M I N U T E S Open - unconfirmed

TARANAKI DISTRICT HEALTH BOARD

6 August 2009
Corporate Meeting Room 1
Base Hospital
David Street
New Plymouth

Present
John Young (Chairman), Peter Catt (Deputy Chairman), Alex Ballantyne, Kura Denness, Karen Eagles, Jenny Nager and Tony Ruakere

In Attendance
Tony Foulkes (Chief Executive), George Thomas (General Manager Finance & Corporate Services), Joy Farley (General Manager Hospital Services), Sandra Boardman (General Manager Planning Funding & Population Health), Pamela Hikuroa (PA to Board), Sue Carrington (Media Advisor)

510.0 Declaration to Open Meeting
The meeting was opened with a karakia.

510.0 Apologies/Leave of Absence
Dan Devadhar, Flora Gilkison, Grant Knuckey (Board Members)

Resolution
That the apologies be sustained.

Eagles/Ruakere
Carried

511.0 Conflicts of Interest
The following new interests were declared:

Alex Ballantyne	Advocating, in another capacity and sphere, for an individual taking civil action against TDHB.

512.0 Public Comment
Dr Catt acknowledged, on behalf of the Board, the sudden passing of our colleague and friend, Heather MacIntosh. Heather had been working for the DHB for the last 20 plus years as an ophthalmologist and was probably the

most universally loved and respected Dr in the whole community and she will be sadly missed. Dr Catt extended the Board's sympathies to her husband and family.

513.0 Presentation

513.1 Project Maunga

Ian Grant, Project Director, updated the Board on progress with the redevelopment, highlighting:

- User Groups established – developed their service and design principles
- The clinical staff were to define the functional briefs which will inform the design.
- Following practice of function before form.
- Concept design will take place when Architectural team on board
- Architects to re-validate and check assumptions still valid and that the shape of the building is correct.
- Quantity Surveyors to review to ensure design is within budget,
- Expect to complete October 2010.
- Approval to proceed and then prepare floor plans
- Great work being done
- Clinical Reference Group established 2 weeks ago. They will provide a clinical advice to the project and to the Steering Group and CEO, both facilitate design and processes and models of care.
- Ensuring moving in same direction facility design supports the delivery of health care in the hospital.
- Consultant Recruitment close to conclusion, very high calibre teams
- Still in process of negotiation of contracts
- Project appointed Probity Officer overseeing the process of consultant recruitment.
- Expect there will be local involvement in the design team
- Planning start up middle August 2009 concept design workshop –
- ➢ Confirm scope and master plan
- ➢ Confirm programme
- ➢ Confirm staging
- ➢ Consider early design matters
- Expect to be able to move into building June 2012.
- Hope to save time on that but too early to promise
- Present concept design report in September.

Discussion

It was noted that the Lean Thinking Project was being involved in the process of development.

Ms Farley referred to the tremendous amount of work being undertaken by staff on the project along with their normal duties and wished to place on record her appreciation of their input.

513.2 Role Delineation Model

Mr Foulkes advised that this presentation related to activity being undertaken over the last year nationally with the Ministry to update the work done many

years ago based upon Australian model to be able to understand, design, categorise services predominantly hospital setting based upon complexity of care, infrastructure available and how services relate to one another. This will enable the DHBs to understand and define across the different hospitals what is currently being provided and would also be useful in terms of future planning in terms of looking whether what is currently in place was appropriate. Expect within the next month for the work to be completed and the report released and Ms Farley would provide an overview on the methodology and context so that when the report is released the Board had an understanding of how the various tables were established.

NZ Role Delineation

- Talking about new role delineation model
- Original model described hospital services using role delineation model borrowed from New South Wales. Problem with model used in past only looked at departments
- Queensland Model different – looks at department and across other services but also had limitations
- The new model commissioned by the Ministry
- Templates created across services for each service area covering key determinants eg
    - Hours of access
    - Clinician characteristics
    - Inter-specialty relationships
    - Procedures/treatments
- Complexity Defined – 6 levels
    - Most complex services are level 6 – generally tertiary hospitals
    - Complex elective procedures – level 5 – usually planned, but not emergency
    - Least complex
- Once completed templates used for determining whether at right balance of complexity of service across DHB
- Many found complex level of medicine but did not have complexity of ICU or theatre
- Begs question over investment or disinvestment
- Overview of findings
- Larger DHBs tend to provide most complex services although may have less services when co-located to major centre, eg Auckland, Wellington and Christchurch
- Major metropolitan and provincial hospitals tend to provide services ranging from level 4 and level 5
- Level 3 providers tend to be smaller provincials providing core acute services to communities
- DHBs with greatest number of Level 5 and Level 6 services provide greatest volumes of service
- IDFs show that in Level 6 specialties Auckalnd DHB has greatest number of caseweight of patients outside their region and Wellington and Waikato have greater share of their workloads coming from out of region.

- TDHB Base Hospital level 4 - consistently one level above Southland and Lakes, who normally benchmark services against. In fact Base is more closely aligned with Hawkes Bay, Hutt Valley and Nelson
- 3.5 for oncology because of strong links with Mid Central and high degree of visiting clinicians
- Surgical level 3
- When looked through all templates two things defined level of service tended to be dependent on ICU and theatre. Approximately 4 years ago decision made to increase capacity and strength of intensive care services to offset IDF requirement. This underpins the higher level of service delivery for surgery and medicine.
- Rural Small Hospitals
- Huge variety in NZ.
- 5 categories
- Includes rural rest homes outside ARC funding – not straight resthomes.
- Conclusions
- Delineates by complexity
- Has a place in describing services and enabling analysis by service category
- Will be further developed for planning purposes
- Very good planning tool for DHB in terms of reconfiguration of hospitals and how interact with themselves and other services.
- P&F perspective use for tertiary adjusters and regional planning.

Report remains in draft obtaining final feedback but next month expect finalisation of the report which will be made available to Board members and hopefully the explanation gives context to the complex methodology but is complex
When final publication released will disclose that some hospitals changed delineations because of different model. Hawera is one which was level 2+ for ED dropped to Level 1 nothing has changed at Hawera just the methodology of describing has changed.

Discussion
General discussion took place around the model.

514.0 Minutes
Resolution
That the minutes of the Taranaki District Health Board meeting held 4 June 2009 be confirmed as a true and correct record of proceedings.
Nager/Gilkison
Carried

Ms Denness left the meeting (feeling unwell).

515.0 Board Committee Reports
515.1 Hospital Advisory Committee
Resolution

That the Taranaki District Health Board receive the unconfirmed minutes of the Hospital Advisory Committee meeting held on 28 July 2009 and notes recommendations contained therein.

Catt/Nager
Carried

Dr Catt reported that the Committee reviewed the year's results, which disclosed from a clinical point of view the result was very good but unfortunately still left with an unsustainable financial position of $7m deficit and this position could not continue.

516.0 Management Reports

516.1 Chief Executive's Report

Mr Foulkes referred to the comments made by the Deputy Chairman and acknowledged the tragic loss of Heather MacIntosh and extended sympathy to her family and work colleagues.

Mr Foulkes took his report as read, highlighting

- Reference to District Annual Plan and advice that the Minister had provided full support. Letter of support attached to the report.
- DAP sets out intentions over the coming year and beyond that towards achieving strategic goals.
- Context into account Government's expectations as made clear through the Minister's letter of expectations and discussed previously and expectations do have focus on hospital services in particular in year ahead as well as starting on going provision of primary care services and community based and plan for the future to be able to deliver on key targets around priority areas – emergency department, cancer treatment services, clinical staff retention and supporting clinical leadership in organisation in the future.
- Very significant challenge in terms of meeting those expectations
- Intended to meet the expectations complicated further by the expectation that all work would be undertaken within budget and within the allocated funding. Very clear expectations around financial management and breakeven in the year ahead
- Will be spending a lot more money than previously for people of Taranaki but as outlined in the plan need to look at how provide services across continuum hospital and community within each of the sectors as well as how we work together and look at what we can do with resources to continue to provide services rather than necessarily expect the only answer is additional funding as that is not realistic.
- Intention to revise reporting template for both Board and Advisory Committees to reflect the activity in the year and how that matches against targets in the DAP.
- The Minister had written to the Chairman last week reminding of us of the very difficult financial pressures in the economy as a whole and what may well mean for future funding cross the public sector particularly in health and there was a strong indication in that letter that the funding, particularly in the out years is likely to be less than previously indicating that the assumptions in the DAP, which has been supported that years 2 and 3 funding assumptions may not materialise.

- Amplifies challenge we have for the next few years and that the explicit nature of the funding will be not known until Government budget next year but strong signal from the Minister at this early stage in terms of the future.
- Draw Board members attention to the accompanying letters from the Minister.
- In addition to the role delineation model outlined in the presentation, another significant piece of work underway is the Regional Clinical Services Plan.
- Strong expectation that collaboration will place between DHBs to increase sustainability from financial and clinical point of view.
- Work is underway with the five DHBs, Lakes, Waikato, Tairawhiti, Bay of Plenty and ourselves, to look at the nature of relationship of services in a more formal way and how we can actually support one another in terms of ensuring appropriate access to services for respective populations.
- Dr Tom Watson, Chief Medical Advisor Waikato DHB, is Chairing the steering group. Kerry-Ann Adlam, Taranaki DHB Director of Nursing, is a member of the steering group. Intention to invite Dr Watson to our DHB in near future to explain how process will work and ensure that from a clinical service and management point of view able to have appropriate input and links into the activity and also synchronise and co-ordinate with the facilities project and role service model activity already underway here.
- Project Maunga – as highlighted in presentation going well and appreciate all of the significant additional work people put in to get project going and expect that will continue over the next 12-18 months.
- Finance – pleasing to report from consolidated perspective end of year prior to audit, little better than plan.
- We have been able to achieve that through controlling costs and reducing expenditure in the Hospital. Tremendous effort in being able to hold the Hospital deficit to the extent it has.
- Significant contribution be able to offset the deficit has come from P&F funding responsibilities as DHB
- Disappointing that we have not been able to make further investment in strategic areas as would have liked during the year, the reality is that we must live within our means and therefore required to phase the investment over a longer period of time.
- Acknowledge and express appreciation of the PHOs work and also NGO providers to ensure day to day service provision has been able to continue for people of Taranaki.
- Significant additional activity took place in the hospital as outlined in the Finance report.
- Acknowledge all of the work clinical and support staff to be able to achieve that tremendous result in terms of more activity than previously. This additional activity comes at a price and we continue to have that challenge of managing activity and financial complexity.
- Looking forward to the challenge outlined in the new DAP.

Discussion

Questions were raised regarding the Ministry's recent advice that it was unable to confirm DSS funding.

Mrs Boardman advised that the Ministry had provided indicative funding advice of DSS for under 65 for the provider arm in the funding envelope in December. This funding amounted to $1.2m and this was used in the planning for the DAP. Recently received notification from the Ministry that the estimated amount provided in December may not be correct and still awaiting formal confirmation of the funding level.

516.2 General Manager finance & Corporate Services

Mr Thomas took report as read, highlighting:

- More detailed than normal and provided details of the 12 month activity and highlights.
- Financial result in line with forecast, with a consolidated deficit of $640,000.
- Hospital Services still carrying deficit.
- Hospital activity ahead of budget which was an excellent result but this activity resulted in additional costs being incurred and were reflected in the deficit.
- Funder operations recorded a surplus which has gone towards the deficit.
- Gave an overview of the various DHBs unaudited financial results noting that the majority of DHBs recorded a deficit in hospital services.
- Note that although Taranaki DHB result was reasonable in comparison to other DHBs, our circumstances were somewhat different in that we were moving forward with a capital project which hinged squarely on the DHB's financial sustainability to carry forward.
- Project will bring down costs, but will involve additional costs during construction.
- Relationship between costs and activity is extremely important and must be managed.

Discussion

Board members extended congratulations to all the staff on the result achieved particularly the increased activity through the hospital provider.

Mrs Boardman concurred with the comments but highlighted that from the funder perspective difficult decisions had been required to be made to enable the support to be provided to achieve the year end position. These decisions had affected relationships with other providers of services in Taranaki because within the DAP there had been commitments to invest in new projects and services which had to be pulled back and this had left providers extremely disappointed.

Resolution

That the Taranaki District Health Board notes and receives the Chief Executive and Management's reports and attachments.

Eagles/Ballantyne
Carried

517.0 General

517.1 Communication

Ms Farley referred to discussions held at the Hospital Advisory Committee around communication and the importance of communication particularly in respect of Hawera and referred to an example which occurred in Hawera earlier in the day. During discussions with midwives on the plans around the long term sustainability of maternity services she discovered that an impression had been gained from media statements that there was a proposal to build a separate birth unit in the Hawera community to run in parallel with the service provided in the hospital which was completely incorrect. This had had a negative impact on staff but she assured the Board that she would be spending time in Hawera over the next few weeks to ensure that correct messages were being received.

The meeting with the midwives around how to build sustainable services for the future of maternity services had been positive.

Board members commented that the same impression appeared to have been formed by Rural Women who were suggesting that birthing units would be built in Inglewood which was also completely incorrect.

518.0 Next Meeting

The next meeting was scheduled to be held on Thursday 10 September in New Plymouth.

519.0 Exclusion of Public

Resolution

That the Taranaki District Health Board exclude the public from the meeting on the basis of the following matters:

1. *To present Taranaki District Health Board minutes pursuant to an earlier resolution publicly excluding the item.*
2. *To present Minutes of Committee meetings pursuant to an earlier resolution publicly excluding the item.*
3. *To present Chief Executive's Report 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).*

Nager/Ruakere

Carried

The meeting adjourned at 3.50pm to reconvene at 4.10pm

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Chairman Date