Review of Health Services in the Waitaki District

Report and Recommendations

8 August 2016

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1. Executive Summary

Southern District Health Board (SDHB) and Waitaki District Health Services (WDHS) have jointly undertaken this review to explore how best to provide sustainable health services for the Waitaki community. The review team of clinicians and management from the organisations participated in a series of workshops and community engagement meetings held between May 2016 and July 2016.

The Waitaki District Health Services Review Team asks the WDHS Board and Southern DHB Commissioners to endorse the recommendations below.

Strategic Recommendations are:

1.1 **Community based services:** Establish a community clinical care hub as a local single point of entry with the aim of keeping people well and safe at home

1.2 **Coordinated urgent care:** Implement a streamlined first response system to ensure people get the right care in the right place when they have urgent health needs

1.3 **Improved post-hospital discharge:** Improve processes for post-hospital discharge to reduce delays, avoid patient readmission and support return home

1.4 **Services closer to home:** Increase specialist outpatient services provided locally to ensure access to care is as close to home as possible and people only travel when they need to

1.5 **System communication and coordination:** Improve systems for communication and coordination to provide patient centred care through better use of technology and enhancing relationships within the healthcare provider community

1.6 **Workforce enhancement:** Develop and maintain a workforce that will meet the needs of future service delivery

1.7 **Measures of Success:** Adopt the following measures in the implementation phase as overall measures of success:

1.7.1 Decreasing numbers of ED presentations
1.7.2 Decreasing numbers of occupied bed days
1.7.3 Decreasing readmission rates
1.7.4 Increasing numbers of outpatients appointments completed locally
1.7.5 Increasing levels of patient satisfaction

1.8 **Implementation process.** Agree an implementation process as follows:

1.8.1 A working group be established to implement the recommendations of this review. A formal process will be undertaken for membership of this group
1.8.2 Provision be made for dedicated project management resource
1.8.3 A prioritised work plan be developed allowing adequate time for further consultation with staff, unions, Māori, and other key stakeholders. The work plan will include assigned responsibility for managing any proposed changes and timeframes
1.8.4 Detailed service models be produced including the framework for funding
1.8.5 A collaborative and alliance approach to decision making be taken, including upholding the principle of 'best for patient, best for system'.

2. Background

Southern District Health Board (SDHB) provides funding for Waitaki District Health Services (WDHS) to provide a range of health services for the Waitaki community including the services provided in Oamaru Hospital. WDHS and SDHB are currently engaged in contract negotiations and this review has been agreed to inform those negotiations.

This review presents the opportunity to explore how best to provide sustainable health services for the Waitaki community. The Review may also produce recommendations on how other services provided for the Waitaki population could be redesigned.

Strategic Context

Southern DHB is currently considering service delivery models as it works towards a health system that will meet the needs of its dispersed population in 21st century New Zealand. This strategic level thinking is informed by the DHB's Southern Strategic Health Plan which has six identified priorities:

Priority 1	To develop a coherent Southern system of care
Priority 2	Build the Southern health system on a foundation of population health and primary and community care
Priority 3	Secure sustainable access to specialised services
Priority 4	Strengthen clinical leadership, engagement and quality improvement
Priority 5	Enhance system capability and capacity
Priority 6	Living within our means

In addition to the Strategic Plan, Owning Our Future outlines immediate areas of activity and focus with particular reference to the principles SDHB will work to, key areas of performance improvement for 2016 and due consideration of organisational culture.

Waitaki District Health Services, as a provider within the Southern health system and a partner in this Review, are impacted by this strategic context.

Strategic Principles

The Review Team agreed to work using the following principle: a 'one health system' approach to health care in the Waitaki District encompassing hospital, community, primary and mental health services.

3. Goals and Objectives

The objectives of the review were to:

- Identify current challenges for service delivery for people in the Waitaki district, including the impact of population demographics, service delivery models, funding and workforce for WDHS and other services provided to the community
- Identify gaps in health and disability service delivery for the Waitaki population and how these could be addressed through service redesign
- Identify improvements in the service delivery models in the district to better meet the needs of the Waitaki community, improve the clinical and financial sustainability of services the Waitaki population receives, improve quality, and promote workforce sustainability
- Produce a set of recommendations for change based on improving the health outcomes for the Waitaki population through service redesign which is both clinically and financially sustainable

4. Methodology

4.1 The Review Team was established (members are listed in Appendix One and Terms of Reference are included in Appendix Two) and participated in a series of three workshops to explore how best to provide sustainable health services to the Waitaki District community. A final fourth workshop was held to review this Report, define measures of success and discuss next steps.

4.2 At the first workshop, the Review Team reviewed the following high-level data presentations for the purpose of identifying opportunities for improvement:

- Demographic summary with Waitaki population projections by age group
- Rates of projected population growth across all SDHB communities
- Profile of population using rural hospitals including the average age at admission and the usual location of residence of patients attending rural hospitals
- Oamaru Hospital Emergency Department (ED) data including numbers of presentations over time, presentations by time of day, presentations by triage category, mode of arrival to ED, time spent in ED, and the result of the ED presentation
- Inpatient data including common groupings of reason for admission (Diagnostic Related Groups) including the number of inpatients and the number of bed days used
- Length of Stay data for inpatients including average length of stay and distribution
- Patient Clinical Complexity Level data over time
- Funding for other services for the Waitaki community including home and community support services, aged-residential care, and community pharmacy services
- WDHS workforce numbers and profile

4.3 Using the data presented, the Review Team identified a number of challenges and opportunities for improvement including:

- Role of primary care and primary care options
- Availability of community services
- Utilisation of inpatient beds
- Models of urgent care, including attendance at ED
- Access to specialist services including the impact of travel for health services on patients
- Workforce enhancement

4.4 At the second workshop, the Review Team process mapped six archetypal patient journeys which had been developed in response to the opportunities for improvement from the data review. The Review Team sought to understand what happens now and what could be improved to achieve the best outcome and experience for the patient.

The journeys used are included in Appendix Three and were focussed on answering the following patient-centred questions.

- How can people living with chronic and long term conditions be enabled to self-manage their condition in order to stay well?
- How can we keep ED for emergencies and make sure people get the right care in the right place when they have urgent health needs?
- How can we ensure timely access to mental health services?
- How can we make sure access to care is as close to home as possible and people only travel when they need to?
- What support services are required to enable people to maintain their independence and stay well at home for longer?

- How can services be provided to those who live remotely yet require home-based care?

4.5 At the third workshop and using the information from the patient journey mapping, the Review Team identified common themes for service redesign and some initial ideas for change. The themes included:

a. Community based services
b. Coordinated urgent care
c. Improved post-hospital discharge
d. Services closer to home
e. System communication and coordination
f. Workforce enhancement

4.6 Communication updates were produced after each meeting – included in Appendix Four.

4.7 The Review Team organised and hosted a series of community meetings to enable engagement with the Waitaki Health Forum members, WDHS and SDHB staff, the Waitaki public, and other providers of health services based in Waitaki. Engagement meetings described the Review process and sought feedback on the ideas for change presented under the six identified themes. A set of frequently asked questions were also produced ahead of the community meetings (included as Appendix Five).

4.8 At the final Workshop, feedback from community engagement meetings was used to inform the strategic recommendations presented in this report, and the Review Team considered an approach for implementation and agreed upon high-level measures for success.

4.9 The strategic recommendations contained in this report will be considered by both the WDHS Board and SDHB Commissioners.

5. Key Considerations of the Review Team

5.1 Population demographic challenges

- 23% of Waitaki population is elderly (aged 65 years and over), compared to 14% average for NZ.
- The Waitaki population overall will grow slowly however similarly in percentage change to Dunedin. By 2043 New Zealand overall is projected to grow 28% from 2013 to 2043 compared to around 5% in Waitaki.
- Age profile data shows that the Waitaki population will age over time, however, this ageing is slower than other parts of the Southern area due to the Waitaki populations relatively older aged start point; in 2018 Waitaki will have the second oldest population after Central Otago, and by 2043 will have the third oldest population after Gore and equal to Clutha.
- With a slow growing but ageing population, there may be different needs relating to managing frailty and levels of dependency on health services than might be experienced in other areas of SDHB
- Challenges are posed by the hidden pockets of low socioeconomic population, rurality of the Waitaki District, an increase in tourism numbers, and transient communities

- There appears to be a discrepancy between the official Census data (2013) for Pacific people where the population was counted as 500. Numbers reported to the Review Team indicate this population may be in the range of 2000-3000 people

5.2 Emergency Department (ED) Services (2014/15 data)

- Oamaru Hospital has experienced increasing ED presentations over time. The trend of increasing presentations has stabilised since July 2014 at around 7500 per year
- Oamaru Hospital receives funding from SDHB for 4000 ED presentations per annum rather than the actual number (7,742 for 2014/15)
- 74% of patients arrive to the ED as walk-ins, with 16% arriving by Ambulance and 10% via GP referral
- The majority of all presentations to ED are triaged as triage four (around 65%)
- Of all the presentations, 76% of patients are discharged home from ED with 20% admitted to Oamaru Hospital
- Of all the presentations, 73% of spend less than 2 hours being treated in the ED
- Of all first presentations, most occur during the afternoon (midday-6pm) at around 240 per month on average. On average there are 140 a month in each of the morning and evening periods (6am-midday and 6pm-midnight). There are around 45 patients a month arriving between midnight and 6am which equates to 1-2 patients per night
- There are around 1000 returns to ED for further planned review and treatment

5.3 Inpatient services (July 2013 to March 2016 data)

- Patients admitted for rehabilitation services (with a Rehabilitation Diagnostic Related Group) make up around 25% of the total bed days. Patients admitted for treatment predominantly relating to long term conditions (mainly respiratory and cardiac) utilise a further 30-35% of the bed days
- The model of care has not changed since 1999
- The number of admissions per 1000 is the highest across all of the rural hospitals
- It is reported that admissions are related to increasing age and medical complexity, however, Waitaki has the second youngest average age of admission across the rural hospitals (66.1 years old)
- There are two outlying areas of length of stay:
    - High number of zero day stays
    - Number of exceptionally long length of stay patients

5.4 Outpatient services

- There are a high number of patients who live in the Waitaki area who travel to Dunedin for appointments with specialists
- There are a number of specialties, ophthalmology in particular, for which WDHS has long wait times for follow up
- There are opportunities to provide increased access to specialist services locally

5.5 Workforce challenges

- Difficulties are posed by an aging workforce (average age of staff is 50+ years)
- Oamaru Hospital employs a 0.2 full time equivalent vocationally registered Emergency Medicine Specialist as required by a Ministry of Health audit established in 2003. However, there are now alternative models made possible through the development of the Rural Hospital Medicine Specialist vocational scope
- There is a particularly high amount of nursing annual leave owing and staff are reporting burn out
- Silos exist between ED, the hospital ward and maternity nursing staff

- Nursing staff levels haven't changed since 1999, although recently a Swing Shift was introduced to alleviate staffing concerns for the Ward and ED

6. Areas for Discussion

The following areas were discussed at engagement meetings in Oamaru in order to describe to stakeholders the types of consideration and ideas the Review Team were developing and to gain feedback:

Area	Description	Discussion Area
1	Community Based Services	How do we provide responsive and comprehensive community based services to keep people at home? Clinical Care Hub • More responsive needs assessment and service coordination • Wrap around community based care focused on rehabilitation and recovery at home • Greater emphasis on prevention and early intervention • Focus on rehabilitation in the home Local Single Point of Entry • Integrated ways of working – one team developing packages of care • Focus on coordination of care for complex high needs and long term conditions
2	Coordinated Urgent Care	How do we provide a streamlined first response system to ensure get the right care in the right place when they have urgent health needs? Out of hospital options • Rapid Response (Nurses, Allied Health) • Role of ambulance services • Role of General Practice • Greater use of pharmacy services • Community leaders promote alternatives – Keep ED for emergencies, alternative pathways for acute MH presentations Hospital options • Enhanced assessment in ED e.g. multidisciplinary input • Refer to enhanced community services to allow direct return home • ED refer directly to specialists to reduce duplication • Co-location of mental health services and improved integration of mental health services
3	Improved Post Hospital Discharge	How do we improve Post Hospital Discharge to avoid readmission and to support returning home? Avoiding readmission • Improved follow up • Services offered through Clinical Care Hub, particularly for people with long term conditions • Patient and family/whanau education

		Supporting Return Home • Increased use of Clinical Nurse Specialists • Increased availability of equipment • Packages of care and local support to those direct discharged from Dunedin • Services and support for carers
4	Services Closer to Home	How do we make sure access to care is as close to home as possible and people only travel when they need to? Increased OP services provided locally • Focus on services that might be needed the most, e.g. ENT, eyes, orthopedics • Increased availability of local diagnostics for pre-op, e.g. ECG • Direct access to CT scanner service for GPs • Specialist nurse follow up clinics • Telehealth • Improved referral processes and timely communication (e-referrals) • Improved communication between Specialists and GPs for managing patients in the community
5	System Communication and Coordination	How do we improve system communication and coordination? Utilising common electronic platform to ensure health information availability • One Health Record e.g. through HealthOne • Use of Telehealth for specialist input from a distance • Ask for information once to reduce duplication • Use of smart technology, e.g. phones, tablets Direct communication between senior clinicians Use of Health Pathways to standardise care wherever appropriate
6	Workforce enhancement	How do we maximise the effectiveness of the existing workforce and plan for future workforce needs? Enhanced scope roles for nursing and Allied Health • Up skilling and education • Roles across the system • Flexible teams Options for a medical workforce for the future • Junior doctor training • Move towards Rural Hospital Medicine senior doctors • Links to other rural hospitals Workforce models and capacity reviewed

7. Discussion Feedback

In addition to the ideas for change presented at the community engagement meetings (as listed in Section Five), the following feedback was presented and accepted by the Review Team under each of the themes:

1	Community Based Services	• Service provision after hours and on a Friday afternoon remains an issue – there should be greater provision of community support services and more rapid access to short term loan equipment to ensure admissions are avoided where possible • Community services should proactively focus on highest needs and highest current users of health care services – this could happen through a local community based hub • There could be opportunities in engaging with the home and community support providers relating to tiered services – restorative, maintaining independence, and short term rapid intervention • Provision of community based services in the evening should be an area of focus, it was suggested that mobile nursing services might support more people remaining at home • Non-Government Organisations (NGOs) providing health services could be included in the integration and/or co-location of services in a local community hub
2	Coordinated Urgent Care	• Enhanced urgent care could be better provided in aged-residential care facilities either through the provision of outreach services or through training and support for capacity and capability building of nurses who work in the facilities • There should be a local agreement on the flow of information between hospital doctors, GPs and community services including the work up of shared care plans for patients who might currently frequently require urgent care • There may be an opportunity to utilise existing infrastructure to further provide services rather than duplicate • An urgent follow up in-home service might provide GPs, St Johns and Hospital Doctors an opportunity to keep patients in their usual place of residence for longer • There may be the opportunity to utilise telehealth for accessing specialist advice from Dunedin Hospital to support Oamaru Hospital ED
3	Improved Post Hospital Discharge	• Could improve the information flow to enhance handover between providers and for those being discharged from Dunedin through the adoption of a standardised handover tool, for example, SBARR (Situation-Background-Assessment-Recommendation-Response) methodology accepted for local use • Should be a focus on Advance Care Planning for patients leaving hospital where appropriate • There is an opportunity to reduce delays associated with hospital discharge processes, and discharge planning should begin on day one • There is an opportunity for providing better education for patients and their family on what to expect when going home from hospital, for example, the use of Teach Back • Services provided by NGOs should be considered when a patient is discharged – are referrals being made? • Discharge summaries need to be available and legible upon a

		patients discharge from hospital • There needs to be greater availability of and more flexible access to respite services
4	Services Closer to Home	• There needs to be a focus on the administrative element of ensuring any appointments using telehealth are successful • There is a significant issue with travelling to Dunedin for multiple appointments on different days • There should be consideration of times of admission for treatment for people who are travelling to Dunedin
5	System Communication and Coordination	• There may be the opportunity to better use visual management tools within Oamaru Hospital, for example, the electronic patient whiteboard • Wifi capability and readiness is critical to ensure accurate capture of patient information and provision of patient care
6	Workforce enhancement	• There should be a greater focus on education for staff, including the provision of local education wherever possible • There is an opportunity to better utilise the admin and clerical teams to support the clinical workflows and free up nurse time • There could be the opportunity for joint Rural Hospital Medicine Registrar training between the Hospital and GPs • There will likely be the need for significant capacity building and enhanced scope roles for allied health staff

8. Strategic Recommendations

The Waitaki District Health Services Review Team asks the WDHS Board and Southern DHB Commissioners to endorse the recommendations below. The strategic recommendations are:

8.1 **Community based services:** Establish a community clinical care hub as a local single point of entry with the aim of keeping people well and safe at home

8.2 **Coordinated urgent care:** Implement a streamlined first response system to ensure people get the right care in the right place when they have urgent health needs

8.3 **Improved post-hospital discharge:** Improve processes for post-hospital discharge to reduce delays, avoid patient readmission and support return home

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8.6 **Workforce enhancement:** Develop and maintain a workforce that will meet the needs of future service delivery

8.7 **Measures of Success:** Adopt the following measures in the implementation phase as overall measures of success:

8.7.1 Decreasing numbers of ED presentations
8.7.2 Decreasing numbers of occupied bed days
8.7.3 Decreasing readmission rates
8.7.4 Increasing numbers of outpatients appointments completed locally
8.7.5 Increasing levels of patient satisfaction

8.8 **Implementation process.** Agree an implementation process as follows:

8.8.1 A working group be established to implement the recommendations of this review. A formal process will be undertaken for membership of this group
8.8.2 Provision be made for dedicated project management resource
8.8.3 A prioritised work plan be developed allowing adequate time for further consultation with staff, unions, Māori, and other key stakeholders. The work plan will include assigned responsibility for managing any proposed changes and timeframes
8.8.4 Detailed service models be produced including the framework for funding
8.8.5 A collaborative and alliance approach to decision making be taken, including upholding the principle of 'best for patient, best for system'.

There is further detail on the recommendations included as Appendix Six. The detail in Appendix Six and discussion feedback in Sections Six and Seven will inform the implementation phase.

Appendix 1: Waitaki District Health Services Review Team

Name	Area	Title
Helen Algar	Waitaki District Health Services	WDHS, Director
Carol Atmore (Chair)	Alliance South	GP, Alliance South Clinical Advisor
Trish Bloxsom	Waitaki District Health Services	Quality, Education and Nursing Support Officer
Victoria Bryant	SDHB Public Health Nursing	Charge Nurse Manager
Peter Curzon	WDHS	ED Specialist
Liz Disney (Planning and Funding Lead)	SDHB Planning and Funding	Senior Manager System Integration and Innovation
Rory Dowding	SDHB Planning and Funding	Senior Funder Analyst
Sue Duthie	Oamaru Pharmacy	Pharmacist
Janet Gafford (Project Support)	SDHB Planning and Funding	Funder Support and Intelligence Analyst
Robert Gonzales (WDHS Lead)	Waitaki District Health Services	Chief Executive Officer
Jenny Hanson	SDHB Provider Arm	Nurse Director
Colleen Moore	Waitaki District Health Services	Director of Nursing and Allied Health
Chris Munro	SDHB Provider Arm	Service Manager, Mental Health and Addictions and Intellectual Disability Directorate
Chris Rohrbach	Oamaru Doctors	GP
Jon Scott	Central Medical - Oamaru	GP
Christiana Skinner	Waitaki District Health Services	Social Worker and Clinical Needs Assessor

Appendix 2:

Terms of Reference: Review Of Waitaki District Health Services Ltd (19 May 2016)

Joint Review
This review will be jointly conducted by Waitaki District Health Services Ltd (WDHS) and the Southern DHB (SDHB).

Background
SDHB funds WDHS to provide some of the publicly funded health services in the Waitaki District including the services provided in Oamaru Hospital. WDHS and SDHB are currently engaged in contract negotiations and this review has been agreed to inform those negotiations. The review presents an opportunity to explore alternative models of care for health services provision for the people of the Waitaki district.

Scope
The scope of the review will include the health needs of and the services funded by the SDHB that are provided by both the SDHB and WDHS for the population of the Waitaki District. This review is not a contract negotiation, but an opportunity to explore how best to provide sustainable health services to the Waitaki district community.
The Review may also produce recommendations on how other services provided for the Waitaki population could be redesigned, for example, services provided by NGOs or primary care. The Review should comment on these findings for future work outside of the direct Scope of this piece of work.

Principles
The review group will be guided by the following principles and values:

- Respect, open, transparent, and trust values will form the foundation for all discussions and working relationships
- A spirit of collaboration, partnership, and innovation will provide direction and support to any change initiatives
- Development of new initiatives or implementation of change will be evidence-informed
- A patient focused approach with community input will be taken

Objectives
The objectives of the review are to:
- Identify current challenges for service delivery for people in the Waitaki district, including the impact of population demographics, service delivery models, funding and workforce for WDHS and other services provided to the community
- Taking into account the current challenges:
  a. Identify gaps in health and disability service delivery for the Waitaki population and how these could be addressed through service redesign

b. Identify improvements in the service delivery models in the district to better meet the needs of the Waitaki community, improve the clinical and financial sustainability of services the Waitaki population receives, improve quality, and promote workforce sustainability

- Engage with the Waitaki community in a process of co-design and conversation to ensure recommendations are owned and supported locally
- Produce a set of recommendations for change based on improving the health outcomes for the Waitaki population through service redesign which is both clinically and financially sustainable
- That the rural nature of the service be particularly considered throughout the review process

Review Team

The review team will be made up of people nominated by WDHS and SDHB respectively and will reflect a diversity of view from across the system covering the following:

- Senior management and governance for WDHS
- Senior management for SDHB
- Primary care
- Medical, Nursing and Allied Health
- Mental health
- Community services
- Public Health
- Hospital and community pharmacy
- Analytical support
- South Canterbury DHB Clinical advice (if available)
- SDHB provided project management support for write-up and administrative support

Chairing Review Team Meetings

Dr Carol Atmore is confirmed as the Chair of the meetings.

Location of Review Team Meetings

Review team meetings will take place in Oamaru.

Governance Team

A small Governance Group will ensure these Terms of Reference are adhered to and all necessary arrangements are made for the Review's success and progress in between meetings of the wider Review Team. The Group will include:

- Robert Gonzales, CEO WDHS
- Helen Algar, Board Member, WDHS
- Senior Clinician WDHS (where available)
- Carol Atmore, Alliance South Clinical Advisor, SDHB
- Liz Disney, Planning and Funding Senior Manager, SDHB

Specific responsibilities of the Governance Team include:

- Agreeing documentation of the progress from each of the Review Meetings
- Agreeing communications and updates about the Review
- Agreeing appropriate next steps and the overall approach for the Review

Agreement

Members of the review team will be nominated on the basis that they are expected to work collaboratively with the rest of the team and work towards achieving a consensus opinion among the wider team. The team is tasked with providing recommendations relating to each of the objectives noted above.

The review team will ensure that all commitments made during the establishment of the current community owned service delivery model to the population of the Waitaki District either in the form of Government policy or by the DHB and its predecessors about location and levels of service provided in the District are identified and given due consideration before any recommendations are made.

Each review team member has the right to express a dissenting view to the team. Where consensus cannot be reached the differing perspectives should be reported back in the team's findings in place of a recommendation.

The review team is not a decision making body. Given the contractual nature of the relationship between the two parties, and in acknowledgement of each party's respective Governance arrangements, both parties will have an opportunity to review and agree recommendations prior to any implementation.

Timing

The review team will report back with initial recommendations to the SDHB Commissioners and WDHSL Board of Directors by early July 2016.

Communication

Progress reports will be completed after each meeting of the Review Team and communicated as agreed by the Governance Team.

Resourcing

All costs of the review, except the costs relating to normal employment of WDHS staff and the venue for the review team meetings, will be paid by SDHB.

Appendix Three:

Patient journeys

1. 80 year old frail elderly lady with fall presents to ED at 4 pm. She lives alone in Hampden
2. 63 year old presents to ED with worsening COPD
3. Patient presents to ED with a sore throat and elevated temperature – triaged as category 4
4. 50 year old presents at ED with seizures and mental health issues and is admitted to the ward for investigation and treatment
5. 62 year old gentleman in Kurow is hospitalised with Stage IV lung cancer with metastases to the bones. Palliative care is required. He wants to return home but this may be not be an option because of support needs.
6. Referral received for a 72 year old gentleman with severe arthritis in right knee. Specialist orthopaedic assessment is required.

Appendix Four: Communication Updates

Waitaki Review Group

Communication Update 24 May 2016

The Waitaki Review Group met on 19 May 2016 and approved amended Terms of Reference. The scope of the review includes the health of and the services provided by both the SDHB and WDHS for the population of the Waitaki District. The review represents an opportunity to explore how best to provide sustainable health services to the Waitaki District Community.

The group reviewed data associated with the health service, including data about

- Waitaki Population Projections
- Diagnosis Related Groups - types of discharges (top DRGs by bed days and number of people admitted)
- Distribution of where patients who use rural hospitals are from
- Length of stay
- Patient Clinical Complexity Level

The group identified a number of challenges and opportunities for the Waitaki District Health Service, including:

- Role of primary care and primary care options
- Availability of community services
- Utilisation of patient beds
- Models of urgent care, including attendance at ED
- Access to specialist services
- Impact of travelling on patients
- Workforce

What's Next

The next meeting will be held on 2 June at Waitaki District Council Offices. At this meeting, the group will consider a number of potential vignettes (typical patient scenarios) and discuss opportunities for improving services to improve patient experiences.

Waitaki Review Group

Communication Update 8 June 2016

The Waitaki Review Group met on 2 June 2016 to discuss patient journeys in Waitaki. The Review Team process mapped six typical patient journeys to understand what happens now and what could be improved to achieve the best outcomes and patient experiences. These patient journeys were chosen because the data show that these are the most frequent causes of admission and use of hospital services. This process has started to identify common themes for service redesign.

Patient Journeys Considered:

- How can people living with chronic and long term conditions be enabled to self manage their condition in order to stay well?
- How can we keep ED for emergencies and make sure people get the right care in the right place when they have urgent health needs?
- How can we ensure timely access to mental health services?
- How can we make sure access to care is as close to home as possible and people only travel when they need to?
- What support services are required to enable people to stay at home longer?

Common Themes Identified:

1. Need for community prevention programmes delivered by community providers to maintain good health and prevent exacerbation of long term conditions, etc., including
    a) Prevention/health promotion programmes
    b) Greater coordination of community services working as a team and the patient to support good health
    c) Coordination of services to prevent admission to hospital

2. Need for streamlined first response system aiming to ensure people access the right services at the right time
    a) Alternative services available when someone needs to access care urgently
    b) Coordination with GPs and other community care providers
    c) Use of alert and information systems

3. Post discharge services and enhanced community support services to avoid readmission
    a) Care coordination
    b) Delivery of home based care
    c) Post discharge short term supports
    d) Improved post discharge follow up to avoid readmission

4. Services delivered closer to home
    a) Increased specialist service access in Waitaki
    b) Only travelling outside of Waitaki when needed
    c) Use of telehealth

5. Communication and coordination between providers
    a) Use of telehealth and shared electronic health records to improve communication between providers
    b) Team approach – wrap around services for patients

6. Workforce

What's Next?

The Review Team will hold a workshop on 16 June 2016 using identified themes and issues and challenges identified at the workshop held on 2 June to ask how services might change and what this would look like. This workshop will form the basis of recommendations for the final report.

Waitaki Review Group

Communication Update 28 June 2016

The Waitaki Review Team held a workshop on 16 June and used identified themes, issues and challenges to ask how services might change and what this could look like.

Summary of Ideas for Change (based on the themes)

1. Community Based Services

Clinical Care Hub

- More responsive needs assessment and service coordination
- Wrap around community based care focused on rehabilitation and recovery at home
- Greater emphasis on prevention and early intervention

Local Single Point of Entry

- Integrated ways of working – one team developing packages of care
- Focus on coordination of care for people with complex high needs and long term conditions

2. Coordinated Urgent Care

Out of hospital options

- Rapid Response Services (Nurses, Allied Health)
- Closer linkages with ambulance services
- Greater use of GP and pharmacy services
- Community leaders promote alternatives – Keep ED for emergencies

Hospital options

- Enhanced assessment in ED e.g. including allied health input
- Refer to enhanced community services to allow direct return home
- ED refer directly to specialists to reduce duplication
- Co-location of mental health services

3. Improved Post Hospital Discharge

Avoiding readmission

- Improved follow up care on returning home
- Services offered through Clinical Care Hub, particularly for people with
  Long Term Conditions
- Patient and family/whanau education

Supporting Return Home

- Increased use of Clinical Nurse Specialists
- Increased availability of equipment
- Packages of care and local support to those direct discharged from
  Dunedin
- Services for Carers

4. Services Closer to Home

Increased outpatient services provided locally

- Focus on services that might be needed the most, e.g. ENT, eyes, orthopaedics
- Increased availability of local diagnostics for pre-op, e.g. ECG
- Direct access to CT scanner service for GPs (utlising agreed Health Pathways)
- Specialist nurse follow up clinics
- Telehealth
- Improved referral processes and timely communication (e-referrals)
- Improved communication between Specialists and GPs for managing patients in the community

5. System Communication and Coordination

Utilising common electronic platform to ensure health information availability

- One Health Record
- Use of Telehealth for specialist input from a distance
- Ask for information once to reduce duplication
- Use of smart technology, e.g. phones, tablets

Direct communication between senior clinicians

Use of Health Pathways to standardise care wherever appropriate

6. Workforce

Enhanced scope roles for nursing and Allied Health

- Up skilling and education opportunities for staff
- Roles across the system
- Flexible teams responding to need

Options for a medical workforce for the future

- Junior doctor training placements
- Move towards Rural Hospital Medicine trained senior doctors
- Links to other rural hospitals

Workforce models and capacity reviewed

Community Engagement Meetings

Community engagement meetings have been held on 28 June 2016 to enable engagement with the Health Forum, Waitaki District Health Staff/SDHB staff, the general public and GPs and other community providers. SDHB and WDHS have included information about the engagement meetings on their respective websites.

The Review Team seeks feedback on the presentation and invites written feedback via email (planningfunding@southerndhb.govt.nz) by Sunday 3 July.

What's Next

The Review Team will meet for a final workshop on 5 July taking into account all feedback. The Review Team will discuss and agree measures of success, for inclusion in the final report.

Waitaki Review Team

Communication Update 11 July 2016

On 28 June 2016, the Waitaki Review Team organized and hosted a series of community meetings to enable engagement with the Waitaki Health Forum, Waitaki District Health staff and Southern DHB staff, the Waitaki public and other providers of health services based in Waitaki. Engagement meetings described the Review process and sought feedback on the ideas for change presented under six identified themes.

The Review Team met for a final workshop on 5 July. Feedback from community engagement meetings was used to inform the development of strategic recommendations in relation to:

- Community based services
- Coordinated urgent care
- Improved post-hospital discharge
- Services closer to home
- System communication and coordination
- Workforce enhancement

At the final Workshop, the Review Team considered an approach for implementation and agreed upon high-level measures for success. The Review Team has subsequently developed a report summarizing background and key considerations and documenting the review process. The strategic recommendations are contained in this report and will be considered by both the WDHS Board and SDHB Commissioners.

Appendix Five:

Waitaki District Health Service Review
Frequently asked Questions

1. Why are Waitaki District Health Services (WDHS) being reviewed?

- Southern DHB (SDHB) funds WDHS to provide some of the publicly funded health services in the Waitaki District, including the services provided in Oamaru Hospital.
- WDHS and SDHB are currently engaged in contract negotiations and this review has been agreed to inform those negotiations.
- The review presents an opportunity to explore alternative models of care for health services provision for the people of the Waitaki district.

2. What is the scope of this review?

- The scope of the review will include the services funded by the SDHB that are provided by both the SDHB and WDHS for the population of the Waitaki District.
- This review is not a contract negotiation, but an opportunity to explore how best to provide sustainable health services to the Waitaki district community.
- The Review may comment on findings for future work outside of the direct Scope of this piece of work, e.g. services provided by NGOs or primary care.

3. Who is conducting the review?

- A Review Team has been established and is made up of people nominated by WDHS and SDHB respectively, reflecting a diversity of views from across the system, including GPs, Pharmacy, Nursing and others.
- The Chair of the Review Team is Dr Carol Atmore, Clinical Advisor, Alliance South.
- A small Governance Group will ensure Terms of Reference are adhered to.

4. What are the objectives of the review?

- Identify current challenges for service delivery for people in the Waitaki district, including the impact of population demographics, service delivery models, funding and workforce for WDHS and other services provided to the community.
- Taking into account the current challenges, identify gaps in health and disability service delivery for the Waitaki population and how these could be addressed through service redesign.

- Identify improvements in the service delivery models in the district to better meet the needs of the Waitaki community, improve the clinical and financial sustainability of services the Waitaki population receives, improve quality, and promote workforce sustainability.
- Engage with the Waitaki community
- Produce a set of recommendations for change based on improving the health outcomes for the Waitaki populations

5. What progress has the Review Team made thus far?

The review team has participated in a series of workshops to:

- Review data associated with health service delivery .Identify challenges and opportunities,
- Process map six typical patient journeys to understand what happens now and what could be improved. This has started to identify common themes for service redesign.
- Discuss opportunities for improving services to improve patient experiences.

6. What's next?

- The Review Team will hold a workshop using the themes, issues and challenges identified in previous workshops to ask how services might change and would look like. The workshop will form the basis of the recommendations for the final report.
- The Review Team is now engaging with the Waitaki community in conversations to ensure preliminary recommendations are understood and there is the opportunity to provide feedback to shape the final recommendations.
- Following community engagement, the Review Team will produce a set of recommendations for change based on improving the health outcomes for the Waitaki population through service redesign which is both clinically and financially sustainable.

Appendix Six: Additional Detail Relating to Strategic Recommendations

1. Community based services:

Establish a community clinical care hub with a local single point of entry with the aim of keeping people well and able to be safe at home. This would involve:

- Local Single Point of Entry with integrated ways of working - one team developing packages of care
- Clinical Care Hub to provide wrap around community based care focused on rehabilitation and recovery at home.
- Risk stratification of patients with long term conditions to ensure greater self-management and intervention by secondary services only when most needed.
- Focus on coordination of care for the frail elderly and those with complex high needs and long term conditions (particularly those with multi-morbidity).
- Implement the restorative model of care, with co-ordinated community based wrap-around services established to prevent hospital admissions and repeat visits to ED. Greater emphasis on prevention and early intervention.

2. Coordinated urgent care:

Implement a streamlined first response system to ensure people get the right care in the right place when they have urgent health needs. This will involve:

- Development of Rapid Response services to prevent ED attendance, with nursing and allied health professionals working at top of scope in locality teams.
- Consideration for St John to complete a comprehensive assessment on options other than ED
- Consideration for a GP to be co-located with ED to assist with triage
- Enhanced assessment in ED, e.g. Social Work, Occupational Therapy
- Potential redirection to primary care (with or without vouchers for patients)
- Review on-call rostering arrangement for GPs
- Nurses in ED working under standing orders
- ED to refer directly to specialists to reduce duplication of information gathering from patients
- Promoting other community based provider services e.g. Community Pharmacy
- Investment into primary and community based wrap-around services
- Community leaders promote alternatives – Keep ED for emergencies
- Refer to enhanced community services to allow direct return home
- Co-location of mental health services and other services expressing an interest in being part of a wider Health Campus

3. Improved post-hospital discharge:

Improve processes for Post Hospital Discharge to avoid patient readmission and to support return home. Improved processes would include:

- Nurse Specialists or Allied Health working in ED to complete full assessment to support return home rather than admission
- Agreed health pathways for management of long term conditions
- Adoption of the Alliance South Long Term Condition Network recommendations
- Community based multi-disciplinary team proactively reviewing most complex patients across the system either seeking to discharge them from hospital or retain them in their home
- Early supported discharge via community based allied health teams operating within the community clinical care hub. Includes Patient and family/whanau education.
- A clinical alliance with lead health professionals to facilitate collaboration and coordination, especially for those with long term conditions. Provision of wrap around

outreach including Rapid Response, Clinical Nurse Specialist services, ambulance services, pharmacy, GP, District Nurse, ED discharge plan, education, etc, to keep person at home.

- Continuation of the quality improvement work Waitaki is undertaking following the Quality Improvement Workshop run with SDHB
- Investment into primary and community based services.
- Increased availability of equipment
- Services for Carers

4. Services closer to home:

Increase outpatient/specialist services provided locally to ensure access to care is as close to home as possible and people only travel when they need to. This includes:

- Increased outpatient services provided locally
- Focus on services that might be needed the most, e.g. ENT, eyes, orthopaedics
- Increased availability of local diagnostics for pre-op, e.g. ECG
- Direct access to CT scanner service for GPs
- Specialist nurse follow up clinics
- Utilisation of telehealth
- Improved referral processes and timely communication (e-referrals)
- Improved communication between Specialists and GPs for managing patients in the community

5. System communication and coordination:

Improve systems for communication and coordination to provide patient centred care through better use of technology and developing relationships within the healthcare provider community. This includes:

- Utilise common electronic platform to ensure health information availability
  - One Health Record
  - Use of Telehealth for specialist input from a distance
  - Ask for information once to reduce duplication
  - Use of smart technology, e.g. phones, tablets
  - Upgrade of current network bandwidth to adequate capacity (1Gbps ideally)
- Direct communication between senior clinicians
- Use of Health Pathways to standardise care wherever appropriate

6. Workforce enhancement:

Develop and maintain a workforce that meets the needs of future service delivery. This includes:

- Reviewing Workforce models and capacities
- Enhanced scope roles for nursing and Allied Health based in the community clinical care hub focusing on ageing in place, rehabilitation in the home and preventing ED presentations and possible hospital admissions
  - Up skilling and education
  - Roles across the system
  - Flexible teams
- Options for a medical workforce for the future
  - Junior doctor training
  - Links to other rural hospitals
- Employment of Rural Hospital Medicine Specialists who are often dual trained as GPs and can operate across the care continuum