



COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

MINUTES – PUBLIC

Unconfirmed

Tuesday 30 October 2007

12.30pm

Corporate Meeting Room 1

Base Hospital

David Street

New Plymouth

Present

Peter Catt (Chairman), Alex Ballantyne, (Board members), Andrew Brock, Tony Waghorn (co-opted members)

In Attendance

Tony Foulkes (Chief Executive), Sandra Boardman (General Manager Planning Funding & Population Health), Christine Henare (Chief Maori Health Advisor), John Doran (Chief Medical Advisor), Sue Carrington (Communication Advisor), Pamela Hikuroa (PA to Board), Rosemary Clements (Clinical/Ambulatory Service Manager), Brian Gubb (Senior Manager Performance and Contracts).

Apologies

Tony Ruakere, Hayden Wano (Board members)

Resignation

The Chairman advised that Dr Tom Mulholland had tendered his resignation from the Committee effective immediately.

The Committee extended thanks to Dr Mulholland for his service to the committee.

440.0 Conflicts of Interest

The following interest was removed from the register:

Tony Waghorn Employee TDHB

The Chairman advised that a presentation on the additional elective services initiative was to be provided and to enable management to return to duties the presentation would be made at the beginning of the meeting.

441.0 Other Business

441.1 Additional Elective Services Initiative

Mr Brian Gubb and Ms Rosemary Clements gave a presentation on the additional elective services initiative:

- Ministry initiative to result in additional 10% elective services over the year
- Initiative introduced October 2006, this would be first full year of programme
- Method of funding initiative is new. Ministry wanted to be able to see actual activity for the dollars spent and funding is tagged to outputs (number of discharges).
- Must maintain ESPIs, ie measure of how elective service processes and activities measured. If do not maintain compliance in this area will lose funding.
- Initiative is for Secondary and Tertiary providers
- Elective base for TDHB is the elective activity purchased from own provider and includes all IDFs. Base Line must be achieved before we are able to access additional funding. Must deliver in entirety therefore major risk around not achieving particularly if IDFs not achieved. If IDF under delivered we will not meet base line.
- The base line is set on actuals achieved in 2005/06. TDHB over delivered by 8% in electives for 05/06 and the base line includes this additional amount.
- Requirement to develop capacity over all services to deliver additional electives
- If provider does not meet total base volume will not be paid, this is despite incurring additional costs to build up capacity.
- Delivery of the initiative results for the DHB being dependent on other DHBs to provide some of the services, eg cardio thoracic. TDHB reliant on Waikato for this service. If TDHB over delivers against plan there is a risk of Funder being required to pay for additional volumes plus IDFs. Ministry will not pay for over delivery of initiative.
- Concern over capacity of other DHBs, eg Waikato to deliver cardiothoracic services when have their own incentives to deliver increased volume for their population
- No formal contract for IDFs but an expectation of the level of activity likely to occur and DHBs plan finances and activities on that basis. Flows do not always eventuate which was case in Taranaki last year because IDFs based on two years prior.
- There are clear clinical prioritisation protocols in place which apply equally to all DHB patients. The expectation is that prioritisation takes place irrespective of where live but reality of how translates into standardised discharge ratios for cardiology shows that Taranaki appears to be disadvantaged in comparison to Waikato. However this cannot be directly attributed to the processes within Waikato, since primary care acutes and primary to secondary referral pathways also impact.

- Additional complexity that secondary hospital cannot refer to another tertiary hospital – must be tertiary to tertiary.
- Prioritisation process may have different criteria to TDHB, so while is a clinical tool we may wish to put more emphasis into say Maori health gain compared to Waikato and therefore we lose control of our process.
- Have contracted with Southern Cross to deliver for Taranaki population to enable increased capacity to be available at Base for other procedures
- TDHB provider have moved ENT public services to Southern Cross to create capacity at base for more complex patients.
- Service will remain at Southern Cross in medium term and the DHB will be looking at other measures to create capacity for services with the greatest need.
- Contact for Provider with Planning and Funding remains the same for base line volumes.
- Currently ahead of plan and a wash-up will be undertaken at end of calendar year, including IDFs, and plan established for the next six months. The current position is planned as it is easier to pull back than to increase activity.
- Doing all we can to mitigate risk, however, it should be noted that acute demand can have a major impact on ability to achieve target.
- Initiative to run in future years but have an assurance from the Ministry that the base line will remain at 05/06 level. If population changes compared to national levels, ie increases from 2.8% to 3% the DHB would be expected to show that degree of growth in level of activity.
- This is a very exciting initiative for the Taranaki population but the risks to the DHB from a financial perspective need to be highlighted.
- Approach taken by management is for Planning and Funding and the Provider to work closely together to manage the risks. Robust systems have been put in place over and above national reporting mechanisms and are confident that the initiative will be well managed and achieved.

In discussion it was noted that all DHBs will be looking for increased resources and workforce issues will have an impact on the ability to deliver. It should also be noted that there would be a flow-on effect to the primary sector from this initiative.

Hospital Advisory and Community and Public Health Advisory Committees will be kept informed of progress with the initiatives and reports will be amended to enable progress to be monitored.

The Committee also congratulated management on the collaboration approach being taken between Planning and Funding and the Provider.

Resolution

That the Community and Public Health Advisory Committee receive the report and note the following:

- TDHB anticipate maintaining ESPI compliance and delivery of the additional new initiative elective volumes
- There are significant challenges ahead for the DHB to meet the Additional Elective Volumes targets
- That a combined Provider and Planning and Funding approach is needed to mitigate the risks associated with the delivery and funding of these services
- Regular monitoring, review and evaluation of performance will take place to inform planning process throughout the year to ensure delivery.

*Waghorn/Ballantyne
Carried*

442.0 Minutes

Resolution

That the Community and Public Health Advisory Committee resolve to accept the minutes of the meetings held 26 June and 28 August 2007 as a true and correct record.

*Ballantyne/Brock
Carried*

442.1 Arising From Minutes

Prioritisation Planning Panel

Mr Brock referred to relationship between primary care and secondary services and need for the two to be aligned and felt there was an opportunity for some primary care representation to be part of the prioritisation process.

Mrs Boardman advised that the Planning and Prioritisation Panel was DHB's panel for operationalising the Board's policy. The Panel is made up of planning and funding people responsible for the contracts and the DHB's professional advisors who have a DHB wide focus, eg Medicine, Nursing to provide support to the planning and funding team in those decisions. The only provider on the panel was the Hospital Provider due to the fact that they are the provider by default if any contracts fall over. If any contracts involving the Hospital Provider are being discussed the provider representative is excluded from participating.

443.0 Management Reports

443.1 General Manager Planning, Funding & Population Health

Mrs Boardman took report as read highlighting:

- National policy initiative underway around long term sector plan. Ministry looking to develop long term sector plan with 20 year timeframe which is aimed at addressing perceived problems within the current health system. Overview expected December with plan available June 2008. The plan will inform every DHBs long term plan.
- Oral Health Dental Procurement work well underway. TDHB one of three DHBs who have gained approval for funding.
- Pleasing to advise that development of plans is to be based on population basis, with Taranaki share being \$17,000. This is significantly lower than the projected cost outlined in the TDHB Business case.

- Have been involved in the development plan for two chair mobile unit which is fully self-contained bus. Very pleased with progress to date.
- Delivery of mobile unit depends on national procurement process but everything going to plan.
- Consultation process just commenced and hopeful of receiving positive feedback particularly around how we address oral health for adolescents.
- The proposed design for school dental clinics is based on 4 chairs capable of taking adults and children.
- Healthy Eating Health Action – considerable amount of activity in this area.
- Moving forward with smokefree and smokefree environments. Intention is to pull together Smokefree Taranaki Project Manager Hospital roles within arm of Healthy Eating Healthy Action.
- Move by Ministry towards focusing on controlling use of tobacco by individuals and cessation services.
- There is potential for securing additional funding for nicotine replacement therapy.
- Steering Group in Taranaki working well. Involves Councils, Agencies, Sport Taranaki and have agreed joint priorities using a collaborative approach.
- Finance Report - overall funder position is positive variance of approximately \$1.5m against deficit of \$629k which is a variance \$2.2m for the year to date. Contributors to this position –
- Personal health underspend against budgeted deficit \$1.15m, mainly due to reduced spend on pharmaceuticals. The PHARMAC rebate was higher than originally planned and growth in drug expenditure has been less than anticipated.
- Underspend in Mental Health, mainly due to reduction in usage of community residential beds which is a demand driven service.
- Health of Older People underspend is result of additional funding received from Ministry to pay for residential home based support services. This situation will reverse as price increases come into effect.
- Underspend of \$175k in Maori Health. Accruing additional funding for investment in Maori Health initiatives which are planned to be in place by year end.

General discussion took place on the report.

Mrs Boardman clarified the proposed specialist dementia services advising that this was to reflect the different requirements for this type of hospital based service and acknowledged the need to audit these services differently to meet their needs.

Committee members requested that consideration be given to providing additional information around progress being made on the aims of the DAP. Mrs Boardman advised that as part of the Health Needs Assessment additional data would become available which would enable measurement of strategic focus areas.

Discussion took place around the Medicines Into the Future Project. Mrs Boardman advised that this was a local project with a strategic focus looking at how medicines contributed to:

- Reducing inequalities
- How does usage and access compare with health needs of the province
- How do we look in terms of prescribing for chronic disease management
- How do we overcome barriers to high needs population groups for access to medicine
- Consider how contract for pharmacy services but in context of dealing with inequalities and improving health of population

The project links into national projects around different models of contracting but this is not the main driver.

Community medicines spend is approximately \$26m and the project will assist in determining whether this is good value for money in terms of reducing inequalities and highlight where improvements could be made.

Public Health Intelligence are providing support to the project by mapping health needs prescribing access to medicines.

Resolution

That the Community and Public Health Advisory Committee receive and note the report.

*Brock/Waghorn
Carried*

443.2 Chief Advisor Maori Health Report

Ms Henare took report as read, highlighting

- Extent of involvement of TWPK with TDHB. Have good robust Maori input into designing and implementation of inequalities projects.
- Number of workforce development projects had go ahead last couple of weeks.
- Number of training courses delivered across DHB all aimed at strengthening our ability as DHB to address Maori health need.

Discussion

General discussion took place with the Committee noting that they were to be included in the upcoming Treaty Awareness Course.

Ms Henare advised that the Kaiawhina appointment would assist in assisting Maori people and other high needs groups accessing services. The role was to be located within the community and would be an enabler/facilitator/advocate role.

Resolution

That the Community and Public Health Advisory Committee receive and note the report.

*Ballantyne/Waghorn
Carried*

444.0 Other Business

444.2 Health Needs Assessment 2007

Mrs Boardman took report as read highlighting:

- Health Needs Assessment for 2007 very comprehensive document
- Some issues with the 2005 document particularly around its credibility with clinicians.
- DHB now has a clear strategic direction and the health needs assessment will enable progress to be measured against the key strategic focus areas.
- Process undertaken –
 - Environmental section undertaken by Auckland DHB's Public Health Unit
 - Used a population model to see anything fundamentally changed. Then identified key issues that we could look at for each strategic focus area.
 - Public Health Intelligence Unit provided the data which will be regularly updated as soon as additional data becomes available.
 - Report produced by Dr Richard Hoskins, Medical Officer of Health and Public Health.
 - Expert advice sought from primary and secondary clinicians and Maori Health team.

Health Needs Assessment is well accepted as clinically credible.

Will be able to track how doing and intention would be as move through DAP and DSP cycle would assist in showing progress made against key areas.

Mrs Boardman advised that the purpose of bringing the report to the Committee was to seek a recommendation to the Board to use the Health Needs Assessment as a basis of identifying relative health need and assessing progress in terms of meeting health need and reducing inequalities.

Discussion

General discussion took place with questions being raised on whether data held on PHO data bases could also be incorporated.

Mrs Boardman advised that the approach taken was that nationally accepted data was required to enable the DHB to benchmark with other DHBs.

Secondly, the DHB does not have access to the same amount of information from every PHO and GP practice and would therefore run into problems with some GPs being unwilling to share information. If only partial data is used the results are distorted, but ideally over time there is the desire to move to a point where we use national data but also have local data available.

In response to questions around reporting areas, the Committee was advised that the Health Needs Assessment would be revised every three years and the opportunity would be available to include additional data.

Resolution

That the Community and Public Health Advisory Committee note and receive the report and recommend the Health Needs Assessment 2007 to the Taranaki District Health Board as the basis for:

- *Identifying relative health needs*
- *Assessing progress in meeting health needs*
- *Assessing progress in reducing inequalities.*

*Waghorn/Ballantyne
Carried*

445.0 Next Meeting

The next meeting was scheduled to be held on Tuesday 18 December in New Plymouth.

The meeting closed at 1.50pm

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Chairman

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Date