

Wairarapa DHB Clinical Services Action Plan

Current Service Status

Appendix to the main report

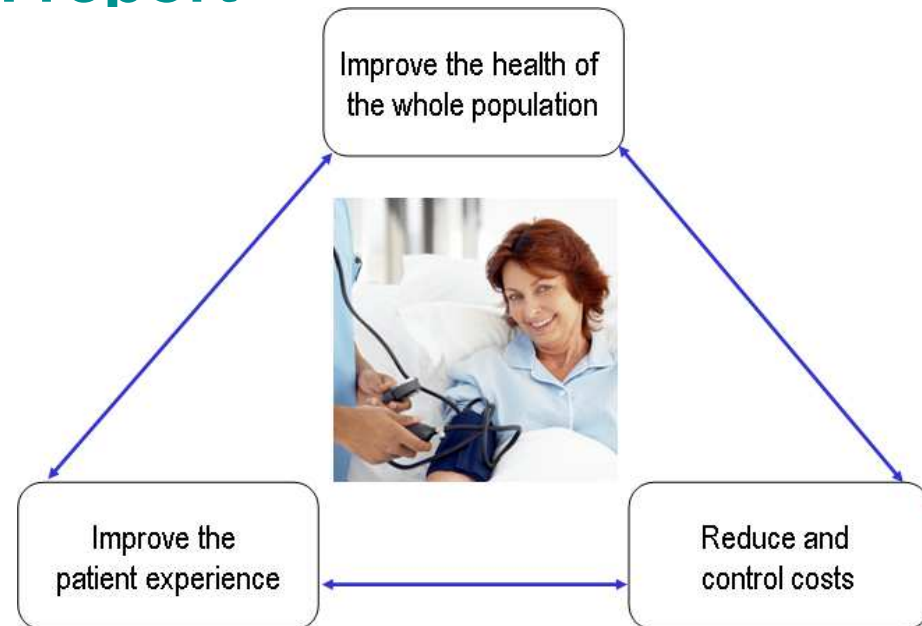


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Introduction

This appendix is provided as background information in support of the Wairarapa Clinical Services Action Plan (CSAP). The appendix provides profiles for each clinical service summarising the service and staff, activity volumes, benchmarks where available, and the issues and challenges faced by each service. The profiles were developed using the following sources:

- Volume and activity data extracts from existing WDHB data sets
- Qualitative data obtained from discussions with clinical specialty groups
 - Meetings were held with each clinical service and qualitative data was collected using a standardised interview schedule.
 - The interview schedule was developed to align with the Vulnerable Services Project which arose out of the Regional Clinical Services Plan. The questions related to the issues, challenges and opportunities for each service with respect to: Workforce, Model of care, Infrastructure, Clinical and Financial Viability. A copy of the interview schedule is provided at the end of this document.
 - Following each meeting the data was collated and summaries returned to the participants for verification and amendment as required.
 - Some clinicians submitted written responses.
 - A series of meetings was held with across-service groups, such as senior nurses, SMOs and GPs. Data from these meetings was also collated and verified.
 - A list of clinicians involved in the formal consultation process is provided on the following page.
- Data from community providers and special interest groups
 - NGOs and community groups were invited to participate in the CSAP through a written survey, individual meetings and/or stakeholder workshops.
 - The survey included the same questions used for the clinical services meetings, in addition to requests for quantitative data on service provision, such as staffing and activity.
 - In total the views of more than 20 community providers or special interest groups were obtained through interviews, survey responses and participation in workshop or meetings. These are listed on page 3.
- Benchmark data from the Health Round Table and the Ministry of Health data sets
 - The Health Roundtable is a non-profit group of hospitals across Australia and New Zealand. The purpose is to share problems and solutions and provide an informal network. The Roundtable collects, analyses and reports benchmark data providing comparisons across the member organisations. The code for Wairarapa DHB is Copia.
 - The Ministry of Health provides Standardised Discharge Rates (SDR) which compare DHBs against national averages, taking into account age, sex, social deprivation and ethnicity.

Consultation Participants

Clinical service involvement

Several General Practitioners from a number of practices	
Mr Alan Shirley	Medical Adviser
Dr Andre Smith	O & G Consultant
Andrew Curtis-Cody	Community Psychiatric Nurse
Anna Reed	Clinical nurse specialist
Anne McLean	GM, Hospital Services
Aynslie O'Reilly	Clinical Nurse Manager, Rehab.
Mr Bob Sahakian	General Surgeon
Cathie Morton	Elective Services Manager
Cathy Smith	Clinical Nurse Specialist
Dr Chris Smith	Anaesthetist
Colleen Daniels	District Nurse
Dr Dan Schual-Berke	ED Consultant
Danielle Farmer	Nurse Coordinator Clinical Training Agency (CTA) Programmes
Deb Severn	Nurse, MSW
Debi Lodge-Schnellenberg	Manager, Public Health & Ambulance
Donna Purvis	Clinical Midwife Manager
Eileen Fahy-Teahan	Whaiaora
Franky Spite	Team leader, Occupational Therapy
Gael Burns	District Nurse
Fred Wheeler	Unit Manager
Helen Mitchell-Shand	Mental Health Services Quality Coordinator
Helen Pocknall	Director of Nursing
Helene Dore	Manager Focus
Helma Van der Lans	Manager Mental Health Services
Dr Hok Mao	Paediatrician
Mr Ian Denholm	Orthopaedic surgeon
Jackie Milo	Paediatrician
Jan Ward	Preadmission Nurse
Janeen Croos	Maori Health Directorate
Janet Saunders,	Medical Officer, Rehabilitation

Jill Perry	Whaiaora
Jill Trower	Clinical Nurse Specialist
John Tibble	Maori Health Directorate
Kathy Lee	Nurse, Acute Services
Mr Konrad Schwanecke	Orthopaedic surgeon
Lesley Marsh	Clinical Nurse Educator
Linda Tatton	Team Leader Physiotherapy
Liz Fellerhof	Clinical Nurse Specialist
Maggie Morgan	GM, Community Public & Mental Health
Mair Moorcock	Clinical Nurse manager, Outpatients
Maree Tonks	Practice Nurse, Carterton Medical
Michelle Dowman	Dietitian
Moiria Courtney	Midwife
Dr Niels Dugan	Physician
Mr Per Henrik Engberg	Orthopaedic surgeon
Dr Peter Bruwer	Anaesthetist
Dr Richard Stein	Physician
Dr Rob Dimock	Anaesthetist
Rob Lewis	Manager Community Nursing & Health Service
Robyn Brady	Unit Manager
Ruth Parker	Nurse, MSW
Dr Sharon English	Urologist
Sharon Woods	Unit Manager
Mr Steve Martyack	General Surgeon
Sue Willoughby	Clinical Nurse Manager CAMHS
Susan Reeves	Clinical Nurse Manager, MSW
Tam Wootton	Laboratory Manager
Tess Geard	Clinical Nurse Manager, Paediatrics
Dr Tim Matthews	Physician
Tina Te Tau	Maori Health Directorate
Trisha Wilkinson	Practice Nurse, Carterton Medical
Vicki Hookham	Clinical Nurse Manager, Acute Services
Viv Peterson	Clinical Nurse Educator

Community Participation

Patient Input

Views and experiences of patients and their families/whanau were obtained through individual interviews and patient advocate/support focus groups.

NGOs and Community Groups

A broad range of NGOs and community groups were invited to participate in the CSAP through a written survey, individual meetings and/or stakeholder workshops. In addition to the survey or interview questions, NGOs were also asked for quantitative data on service provision, such as staffing and activity.

The following organisations chose to participate in the formal consultation process.

- Arthritis New Zealand
- Cancer Society
- Child Health Executive Group
- Diabetes NZ, Wairarapa Inc.
- Duncan's Pharmacy & Chapel St Pharmacy
- Foot Mechanics
- Iwi Kainga
- King Street Artworks
- Mental Health Consumers Union
- Multiple Sclerosis Society
- Post Polio Support Group
- Plunket
- Residential Care Facilities (Arbor House, Aversham House, Lansdowne Court, Roseneath Care Services)
- Stroke Foundation
- Supporting Families (SF Wairarapa)
- Te Hauora
- Te Whare Atawhai
- Wairarapa Addiction Services
- Wairarapa Care Network
- Wairarapa Community PHO
- Whaiora

Steering Group Members

Dr Robert Logan	(Chair) Chief medical Adviser, Hutt Valley DHB
Mr Alan Shirley	Medical Adviser
Dr Andre Smith	O & G Consultant
Anna Reed	Clinical nurse specialist
Anne Davies	Practice Nurse, The Family Doctors, Chapel Street
Anne McLean	GM, Hospital Services
Dr Annie Lincoln	GP liaison
Cheryl Powell	Nurse manager, Aversham House
Dr Dan Schual-Berke	ED specialist
Fiona Samuel	Whaiora
Franky Spite	Occupational Therapist, Allied health
Helen Kjestrup	Nurse Manager, Masterton Medical
Helen Pocknall	Director of Nursing
Dr Hok Mao	Paediatrician
Mr Ian Denholm	Orthopaedic surgeon
John Tibble	Maori Health Directorate
Joy Cooper	(Project Manager), Deputy Chief Executive
Maggie Morgan	GM, Community Public & Mental Health
Dr Richard Stein	Physician
Dr Rob Dimock	Anaesthetist
Rob Lewis	Manager, Community Nursing & Health Service
Dr Steve Phillip	GP, Martinborough Medical Centre
Susan Reeves	Clinical nurse manager, MSW
TakuruaTawera	Te Hauora Runanga O Wairarapa Inc
Dr Tony Becker	GP, Masterton Medical
Dr Zarko Kamenica	Psychiatrist
Carol MacDonald	Project Support

Abbreviations and Definitions

Abbreviations

ACC	Accident Compensation Corporation	IV	Intravenous
ALOS	Average length of Stay	LMC	Lead Maternity Carer
ARC	Aged Residential Care	LOS	Length of Stay
AT&R	Assessment Treatment and Rehabilitation	MCDHB	MidCentral District Health Board
CAPEX	Capital Expenditure	MDT	Multidisciplinary Team
CCDHB	Capital & Coast District Health Board	MMHA	Maori Mental Health, Adult
CNE	Clinical Nurse Educator	MOH	Ministry of Health
CNS	Clinical Nurse Specialist	MOSS	Medical Officer Special Scale
CSAP	Clinical Services Action Plan	MSW	Medical Surgical Ward
CWD	Case Weighted Discharge	NASC	Needs Assessment and Service Co-ordination
DHB	District Health Board	NGO	Non-Government Organisation
DRG	Diagnostic Related Groups	NZNO	New Zealand Nurses' Organisation
ED	Emergency Department	O&G	Obstetrics and Gynaecology
ENT	Ears, Nose and Throat	OPD	Outpatients Department
FTE	Full Time Equivalent	PACU	Post Anaesthetic Care Unit
FU	Follow up Visit	PHO	Primary Health Organisation
HDC	Health and Disability Commissioner	RCSP	Regional Clinical Services Plan
HDU	High Dependency Unit	RMO	Resident Medical Officer
HEHA	Healthy Eating Healthy Action (programme)	RN	Registered Nurse
HVDHB	Hutt Valley District Health Board	SCBU	Special Care Baby Unit
GP	General Practitioner	SDR	Standardised Discharge Rates
ICU	Intensive Care Unit	SMO	Senior Medical Officer
IDFs	Inter district Flow(s)	WDHB	Wairarapa District Health Board
IT	Information Technology	WIPA	Wellington independent Practitioners Association

Definitions

Acute	Hospital services for patients who need immediate hospital treatment.
Average length of Stay (ALOS)	Length of stay measures the duration of a single episode of hospitalisation. Inpatient days are calculated by subtracting day of admission from day of discharge. Average length of stay (ALOS) is calculated by dividing the sum of inpatient days by the number of patients admitted with the same diagnosis-related group classification.
Case weighted discharges (CWD)	Relative measure of the cost of different types of surgery. For example cataract surgery has a lower case weight than hip replacement surgery.
Clinical Nurse Specialist (CNS)	Registered nurse trained and practising at an advanced level in a specific scope of practice.
Day case	A procedure that requires an admission period more than 3 hours but less than 24 hours and does not cross midnight.
Discharge	A discharge occurs each time a patient leaves hospital following an episode of care. Discharge numbers and actual patient numbers differ as a single patient may have more than one hospital discharge.
Elective	Hospital services for patients who require less urgent treatment and whose treatment can be scheduled for a later date.
Full Time Equivalent (FTE)	Describes hours of labour. 1 FTE is equivalent to 40 hours within 1 working week.
Health Roundtable	The Health Roundtable is a non-profit group of hospitals across Australia and New Zealand. The purpose is to share problems and solutions and provide an informal network. The Roundtable collects analyses and reports comparative data.
Hospitalist	A hospitalist is a clinician who specialises in hospital medicine and manages a patient's acute hospital care. They are specialists with skills in general internal medicine, who care for patients with a wide range conditions/illness within the specific location of an acute hospital.
Model of Care	The term "model of care" has been used to refer to both methods of care at the individual patient level, and the clinical and organisational framework at the department, service, or hospital level.
Inter District Flow (IDF)	Inter District Flow(s) occurs where the DHB of service is different from the patient's DHB of domicile. Inflows occur when Wairarapa DHB receives funding from another DHB for services provided to their resident populations. Outflows refer to payments Wairarapa DHB makes to other DHBs for services which they provide to our resident populations.
Primary care	The care to which any patient can refer themselves. It includes but is not limited to general practice.
Secondary care	Carried out in most hospitals. This is usually the first port of call for patients who are referred by their GP, except in circumstances when a GP may refer a patient directly to a tertiary centre.
Stakeholder	Groups or individuals who have a direct or indirect interest in the DHB and its activities
Standardised Discharge Rates (SDR)	Ministry of Health Standardised Discharge Ratios compare DHBs against national averages, taking into account socio-demographic variables.
Tertiary centre	Advanced clinical services provided to patients usually referred from secondary care hospitals. These services offer the most complex and technologically sophisticated care and are generally a regional level resource.

Acute Services

Services and People

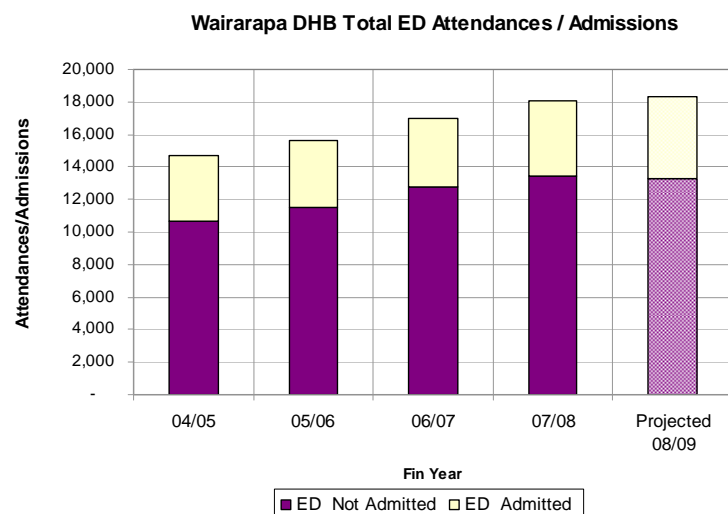
The Emergency Department (ED) provides 24 hour 7 days a week emergency access to clinical care. It is a distinct unit in Wairarapa Hospital with the staffing and resources to provide initial assessment, stabilisation and clinical management of patients presenting with acute illness and/or injury.

The Acute Assessment Unit (AAU) provides ongoing treatment, diagnostic testing and evaluation for patients requiring less than 24 hour stay. The High Dependency Unit (HDU) provides more intensive level of care for complex and high acuity patients following an acute episode of illness and/or injury.

Staffing (FTE's) – Clinical Type

Acute Services	FTE
Consultants/Medical Officers	2.8
House Surgeon (shared with ED)	1.0
Registered Nurses	23.3
Clinical Nurse Manager	0.8
Resuscitation trainer	0.2

Activity



Total ED Attendances / Admissions

	04/05	05/06	06/07	07/08
Not Admitted	10,632	11,486	12,808	13,424
Admitted	4,072	4,109	4,200	4,661

Overall Trends in ED Attendance

Referral Source	Volume				Change 04/05 - 07/08
	04/05	05/06	06/07	07/08	
Total Attendances	14,704	15,595	17,008	18,085	23%
Self-Referrals	6,929	8,037	9,381	10,424	50%
GP Referrals	4,607	4,125	4,319	4,406	-4%
Ambulance	2,756	2,641	2,709	2,707	-2%
Other	410	791	599	548	34%

Frequency of ED attendance*

Number of ED Attendances	Distinct Patients	% of ED Patients	Attendances	% of ED attendances
1 - 2	8,792	59.49%	10,759	84.00%
3 - 5	1,397	27.40%	4,955	13.35%
6 - 8	192	7.02%	1,270	1.83%
9 - 14	67	3.90%	705	0.64%
15 +	19	2.19%	396	0.18%
Total	10,467		18,085	

* Based on data 1/7/07 - 30/6/08

Attendances by Triage Level

	2004/05	2005/06	2006/07	2007/08
Triage 1	45	28	30	34
Triage 2	1,137	1,059	1,120	1,051
Triage 3	6,020	5,954	6,118	6,811
Triage 4	5,603	7,107	7,634	6,247
Triage 5	1,862	1,447	1,954	3,635
Total	14,667	15,595	16,856	17,778

Benchmarks

Health Round Table Data

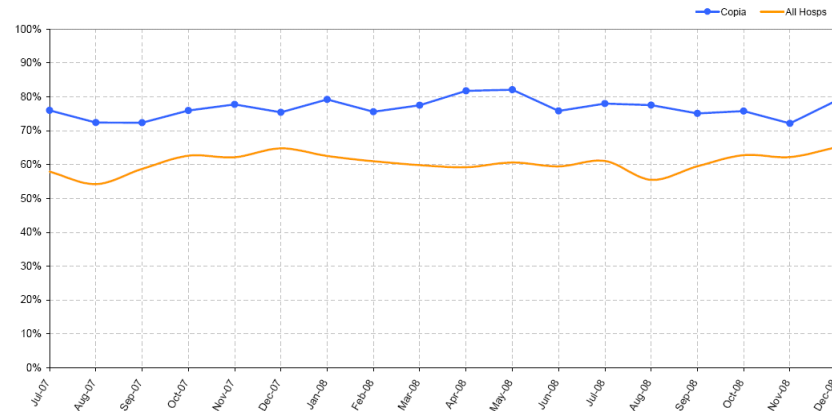
- ED is a high performer with respect to the time taken for patients to be seen and treated, consistently meeting triage guidelines.
- We have a high proportion of triage 5 presentations to ED compared with other DHBs.

Copia Emergency Presentation Analysis for the 2008 Jul-Dec Period

Time to Be Seen / Triage Data

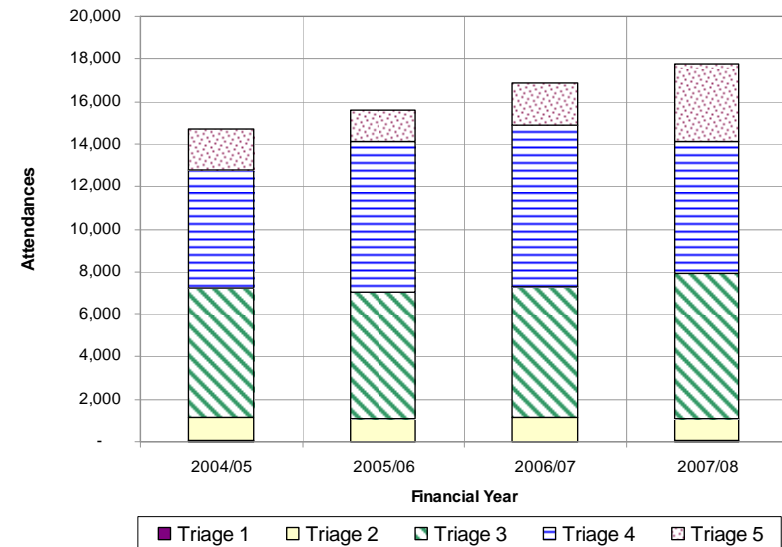
S1.0 b - Overall Performance Proportions (Current Period)

Triage Guidelines - Triage 1: Immediate, Triage 2: 10 minutes, Triage 3: 30 minutes, Triage 4: 60 minutes, Triage 5: 120 minutes



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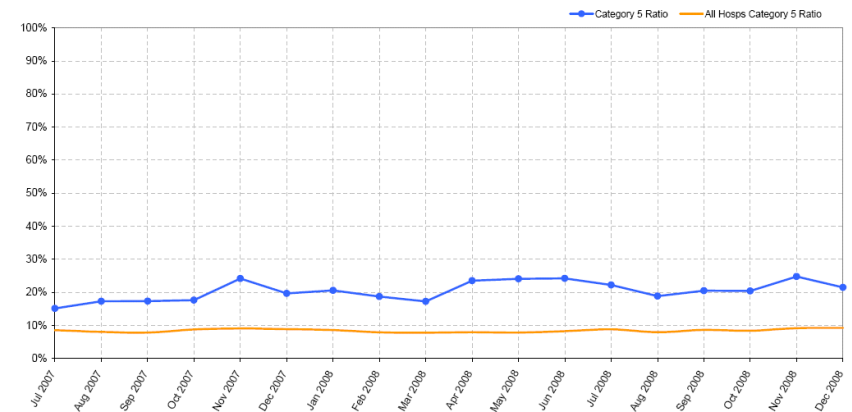
Wairarapa DHB Total ED Attendances by Triage



Copia Emergency Presentation Analysis for the 2008 Jul-Dec Period

Presentations / Triage Data

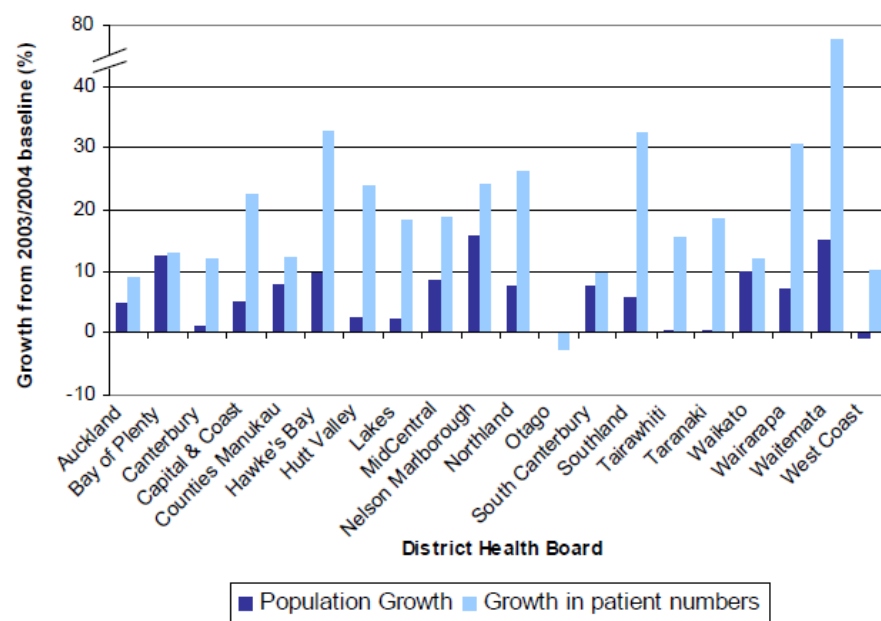
T1.5 a - Triage 5 Proportions (Copia)



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A ministerial working group report¹ shows that as with most small and medium-sized DHBs, Wairarapa has experienced large rates of growth for patient attendances and especially for total patient hours in the emergency department.

The working group also reported that national rates of growth in patient attendances (19.9% over 5 years) and hours (34.4%) are considerably higher than the national population growth rate (11.5%). The following graph shows that the growth in patient attendances is well above the population growth for Wairarapa



¹ Recommendations to Improve Quality and the Measurement of Quality in New Zealand Emergency Departments. A report from the working group for Achieving Quality in Emergency Departments to the Minister of Health – December 2008.

Issues and Challenges: Acute Services

Workforce

- Recruitment is the prime issue, not retention.
- Reliance on short-term locums, and precarious night-time staffing with House Surgeons not only for ED but sole position for Wairarapa Hospital at night. High risk.
- Overtime concerns limit the flexibility in rostering SMOs.
- Lack of incentives to devote time attending to the many facets of ED competence and functionality. E.g. staff education, self improvement, ED related process improvements, etc.
- Inability to release time to care, hence clinical audit, leadership and self development are progressed in a very piecemeal way. This leads to frustrations and inability to maintain momentum and motivation for staff.
- Need a technician for acute services who ensures equipment is checked, monitors supplies, assists with general housekeeping etc. Freeing up nursing time.

Model of care

- Deficiencies in service provided by current Radiology contract.
- RMO contract limits the effectiveness of their role in ED
- RMOs are not directly involved in patient admission. Lack of contact with the acute presentation and initial treatment.
- There are no written discharge instructions provided to ED patients upon their departure
- Emergency nursing is about patient education. A stressful environment is not conducive to this.
- Need a CNS emergency role to transition people across the primary/secondary interface, to enable closer relationships and directing people to the appropriate level of care provider dependent on their acuity and complexity.

Clinical Viability

- Rate of patient inflow over which ED has minimal control.
- ED staff feel ethically obliged to manage all people who present to ED and feel potentially at risk should any patient directed elsewhere suffer an adverse outcome.
- Opportunity to link with GPs and ambulance in regard to referring patients back with appropriate clinical criteria in place, and having selected ambulance cases transferred to GP practices as opposed to transporting directly to ED. Funding mechanism will need to be realigned.
- Lack of opportunity to rotate through other DHBs such as Wellington, Mid Central, and Hutt for collegial support and development.

Infrastructure

- Lack of IT systems and support.
- Documentation is paper based (notes are all hand written).
- Inadequate clerical/administrative support.
- No patient tracking system.
- Limited functionality of bedside ultrasound.
- Limited clerical input both front and back of house.

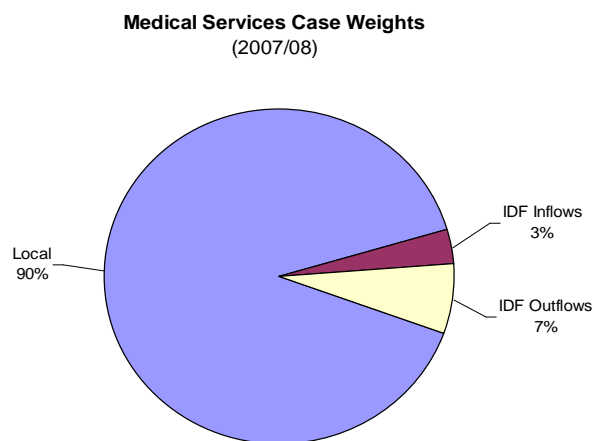
Medicine

Services and People

Secondary medical services are provided on an inpatient, day case and outpatient basis. Services are supported by allied health practitioners, home support services, and a range of specialist community nurses. Visiting specialists provide regional services for an increasing number of specialties, including endocrinology/diabetes, neurology, oncology/radiotherapy, rheumatology and clinical haematology. Nursing outreach services work collaboratively with other disciplines, and include the Cardiac Outreach programme, Asthma and Diabetes nurse educators and a respiratory outreach nurse.

Activity

Inpatient Activity		04/05	05/06	06/07	07/08
Case Weights	Local	2,060	1,872	1,678	1,854
	IDF Inflows	61	99	43	66
	IDF Outflows	214	126	221	137
Discharges	Local	2,451	2,070	1,952	2,252
	IDF Inflows	117	126	80	101
People	IDF Outflows	98	91	121	101



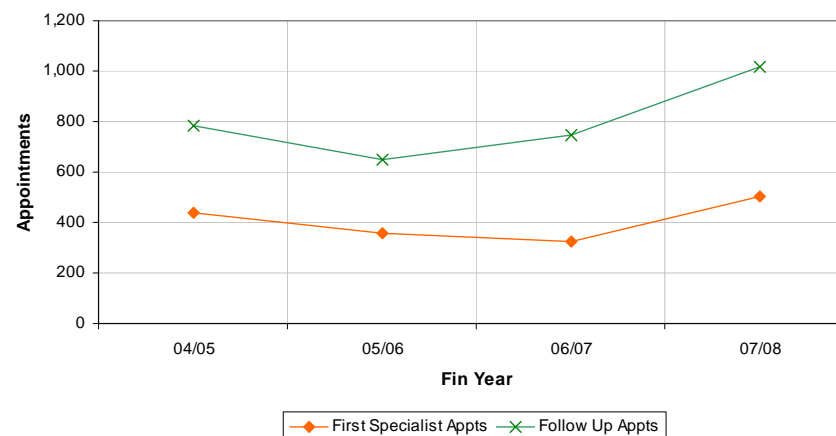
Staffing (FTE's) – Clinical Type

Medicine	FTE
Physicians	4.8
House Surgeon	3.0
Registrar	1.0
Clinical Nurse Specialists	3.5

Local Outpatient Activity by Financial Year - Medical

	04/05	05/06	06/07	07/08
First Specialist Appts	437	358	325	505
Follow Up Appts	784	649	745	1,015

Wairarapa DHB Local Outpatient Activity - Medical



Local Outpatient Activity by Financial Year - Cardiology

	04/05	05/06	06/07	07/08
First Specialist Appts	110	185	67	61
Follow Up Appts	188	127	106	112
Education & Mgmt	231	165	149	186

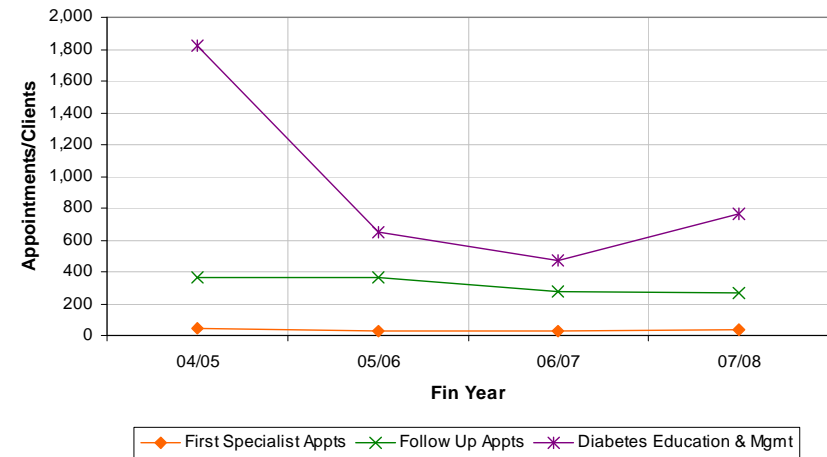
Local Outpatient Activity by Financial Year - Diabetes

	04/05	05/06	06/07	07/08
First Specialist Appts	41	27	31	38
Follow Up Appts	361	361	276	267
Education & Mgmt	1,822	653	473	762

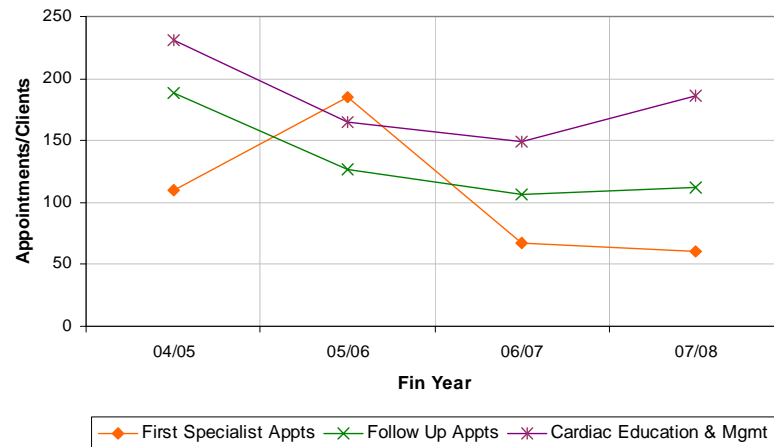
Local Outpatient Activity by Financial Year - Respiratory

	04/05	05/06	06/07	07/08
First Specialist Appts	30	62	28	42
Follow Up Appts	51	170	72	89
Education & Mgmt	375	339	327	510

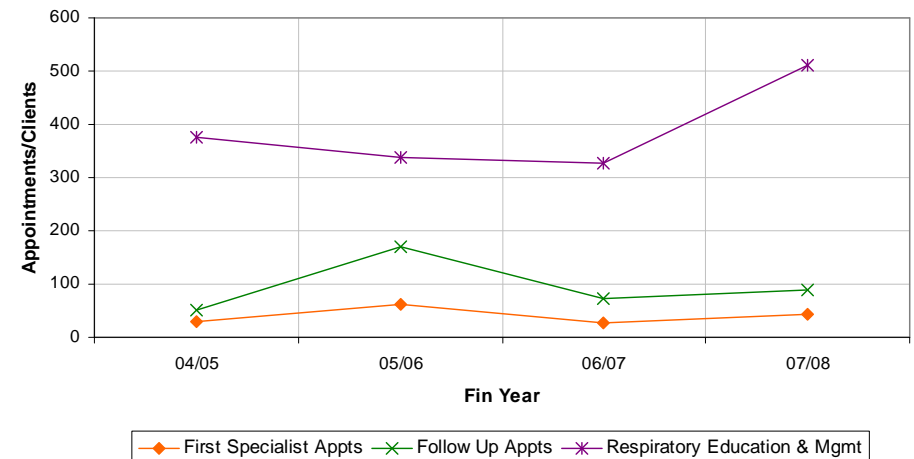
Wairarapa DHB Local Outpatient Activity - Diabetes



Wairarapa DHB Local Outpatient Activity - Cardiology



Wairarapa DHB Local Outpatient Activity - Respiratory



Acute/Elective - Medicine

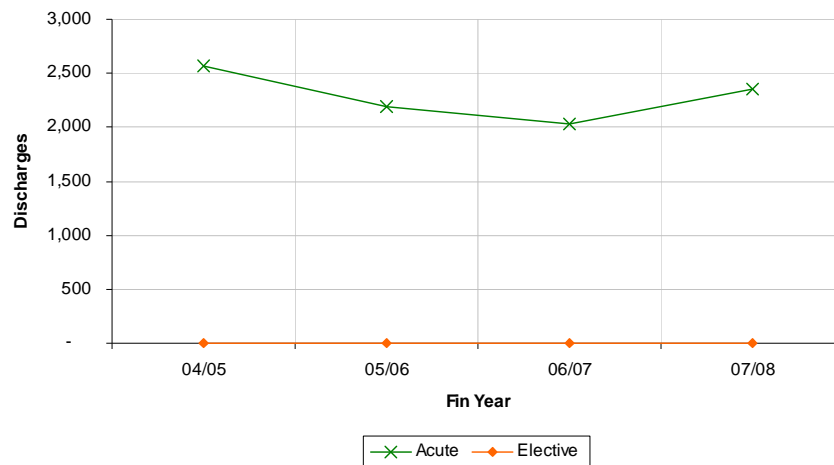
Admissions by Discharge Type

Type of Admission	04/05		05/06		06/07		07/08	
	Inpatient	Day Case	Inpatient	Day Case	Inpatient	Day Case	Inpatient	Day Case
Acute	1,966	602	1,640	555	1,607	424	1,704	648
Elective	-	-	-	1	1	-	1	-
Total Admissions	1,966	602	1,640	556	1,608	424	1,705	648
Total	2,568		2,196		2,032		2,353	
Percentage Day Case	23%		25%		21%		28%	

Total Admissions by Discharge Type

	04/05	05/06	06/07	07/08
Acute	2,568	2,195	2,031	2,352
Elective	-	1	1	1

Wairarapa Medical Admissions by Discharge Type



Benchmarks - Medicine

Health Round Table

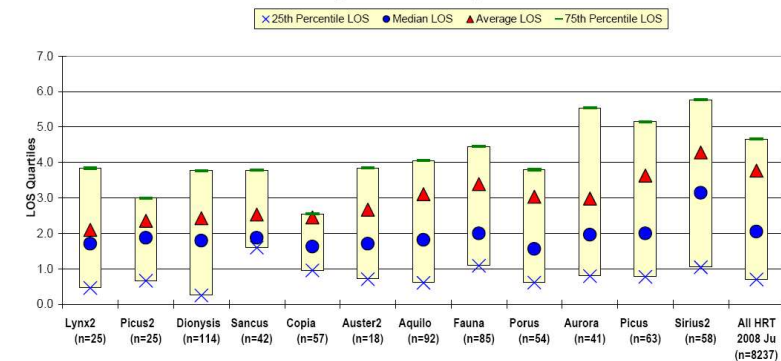
- The average length of stay (ALOS) for diabetes at Wairarapa Hospital is lower than the average but the emergency readmission rate for diabetes is dramatically higher than the average.
- For Chronic Obstructive Airways Disease both the ALOS and emergency readmission are higher than the 4 exemplar hospitals.

Data Extract 2008 Jul-Dec HRT v2

K60 - DIABETES

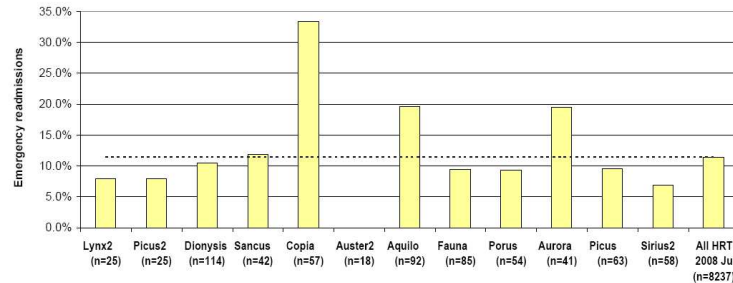
DRG Family K60 - DIABETES

ALOS at Copia is 2.5 days, 35% shorter than the All HRT
2008 Jul-Dec v2 average at 3.8 days



DRG Family K60 - DIABETES

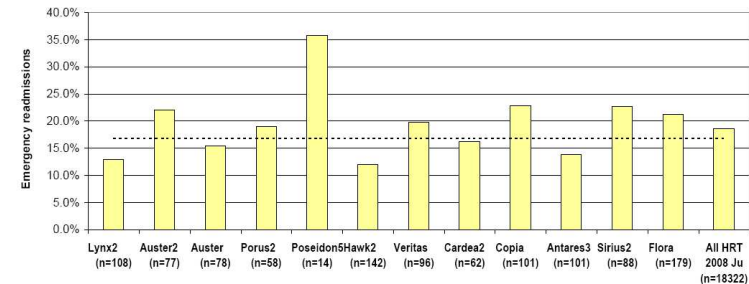
The emergency readmission rate at Copia is 33.3%, 191% higher than the All HRT 2008 Jul-Dec v2 average at 11.4%



* Emergency readmission rate is the percentage of episodes that have an unplanned admission to your hospital within 28 days after discharge, for any reason

DRG Family E65 - CHRONIC OBSTRUCTIVE AIRWAY DIS

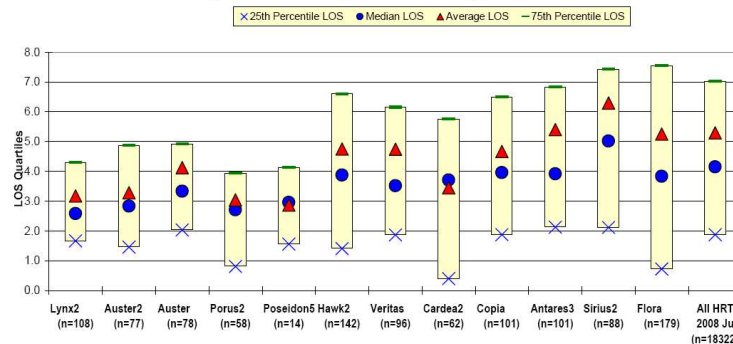
The emergency readmission rate at Copia is 22.8%, 35% higher than the 4 exemplar hospitals' weighted average at 16.8%



* Emergency readmission rate is the percentage of episodes that have an unplanned admission to your hospital within 28 days after discharge, for any reason

DRG Family E65 - CHRONIC OBSTRUCTIVE AIRWAY DIS

ALOS at Copia is 4.7 days, 37% longer than the 4 exemplar hospitals' weighted average at 3.4 days



Issues and Challenges: Medicine

Workforce

- Inconsistent supply of Junior Doctors - the three months rotation creates a roller coaster effect.
- Lack of development for nurses (especially specialist nurses).
- No specialist nurse to assist with Hospital Clinics.

Model of care

- No system in place to ensure that Doctors orders are carried out.
- Under utilisation of RMOs.
- Clinics could be much more effective with assistance from a dedicated nurse.
- Lack of hospital-based Medical oversight for rest homes.
- Failure to get rest homes to take patients on weekends results in unnecessary delays in discharge.
- Inconsistent palliative care service.

Clinical Viability

- Inconsistent approach to credentialing / vocational registration.
- No dedicated clinical audit role.

Infrastructure

- Lack of administrative/clerical support for Doctors.
- Lack of funding to support nurse-led projects/improvements on the wards.
- Inadequate IT system.
- Physicians are consistently left out of CAPEX.
- Lack of standardized form or procedure for approval of extraordinary investigation/medications.

Financial viability

- Inadequate funding for specials (one-on-one supervision) for dementia/confused patients in AT&R.
- No training for clinicians for appropriate clinical coding to maximize revenue.
- There are follow-ups being done in other DHBs that should be done here.

Obstetrics and Gynaecology

Services and People

Obstetrics and Gynaecology services are provided 24 hour 7 day a week for acute and electives on an inpatient, outpatient and day stay basis. The services are provided by Obstetric and Gynaecological Specialists, GP Obstetricians and Midwives as Lead Maternity Carers.

The Obstetrics service provides an integrated primary and secondary service including health promotion, advice and counselling, antenatal care and education, care during labour and birth, postnatal care and lactation consultancy services.

Activity

Obstetrics

Case Weights	04/05	05/06	06/07	07/08
Neonatal inpatients	50	36	88	63
Neonatal IDF Inflows	5	1	4	0

Gynaecology

Inpatient Activity		04/05	05/06	06/07	07/08
Case Weights	Local	181	224	201	196
	IDF Inflows	8	13	6	9
	IDF Outflows	54	44	36	49
Discharges	Local	260	310	298	328
	IDF Inflows	11	16	12	18
People	IDF Outflows	58	49	32	42

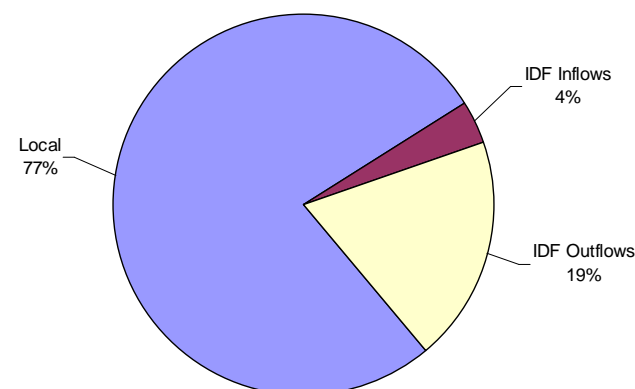
Local Outpatient Activity by Financial Year

Obstetrics volume	04/05	05/06	06/07	07/08
Facility - deliveries	448	476	495	481
Pregnancy and Parenting Education courses	12	10	12	22

Staffing (FTE's) – Clinical Type

	FTE
Obstetrician & Gynaecologist	1.9
House Surgeon	1.0
Clinical Midwife Manager	1.0
Midwives	11.5

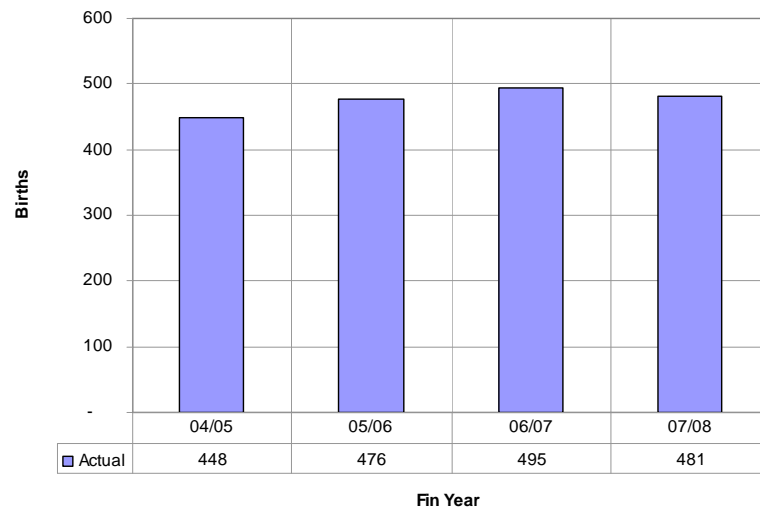
Gynaecology Case Weights
(2007/08)



Delivery by Type

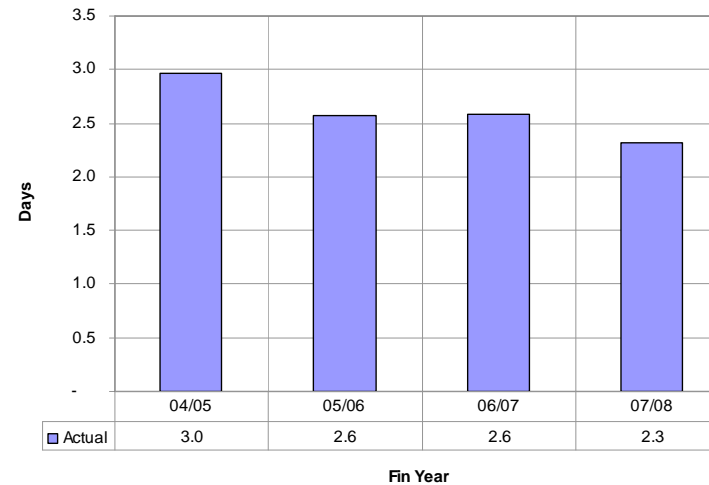
	04/05	05/06	06/07	07/08	07/08 %
Elective Caesarean	58	40	58	78	16%
Emergency Caesarean	62	70	68	61	13%
Forceps	19	8	6	5	1%
Ventouse	34	42	45	28	6%
Normal Delivery	275	316	318	309	64%
Total hospital deliveries	448	476	495	481	100%

Wairarapa DHB Total Hospital Births

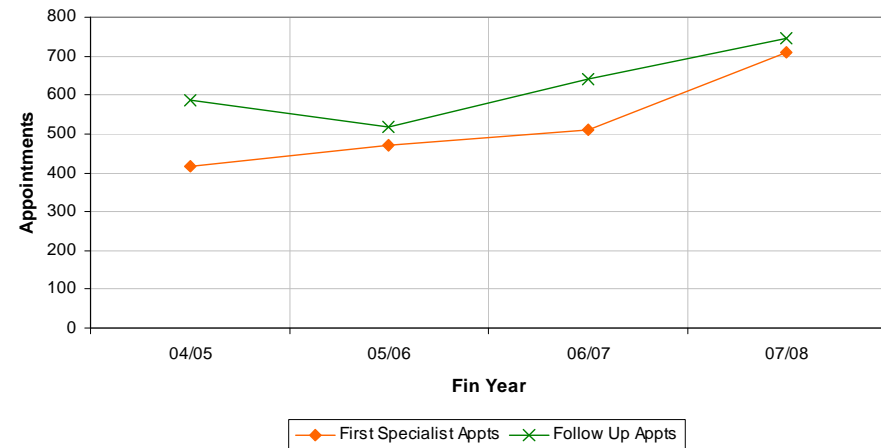


Gynaecology volume	04/05	05/06	06/07	07/08
First Specialist Appts	417	472	510	710
Follow Up Appts	588	518	641	747

Wairarapa DHB Total Maternity Ward Average Length of Stay



Wairarapa DHB Local Outpatient Activity - Gynaecology



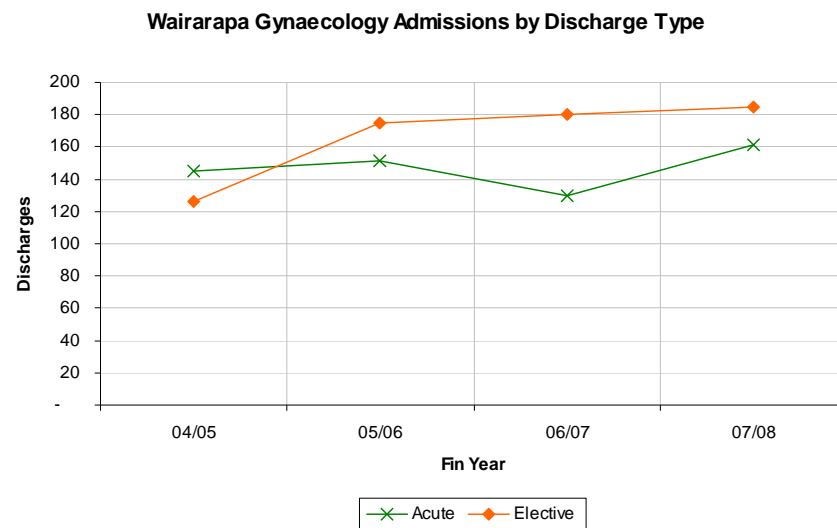
Acute / Elective - Gynaecology

Gynaecology Admissions by Discharge Type

Type of Admission	04/05		05/06		06/07		07/08	
	Inpatient	Day Case	Inpatient	Day Case	Inpatient	Day Case	Inpatient	Day Case
Acute	90	55	91	60	71	59	84	77
Elective	63	63	76	99	69	111	50	135
Total Admissions	153	118	167	159	140	170	134	212
Total	271		326		310		346	
Percentage Day Case	44%		49%		36%		61%	

Total Gynaecology Admissions by Discharge Type

	04/05	05/06	06/07	07/08
Acute	145	151	130	161
Elective	126	175	180	185

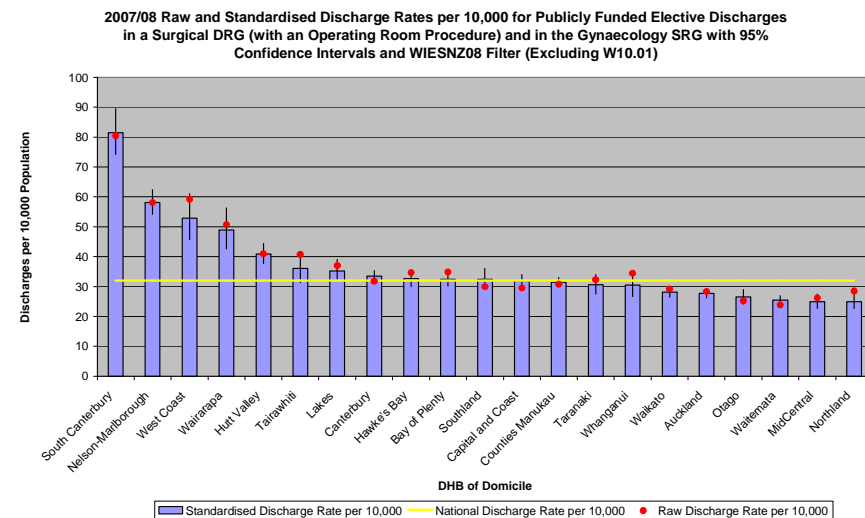


Benchmarks - Gynaecology

Ministry of Health Standardised Discharge Rates:

Gynaecology

- The Wairarapa Hospital is providing gynaecological surgical interventions at a higher rate than the national average.



Health Round Table: Obstetrics

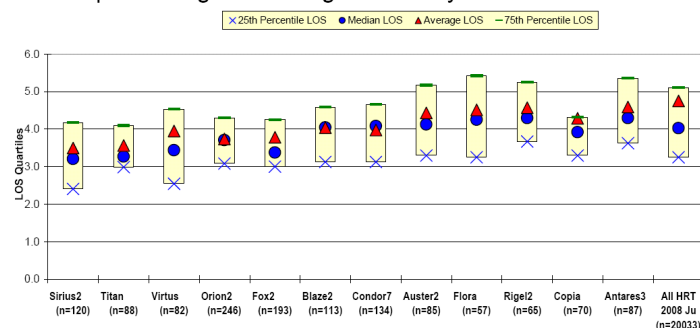
- The average length of stay (ALOS) for Wairarapa caesarean delivery is longer than the average and the emergency readmission rate is slightly lower than the four exemplar hospitals.

Data Extract 2008 Jul-Dec HRT v2

001 - CAESAREAN DELIVERY

DRG Family 001 - CAESAREAN DELIVERY

ALOS at Copia is 4.3 days, 16% longer than the 4 exemplar hospitals' weighted average at 3.7 days



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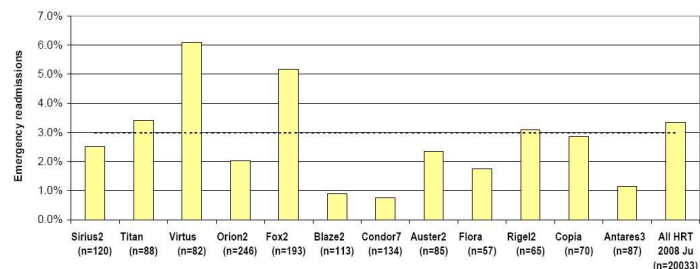
13/04/2009 - v1

Data Extract 2008 Jul-Dec HRT v2

001 - CAESAREAN DELIVERY

DRG Family 001 - CAESAREAN DELIVERY

The emergency readmission rate at Copia is 2.9%, 4% lower than the 4 exemplar hospitals' weighted average at 3%



* Emergency readmission rate is the percentage of episodes that have an unplanned admission to your hospital within 28 days after discharge, for any reason

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Issues and Challenges: Obstetrics & Gynaecology

Workforce

- Recruitment and retention of specialists.
- The workload for normal duties is manageable with two consultants, however on-call emergencies in working hours lead to cancellation of clinics and routine theatre sessions.
- Onerous after hours on-calls impact negatively on quality of life.
- Lack of junior medical staff.
- Heavy reliance on locum cover for specialists.
- Midwife recruitment difficulties (a national problem).
- No succession planning for Clinical Midwifery Manager / Clinical Midwifery Specialist role.
- No clinical educator or formal links with other DHBs for midwife training.
- "Numbers of births" doesn't adequately capture the work volumes in maternity.

Model of care

- Not enough midwives to sustain a totally registered workforce.
- Sustainability of the service provided to Lead Maternity Carers (LMCs).
- Legal post-natal obligations use significant midwifery resources due to large geographical area and increasing number of DNAs.
- Appointment duration doubled due to increased preventative screenings required (smoking, family violence etc).

Clinical viability

- Reliance on locum obstetricians.
- Lack of peer support and opportunities to maintain regular academic contact at consultant level.
- Referral to tertiary centres for non-urgent cases can be an issue.
- Inadequate clinical audit.

Infrastructure

- Lack of clerical/administrative support.
- Inadequate IT system. Paper records with a lot of duplication.
- Office space and computer hardware is severely limited in maternity.
- Requirement to offer an extra day increases demand on bed capacity.

Financial viability

- Mismatch between funding and demand.
- Ministry has devolved funding without full recognition of the GPO relationship.
- Increasing number of unfunded day case procedures in maternity, such as monitoring of patients referred by GPs.
- Cost of locum obstetricians.
- High cost of education to achieve annual practicing certificate.
- Increasing amount of unfunded work from women seeking pregnancy confirmation/advice instead of seeing a GP.

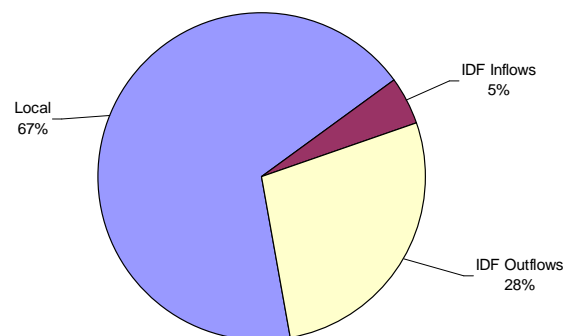
Paediatric Services

Services and People

The Paediatric service provides acute and elective services on an inpatient, outpatient and day stay basis. Paediatrics are regarded as children aged 15 years and under and includes a three bedded SCBU for neonates. The service also provides education and support for parents/caregivers and a home-based community paediatric service. Outpatient clinics are held at Wairarapa Hospital and Greytown Medical Centre.

Activity

Paediatric Case Weights
(2007/08)



Inpatient Activity		04/05	05/06	06/07	07/08
Case Weights	Local	231	186	212	249
	IDF Inflows	18	17	9	17
	IDF Outflows	99	115	143	101
Discharges	Local	426	384	414	487
	IDF Inflows	57	37	34	45
People	IDF Outflows	89	106	81	80

Note: IDF Local and IDF Inflows include Paediatric Medical and Surgical inpatient services. IDF Outflows include Paediatric Medical, Surgical, Specialist Cardiac, Specialist Oncology, Specialist Neurology and Specialist Haematology inpatient services

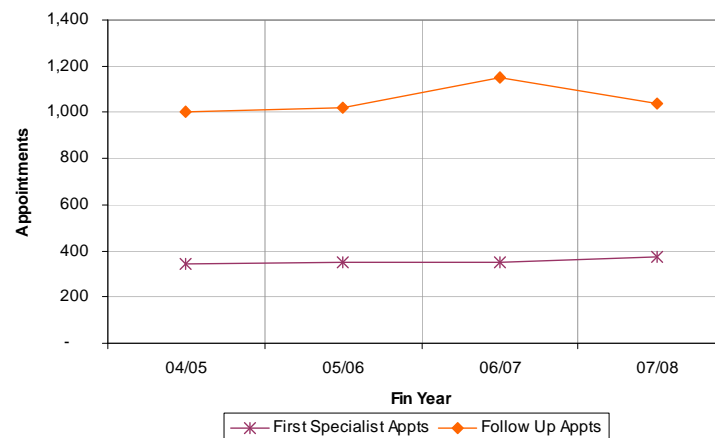
Staffing (FTE's) – Clinical Type

Paediatric	FTE
Paediatrician/Medical Officer	2.0
Clinical Nurse Manager	1.0
Registered Nurses	5.3
House Surgeon (shared with ED)	1.0

Local Outpatient Activity by Financial Year

	04/05	05/06	06/07	07/08
First Specialist Appts	345	349	352	375
Follow Up Appts	1,005	1,022	1,149	1,040

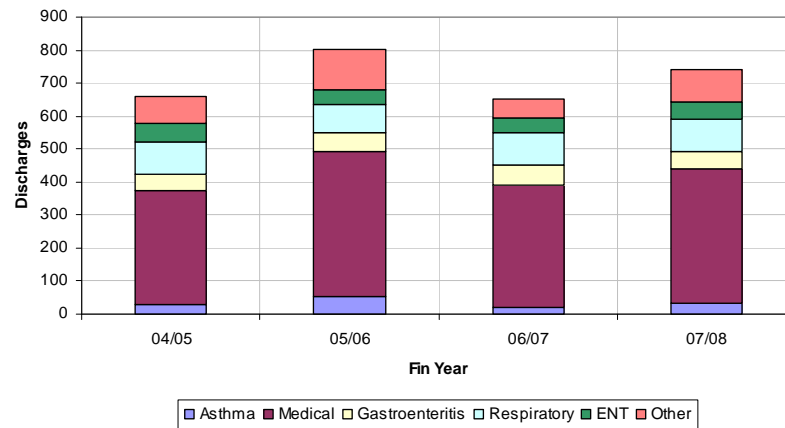
Wairarapa DHB Local Outpatient Activity - Paediatric



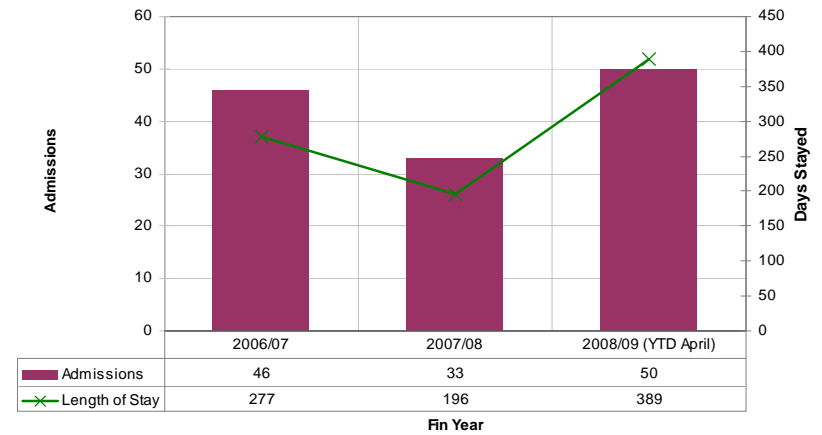
Paediatric Admissions by Conditions

	04/05	05/06	06/07	07/08
Asthma	29	52	19	32
Medical	347	442	370	409
Gastroenteritis	49	54	64	51
Respiratory	98	88	97	97
ENT	55	46	43	54
Other	82	120	60	100

Wairarapa DHB Paediatric Services



Special Care Baby Unit (SCBU) Patients & Days Stayed

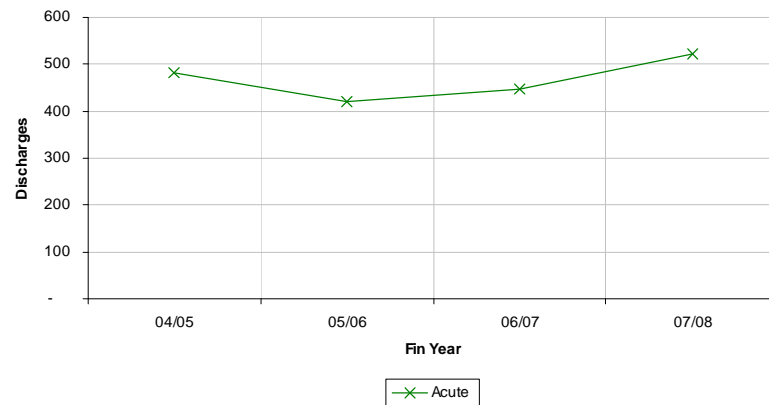


Acute / Elective – Paediatric

Admissions by Discharge Type

Type of Admission	04/05		05/06		06/07		07/08	
	Inpatient	Day Case	Inpatient	Day Case	Inpatient	Day Case	Inpatient	Day Case
Paediatric Admissions	371	112	353	68	363	85	429	103
Total	483		421		448		532	
Percentage Day Case	23%		16%		19%		21%	

Wairarapa DHB Paediatric Admissions by Discharge Type



Total Admissions by Discharge Type

	04/05	05/06	06/07	07/08
Acute	483	421	448	523
Elective	-	-	-	9

Issues and Challenges: Paediatric services

Workforce

- Recruitment and retention of paediatricians.
- The workforce (nurses and medical) is aging.
- Difficult to get skilled specialist paediatric nurses.
- Small nursing team.
 - Can feel isolated and lacking in support when on duty.
 - Difficult to get people away for training/development.
- Only 2 paediatricians.
 - Heavy on-call demands.
 - Feel that can't take leave because of the burden it places on their colleagues.
- Feel that we constantly have to justify having 2 nurses on when we have a SCBU patient. For infection control purposes we must be able to isolate patients, so need separate staff.
- Paediatric patients need more intensive nursing than, say MSW patients. Requirements are higher for the nurses.
- As a service, use RMOs the least but they are an important part of the team/service.
- RMO support is inconsistent – Paediatrics gets dropped when there are shortages.
- Share an RMO with ED but the agreement isn't adhered to. Needs to be a formal agreement.

Model of Care

- The service lacks cohesiveness across multi-disciplinary team.
- System does not support the development of a truly multi-disciplinary team.
- There is no Child Development team (promised funding did not materialise).
- Locums do the minimum when they are here and disrupt the continuum of care.

Clinical Viability

- Difficult for Paediatricians to take leave means it is difficult to get peer/collegial support or attend conferences to stay abreast of changes and developments in the service.
- SCBU is a vital part of the maternity/paediatric service and integral to patient safety.

Infrastructure

- IT systems don't link up and are very frustrating.
- We have good tools but lack the support / training to use them.
 - E.g. TrendCare could be used much more than it is.
- Micro-management, e.g.
 - Need too many signatures to get simple things done.
 - Have no information about budgets/costings.
 - It feels like you only get things when you make a big enough fuss.
- Inconsistent access to concerto for nurses.
- WINScribe should be available to all clinical staff – the Neurodevelopmental Therapist does not have access so has to write or type her notes. The team can't readily access these on the computer.
- The telephone system is frustrating. Clinicians have to go through the switchboard to get to the ward to check patient status – need a direct dial number for clinicians.
- Computer resources/systems are inadequate, and outdated.

Financial Viability

- Lack of funding for training & development for nurses – makes it difficult to plan professional development.
- There was a commitment for ongoing training for SCBU staff but it is difficult to get this.
- We think we are a cost effective service but we don't get given the information, so we don't know.

General Surgery

Services and People

A full range of secondary level surgical services (acute and elective) are provided at Wairarapa Hospital 24 hours a day, 7 days a week. Resident services of general surgery are well supported by a team of anaesthetists, radiology, laboratory and pharmacy services, and allied health disciplines. Visiting specialists support resident services by providing an increasing number of specialties on site including ENT, ophthalmology and urology and many outpatient clinics.

Activity

Inpatient Activity		04/05	05/06	06/07	07/08
Case Weights	Local	917	955	908	1,011
	IDF Inflows	25	48	41	66
	IDF Outflows	209	203	231	199
Discharges	Local	1,062	1,224	1,235	1,306
	IDF Inflows	46	78	85	88
People	IDF Outflows	128	158	134	100

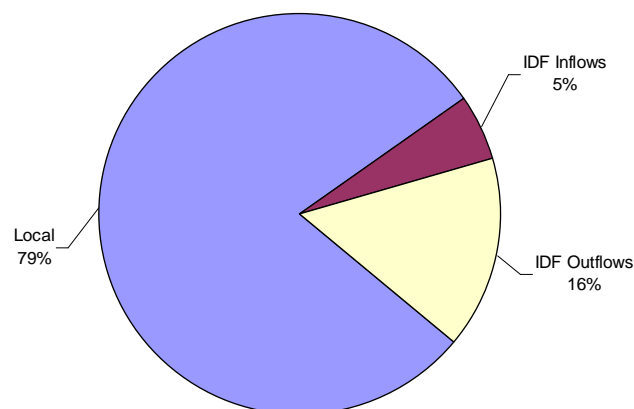
Staffing (FTE's) – Clinical Type

General Surgery	FTE
General Surgeon	2.8
House Surgeon (this varies)	1.0

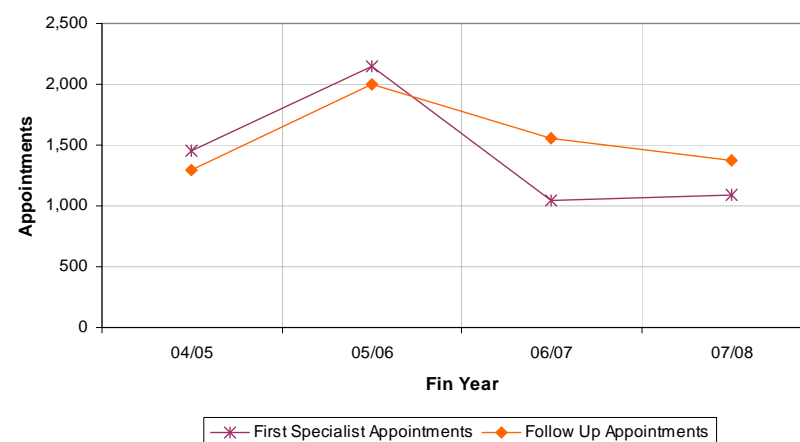
Local Outpatient Activity by Financial Year

	04/05	05/06	06/07	07/08
First Specialist Appointments	1,450	2,149	1,047	1,095
Follow Up Appointments	1,294	2,005	1,553	1,373

General Surgery Case Weights
(2007/08)



Wairarapa DHB Local Outpatient Activity - General Surgery



Acute / Elective – General Surgery

Admissions by Discharge Type

Type of Admission	04/05		05/06		06/07		07/08	
	Inpatient	Day Case	Inpatient	Day Case	Inpatient	Day Case	Inpatient	Day Case
Acute	588	238	587	334	602	315	602	464
Elective	109	173	105	276	123	280	139	189
Total Admissions	697	411	692	610	725	595	741	653
Total	1108		1302		1320		1394	
Percentage Day Case	37%		47%		45%		47%	

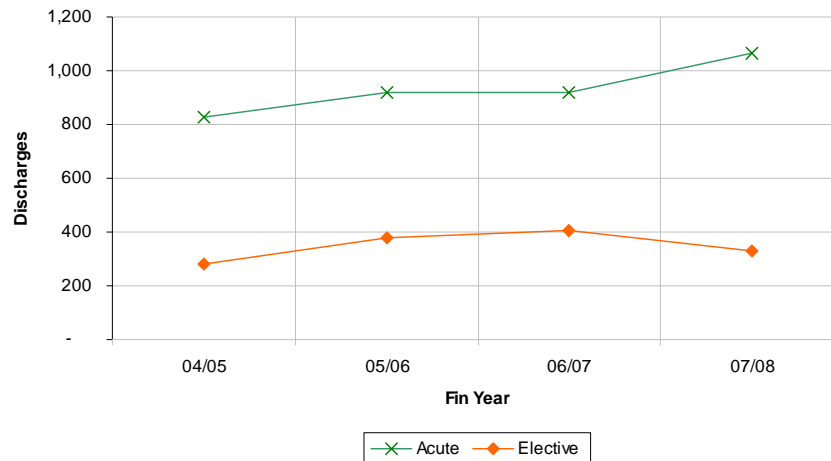
Total Admissions by Discharge Type

	04/05	05/06	06/07	07/08
Acute	826	921	917	1,066
Elective	282	381	403	328

Bed Occupancy and Length of Stay

	Bed Days	Inpatients	Average LOS
2004/05	2,762	697	4.0
2005/06	2,203	692	3.2
2006/07	2,362	725	3.3
2007/08	2,667	741	3.6

Wairarapa General Surgery Admissions by Discharge Type



Benchmarks – General Surgery

Ministry of Health Standardised Discharge Rates

- The Wairarapa Hospital is providing general elective surgical interventions at a much higher rate than the national average.

Issues and Challenges: General Surgery

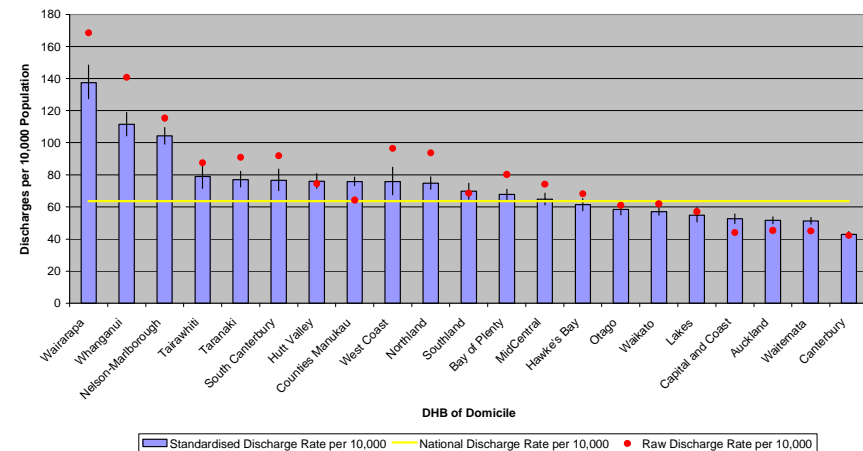
Workforce

- Stability and number of consultant staff.
- Recruitment and retention of SMOs.
- Specialisation within general surgery is changing the historical workload.
- Require a reliable and appropriate method of referral for problems outside our areas of expertise.
- Need to formalise relationships with outsourced departments.
- Need to review the role of RMOs.
- Lack of opportunity for SMOs for study/development leave.
- Challenge to balance the demand between on-call and elective work.
- Lack of clerical/administrative support.
- Lack of imaging support in ultrasound.

Clinical viability

- Instability of workforce.
- Audit system needs review.
- At times general surgeons are obliged to work outside their scope of practice.

2007/08 Raw and Standardised Discharge Rates per 10,000 for Publicly Funded Elective Discharges in a Surgical DRG (with an Operating Room Procedure) and in the General Surgery SRG with 95% Confidence Intervals and WIESNZ08 Filter (Excluding W10.01)



Model of care

- Scope of service delivered is limited which in turn can limit a surgeon's skill over time.
- Need to support GPs to achieve greater empowerment and responsibility in primary care.
- Increasingly seeing clinical problems that in the past GPs would have done.
- Outpatient nursing workforce does a good job but may be overqualified for some of the tasks that need to be done.
- Balancing patient needs/desires against family expectations (advanced care planning).
- Increasing expectations of care in the community which are disproportionate to the ability of the health Service to deliver.

Infrastructure

- Lack of electronic health record.

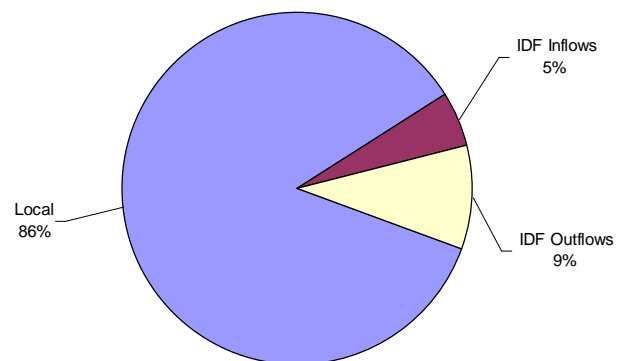
Orthopaedics

Services and People

The Orthopaedic service provides 24 hour seven day a week care for acute and elective services on an inpatient, outpatient and day stay basis. The most common orthopaedic procedures performed at Wairarapa Hospital include reduction of fractures, hip and knee replacement and carpal tunnel.

Activity

Orthopaedic Case Weighted Discharges
(2007/08)



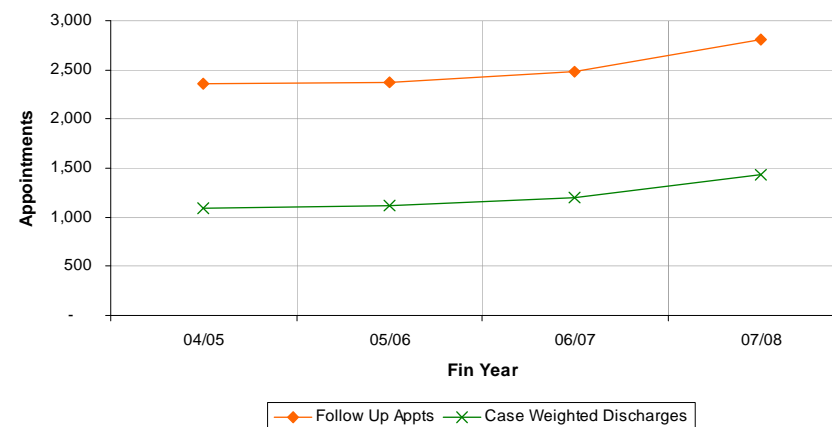
Staffing (FTE's) – Clinical Type

Orthopaedics	FTE
Orthopaedic Surgeon	2.6
House Surgeon	1.0
Clinical Nurse Specialist	1.0

Local Outpatient Activity by Financial Year

	04/05	05/06	06/07	07/08
First Specialist Appts	1,137	1,049	980	1,375
Follow Up Appts	2,356	2,368	2,479	2,806

Wairarapa DHB Local Outpatient Activity - Orthopaedic



Inpatient Activity		04/05	05/06	06/07	07/08
Case Weights	Local	1,024	1,064	1,141	1,359
	IDF Inflows	60	56	65	79
	IDF Outflows	242	311	196	149
Discharges	Local	708	711	742	917
	IDF Inflows	56	42	47	65
People	IDF Outflows	149	144	106	80

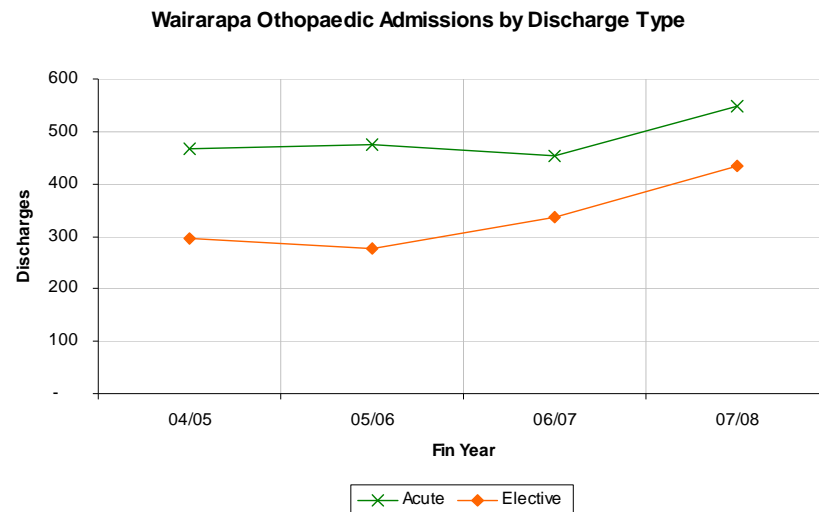
Acute / Elective - Orthopaedics

Admissions by Discharge Type

Type of Admission	04/05		05/06		06/07		07/08	
	Inpatient	Day Case	Inpatient	Day Case	Inpatient	Day Case	Inpatient	Day Case
Acute	311	157	328	148	345	108	384	164
Elective	183	113	143	134	234	102	267	167
Total Admissions	494	270	471	282	579	210	651	331
Total	764		753		789		982	
Percentage Day Case	35%		37%		36%		51%	

Total Admissions by Discharge Type

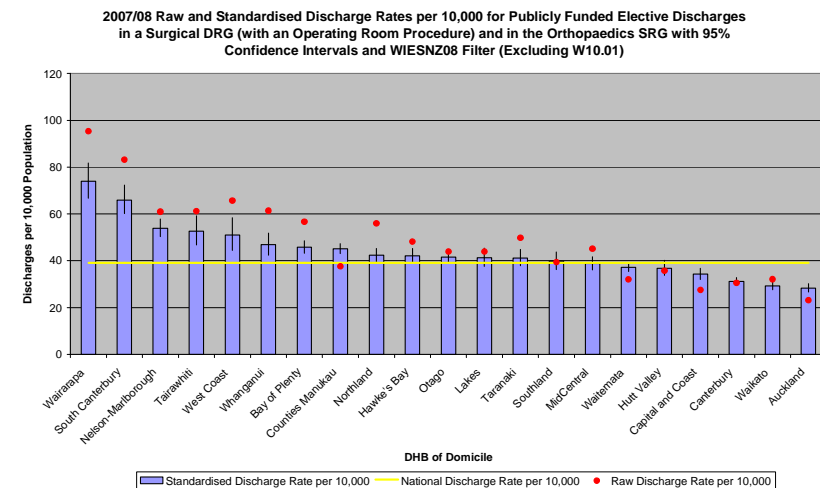
	04/05	05/06	06/07	07/08
Acute	468	476	453	548
Elective	296	277	336	434



Benchmarks - Orthopaedic

Ministry of Health Standardised Discharge Ratio Data

- The Wairapa Hospital is providing orthopaedic surgical interventions at a much higher rate than the national average.



Health Round Table

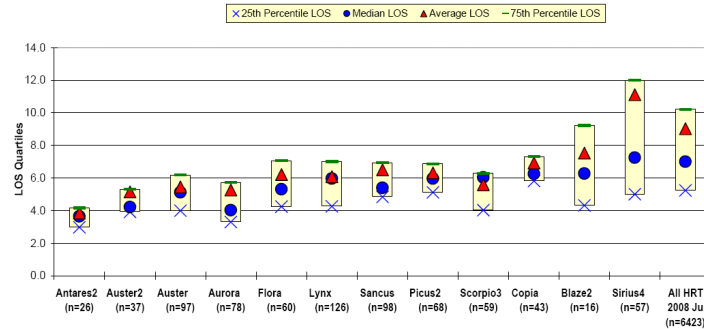
- The average length of stay (ALOS) for hip revision or replacement is slightly longer than the average and the emergency readmission rate is slightly higher than the four exemplar hospitals.

Data Extract 2008 Jul-Dec HRT v2

I03 - HIP REVISION OR REPLACEMENT

DRG Family I03 - HIP REVISION OR REPLACEMENT

ALOS at Copia is 6.9 days, 34% longer than the 4 exemplar hospitals' weighted average at 5.2 days



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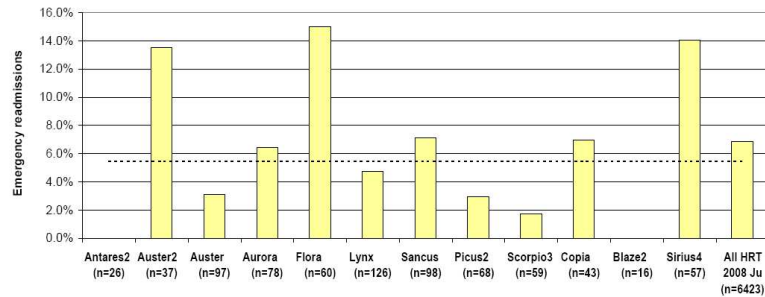
13/04/2009 - v1

Data Extract 2008 Jul-Dec HRT v2

I03 - HIP REVISION OR REPLACEMENT

DRG Family I03 - HIP REVISION OR REPLACEMENT

The emergency readmission rate at Copia is 7%, 28% higher than the 4 exemplar hospitals' weighted average at 5.5%



* Emergency readmission rate is the percentage of episodes that have an unplanned admission to your hospital within 28 days after discharge, for any reason

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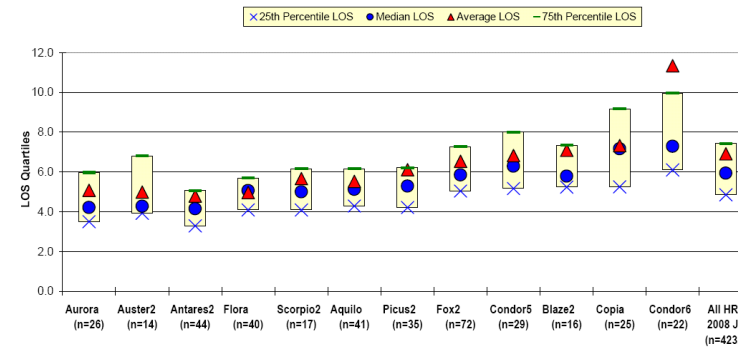
- The average length of ALOS for knee replacement and reattachment is longer than the average and the patients are of a higher complexity than the four exemplar hospitals.

Data Extract 2008 Jul-Dec HRT v2

I04 - KNEE REPLACENT & REATTACH

DRG Family I04 - KNEE REPLACENT & REATTACH

ALOS at Copia is 7.3 days, 49% longer than the 4 exemplar hospitals' weighted average at 4.9 days



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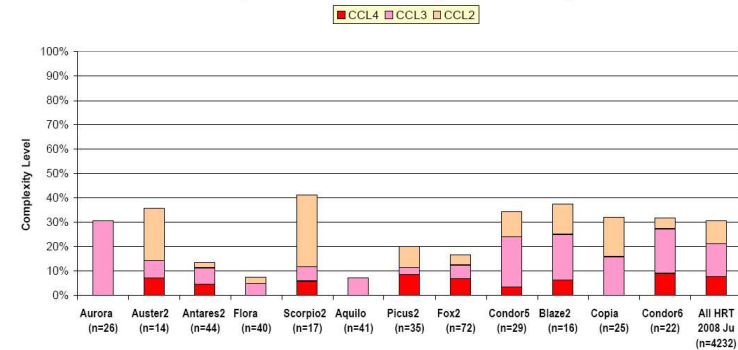
13/04/2009 - v1

Data Extract 2008 Jul-Dec HRT v2

I04 - KNEE REPLACENT & REATTACH

DRG Family I04 - KNEE REPLACENT & REATTACH

32% of patients are higher complexity at Copia, 80% more than the 4 exemplar hospitals' weighted average at 18%



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Issues and Challenges: Orthopaedic

Workforce

- Nationally Orthopaedic surgeons are in short supply and there is a reliance on locums.
- Will be down to two surgeons soon.
- Role of House Surgeon is vital yet the calibre of junior staff varies considerably.
- No dedicated/specialised orthopaedic theatre staff familiar with implants, instruments and patient care.
- The current CNS (orthopaedic) role problematic and need revising.

Model of care

- Wide variability in care – inconsistency in pre-assessment and theatre processes and systems.
- Plan to have all patients pre-assessed and seen by the anaesthetist is not happening.
- Surgical patients from ward are called for just before they are needed delaying the theatre team.
- The way theatre is run needs to be revised. It could be much more efficient.
- Mixed medical/surgical ward means orthopaedic patients don't get specialist nursing care.

Clinical Viability

- Not capturing everything that we could.
- We are offering surgery to people who wouldn't be offered it elsewhere.
- Waiting lists will lengthen with only two surgeons.

Infrastructure (i.e. facility, equipment, IT, records)

- Equipment is poorly maintained with no regular service program and inadequate checking after repair work.
- Inadequate clinical audit system.
- Duplicate paper-based records.

Financial Viability

- Lack of time/resources for training and development for nursing staff.
- Need to be bigger with permanent staff to be sustainable.
- We are missing out on ACC revenue because the infrastructure and processes are not in place to capture ACC cases properly.

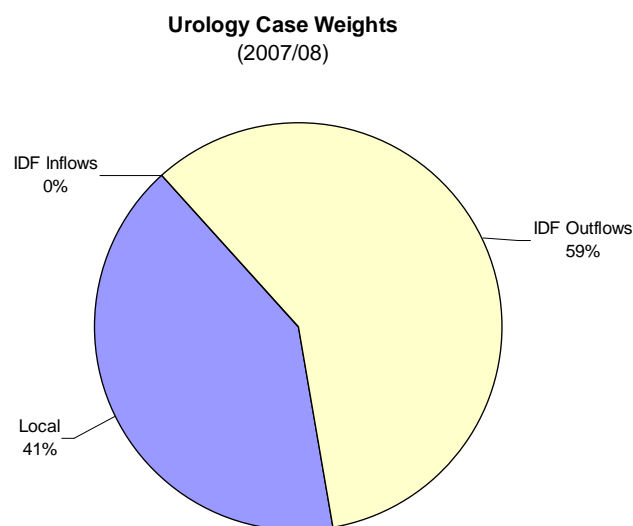
Sub-Specialty Surgery

Urology

Urology Associates is contracted to provide a complete Urology service aside from the most complex surgery which is transferred out to neighbouring DHBs. Urologists visit once a month only for 2-3 days, performing all surgery and clinic appointments.

On-site nursing staff employed by Urology Associates triage all referrals, order diagnostics and book appointments according to priority, length of wait and what is required at First Specialist Assessment (FSA)

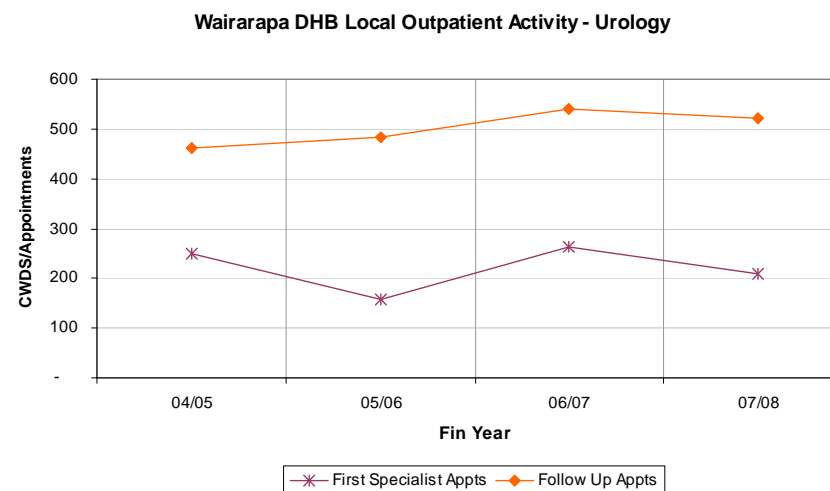
Activity



Inpatient Activity		04/05	05/06	06/07	07/08
Case Weights	Local	90	39	51	58
	IDF Inflows	1	-	1	-
	IDF Outflows	60	52	47	83
Discharges	Local	152	67	83	78
	IDF Inflows	4	-	2	-
People	IDF Outflows	46	35	32	45

Local Outpatient Activity by Financial Year

	04/05	05/06	06/07	07/08
First Specialist Appts	249	157	264	209
Follow Up Appts	462	484	540	521



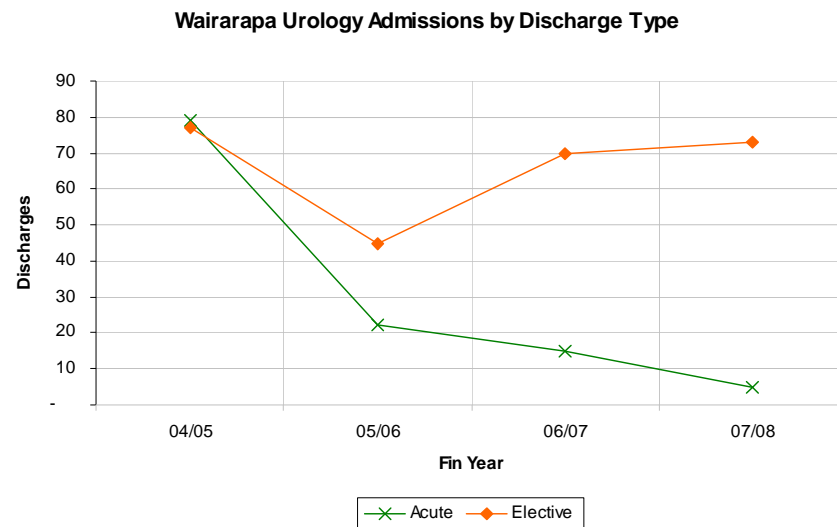
Acute / Elective - Urology

Admissions by Discharge Type

Type of Admission	04/05		05/06		06/07		07/08	
	Inpatient	Day Case	Inpatient	Day Case	Inpatient	Day Case	Inpatient	Day Case
Acute	37	42	10	12	9	6	3	2
Elective	50	27	34	11	45	25	48	25
Total Admissions	87	69	44	23	54	31	51	27
Total	156		67		85		78	
Percentage Day Case	44%		34%		36%		35%	

Total Admissions by Discharge Type

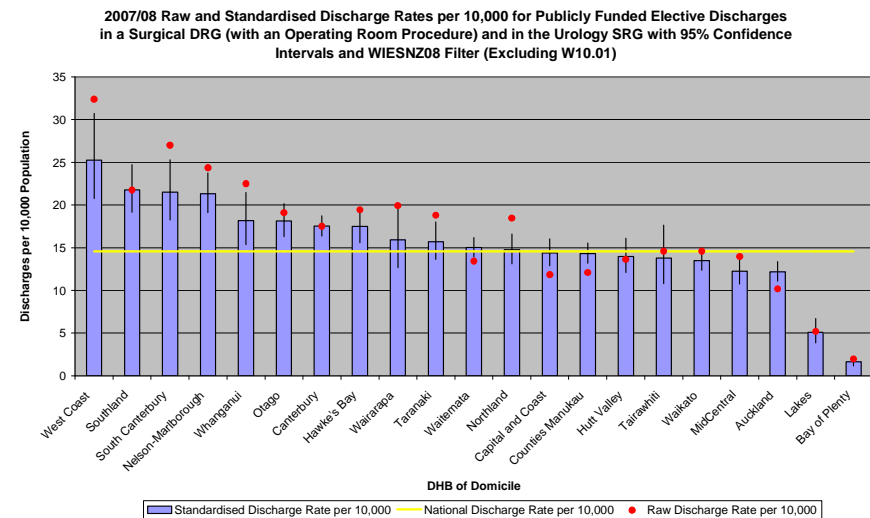
	04/05	05/06	06/07	07/08
Acute	79	22	15	5
Elective	77	45	70	73



Benchmarks - Urology

Ministry of Health Standardised Discharge Rates

- The Wairarapa Hospital is providing urology surgical interventions at a rate a little above the national average.



Issues and Challenges: Urology

Workforce

- Local urology nurses have no support staff and no access to or time for training and education.
- Potential succession problems.
- Do procedures that are unfamiliar to the nursing staff in theatre & MSW.

Model of care

- Local urology nurses are vital to the service.
- ED returns patients to GP rather than refer to urology nurse.
- Hospital consultants are not using the Christchurch on call service.
- Reliant on management support to continue to develop the service.

Clinical viability

- Access to services not available here e.g. urodynamics.
- Complex patients who we can't operate on here – Palmerston North don't want us to spend operating time on Wairarapa patients.
- Need formal agreements with other DHBs to ensure the sickest and most urgent patients receive care e.g. stones and major cancers.

Infrastructure

- The service creates a high demand on inpatient beds.
- There is a high demand from the service for a short period each month as they are reliant on facilities and staff being available to ensure things run smoothly.
- Inability to place typed documents on concerto (own IT system for patient notes provided).
- Resourcing of equipment is mixed. Some equipment is borrowed but problems have occurred with damage in transit.
- Have to borrow the ultrasound machine from Imaging.

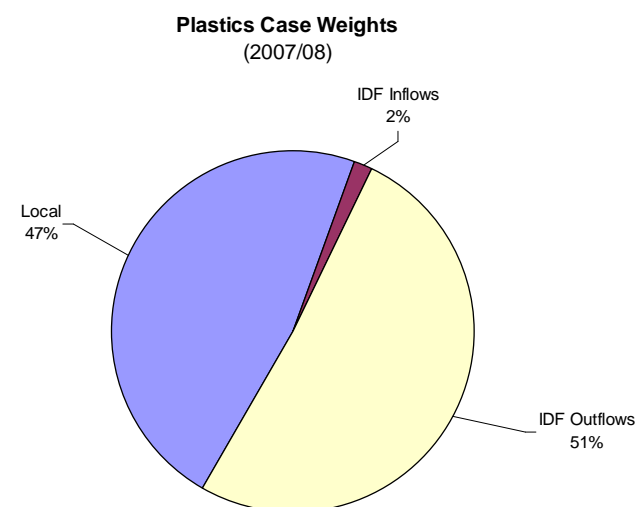
Financial viability

- Cost of training and workforce development.
- This is a work in progress but we are heading in the right direction.

Plastics / Skin Lesions

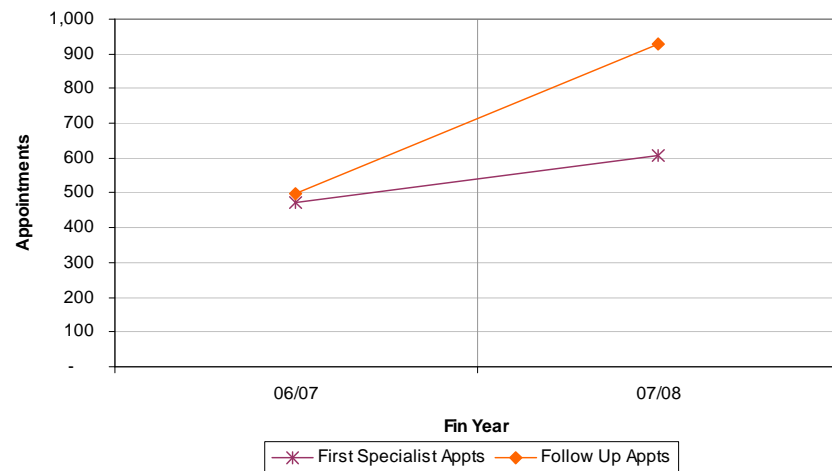
The plastics service is contracted to Hutt Valley DHB and provided by a visiting consultant arranged on an “as required” basis. This is generally once every 3 to 6 months. Only the most complex cases are referred out, with minor and moderate skin lesion surgery being performed locally by a single doctor.

Activity



Inpatient Activity		04/05	05/06	06/07	07/08
Case Weights	Local	-	-	101	177
	IDF Inflows	-	-	2	6
	IDF Outflows	176	153	173	191
Discharges	Local	-	-	240	406
	IDF Inflows	-	-	6	18
People	IDF Outflows	186	172	140	174

Wairarapa DHB Local Outpatient Activity - Plastics



Local Outpatient Activity by Financial Year

	06/07	07/08
First Specialist Appts	474	608
Follow Up Appts	499	927

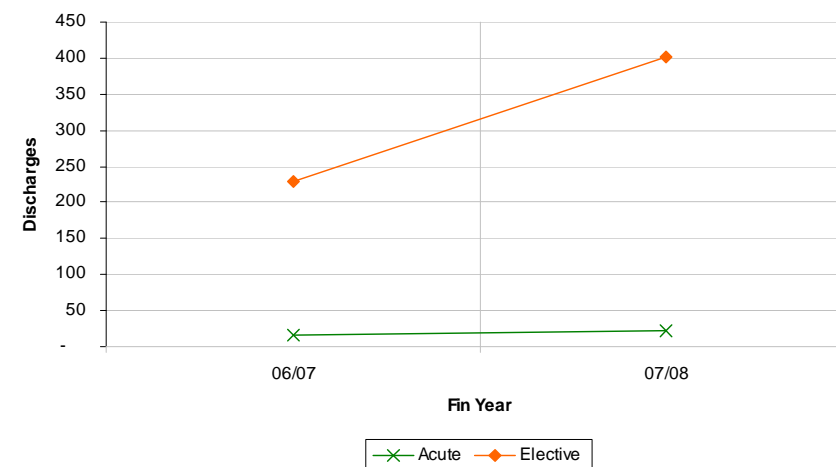
Acute / Elective - Plastics

Total Admissions by Discharge Type

	04/05	05/06	06/07	07/08
Acute			16	22
Elective			230	402

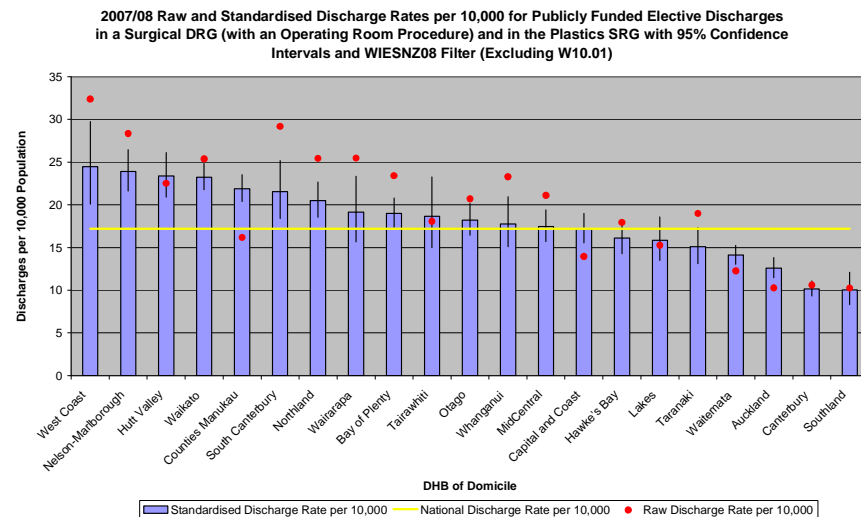
Type of Admission	06/07		07/08	
	Inpatient	Day Case	Inpatient	Day Case
Acute	5	11	5	17
Elective	4	226	1	401
Total Admissions	9	237	6	418
Total	246		424	
Percentage Day Case	96%		99%	

Wairarapa DHB Plastics Admissions by Discharge Type



Benchmarks - Plastics

Ministry of Health Standardised Discharge Rates



Issues and Challenges: Plastics

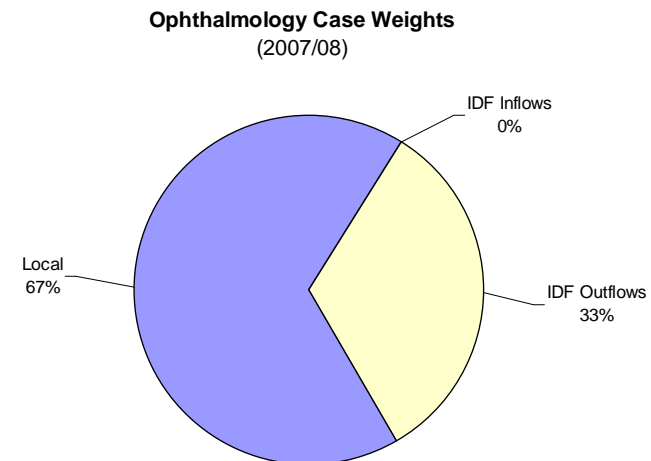
- Being reliant on a single physician responsible for the surgery represents a risk to the DHB should he leave.
- Other DHB's contract skin lesions out to primary care.

Ophthalmology

There is no acute Ophthalmology service at Wairarapa Hospital unless a patient is seen opportunistically while a visiting specialist is on site. The contracted specialists provide services on either a fortnightly or monthly basis.

Wairarapa Hospital does not have optical coherence tomography for performing retinal screening. This and all laser surgery is performed at Capital and Coast DHB. A .5 FTE Registered Nurse coordinates the Elective Ophthalmology service.

Activity

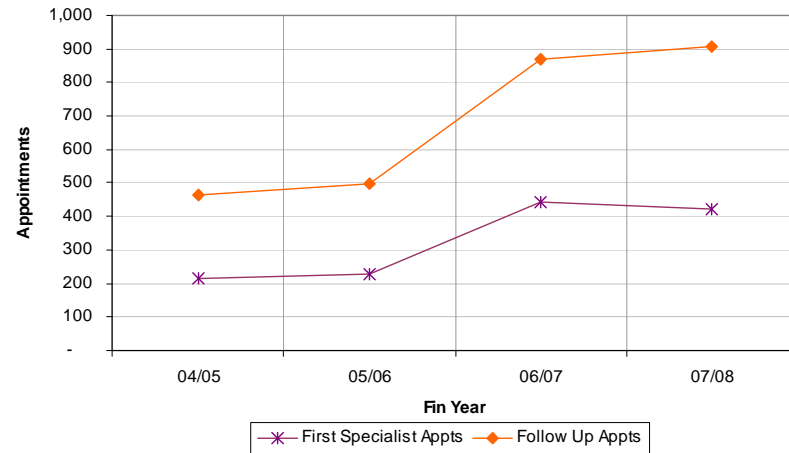


Inpatient Activity		04/05	05/06	06/07	07/08
Case Weights	Local	43	58	104	109
	IDF Inflows	-	-	-	-
	IDF Outflows	51	53	49	53
Discharges	Local	86	106	189	192
	IDF Inflows	-	-	-	-
People	IDF Outflows	62	66	64	77

Local Outpatient Activity by Financial Year

	04/05	05/06	06/07	07/08
First Specialist Appts	215	228	443	422
Follow Up Appts	463	496	870	907

Wairarapa DHB Local Outpatient Activity - Ophthalmology

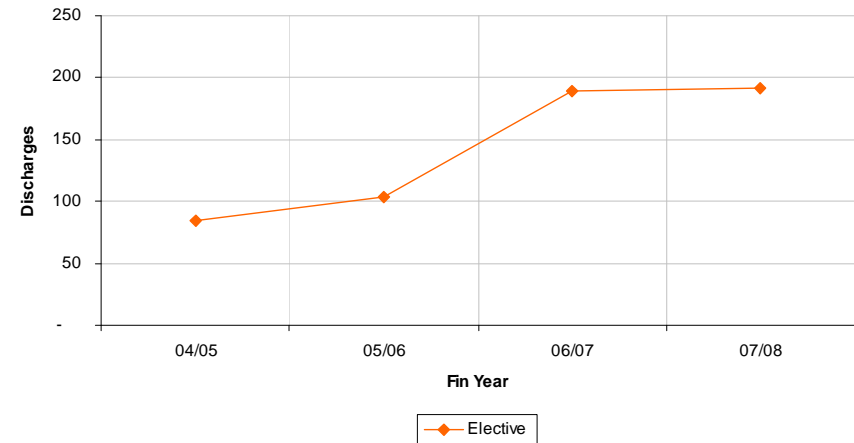


Acute/Elective Ophthalmology

Total Admissions by Discharge Type

	04/05	05/06	06/07	07/08
Acute	1	2	-	-
Elective	85	104	189	192

Wairarapa Ophthalmology Admissions by Discharge Type



Admissions by Discharge Type

Type of Admission	04/05		05/06		06/07		07/08	
	Inpatient	Day Case	Inpatient	Day Case	Inpatient	Day Case	Inpatient	Day Case
Acute	1	-	-	2	-	-	-	-
Elective	-	85	-	104	3	186	-	192
Total Admissions	1	85	-	106	3	186	-	192
Total	86		106		189		192	
Percentage Day Case	99%		100%		98%		100%	

Issues and Challenges: Ophthalmology

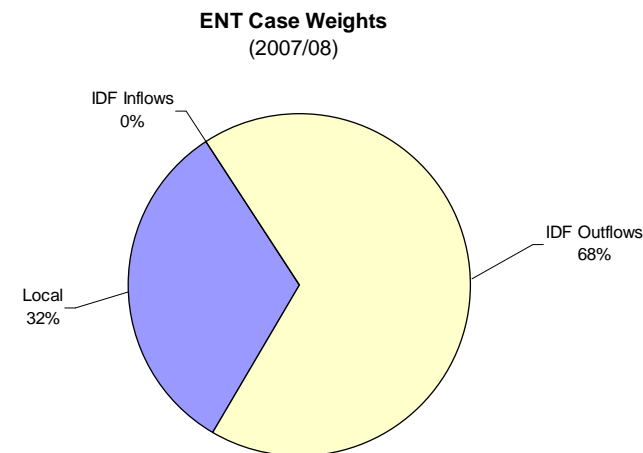
- Ophthalmology Nurse role was created to enhance the flow of patients through the Outpatient clinics and free up appointment times with the Consultants.
- It also creates a relationship with the patients, reduces DNA's and reduces non medical appointments with Consultants.
- The role could be further enhanced with the purchase of equipment to allow the nurse to perform intra ocular pressures and by having an area more suitable to performing visual acuity.
- There is significant risk to the continuity of the service in that it relies on visiting specialists with other, larger commitments.
- This risk is mitigated by contracting a number of specialists, each with particular sub-specialties covering most of the range of Ophthalmology. They agree to accept each other's patients for surgical procedures, reducing the double handling.
- There is high demand in the Wairarapa reflecting a long time shortage of public service.
- There is still not the capacity to accept routine referrals from primary care and the threshold for cataract surgery was higher than other districts until recently.

Ear, Nose and Throat (ENT)

There is no acute ENT service at Wairarapa Hospital, this is covered by the General Surgeons on call unless a patient is seen opportunistically while a visiting specialist is on site.

Wairarapa Hospital contracts with Hutt Valley DHB to provide Consultants for Elective surgery and outpatient clinics. All clinics have an Audiometry clinic running simultaneously reducing the need for extra visits. This service is contracted to a private Audiology company. Complex ENT surgery is transferred out to neighbouring DHBs, Hutt Valley and MidCentral.

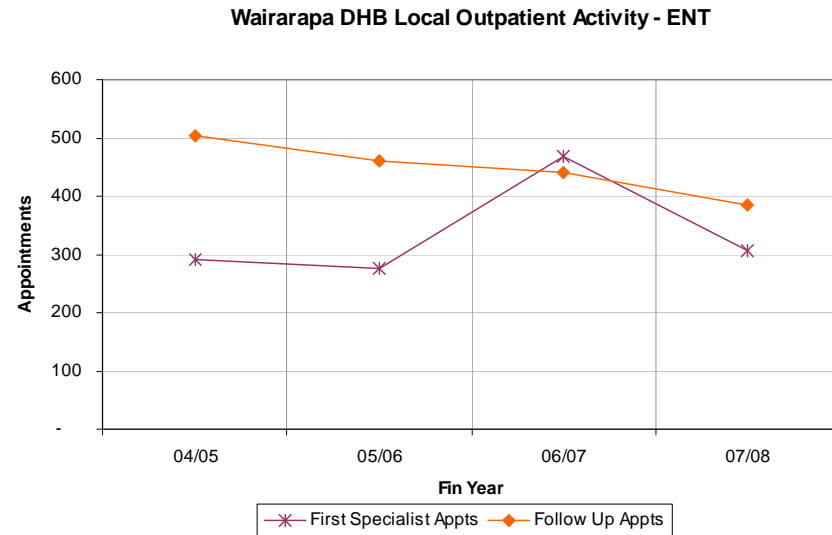
Activity



Inpatient Activity		04/05	05/06	06/07	07/08
Case Weights	Local	19	25	24	46
	IDF Inflows	-	-	2	-
	IDF Outflows	75	64	91	96
Discharges	Local	48	65	56	110
	IDF Inflows	-	-	6	-
People	IDF Outflows	114	90	101	100

Local Outpatient Activity by Financial Year

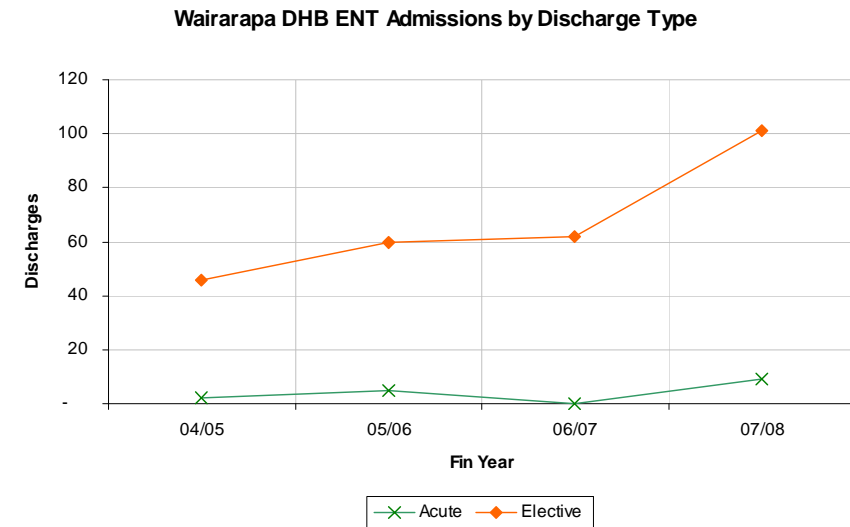
	04/05	05/06	06/07	07/08
First Specialist Appts	291	275	469	306
Follow Up Appts	504	462	441	384



Acute / Elective -ENT

Total Admissions by Discharge Type

	04/05	05/06	06/07	07/08
Acute	2	5	-	9
Elective	46	60	62	101



Admissions by Discharge Type

Type of Admission	04/05		05/06		06/07		07/08	
	Inpatient	Day Case	Inpatient	Day Case	Inpatient	Day Case	Inpatient	Day Case
Acute	2	-	2	3	-	-	1	8
Elective	13	33	19	41	19	43	46	55
Total Admissions	15	33	21	44	19	43	47	63
Total	48		65		62		110	
Percentage Day Case	69%		68%		69%		57%	

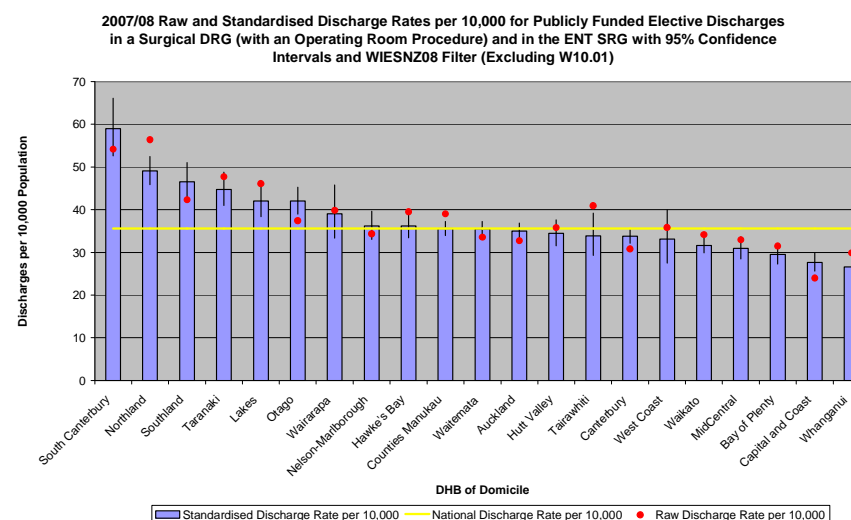
Issues and Challenges: ENT

- One specialist comes fortnightly for surgery and clinics and the other monthly. This is not enough to cover the demand from primary care for specialist input.
- A three pronged approach is taken to managing the high demand.
 - Screening of referrals and non-acceptance of the least need, with written advice provided to the referrer.
 - Contracting other Specialists on an “as needed” basis. ENT lends itself well to the blitz approach. Full days, sometimes weekends, are given over to seeing new patients and performing surgery.
 - Having some procedures performed by other practitioners, eg Aural toilet and wax removal. In other DHB's CNS's perform this role but Wairarapa does not have enough patients to enable a nurse to maintain the skills needed.
- Complex ENT surgery is transferred out to the DHB the Specialist usually works in, ie Hutt Valley and MidCentral.
- To reduce this outflow of patients would require surgical equipment and training.
- The Specialists would probably need to stay longer due to the risk of post operative complications.

Benchmarks - ENT

Ministry of Health Standardised Discharge Rates

- The ENT intervention rate at Wairarapa Hospital is a little above the national average.



Mental Health

Services and People

Mental health is a term used to describe either a level of cognitive and emotional wellbeing or an absence of a mental disorder. The Mental Health Service provides specialist health services for all people of the Wairarapa region, who are experiencing a moderate to serious mental health problem.

Improving the health status of people with mental health illness is one of the Wairarapa DHBs strategic priorities. Mental health services funded by the Wairarapa DHB include a mix of local and regional services that cover a wide range of mental health and alcohol and other drug addiction needs. These include a mix of residential support, community support, day programmes and services for adults, children and adolescents.

Staffing (FTE's) – Clinical Type

Mental health	Adult	CAMHS	Total FTE
Psychiatrists/medical officer	2.6	0.9	3.5
Psychologists	1.0	1.4	2.4
Registered nurses	9.5	2.0	11.5
Clinical Nurse Manager/ Team Leader	1.0	1.0	2.0
Community Support workers	7.8	2.0	9.8
Social Workers	1.0	1.0	2.0
Occupational Therapist	1.0		1.0
Counsellors		1.4	1.4
Maori mental health professionals	2.0	2.0	4.0
Technical / Administrative	3.0	1.0	4.0

Crisis Respite

There is a Crisis Respite Unit at the Wairarapa Hospital to support individuals and families in crisis where the need is insufficient to warrant admission to hospital.

	2006/07	2007/08
Admissions	190	167
Nights	902	1104

Mental Health Inpatient Admissions

Wairarapa DHB does not have inpatient facilities for mental health patients. Admissions are by arrangement with other DHB's. Wairarapa DHB mental health service holds a budget for access to acute and intensive care for adults at other DHBs. The table below shows how this is used.

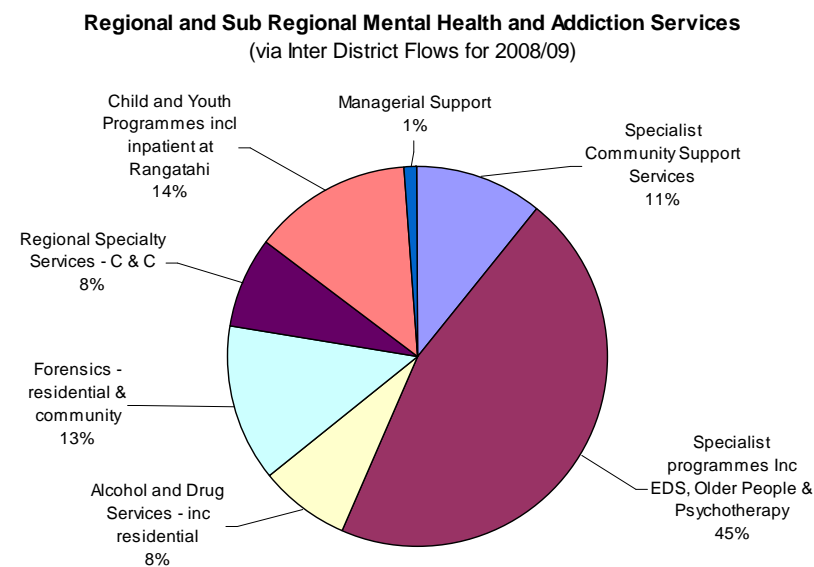
DHB		2006/07	2007/08
Capital & Coast	Admissions	2	3
	Bed Nights	8	19
Hutt	Admissions	9	12
	Bed Nights	141	154
Mid Central	Admissions	28	23
	Bed Nights	320	221

The Wairarapa Health Needs Assessment 2007 indicates that the top five diagnoses for admitted patients were:

- Schizophrenia
- Depressive episodes
- Mental and behavioural disorders due to the use of alcohol
- Bipolar affective disorder
- Reaction to severe stress, and adjustment disorders

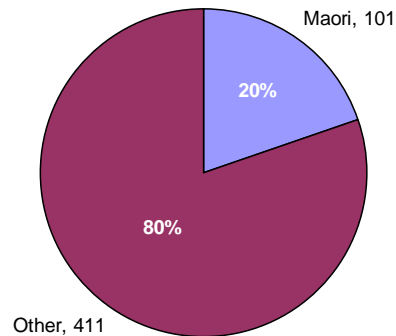
Wairarapa patients also have access to other regional services funded through Inter District Flows.

Regional and Sub Regional Mental Health and Addiction Services (via Inter District Flows for 2008/09)	
Specialist Community Support Services	
Peer Support Community Support Work (Masterton based)	\$ 157,548.14
Refugees Community Support Work	\$ 4,416.16
Deaf Mental Health Support Service	\$ 7,910.66
Total	\$ 169,874.96
Specialist programmes Inc EDS, Older People & Psychotherapy	
Speciality Psychotherapy Services Residential programme	\$ 15,210.89
Central Region Eating Disorder Service (Hutt)	\$ 10,276.42
Advocacy and support programmes	\$ 29,393.89
Clinical rehab / sub acute (approx 4 bed days p.a)	\$ 621,476.91
Extended care, older people	\$ 47,355.90
Total	\$ 723,714.01
Alcohol and Drug Services - inc residential	
AOD residential programmes	\$ 22,120.52
MST programme for AOD (Youth)	\$ 36,450.00
AOD residential and community support	\$ 42,651.65
AOD Detox & Residential - Kenepuru	\$ 23,113.02
Total	\$ 124,335.19
Forensics - residential & community	
Forensic Services - Capital & Coast based	\$ 209,216.75
Total	\$ 209,216.75
Regional Specialty Services - C & C	
Maternal mental health	\$ 15,376.95
DD Intellectual Disability	\$ 18,650.42
Specialist Psychotherapy Service	\$ 24,657.27
Total	\$ 123,400.88
Child and Youth Programmes incl inpatient at Rangatahi	
C & Y Inpatient beds - Rangatahi Unit (approx 210 bed days p.a)	\$ 118,136.83
MST programme for mental health (C & Y)	\$ 69,182.66
Youth AOD residential programme in HB	\$ 29,859.81
Total	\$ 217,179.29
Managerial Support	
Regional Contracts manager - Hutt	\$ 5,235.57
Maori Provider Development	\$ 11,804.52
Total	\$ 17,040.09
Grand Total	\$ 1,584,761.17

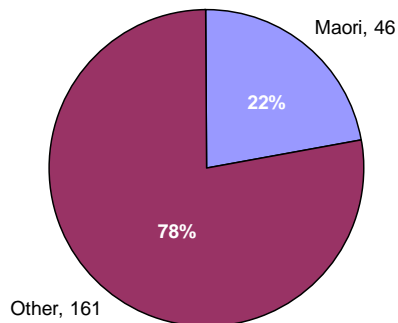


Mental Health access rates by ethnicity

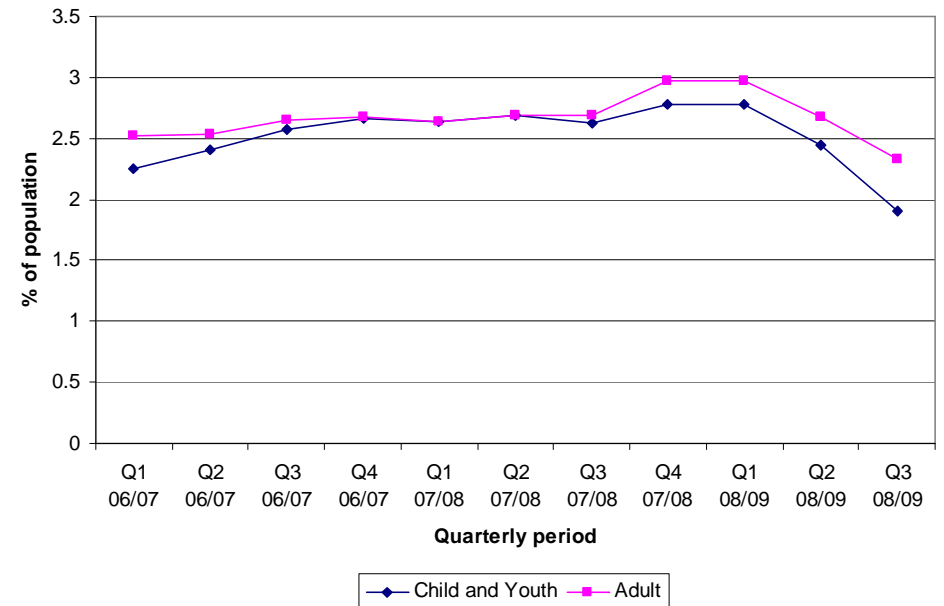
Number of Adult mental health service users
Quarter 3 2008/09



Number of CAMHS service users - by ethnicity
Quarter 3 (2008/09)



Mental Health access rates by service

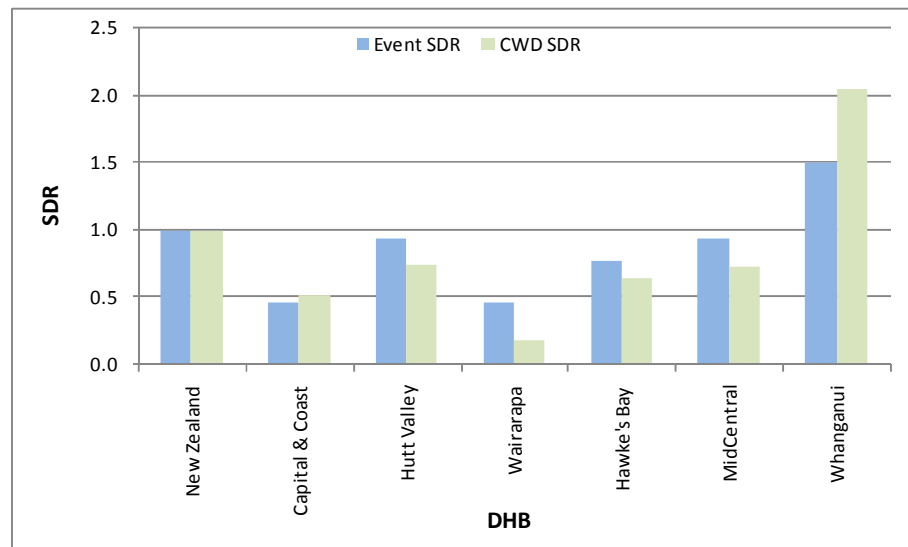


Benchmarks – Mental Health

Twenty five Diagnostic Related Groups (DRGs) make up the Service Related Group (SRG) for mental health inpatient services. When age standardised rates for each DHB are compared against the national rate, DHBs with a ratio (SDR) below one are receiving less service for their population than the average for New Zealand.

However due to the notable variation within the Central Region, with Whanganui having a very high rate and all the other DHBs having a rate below the national average, reporting inconsistencies are possibly biasing this data.

Standardised discharge rates for the Central Region DHBs for the mental health SRG (all events), 2007/08



Three of the 25 mental health DRGs make up 80% of the service case-weights provided to the region's population, the largest being U61A - schizophrenia disorders with mental health legal status (44%) with 5391 case-weights. By volume, this DRG accounts for 15% of all mental health discharges, ranking second behind U63B - major affective disorders age <70 without catastrophic or severe complicating conditions which accounts for 18%.

Issues and Challenges: Mental Health

Workforce

- Recruitment of psychiatrists and subsequent reliance on locum psychiatrists.
- Recruitment of registered Maori mental health professionals.
- CAMHS have a challenge to integrate part time staff into the team.
- Issue with aging workforce in the future.

Model of care

Adult Mental Health Services.

- Utilisation of crisis respite to move away from a bed focus to a community focus.
- Transferring patients between community teams and inpatient.

Child and Adolescent Mental Health Services (CAMHS).

- Funding model does not always facilitate an inter-sectoral approach.
- Difficulties accessing local youth consumer input.
- Lack of knowledge of the service creates a barrier to access.
- Challenge to stay involved with the range of different agencies working with patients.

Clinical Viability

- Difficulty in providing Maori mental health clinician for Maori client when required.
- Difficulty in recruitment of psychiatrists requiring locum psychiatrists to cover necessary roster.

Infrastructure

- Inadequate patient management system
- Insufficient IT hardware
- Limited information system impedes the extraction of information
- Difficulties getting timely HR information
- Over-bureaucratic DHB processes which impede on timely service manager's ability to respond to accountability and responsibility issues (e.g. unnecessary duplication of tasks/duties/signatures which should be at service management level but have to be elevated as part of DHB organisational structure)

Financial viability

- Psychiatrist locums costs
- CAMHS facility is not best suited to purpose – expensive long term lease and high maintenance costs due to age of facility
- Current expensive lease of DAO vehicle

Disability Support Services

Services and People

Disability Support services are provided on an inpatient, outpatient, domiciliary and day stay basis. The range of services includes: Assessment, Treatment and Rehabilitation (AT&R) and FOCUS providing home support.

The rehabilitation service has changed its focus from treating mainly inpatients, to moving out and supporting people in their own environment. Allied health disciplines are an integral part of the multi-disciplinary approach to rehabilitation.

The Wairarapa Hospital Rehabilitation Unit has 10 beds for people with highly complex rehabilitation needs. It provides rehabilitation for patients recovering from post acute exacerbations of typically medical conditions i.e. strokes and other neurological problems, as well as recovery from major orthopaedic surgery. The unit also includes a room designed for people with psycho-geriatric needs, and a 'transition flat' simulating a home environment.

FOCUS is a weekday service providing:

- a single point of entry for all referrals for support, palliative and community nursing.
- needs assessment and service coordination to people with a life long or age related disability; and/or long term personal health conditions.
- packages of support for those with needs that fall between funding streams.
- management of the health recovery programme.
- a link to hospital services to assist with discharge planning.

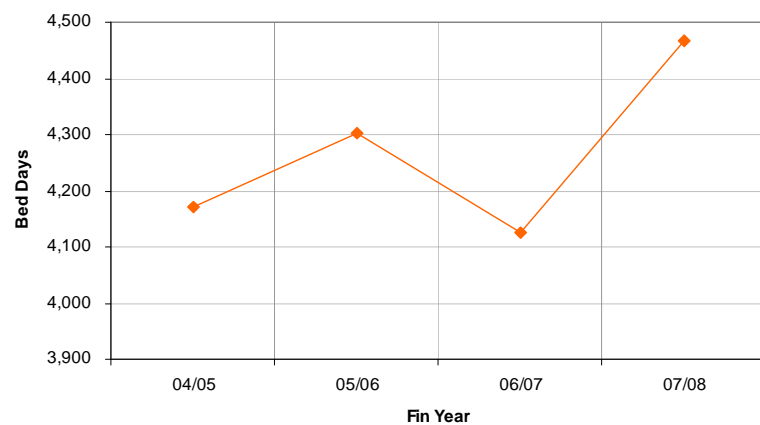
Staffing (FTE's) – Clinical Type

Position	FTE
Medical Officer	1.0
Clinical Nurse Manager	0.7
Clinical Nurse Specialist	1.0
Registered Nurses	6.4
Enrolled Nurses	2.8
Rehabilitation Support Worker	2.1
FOCUS staff with practicing certificates	5.2

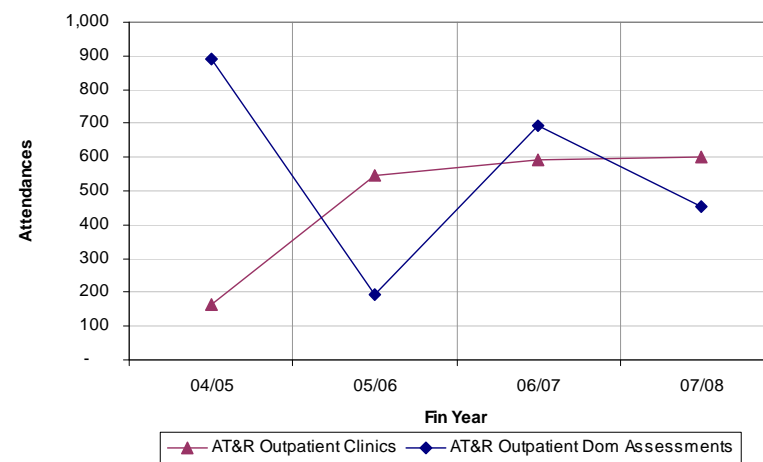
Activity

AT&R	04/05	05/06	06/07	07/08
Needs Assessment (FOCUS)	74	59	164	188
AT&R Inpatient Bed Days	4,172	4,302	4,126	4,466
AT&R Outpatient Clinic Attendances	162	546	593	600
AT&R Outpatient – Domiciliary Attendances	890	193	692	452
AT&R Orthotics Assessments	153	174	446	745
AT&R Inpatient Bed Days - Mental Health for Elderly	506	397	196	435
Hearing Assessments (now outsourced)	612	875	852	952

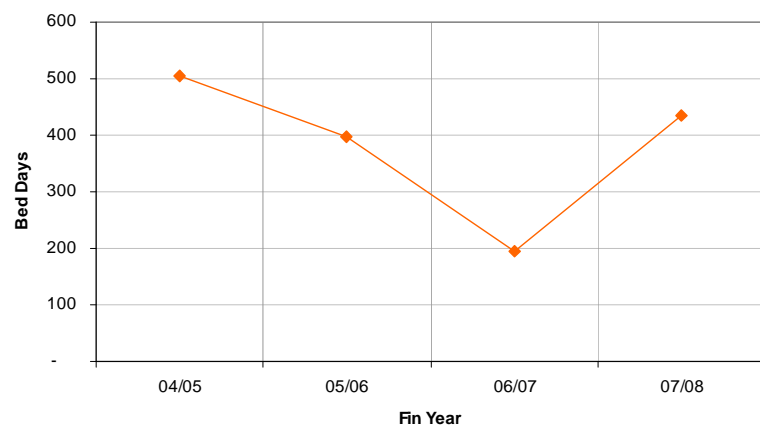
Wairarapa DHB AT&R Inpatient Bed Days



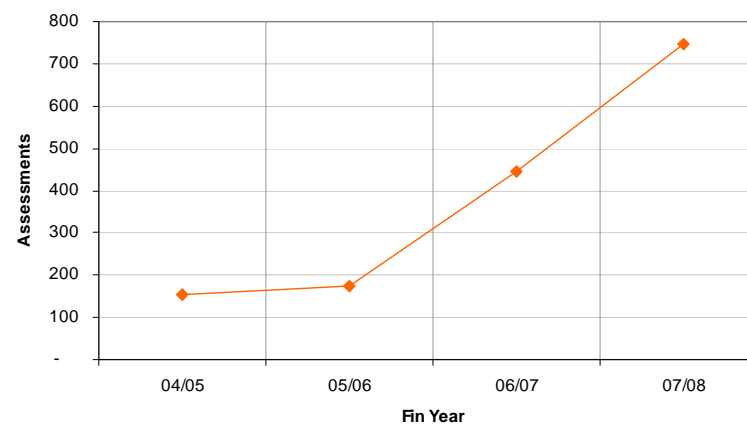
Wairarapa DHB AT&R Outpatient Activity



Wairarapa DHB AT&R Inpatient Bed Days - Mental Health for Elderly



Wairarapa DHB AT&R Orthotics Assessments



Issues and Challenges: Disability Support Services

Workforce

- Rehab is reliant on Allied health – it's an important part of the MDT. It needs the whole team, issues affecting Allied health impact on AT&R (See Allied health).
- Lack of communication between theatre planning and Allied Health/Rehab impacts on our workload.
- Because of the AT&R load the AT&R physiotherapist can't always do rehab outpatients.
- Growth in senior service referrals stretches existing FOCUS staff.
- Palliative demand is bigger than anticipated by FOCUS.
- Difficult to recruit and retain casual workforce because of the "as required" nature of the work (FOCUS) and it's a challenge to keep casual workforce up to date with changes.
- Lack formal training opportunities for staff development.
- The huge number of meetings attended uses a lot of resource but they are important because networking/knowing what is out there is essential for the service.
- FOCUS nurses ability to maintain practising certificate, not sure if they will have to keep skills up to date in other areas. If this is the case there will be a flow on effect on providing cover.
- There is a risk with "single point of failure"– information currently sits with single individuals.

Model of care

- Patients could be discharged earlier if day care was available.
- Need to review FOCUS model of care and assessment methods.
- Need to improve the way we assign a key worker to take the lead in multi-disciplinary teams (FOCUS).

- FOCUS is also small enough in size that trialing new ways of working and implementing new models of care is easier than in its larger more complex counterparts.
- Combined MSW is problematic – surgery always take priority.
- Lack of interdisciplinary approach in MSW.
- Psychiatrists reluctant to engage with dementia patients.
- Dementia patients are an ongoing problem as they block beds for a long time. This could increase with the increasing age of the population.
- Not capturing stroke patients in the weekend because of the number of different admitting physicians.
- Disjoint with Allied Health Services as their referrals go to a different place.

Clinical viability

- Increased waiting times for FOCUS due to increased referrals.
- Older people are getting more complex conditions as they live longer and we need to support them where they want to live.
- Lack of psycho-geriatric beds here - is there a "hidden" demand?
- Psycho-geriatric admissions can be inappropriate given the patient mix. They can be high risk, time-consuming & disruptive to other patients
- Lack of resources or support for auditing.
- Difficult for those with full clinical loads to find time to do non-clinical tasks.
- Lack of quality assurance.
- Audit system needs to be linked to quality improvement processes.

Infrastructure

- IT - FOCUS have an old modified system and numerous .spreadsheets which do not communicate with each other.
- Inadequate IT support has lead to the creation of unique FOCUS systems.
- Limited administrative support which did not increase with single point of entry.
- Introduction of InterRai assessment tool will stretch the skills of current FOCUS workforce; on ongoing training will be required.
- Need to streamline the large amount of hand written paperwork and duplication.
- Lack of clerical/administrative support for Team ILeaders.
- Lack of dedicated wheelchairs (and storage space) for AT&R.

Financial viability

- Cost of training becomes a hidden internal cost because most of FOCUS training is “on the job”.
- Not using internal payments results in more admin work for FOCUS and makes it challenging to track performance on an ongoing basis.
- FOCUS is close enough to Wellington to be included in national projects without huge travel costs.

Community Nursing and Support Services

Services and People

Community Nursing provides generalist and specialist nursing care for people in their own homes or on an ambulatory basis. Care is provided by Acute, Chronic and Palliative teams. The service includes complex wound care, home oxygen, stomal, continence, IV therapy in the home, palliative and oncology.

Support workers, through HomeLinks, provide short term post hospital personal cares and/or household management for people in their homes. Foot Mechanics is contracted to provide a podiatry service for people with at risk/high risk feet. The current contract for podiatry commenced in July 2008. Year to date (1 May) the provider has completed 1197 visits.

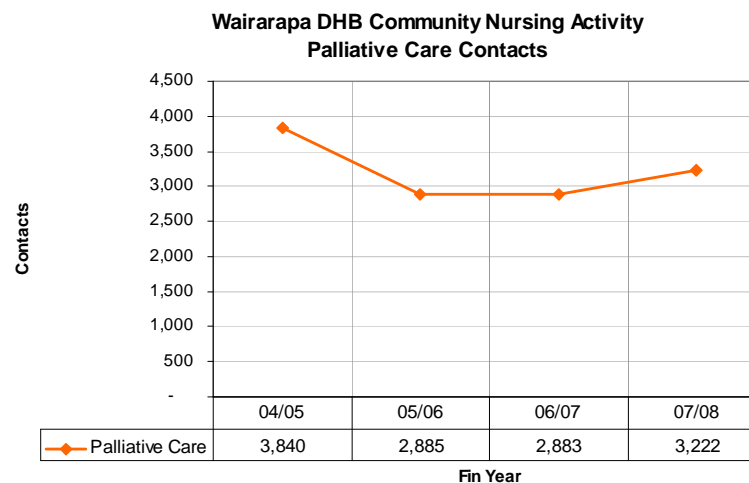
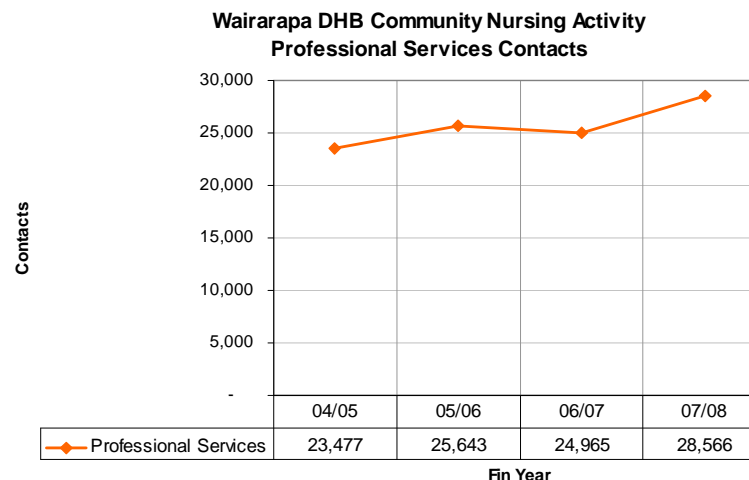
Staffing (FTE's) – Clinical Type

Community Nursing	FTE
Registered nurses	13.1
Clinical Nurse Specialists	3.4
Palliative Care Educator	1.0
Enrolled nurses	2.0
Clinical Nurse Manager	1.0
Home Aides / Homecare workers	10.0

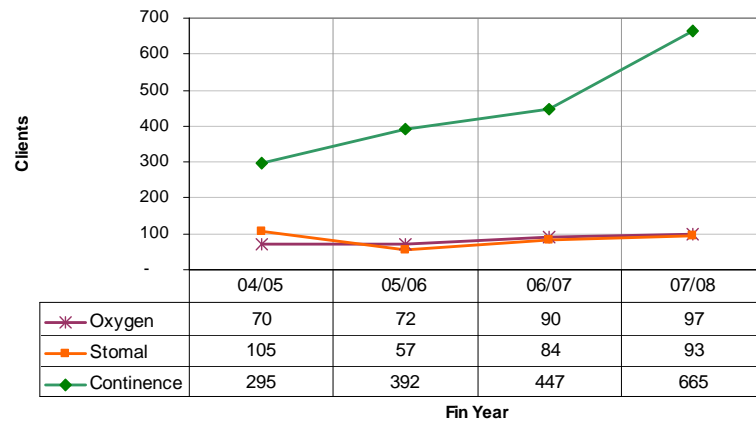
Service Provision

Community Nursing	05/06 Volume	06/07 Volume	07/08 Volume
Professional Services (contacts)	25,643	24,965	28,566
Palliative Care (contacts)	2,885	2,883	3,222
Oxygen (clients)	72	90	97
Stomal (clients)	57	84	93
Continence (clients)	392	447	665
Home help (hours)	3,298	3,572	3,364
Personal Care (hours)	2,504	2,484	3,320

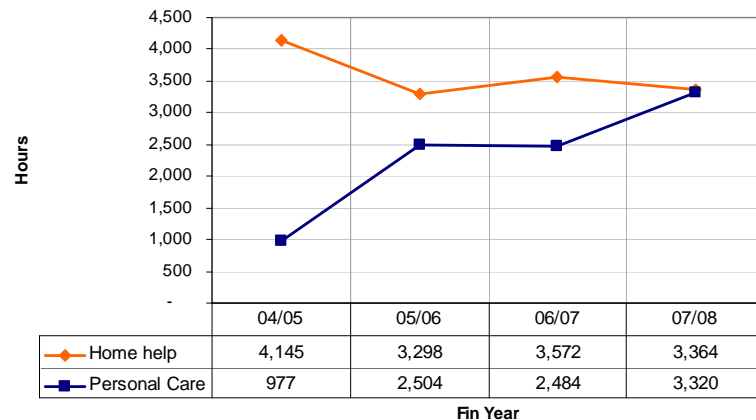
Activity



Wairarapa DHB Community Nursing - Specialist Nurse Activity



Wairarapa DHB Community Support Services
Home Help / Personal Care



Issues and Challenges: Community Nursing

Workforce

- Limited workforce over large geographical area.
- Have new graduates and staff who still need some development.
- The changes made to the role (more specialised) are making it more attractive.
- Need to centralise CNS resources into one base to better manage the needs/demands of the service.

Model of care

- Secondary care – we can't flag when a patient comes into ED so that we can action quickly.
- No champion in ED for IV in home service – patients are still being accepted and treated in ED.
- Inadequate identification of key worker who is responsible for the patient when they become an inpatient.
- Insufficient collaboration with NGOs (cancer, stroke etc).

Clinical viability

- Plenty of demand but not always channeled through from the hospital.
- Standardising assessment and clinical pathways across systems.
- A growing problem to meet podiatry demand under current funding.
 - Demand affected by provision of podiatry for foot ulcers which, in other DHBs is provided as a separate secondary service.
 - 480 patients waiting to be seen; 380 have appointments.

Infrastructure

- Information system impedes collaborative care.
- Lack of communication with GP surgeries, including lack of access to Medtec.
- Assessment is paper-based.

Financial viability

- Need IT investment.

Allied Health

Services and People

The following services are provided both within the hospital and community setting.

Dietetics The dietitian is an expert in food and nutrition. Dietitians promote health through good nutrition. They are also involved in all aspect of nutrition support for those who cannot eat.

Occupational Therapy provides a service of standardised and functional assessments, adaptive techniques, prescription of equipment, modification of home and work environments to facilitate safe discharge from Hospital or to enable a person and their caregivers to remain in their own home and manage activities of daily living.

Physiotherapists assess, treat and educate individuals and their carers using a range of techniques to restore movement and function.

Social Work promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments.

Speech Therapy use procedures, training, and remedies for the cure, alleviation, or prevention of speech and associated swallowing disorders.

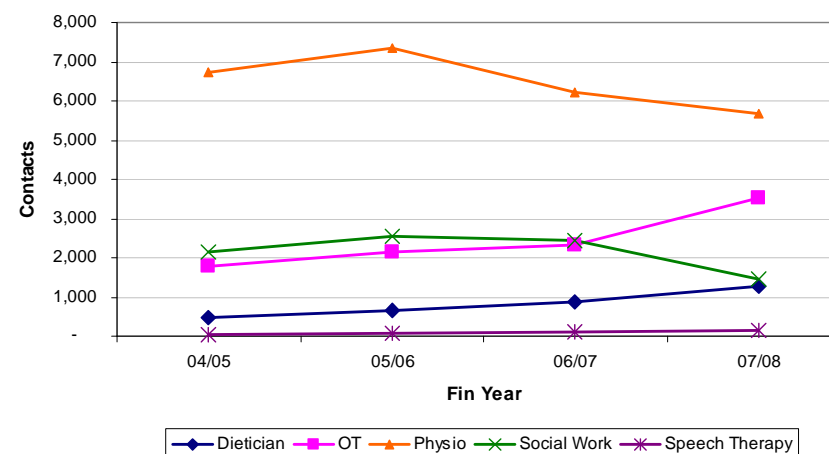
Neurodevelopmental Therapy is a service for children under five years old who have a diagnosed disability, general developmental delay and/or are at risk of possible developmental problems

Staffing (FTE's) – Clinical Type

Allied Health	FTE
Occupational Therapists	3.8
Physiotherapists	4.6
Speech Language Therapist	0.9
Social Workers	2.8
Dietitian	1.0
Technicians	1.2
Neurodevelopmental Thearpaist	0.5

Activity

Wairarapa DHB Allied Health Community Contacts by Specialty



Note: The community contacts are funded via separate contracts with the Funder, whereas the inpatient contacts are an input into the overall case weight (data not available).

Allied Health Community Contacts

	04/05	05/06	06/07	07/08
Dietician	489	641	857	1,278
Occupational Therapy	1,772	2,141	2,332	3,518
Physiotherapy	6,726	7,328	6,226	5,666
Social Work	2,137	2,560	2,423	1,447
Speech Therapy	54	75	91	144

Issues and Challenges: Allied Health

Workforce

- Dietitian is sole practitioner - no cover for annual leave, high risk (TPN prescribing), no succession planning.
- Dietetics requires a highly skilled senior staff member – not a role for a new graduate. Needs to be a generalist.
- Retention difficulties for allied health.
- Physiotherapy has high turnover as they tend to have younger staff wanting to move on for experience after a couple of years.
- In a small DHB some individuals take on extra responsibilities, wear a “number of hats”. They need to be supported to do this.
- No real succession planning.
- Because of the AT&R load the AT&R physiotherapist can’t always do rehab outpatients.
- Physiotherapy demand is driven by orthopaedic surgery but they are never consulted or informed about the surgical list.
- Difficult to find time to do non-clinical tasks when you have to take a full clinical role.
- Social Work service under pressure since the reduction of staff in 2005. Current workload unmanageable and has increased as initiatives have been introduced (e.g family violence, pregnancy termination counselling, palliative care).
- The 3 social workers are the only qualified/experienced health social workers in the Wairarapa.
- Social Work has an aging workforce.

Model of care

- Lack of administrative/secretarial support for clinical staff.
- Hospital patients take priority for Allied Health – creates waiting lists in community.
- There is an attitude that if people are active and mobile they don’t need allied health – means we miss educational and preventative opportunities.
- Service silos and poor communication.
- Clinical staff are disempowered by the reporting structure.
- Future demand means we need to start creating a social work speciality for later life.
- Gaps/limitations in Social Work support for AT&R, maternity, palliative care, young persons grief counselling, community dementia, chronic pain.
- Complex referrals for social work that in the past would have been referred to mental health but now don’t seem to meet the criteria for access to the crisis team.

Clinical viability

- Maintaining practicing/professional competency is time consuming. Allied health staff are not supported to meet these.
- Now Cultural Competency has been added to the competency requirements for all allied health but the DHB does not provide the formal training that is expected.
- Breakdown in referrals from RMOs and nurses. Messages not passed on. (For dietitians).
- Lack of administrative support for internal clinical audit.
- Inadequate or insufficient funding for professional and/or clinical supervision.
- Need time to build resources for clients and selves & to reflect on what we are doing – don’t have the time.
- Social Work referrals are increasingly complex due partly to demographics and partly to lack of skilled social workers in community.

Infrastructure

- Inadequate IT.
- Difficulties accessing DHB car for allied health outreach clinics or home visits.
- Team leaders need to be given responsibility and accountability for their own service, including some aspects of the budget, and workforce (recruitment & retention).
- Documentation an ongoing problem for all clinical staff.
- Lack of appropriate storage space for occupational therapy equipment.

Financial viability

- Allied Health funding model does not match acuity of patients.
- No allocation for training and development.
- Concerns about the credibility of benchmarking.
- Occupational Therapy does not have the contract to provide services for ACC patients beyond 6 weeks after discharge from Wairarapa Hospital.
- Need a model that captures the internal activity – e.g. ward work.

Public Health

Services

The Public Health Directorate of the Ministry of Health funds a range of public health programmes and services in the Wairarapa through its contract with Regional Public Health as well as contracts with Wairarapa District Health Board. Regional Public Health contracts with Wairarapa Public Health, Wairarapa DHB, to provide health protection, some health promotion, and health information services to the Wairarapa population.

The Wairarapa DHB contracts Wairarapa Public Health for the provision of Public Health Nursing, some health promotion, Pacific Community Health, Vision Hearing Testing, Immunisation Facilitation, National Immunisation Administration, and Technical Assistance for Small Drinking Water Suppliers

Wairarapa Public Health shares responsibility for the delivery of public health services with a range of other providers ranging from large national organisations to local government and issue specific providers. The key statutory bodies with responsibilities for public health delivery are summarised below.

Staffing (FTE's) – Clinical Type

Public Health	FTE
Clinical Team Leader	1.5
Dental Assistant	4.5
District Immunisation Facilitator	.6
Health Promoter	5
Maori Health Promoter	1
Health Protection Officer	2
Public Health Nurse	5.5
Support worker	1.4
Vision Hearing Technician	1

Service	Wairarapa Public Health	Wellington Regional Council	Territorial Authorities
Drinking water quality	✓		✓
Recreational water	✓	✓	✓
Water supply		✓	✓
Emergency Planning and response	✓	✓	✓
Bio security and Hazardous substances	✓	✓	
Resource management	✓	✓	✓
Waste management	✓	✓	✓
Social environments	✓		
Communicable disease	✓		
Alcohol, tobacco and drug related harm reduction	✓		
Food safety and quality	✓		✓
Health promotion	✓		
Injury prevention	✓		
Nutrition and physical exercise	✓		
Flood protection		✓	✓
Pollution control		✓	✓
Pandemic Planning	✓		✓
Immunisation Services	✓		

Issues and Challenges: Public health

Workforce

- Easy to recruit staff but nurses have a tendency to work outside their scope of practice because of the lack of social workers.
- Staff become fatigued because they are over stretched.

Model of care

- There is a lack of understanding about what public health nurses do.
 - They do assessment and intervention. Don't do primary care.
 - School nurses are primary care nurses – they “treat” individuals.
 - Public health nurses treat the individual's complaint as a symptom of their environment.
 - They also deliver health education services and are aligned to health promotion.
- There is so much successful stuff going on that is not communicated to the Board or wider.

Infrastructure

- Inadequate support from maintenance.

Financial viability

- Funding model creates potential critical mass issues and accountability problems.
- No contract for district immunisation facilitator for next year.
- No contract for NIR Administration for next year.
- No contract from Regional Public Health for next year.
- No funding for training costs beyond the core.
- If Public Health funding was devolved from the Ministry there would be a more secure capacity and clear lines of accountability.

Wairarapa Community Primary Health Organisation

The Wairarapa Community PHO's providers deliver health care services within the area bounded by Mt Bruce in the north and Cape Palliser in the south. The Wairarapa Community PHO is a not for profit Charitable Trust.



The current formal partners of the PHO include:

- local Iwi of Rangitaane and Ngati Kahungunu
- the Wairarapa Community
- seven Medical Centres in the Wairarapa
- Maori providers of Whaiora Whanui, Te Hauora Runanga O Wairarapa Inc. and Rangitaane O Wairarapa Inc.
- Wellington Independent Practice Association (WIPA) that hold the management contract for WCPHO.

Resources

Number of FTE

Practice	GP	Practice Nurse	Other staff	Total Practice
Carterton	3.5	8.5	4.4	16.4
Feathertson	1.75	1.4	2.4	5.5
Masterton Medical	13.7	12.5	14.5	40.7
Chapel Street Family Doctors	4.2	6.1	5.6	15.9
Kuripuni	1.2	1.2	2.0	4.4
Greytown	1.7	1.3	2.2	5.2
Martinborough	1.8	1.8	2.7	6.3
TOTAL PRACTICES	27.9	32.8	33.8	94.5
PHO	0.6	3.4	2.5	6.5
TOTAL PHO	28.5	36.2	36.30	100.9

Services Provided

- B4 School Checks
- Care Plus
- Community Child Health Co-ordination
- Diabetes
- First Contact Services
- Health Promotion
- Palliative Care
- Primary Health Care Nursing (Outreach)
- Primary Mental Health
- School Clinics
- Sexual Health – first contact
- Smoking Cessation

Service Locations

Practices	Opening Hours	Days
Carterton Medical Centre	8am – 5pm	Monday, Wednesday, Thursday, Friday
	8am – 7pm	Tuesday
Chapel Street Family Doctors (effective 11 May 2009)	7.30am – 7.30pm	Monday to Thursday
	7.30am – 5.30pm	Friday
	9am – 5pm	Saturday
	9am – 1pm	Sunday
Featherston Medical Centre	8am – 7pm	Monday
	8am – 5pm	Tuesday, Wednesday, Thursday, Friday
Greytown Medical Centre	8am – 5.30pm	Monday, Thursday, Friday
	8am – 7pm	Tuesday, Wednesday
Kuripuni Medical Centre	8.30am – 1pm	Monday to Friday
	2pm – 6pm	
Martinborough Health Services	8.30am – 5pm	Monday, Tuesday, Wednesday, Friday
	8.30am – 7pm	Thursday
Masterton Medical	8am – 7pm	Monday to Friday
	9am – 5pm	Saturday, Sunday

Outreach Clinics	Opening Hours	Days
Cameron Community House, Masterton	12noon to 4pm (1 hr GP)	Tuesday
Kuranui College - Greytown	9am to 2pm	Monday – Thursday during school terms
Makoura College - Masterton	9am-2pm Mon (3 hrs GP) 9am-12noon Thurs	Mondays and Thursdays during school terms
Rangimarie - Masterton	9am to 5pm	Wednesdays during school terms

Practice Fees

The following table lists the **standard fees** each practice charges for a standard General Practice consultation, for enrolled patients, **within usual business hours**. Varying charges may be incurred in a range of circumstances including for instance: casual visits, after hours, weekends, for longer consultations, minor surgery, for services involving equipment of supplies, or allied services eg. homeopathy.

Patient Age	Under 6	6~17	18~24	25~44	45~65	Over 65
Practice Name	Standard patient fee for enrolled patients					
Carterton Medical Centre	\$0.00	\$24.00	\$26.00	\$30.00	\$30.00	\$26.00
Chapel Street Family Doctors	\$0.00	\$10.00	\$10.00	\$16.00	\$16.00	\$16.00
Featherston Medical Centre	\$0.00	\$24.00	\$25.00	\$26.00	\$27.00	\$26.00
Greytown Medical Centre	\$0.00	\$23.50	\$24.50	\$26.50	\$27.50	\$27.50
Kuripuni Medical Centre	\$0.00	\$25.50	\$27.00	\$29.00	\$30.00	\$29.00
Martinborough Health Services	\$0.00	\$25.00	\$25.00	\$26.50	\$26.50	\$26.50
Masterton Medical	\$0.00	\$25.50	\$26.00	\$28.50	\$28.50	\$27.50

After Hours / Weekends / Public Holiday Fees

All GP Practices charge their standard fees for all patient consultations after hours, weekends and public holidays with the exception of Masterton Medical.

Masterton Medical After Hours Fees

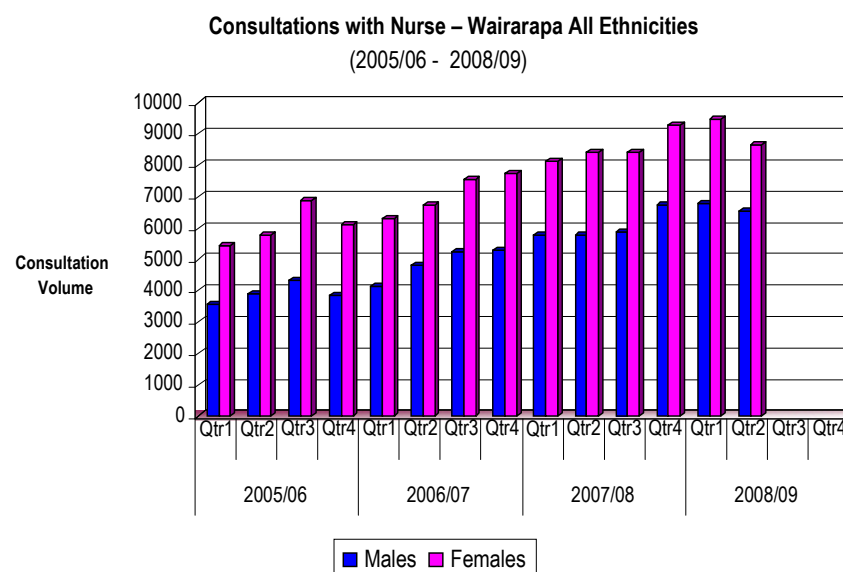
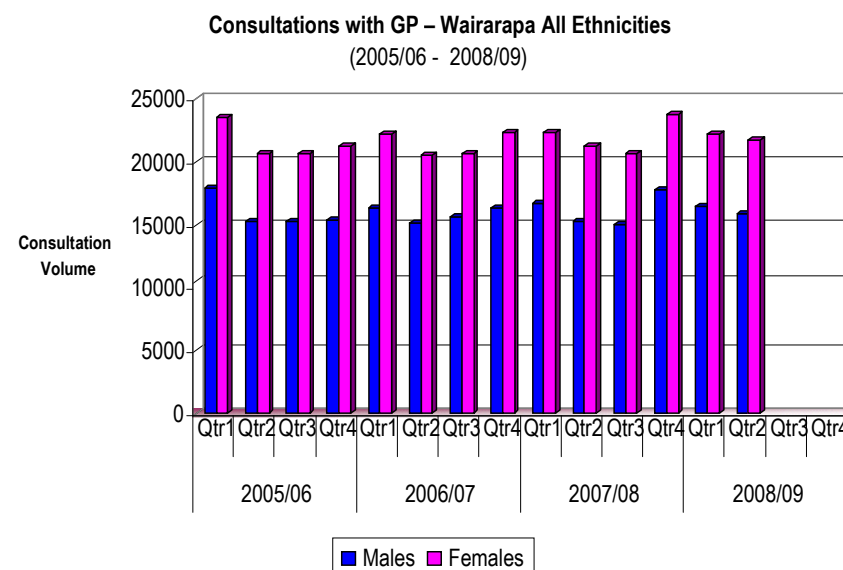
	Standard Saturday / Sunday Fees	Community Services Card Holders
Under 6 years	\$5-00	\$5-00
6-18 Years	\$40-00	\$35-00
Over 18	\$60-00	\$45-00

Snapshot of Wairarapa Community PHO enrolled patients

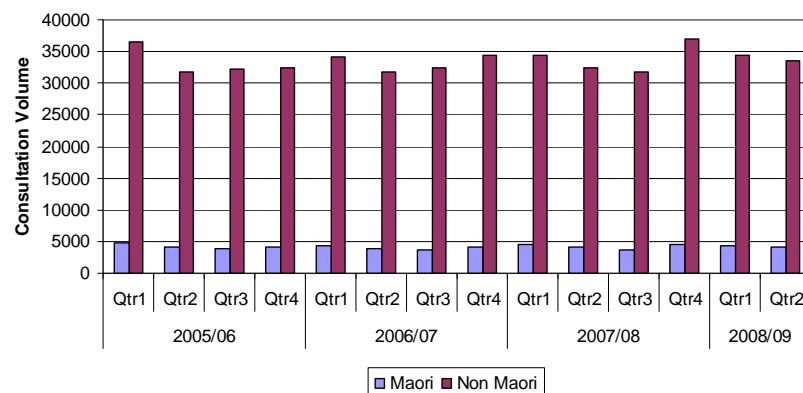
Practice	Total Wairarapa Population (Age Groups)						
	0-14	15-24	25-44	45-64	65-74	75+	Total
1	1,062	617	1,234	1,723	607	490	5,733
2	1,232	922	1,554	1,511	476	356	6,051
3	777	398	811	1,056	319	208	3,569
4	537	246	526	737	298	255	2,599
5	326	272	359	766	170	146	2,039
6	460	209	533	600	253	152	2,207
7	3,694	2,313	3,968	4,630	1,479	1,507	17,591
Total	8,088	4,977	8,985	11,023	3,602	3,114	39,789
Practice	Maori Population (Age Groups)						
	0-14	15-24	25-44	45-64	65-74	75+	Total
1	162	89	124	99	22	10	506
2	362	218	312	200	38	21	1,151
3	153	88	123	103	13	8	488
4	46	22	37	40	12	9	166
5	36	15	19	17	1	2	90
6	97	60	80	60	22	6	325
7	903	484	606	423	76	51	2,543
Total	1,759	976	1,301	942	184	107	5,269
Practice	Pacific Population (Age Groups)						
	0-14	15-24	25-44	45-64	65-74	75+	Total
1	24	11	20	6	3	2	66
2	39	24	45	33	2		143
3	12	5	17	8	2	2	46
4	6	3	4	4	1		18
5	9	1	7	3			20
6	6	3	6	2	2	2	21
7	129	45	104	64	6	9	357
Total	225	92	203	120	16	15	671
Practice	Other Ethnicities Population (Age Groups)						
	0-14	15-24	25-44	45-64	65-74	75+	Total
1	876	517	1,090	1,618	582	478	5,161
2	831	680	1,197	1,278	436	335	4,757
3	612	305	671	945	304	198	3,035
4	485	221	485	693	285	246	2,415
5	281	256	333	746	169	144	1,929
6	357	146	447	538	229	144	1,861
7	2,662	1,784	3,258	4,143	1,397	1,447	14,691
Total	6,104	3,909	7,481	9,961	3,402	2,992	33,849

Service Utilisation

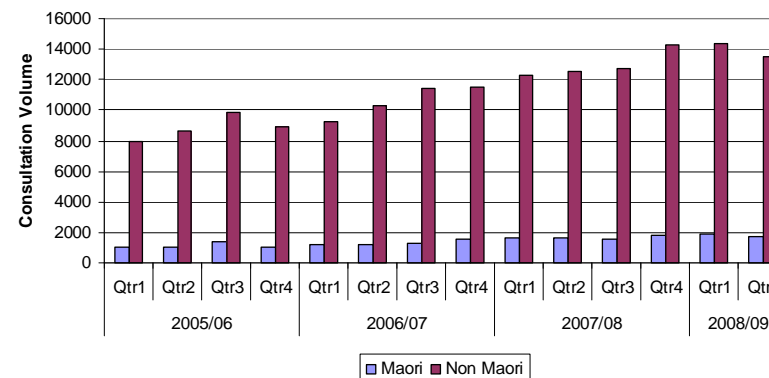
The following graphs of consultation volumes for GP's and nurses show a trend for increasing consultations with nurses for both males and females and for Maori and non Maori in the Wairarapa.



Consultations with GP - Wairarapa - Maori & Non Maori
(2005/06 - 2008/09)



Consultations with Nurse - Wairarapa - Maori & Non Maori
(2005/06 - 2008/09)



PHO Performance Indicators

Some groups of our population are at higher risk than others of having certain diseases or illness, such as cardiovascular disease (CVD) and diabetes. The PHO targets these groups by assessing individuals to identify and record their risk.

CVD Risk Assessment

CVD risk assessment is a screening process that identifies the risk of an individual developing cardiovascular disease. Eligibility for CVD risk assessment is based on those most at risk within ethnicity, gender and age groups (see table below)

For the high needs population eligible for CVD risk assessment (see table below) 40.74% have had a CVD risk recorded within the last five years, compared to 18.72% nationally.

Total Eligible Population

Age Group		Ethnic Groups
Male	Female	
35-74	45-74	Maori, Pacific, Indian sub-continent
45-74	55-74	Others

Almost half (49.43%) of the total population eligible for CVD risk assessment have had their risk recorded within the last five years, compared to 14.73% nationally.

High Needs Eligible Population:

Age Group		Ethnic Groups
Male	Female	
35-74	45-74	Maori, Pacific, Others (Quintile 5)

Diabetes Detection

The Ministry of Health estimates the number of people who are likely to have diabetes. PHO detection and management of diabetes is measured against that estimate.

The Wairarapa PHO has identified 92.03% of the number of people estimated to have diabetes within the population aged 15-79. This compares favourably to the 81.08% identified nationally within the same age group.

The high needs population group is identified as those aged 15-79 for all Maori, Pacific People, and Others living in areas designated as Quintile 5. The Wairarapa PHO has identified 3.47% more individuals within this group with diabetes than the Ministry of Health estimated. Nationally, 95.45% of individuals within this group have been identified

Diabetes Review

For those estimated to have diabetes, the Ministry of Health has set a target that 80% of them should receive an annual diabetes review.

The Wairarapa PHO has identified 69.18% of the eligible people estimated to have diabetes received an annual diabetes review. This compares to 43.01% nationally.

The high needs population group is identified as those aged 15-79 for all Maori, Pacific People, and Others living in areas designated as Quintile 5. The Wairarapa PHO has identified 80.09% of the eligible people within this group received an annual diabetes review, meeting the Ministry of Health target. This compares to 49.58% nationally.

Influenza Flu Vaccination Coverage – Age 65+

The complications of influenza in the elderly can be serious or life threatening. As a result the government funds the cost of influenza vaccines and their administration for persons 65 years and over, and persons of any age with certain chronic conditions.

The influenza campaign covering the 2008 flu season (ending 30th June 2008.) achieved the following vaccination rates:

68.68% of the ***total eligible population*** (All people aged 65 years and over enrolled with the PHO): This was higher than the national rate of 63.71%.

67.18% of the ***high needs eligible population*** (Aged 65 years and over for all Maori, Pacific People, Others (Quintile 5). This was also higher than the national rate of 60.54%.

Child Immunisations - Age Appropriate Vaccinations - 2yr Olds

Children who receive the complete set of age appropriate vaccinations are less likely to become ill from certain diseases. This indicator measures the number of enrolled children up to 2 years old who have received the full set of vaccines.

87.34% of children up to the age of 2 years (PHO enrolled) received the complete set of age appropriate vaccinations, compared to 76.78% nationally.

84.72% of ***high needs eligible population*** (all Maori, Pacific People, Others (Quintile 5) children up to 2 years of age and PHO enrolled) received the complete set of age appropriate vaccinations, compared to 71.49% nationally.

Access to Primary Care Services in the Central Region

Table 1: Number of Consults and Practitioners in the Central Region for the year 2008

Name of DHB	Name of PHO	GP Head Count	Number of GP Consults	Number of Nurse Consults	Average Enrolment	Consult / enrolee
Capital & Coast DHB	Capital PHO	153	468,028	69,982	145,602	3.7
	Kapiti PHO	44	151,324	49,122	35,566	5.6
	Karori PHO Trust	9	38,853	17,158	12,906	4.3
	Ora Toa PHO Limited	10	26,975	17,904	10,679	4.2
	Porirua Health Plus Limited	5	9,419	11,519	4,699	4.5
	South East & City Primary Health Organisation	16	21,865	11,771	8,892	3.8
	Tumai mo te Iwi Inc	38	151,912	23,208	45,291	3.9
Hawkes Bay DHB	Hawkes Bay PHO Limited	105	422,215	87,162	124,715	4.1
	Tu Meke - First Choice PHO Limited	15	48,046	14,830	13,931	4.5
	Wairoa District Charitable Health Trust	6	23,889	8,117	8,217	3.9
Hutt Valley DHB	Family Care PHO	6	47,786	10,257	15,641	3.7
	Piki te Ora ki Te Awakairangi	15	27,529	22,672	12,208	4.1
	Ropata Community PHO	15	58,944	10,325	18,838	3.7
	Tamaiti Whangai PHO	3	12,092	1,056	5,622	2.3
	Valley Primary Health Organisation	50	204,548	34,366	79,830	3.0
MidCentral DHB	Horowhenua PHO Limited	19	110,403	14,383	25,881	4.8
	Manawatu PHO Limited	72	377,390	53,586	98,298	4.4
	Otaki Primary Health Organisation Trust	6	26,424	7,887	6,468	5.3
	Tararua PHO Limited	12	52,986	23,853	15,559	4.9
Wairarapa DHB	Wairarapa Community PHO Trust	26	153,211	61,083	39,075	5.5
Whanganui DHB	Te Oranganui Trust Incorporated	4	16,460	11,537	5,394	5.2
	Whanganui Regional PHO	28	205,460	8,093	57,371	3.7
Total		657	2,655,759	569,871	790,683	4.1

Number of Consults

Source:

1. PHO Enrolment Data is sourced from the PHO Enrolment Collection (CBF Register) as at 13/05/09 for the quarters 01/01/08 to 31/12/08
2. 2008 GP & Nurse Consults are sourced from PHO Service Utilisation Reports for Consults between 01/01/08 to 31/12/08
3. Practitioner Numbers are sourced from the Provider List current to 30/06/08

Issues and Challenges: PHO

Workforce

- The number of GPs is always tenuous.
- Based on changing population demographics we will need another ½ to 1 GP FTE per year.
- Within the next 5-10 years there may be number of older GPs wanting to reduce hours or retire.
- Management, administration and leadership capability needs to be developed.
- GP workforce needs to be up-skilled, especially in terms of LTC and specialisation.
- Need to develop Maori/Pacific content of workforce.
- Need to develop cultural competence of the workforce.
- Have an aging senior nursing workforce.
- New, younger UCOL trained nurses will require 5 years to build up the necessary experience.

Model of care

- LTC is a key model of care issue. Practices need to act more proactively on the information produced by their LTC systems.
- What are the implications of the Ministry favoured “Integrated Family Health Centre” model?
- Lack of integration of primary and secondary services.
- Yet to achieve full Integration of ambulance, community based services and pharmacy into Primary Health care services.
- Challenges remain in respect to the provision of after hours care and care in rest homes.

Clinical viability

- Increasing demand can not be met by GPs alone.
- Access is likely to reduce and waiting times increase as demand increases.
- How to fund the development of G and nurse specialisations?
- How to fund the capital investment that will be required for fully fledged integrated family health centers.

Infrastructure

- Some facilities will require investment.
- Medtec is fast becoming a legacy system. Can it keep up?
- Single patient record and integrated primary-secondary system is an imperative.

Financial viability

- Continually challenged in respect to funding primary care representation on committees etc.
- The problem of funding professional development and training/ is problematic, especially for nurses.
- Masterton Medical is going to need costly expansion in the foreseeable future.
- We are coping with capital costs and investment in new technologies currently but this is likely to become problematic in the future.

Whaiora



VISION

Wairarapa – He Waiora
(Wairarapa A Place of Wellness)

MISSION

He Rarapa I Ngā Āhuatanga E Ū Ai Te
Hā O Te Ora
(To pursue and participate in ways of
bringing about wellness)

Whaiora Whānui Trust was established as an independent charitable trust on December 13th 2000. It began operations on January 1st 2001.

The organisation, Whaiora, grew out of a previous health unit established within Ngāti Kahungunu ki Wairarapa Māori Executive Taiwhenua. Hapū of Wairarapa gave Whaiora Whānui Trust the mandate to set up as an entity separate from the Taiwhenua to better enable the organisation to operate with a whole community-wide focus in the provision of health services. Later, the provision of services expanded to include not only health services, but also education and social services.

Resources

Number of FTE

Resource	FTE
Registered nurses	5.0
Community Support workers	8.5
Social Workers	1.0
Health promoters/educators	2.0
Technical / Administrative	4.8
Other	4.0

Services Provided

- Aukati Kai Paipa (Smoking Cessation)
- Mana Wahine:
 - Cervical Cancer Screening
 - Support to Breast Screening /Promotion
- Family Start
- Health Promotion
- Outreach Immunisation
- Tamariki Ora (Well Child)
- Whānau Ora (Family Wellbeing)
- Maori Outreach Liaison
- B4 Schools Checks

Snapshot of Whaiora clients

Total registered clients - 1155

Maori	Pacific	NZ European	Other	Unknown	TOTAL
730	35	294	21	75	1155

Total registered clients - age groups

0-14	15-24	25-44	45-64	65-74	75+	TOTAL
430	104	299	238	57	27	1155

Maori registered clients – age groups

0-14	15-24	25-44	45-64	65-74	75+	TOTAL
294	53	181	139	45	18	730

Total number of client appointments 1st May 2008 – April 30th 2009 – 16,506. NB: This does not include telephone consultations

Issues and Challenges: Whaiora

Workforce

- Local and national shortage of qualified, experienced staff.
- Kaikōkiri (Champions of Wellness) staff would be difficult to replace with equally qualified, experienced people.
- Succession planning.

Model of care

- Current contractual reporting obligations have driven a siloed, disparate way of programme provision impeding a more seamless, total organisation response.
- The contractual focus on outputs rather than real measured outcomes prevents the kind of improvement in Maori health status desired by the MOH, DHBs and PHOs.
- Implementation of our model of care is undermined by inconsistencies in the funding formulae used by different funders.

Clinical viability

- Growing a sustainable client base has been challenging – because we do not have funded and enrolled patients and rely heavily on referrals from external agencies.

Infrastructure

- IT issues are trying to keep abreast of the ever-evolving technology and ensuring training of staff members results in competent end-users.
- Management and information systems are ever improving, issues/challenges in this area would be the cost of purchasing supporting software that is easy to use / time spent on training to ensure the successful implementation.
- It is a challenge to pay experienced administrative support staff as the contracts are developed around service delivery staff.
- In depth clinical quality performance monitoring, supervision and staff development are not possible without appropriate management structures in place.

Financial viability

- The overhead costs attached to contracts are insufficient to cover the cost of experienced administrators.
- Forced to spread the already sparse resource creatively so that the same overhead costs that provide the infrastructure around our staff on the ground remains strong.
- Training and development is a key objective of our organisation, however there is not enough financial scope to ensure staff positions are able to be back-filled if they were to undertake tertiary level development.

Te Hauora Runanga O Wairarapa Inc.

Te Hauora Runanga o Wairarapa Inc's focus is the total holistic well being of Tangata Whaiora. This is achieved through the delivery of Kaupapa Maori Health and Support services. The Service is Kaupapa Maori, however all ethnic groups may access the services.

The organisation was established in 1985 as a community support service for Maori Health in the Wairarapa region. It grew from initiatives developed by Maori Health workers seeking to establish a more focused approach to the delivery of Community Health Services.



The organisation has established extensive networks both within Maori and mainstream environments and adopts a "Kaupapa Maori" approach to support activities.

Service Locations

Address: 15 Victoria St, Masterton

Phone: 06 378 0140 / Free phone: 0800 666 744

Resources

Snapshot of Service use March 2009

Service		No. of Clients	Cases per FTE Equiv
AOD Clinical	4 FTE	75	18.75
AOD non Clinical	1 FTE	25	25
Mental health community support work	2 FTE	35	17.5
Koroua and Kuia Programme	\$42000		
Rongoa programme	\$42000		

Services Provided

- Kaupapa Maori Mental Health Support Services
- Drug and Alcohol Community Support Services
- Koroua and Kuia
- Maori Disability
- Rongoa Services

Hauroa Mental Health and Addiction Service Users

2007/08

	Mental Health	A & D Adult
July	27	66
August	31	62
September	31	67
October	39	60
November	28	69
December	29	50
January	28	59
February	32	69
March	30	63
April	32	85
May	24	67
June	25	71

Issues and Challenges: Hauroa

Workforce

- Difficult to recruit qualified staff who are trained to deliver Kaupapa Maori and on-job training takes time. This is a rural problem nation-wide.
- Lack of Maori and Pacific Island students in AOD, mental health & Kaupapa Maori.
- Difficult to get training from a Kaupapa Maori perspective accepted as credible.
- Existing funding doesn't allow taking on new staff.

Model of care

- Biggest difficulty is trying to access clinical services.
- Are constantly needing to remind DHB Provider Arm that we exist and of the services that we offer.
- Current funding model creates silos based around contracts. Reporting is based on numbers rather than outcomes.
- We have made Team leaders pivotal in the link between management and clinical work. They need skills to balance these demands.

Clinical viability

- Barriers to engagement with providers.
- In absence of a Maori clinical psychologist, are reliant on main stream services for clinical diagnoses.
- Maori Youth have no choice for clinical or non-clinical services in mental Health other than CAMHS.

Infrastructure

- IT is a big cost for small organizations as they are reliant on private consultants.
- Multiple databases with limited capability.
- Premises lease is not sustainable on current funding.

Financial Viability

- Financial viability depends on how well you manage contracts and how you can invest but this can be viewed negatively by others.
- Lack of funding for any infrastructure or management costs challenges the sustainability of the service.
- We are funded on FTEs but have to make a margin on each contract to support the service. It means we can't pay staff the full amount, which in turn compounds the recruitment difficulties.
- Training and development would be a major issue if we were not supported by the Maori Provider Development Fund.
- There is no reflection in the funding for the increasing demand on time to attend meetings and other external work. Last year the manager spent 33% of her time on DHB work.

Mental Health Non Government Organisations (NGO's)

Wairarapa Addiction Service Incorporated

Wairarapa Addiction Service Incorporated (WASI) was formed following the closure of Totara House (which offered residential AOD programmes to people throughout New Zealand) at 20 Victoria Street Masterton and formed what is now the community AOD (Alcohol & Other Drugs) service in 1993. The currently stated objectives of the Wairarapa Addiction Service are to:

- Provide an educational programme aimed at preventing alcohol and other drug abuse in the Wairarapa.
- Provide a counselling and information service to all those in the community affected by alcohol or by other drug addiction.

Resources

Service Type	FTE	No. of Clients	Cases per FTE Equiv
Child and Youth	1.5	29	19.3
Adult	4.0	160	40
Community Support Work	0.8	N/A	N/A
Detoxification	1.0	22	22
Hep C Clinic	0.2	10	N/A

	No. Funded	Actual Clients
Methadone GP	13 Cases	8
Methadone Specialist	85 Cases	89

Services Provided

Wasi offers a full range of **free** specialist addiction services to all people of the **Wairarapa**. Wasi is funded by the WDHB to offer the following services:

- Youth Education, Assessment and Treatment
- Adult assessment & treatment for all AOD problems
- Detox and Referrals
- Methadone Programme
- Gambling Help
- Day Programme – (Activity and Therapeutic)

Issues / Challenges: WASI

Workforce

- Retention and availability of doctors with AOD experience.
- We have a very small turnover of staff.
- Difficult if key staff members are away at the same time.

Model of care

- Not being part of the DHB has its own challenges and disadvantages at times.
- Need better communication with ED.
- Information sharing challenges with DHB.
- Lack of transport options in a region that covers a large area.
- Pharmacies are not open to supply methadone to clients starting work early.

Clinical viability

- Waiting lists are only a problem for non-urgent cases if staff are on leave or several staff are off sick.
- It is difficult to get sound outcome measures due to the nature of addictions and time constraints.

Infrastructure

- Governance is always a challenge at times as all Board members are voluntary and not paid.
- IT system would be better if linked to the DHB and GPs.

Financial viability

- Managing funding innovative thinking and taking chances on new ways of delivering services.
- Employment agreements may impact on the next budget.

Supporting Families (Schizophrenia Fellowship)

SF New Zealand is committed to providing the best possible information, support, education and advocacy for families/ whānau with a member experiencing serious mental illness. The National Office, based in Wellington, provides high-level advocacy on issues of concern to families with a member experiencing mental illness. SF New Zealand produce a range of mental health resources and provide information and support to SF Branches nationwide.

Community Support – Snapshot of SF Service use March 2009

	Resource	No of people supported
Community Support workers	1.2 FTE	83
Resource centre	N/A	185
Vocational support Funded by MSD	0.6	N/A

Issues and Challenges: SF Workforce

- Lack of pay parity with similar roles in DHB can create recruitment problems.

Model of care

- Vocational support services are inadequately funded.
- Limited referrals for family/whanau support from DHB sources.

Clinical Viability

- Waiting list for vocational service and inability to provide adequate follow up support.

Infrastructure

- Need to develop database and client management systems.

Financial viability

- Ongoing funding for current services in the current political environment.
- Costs of IT systems.
- Upgrading facility to enable disability access.
- Concerns over ongoing funding for resource centre.

Richmond Fellowship

Richmond New Zealand Incorporated (Richmond) is a major national provider of community mental health and support services and is one of New Zealand's largest Non-Government Organisations (NGO's). Richmond New Zealand provides a wide range of services designed to cater for the diverse needs of clients.

Residential - Snapshot of Service use April 2009

Service Type	No of beds	Available Bed Days	Total Used	Occupancy Rate
Detoxification	3	90	85	94%
Planned Respite	2	60	21	35%
Residential	14	420	304	72%
Total bed days / nights		570	410	72%

Just over half of Richmond's services involve the provision of evidence-based community services for adults who experience mental illness, with a further quarter focusing on services for young people who have serious mental health issues and, in some cases, conduct disorders.

The remainder of Richmond's activities involves working with adults and young people with high and complex needs who require specialist community support systems.

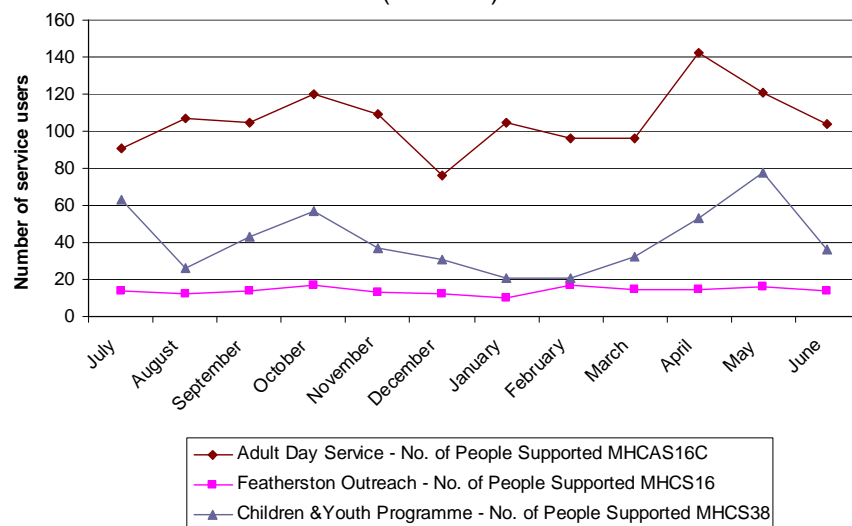
Community Support – Snapshot of Service use April 2009

Service Type	No of FTE	No of clients	Cases per FTE equiv
Community Support Workers	3.5	48	13.7
Medication Support	1	14	14
Family / Whanau	0.5	10	20

King Street Artworks

The aim of King Street Artworks is to promote well being in the community through creative expression placing whanaungatanga (family togetherness) at the heart of what they do.

King Street Artworks People Supported - Monthly
(2007/08)



Te Whare Atawhai

Te Whare Atawhai is a drop in centre that is run for and by people who live with mental illness and addiction. They say it's the simple support things that make the difference. The support team offer encouragement, understanding and a place to share stories. They know that when you are alone, finding a group of people who understand the impact mental illness can have on everyday life makes all the difference to staying positive about recovery.

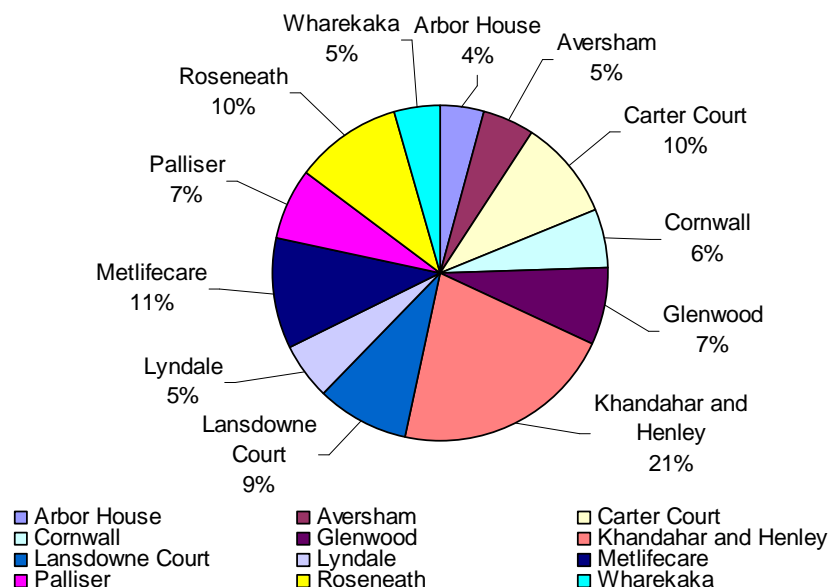
Activity Programmes: Snapshot of Service use March 2009

	Resource	No of people supported	Average number attending daily
King Street Centre (5.5 days per week)	Adult	162	55
King Street Centre (5.5 days per week)	Youth	35	
Featherston Centre (2 days per week)	N/A	13	13

Residential Care for Older People

There are eleven aged residential care providers (thirteen facilities) in Wairarapa, with a total of 422 beds, of which 10 of these have been added recently. The following data for aged residential care residents was obtained from all residential facilities in the Wairarapa for one day (17th February 2009). The total number of residents in this survey was 393.

Residential Care Residents by provider

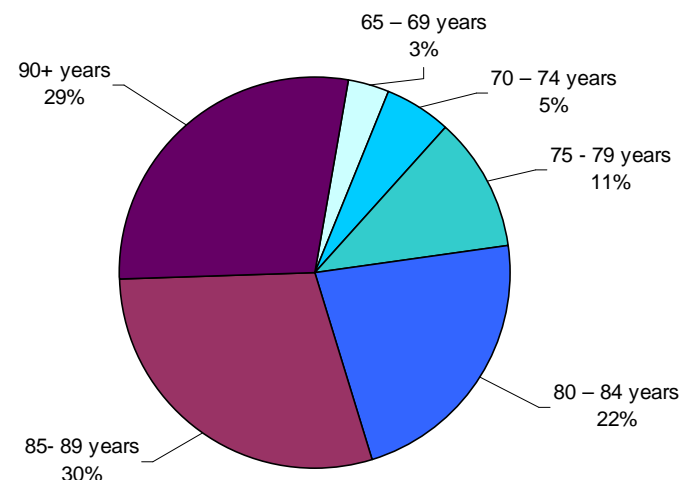


The following graph gives an overall summary of the results of this "Slice of Time" survey by age bracket. It shows that 59% of residents are over 85 years old (almost the same proportion as for 2008). If those over 80 years old are included with the "older seniors" group, then this group would account for 81% of all residents.

The 2006 census data indicates that people over 65 years account for 18% of the total Wairarapa population (compared

with 13% for all NZ). The estimated Wairarapa population over 65 years old 2009 is 7040 (Department of Statistics).

**Slice of Time Survey February 2009 - Overall Results
- Percentage Aged 65+ by Age Range -**



While occupancy of residential care facilities in Wairarapa remains relatively high, proportionately fewer older people are in residential care in the Wairarapa in 2009 (5.6%) compared to 2005 (6.2%). While the total population of older people has grown, there has been little growth in the number of residential care beds. There are plans for an additional 20 beds to be added in 2010, with the possibility of more in the future.

Generally, there are very few residents under 75 years and providers report that residents are more disabled on admission to a residential facility than in the past. This will have an impact on staffing requirements in the future as these people have higher needs. The length of stay of these people is becoming shorter, currently on average 2 years.

Long Term

Long term residents had increased from 372 in 2008 to 382 in 2009, reflecting generally higher occupancy rates. The current average 2008-09 occupancy rate for both rest home care in and for hospital level continuing care in Wairarapa is 95%. This average tends to hide the fact that for a number of months, occupancy at Continuing Hospital level and for dementia care can be at 98% - 100%, with few beds available.

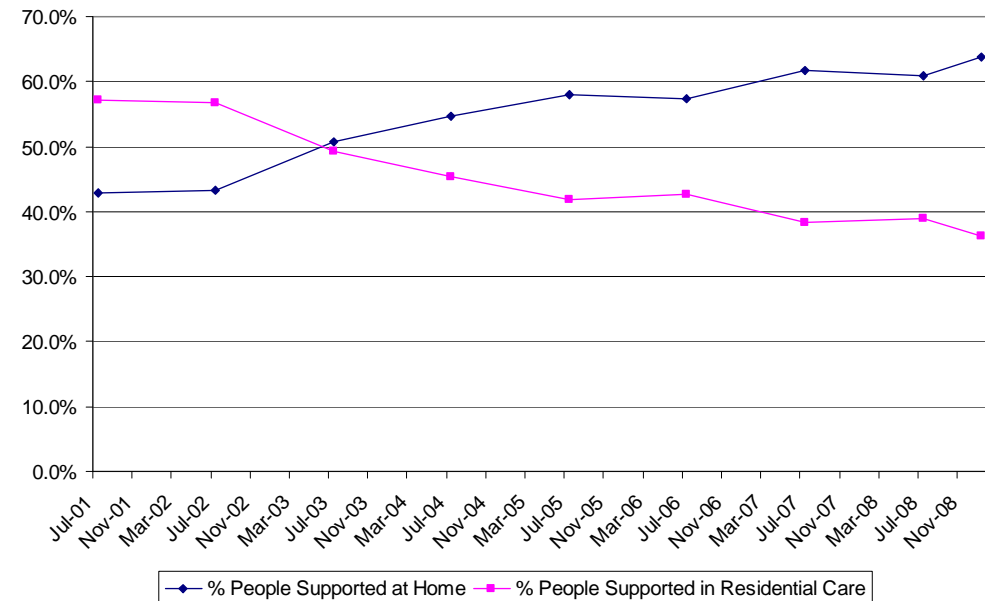
Short term

In Wairarapa, about 5% of beds in residential care facilities are used for purposes other than long term care. The 5 capacity funded beds are used for a variety of short term use, with access to these beds managed by FOCUS. Other beds are also used for respite care, Health Recovery (transitional) programme, chronically medically ill and palliative care.

The numbers in short term care have not changed much since the last survey, with short term care accounting for between 10 beds in 2007, 9 beds in 2008 and 11 beds in 2009.

For all older people assessed as needing support services, (not the total population of older people in Wairarapa.), the ratio of older people being supported in residential care continues to decrease in comparison to the proportion being supported at home. This trend is illustrated in the next graph.

People aged 65+ with assessed support needs.



The “Slice of Time” survey did not request providers to report on residents’ length of stay in care as this data is not readily available for all providers to extract. Anecdotally, length of stay has decreased over the past few years as residents enter care in a more frail state. The need for short term residential care continues to increase (e.g. to support family carers in the community).

The impact of this trend in the need for short term beds could either reduce the availability of long term beds or mean that the need for short term beds is not met. Wairarapa DHB ensures access to respite care through its capacity funded beds in long term residential care facilities.

Issues and Challenges: Residential Care

The following is a summary of the issues and challenges reported by five residential care facilities. As such they represent a range of views rather than a consensus view. For example, some respondents indicated that recruitment was a workforce issue whilst others felt that they had no difficulties with either recruitment or retention of appropriately qualified staff.

Workforce

- Linking with national careers framework & ensuring that support workers are at least on level 2 (foundation), preferably 3 (competency).
- Need to diversify to remain viable.
- Recruitment difficulties (not all facilities).
- Concern over the reduced numbers of qualified caregivers available.

Model of care

- Need to change the stigma attached to going into care.
- Staff can be reluctant to change.
- Resources not being used to full extent.
- Inadequate communication between staff.
- Discharges from hospital don't arrive in the arranged time frames causing causes problems in the afternoon as we have less staff available and problems arise over medications with less time to follow-up.
- Ensuring the assessment process prior to admission (FOCUS) has been explained and understood by clients.
- Minimising disruption to client caused by transfer to hospital or between facilities.
- Documentation is always sent with the client when transferring.
- Duplication of some documentation, lack of standardised forms.

Clinical Viability

- Keeping workforce skills current.
- Access to services in acceptable timeframe.
- Access to clinical supervision.
- Growing demand and challenge to ensure resources are available.
- Referral waiting times can vary and can be delayed.

Infrastructure

- Need good IT for wages, accounts, correspondence, quality assurance.
- Room to do the job well and safely.
- Keeping up to date and well maintained equipment.
- Equipment – e.g. Demand for standing hoists with more elderly needing this type of transfer to aid reduced manual handling injuries and use time more effectively.

Financial Viability

- Upgrade – it costs money to make money.
- Funding received doesn't equate to cost of living.
- Funding to update and maintain facility, vehicle, IT and equipment.
- Unable to pay staff what they are worth.
- Feel that caregivers do not get enough recognition financially for the work they do. Would like to see better pay parity.
- With increasing costs, need to ensure residents needs are not compromised.

CSAP Survey and Interview Questions

What are the key WORKFORCE issues/challenges for your service? For example:

- Do you have sufficient staff to deliver your service?
- Do you have recruitment or retention difficulties?
- Is your mix of skills & competencies adequate?
- What are the opportunities for staff development & training?
- Do you have succession plans in place for key staff members
- Do you rely on short term and/or locum workforce to cover vacancies

What do you see as the key opportunities of your service with respect to WORKFORCE? (Please explain)

What issues/challenges do you face in terms of your MODEL OF CARE?

A Model of Care refers to the way healthcare is organised and delivered. Model of care issues might include:

- Processes that do not maximise the use of resources
- Clinical services in silos that impede a seamless continuum of patient care
- Communication problems that impede coordinated or shared care
- Disjointed patient pathways and multiple patient handovers
- Processes that do not easily match the needs of your patients/clients

What do you see as the key opportunities of your service with respect to your MODEL OF CARE? (Please explain)

What are the key issues/challenges for your service with respect to CLINICAL VIABILITY? For example

- Is the demand, number/complexity of patients sufficient to sustain workforce and skills, equipment and other resources?
- Is your access to and waiting times for services acceptable?
- Do you have sound clinical quality performance (with systems in place to support this e.g. clinical supervision, credentialing, clinical audits etc)?

What do you see as the key opportunities of your service with respect to CLINICAL VIABILITY? (Please explain)

What are the INFRASTRUCTURE (i.e. facility, equipment, IT, records) issues/challenges for your service? For example, do you have:

- Sufficient facility capacity to meet service needs
- Up to date and well maintained equipment
- Appropriate governance and accountability structures
- Appropriate management and information systems
- An adequate level of support services for the service

What do you see as the key opportunities of your service with respect to INFRASTRUCTURE? (Please explain)

What are the key issues/challenges for your service with respect to FINANCIAL VIABILITY? This might include issues related to:

- Cost of service delivery staffing costs (especially specialists)
- Cost of training and workforce development
- Capital costs of facilities, information technology, vehicles, etc.
- Investment in new technologies, essential capital items and/or clinical equipment

What do you see as the key opportunities of your service with respect to FINANCIAL VIABILITY? (Please explain)

What other issues/challenges or opportunities for your service which are not covered yet?