



HOSPITAL ADVISORY COMMITTEE

MINUTES – PUBLIC - unconfirmed

Tuesday 29 September 2009

10.00am

Corporate Meeting Room 1

Base Hospital

David Street

New Plymouth

Present:

Peter Catt (Chairman), Jenny Nager, John Young (ex officio) (Board Members), Jan Dunlop, Brian Jeffares, Peter Moeahu (co-opted members)

In Attendance:

Tony Foulkes (Chief Executive), Joy Farley (General Manager Hospital Services), George Thomas (General Manager Finance & Corporate Services), John Doran (Chief Medical Advisor), Rosemary Clements (Clinical Services Manager), Paula Hakesley (Service Manager Mental Health & Addiction Services), Katherine Fraser-Chapple (Management Accountant), Sue Carrington (Media Advisor), Pamela Hikuroa (PA to Board)

512.0 Declaration to Open Meeting

The meeting was opened with a karakia at 10.00am.

Members of the Hospital management team were welcome. Managers would attend the Hospital Advisory Committee meetings to speak to reports and gain experience.

513.0 Apologies/Leave of Absence

Karen Eagles, Kura Denness (attending Allied Laundry Board meeting), Dan Devadhar, Grant Knuckey (Board Members), Nic Boheimer (Co-opted Member)

514.0 Conflicts of Interest

The Register was circularised for updating by members, with no new interested being declared.

515.0 Minutes

Resolution

That the Hospital Advisory Committee resolve to accept the minutes of the meeting held on 29 August 2009 as a true and correct record.

Jeffares/Nager

Carried

516.0 Presentation

516.1 Update on Future Workforce/Medical Training

Dr Doran, in introducing the presentation advised that he would be focusing on Doctors but all the comments applied to the total clinical workforce nurses and allied health workforce.

He noted that the sector still needs to gain a better understanding of the needs of the Allied Health workforce to develop ways to support those groups.

Reports

- Past year large number of reports presented on medical workforce training and education
- All resulted in basically highlighting the same problems
- His view is that the current crisis in medical workforce, will continue for the foreseeable future
- A coherent planning structure nationally around medical workforce in widest context is still in development.

Taranaki Doctors

Resident Medical Officers (RMOs)

- Currently 59 junior doctors working in the hospital
- Consist of –
- 11 First year house surgeons. Will receive general registration at the end of their year of provisional registration.
- 2 of them are international medical graduates. New Zealand health workforce has huge reliance on international medical graduates. Somewhere between 40-50% of all doctors in New Zealand are international medical graduates. This needs to be taken into account for workforce planning.
- 3 of the current first year RMOs have received scholarships through Taranaki Base Hospital.
- Now seeing the value of the scholarships. 25-30 scholarships awarded across variety of specialties.
- First year RMOs very secure workforce as only provisionally registered which is in contrast to the Year 2 and 3 RMOs.
- 17 RMOs are Year 2, 3 or 4 and at various stages of their regional registration
- (2 international graduates included in this group).
- 8 international doctors – obtaining overseas experience
- Only 3 RMOs who were with us Year 1 are included in this group which highlights the mobility of the workforce. Expect young doctors to seek overseas experience but does create problems for the DHBs

- 30 registrars – this is a stable workforce in most specialties as they are locked into training programmes and have to fulfil certain requirements to advance through their training. Some directed to come to us.
- Registrars workforce increased in last 10 years.
- May and August large number of vacancies which reflects mobility of Years 2, 3, 4, junior doctors.
- Full quota until end of second quarter when will have 8 vacancies
- Likely will require 10-12 locums until UK graduates arrive in mid-August
- Overseas experience great opportunity for Junior Doctors but creates problems in terms of providing service and continuity of service for the organisation.

Senior Medical Officers (SMOs)

- 96 hospital specialist by head count, this includes part time doctors
- 6 Hawera
- 5 MOSS – special skills
- 2 medical officers
- 69 general practitioners
- Number of GPs may appear large but when look at FTE of practitioners per 100,000 population equates to 59 which is lowest in country
- South Taranaki ratio is even lower
- No definite ratio set but generally accepting one GP per 80,000-100,000 population
- In terms of senior medical officers, most critical issue at the moment is lack of General Practitioners
- Hospital specialists essentially fully recruited except in medicine.
- Successfully recruited to number of long standing vacancies (Psychiatry and Obstetrics) and pleasing that after 8 years have recruited a Geriatrician. This is junior doctor returning to Taranaki
- ED fully staffed but using locums. Locums tend to be American doctors here for 6-12 months
- By and large gaps if all goes well will be sorted expect for medicine and ED
- General Practice remains an issue with locums being required.
- Very active recruitment underway, particularly in South Taranaki for GPs and there is a reliance on international medical graduates in this area.
- At present do not retain the international medical graduates need to understand why and tailor programmes in order to improve retention

Future

- In response to increased number of medical graduates, have vision for developing a Health Education or Training Campus here at Base for all health care workers
- Aim to provide training with view to longer term recruitment to work in Taranaki
- Integrated training programmes - future will mean when young doctor or young health care worker starts as student a programme established to cater for the requirements of the particular student.
- General practice runs – DHB with Clinical Training Agency Funding will be establishing General Practice Runs for second year RMOs. This

will introduce young doctors to general practice but also way of retaining those second years because different run that not lot of other DHBs offering.

- General Practice Registrars – Pilot project funded by Clinical Training Agency. Hopefully have 4 registrars employed by the DHB training in general practice. This is a different model from previously where no relationship with DHB.
- Must be innovative in recruiting and retaining medical staff. Using NZ health workforce web site.

Altered Work Practice –

- Recent workforce papers highlighted different work practices being developed, eg physicians assistants which is an American model.
- Expect to see more nurse practitioners or expert nurses.
- Taranaki already has some expert nurses and nurse practitioners and this number will grow and develop as senior nurses want to change their practice to other areas.

Discussion

Ms Farley emphasised that all the strategies and issue outlined in the presentation applied equally to nursing, allied health etc.

Questions were raised around role of nurse practitioners and nurse experts. Ms Farley advised that the nurse practitioner followed extensive training (at masters level taking up to 4 years) and worked to a particular scope of practice identified by their registration. They were accountable for this advanced scope that included prescribing rights. An expert nurse was one recognised as expert in their field and may have done advanced training but remained registered under the general register.

Ms Farley advised that the requirements for Nurse Practitioners or expert nurses depended on the factors such as the environment, workforce makeup and the size of the DHB. For the base hospital there was a view that expert nurses would be preferable but in say Auckland in specialised areas there may be a preference for nurse practitioners and physicians assistants. For the NGO sector nurse practitioners were suited and would be supported by the DHB.

A flexible workforce in the future which met the needs of the health sector was the aim.

Questions were raised as to whether the Taranaki culture was seen as encouraging and supportive to Junior Doctors and the Medical Schools. Dr Doran advised that he believed that from feedback received from students Taranaki was seen in a very positive way due to the experience they received in terms of actual contact with patients, contact with senior junior doctors and clinicians. This was mainly due to the size of the hospital which enabled easy contact.

With respect to ED it was noted that this was the 'window' to the hospital and the committee questioned whether the use of locums was under-estimating the importance of the area to the community. Ms Farley advised that locums were only used due to the difficulty in recruiting. Dr Doran also advised that work was in progress to develop the ED to gain college approval as a training site which will help to encourage retention of personnel. He noted that two

American locums had agreed to stay and go through the college and obtain qualification which was due to the fact that they enjoyed living in Taranaki. It was also the intention to look at developing a training base for psychiatry.

517.0 Management Reports

517.1 General Manager Hospital Services

Ms Farley took report as read highlighting

- Financial result better than plan. Noted that the figures for the budget had been transposed and apologised for this error.
 - Note of caution with respect to the result. The result was driven off two factors - underspend in pharmaceuticals and clinical supplies.
 - Highlighted that another issue which would face the service was the introduction to the market of biologics.
 - Dr Doran advised that biologics was the name given to particular groups of medications which focused on the auto-immune processes. They were not curative but disease altering in a positive way. Universally expensive and required on-going use. Looking potential costs in the hundreds of thousands per individual. This was an area which would develop over the next two to three years and at present there was no national plan on usage. Chief Medical Advisors were considering this matter.
 - Achieved contract for casemix and maintained elective service delivery
- General Service Issues –
- Series of reviews underway – Allied Health, Oral Health Strategy, booking office, Hawera Hospital
 - Currently using MidCentral to deliver ECT services

Finance

Ms Fraser-Chappel noted that Hospital Service was close to budget for different number of reasons. Outsourced clinical services low as DHB not sending work to Southern Cross. Over budget in locums. Pharmaceuticals has biggest impact on hospital budget.

Mental Health

Ms Hakesley spoke to report

- Budget variance number of factors.
- In patient unit lower occupancy than previous month but had very high acuity.
- Large number of adolescents and older adults and also some in patient unit staffing requiring 2:1 care 24x7 had been necessary.
- Contracts with two psychiatrists signed with commencement date March.
- Involved in two large projects:
Key performance indicator national project phase 2 Mental Health Services
Child and Adolescent Mental Health Services Continuum Care – how provider and NGO sector work together to provide better range of services for Maori and non-Maori children and adolescents.

- Noted that Taranaki DHB was only DHB with kaupapa NGO partner. DHB had a number of joint venture arrangements with NGOs for the provision of services which had been operating very successfully for a number of years.

Discussion

In response to a query on progress with the review of ED services in Hawera, Ms Clements advised that the working groups were in place and feedback was that all staff were participating with some good ideas coming forth.

Clarification was sought regarding the outstanding KPI for the Emergency Department.

Ms Farley advised that the DHB indicator of performance was for 95% of patients to be discharged from ED within 6 hours. For Base Hospital this target was not achieved. The Ministry's Emergency Department Advisory Group had visited recently to look at our progress in this area and a pleasing report had been received. It was noted that the first 80% was able to be achieved with the least amount of effort but the remaining part was more difficult and this was where we were at currently.

There were many reasons why patients were not discharged within this timeframe, eg chest pain pathway. In many instances other operations in the hospital impacted on the ability of ED to meet the target, eg bed blockage. It is well recognised that this is not just an ED problem and work was ongoing to enable the target to be met.

General discussion took place around the recent newspaper articles with respect to a patient discharged from the hospital with a Venflon still in place.

Ms Farley advised that meetings had been held with a family and it was noted that there were quality issues over discharge arrangements which required improvement. She also advised that it was not possible to promise that such an incident would not occur in the future but every endeavour was made to ensure that this would not occur.

There were highlighted issues around the discharge of frail elderly and work was underway to ensure that supports were in place to trigger referral to the appropriate service.

The recent newspaper article regarding the Minister's praise of the DHB's level of elective surgery was noted and questions raised on the level of elective surgery to be undertaken in the current year. Ms Clements advised that additional elective surgery would be undertaken as per contract but it was not the intention to deliver more than plan as had occurred in 2008/09.

Resolution

That the Hospital Advisory committee note and receive the report and attachments.

*Nager/Jeffares
Carried*

518.0 Date of Next Meeting

The next meeting is scheduled to be held on Tuesday 27 October in New Plymouth.

The meeting closed at 11.20am

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Chairman

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Date