NOTES OF THE HOSPICE TARANAKI MEETING
HELD MONDAY 11TH JULY 2011 AT 11AM – 12 NOON
AT THE HAWERA HOSPITAL LIBRARY

Sandra Boardman (TDHB GM Planning, Funding & Population Health), Jackie Broughton (TDHB Project Manager), Rebekah Barr (TDHB Administration Assistant), Kevin Nielsen (CEO Hospice Taranaki).

The group of five were given handouts including frequently asked questions, submission form and a copy of the Powerpoint presentation which Sandra Boardman went on to discuss. The Powerpoint gave an overview of where the information for the draft proposal had come from, who was involved in the process and what the main points of the draft proposal were.

After Sandra Boardman's presentation where she highlighted the three reasons for change ie
1) the TDHB deficit and increasing demand due to an ageing population
2) the ageing workforce and lack of sufficient staff in the future to deliver services in the same way
3) Specialists are saying we can provide better service

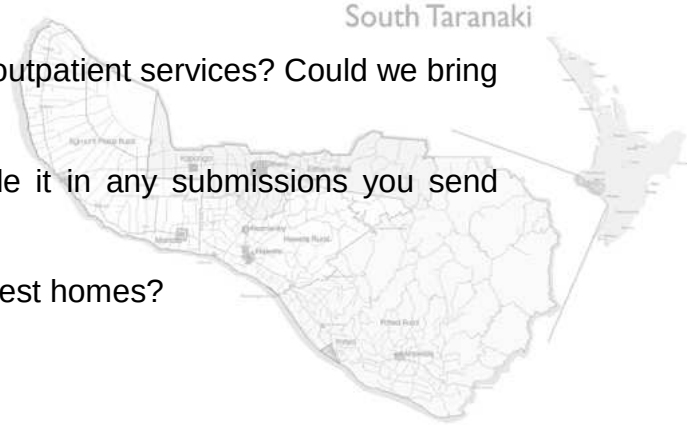
The group were provided an opportunity to ask questions, below is some of the questions and answers captured from the morning;

Comment. We need to ensure we have the right systems in place before rolling anything out. We need to make sure we do this in the right order.

A. Agreed however we may be restricted in some areas by the timeframes others have scheduled eg the National IT Board and moving to a single health record.

Q. Are intermediate care beds being used elsewhere in New Zealand?

A. Waikato have them in their rest homes and the specialists in Taranaki are supporting the move. Intermediate care may not all be in rest homes some will be in patients own homes. We require more allied health staff to support with rehabilitation services in home.



Q. Will this mean we get more community outpatient services? Could we bring preadmission type services to Hawera?

A. Yes this is a good idea, please include it in any submissions you send through to us.

Q. How would blood transfusions occur in rest homes?

A. This model would need to be discussed with Hospice on how we would go about training and providing nurse support. We would also need to talk to GPs and receive medical input from them.

Comment. We need to see medical collaboration between the Hospice and the TDHB. Medical staffing and resources provided are major issues that need to be addressed. The location of palliative care beds is not the issue, it's the resourcing of those beds with palliative care expertise.

A. We supported a shared specialist palliative care physician for the Taranaki region. However mid central DHB withdrew their support. We are keen to encourage GPs to develop experience in this area.

Q. Patients are admitted to Hospice not to rest homes because of the quality of care. Because patients see Hospice as being quality care there is now a waiting list. Patients are sent to the emergency department because they cannot get care and they clog up the wards.

A. This service isn't working for patients at the moment. We need a different solution.

Comment. Doctors are not prepared to work after hours.

A. There is a difference between a GP not wanting to work after hours often and working after hours on occasion, whilst being appropriately remunerated.

Comment. Hospice provide a funding package available for GPs who deliver palliative care to patients.

Q. Staffing is one of the main issues. Palliative care staff need after hours advice which they currently struggle to receive.

A. We are currently organising training programmes with medical graduates providing them an opportunity to train in our rural hospitals. We hope this will help them to create roots to the region and continue to work and live here.

Q. How are the palliative care beds in a rest home more cost efficient than if they were in the hospital?

A. The cost of a bed in the resthome is more than 3 times the cost of them being located in a resthome. If you include all the services required should they be in a rest home such as GP visits then it is still 2 times more expensive.

Comment. There has recently been a younger lady staying in a rest home receiving palliative care however I imagine a majority of younger patients would prefer not to.

Q. Would these palliative care beds be available for rest homes to use for their patients when they are not needed for palliative care patients?

A. No, these beds would be specially funded for palliative care use only. We would be very specific about all requirements these rooms would need right down to floor space. The standard of accommodation would need to be similar to that provided by Te Rangimarie Hospice in New Plymouth. We have to be aware that what we are talking about is a totally new service it could be similar to the maternity unit based at Elizabeth R in Stratford. In other words a separate and completely distinct service that happens to be co-located with a rest home.

Q. I am concerned around the timeframe for implementation, can you tell us about this?

A. Once we get the high level agreement on the proposal from the TDHB an implementation plan on each area will need to be written. This will take at least six months and will include a lot of discussion with stakeholders to ensure any roll out plan will be done over an appropriate timeframe for each service.

Q. Can you tell us about the ED doctor on call over night?

A. We had a meeting with doctors and GPs where they advised that we needed to maintain a 24 hour service. We have proposed that nurses would work overnight and triage as is currently the practice and they would deem if the patients illness was serious enough to call the doctor. There have been questions at other meetings on how appropriate it would be to wake a doctor for them then to diagnose a patient and there have also been questions raised about the doctors travel time to the hospital.

Q. Have you taken into account expenditure for this proposal?

A. Yes, it is at a high level. We expect to have more accurate costings by the time the Steering Group get to see the revised proposal.

Sandra wrapped up the meeting at 12 noon.