



HOSPITAL ADVISORY COMMITTEE

MINUTES – PUBLIC - Unconfirmed

Tuesday 25 September 2007

10.00am

Corporate Meeting Room 1

Base Hospital

David Street

New Plymouth

Present

John Young (Chairman), Kura Denness, Jan Dunlop, Flora Gilkison (Board members), Brian Jeffares (Co-opted member).

In Attendance

Joy Farley (General Manager Hospital Services), George Thomas (General Manager Finance & Corporate Services), Sandra Boardman (General Manager Planning, Funding & Population Health), Sue Carrington (Communication Advisor), Pamela Hikuroa (PA to Board)

351.0 Declaration to Open Meeting

The meeting was opened at 10.00am with a karakia.

352.0 Apologies

Dan Devadhar (Board member), Tony Foulkes (Chief Executive)

Resolution

That the apologies be sustained.

*Dunlop/Jeffares
Carried*

353.0 Conflicts of Interest

The following amendments were made to the interests declared by committee members:

Hayden Wano

CEO – Taranaki Hauora PHO Ltd
(formerly Co-CEO)

Removed from Register
Trustee Taranaki Community Arts Trust (resigned)

Co-opted Member – Quality Health NZ (Company wound-up)

354.0 Minutes

Resolution

That the Hospital Advisory Committee resolve to accept the minutes of the meeting held on 31 July 2007 as a true and correct record.

*Dunlop/Denness
Carried*

355.0 Chairman's Report

355.1 Resignation Dr John Doran

The Chairman advised that Dr Doran had forwarded his resignation as a member of the Hospital Advisory Committee, due to his new appointment as Chief Medical Advisor to the DHB. The Chairman looked forward to the contributions Dr Doran would make to the Committee in his new capacity.

Mr Wano, as Chairman of the DHB, in response to question from Mr Young advised that unless requested by the Committee it was unlikely that the Board would appoint a replacement. The co-opted members' term on the Advisory Committees concludes 31 March 2008 and the Board would be reviewing membership prior to this date.

356.0 Management Reports

356.1 General Manager Hospital Services

Ms Farley took report as read and advised that the majority of her comments would be focused on elective services and the effect on the financial results.

- Overall focus last two months had been in preparing the business case for submission to the National Capital Committee, which had taken place. Independent Audit of the business case, as required, had commenced and feedback would be actioned as appropriate.
- Elective services had had a material effect on the financial result and it would be necessary for the reporting to be revised in future to take into account the changes.
- Ms Farley gave a full explanation of the effect of changes to how elective services were reimbursed:
- Revenue spreadsheet represents value for the prices agreed with the Funder
- through the Service Level Agreement but orthopaedic and cataract initiatives are funded separately but all activity is fed through the revenue spreadsheet.
- Initiative volumes have been extracted from the base volumes contract. Payment for these initiatives cannot be claimed until the base contracts have been completed. As a result production plan is vastly different to the revenue spreadsheet and therefore a new way of reporting is required.
- The 10% additional elective funding is a DHB obligation as it includes all IDFs.

- Creates monitoring difficulties as IDF information is not immediately available
- Decision made with the Funder to undertake base contract in first six months of the year, this would ensure that Provider was able to meet base contract requirements and would be in the position to reduce volumes if required. This would ensure that the DHB maximised the amount of elective services funding available and minimise the risk to the DHB, as the funding for the additional elective services was not able to be claimed until the base contract had been completed. If not managed well, this could result in the DHB not receiving funding for work which had been undertaken.
- The risk to the DHB was around IDFs but robust processes had been put in place to monitor the position.

Considerable discussion took place around this issue:

In response to a question from the committee on whether the base contract levels would change in the following years, Ms Farley advised that this was not known but was likely.

Essential that the DHB is very careful around planning in this area as previously the DHB had purchased additional hips through the Service Level Agreement and this had been included in the base, and additional funding had to be injected. The Provider and Funder are working very closely to ensure that the DHB is not put in the position of being forced to purchase at a level it does not wish to.

The Ministry is currently working on core standardised discharge ratios to enable comparisons between DHBs average intervention rates. This system takes into account demographic profile and should ensure that across the country access to elective services is standardised.

With respect to planning assumptions, the additional 10% is based on the Funder's view of the requirements for the Taranaki population and includes work such as cardiovascular which was delivered through IDFs. This work although small in number has very high case weighted activity and there is therefore considerable risk to the TDHB if the tertiary provider does not deliver. Information on IDFs comes out eight months into the year and is one of the major reasons why the decision was taken to ensure that our base contract was undertaken early to ensure that we met the required target as at that point it would not be possible to increase electives either locally or with eg Waikato.

The figures provided in the reports reflect the production plan and revenue streams but do not reflect correctly the cost structure, this is due to the fact that when the budgets and phasing were set in January/February the implications of the additional elective services was not known. The current over spend of \$900k includes the additional activity and it is the intention to provide updated forecasts outlining the costs of the additional activity and the structural deficit position. Current estimated that \$400k of the overspend is directly related to the increased activity being undertaken.

Noted all DHBs in similar position, however, tertiary DHBs in stronger position as they do not have the difficulties presented from an IDF perspective.

A paper outlining the position and the processes put in place to monitor the DHB's position was being prepared and would be provided to the Committee in due course.

- FTE
- Staff numbers tracking slightly below budget but noticing impact of cost per FTE. Over a period of high occupancy and activity Managers and Clinical Nurse Managers had managed FTEs well.
- Junior Doctors remain a tension but service will be fully staffed by beginning of second quarter.
- Mental Health - some recruitment success with consultant psychiatrists but continues to be a real tension in terms of specialist staff.
- Ambulance Services –everything that we agreed to do with Central Comms implemented. Unfortunately had an incident at the weekend which was not managed well and is subject to investigation.
- National focus on double crewing and DHB has received notification of an inquiry into the provision of ambulance services by the Health Select Committee. TDHB will be making a response.
- Strong view within clinical management and staff that Hawera Hospital must be seen as continuum of care and work is being undertaken around integration of nurse education across Emergency Departments. Nursing staff see this initiative as a positive move towards the integration of models of care.

Questions

Questions raised around the new acute home based treatment service and Ms Farley advised that a presentation will be made to the Committee after the first quarter on the service.

The Chairman thanked Ms Farley for her report and the explanation of the implications of the additional elective services and the major challenges facing the provider and noted that the reports would include updated forecasts taking into account this issue.

Resolution

That the Hospital Advisory Committee note and receive the report.

Gilkison/Denness

Carried

357.0 Other Business

357.1 Financial Position

Ms Denness, noted that this matter had been discussed previously, but wished to voice her concern that as a Committee we had entered the year knowing that the provider would return a negative result. The fact that every effort was being made to minimise the risk did not change the fact that a negative outcome would result and questioned when would the Committee and Board advise management that a negative result was not acceptable and required that the budget be prepared without a cost to funding gap.

The Chairman invited management to respond, noting that from governance perspective true governance skills were not being shown by acknowledging

and accepting the budget but knowing that the provider would still function outside the budget.

Mrs Boardman advised that the funding of Provider units was based on national prices and as outlined previously, economies of scale and efficiencies are difficult to achieve given the size of the provider and the expectations of the population about the range of services to be provided and the location of services. These services all come at a cost and such costs are not fully recognised by the national pricing system. The Funder already provides sustainability funding to the provider arm over and above national prices. Mrs Boardman noted that the Provider and the Funder meet quarterly to review performance, including financial performance. There are also a number of constraints around the Base hospital site which cannot be overcome until the facility is redeveloped.

Committee Members noted the comments around the expectations of the population but were concerned that the efficiency gains from the capital expenditure on the redevelopment would not result in a reduction in the deficit as these efficiencies would go towards meeting the capital cost repayment.

Mr Thomas agreed that unless there was a change in the structure around models of care, the provider would continue to run at a loss. However, one of the main issues facing the DHB was the fact that although TDHB was in effect undertaking some services which were bordering on tertiary level, the DHB only received secondary level prices. As a secondary level DHB we were not entitled to receive the tertiary adjuster.

Even if the Funder opted to fund the Provider deficit it would not change the bottom line for the DHB on a consolidated basis.

Ms Farley advised that in her opinion it was preferable to clearly show the inherent structural difficulties facing Provider and this created the climate for change. It must be noted that with the new facility the change will not just affect the provider arm but would also involve the primary sector and was the catalyst for changes to be made in the way in which services are delivered on a regional basis. Ms Farley also advised that management was committed to driving the structural change off the new facility development and was working hard to ensure the desired results were achieved.

The Chairman thanked the Committee and management for the discussion which clarified to a degree the dilemma facing the DHB. Due to the concern over the deficit, an element of dissatisfaction is created when in fact as a province we should be proud of what is achieved by the DHB given the financial constraints placed upon us.

357.2 Allied Laundry

Ms Gilkison referred to discussions at Allied Laundry around the possibility of standardising linen supplies for the five DHBs and suggested that if a change to the current situation for Taranaki DHB was proposed that the matter should at least be discussed by the Committee.

Ms Farley undertook to provide information via her report.

358.0 Next Meeting

The next meeting is scheduled to be held on 30 October in New Plymouth.

The meeting closed with a karakia at 11am.

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Chairman

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Date