Roundtable – Summary of Discussions

Acute Care in Provincial Hospitals

Roundtable convened by the Ministry of Health,
and held in Wellington on 26 March 2010

BACKGROUND

Purpose and Approach

The purpose of this project is to develop a greater understanding of the existing and potential vulnerability of 24/7 acute service provision in provincial hospitals, so that action can be taken at appropriate levels of the system (district, regional, national) to reduce the risk of service failure. Ten hospitals across New Zealand were identified as provincial for the purposes of this project (see Appendix 1).

This project is part of a wider body of work commissioned by the Minister of Health to strengthen the viability of health services. DHBs are working regionally to identify services of particular concern, and taking action collectively or individually as appropriate. A subset of services have been prioritised and lifted to the national level for action; this includes acute care in provincial hospitals.

A key early aspect of this project was a Roundtable held in Wellington on 26 March 2010, and convened by the Ministry of Health ('the Ministry'), that gathered representatives (listed in Appendix 2) from a broad range of health sector organisations to contribute their expertise and experiences. In preparation for the Roundtable, the Ministry met with key Colleges in late 2009 to begin the process of engagement and identification of issues. From information gathered from case studies, site visits, stakeholder interviews and a literature review, the Ministry produced a series of papers that were circulated in advance to participants.

The Roundtable was chaired by John Henley, a well respected medical practitioner with four decades of experience at Auckland Hospital, who has been working as a locum in a number of provincial hospitals across New Zealand. He was assisted by deputy chair David Galler, the Ministry's Principal Medical Advisor.

The Roundtable operated within the Chatham House Rule, with all views presented at the meeting and papers associated with it being confidential. Hence this Roundtable report does not attribute specific comments to particular speakers (other than Ministry personnel), and was circulated to attendees for comment prior to finalisation.

Next Steps

The discussion at the Roundtable is summarised in this report, which captures the issues discussed and starts to identify areas of focus for the Action Plan. It will be used by the Ministry's National Health Board (NHB) to inform further sector engagement, leading to development of an agreed Action Plan. This Plan will include future structures and processes required to advance the project through implementation.

The NHB Advisory Board and Minister of Health will be provided with regular updates on progress, and be invited to make decisions where required at key points in the project.

Introduction

1. David Galler opened the meeting by thanking everyone for their attendance and contributions to date, particularly the Colleges that had hosted Ministry personnel at early stages of the project. The clear messages that he had taken from these meetings was that the Colleges were interested, recognised the problems, had solutions in mind, but did not have a place to take their ideas. This was the basis for the Roundtable.

2. John Henley stated that the Roundtable demonstrated the collective commitment to finding solutions for the problems faced by the ten provincial hospitals selected for the project (see Appendix 1). The process was not about assessing the individual capability or capacity of the hospitals, but rather assisting each hospital to maintain the appropriate level of care. The focus was primarily but not exclusively on the Senior Medical Officer (SMO) workforce, given that their presence or absence was pivotal to the viability of an acute service. Similarly, the focus was not on issues specific to particular specialties, but rather on generic issues. He drew a distinction between a puzzle and a mystery – the difference being that the first has a solution. He believed that there were solutions to this puzzle.

Context

3. Chris Mules provided a context for the acute care in provincial hospitals project. He covered the challenges facing the health system, including workforce availability, and development and implementation of Government health policy.

4. Chris Mules indicated that while New Zealand compared relatively well in terms of international indicators of health sector outcomes and outputs, there was room for improvement, and pressures on the sector were intensifying. Action was needed now to avoid the system becoming crisis driven. As a consequence particularly of the global financial crisis, New Zealand could not maintain the current growth path of health spending. The demographic profile of New Zealand would change considerably over the next 20 years, with population ageing, continuing urbanisation (particularly growth in metropolitan Auckland), and increasing ethnic diversity. Current workforce shortages could be expected to worsen before action being taken now delivered results. These and other pressures posed difficult questions about how to meet New Zealand's health service needs and, particularly for the purposes of this project, how to maintain health delivery infrastructure in provincial areas where the population was ageing, and declining as a share of the country as a whole.

5. With these issues as a backdrop, Chris Mules provided some details around implementation of the Ministerial Review Group recommendations for the structures and processes of the future health system. Key themes were: strengthened clinical leadership and engagement, and support for clinical networks; discipline around the introduction of new technologies and clinical procedures; changes to the level of the system (district, regional, national) where decision rights should sit; an increased focus on long-term service and capacity planning to reflect required changes in service configuration and models of care; and centralisation of backroom functions for efficiency reasons. Structural changes included: the creation of a National Health Board; a National Shared Service Agency; and a Health Quality & Safety Commission; and restructuring within the Ministry of Health.

Presentations

6. A number of additional presentations were made by a range of participants to inform the discussion.

7. Firstly, College and DHB representatives presented their perspectives. The points raised in these presentations and ensuing discussion are summarised later in this report.

8. Paul Malpass reported on his Ministry-commissioned survey of the ten provincial hospitals, and the frank conversations he had with a wide spectrum of DHB SMOs, nurse leaders, and managers. The key issues highlighted by staff at the hospitals were:

   - Difficulty in retention and recruitment of SMOs;
   - Reliance on locums;
   - Absence of registrar training posts;
   - Registration difficulties and supervision requirements for International Medical Graduates (IMGs);
   - The quality/volume relationship;
   - Inadequate provision of after-hours general practice care;
   - Reduction in generalist skills;
   - Concerns about ambulance service provision; and
   - Low priority being given to investment in communication technology.

9. Three DHB case studies were also presented, describing challenges faced in providing acute services and solutions developed to overcome these. The three presentations were general surgery at Masterton Hospital, maternity services in South Canterbury, and paediatric services for West Coast DHB. There was also discussion of the models used by Northland DHB to maintain rural hospital services in Kawakawa (Bay of Islands) and Kaitaia (Far North).

Problems and solutions identified

10. The problems and potential solutions identified by the speakers and through subsequent discussion were grouped in the categories below. They are listed in the order that the issues were discussed in the final session on the day and do not reflect relative priority.

Workforce availability

Problems

11. A repeated theme was the increase in sub-specialisation to the detriment of generalist skills and practice. Drivers identified for this trend included the modular way that training is organised, financial incentives, and the desire to escape acute rosters. Private practice also has an influence on the public system (eg, a significant proportion of elective procedures are now done privately, either publicly or privately funded, and this draws on the same workforce).

12. Of greatest concern for the quality, safety and viability of acute services was the shortage of the available SMO workforce generally, the reliance on IMGs, and SMO distribution (being concentrated in urban areas). One of the hospitals covered in this project had only 11 of its 25 SMO posts filled with permanent staff (the others being locums). A number of push and pull factors were identified, such as remuneration packages overseas, the on-call commitment, overwork leading to burnout, and lack of variety (interesting work 'skimmed off' to large centres). While these were particular SMO issues, they require strategic and system-based responses that look across the whole sector and do not focus on workforce groups in isolation.

13. Many of the same issues apply to the nursing workforce, which is ageing in the provinces and reducing their hours. A significant retirement cohort is looming. The provincial hospitals often rely on the goodwill of nurses to provide adequate cover. Fortunately there has been a rise in

interest in nursing which may reduce the recruitment concerns, but sufficient numbers of nurses alone is not enough to address quality and safety issues. Further points we raised indicating that post education for nurses had been shown to improve patient outcomes but that this was more difficult for nurses in provincial hospitals to attain

14. There is more to be done structurally and in terms of support and training for this workforce. There are also problems in recruiting and maintaining 24/7 cover for specialist support roles such as radiographers and sonographers.

15. More medical registrars are needed in provincial settings, but there are significant barriers to this including issues with supervision, range and volume of work, as well as perceived cost (although this is generally significantly lower than locum costs). This would necessitate SMO time being made available for supervision as well as clinical activity.

16. Locums are increasingly sourced from the United States and are therefore more likely to be short-term contractors who will return home, rather than migrants who would be interested in settling in New Zealand. Hence reliance on locums means there will always be issues with staff turnover and skill loss, and the resulting instability. Locums also require significant support to function effectively. To fill the SMO gaps, advertising for overseas based staff is critical and has that it could be coordinated better across New Zealand

Solutions

- Regionalisation of some service delivery, which could where practicable include shared acute rosters with formalised linkage of the provincial hospital to a larger neighbour, but also diverting activity and resources from the larger hospitals to the provincial hospital to ensure critical mass and efficient use of the latter's capacity. SMOs (and registrars in some cases) would need to travel between sites. Regionalisation would also assist with supervision of registrars and IMGs.
- Rotating medical staff through provincial and urban posts, through regional or sub-regional employment contracts and inclusion of a commitment to this in the MECA. For example, the present Resident Doctors Association (RDA) MECA only permits work within 55 kilometres of the hospital the registrar is employed by, limiting opportunities to move between hospitals and do off-site work.
- The sector needs to better understand the problem of sub-specialisation. Where has it come from? What are the drivers? The goal should be to reduce perverse incentives for sub-specialisation, and plan the mix of generalists (often with a specialist interest) and specialists needed in the system.
- National as well as regional planning is required across the health workforce as a whole, rather than each workforce in isolation. They all face similar problems (eg, shortages, ageing, quality/volume relationships) and changes in one will impact on others. A 'whole system' approach is needed, with an active programme to encourage New Zealand graduates into prioritised fields. This may require a better understanding of the respective workforces through mapping of the current state, and better projecting future needs.
- Locums should be provided with adequate training (eg, cultural norms) and support so they can be more cost-effective in provincial settings.
- The Medical Council could help facilitate international staff coming to New Zealand by further streamlining the approval for IMGs. Supervision requirements also need to be revisited, including allowing for models of remote supervision where appropriate.
- International recruitment could be nationally co-ordinated. New Zealand may not be able to compete on price, but can on intangibles (eg, quality of life, professional satisfaction through being involved in service planning and decision-making).
- Working in provincial areas could be promoted and incentivised (eg, bonding, immersion schemes). It was considered that increased training in provincial centres and selection of

medical trainees and nurses from provincial New Zealand are both likely to result in increased numbers of local trainees returning there.
- Career management will be required to ensure that appropriate positions are available at the end of training. This will be required during training, and will need to be aligned with service planning.

Quality/volume relationships

Problems

17. Quality/volume issues are more likely to exist in provincial hospitals for the simple reason that the catchment populations are smaller than those of their larger neighbours, and hence the numbers of patients seen/admitted is smaller. Workload will of course depend not on the population itself, but on its size relative to the workforce. Two problems may arise: first, maintaining a viable 24/7 roster requires a critical mass of SMOs (for example between 3-5) for each acute specialty, which may be at odds with the health needs of the local population; and secondly, development and maintenance of professional standards is likely to require a minimum number of cases and activity of certain types, that may be in excess of that referred from the local population. The quality/volume relationship is, however, complex and we do not know for sure the extent to which it applies to these hospitals. It may relate more to complex procedures, which are generally not done in provincial hospitals (or at least in the smaller ones).

18. This has major implications not only for individual health practitioners, but also for the configuration of services and the workforce numbers and mix across disciplines needed to support them. Medical college guidelines on such issues are not always available and relevant, in some cases being tailored more for the Australian than the New Zealand setting. The support workforce also faces the same quality/volume challenges.

19. These issues, as well as concerns about training opportunities, working in isolation and having reduced access to peer review, can make provincial hospitals unattractive workplaces. On the other hand, the higher levels of clinical independence and breadth of experience that provincial hospitals offer staff can also be a draw card.

Solutions

- Colleges to provide guidance on appropriate workforce to population ratios and volumes of professional activity to maintain skills, that are relevant to the New Zealand setting, and that reflect the interdependence of clinical services within a hospital.
- Regionalisation of services and rosters (‘one service, two sites’) can help provide the critical mass needed.
- A specific programme for provincial and rural hospital nursing staff has been developed. Otago University has agreed to deliver it, but it has not yet been offered. This programme needs to be supported.

Role of the Medical Colleges in Training

Problems

20. Medical colleges have a significant role to play in addressing issues around training and supervision. Current medical training does not equip doctors adequately for provincial hospital (or rural) practice, with sub-specialisation bringing a continuing reduction in the scope of practice of the 'specialist generalist' (whether physician, surgeon or psychiatrist). Doctors need early exposure to provincial environments. The modular approach has encouraged the proliferation of sub-specialisation and has not produced sufficient numbers of generalists.

21. Medical colleges argue that they have no jurisdiction over non-fellows, including locums and IMGs. Because non-fellows are a significant proportion of the provincial hospital workforce, the Colleges currently have only a limited role. International medical graduates (IMGs) must have continued medical education plans under new Medical Council of New Zealand (MCNZ) Approved Practice Setting model (APS) guidelines and all must do continued medical education for an annual practising certificate.

22. An area medical colleges can address is provincial placements in the PGY2 and subsequent years, and accreditation of provincial hospitals as registrar training sites.

Solutions

- More training should be done in provincial hospitals. Consideration should be given to Clinical Training Agency (CTA) funding of training posts, and for the funds to follow the trainees to the provincial hospitals. This funding is also needed for nursing staff.
- Health Workforce New Zealand and DHBs need to give a clearer signal to the Colleges about what workforce volume and mix they need, allowing the Colleges to better balance their output of generalists and sub-specialists, and ensure generalists have an area of special interest that they can pursue within the provincial hospital, and a mandatory period of training in a provincial hospital (options include a period of basic training, but also the final year of specialist generalist training).
- Major increases in intakes into Australian medical schools should in time reduce Australia's demand for New Zealand-trained health professionals.
- The Medical colleges should be more actively involved in assessing the quality of acute services, as well as approval for training purposes. The Ministry may need to formally request this of the Colleges. Assessing service quality would also require the various Colleges to work more closely together to ensure cross-discipline assessment. It may also require a uniquely New Zealand oriented role for the Colleges that is different from their Australian colleagues.
- Rural hospital practice is now recognised by the MCNZ as a separate speciality, and funded training posts have been developed (i.e. two year funding for eight doctors). This may help to fill currently vacant posts.
- Medical colleges should consider how they could encompass the needs of IMGs and locums by creating 'affiliate' membership.

Accreditation and Registration

Problems

23. The bar may be set too high for accrediting provincial hospitals for training. However, certain minimum standards must be maintained and this may only be possible through formalised linkages with larger neighbouring hospitals and training programmes being offered across sites. The Colleges and Medical Council have a big part to play in addressing these problems. This should not mean, however, that standards could differ between centres.

24. Some DHBs believe that the Medical Council is excessively slow in considering applications for registration by IMGs. However, it may be that the Medical Council has information about candidates that the potential employer does not. Cases may therefore not be as simple as they appear, but the Council cannot release the information due to privacy concerns.

Solutions

- Registration issues must be addressed on a systems basis, as the issues are bigger than simply procedural. The DHBs and Medical Council need a better understanding of each other's needs, and how to work together to address these.
- Discussion between provincial hospitals and key Colleges are needed about options for training accreditation.

Service Configuration and Models of Care

Problems

25. There are a range of innovative models of care being employed in New Zealand and internationally to sustain acute service provision. New Zealand needs to become better at evaluating such models and spreading success. This requires closer ties between hospital providers to share experiences, more effective regional and sub-regional partnerships, redefining the role of the specialist in the health system, and stronger support from the sub-specialist for the 'specialist generalists'. Barriers to this collaboration need to be addressed, including employment contracts and inter-district flow (IDF) payment models. Multi-disciplinary teams, substitution and delegation, clinical networks, regional/sub-regional services, improved transport and retrieval systems, workforce/ population guidelines, improved access to diagnostics, a nationally co-ordinated telemedicine system, and defined clinical pathways are all part of the solution.

26. Local community factors can also act as barriers to development of clinically sustainable services, and consideration of options and decision-making must take these into account. For many provincial communities the hospital is the largest employer and hence a major economic contributor. There would be concerns about a significant drop in the overall socio-economic status of a community with associated health issues were the hospital to be substantially downgraded. This may be compounded by the increased costs to the community of having to travel further to access 'secondary' health care. These impacts need to be considered in health service planning.

27. National leadership and decision-making is required on the future configuration of New Zealand's hospitals and the level of service that each of them is to provide. Some of the current provincial hospitals may prove to be no longer clinically viable given their catchment populations and workforce availability. They should be replaced by local delivery systems centred on integrated family health centres, and supported by specialist regional delivery

systems. Such clarity is needed regarding the intended longer term configuration of services to inform workforce and facility design.

Solutions

- The National Health Board (NHB) should produce national service planning guidance as a yardstick to suggest what level and mix of service is appropriate for different populations to sustain access to clinically and financially viable services. This should only be guidance, with more detailed district and regional planning and decision-making that balances clinical and community needs. Transparent and relevant advice from Colleges would be an important contributor to this guidance.
- Service planning and delivery must be evidence-based, and able to draw on evaluation of models and configurations adopted in other communities.
- Colleges and the Ministry have a key role in supporting and promoting uptake of innovative models and configurations. Clinical leaders must be at the forefront of this change within their local areas, working closely with colleagues and their communities in building understanding and designing the changes.
- Colleges will need to work together more effectively given the need for cross-specialty and cross-discipline service planning and delivery. The Council of Medical Colleges can play a key facilitative role in this, both across the medical colleges, and with the College of Nursing.
- New models of care must be 'competency led', meaning those with the right skills and experience should do the work. They should also be 'patient-focused'.
- Services should be integrated and settings-based, and terms such as 'primary' and 'secondary' care should be abandoned. For example, general practitioners (GPs) may have a strong role in hospital-based acute care, and specialists may have a strong role in community-based service delivery. Sub-specialists must be provided with the infrastructure they need to support clinicians in provincial hospitals.
- Better use must be made of the growing nurse practitioner and nurse specialist workforce. Provincial hospitals have the greatest potential to use for this workforce, but have been slow to develop posts. The system as a whole must fully commit to these advanced nursing practice roles, including establishing career pathways; removing legislative barriers; providing support for postgraduate education and training that addresses issues of distance, cost, and back-filling; and creating opportunities for nurse practitioners to demonstrate their skills in acute care. Similar opportunities must be created for other health professional roles (such as physician assistants and paramedics).
- GPs should be seen as part of the locally available workforce for acute rosters.
- Greater use should be made of the 'multidisciplinary team' that goes beyond medical and nursing staff to include allied health and working with GPs and practice nurses.
- The NHB should actively promote to the DHB sector alternative funding models that support regional and sub-regional services, given that IDF payments are only a default mechanism (to be used in the absence of other agreement).

System Issues

Problems

28. A number of wider system policy issues were also identified as creating problems for viable acute care. These need to be considered over the longer term.

29. These include the perverse incentives that are created by the current patient fees (ie general practice visits incur fees, while attendances at the hospital Emergency Department (ED) do not). Of particular concern in provincial communities was decreasing general practice after-hours coverage, which is placing an unplanned burden on hospital ED services. The priority placed on elective surgery was also having unintended consequences for acute surgery, with

some surgical specialists withdrawing from the acute roster and focusing solely on elective procedures (public and private). This was also perpetuating an imbalance in remuneration between procedural and cognitive skills.

30. The way triage and referral decisions are taken and particularly who decides where patients are sent needs to be looked at from a regional (or sub-regional) perspective, and guided by defined and agreed clinical pathways. This ties in closely with transport and accommodation issues for patients and health professionals.

31. The Role Delineation Model (RDM) needs to be developed further if it is to be used as a planning tool. At the moment it is seen as not sensitive or specific enough – for example, within the ten provincial hospitals included in this project, there are likely to be 'Level 3a' and '3b' hospitals. Similarly the RDM is presently descriptive of the current state of the hospital's services, rather than indicating future possible configurations. The current information has also not been through a validation process. This needs to occur.

Solutions

- Improve infrastructure supports for hospital clinicians (eg, clerical services).
- Systems need to be adapted to support nurses to be most effective (eg, standing orders need to support generalist nurses to deliver services).
- Develop national co-ordination of patient transport and retrieval.
- Strengthen cross-DHB service provision and referral.
- Primary care should take a greater role in 24-hour cover, and ensure that the roles of this and hospital ED are planned and agreed rather than ad hoc (eg, put the 'E' back in ED through sustained public education).
- Further develop the RDM to meet future sector needs.
- Review funding structure in respect of both IDFs and co-payments.

Information Technology (IT)

Problems

32. Technology is a key enabler for a lot of the solutions posed around regional and sub-regional clinical pathways. There was strong feeling regarding the need for investment in IT (systems, telemedicine, RIS/PACS, video conferencing) to enable care to be provided remotely.

Solutions

- Increase support for provincial hospital clinicians and nursing staff through smarter use of technological advances (eg, tele-medicine/tele-radiology) to link with larger hospitals.
- Better integrate and co-ordinate IT planning across hospitals and DHBs.

APPENDIX 1

Provincial Hospitals

For the purposes of this project, the Ministry of Health identified provincial hospitals as those offering Role Delineation Model Level 3 services to a population of less than 120,000 people. These hospitals are listed in the table below.

The current hospital catchment populations vary from 28,000 at Ashburton to 110,000 at Invercargill. The populations are expected to stay at similar levels over the next decade, with some slight increases or decreases. The age cohort compositions are likely to change, particular the percentage of older people (especially those aged over-75 years). These Level 3 hospitals serve a total population of over half a million people.

Hospitals included in the acute care in provincial hospitals project, with current and projected populations (based on Census 2006 data)

Provincial centre (hospital)	DHB		Catchment population 2018/19
Whakatane	Bay of Plenty	51,037	50,613
Rotorua	Lakes	102.650	106,003
Gisborne (Cook)	Tairawhiti	45,910	45,132
Whanganui	Whanganui	63,328	60,572
Masterton (Wairarapa)	Wairarapa	39,713	39,312
Blenheim (Wairau)	Nelson Marlborough	44,600	46,900
Greymouth (Grey)	West Coast	32,108	31,727
Ashburton	Canterbury	28,667	30,100
Timaru	South Canterbury	55,317	55,448
Invercargill (Kew)	Southland	110,585	111,717

APPENDIX 2

Roundtable Participants

Sector	
Tracey Adamson	Wairarapa District Health Board
Phil Cammish	Bay of Plenty District Health Board
Jenny Carryer	College of Nurses
Pauline Clark	Canterbury DHB
Peter Foley	New Zealand Medical Association
Peter Freeman	Royal Australasian College of Emergency Medicine
John Garrett	Canterbury District Health Board
John Henley	Roundtable Chair
John Kyngdon	Royal Australasian College of Surgeons and NZ Association of General Surgeons
Brett Lyons	The Royal Australian and New Zealand College of Radiologists
Lyndy Matthews	Royal Australasian College of Psychiatrists
Johan Morreau	Royal Australasian College of Physicians, Division of Paediatrics and Child Health
Alan Murray	Royal New Zealand College of General Practitioners, Division of Rural Hospital Medicine
Christine Nolan	South Canterbury District Health Board
Ian Page	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Philip Pigou	New Zealand Medical Council
Ian Powell	Association of Salaried Medical Specialists
Claudia Schneider	Southland District Health Board
Alan Shirley	Wairarapa District Health Board
Paul Smeele	Australia and New Zealand College of Anaesthetists
Bill Taine	Royal Australasian College of Surgeons and NZ Association of General Surgeons
Tom Thompson	Royal Australasian College of Physicians
Susanne Trim	New Zealand Nurses Organisation
Ministry of Health (MoH)	
James Caldwell	Policy Analyst
Ezrai Fae	Policy Analyst
David Galler	Roundtable Deputy Chair
Deborah Kent	Group Manager
Paul Malpass	External Clinical Advisor
Chris Mules	Director, Health Service Planning
Iwona Stolarek	Clinical Advisor, Workforce
Api Talemaitoga	Chief Advisor, Pacific Health
Apologies	
Joy Cooper	ACC
Michael Johnson	Programme Manager, Health Services Planning, MoH
Faye Ryan	Service Planner, MoH
Richard Steele	Council of Medical Colleges