HOSPITAL ADVISORY COMMITTEE

MINUTES – PUBLIC - Unconfirmed

Tuesday 29 January 2008
10.00am
Corporate Meeting Room 1
Base Hospital
David Street
New Plymouth

Present
Kura Denness (Chairman), Flora Gilkison (Board Members), Jan Dunlop, Brian Jeffares (Co-opted member).

In Attendance
Peter Catt (Deputy Chairman held delegated authority to attend the meeting on behalf of the Chairman of the Board), Jenny Nager, Karen Eagles (Board Members)
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), Debbie Taylor (General Manager Organisational Development and Communications), Sue Carrington (Communication Advisor), Pamela Hikuroa (PA to Board)

372.0 Declaration to Open Meeting
The meeting was opened at 10.00am with a karakia.

373.0 Apologies
John Young (Chairman), Dan Devadhar

Resolution
That the apologies be sustained.

Denness/Gilkison
Carried

374.0 Conflicts of Interest
The following amendment to the interests was declared:

K Denness	Removed – Chairman PHO Community Council

Ms Denness also declared her interest due to her role as Chairman of Hauora Taranaki PHO, in respect to the paper which was to be considered in the closed section of the meeting and advised that she would be vacating the Chair for that part of the meeting and the Chairmanship would be assumed by Dr Catt, Deputy Chairman Taranaki DHB.

375.0 Minutes

Resolution that the Hospital Advisory Committee resolve to accept the Minutes of the meeting held on 27 November 2007 as a true and correct record.

Dunlop/Jeffares
Carried

375.1 Arising From Minutes

Ms Farley referred to the question raised at a previous meeting with respect to the reasons for the increased number of caesarian births, stating that she had spoken with the MidWifery manager and the Head of Department Obstetrics and Gynaecology.

The advice received was that there was no definitive reason for the increase but generally speaking was the result of:

- changes in clinical practices, eg all breach births were now delivered by caesarian
- Element of customer demand
- Multiple births delivered by caesarian due to risk factors

The rising rates of caesarian deliveries was now a national feature and in some DHBs the rate of as high as 33%, whereas currently Taranaki DHB was 27%. The Ministry was actively engaged with the sector and clinicians over this issue.

In response to further questions from the committee on whether obesity was also a factor, Dr Doran, Chief Medical Advisor, advised that weight issues were not a factor in the Taranaki population. He advised that increased caesarian births was an international factor but noted that Ireland used a benchmark figure of 10%-12% and were actively managing the number of their caesarian births in an endeavour to attain this level.

376.0 Management Reports

The Chairman advised that in order for the papers on the financial issues facing the Hospital Provider to be considered in total, she sought the Committee's agreement to review the Quality and Risk, Workforce and Hospital Benchmark reports first and then discuss the reports from the General Manager Hospital Services. The Committee agreed to the change in order.

376.1 Quality Risk Report

Ms Farley in presenting the report noted the apology from Ms Kemp, Quality/Risk Manager who was away on annual leave, and took report as read highlighting the following:

- Patient satisfaction – very good results
- Patient complaints – trending down.

- Significant work progressing around Emergency Preparedness.

Discussion
Questions were raised regarding the five national quality improvement programmes and whether this would require increased resources to comply. In response Mr Foulkes advised that some systems were currently in place and it was expected that the national projects would provide a means of reflecting on those and provide advice on improvements which could be made. In some areas additional systems would require to be developed, but the national programmes would be a major focus and potentially an opportunity for some additional resource n these important areas. Dr Doran supported the view of Mr Foulkes.
Discussion also took place around the new accreditation standards with it being noted that the new standards were outcome focused and more aligned with the continuum of care. It was understood a pilot was currently underway in one DHB which would provide feedback to the other DHBs.
The Committee noted the excellent results achieved in the resolution of complaints and patient satisfaction and requested that their congratulations be conveyed to staff.
Ms Farley undertook to relay the Committee's comments and advised that the quality framework in place meant that across the whole staffing spectrum everyone endeavoured to do the right thing for the individual patient and the complaints team support to clinical staff enabled any complaints to be responded to in a proactive manner. This enabled any complaints to be resolved at low level rather than allowing things to escalate.

376.2 Workforce Development
Ms Taylor took report as read highlighting:
- Pressure around recruitment continues. Worldwide shortage of skilled health professionals.
- Becoming more difficult to obtain locums.
- Focus remains on recruitment of permanent staff members but where this is not possible rely on the locum market to ensure services are able to continue to be provided.
- Industrial environment – Majority of collective employment agreements negotiated at national level
- Fair to say expectations of the Union groups is out stripping the DHBs' ability to afford which creates an environment of unease and creates media attention.
- Staff and management working hard to maintain relationships at the local level

Discussion
Ms Farley highlighted to the Committee the workforce development project initiated at Hawera to identify and prioritise medical workforce development activity in south Taranaki. This initiative has been very positively received by all stakeholders and is a good example of looking across the DHB rather than just the hospital.

Discussion took place around the recruitment difficulties for junior doctors and whether it is anticipated that this would worsen in future years.
Ms Taylor advised that from in the short term the current position was expected to continue, noting that the lead in time for training of health professionals was approximately 5 - 6 years. To assist a number of initiatives were in place to attract and retain junior doctors but it was also apparent that a number of doctors were undertaking locum work as a lifestyle choice.
Ms Farley advised that it was important when looking at workforce issues to look at the whole spectrum and any change in one area had on-going effects in other areas. She did not see the junior doctor shortage changing in the future and it was there imperative that the way in which we work was changed to adapt to the situation. This was not going to be a simple issue and would take time to resolve.
Dr Doran agreed with the comments and advised that although the numbers of medical students had been increased the requirements would continue to increase over the years. There was the potential for increased numbers becoming available from the new Australian Universities but he did not expect any great improvement. It was therefore important to redevelop the roles to attract doctors and keep them here for 2 – 3 years.
Mr Foulkes was pleased to advise that Taranaki provided a very supportive environment for new doctors and doctors in training and this was confirmed from feedback recently received after an accreditation visit by Medical Council representatives. They had used the phrase ‘Taranaki is a model provincial hospital’ in terms of medical staff training and what we do for doctors. This type of comment will not go unnoticed amongst the medical fraternity and it is hoped this grapevine can help with recruitment and retention.
The Committee was also informed that the Ministry had recently approved the establishment of Medical Training Board reporting to the Minister of Health which would be looking amongst other things, at purchasing places in tertiary education in the medical area.

376.3 Hospital Benchmark Information Report
Ms Farley took report as read highlighting

- Day case procedures, Taranaki doing less well, but was above average
- Day of Stay admissions where people come for surgery and admitted on the day as opposed previous night, was higher than average.
- The results all paint a picture of how imperative the new facilities were to improve efficiencies. Currently the DHB was doing as much day stay surgery was possible within the current facilities.

Discussion
Discussion took place around the paper with the Committee being advised that weightings for age of population etc. were taken into account in the results indirectly. This was reflected in the rates for the smaller DHBs, eg Whanganui, South Canterbury which have higher rates of day stay than the larger DHBs, eg Auckland, Wellington, where the rates are lower due to the complexity of the surgery undertaken.

376.4 General Manger Hospital Services Report and Update financial Management

Ms Farley took report as read advising majority of comments would relate to the financial position, but wished to highlight the following:

- Elective programme continuing according to plan and currently going through wash-up procedures with the Funder around electives
- Issues around elective programme going forward:
- Vacancy in gynaecology will impact on surgery
- Inability to appoint sixth orthopaedic consultant. Working with Orthopaedics Department to deliver through existing five consultants.
- 5th general surgeon commenced and will be working towards general surgery target
- Anaesthetics poses challenges due to workforce shortages and will cause difficulty around electives.
- Acute adult medicine settled in line with seasonal trends. Paediatric medicine has not followed usual trend and has remained extremely busy over summer.
- Maternity well ahead of usual trends which is creating some challenges for hospital and midwifery workforce across the region. This is a national trend. Has impact on efficiencies and also impacts on other services for example theatres, anaesthetics and paediatric medicine etc.
- Over the Christmas period encourage staff to take leave and also employ students which is reflected in the FTE numbers
- Mental health – note correction of figure on Page 17 should read $3,844 not $3,844K.

Financials

- Forecasting at this point a $8.1m year end deficit with the major drivers being:
- Cost of funding gap $3.7m, primarily wages, clinical consumables and diagnostic costs
- Significant additional cost provisions to meet MECA settlements $2.40m
- Outsourced medical locum costs expected to exceed budget by $3.0m
- Update on financial management details, short, medium and long terms actions identified to try and address problem
- Detail not contained in the report as currently in process of engaging with Unions and staff. Imperative to follow a consultation pathway to ensure have staff on board to achieve outcomes required. The financial result is a product of clinical decision making and it is imperative clinicians are involved in any initiatives undertaken.
- Short term actions highlighted around discretionary activities, eg conference leave, annual leave and deployment of discretionary items such as cars. One of the reasons this approach taken was to manage discretionary expenditure in a tight controlled manner and also to give a clear signal to the organisation about having to do things differently and bring a sense of urgency.
- Medium and long term strategies developed and prioritised by Executive Management Team

- When considering initiatives looked at whole spectrum, even those where currently performing well, eg one of the medium term activities was sick leave management. Although TDHB at lower end relative to national average from benchmarking data, this area does involve a large amount of resource. Working with HR to look at ways of further reducing the level of sick leave.
- Staff education programme has been reviewed by professional advisors, HR and Quality Assurance to produce a programme structured around what we need to maintain professional qualifications and to meet accreditation and also what is reasonable to provide in terms of financials.
- Specialling is a difficult area and is driven around the surgery undertaken and the more complex and co-morbidities of older people in our population. This area is undergoing a review and looking for ways to do specialling differently however do not envisage significant savings to be able to be made within existing facilities
- Management working hard to reduce employment wherever possible of Locums.
- The last two items do not have easy solutions.
- Have reviewed all contracts to ensure no duplication or work that can be done by other contracts.
- Reviewed all ACC contracts to ensure that they are making a contribution to overheads and can advise that this is the case. Have undertaken an extensive analysis of revenue vs costs. Two contracts not used extensively and considering whether pursue. Confident that ACC work is making a contribution.
- A review is to be undertaken of our supply chain to make sure treatment consumables are purchased in the most cost competitive way and this will be linked into the Value for Money Project.
- Long term initiatives will certainly make substantial savings, the quantum yet to be defined and subject to consultation.
- Forecast at this stage, does not take into account all variables and once detailed costings completed and discussions with staff and Unions the forecast will be updated and reported back to the committee.
- Fair to say longer term aspects of how we manage through has been the focus because the problem faced has been highlighted over a period of years. We have struggled with our budget and with deficits and it is not anticipated that over time we will be able to relax around our financial performance.
- The initiatives alone will not deal with the structural problem which exists. The workforce development initiatives through the primary and community sector and the new building facility will ultimately bring us to a point where we hope to see the Provider carrying its own, however, must caution that the health environment changes rapidly and even taking into account all these things the Hospital Provider will still have financial constraints into the future.

Mr Thomas spoke to the report

- The forecast deficit outlined of $8.1m took into account typical cost movement trends and was the worst case scenario.
- Not all of the initiatives will realise their full potential in this financial year and some will flow into the next financial year. However, it is hoped that the initiatives will enable the forecast deficit to be reduced over the remaining months
- Note that although forecasting a deficit there has been no decrease in service levels and in fact the deficit has been driven off the back of increased service levels.
- Capital investment in infrastructure and clinical equipment, IT in particular, has not stopped because off that is driven retention/recruitment.
- The deficit also results from MECA agreements for which we have not received any additional revenue. It is hoped that the Ministry may come forward with additional funding but this cannot be expected.
- Also note that although in a deficit position the quality of care provided will not be compromised.

Mr Foulkes reiterated the previous comments and noted that the deficit was of significant concern and although we can explain why it has happened and that is predominantly around providing services and paying staff, resolution of the matter will not be easy. The initiatives being put in place will not provide sufficient gains by the end of the year but will bring the result closer in line with our plan. From a DHB consolidated point of view, the results will again be closer to the overall plan but the problem will remain and the longer term system issues and models of service delivery which links into the facilities project, must be part of the solution to move to a more sustainable position.
Mr Foulkes encouraged the committee to also look at the position in the broad context of the initiatives and from a consolidated position for the DHB.

Discussion
Considerable discussion took place with committee members noting their concern. They were particularly concerned over the issue of locums and the cost of employing locums. The view was expressed that more was needed to be done nationally with the Medical Council and Ministry of Health to provide leadership in this area and work towards a system whereby doctors could not make locum positions a lifestyle choice. It was suggested that this could perhaps be done through changes to the way in which doctors could maintain registration.
Committee members also enquired whether the review of the Provider arm had included looking at all process systems under the 'LEAN' system used in engineering, which could result in major savings being able to be achieved through implementing changes to current practice.
It was also felt that as this matter was not solely a Taranaki DHB issue and funding was one of the main concerns, that the sector work together to achieve a stronger sector.
The Chief Executive advised that considerable work was underway nationally around the cost of locums but unfortunately there was no simple solution.

The reality of the situation was that we were required to work in the current market and in some instances to ensure the ability to provide a safe service locums were required to be recruited at short notice. He advised that he expected the current situation to continue in the immediate future but assured the committee that work was progressing nationally on this matter.

Similarly, funding issues had been recognised and an analysis had been undertaken jointly with the Ministry and DHBs and it was anticipated that the standard price paid for particularly procedures and services within the hospital setting would increase, but it was still essential to address model of care issues.

Ms Farley also confirmed that the item raised around reviewing systems and processes had been undertaken as outlined and the results would be communicated fully to the committee after discussions had been finalised with staff and unions.

The Chairman reassured the Committee that following discussions with the General Manager Hospital Services, she was confident that the matter was being managed appropriately.

Discussion also took place around quality of care and whether it was possible to reduce this level in the short term to reduce costs.

Management advised that they did not consider this a realistic option and in fact the Board's approach had not supported a reduction in quality or service provided. Also from a financial point of view reducing quality would not realise the quantum required.

Ms Farley advised that clinicians would always strive to deliver best quality of care expected and we could expect nothing less. She pointed out that the review had looked at our quality practices which included the complaints process discussed earlier in the meting. This process involved 1.5FTEs who worked to achieve the low level resolution of complaints. They provided support for the clinical teams and it was felt that the process used should continue as it would be a false economy to remove because if complaints are not resolved quickly they escalate into situations which involve considerable resource and time to resolve.

Another example is the infection control nurse employed to undertake surveillance of practice, education, and training for staff. It could be argued that health professionals should manage themselves but our experience has been that this resource reduces infection rates and readmissions. It is important that our clinicians are supported in providing services the patients.

Committee members advised accepted the explanations but questioned whether the customer surveys, eg patient satisfaction, were necessary or merely added to the overhead costs.

Ms Farley advised that surveys were reported back through the clinical board and quality committees which enabled quality improvements to be effected. She also pointed out that the surveys were a requirement of the Ministry as part of the quality indicator and therefore must be undertaken.

In response to a question on the ramifications of a deficit result, the Chief Executive advised that the Hospital result was included in the consolidated financial result for the DHB and it was anticipated that this result would be closer to the plan outlined in the DAP. In the current DAP it had been highlighted that the provider arm would incur a deficit and we had signalled that we were not expecting to receive additional financial support by way of

equity from the Government and at this point in time this position had not changed. The DHB has been able to manage its finances in a prudent fashion year on year and the current situation was not expected to create cashflow problems. If the situation was to continue to a longer term trend the matter would require to be revisited through the Annual Planning process.

Resolution
That the Hospital Advisory Committee note and receive

1. *management report and attachments*
2. *Update on financial management report*
3. *Hospital benchmark Information report for quarter ended September 2007.*

Gilkison/Jeffares
Carried

377.0 Date of Next Meeting
The next meeting of the Hospital Advisory Committee is scheduled to be held on Tuesday 26 February in New Plymouth.
Mr Jeffares tendered his apology for the February meeting.

378.0 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 section 7 or section 9 of the Official Information Act 1982, as the case may require which would 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 Legal Action From Southcare Update in that the public conduct of the meeting would be likely to result in the disclosure of information where the withholding of the information is necessary to:*
   - *(g) enable the DHB, Board or Board Committee holding the information to carry out, without prejudice or disadvantage, commercial activities*
   - *(h) Enable the DHB, Board or Board Committee holding the information to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).*

Gilkison/Dunlop
Carried

The meeting adjourned at 11.30am and reconvened at 11.35am

…………………………… ……………….
Chairman Date