



HOSPITAL ADVISORY COMMITTEE

MINUTES – PUBLIC - Unconfirmed

Tuesday 30 October 2007
10.00am
Corporate Meeting Room 1
Base Hospital
David Street
New Plymouth

Present

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

In Attendance

Peter Catt (Board Member), Tony Foulkes (Chief Executive), Joy Farley (General Manager Hospital Services), George Thomas (General Manager Finance & Corporate Services), Sandra Boardman (General Manager Planning, Funding & Population Health), John Doran (Chief Medical Advisor), Anne Kemp (QA/Risk Manager), Sue Carrington (Communication Advisor), Pamela Hikuroa (PA to Board), Rosemary Clements (Clinical/Ambulatory Service Manager), Brian Gubb (Senior Manager Performance and Contracts).

359.0 Declaration to Open Meeting

The meeting was opened at 10.00am with a karakia.

360.0 Apologies

Flora Gilkison, Hayden Wano, (Board Members)

Resolution

That the apologies be sustained.

*Devadhar/Denness
Carried*

361.0 Conflicts of Interest

The following interest was removed from the register –

John Young

Director WITT

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.

362.0 Other Business

362.1 Additional Elective Services Initiative

Ms Farley took report as read and introduced Ms Clements (Clinical/Ambulatory Service Manager) and Mr Gubb (Senior Manager Performance and Contracts) who were to provide a presentation on the initiative. The Committee had discussed this matter at length at the previous meeting and the paper and presentation provided an overview of the implications in terms of the financial position for the DHB.

- Management advised that the Ministry had indicated that a considerable sum of money had been allocated to health but increased activity had not always resulted, therefore the elective services initiative was specifically tagged to see actual volumes delivered for the investment. This was a totally different way of funding to other initiatives. The 10% additional elective services were over a wide range of services and the DHB must also maintain ESPIs and there was also a reliance on other DHBs to deliver our volumes. The initiative was introduced in October 2006 but this was the first year for delivery of the full 10% increase in elective services.
- From a base line perspective Planning and Funding was concerned over whether the provider locally had capacity to deliver the required volumes and the effect on the operations of the hospital, and also from a DHB perspective on the reliance on other DHBs to deliver IDF.
- Risk from a funding point of view that these may not be met both in the Provider and IDF component and if this was to result the DHB would not be funded for any of the work undertaken. Also note that if over delivered additional funding would not be provided by the Ministry to cover this work. Therefore essential to maintain activity in accordance with the plan.
- Provider perspective – know accurately activity undertaken through the provider, but do not know the impact of IDFs and therefore raises risks of over or under delivery. Requires activity to be monitored closely.
- Risks outlined in the report, but note workforce issues will be a challenge and acute demand will impact on electives.
- Capacity issues face the provider therefore decision taken to move ENT services off site and deliver through Southern Cross. This has enabled capacity to be created for additional elective work.
- Due to the funding mechanism even though increasing capacity if do not meet the targeted volumes funding will not be provided.
- Major risk to the DHB with IDFs all our cardiothoracic and cardiology interventions undertaken by IDFs.
- If for example, Waikato for their own reasons, focus on own population to delivery own additional volumes, there is a real risk that our population will not be addressed. Therefore must think about where we can purchase volumes and have looked at Christchurch and Otago. However, all other DHBs doing the same.

- Could have proceeded for the additional electives using procedures with the highest case weights but this would not meet the requirement under the discharge ratios. Therefore initiative must be balanced across all specialties.
- Currently provider slightly ahead of target and taking into account IDFs expect to reach overall target all things going well.
- A wash-up will be undertaken at the end of six months with the funder and the plan for the next six months agreed.
- If TDHB does not meet base volumes, the Ministry will not pay. This could be despite the fact that have increased capacity and spent money on additional staffing and resources to deliver.
- If acute volumes increase could result in cancellation of electives, and negatively impact on our targets.
- Funding will also be lost if we do not comply with ESPIs.
- Cannot stress enough the importance of working within budget and ensuring that our IDF component is achieved.
- From funder perspective decision taken with the provider to run ahead of plan at the beginning of the year as it is easier to pull back than to increase activity later in the year.
- Planning and Funding and Provider working closely together to monitor progress so that appropriate action can be taken to adjust activity both within provider arm and with outside DHBs where required.
- Confident, whilst complicated and significant risks to the DHB, that we will be able to manage the initiative to achieve the desired outcomes.
- In summary, there were financial risks that activity would be done locally that was not funded; and/or IDF activity in other DHBs would exceed plan.

Discussion

In response to a query as to whether this was the Ministry's way of endeavouring to improve productivity, Ms Farley advised that this could be seen as an outcome. However, it depended on how productivity was defined. Elective Services were seen by some as the window of the hospital and the initiative forces the DHB to look at different ways of achieving the desired outcomes. In fact outsourcing to Southern Cross was not necessarily the most productive way of undertaking the work, however, it enabled additional capacity to be made available at Base for more complex cases in the short to medium term.

Must be noted that the focus on elective services would also have a flow-in effect to out patients, first specialist assessments, GPs, physios, OTs etc. This was not a simple exercise and would have a major impact on the total health sector. The collaborative approach between Planning and Funding and the Provider was therefore an important strength for the DHB.

The initiative was very exciting for the Taranaki public and clinicians and staff were very happy to pick up the extra work, however, important that the Committee is aware of the risks attached to the initiative.

Reporting to the Committees will be updated to enable the progress on the initiative to be monitored.

Resolution

That the Hospital Advisory Committee 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.*

*Dunlop/Denness
Carried*

363.0 Minutes

Resolution

That the Hospital Advisory Committee resolve to accept the Minutes of the meeting held on 25 September 2007 as a true and correct record.

*Jeffares/Dunlop
Carried*

363.1 Arising From Minutes

Ms Farley advised that it was anticipated the report on the Acute Home Based Treatment Service would be provided to the February meeting.

364.0 Management Reports

364.1 General Manager Hospital Services

Ms Farley took report as read, noting that reports were also included on QA/Risk and Human Resources.

- Full details of financial position at end of first quarter provided, together with issues and challenges.
- Note TDHB quarterly activity report includes IDFs undertaken as provider, however, volumes only extracted out in terms of delivery price volume schedule in the revenue spreadsheet therefore percentages do not match.
- As with past month looking at financial deficit position and an estimation of the cost equating to additional elective work. Deficit reported is \$1.523m, of which additional elective activity equates \$550k, leaving a structural deficit of \$973k.
- Financials were significantly impacted by FTEs compared with last month. Analysis shows worked FTE up by 4 with the remaining FTEs relating to study leave, sick leave, paid leave. This has raised the question of how we schedule study leave and workshops due to the significant amount being incurred, particularly in the nursing area. The training is absolutely essential but we need to focus on how this is scheduled to ensure that the impact on FTEs is managed.
- Some recruitment into medical staff impacts on FTEs but of course this improves the position for outsourced services.

- Sick leave remains steady.
- Specials continue to have significant impact on FTEs.
- Note accruing at conservative rates for wage settlements which have yet to be finalised.
- Outsourced services remain key challenge. Locums are a national problem and in fact looking into early New Year still better off than number of DHBs in terms of recruitment. Eight first year appointments made. Work outlined in HR report around regional issues with locums.
- Locums can sometimes be essential to enable delivery of services.
- Looking at all the implications on models of care. Changes to roles not easy to make and will take a long time and require considerable thought. Important to have all key stakeholders on board when moving forward with more advanced nursing roles and training demands from institutions on roles of junior doctors.
- Dr Doran advised that the absolute need for junior doctors was 'not written in stone' but there was an obligation on the DHB to employ junior doctors. Different models of care could see junior doctors undertaking different roles but he would be vigorously opposed to any suggestion of ceasing employment of junior doctors. The DHB had a training responsibility which must be taken into account when considering changes to the way in which services are delivered.
- Ms Farley concurred with Dr Doran's comments.
- Drug Costs underspent at this stage, but emphasised provider drug costs were small in comparison to community pharms.
- Note that the structural deficit gap approximately equals the cost of funding gap and the question now was how to move forward. Work was being initiated under the 'value for money' national project across the provider arm. A dedicated resource had been put in place to look and apply the 'value for money' principles across the organisation in an endeavour to look at how the structural cost of funding gap could be reduced.

Discussion

Further discussion took place around the employment of locums with the Committee being advised that there was now a section of junior doctors who had chosen to only undertake locum work and were looking for contracts for a six month period. This increased the costs to the DHBs.

There were also implications in terms of training of junior doctors, but a further issue related to the changed labour market when it comes to negotiating the national collective agreement for junior medical staff. This was a major issue because the people represented through those negotiations were also in the pool that operated in a separate labour market and the ability to manage that and plan was difficult and had a huge cost implication for the whole sector.

- Mental Health
- Pleased to report bed occupancy TPW declining but IPC remains a particular challenge. Work with mental health service to look at impacts may mean more IPC beds. Impact of acute home based service has had very good effect.
- Facility Development

- Progressing through independent review of the business case, expect to complete by end of year. National Capital Committee meeting in December hoping for feedback in New Year around that.

Discussion

In response to questions from the Committee on the facility development and whether there was buy-in from key stakeholders, Ms Farley advised that terms of new facility process the business case was a very high level footprint and direction not a detailed design. The process adopted in formulating the business case was robust with advice being taken from heads of departments, staff forums and further presentations had been held with all staff. It was fair to say that there was acceptance around the direction, but that did not say that individual departments or services believed the priority allocated in the business case was what they would individually like, but accepted the general principles and the fact that this was a master planning process and that there was the need to prioritise the various development stages. Ms Farley also advised that the opportunity would be taken as part of the facility development to leverage sector change across the entire health centre to ensure improved efficiency and productivity.

The Committee noted that to ensure improvements in efficiency or productivity the people involved required to buy-in to the process and it was pleasing to hear that the processes adopted had involved involvement across the board. The increase in the number of caesarian sections performed was noted and Ms Farley undertook to provide comment on the clinical view around the reasons for this increase.

Ms Farley also undertook to arrange for the Mental Health Service to include information on the Dialectical Behavioural Therapy when they make their presentation to the Committee.

Resolution

That the Hospital Advisory Committee note and receive the report.

*Dunlop/Denness
Carried*

364.2 Quality Risk Report

Ms Kemp took report as read and highlighted:

- Quality Health New Zealand making good progress with move to EQUIP 4 Standards. Expect to be implemented from 2008.
- Patient Satisfaction – Ministry of Health developed new way of reporting on in-patient satisfaction surveys. TDHB June 2007 quarter results above national average for all but one.
- Infection control issue in renal unit identified and investigation resulted in the cessation of a new type of dressing pilot scheme.
- Smokefree –
- Updated contract received from the Ministry.
- Ministry now wishing to move focus to cessation of individuals smoking.
- Decision made for Smokefree Co-ordination role to be incorporated with Population Health to give a focus on total DHB.

Discussion

Clarification was sought on how complaints highlighted in the patient satisfaction surveys were followed through, particularly with respect to the attitude of clinical staff.

Ms Kemp advised that all complaints were taken back to the individuals concerned and where appropriate additional training was provided to assist in overcoming issues.

With respect to the Smokefree Co-ordinator, Ms Kemp advised that it was the intention for Future Taranaki initiatives to be combined with the Health Eating Healthy Action and smokefree roles to enable greater progress to be made in this area.

Resolution

That the Hospital Advisory Committee note and receive the report.

*Jeffares/Denness
Carried*

364.3 Workforce Planning & Development Report

Ms Farley took report as read highlighting

- Service delivery medical consultants - number of vacancies which will be challenging to manage.
- Note offer of employment made to third medical officer in Hawera
- Risk around midwifery at moment at Base hospital, Stratford and particularly in Hawera in terms of reliance on very experienced qualified midwives. Details of collective bargaining activity currently underway outlined.

Discussion

Concern was expressed over the apparent high turnover rate, 5%-6%, and questions were asked regarding the reasons for this level of turnover.

Ms Farley advised that when looking at benchmark results with other DHBs Taranaki DHB fared very well, however this quarter highlighted greater turnover in management and admin staff. Every endeavour is made to ascertain the reasons why staff leave but generally management was happy with the current annual turnover rate.

The Chief Executive also noted that one of the down sides of having a positive environment for staff was that some people left for professional development reasons. The DHB encouraged staff development personally and professionally and wherever possible tried to provide opportunities for staff within the organisation, but this was not always possible and some staff chose to gain experience elsewhere.

Resolution

That the Hospital Advisory Committee note and receive the report.

*Denness/Devadhar
Carried*

365.0 Next Meeting

The next meeting was scheduled to be held on Tuesday 27 November in New Plymouth.

The meeting closed with a karakia at 11.05am

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Chairman

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Date