

# **Communication Update - Acute Care in Provincial Hospitals Project - December 2010**

## **Purpose**

1. The purpose of this communication is to provide you with an update on the National Health Board (NHB) supported project on acute care in provincial hospitals. Please distribute this communication update as you feel necessary and it may also be accessed via the NHB website.

## **Background**

2. Over recent years, there has been growing awareness across the health sector of the increasing vulnerability of acute 24/7 service provision in provincial hospitals. Key factors in this vulnerability are the closely related issues of availability of the required Senior Medical Officer workforce; increasing sub-specialisation; the workforce: population ratios required to maintain standards; and the number of specialists required to staff reasonable rosters.
3. In addressing acute care vulnerabilities within provincial hospitals the status quo is often not sustainable and DHBs are progressively faced with the need to explore whether their local populations would be better served by some of their acute services being provided through new clinical models, including new collaborative relationships with primary care practitioners and with larger neighbouring hospitals.
4. Government's intention is for DHBs to work together more effectively at a regional level to make better use of available resources, strengthen clinical and financial sustainability, and improve equity of access. The aim of the acute care in provincial hospitals project is to complement DHB action at local, sub-regional and regional levels.

## **Project work to date**

5. The initial phase of the NHB project began in late 2009 through engagement with relevant professional bodies and DHBs, site visits and interviews with clinical and managerial leaders in the hospitals concerned, and preparation of a series of papers and case studies that helped define the problem and potential solutions. Dr John Henley provided clinical leadership for the project, with strong support from Dr David Galler. The site visits and interviews were conducted by Dr Paul Malpass, who provided a report on each hospital for the respective DHB CEO, and a generic report for the project.
6. The DHB Chief Executive Officer Group acknowledged the importance of this project and nominated three DHB Chief Executive Officers (CEOs) to work with the NHB. Those three are: Chris Fleming (South Canterbury DHB), Tracey Adamson (Wairarapa DHB) and Phil Cammish (Bay of Plenty DHB).
7. The second phase of the project was a NHB Roundtable held in late March 2010, chaired by Dr Henley. The Roundtable was attended by a wide range of stakeholders including representatives of DHB CEOs, clinical leaders and service managers; key Colleges (surgery, medicine, anaesthetics, obstetrics, psychiatry, paediatrics, radiology, general practice, emergency medicine and nursing); the Council of Medical Colleges; the Medical Council; and the Association of Salaried Medical Staff and the New Zealand Medical Association. The report summarising the findings of the Acute Care in Provincial Hospital Roundtable discussions can be found on the NHB website

<http://www.nationalhealthboard.govt.nz/sites/all/files/rtsummary-acute-care-provincial-hosp-mar2010.pdf>

8. A subsequent half-day session was held with a subgroup of Roundtable participants ('the subgroup'). The purpose of this session was to prioritise the Roundtable suggestions for further scoping. At this session, the subgroup identified eight priorities across four areas: workforce; telemedicine; transport and funding models.
9. The subgroup has now completed their scoping exercise. This included attaining a greater understanding of the problems the identified priority actions were intended to solve; becoming familiar with work already underway across the sector in each priority; analysing opportunities, risks and barriers to success; and identifying gaps where national action would add the most value, including which agency would be best placed to lead further work. A copy of the key points discussed by the sub-group is attached as appendix one.
10. In addition, discussions have been held with a number of national DHB groups including Chief Medical Officers, Chief Operating Officers, Directors of Allied Health, Directors of Nursing, and Chief Information Officers and General Managers Planning and Funding to discuss project findings to date, and to further refine the identified actions.
11. A paper on the NHB's acute care in provincial hospitals project was provided to the NHB at their September 2010 meeting. It was agreed that the following actions would be incorporated into the NHB work programme:
  - a) Working with clinical champions to provide advice to the NHB and National Health Information Technology Board (NHITB) on how to support the uptake of telemedicine solutions.
  - b) Working with the ACC and the National Ambulance Sector Office to undertake some initial scoping work to assess what a review of patient ambulance transport (both retrieval and transfer) would entail and to present this to the NHB to consider in early 2011.
  - c) Providing improved support for DHBs considering the financial dimensions of moving to new collaborative services arrangements.
12. In October 2010 the NHB provided the Minister of Health with a report on the acute care in provincial hospitals national work program. The Minister requested further updated information on the current status of acute care needs at the ten designated provincial hospitals and what is being done to address those needs. The NHB is now working with relevant DHBs to collate the information to respond to the Minister's request.

### **Next Steps**

13. The NHB is now reviewing its work programme including timeframes to ensure coordinated implementation of agreed initiatives.
14. In October a national telehealth forum was held which has resulted in a proposal being developed for submission to the NHITB to establish a New Zealand Telehealth Forum.
15. Health Workforce New Zealand (HWNZ) has work underway that will impact on rural and provincial hospitals and other local services. The review of general practitioner (GP) training aims to increase the skills and numbers of GP to support them in taking on wider roles. The voluntary bonding scheme and the new advanced trainee scheme both target provincial hospitals. More information on these bonding schemes and other work underway can be

found on HWNZ's website [www.healthworkforce.govt.nz](http://www.healthworkforce.govt.nz). HWNZ also plans to start a workforce service review on the interface between primary care and rural/provincial hospitals early in 2011. More information will be posted to the website as it becomes available.

16. Following feedback from DHBs, a report will be provided to the Minister of Health, hopefully prior to Christmas, on the current status of acute care needs at the ten designated provincial hospitals and what is being done to address those needs

## **Appendix 1 - Key Discussion Points- subgroup of Roundtable participants**

### **Workforce**

#### **Health Workforce New Zealand**

1. Health Workforce New Zealand (HWNZ) was established in 2009 to oversee, manage and advise on all aspects of health workforce policy, education, training and development for the health and disability services sector. The Acute Care in Provincial Hospitals has become part of the HWNZ work programme and HWNZ is committed to implementing agreed actions arising from the project.
2. Further analysis will be needed on a specialty/profession basis to improve the understanding of the specific workforce issues in the provinces. HWNZ intends to run a number of workforce service reviews to complete this analysis.

#### **Recruitment**

3. Many provincial hospitals are dependent on older generalist staff who are nearing retirement age. Increasing specialisation has created an increasing recruitment problem for provincial hospitals which rely on such generalist staff, and compounded when patient volumes for specialty services are insufficient to maintain professional standards or justify employment of enough specialists to allow for sustainable rosters. Action to improve recruitment of professionals therefore must take place within what is considered to be a sustainable model of care for the future, and is not only about filling immediate vacancies.
4. Any increased use of provincial hospitals for training with greater support from clinicians from larger neighbouring DHBs (or the larger hospital in the same DHB). This could include formal staffing, facility and IT linkages across multiple specialties, or apply on a specialty by specialty basis. The support can be remote and supported through telemedicine, and/or include visiting specialist staff or a combined acute roster. A key requirement will be to develop the expectation that an integral part of the work of SMOs to work across hospitals and DHB boundaries.

#### **Medical workforce regulation**

5. A memorandum of understanding (MOU) between the Medical Council New Zealand (MCNZ) and DHBs has been signed. The objective of the MOU is to enable DHBs and the MCNZ to work in a collaborative and equal relationship, and to clarify respective roles and responsibilities related to the regulation of doctors in New Zealand, including the registration of doctors and the management of any competence, performance, conduct and health issues. The performance of the MOU will be monitored by the MCNZ and DHB CMO group, and the former is now exploring the option of extending the arrangement to primary care.

#### **Medical supervision**

6. The MCNZ has implemented a new model for supervision of International Medical Graduates (IMG's) and for individual applications including remote supervision, and also recognising services as approved practice settings (APS). Once a service is recognised as an APS, individual supervision proposals do not have to be submitted, cutting down on administration for DHBs and streamlining processing of applications at MCNZ. An additional benefit is that an APS can span more than one site, allowing services which would normally struggle to meet requirements to be recognised, by their working with a neighbouring site(s). MCNZ has agreed to work further with the Council of Medical Colleges to explore how this approach could best serve provincial hospitals. Also of importance is the need for IMG to ensure they have the appropriate culturally focused induction.

## **Role of the Council and Medical Colleges**

7. The Council and Medical Colleges (CMC) has taken a lead role in the Acute Care in Provincial Hospitals project and at their national meeting on 27 August 2010 placed this issue as a core component of their strategic planning session.
8. The CMC acknowledges that it has a leadership role in matters that relate to new service configurations and regionalisation of services. It has also acknowledged that, collectively and individually, medical colleges can play a key role in service change through exercising leadership; informing and advising communities, and DHB management and boards to improve and provide the best medical care delivered in accordance with accepted clinical knowledge and principles.
9. Areas of particular interest to the CMC in respect of the sustainability of provincial hospitals include ensuring:
  - a. fit for purpose training, supervision and credentialling is provided in a regional context with regard to workforce, specialisation and skills (volumes) and quality of care,
  - b. development of clinical pathways that make best use of the generalist and sub-specialist workforce and;
  - c. to bring frontline working knowledge and skills together to help identify, and advocate for, novel and practical solutions that can ensure the highest quality medical care, protect and promote public health.

## **Information Technology including Telemedicine**

10. Telemedicine will play a key role in enabling adoption of new models of care and service configuration for acute care in provincial hospitals. For example, provincial medical/surgical generalists will be supported by specialists at larger neighboring hospitals..
11. Telemedicine currently exists in localised pockets of uptake in particular specialties and DHBs. The identified barriers to wide uptake include training of clinicians and development of their confidence in the technology. Cost and technological barriers also exist to effective clinician/clinician, clinician/patient and corporate use of telemedicine.
12. Phase one of the National Health IT Plan focuses on the continuum of care, which includes: e-referrals, transfer of care, safer medications management, and improving primary care systems. This will create a standard set of interfaces that will feed into regional clinical data repositories.
13. One of the key objectives must be to develop a network whereby there can be a seamless transfer of patient data between providers. This would allow small community providers to have access to the patient record, including labs and imaging, enhancing their ability to manage patients locally.
14. There is often a perception that the focus is to enable the large tertiary hospitals to have ready access to regional patient information, but of course the converse is equally valuable for a patient returning to a regional centre. It may be easier to think of it in terms of the medic alert bracelet system. These patients have a medical record stored for ready access should they turn up to any health provider.
15. This would allow for appropriately tailored treatment from the point of first presentation. At times, in the case of a terminal illness, this may be no treatment. It would avoid some duplication of investigations. This may avoid treatment regimes which have previously been unsuccessful and diagnoses which have been previously excluded. There is tremendous potential for improved patient outcomes and an example of this is: renal colic can present similarly to an abdominal aortic aneurysm.

16. Telehealth enables patient diagnosis and treatment to be delivered "at a distance", but it can be even more useful if the patient's information is available at the same time. The potential benefits of such a system are numerous, but it would be a very challenging and costly undertaking. The National Health IT Plan supports seamless access to the patient's record to authorized clinicians through the development of regional clinical data repositories which hold key items of patient information such as lab tests, discharge summaries and referrals. These clinical data repositories will be accessed via a common clinical workstation solution available throughout the region that will provide a view of the patient's data to support the diagnostic and treatment process in the field.
17. Telemedicine is not specifically identified as a priority in the National Health IT Plan. A significant business driver is needed to lift telemedicine as a priority; provision of sustainable acute care for provincial populations could be this driver. An identified next step would be development of a position paper for the NHB and National Health IT Board, in conjunction with clinical champions.

### **Transport**

18. It is recognised that future models of acute care services may increase the need for a relatively small number of patients with high acute needs to travel between hospitals.
19. Issues relating to patient transport were identified in the acute care project as barriers to provision of high quality services, and to the reconfiguration of services necessary to ensure sustainable services.
20. There is considerable activity underway at all levels of the system regarding patient transport, and including rollout of the National Ambulance Strategy.
21. However, it was noted by the subgroup that there remains a complicated and fragmented arrangement for the planning and funding of patient transport, across both road and air ambulance, and noting that the same operators cover both emergency retrieval and hospital transfers. Further work could be undertaken to co-ordinate a whole system approach to planning and delivery of all ambulance services, with helicopter transport appearing a particular priority given current CAA enforcement of its safety requirements.

### **Funding**

22. The Government has recently determined future planning, funding and accountabilities arrangements. A key change to be introduced will be Regional Service Plans as the medium term (5-10 years) accountability document for the DHB sector, replacing District Strategic Plans. This is intended to encourage DHBs to work more collaboratively in determining the most clinically and financially viable option for service delivery within the region.
23. The bulk of health sector funding will continue to be allocated to DHBs in accord with the population-based funding formula. The way in which each DHB will pay its share of the costs of a collaborative service arrangement (either regional or sub-regional) will be agreed with neighbouring DHBs as part of the Regional Service Plan.
24. The subgroup saw current payment arrangements for inter-district patient flows as a barrier to optimising acute care configuration for provincial populations. Those arrangements – essentially a fee-for-service arrangement, based on national prices – have always been the 'default' to be used in the absence of a site-specific negotiated settlement between DHBs. However, they have become institutionalized as the sector norm, and the subgroup believe that the following work could be progressed at a national level:
  - a. Options for paying for new service configurations across DHB boundaries could be described by the NHB

- b. A consistent set of principles and methodologies could be provided to all DHBs to assist with scenario costing and cost allocation
- c. Trouble shooting/mediation support could be provided to DHBs to assist in negotiating fair collaborative service arrangements (in addition to the more formal dispute resolution)
- d. The NHB could consider easing requirements for individual DHB financial performance, where service reconfiguration means improved collective sub-regional or regional financial status, but with uneven financial impacts on individual DHBs

**Members of the Acute Care in Provincial Hospitals Roundtable subgroup**

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Chris Fleming	South Canterbury DHB
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Jim Primrose	Ministry of Health – Primary care
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