



HOSPITAL ADVISORY COMMITTEE

MINUTES – PUBLIC

Tuesday 29 May 2007

10.00am

Corporate Room 1

Base Hospital

David Street

New Plymouth

Present

John Young (Chairman), Dan Devadhar, Kura Denness, Jan Dunlop, Hayden Wano (Board members), Brian Jeffares, John Doran (Co-opted members).

In Attendance

Peter Catt (Board Member), Tony Foulkes (Chief Executive), Joy Farley (General Manager Hospital Services), George Thomas (General Manager Finance & Corporate Services), Sue Carrington (Communication Advisor), Pamela Hikuroa (PA to Board)

387 Declaration to Open Meeting

The meeting was opened at 10.00am with a karakia.

388.0 Apologies

Flora Gilkison (Board member)

Resolution

That the apologies be sustained.

*Denness/Doran
Carried*

389.0 Conflicts of Interest

The following alterations to interests were declared by committee members:

Kura Denness

Chairman Tui Ora Limited (previously Director)

Dr Peter Catt, Board member, declared the following interests:
GP Family Health Clinic
Director Family Health Clinic
Clinical Director Hauora Taranaki PHO

390.0 Presentation – Diagnostics - Radiology

Ms Farley advised that unfortunately advice to the radiologists regarding the presentation to the Committee was insufficient to allow representatives to attend. Therefore, the presentation to this meeting would be an overview from the secondary sector supported by Linda Whitehead, Clinical Imaging Manager Fulford Radiology, and next month the clinical team from Fulford would give a radiologists' perspective.

Noted that previous presentations on diagnostics had covered pharmacy and laboratory.

Purpose of this presentation was to look at history of where relationship with Fulford had come from and where going to.

Part 1 –

Background to Joint Venture

Volume/Trends

Upcoming Challenges and implications from secondary view

Joint Venture

- Radiology services in Taranaki is by way of a joint venture between TDHB and Taranaki Radiologists. The joint venture being established in 1999. Unique arrangement
- All radiology services in province are delivered by Fulford Radiology irrespective of funding source
- 1999 management structure: three person Board equal balance between JV partners, with an independent chairman and independently appointed General Manager based on corporate model
- Significant progress in radiology services, eg development of MRI.
- Modern pleasant department in place with good capital outlay
- A year ago Fulford looked at performance and how it was organised in terms of management structure.
- Resulted in change of structure to a partnership model which will better meet future challenges
- Board enlarged – Chairman filled by one of JV partners, currently John Young, TDHB. General Manager Hospital Services now a board member.
- Equal representation from Taranaki Radiologists and DHB.
- Management – No independent general manager. Now have managing partner who is one of the radiologists, an administration manager, and a clinical imaging manager.
- Aim is to position the model to move towards shared governance to meet challenges of the future.

Volume Trends over last 5 years

- Costs increasing yearly.
- Driven by different factors not just numbers of people
- Last 6 years number of examinations has not increased. Number remains relatively stable but clearly increased complexity of tests
- Funded by Relative Value Unit Model (RVU) similar concept to case mix.
- Assigns value to particular procedure and funding according to unit cost
- As complexity increases cost increases irrespective of the number of examinations
- Same trend in radiology as outlined in presentation on laboratory services. Moving away from standard tests to complex.
- Facing challenge of how manage different types of tests and radiologists will speak to this in their presentation
- Advances in technology leads to increased efficiency but more complex.
- Tests ordered are clinically driven and evidence based but Radiologists do take a proactive approach and clarify with clinicians what is required and to avoid duplication.
- New technologies have resulted in changes to clinical practice which results in changes to diagnostic services required.
- Screening programmes result in higher demand for diagnostics and therefore increased costs.
- Current service is seeing increased number of out of hours callouts. Service presently operated on call from 11pm to 7am. Approaching point where have to consider whether there is a need to staff the service on a 24 hour basis.

Upcoming Challenges

- Demand from community increasing
- Must meet continually evolving higher quality results
- Community expect best service regardless of whether we can afford it as a society

Technological Challenges

- CT scanner coming to end of life (only 5 years old)
- Business case under development
- Every time update modality create greater demand
- Move to Digital Acquisition System is in progress
- PACS (Picture Archive and communication Systems) implementation in 07/08
- Dramatic improvement in efficiency and ability for GPs etc to access information through web browser
- This is quantum leap in terms of information sharing and will have huge impact on how GPs, specialists and hospital works
- Requires significant business re-engineering
- GPs may require to update current systems

- Exciting from radiology perspective but will require consultation with the health sector and will require to be well planned.

Secondary View

- Move to more complex diagnostics is inevitable
- Will create challenges, particularly when looking to put restrictions on availability.
- Heads of Departments have expressed strong view that must be very careful about how implement restrictions, as diagnostics help to reach a diagnosis. This is an area of on-going debate.
- Expanding role of primary care
- GPs until recently only able to access plain film. A year ago launched ultrasound project with primary sector with certain criteria. This enabled GPs to access ultrasound and was managed closely by the Chief Medical Advisor.
- This has now been rolled out into a permanent arrangement.
- Costs have increased without the provider being able to exit any costs from the secondary sector but the project has improved efficiency and effectiveness of GP. In some instances the First Specialist Appointment for a patient is not required, however that appointment is not lost it is merely filled by another patient. The shift in threshold becomes an issue for unbundling and transfer of the costs to the primary sector.
- Support from diagnostics has implications for recruitment and retention of medical staff.
- They look at lots of things but one of the things how maintain their clinical practice how enhance given strong diagnostic service is an enhancement
- Strong vibrant diagnostic service is important for clinicians.

Discussion

Committee members questioned whether the RVU funding methodology, which was volume driven, vs capped arrangements with quality and best practice principles built in would be a better option.

Ms Farley advised that irrespective of the funding methodology the increasing demand would drive an increase in costs.

Noted that new equipment or clinical techniques had Human Resource implications through the need for continuing training. Ms Farley advised that this was indeed an additional cost, but the nature of clinical practice required the learning of new skills to take advantage of the latest technology and was merely part and parcel of development of the health workforce.

Dr Doran advised that the provision of up to date technology enabled the DHB to attract Junior Doctors for training purposes and they gained a favourable impression of Taranaki DHB and it was hoped that this would encourage them to come back to the DHB later in their careers.

Future Trends

- As tests more complex can they be added or do we remove with potential shifts of costs to other areas
- Key questions moving forward of how manage radiology budget within variables and what suite of tests should be offered.
- Is suite of tests offer here and what does it mean for clinical practice.
- What are implications – this will be covered in part 2 by the Radiologists.

Discussion

In response to a query as to whether the principles of a joint venture could be applied to elective services, Ms Farley advised that the principles of partnership could be applied to many aspects of health. This could be by way of a formal joint venture or having good working relationships. Currently the DHB was undertaking work at Southern Cross through the elective surgery initiative due to lack of theatre capacity at Base. This will continue over the next two to three years as we move forwards the facility redevelopment. The service is always keen to consider all opportunities which exist within the sector.

The question was raised as to whether there was political support for this type of approach. Mr Wano advised that a pragmatic approach is taken and if it can be proven that the arrangement was working well and beneficial approval was forthcoming.

The Chairman thanked management for the presentation.

391.0 Minutes

Resolution

That the Hospital Advisory Committee resolve to accept the Minutes of the meeting held on 24 April 2007 as a true and correct record.

*Devadhar/Doran
Carried*

390.1 Arising From Minutes

Committee queried the response received to the advertisements for UK doctors and generally querying reasons behind the shortage of health professionals. Ms Farley advised that she did not have all information to hand, but at this stage the response had not been large. Dr Doran advised that the numbers of doctors applying to medical school remained high with numbers increasing. A third medical school was likely to be established.

One of the issues is around the change in expectations and workflows. The workforce had changed with half the workforce now being female and a vast increase in parttime workers. Numbers going overseas not greater than they were previously but work being undertaken and the impact of expectations about doctor/patient ratio was having a marked effect.

Dr Devadhar also felt that the income differential between New Zealand and Australia and Canada had a significant impact.

Ms Farley noted that the DHB had to ensure that it maximised its ability to participate in training programmes.

392.0 Management Reports

392.1 General Manager Hospital Services

Ms Farley took report as read, highlighting the following

- Emphasise time involved by staff in external audits. Good feedback from the audit of all training programmes. These visits were essential when consider advanced training as we have to be accredited by the appropriate Medical College and if we lose the quality focus opportunities reduce and it is difficult to retain the training programmes. This has a direct impact on recruitment and retention of medical staff.
- Feedback to date has been around the detail as opposed to large widescale issues.
- An issue raised is how we continue to support training programmes and the Chief Medical Advisor has been looking at how we can better support the programmes.
- Advice received from National Capital Committee which requires TDHB to develop full business case for the facilities redevelopment.
- Activity
- General medical volumes ahead of budget at base with Hawera being significantly under budget.
- Medical acutes tracking to budget for the month. Have managed demand which is a credit to staff and also reflects the initiatives put in place with the primary sector.
- Elective service additional 5% underway
- Forecast year end position has resulted in reforecast of two specialties, urology and general surgery. Expect to meet target by year end.
- Some of the additional elective work being undertaken at Southern Cross, particularly general surgery due to capacity issues with our theatres. Southern Cross is an accredited and certified facility.
- Financial
- Deterioration this month, which was totally due to personnel costs. Closing FTE 8 above budget in mental health and hospital services. Also influenced .improvement on previous months all localised to nursing and split across mental health and physical hospital. Influenced by annual leave accruals and accruals in lieu of salary negotiations.
- Outsourced services and clinical supplies remained similar to last month's result.
- Forecast remaining at \$1.6m deficit with risks highlighted around controlling FTEs and managing demand through specialising.

Discussion

Committee members noted that the DHB had a reasonably stable workforce and therefore felt that the impact of awards should have been reasonably predictable. Ms Farley advised that settlements funded through the pay jolts applied only to existing FTEs not new ones and it was therefore increasingly important to minimise casuals. There were aspects of the settlements which had costs attached to them which had not been well recognised at the time particularly around senior nurses. There was also the impact of accruals made in lieu of anticipated wage From a benchmarking perspective the DHB was well within national consistency with two cases below which was good

from a financial perspective but raised questions in terms of retention and recruitment.

- Operations –
- Number of severely obese patients in hospital during April resulting in all three bariatric beds being in use. Looking at purchasing additional equipment. These patients have a significant impact on FTEs
- Also faced with how to manage the transition of people with complex needs back into the community. These people not disabled. Discussions with the funder on how to develop community support for these people. The Ministry is looking at the definition of disability and how it relates to long term community based funding and therefore it is an opportune time to highlight this issue to the Ministry.
- Mental Health
- Occupancy in TPW in April 60%.
- Cautiously optimistic that initiatives becoming effective in maintaining levels.
- Continue to have significant vacancies for psychiatrists and senior mental health team workers.
- Industrial Action
- Strike notice received from Service and Food Workers' Union for action over a number of days and will present challenges.
- After writing the report received notice from clerical workers under PSA of strike action. Looking at contingency plans. Clerical people essential in how we run the business and strike action will have a significant impact on operations.
- Appointment of Family Violence Co-ordinator. Specific funding is provided for this role. The Co-ordinator will roll out our whole family violence policy and will focus on hospital initially and then move out across sector. The roll includes training of staff on how to raise issues with patients and action to be taken when violence is reported.

Discussion

Queries raised around the ambulance service and whether management had considered developing the service based on the Order of St John. Ms Farley reported that the service had substantial volunteer recruits but as with other services the main issue was around people's availability.

Resolution

That the Hospital Advisory committee note and receive the report.

*Denness/Devadhar
Carried*

393.0 Work Programme 2006/07

Resolution

That the Hospital Advisory committee note the updated workplan for 2006/07.

*Doran/Dunlop
Carried*

394.0 Next Meeting

The next meeting is scheduled to be held on Tuesday 26 June. It was noted that with the proposed Radiologists presentation to the June meeting that the venue would require to be changed. It was agreed that the venue would be confirmed in due course.

395.0 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 7 or section 9 of the Official Information Act 1982, as the case may require which would not 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.*

*Wano/Jeffares
Carried*

The meeting adjourned at 11.20am to reconvene at 11.35am

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Chairman

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Date