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Submission from the Dr Keith Blayney GP Practice

Feedback on the Draft South Taranaki Health Proposal

Background:

This submission asks the TDHB through the Steering Group to ensure any proposal, model or recommendation for change in South Taranaki not only clearly addresses the identified health needs of the district but has the support of the **local** clinicians and wider community. [i]

Health needs have been identified at a number of levels:

- **Expectations from the Minister of Health** clearly identify:
  - Improved services with reduced waiting times
  - Services closer to home.
  - More clinical leadership, regional collaboration and [lastly]
  - "Improved financial performance", by reducing administration, not clinical services [ii].
  - The TDHB must "engage with the South Taranaki community over changes to models of care as part of possible plans to reconfigure hospital services" [iii] .

- **The TDHB Statement of Intent** [iv] identifies as it's top two priorities as:
  - Shorter stays in Emergency Departments
  - Improved access to elective surgery

  So any proposal should make these priorities easier, not harder to achieve.

- **South Taranaki Community feedback** on local health needs from
  - Clinical Forums including GPs
  - The Bishops Action Foundation Report [v]
  - South Taranaki Business Analysis
  - Almost 8,000 South Taranaki petition signatories [vi]
  - 870 people who "like" the Facebook page "***South Taranaki needs Hawera Hospital***"

  The identified issues were similar and I believe are linked. They are, in order:
  - Access to GPs is the greatest identified problem, followed by

- Access to specialist consultations and investigations. GPs want better access to investigations, specialists and simpler pathways.
- Retention of Hawera Hospital (including ED, OP, 20+ inpatient beds, Lab, Maty, HH District Nursing, 2ndary Dentistry) was the key theme of the Petition and Facebook comments
- Retention and recruitment of Medical staff (both GPs and Hawera Hospital Medical Officers) are clearly required for bullet points 1 and 3 above while bullet point 2 is a requirement for local doctors.

Model Evolution:

The "**Gemba 3 day workshop**" model [vii] suggested a "hub and spoke" model but virtually all locally based clinicians did not agree with this being based in an Integrated Family Health Centre (IFHC), even if it was the biggest practice. More patients attend non-SouthCare practices in South Taranaki and GPs from these practices all felt they were already more integrated and efficient than the large clinics, confirmed by the Bishops Action Foundation report. Furthermore, all local GPs did not agree with a system that bypassed the GP team. We therefore offered another model (**Roma Tika**, meaning correct [tika], flow [roma]), whereby patients needing community health related services are referred to a co-ordinating centre and TDHB case managers ensure they obtain the relevant services. This concept could clearly link in (rather than compete) with other works in progress such as Project Splice TDHB Care Managers for the over 65s and those with chronic illness [viii] and Whānau Ora [ix].

A further concept arising from the Gemba workshop was an "**A&M Plus**" emergency service to replace the current Emergency Department (ED). This was totally rejected by all South Taranaki based medical practitioners (GPs and hospital Medical Officers) as both impractical and unattractive for doctors to staff. It would result in a loss of all hospital medical staff and likely to drive away some permanent GPs.

At a very late stage in discussions at the doctors' meetings, the Hawera Hospital bed number and configuration was raised by management. No local GP or Medical Officer supported proposals to further reduce numbers of beds at Hawera Hospital from the present.

Consultation Document [x]

This Management Proposal tries to address some access issues but largely fails because, although some proposals are good (and others already exist in the efficient GP private practices), many others will make retention difficult, particularly the efforts to move services out of Hawera Hospital (either centralized to Base or into Rest Homes). The downgrading of bed numbers is clearly motivated by a perceived need to save money, despite the severe staff cutback of 12 nurses at Hawera Hospital last year. I, and many others believe this is short sighted and will lead to poorer health outcomes, worse staff (particularly medical) retention and eventually increased costs to the TDHB.

We do not accept as valid the reasons for reducing bed numbers, namely:

- This was "designed by doctors, nurses and other health care professionals working for South Taranaki people". The only doctors supporting this bed reduction are not based in South Taranaki and no-where in the Gemba Outcome are bed reductions recommended.
- "Beds cost more at Hawera". Clearly reducing the number of beds increases their unit cost given fixed costs to maintain a hospital. This is actually a valid argument to increase bed numbers and thus reduce average cost.

Having more South Taranaki patients in Base also increases transport costs considerably, both for the patient and their Whānau. This cost is caused by DHB centralization so it must be borne by the TDHB, not shifted to the public.

- "Hospital level Rest Home beds cost less than Hawera Hospital beds" may appear true, but not for the same service. Nursing numbers, appropriate experience and qualifications are less, co-ordinating rehab. services will be far more expensive than on-site at Hawera and what about medical cover costs? It is certainly not "the same or better".
- "Hawera only needs 4 Intermediate, two palliative and 4 observation/treat beds" is easily shown to be a wild underestimate based on incorrect figures [xi]. If Hawera only had 10 in-patient beds (and this proposal is actually to have most, if not all in Rest Homes or ED), the Trendcare figures for the previous 9 months [xii] reveal the ward could have managed only 37% of the time (63% of days had more than 10 in-patients).
- "Bed numbers are determined by staffing levels" so the aggressive reduction by management of nursing staff numbers from 31 to 19 in 2010's "**Vision for the Future**" is the cause of this push for reduction in bed numbers, not any lack of need!
- "The TDHB is running a deficit and must cut costs" is an unacceptable reason, given both the $50,000 per month already cut by the above staff reductions at Hawera (but not Base) and the additional government funding provided 1 July 2011 to cover the TDHB deficit in order to prevent service cuts.
- "It is hard to staff Hawera Hospital" and is that any wonder given the repeated cuts, disincentives, lack of security, and lack of retention efforts experienced by Medical Officers in recent years.
- "GP beds are the future" fails to understand that any GP even vaguely interested in hospital beds wants them to be in Hawera Hospital, not a rest home. However, the most important response to this is that we don't have any spare GPs. South Taranaki has only 33 GPs/100,000 (the second lowest ratio in the country and exactly half the New Plymouth ratio [xiii]). Expecting GPs to do more work (whether it be GP beds, covering A&M clinics or taking on unsafe patient loads) is one of the reasons we have such a poor retention record and demonstrates again the unwillingness of the TDHB to either recognise there is a GP shortage or to do anything to improve retention.
- "Base specialists support reducing beds at Hawera" may be true for some but others are horrified. Unless South Taranaki patients are denied care at Base, there will be far more "bed blocking" if South Taranaki patients don't have the option of early transfer to Hawera for rehab after surgery, other intervention or specialist investigation. How is this going to help reduce waiting times on elective lists or clearing ED patients earlier from base ED?
- "The 4 observation/treatment beds are to be housed in ED" So if 4 of the potential 9 beds in ED (excluding the resus, plaster and triage beds) are taken by these in-patient beds, Hawera ED would find the 5 remaining beds clogged with "normal" ED patients, leaving no ability to deal with a major industrial incident or car accident. Given the likelihood that a major natural event such as a volcanic eruption (for which Civil Defence estimates a 30-50% chance in the next 50 years [xiv]) or earthquake would in all probability prevent road or even air transport to New Plymouth or Whanganui Base hospitals and as the few GPs we do have are not included in any Civil Defence plans, there would be a near total inability to provide co-ordinated emergency health care in South Taranaki.

A better plan

Instead of accepting a management driven plan aimed at reducing services and making a valuable asset (the rural Hawera community hospital) far less efficient, against the wishes of the community and locally based clinicians, some attention to modern health planning concepts should be taken into consideration and applied.

Not only is there a political expectation that any changes are clinician led, there is mounting evidence that hospital performance improves when hospitals are physician,

rather than management led [xv]. The physicians and nurses at Hawera Hospital feel disempowered and constantly under threat. A change from management direction of clinicians to management facilitating clinicians' needs is required.

Instead of Hospital capacity planning being based on beds, modern thinking is to base it on the **ability to deliver processes**. [xvi] We should be talking about patient flows and **flexible bed use**. Even a moderate epidemic could be managed if hospital "viability measures" such as maintaining a hospital's critical axis, staffing, logistics, and surge capacity are not removed [xvii].

To achieve this, I have suggested that we take the best suggestions from the much maligned management model and combine it with the GP model based on patient flow to achieve improved and more efficient patient care, (including better health protection) while not destroying the flexibility and viability of an important and valued community asset, the Hawera Hospital. Bed capacity **[namely 20+ in-patient and 9+ ED beds]** isn't lost but function and capacity are allowed to change according to current needs and best practice. Retention of staff, both TDHB hospital and primary (both TDHB and private) has to take its true position, which will mean a major change in management function, attitude and even numbers.

I have called this model Roma Tika Plus [xviii]. It has been developed by local clinicians and designed to have resilience, efficiency and the ability to support local and visiting clinicians. It does remove excessive management by having a locally based advocate as South Taranaki General Manager replacing the Hospital Manager position and promotes the retention of medical practitioners in South Taranaki by valuing and supporting them. It continues to be compatible with Project Splice, Whānau Ora, IFHCs while recognising and supporting other primary health care delivery, such as the small GP practices which account for 50% of the population.

It specifically avoids any attempt to generate an income stream for the TDHB as this is not the South Taranaki's responsibility. I believe it is the efficient delivery of healthcare which will save money by disease prevention, early detection and timely management, avoiding costly and poorly productive late interventions. The evidence is that a better ratio of GPs to specialists gives better outcomes for less cost.

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[xii] Hawera Hospital Overnighters and Day Stay (am shift) **Trendcare figures** Oct 2010 – June 2011 http://www.drblayney.com/Hawera_IPbeds_Oct10-Jun11.pdf

[xiii] **Medical Council Medical Workforce Survey 2010** pgs 17 & 18 (by TA, New Plymouth has 66 GPs/100,000, Stratford has 57 and South Taranaki has 33, the 2nd lowest in NZ. NZ total is 74 FTE GPs/100,000. http://www.mcnz.org.nz/portals/0/publications/Workforce_2010.pdf

[xiv] Reported on "Target", TV3 26 July 2011

[xv] "**Physician-leaders and hospital performance**: Is there an association?"
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