Michael Gardam.

I hope that you will support us in this endeavour as you have in the past. This process will be coordinated by Ms. Effie Henry, Executive Director, Hospital and Provincial Services, and if you have any questions please feel free to call me by telephone at: 250 952-1049 or Effie by telephone at: 250 952-1178.

Sincerely,

Barbara Korabek
Assistant Deputy Minister

pc: Mr. Graham Whitmarsh, Deputy Minister, Ministry of Health
Ms. Effie Henry, Executive Director, Hospital & Provincial Services Branch
Ministry of Health

Appendix B: Burnaby Hospital: Identified Issues and Next Steps

The following table is a summary of issues and associated action items from the situation analysis of Burnaby Hospital. They have been grouped by major themes and include some items identified only at the November 2 focus group. Issues have been included in detail to show the breadth of the concerns. Vivian Giglio, VP, Clinical Operations, will oversee the implementation of the action plan.

Table of Major Themes:

Theme A: Perceived lack of a fair share of resources:

Issue	Root Cause	Objectives	Action	Lead	Timeline	Status
No BH physicians on FHA leadership team	S13	Fair representation of BH issues at appropriate tables; effective physician representatives. Peer assessment of validity of issues and agreement on acceptable solutions. Accountability in both directions for effective identification, communication, management and resolution of legitimate issues using agreed-to/legitimate processes and structures.	**FH commits to communication of opportunities through established channels of communication (e.g. MHCC, programs, HAMAC, Physician Newsletters) most appropriate for the position.**	Program PMDs & Medical Coordinator	Ongoing	Communication Ongoing
Outpatient Clinic		Access to needed ambulatory surgical space. Adequate ambulatory space to provide appropriate services is included as part of the Master site plan.	**FH will investigate possibility of renovations to the existing space as part of a smaller, interim, capital project.**	Cathie Heritage	April 2013	Early discussion stage

Issue	Root Cause	Objectives	Action	Lead	Timeline	Status
		JPOCSC space is limited for BH as it is primarily used for SMH.				
Lack of Echo-Bronchial Ultra sound (EBUS) capacity		BH is able to deliver same standard of care as other sites.	**FH commits to a meeting with key stakeholders to discuss possibilities and agree to a plan of action.**	Cathie Heritage	March 2013	Discussions have began with Dr Dave Williams re plans for EBUS on a regional level

Theme B: Lack

Issue	Root Cause	Objectives	Action	Lead	Timeline	Status
Lack of progress on identified issues	S13	Progress on identified issues with a view to closure on agreed-to outstanding concerns. Clarity on processes, roles and responsibilities. Accountability in both directions for effective identification, communication, management and resolution of legitimate issues using agreed-to/legitimate processes and structures.	**FH leadership at program and site level has committed to closing the loop and keeping physicians informed of status on initiatives.**	Cathie Heritage / Judith Hockney	Ongoing: Status updates provided regularly (minimally every 2 months)	Channels of communication in use are (but not limited to): 1) Local Dept. Head as the go to people; they can escalate to program medical director/executive director for the programs; 2) Medical Coordinator can bring issues of patient quality and safety to HAMAC 3) Multidisciplinary Health Care Committee (MHCC) at the site is another forum to bring site quality issues. 4) Site Executive Director is providing regular updates to MHCC and the site as a whole. The site director is onsite for at least three days per week. 5) Surgical ED and Program Medical Directors meet with surgeons via the regular Department meetings if

Issue	Root Cause	Objectives	Action	Lead	Timeline	Status
						invited. Plan to attend the Jan/Feb meeting. 6) BH Surgical Chief is a member of the Surgical Leadership Council (physician meeting with surgical program admin attendance) and is attending. Chaired by Regional Division Heads (RDH) Anesthesia and RDH Surgery (decision making body).
Program management model		Better understanding of program management model and of inherent roles and responsibilities. Greater sense of "inclusion" of BH in FHA/ "bigger picture".	**FH will re-commit to an Executive Director responsible for BH.** **The ED will work on strengthening the BH based MHCC to improve site accountability**	Cathie Heritage	Dec 2013	Cathie Heritage is the ED for BH; is regularly on site; attends MHCC; regularly meets with Medical Coordinator

Theme C: Oper tion

Issue	Objectives	Action	Lead	Timeline	Status
Endoscopy	Adequate resourcing of endoscopy (space, technology, etc.)	**FH has committed to a local task group to address the local immediate needs and following up on the business case they submitted as well as agreement to a go forward plan.**	Judith Hockney	Dec. 31, 2012	A FH Committee has been established to look at the endoscopy issue FH wide. In addition, FH will be implementing new tools to ensure we have up to date waitlists etc to ensure fair and equitable access by all in FHA. This work has just begun. Local Ambulatory Care operations Group has been established and first meeting took place and well represented

S13

Issue	Root Cause	Objectives	Action	Lead	Timeline	Status
						by physicians. These will be monthly.
		Closure on endoscopy issues	**There has been an increase in time allocated to 59 hours.**	Judith Hockney	Plan by Feb 2013	A Sterile Processing renovation is necessary before volumes can be increased beyond 59 hours. This will be part of the short term master site plan renovations. Funding source needs to be identified.
Endoscopy		Closure on endoscopy issues	**Expansion will require capital dollars; FH has indicated this is a priority but it will require time and funding.**	Judith Hockney	Plan by February 2013	As above
Endoscopy	S13	Closure on endoscopy issues	**FH commits to purchasing adequate numbers for BH to function**.	Judith Hockney	February 2013	An inventory of scopes is underway and a plan will be tabled at the Regional GI Steering committee as well as the GI physician advisory group.
Plastics		Reasonable access to needed plastic surgery for Burnaby residents without compromising quality and safety.	**FH has committed to meeting with the plastics group to find a way to resolve issues in this area.**	Judith Hockney Dr. Peter Blair	January 2013 meeting Plan by March 2013	JPOCSC is currently being accessed by SMH/RCH Plastics Group. Will confirm available options for JPOCSC to support this work. Discussions with FH Plastic group have commenced, lead by Dr Peter Blair to plan for microsurgery ; where breast reconstruction will take place etc….this work to be completed by March 2013

Issue	Root Cause	Objectives	Action	Lead	Timeline	Status
	S13					
Ophthalmology		Reasonable access to needed ophthalmology surgery for Burnaby residents without compromising quality and safety.	**FH has committed to having an external expert conduct a LEAN review of this area.**	Judith Hockney	March 2013	LEAN process improvement agreed to by ophthalmology group.

Issue	Root Cause	Objectives	Action	Lead	Timeline	Status
Anesthesia	S13	More efficient use of OR time	**Surgical Program has identified anaesthesia assistants as an important part of the care model for delivery of anaesthesia services in FH.**	Judith Hockney	Ongoing	A review of the plan will be tabled at Surgical Leadership Council for endorsement in the spring. Locally, we currently have anesthesia assistants at several sites (SMH/JP). Want to expand model however funding is one of the barriers to expansion of this program.
Funded OR time less than physical capacity.		More efficient use of existing infrastructure.	**Surgical Program reviews utilization, waitlists, and allocation of time, on a regular basis. Reallocation will happen as agreed to by Surgical Leadership Council.**	Linda Lemke Dr. Bell	Feb 2013	A Resource Allocation Methodology (RAM) process will be re-initiated at BH (Dec 2012)**.**
Lack of knowledge of OR allocation		Understanding of who has what time.	**FH will compile and share OR allocation by site, program and surgeon.**	Cindy Laukkanen	Dec 31, 2012	

Theme D: Aging Infrastructure

Issue	Root Cause	Objectives	Action	Lead	Timeline	Status
Overcrowding		Optimization of available space for highest possible quality patient care/optimization of patient experience – “releasing *space* to care”.	**None**	Cathie Heritage	Ongoing	Is addressed in site Master plan.
Old Facility	S13	Maximize the impact of capital improvements within the means of current expenditure constraints	**None**	Cathie Heritage	Ongoing	Is addressed in site Master plan.
Infection Control		Measured improvement in infection control with a view to reaching and maintaining and/or improving on targets	**FH is monitoring infection rates on a by-period basis and reports are available.**	Cathie Heritage / Infection	Ongoing	

Issue	Root Cause	Objectives	Action	Lead	Timeline	Status
	S13	within [a defined time frame].		Control		
Lack of appropriate space for Mental Health and substance use patients in the ED.		Improved care for this patient group and enhanced quality of care for others using the ED.		Cathie Heritage	6 Months	Renovating the ED is part of the smaller, priority capital project within the Master site plan.

Theme E: Other

Issue	Root Cause	Objectives	Action	Lead	Timeline	Status
Discontinuity in Care for VCH residents who come to BH.		Seamless care; specifically discharge planning; for BH patients.	**FH will approach VCH and work with them to improve the situation.**	Cathie Heritage	3 months	
Electroconvulsive Therapy (ECT)		Need more access to ECT for Mental Health program.	**To be addressed at MHCC.or with Mental Health Substance Use program**	Cathie Heritage		
Lag in transcription times delaying care	S13	Better care.	**See if specific lag times in transcriptions can be reduced.**	Cathie Heritage		Discussions have happened with LMC Health Management group ; plan in place
Lack of qualified staff		Ability to use resources efficiently.	**To be addressed at MHCC.**	Cathie Heritage		
Physician Leadership at BH		S13			Ongoing	S13
FH Bureaucracy			**FH will address concerns**	Cathie	Ongoing	

Issue	Root Cause	Objectives	Action	Lead	Timeline	Status
	S13		**through MHCC.**	Heritage		