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Public Deputation to the Taranaki District Health Board (TDHB)

Provision of adequate lower-level Secondary medical services in South Taranaki

Background:

It has been the strongly expressed wish of the people of South Taranaki that out-patient and "low-level" in-patient services are provided where possible in South Taranaki, a wish supported by the independent report of Dr Dennis Pisk in 2001, recognised and supported by the TDHB when it adopted the Pisk report and by the Government when it supported the construction of the new Hawera Hospital which opened in 2002. **Current medical staff levels are below the ideal for retention and it is the purpose of this paper to alert the Board Members to this situation with a view to avoid further downgrading.**

It is known that the health needs of people over 65 are much higher than people aged 16-64 and the cost for the over 65 group in OECD countries is 3-5 times more than for the 16-64yr old group. NZ statistics reveal over 65s accounting for over half the hospital bed days and population estimates indicate a significant increase in the proportion of over 65s is occurring. Also, if policies for reducing poor Maori health statistics are correctly targeted towards the causes of this disparity, we should expect to see more Maori living longer and facing the same increased health needs.

The advantages for the aging population of having local in-patient facilities for conditions not needing the "high tech" facilities of a base hospital is real and considerable and reduces the use of Base beds by a significant number. Hawera also provides AT&R, Hospice beds and post-op and post injury rehabilitation in-patient services. Maori in particular see the value of secondary care close to their whanau and would have great difficulty and reluctance going to Base for the sort of care that has been able to be provided in Hawera in recent years.

To achieve a viable in-patient service, the Pisk Report accurately advised the need for a team of three "**Multi-skilled**" Medical Officers (plus cover) as well as a "Steering Committee" to overview and facilitate the implementation of the Pisk recommendations as well as the recruitment and retention of the Medical Officers. An internal audit was carried out by Deloitte Touche Tohmatsu in July 2002 which praised the Steering Committee for its successful recruitment activities but was critical of the lack of transparency and opportunity for public involvement [1].

Problems:

[1] Reduced Medical Officer numbers:

There has been a reduction in the number of Hawera In-patient (HIP) Medical Officers from three to two for some time resulting in a predictable decline in services and increased recruitment and retention difficulties. In particular we have had:

- Closure of the monitored beds (ward reduced to 17 beds)
- Reduction in availability of services such as the number of Exercise ECGs (aka ETT), when Medical Officer numbers are reduced.

- Increased difficulties with CME and general leave for Medical Officers.
- Reduced collegial support and Peer review.
- Reduced outpatient follow-ups by Medical Officers
- Reduced patient numbers (Medical "volumes" at Hawera "under budget").

[2] Reduced Specialist Physician support:
Putting aside the issue of numbers of outpatient clinics at Hawera, there has been the loss of a "dedicated" visiting outpatient physician, so that those now visiting are less familiar with the HIP Medical Officers. This results in:

- Less opportunity for Peer-review (in particular, patient management review) between HIP Medical Officers and the visiting physicians which should improve patient care and Medical Officer confidence and quality and
- Possibly as a result of less interaction, visiting physicians are less likely to recommend admission of difficult outpatient cases of the sort that would previously have been satisfactorily managed at Hawera.

[3] Retention and Recruitment:
Despite efforts of the Hawera Hospital Steering Committee **(**HHSC) to improve the attractiveness of the Hawera In-patient (HIP) Medical Officer posts for both retention and recruitment purposes, there remains an apparent resistance by the Board to implement virtually any of their suggestions, particularly where they involve money or better conditions of employment than at Base. Whenever this issue has been raised with the Board Chair, we are told that it is a management issue.

- The HIP Medical Officers have more professional isolation, greater responsibility and no recognised vocational training pathway (hopefully to be changed in August) compared to Registrars at Base.
- The type of training and experience needed for the Hawera position is higher and much broader (as it involves cross specialty knowledge) than non-specialist positions at Base.
- Hawera must not only compete with Australia, Canada etc, offering better remuneration, but also face exciting and innovative recruiting and retention packages offered by other DHBs.
- If, as management claims, the financial package offered is better, we should be fighting off applicants, which we are not. The advertisements don't indicate a "better deal".

[4] Access to appropriate candidates:
Access to New Zealand and British graduates with two or more year's postgraduate training has been nearly impossible. South African graduates are now unlikely to be available for recruitment.

- There was no specific attempt by this DHB to attract the pick of the supposed British Medical Officer glut, despite a number with four or more year's post-graduate experience.
- Overall advertising is deficient in obtaining responses from appropriate candidates. Nothing really stands out such as a "retention package" or starting at a higher pay scale.
- NZ graduates are not well targeted. Little or no advertising seems to appear in the on-line NZMJ or the FREE classifieds of the New Zealand Doctor journal. The eight Registrars at Base are not given a routine "rotation" to experience Rural Hospital medicine; apparently because time spent at Hawera "doesn't count" towards their physician training.

[5] Negative reporting to Board:
Management reporting of Hawera In-patient services tends to be negative, despite the facts. If more patients are seen than predicted, there is the implication of "over-servicing" whereas the more recent reduction is likely to be raised as a reason to reduce services further. However the figures actually reveal a significantly better cost-effectiveness: -

- When there were three HIP Medical Officers at Hawera, compared to 30 Base Hospital Medical Department doctors[2], Hawera was responsible for an average of 18% of the total Taranaki turnover of Medical inpatients with only 9% of the total medical manpower.
- This 100% better cost-effectiveness cannot be explained by the greater complexity of patients at Base as determined by Case Weight Delivery, as the CWD of Hawera was 0.91 compared to 1.07 at Base.
- Hawera Bed occupancy in the 6 months May-Oct 2005 (3 HIP MOs) accounted for 17.96% of the Taranaki total while in the 6 months May-Oct 2006 (2 HIP MOs) it was

17.61%, so Hawera became even more cost effective but at a cost of higher Medical Officer stress.
- Often patients are seen in the Emergency Department by the HIP Medical Officers at the request of the ED Officers and not admitted and so do not show on HIP statistics.

[6] **Hawera Hospital Steering Committee issues:**
- The 2002 recommendation by Deloitte Touche Tohmatsu to "*increase the transparency and improve the public disclosure*" [1] of the HHSC has received only lip service. The Minutes are available on the TDHB web-site (which most elderly can't access) and after pressure from the HHSC have been made available at the Hawera Public Library but are not otherwise released even to TDHB members as a hard copy.
- The fourth function of the HHSC is "To facilitate communication between the local community and Taranaki District Health Board" [3], yet Board members don't hear of public concerns and ideas discussed by HHSC.

Solutions:

Many of the problems listed are likely to be addressed by some simple policy changes and the costs involved are likely to be less than allowing the problems to continue. The key, we believe, is obtaining a commitment from the Board itself to fully support the "**three Medical Officers plus cover for Hawera policy**" to enable the hospital to remain viable and to function as it should and to be able to reduce the future impact of the increasing need for lower level secondary services for our aging population.

[a] We believe there should be a Board level change in policy that directs management towards "affirmative action" for **retention** of HIP Medical Officers, thus making expensive recruitment less necessary. "Word of mouth" works, but only if the job is something worth talking about!
- The Board could give specific approval to create a better paid Hawera "Multi-skilled Medical Officer" position (as already agreed in accepting the Pisk Report), with an attractive "Retention Bonus" i.e. not just for a MOSS position.
- Alternatively, those Medical Officers employed at Hawera are able (under the MECA agreement) to be placed higher on the Salary Scale "taking into account years of experience, qualifications, duties and responsibilities of the position, and recruitment and retention"[4] and to receive an additional "availability allowance" when called after-hours.
- A "Retention Package" should be formalised. The HHSC has put forward a number of quite low cost "benefits" that could be added to this package and offered additionally to the above financial bonus. This should be clearly indicated in any advertising.
- An emphasis should be placed on attracting NZ graduates, which could include better targeting of advertising as well as further lobbying of the Medical Council and RNZCGP to fast-track the Rural Hospital Vocational pathway.
- Investigate what it would take for Hawera Hospital to become a RACP[5] recognised "Level I" hospital like Balclutha and Oamaru (to allow Registrars to work for up to 6 months).

[b] As in Pisk Recommendation 31, at least four of the eight TDHB physicians should be identified who are prepared to be regular visitors to Hawera (including at least one Cardiologist and one Endocrinologist) to not only have an improved patient continuity of care but an improved and on-going relationship with the local Medical Officers (and GPs). Each visit should where possible include a formal visit to the ward to discuss any interesting or difficult patient management and perhaps a regular CME–lunch time meeting (with GPs invited). These visits could also fulfil the need to provide supervision for Medical Officers while they remain provisionally registered.

[c] Community support to be sought and maintained by more open reporting to the public and inclusion of public input concerns and ideas to the HHSC. Minutes of the meetings could be tabled at and appended to the Hospital Advisory Committee meeting agendas to enable comment from that governance committee as well as an opportunity for any issues to be raised at the full TDHB meetings, rather than filtered through management.

Thus support by the South Taranaki public (not just the members of the HHSC), the visiting Physicians, the Hospital Advisory Committee and the full TDH Board members will encourage management to approve more positive, active and innovative ways to maintain a functional Community Hospital that is an asset to Taranaki rather than appearing to be portrayed as a liability.

Dr Keith Blayney [General Practitioner; GP representative HHSC]
Shirley Blayney [Practice Manager & Legal Secretary]
Jenny Nager [Secretary Grey Power]
Neil Walker [Councillor TRC; Community Member HHSC]

Footnotes

[1] TARANAKI DISTRICT HEALTH BOARD INTERNAL AUDIT REVIEW HAWERA HOSPITAL **-** Investigation into Announcement of Potential Closure of Hawera Hospital Inpatient Services July 2002 Deloitte Touche Tohmatsu "*Processes for minuting meetings for the Hawera Hospital Steering Committee (HHSC) should be changed to increase the transparency and improve the public disclosure.*" http://home.bitworks.co.nz/blayney/DeloitteExecSum.doc

[2] The 30 TBH Medical Department doctors include 8 Physicians, 8 Registrars, 7 Medical House Surgeons and 3 AT&R, 3 Palliative Care and 1 Oncology doctors, not counting Intensivists.

[3] 2004 Terms of Reference, Hawera Hospital Steering Committee.

[4] NEW ZEALAND DISTRICT HEALTH BOARDS SENIOR MEDICAL AND DENTAL OFFICERS COLLECTIVE AGREEMENT 11.3 (a)
http://www.asms.org.nz/SITE_Default/SITE_Employment_in_NZ/x-files/19070.pdf

[5] RACP = Royal Australasian College of Physicians.
Accredited Hospitals for basic Physician Training in New Zealand at
http://www.racp.edu.au/index.cfm?objectId=769A0747-F720-7E4C-EB550F60BD04F9F1#adult