New Zealand Rural Hospital Network

NEWSLETTER

June 2013

CHAIRPERSON'S REPORT

Welcome to our second newsletter for 2013. The year has started with a bang for the New Zealand Rural Hospital Network (RHN)!

New Zealand Rural Hospital Network Workshop/ Conference

On 14 March 2013, RHN held its second annual workshop/conference in Rotorua as a tag on event to the New Zealand Rural General Practice Network (NZRGPN) conference. We were lucky enough to have Ray Anton, Secretary, represent the RHN on the NZRGPN conference planning committee, which ensured the hospital components were a part of the day.

During the RHN day we had a high-quality workshop which was attended by a small, but enthusiastic group.

The following items were covered during the workshop;

- The New Zealand Institute of Rural Health provided an update on the research work they are undertaking.
- Roy Davidson (Telemedicine project leader), Northland District Health Board spoke about the work they are doing in Northland around telemedicine, this lead to a lengthy discussion around outpatient clinical management and how technology could improve the service delivery of health services to our rural communities.
- Ray Anton provided an update on our annual plan.
- Dr Peter Rodwell gave a brief update on the importance of rural research.
- Nikki Close, board member and Manager of Te Aroha Hospital gave a thought provoking presentation about the Shake Out Day 2012 of which during this 24 hour period all services (running water, electricity and telephones) had been cut to the Hospital.

Thank you to everyone who attended and supported the 2013 RHN workshop/ conference. Thank you also the NZRGPN for allowing us to be a part of the organising committee.

If you would like a copy of any of the presentations please contact Kylie Paish at kylie@rgpn.org.nz.

2013 Annual General Meeting

During the 14 March workshop day we were scheduled to hold the Annual General Meeting, unfortunately we did not have a quorum. As we did not have a quorum for the AGM an electronic Special General Meeting was called for , for 21 March 2013. Please remember if you are not able to attend the AGM please send in a proxy form which is enclosed in the AGM supporting documents.

Constitutional Changes

Currently we are in the process of changing the constitution to enable the RHN to gain charitable status with the Charities Commission. To make any changes to the constitution a Special General Meeting is required. You all should have received notice of this via e-mail. This takes place on Thursday 27 June 2013. Again it is an e-mail vote.

It is imperative that all members vote in this forum. Once we have these changes signed off we can go forward to become a charitable trust. It also means we will be able to get on with the business of moving forward and concentrate on how we can become more proactive in helping you deliver health care in your community.

Final thoughts...

Thank you to those who have contributed to the newsletter and continued support of the RHN. If you or someone you know is interested in taking on a more active role within the RHN please contact me at jen.thomas@northlanddhb.org.nz.

Jen Thomas
Chairperson
Rural Hospital Network

New Zealand Rural Hospital Network

STUDENT PLACEMENT
DARGAVILLE HOSPITAL

BY JENNY BEESLEY AND JOSHUA SAPONG KNUDSEN

Below is a report from two of the 5th year medical students who were on placement at Dargaville Hospital at the start of the year. Jenny and Josh had their first placement at Dargaville as part of the Pukawakawa programme. Thanks to both of them for submitting this report.

Having just arrived in Northland, as part of the University of Auckland's Pukawakawa regional-rural immersion programme, we were sent straight to Dargaville Hospital for our Integrated Care and General Practice attachment.

For a fifth-year medical student, Dargaville Hospital presents an excellent learning opportunity – not least because all of the staff (without exception) are genuinely happy to share their knowledge and to teach students. The caseload is varied and the programme, administered by Jen Thomas and supervised by Dr. Liz Humm and Dr. Laurie Herd, is flexible – which allowed us to set our own goals and choose where we focused our learning. This is unique to the regional hospital teaching in fifth-year and really allowed us to get the most out of our time in Dargaville.

The time spent on the 12-bed medical ward with Dr. Derek Gibbons was equal to any medical run in any large hospital – with the added bonus of one-on-one teaching from an experienced consultant whenever we wanted it. Now there's something you're unlikely to find in Auckland or Hamilton! The cases we saw were surprisingly diverse and included a subarachnoid haemorrhage, myocardial infarctions, arrhythmias, sub-acute small bowel obstructions and the advanced management of several palliative care patients.

We both got to spend time with Mandy, the Paediatric Nurse, and the home visits we experienced were a real privilege and very interesting.

She, like many Dargaville staff, seemed to know almost everyone in the community. This really helped her work, in keeping an eye on vulnerable children and families, and it also helped us to integrate well into the town during our 8 week stay.

There were plenty of opportunities to see patients at Dargaville Medical Centre, too. Sometimes when it was busy, we really felt like we were making a useful contribution by seeing emergency patients and recommending management plans to the GP supervising us. We also gained valuable experience in Dr. Herd's minor skin surgery clinics. Our time with him was definitely the single best opportunity we've had so far in medical school to learn about dermatology.

The Community Mental Health team, headed by Dr. Margaret Honeyman, was a stand-out in terms of the enthusiasm and support that every member of staff afforded us. It was a real privilege to be allowed to work alongside the team, visiting clients at home, going out on crisis calls and following up clients who were admitted to the Tumanako inpatient unit in Whangarei Hospital.

There were also opportunities for us to learn from the District Nurses, the Alcohol and Drug detox unit, the laboratory, hospice, Te Ha Oranga Maori Health Provider and St. Johns ambulance.

It wasn't all work, however: Dargaville is ideally placed for fishing, surfing, road cycling and generally getting out and about and seeing the Kaipara district. We made many trips out to Baylys Beach (once in an aeroplane – thanks to Dr. Greg Van Der Hulst) and north up to Kai Iwi Lakes and Waipoua forest. Laurie Herd is a keen fisherman and we were lucky to get the chance to go out on his boat and catch some kai moana for dinner one night.

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STUDENT PLACEMENT
DARGAVILLE HOSPITAL

Craig, the final year Occupational Therapy student living with us, just happened to be a mean hand at gutting and filleting snapper and the three of us ate ridiculously well that week!

By the end of our stay, we didn't want to leave. Eight weeks seemed to go so fast, yet we had made so many friends and learnt so much medicine. We were both converted to small-town hospital medicine – I mean where else do you get to excise skin cancer, cardiovert a patient, go for a swim and then hop in an aircraft and go for a fly all in the same day?!

Thanks to everyone in Dargaville Hospital who so generously gave their time to teach us. We had a fantastic experience and both hope to return sometime in the future.

Jenny and Josh

CORPORATE MEMBERSHIP SPECIAL BENEFIT WITH NZMEDICS

At NZMedics, we pride ourselves on being able to offer you a comprehensive and stress free service which makes us the **medical recruitment agency of choice**.

Our team of highly skilled and knowledgeable staff, who have an excellent understanding of and empathy for New Zealand, are key to the success of our services.

We are committed to providing you with a professional and personalised service tailored to meet your needs.

What's more, NZMedics is proud to offer all RHN corporate members a discounted rate on recruitment services, so contact us now to find out more.

NEW ZEALAND RURAL HOSPITAL NETWORK CONFERENCE 2014.

The Rural Hospital Network is planning on participating in the next New Zealand Rural General Practice Conference in 2014 and as such will host a series of presentations within a Rural Hospital stream of the conference.

The purpose of this communication is to invite members to present at the conference on a topic that relates to rural hospitals and health centres. The conference is scheduled for 13/14 March 2014 in Wellington.

Here are some ideas of topics that could be considered:

- Explosion of compliance costs affecting rural hospitals disproportionately.
- Where are rural hospitals going with Physician Assistants as compared to Nurse Practitioners, and in what roles.
- Where and should rural areas manage emergencies, the Emergency Department vs General Practitioner debate, and how this affects after hours coverage?
- Management of stroke in rural areas.
- Management of cardiac patients in rural areas.
- Alternatives to outpatient clinics, Tele dermatology, diabetes nurses, GPs with special interest (skin lesions, etc...), diagnostics access for elective cardiac referrals, so on. What can we do in rural areas to provide a better, sooner, more convenient service?
- Examples of public, private arrangements within rural hospitals.
- The generalist nursing role within rural hospitals and its challenges, not least of which is maintaining needed competences.
- AROC, FIM and how rural hospitals are excelling at providing a comprehensive rehabilitation programme.
- Examples of Integrated Family Health Centres.

The previous listed items are just examples of topics that can offer a forum for demonstrating the excellent innovation that is being achieved in rural hospitals. Any other innovative projects or ideas would be welcome.

The Rural Hospital Network is looking forward to hosting this stream and providing a national forum for our members to share out achievements and an opportunity to learn from each other and also network.

Speakers at the conference will receive complementary registration to the whole conference and free attendance at all social functions.

If you are interested to speak at the conference next year, then please provide the following details:

1. Title of session (40 min including 10 min Q&A)
2. Name and contact details, phone number and email.

Please provide the above information to:

Ray Anton
Secretary
New Zealand Rural Hospital Network
ray.anton@chf.co.nz
027 229 9960 to discuss.

We need to firm up the conference content by the 15th of July.

I hope that you are as excited at the prospect of this conference as I am and look forward to your feedback.

Ray Anton
Secretary

New Zealand Rural Hospital Network

ISSUE THREATENING VIABILITY OF RURAL HOSPITALS

In 2001 legislation setting how hospitals were regulated changed significantly with the Introduction of the Health And Disability Services (Safety) Act 2001, and the introduction of service specifications to determine how these hospitals should operate. In theory, this seems to be a sensible and reasonable way to ensure hospitals are run to proper standard, something we all want in New Zealand.

Sadly, in practice 13 years later we are seeing the service specifications prescribed by this act evolve to a level where they do not meet the needs of the small rural hospitals, and are in fact placing rural services at risk due to unrealistic audit and compliance expectations and costs.

This report has been prepared by the charitable company who operates a small rural maternity hospital, on behalf of the community. This model of operation has worked effectively for approximately 25 years to provide what the community considers to be essential services in a remote rural location.
The purpose of this report is to highlight government controlled issues threatening the sustainability of services in remote rural locations. We aim to highlight the challenges faced in one remote rural community, and urge others who are experiencing the same difficulties to address this with the government through their local MP.

About the Example Hospital:
The example hospital is in a remote rural location, providing services to families in a large geographical location. The hospital offers primary birthing services through Independent LMC's (Midwives), and postnatal stays. The hospital was opened in 1956 and government run until early 90's.

For the last 25 years it has been run by a community owned charity. The hospital is well staffed, well operated with an excellent record of safety and compliance. The hospital has been recently refitted to a high standard.

The example hospital has recently been hearing from it's DHB that services are unsustainable in it's remote rural location. The factors that can be influenced by the operators of the hospital seem to be more sustainable now, than in the past, including:

- Use of hospital is very good considering population, population is stable
- More midwives based in the area than ever before
- Good staffing level, of well trained professional nursing and support staff
- Consistently high level of safety and compliance
- High level of satisfaction by users of the service.

It is factors controlled by the DHB, Ministry of Health and Government that are actually making the service unsustainable. Two key issues are:

- Reduced funding level
- Increasing cost of compliance

This is at a time when government policy assures "Better, Sooner, More Convenient Healthcare", and the government appears to be putting more funds into maternity services and health in general. This raises serious issues about the measure used to determine the 'sustainability' of health (and other) services in remote rural locations, and the process that determines which services are considered to be of value when applying funding.
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ISSUE THREATENING VIABILITY OF RURAL HOSPITALS CONTINUED

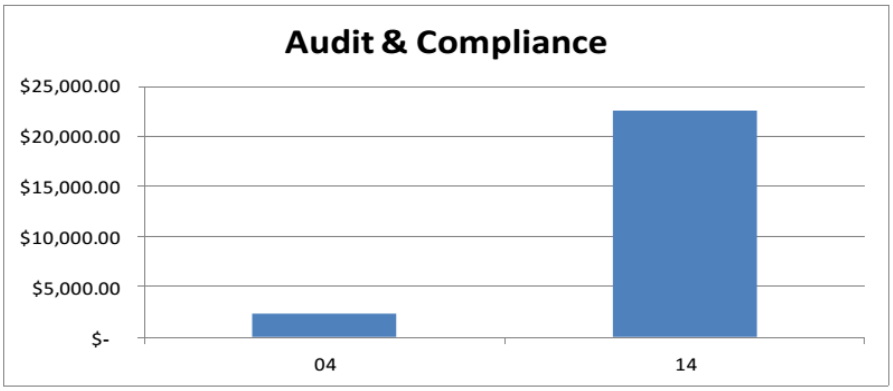
Residents in remote rural locations deem their health services as necessary and consider they have a right, like all New Zealanders, to access quality health care in their community.

Non-profit rural health trusts are an efficient and cost effective way of providing health services where larger providers cannot. This has to be recognised and supported. The rising cost of Audit & Compliance requirements and reduced funds are two key threats to the sustainability of these rural health services.

The Rising cost of Audit & Compliance

Not only are hospitals facing massive price hikes in the cost of audits, but the audit regime is constantly changing, with new audits being introduced and the time frames becoming more frequent. Only ten years ago the main Audit & Compliance cost consisted of building related compliance. There was a small cost each year involved with building warrant of fitness, but the main cost of $2000-$3000 was fire safety compliance.

Only Ten years later the example hospital is expecting to spend over $20,000 in audit and compliance for financial year 2013-14 based on quotes received for scheduled audits. In a decade Audit and Compliance has become ten times more expensive.



What Makes Up Audits & Compliance

Building Warrant Of Fitness:

This has been around for a long time and is an annual cost. The current cost is around $500 per annum for the building inspection. Only one provider can realistically provide this service in the remote rural location.

Fire Safety

This requires monthly monitoring and testing of Fire Safety Systems. Current cost is approximately $5000 per annum. Only one provider can realistically provide this service in the remote rural location.

Baby Friendly Hospital Initiative

Three yearly audit from a single provider being NZ Breast Feeding Authority. The focus of this audit is around systems, training and procedures to encourage and achieve baby friendly objective s in hospitals (mainly breast feeding focused). The cost of this audit is currently around $6000 Ministry of Health – Hospital Audit.

This auditing regime is required by MOH to retain hospital registration. It is made up of two parts:

Three Yearly full Audit:

Full audit of all hospital systems, policies and procedures and evidence to support implementation of policies and procedures, physical site inspection. The cost of this years full audit is approximately $10,000. The example hospital must pay for all travel costs and disbursements of the auditor (air travel, accommodation, rental car etc).

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Annual Surveillance Audit:

A follow up audit that focuses on issues arising from the full audit. 1 day site inspection and paperwork audit. The cost of the annual surveillance audit is approximately $3000. The example hospital must pay for all travel costs and disbursements of the auditor (air travel, accommodation, rental car etc).

These audits are carried out by only four companies nationwide, only one is based in the South Island.

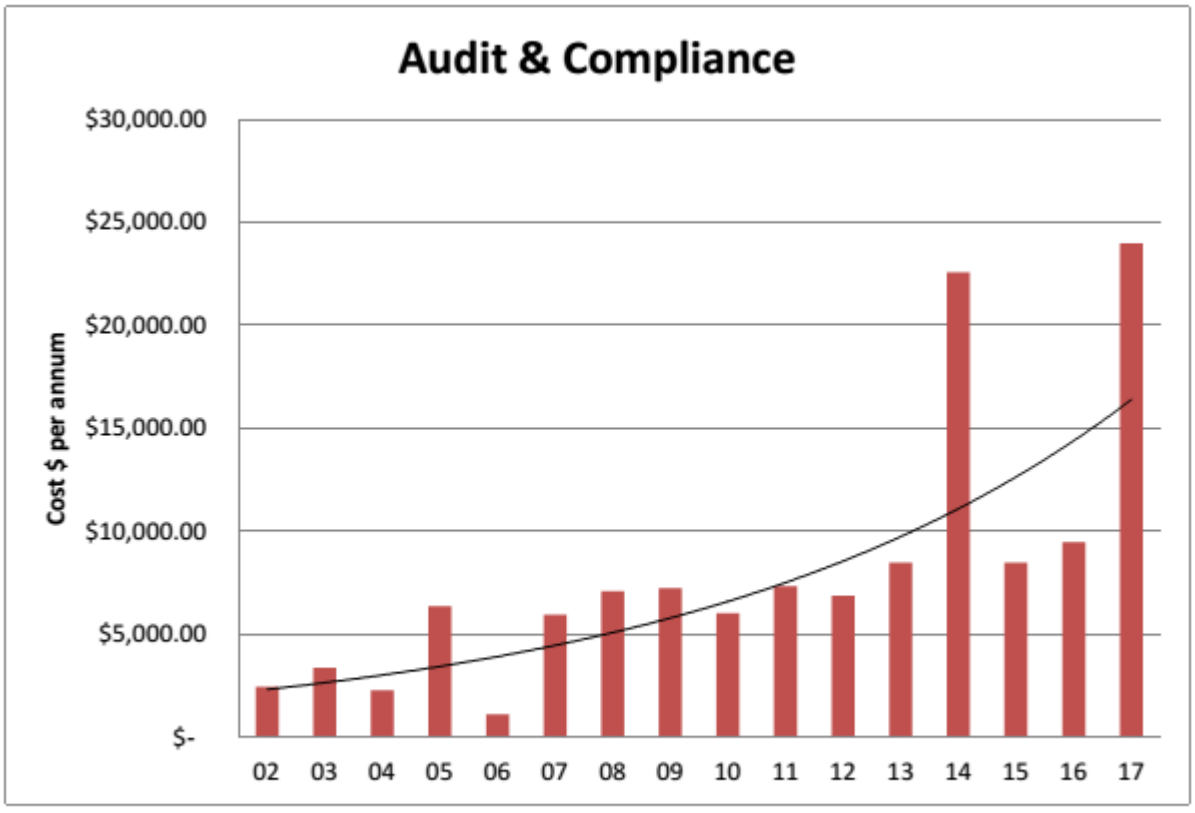
Combined Cost of Audit

The following is audit and compliance cost for the example hospital, both historical and projected.
The graph shows the extent of the rapidly rising costs in this regard.

Price Hikes in Audit & Compliance

Price hikes amongst a very limited number of private audit and compliance providers seem to be common place now with prices dramatically increasing, well beyond the rate of inflation. We believe this is occurring due to a very limited number of providers of services nationwide. Because we must comply, the purchaser of these services has no negotiating power and there seems to be little motivation amongst providers to be competitively priced.

There is also a disturbing trend of more rigorous requirements being placed on the auditors, such as the requirement for the auditors to be audited. The Baby Friendly Hospital Initiatives audit is a relatively new auditing regime. There is only one provider nationwide of this audit being New Zealand Breast Feeding Authority. There is no choice but to pay whatever cost they request. This cost is currently approximately $6000 for a 2 day audit. *Continued on next page...*



2014 & 2017 are 'double audit' years, in that there is an MOH full audit and BFHI audit in the same year.

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Audit Schedule – Example Hospital

2002	$2,449	• Fire Safety • Building Warrant of Fitness
2003	$3,385	
2004	$2,279	
2005	$6,389	• Fire Safety • Building Warrant of Fitness • Ministry of Health
2006	$1,118	• Fire Safety • Building Warrant of Fitness
2007	$5,951	• Fire Safety • Building Warrant of Fitness • Ministry of Health
2008	$7,096	• Fire Safety • Building Warrant of Fitness • Ministry of Health – Full Audit
2009	$7,247	• Fire Safety • Building Warrant of Fitness • Ministry of Health – Surveillance
2010	$6,030	• Fire Safety • Building Warrant of Fitness • Ministry of Health – Surveillance
2011	$7,334	• Fire Safety • Building Warrant of Fitness • Ministry of Health – Full Audit
2012	$6,878	• Fire Safety • Building Warrant of Fitness • Ministry of Health – Surveillance
2013	$8,500	• Fire Safety • Building Warrant of Fitness • Ministry of Health - Surveillance • Baby Friendly – Self Audit
2014	$22,000 (quoted)	• Fire Safety • Building Warrant of Fitness • Ministry of Health – Full Audit • Baby Friendly – Full Audit
2015	$8,500 (estimate)	• Fire Safety • Building Warrant of Fitness • Ministry of Health – Surveillance
2016	$9,500 (estimate)	• Fire Safety • Building Warrant of Fitness • Ministry of Health – Surveillance
2017	$24,000 (estimate)	• Fire Safety • Building Warrant of Fitness • Ministry of Health – Full Audit • Baby Friendly – Full Audit

Tip of the Iceberg:

The actual amount paid to auditors is only the tip of the iceberg when considering the cost of audit to small rural facilities. There are very large costs associated with such a rigorous compliance regime.

On the current level of funding the example hospital can only afford to pay a part time manager for 8 hours per week. As the business is only small, this would usually be sufficient to meet the needs, however preparing for and working through two audits this year will take up almost six months of this managers entire time. There will also be considerable input required from the volunteer board members in the review process, and considerable demand placed on limited administration, support staff and nurses.

A certain proportion of this time working on policy and systems will be time well spent as reviewing systems etc is beneficial for the business. But the rigorous nature of the process, actually designed for larger hospitals, is disproportionate to the size of the business that simply cannot justify this amount of resource being spent on compliance.

The massive amount of human resource put into audit and compliance would be better spent on quality improvement programmes, training and actual care of patients.

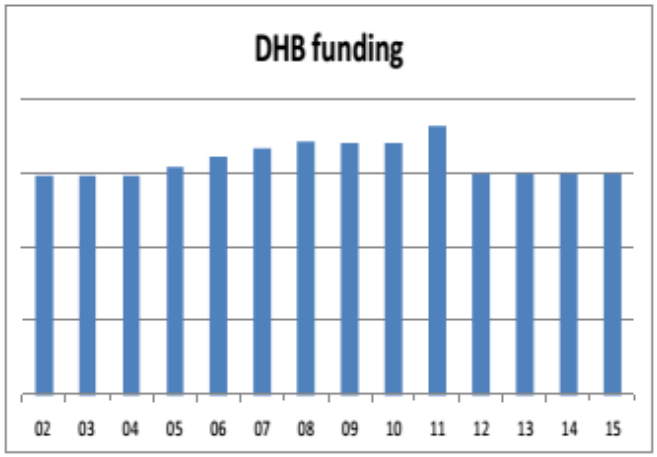
The Funding Environment:

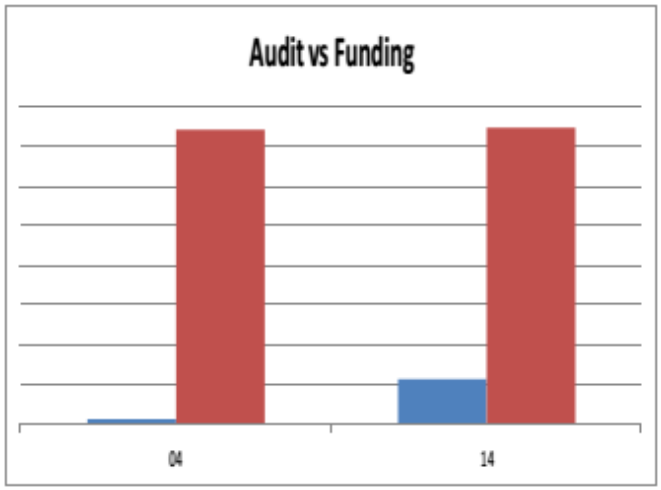
The latest contract for provision of Maternity Services from the DHB represented an 18% decrease in funding.

This brought funding back to the same level received in 2002, over a decade ago. The graph demonstrates the reduction in funding, effective until 2015.

The example hospital did not accept this funding decrease lightly, however it was very strongly presented in an 'accept it or close down' context, with no negotiation possible. It was not felt this funding offer was made in goodwill.

Obviously the above funding model has not, and will not keep up with inflation. Costs have been trimmed, and savings through efficiency made, but at some point as funding reduces and costs increase services will become 'unsustainable'.





Conclusion:

It is felt that audit and compliance is out of control with constant price hikes and a totally unrealistic ratio of audits to patients for small rural facilities. This is being faced in a reduced funding environment for the example hospital, so of course it is appearing that remote rural services are becoming unsustainable in this location.

Some relief must be found from this situation which seems to be escalating, and is hugely out of proportion to the size of the facilities under this extreme pressure. The Government departments instigating this audit and compliance regime must recognise that not all hospitals are the same, and relief must be offered to small rural facilities to recognise the important role they play in providing services to remote rural locations.

We must also bear in mind the importance of integrated service, being aware that a threat to one component of our rural health provision could easily place other services at risk and place the entire integrated service at risk.

Summary:

Steeply increasing Audit and Compliance costs in reduced or static funding environments is a major threat to the provision of rural health services.

These issues are beyond the ability of the community to control.

Key Issues:

Audit & Compliance costs are essentially the same regardless of the size of the hospital and the services provided.

Audit providers' charges are rising dramatically, particularly for rural hospitals.

Cost of audits goes beyond the auditor's charges. Staff spend non-proportional amount of time and effort preparing for and completing the audit process.

In FY 2013-14 our example hospital expects to spend 15% of total funding on auditing charges (excluding financial audit, staff time, and associated costs).

These issues seem to be consistent right across the region where our example hospital is located.

We feel Members of Parliament must be made aware of these issues to bring about change at a government level.

For further information please contact

Ray Anton
Secretary
New Zealand Rural Hospital Network
ray.anton@chf.co.nz
027 229 9960 to discuss.

New Zealand Rural Hospital Network

RHĀNZ UPDATE

BY SHARON WARDS

The first meeting of the elected Rural Health Alliance of Aoteoroa New Zealand (RHĀNZ) Council took place on 13 June 2013. RHĀNZ was established as an umbrella organisation of many "organisations" which represent health and other areas of wellbeing for our rural communities. There is strong representation from a number of health organisations but membership also includes district councils, PHO's and trusts and the list is growing! The Rural Hospital Network was one of the founding member organisations and Sharon Wards (RHN) has been elected on to the council which was established following the AGM in March 2013.

The Council meeting focused on formalising the role of RHĀNZ and establishing its working priorities for the next 12 months. Robust discussion from a wide range of groups discussed some key topics:

- Determining the priorities for rural health in NZ.
- Overview of recent meetings attended;
  - NRHA Conference Adelaide, 7-11 April 2013,
  - Farmers Wellbeing Day, 23 April 2013
  - Farmsafe Rural Safety Day, 15 May 2013
- 8 top priorities of the National Rural Health Alliance Australia.
- Brainstorm the major issues impacting rural health in New Zealand.
- Prioritize issues (immediate, medium term, longer term)

Rural Health Alliance Aotearoa New Zealand

The outcome from this forum will see a focus on ensuring we have well researched evidence to support some of the issues that we believe we could make a difference about. It was agreed that there will be a focus from RHĀNZ on formalizing the rural health strategy, sharing current information, identifying where the gaps are in our models of care and support a research agenda. The focus for the conference that RHĀNZ is partner to with the New Zealand Rural General Practice Network (RGPN), in conjunction with the RHN will be a workshop forum rather than a "listening" one. This is the forum were we will further ratify the national health strategy. The conference programme will include a forum stream for RHĀNZ on one day and a keynote panel forum during the final day of the conference.

Towards the end of the council meeting we formally elected Dr Jo Scott-Jones as Chair which is an extremely positive signal of the close alliance this organization will have with RGPN. Two executive members of RHN are representatives on the RGPN and RHĀNZ board/council, so it is an extremely positive signal that the strategic priorities of RHN will continue to be represented.