BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

one-two-one

GP LIAISON NEWSLETTER

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Service delivery and clinical governance enhanced under new structure

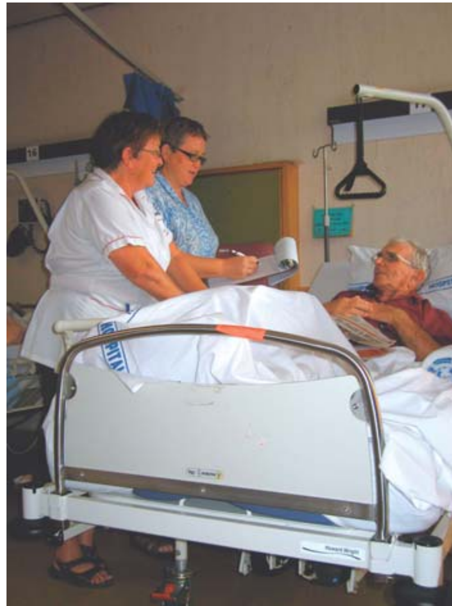
Bay of Plenty District Health Board has firmed up its provider arm, Pacific Health's structural changes, aimed at improving service delivery to the community and enhancing clinical governance within the organisation.

Changes in brief:

- Geographic alignment moving to a clinical services focus
- Development of eight 'clusters' – Mental Health; Surgical; Medical; Women, Child and Family; Clinical Support; Maori Health; Non-Clinical Support, Community Health and Disability Services.
- Doctors reporting through to the Medical Director, and Nurses reporting to the Provider Director of Nursing to enhance clinical decision-making.
- Reinforcing clinical governance principles through new clinician-led committees.

The new structure, which has its principles based on service delivery across the whole Bay of Plenty geography rather than aligned to a hospital site, sees Pacific Health move from a facility model to a service model, with 'cluster' managers responsible for the delivery of services across both Tauranga and Whakatane Hospitals.

Chief Operating Officer, Graham Dyer, explains that the service model will assist with better delivery and more equitable access to health care across the district by focusing on the service, rather than the facility or area in which the service is delivered.



The new structure will be effective from 3 July 2006.

GOOD NEWS ON CHRONIC CARE MANAGEMENT

There is a renewed interest in this subject locally, nationally, and internationally.

A recent article from the NHS summarises the situation in the United Kingdom.

"Medical advances provide treatment for illnesses that in the past were life threatening or fatal. However many people now live long lives with poor health and chronic conditions. Those with more than one chronic condition become heavy users of health services. We need to move away from episodic treatment, usually provided in hospitals, towards continuous, high quality care provided in the community."

This renewed interest is good news for our patients, as it is an area in which GPs in the Bay of Plenty already have a wealth of experience and expertise. Look out for articles appearing in the near future on the following subjects.

- The Primary Health Care Strategy
- Care Plus
- The Flinders Model of Chronic Care, from Australia
- Kaiser Permanente Models of Care, from the United States

There is no doubt GPs will become involved at some level. The health board is also interested in joining this discussion because of its impact on secondary care services, but also because it is funded to work with chronic care.

Hello Fellow GPs

I am now in this role 7/10 and I am in the process of tidying up my email lists for the purpose of sending you the GP Liaison Newsletter. If you receive a hard copy and you'd prefer an email version, please let me know. In this issue of One-Two-One, the waiting list issue continues to dominate as the 30 June deadline approaches, the Ministry of Health starts to get tough on some health boards and a Health and Disability Commissioner ruling has implications for GP referral letters.

Andy Humphrey
GP Liaison, BOPDHB

Implications of recent HDC ruling

Health and Disability Commissioner, Ron Paterson, recently ruled on the Southland case whereby a patient with a markedly raised PSA was not seen by a urologist within the required six-month time frame. The Southland District Health Board and the urologist were censured. As a direct result of this case, health boards around the country are now considering where the duty of care lies in the whole non-acute referral process. It seems that this duty lies with the GP until the patient's referral letter has been graded. If your referral letter does not contain all the information that the grading clinician requires, or if it is supplied in a form that makes grading difficult, it is likely that it will now be returned to you. In this situation, you will carry the medico-legal liability until the required information has been provided, and the clinician grades your referral. Of course, all this to-ing and fro-ing is likely to increase the chance that the referral may get 'lost' in the system, so it would seem more safe for you to include as much information in the first place for the clinician to go on. Primary referral guidelines are available at www.electiveservices.govt.nz/guidelines.html As far as I am aware there has been no ruling on where the duty of care lies for those patients who have been 'returned' from the hospital to your care. I would be interested in your thoughts. Email andy.humphrey@bopdhb.govt.nz

Not enough room to swing a cat!

It is election time. A politician who has been in opposition for what seems like an eternity is visiting elderly people in his electorate. He has a television crew in tow, hoping to get some vote winning footage.

One woman complains, "Look at this state house I'm in. It's tiny. It's a disgrace. There's not enough room to swing a cat!"

The politician senses a golden television moment. "This is terrible," he thunders with righteous indignation. "I can plainly see that this government has let you down badly. What you need is our leadership and our vision so that this situation will never happen again. Only my party can put an end to your misery."

He turns and looks directly into the camera. "If we are elected," he says solemnly, " We will bring joy and happiness back to this poor lady. We will not neglect her. We will provide for her. We will get her…" " He looks at the woman, "A smaller cat."

Atrovent/Spiriva combination problems

Please be aware that Atrovent/Combivent should not be combined with Spiriva.

Spiriva (Tiatropium) is the long half-life version of Atrovent (Ipatropium). Atrovent has a half-life of two hours, whereas Tiatropium has a half-life of somewhere around four days.

As both are derivates of Atropine, you could expect anticholinergic side effects if both are combined.

Most patients who have had problems with these drugs have not followed the doctor's advice.

Respiratory Department
Tauranga Hospital

ACUTE REFERRAL PROJECT

Following numerous complaints from both GPs and hospital doctors, I am arranging for a GP group to meet with hospital staff to formalise and agree on best practice for the following areas:

- GP referrals for urgent, acute and ED assessments
- GP referrals for acute admissions
- Referral from ED or in patient acute care, back to primary care, including discharge summaries.

Similar issues have arisen nation-wide and are part of the changing medical landscape. To date, six GPs have agreed to meet to develop policy and put this to hospital clinicians and ED staff.

These GPs are:

Sandy Dinsdale, Brookfield

John Gemming, 5th Ave

Kevin Giles, Farm Street

Rob Hilligan, Mount Medical Centre

Ross Ogle, Cameron Medical

Andy Humphrey, GP Liaison.

If you have an opinion on the subject, feel free to contact me, email andy.humphrey@bopdhb.govt.nz so that I can include your voice in the discussion. I'll keep you informed as this issue progresses.

ESPI Compliance Day approaches

'C' day is fast approaching for the health board as Ministry of Health compliance to managing waiting and treatment lists is expected by 30 June 2006. From that date onwards, the health board will only accept referrals from GPs for a First Specialist Assessment (FSA) that can be seen within six months of the referral letter being accepted by the grading specialist. In addition, if a procedure is recommended by the hospital specialist at this FSA, the health board will accept only those patients that can be treated within six months from the date the patient is offered this treatment.The Ministry of Health strategy is to ensure patients receive clarity, are treated fairly and in a timely manner. The days of languishing on hospital waiting/treatment lists for years will come to an end.

The health board has undertaken a review of each service where 'referrals in' exceed what can be realistically 'be delivered' within a six-month period taking into consideration what we are funded to deliver, resourcing levels and capacity. Access thresholds have been set for these services, which unfortunately has resulted in low priority patients being returned to their referral source, usually GPs. Where possible, treatment has been offered at Whakatane Hospital to this group of patients.

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