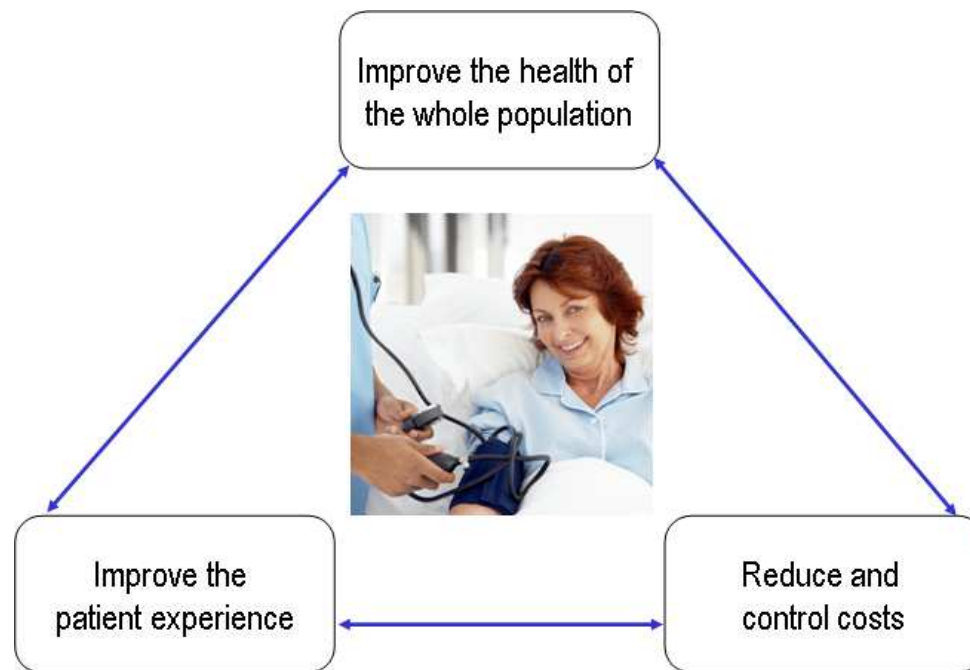


Wairarapa DHB Clinical Services Action Plan



Wairarapa DHB Clinical Services Action Plan

Prepared by Wairarapa DHB
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Executive Summary

This Wairarapa Clinical Services Action Plan shows how health services in Wairarapa will work together to provide the best possible treatment and care for patients and whanau.

The plan is the culmination of a significant collaborative effort between many individuals from across a range of service providers

The steering group and project team would like to thank the many individuals and groups who have contributed to the Wairarapa Clinical Services Action Plan by attending meetings, workshops and stakeholder forums; taking part in the clinical service scan; assisting with data analysis; and providing valuable feedback. The project team are particularly grateful to the patients and their families/whanau who so willingly shared their stories.

The Wairarapa Clinical Services Action Plan steering group was comprised mainly of clinicians from across the range of health services in Wairarapa, and chaired by Dr Robert Logan the Chief Medical Adviser at Hutt Valley DHB

The steering group agreed that all services and frameworks must be more firmly centred on the needs of patients and then considered the issues and options for achieving this. They worked over three months from May 2009, and were informed by views and suggestions collected by project staff through many forums and meetings held with other groups and individuals throughout this period.

The steering group recognises that the DHB needs to move quickly to make decisions about how we will deliver services and what services we will deliver in the face of increasing financial and workforce constraints. This is a world wide issue.

Steering Group Members

Dr Robert Logan	(Chair) Chief Medical Adviser, Hutt Valley DHB
Mr Alan Shirley	Medical Adviser
Dr Andre Smith	Obstetrics & Gynaecology Consultant
Anna Reed	Clinical Nurse Specialist
Anne Davies	Practice Nurse, The Family Doctors, Chapel Street
Anne McLean	General Manager, Hospital Services
Dr Annie Lincoln	GP liaison
Carol MacDonald	Project Administrator
Cheryl Powell	Nurse Manager, Aversham House
Dr Dan Schual-Berke	Emergency medicine specialist
Fiona Samuel	Team leader, 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	Gen.Manager, Community Public & Mental Health
Dr Richard Stein	Physician
Dr Rob Dimock	Anaesthetist
Rob Lewis	Manager, Community Nursing & Health Service
Mr Robert Sahakian	Surgeon
Dr Steve Phillip	GP, Martinborough Medical Centre
Susan Reeves	Clinical Nurse Manager, Medical-surgical ward
TakuruaTawera	Te Hauora Runanga O Wairarapa Inc
Dr Tony Becker	GP, Masterton Medical
Dr Zarko Kamenica	Psychiatrist

Background

The Steering Group noted that:

- Wairarapa residents have high rates of health service utilisation. Standardised access rates to both primary and secondary services are well above the NZ average
- Strong growth in productivity in the last three years has enabled this
- Wairarapa DHB services are generally very efficient
- Regional clinical networking is beginning to develop
- The Regional Clinical Services Plan suggests little change to delivery of services in Wairarapa
- Wairarapa is widely perceived as a high performing high achieving DHB

But

- Many services are provider or diagnosis focused rather than focused on meeting needs of the patient as a whole person
- Demand and expectations are continuing to increase
- Our clinical workforce is aging, it is difficult to recruit doctors in training and vocationally registered specialists, with frequent need for locums
- Medico-legal risks and increased HDC scrutiny is driving defensive practice
- The current position is not financially sustainable
- Some aspects of patient care are fragmented and poorly co-ordinated between services
- Opportunities exist for improvements in services and system design
- Some interventions may be avoidable, such as diagnostic duplication, some follow-ups.

We cannot continue with current ways of working, but there is scope to improve how we do things so that we can deliver better, sustainable services into the future.

Tensions and constraints that are holding us back include:

- Limited inter-professional communication and collaboration
- Unclear roles and responsibilities for system integration across providers and services
- Unclear roles and responsibilities for co-ordination of services for the individual patient
- Ambiguous accountabilities when working in teams
- Perceived lack of system/organisational support, particularly in regard to duty of care and medico-legal risk
- Clinical governance not yet developed fully

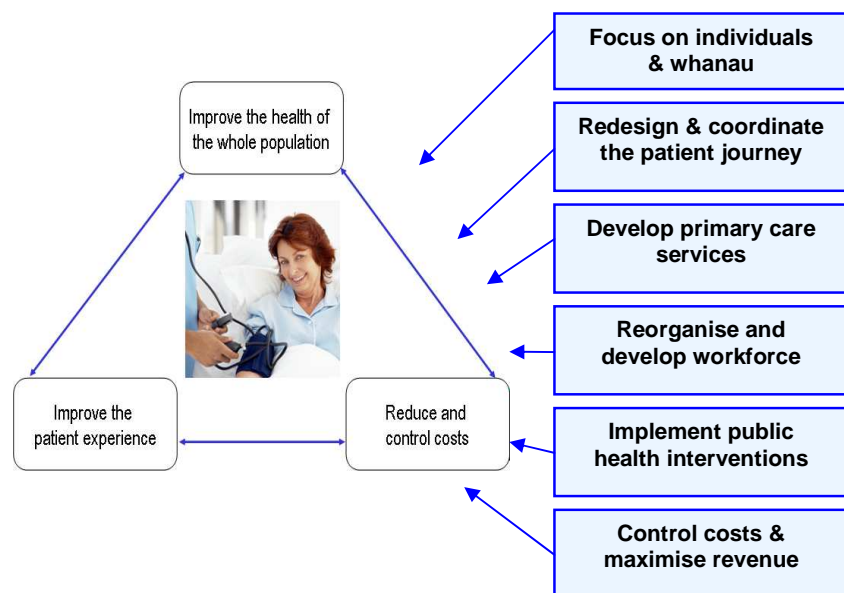
The Steering Group members agreed that to achieve the changes we need to make, we must all take responsibility for supporting and promoting the changes and for working together better than we do now.

This plan identifies the changes necessary to put Wairarapa DHB back onto a financially sustainable pathway, manage increasing workforce constraints, and improve patient experiences and health outcomes, the actions needed to realise the changes, and timelines for the actions. This is encapsulated in the Triple Aim, first developed by Dr Don Berwick in the USA.

Achieving the Triple Aim

The Triple Aim puts the patient at the centre of all endeavours and says patient needs will be served best when we simultaneously provide the services which make the most difference to health overall, in ways which provide the best possible experience for the patient, and provide them at the lowest cost. Wairarapa DHB has adopted this approach as its guide for the way forward.

The Steering Group identified six system components or areas in which actions are required to achieve the Triple Aim. These are illustrated in the following diagram. The accompanying tables show objectives and recommended actions for each component. The recommended actions and proposals for service redesign have all been developed bottom-up, from suggestions from steering group members and consultation.



Focus on individuals and whanau

Put the patient at the centre of all endeavours

- Promote WDHB values across the organisation and to other health providers.
- Hold workshops for staff on what being patient centred means
- Add session on patient focus to DHB staff induction programme

Support patients as active participants in planning their own care

- Promote whanau ora: – Maori families supported to achieve their maximum health and wellbeing
- Implement an Advanced Care Planning programme

Manage patient and community expectations of ever-increasing access to health services

- Increase community understanding of the DHB's resource limits and options

Redesign and coordinate the patient journey

Streamline patient pathways encompassing all providers

- Develop district-wide care pathways and guidelines, and reduce service duplication for common conditions.
- DHB takes responsibility for system-wide integration across all providers

Collaborate effectively with other DHBs, including shared staffing

- Participate in regional clinical networks
- Hold regular senior executive meetings with CCDHB, HVDHB and MCDHB
- Develop shared staffing of clinicians with other DHBs

Increase capacity and capability of aged residential care (ARC) services to manage their own patients

- Provide advisory nurse support to aged residential care (ARC) facilities
- Provide training for registered and enrolled nurses in ARC facilities
- Implement GP support and supervision for ARC facilities in Masterton

Achieve good communications and easy communications pathways between GPs and specialists

- Develop processes for virtual GP consults with specialists
- Establish a joint clinical forum to support, advise, and monitor progress in implementing the Clinical Services Action Plan

Improve processes and pathways within Wairarapa Hospital

- Streamline patient pathways, e.g. for pre-operative assessment
- Improve admission to discharge planning
- Increase the patient focus groups; facilitate patient input into process redesign
- Redesign outpatient services to reduce clinics and support virtual GP consults

Create effective integrated IT/IS systems

- Implement Wairarapa DHB's IT initiatives

Executive Summary

Develop primary care services
Establish general practices as the “medical home” for each patient <ul style="list-style-type: none"> ➤ Support practices to develop case manager/key worker roles in primary care ➤ Develop primary health care teams including providers external to the PHO ➤ Establish case management for patients with complex and/or long term conditions, including a review of the Care Plus programme
Re-orient services to support self care and independence from medical services <ul style="list-style-type: none"> ➤ Increase linkages and referrals between primary / secondary care and NGO and voluntary / community services
Create one virtual Integrated Family Health model for Wairarapa incorporating primary and secondary services <ul style="list-style-type: none"> ➤ Develop GP and nurse specialists working across practices ➤ Develop referral pathways between practices and between practices and other primary care providers (e.g. Maori providers and pharmacists)
Ensure acute first contact care occurs in the most appropriate setting for best use of health service resources <ul style="list-style-type: none"> ➤ Review and implement After Hours Plan ➤ Investigate use of advanced paramedics as first response providers. ➤ Extend Community Nursing support into general practice. May include wound care and IV antibiotics.
Reorganise and develop the healthcare workforce
Ensure tasks are allocated to maximise the use of the skilled workforce <ul style="list-style-type: none"> ➤ Review the composition of the hospital clinical team, including the role of RMOs and investigate alternative workforce roles. ➤ Implement recommendations from the Clinical Administration Review ➤ Implement <i>The Productive Ward: Releasing Time to Care</i> ➤ Review use and placement of Clinical Nurse Specialists (CNS) and Clinical Nurse Educators (CNE) ➤ Review maternity services and use of maternity workforce
Strengthen clinical leadership <ul style="list-style-type: none"> ➤ Establish clinical lead for each sub specialty at Wairarapa Hospital ➤ Increase regional peer support for SMOs
Develop a culturally competent clinical workforce <ul style="list-style-type: none"> ➤ Implement cultural competency framework, Te Arawhata Totika
Provide relevant and accessible training programmes <ul style="list-style-type: none"> ➤ Create an annual calendar of training programmes to support skills development across the DHB and service providers.

Public Health interventions
Improve quality of life and reduce morbidity and mortality through improved understanding of the determinants of health <ul style="list-style-type: none"> ➤ Review actions and functions of Healthy Lifestyles oversight and governance groups ➤ Clarify and streamline health promotion actions between the PHO, Public Health Unit and NGOs ➤ Embed <i>Keeping Well</i> priorities into public health planning and contracting ➤ Continue <i>Go 4 Your Life</i> and Healthy Lifestyles programmes ➤ Further develop tobacco control and smoking cessation programmes ➤ Complete and implement suicide prevention plan ➤ Support Masterton East project ➤ Targeted programmes in high needs communities
Control costs and maximise revenue
Maximise revenue generating opportunities <ul style="list-style-type: none"> ➤ Improve clinical coding and ACC claiming processes ➤ Capture all revenue for IDF inflows through improved address coding
Reduce expenditure outflows <ul style="list-style-type: none"> ➤ Reduce referrals to other DHBs for services available at Wairarapa hospital ➤ Review referral patterns to other DHBs and introduce prior approval policy
Use all resources more efficiently <ul style="list-style-type: none"> ➤ Rationalise use of diagnostics ➤ Investigate sharing of back office support functions between DHBs ➤ Continue/expand projects to improve use of pharmaceuticals ➤ Share specialist staffing with other DHBs
Increase efficiency of hospital services <ul style="list-style-type: none"> ➤ Implement recommendations from perioperative service review ➤ Introduce hospital capacity planning
Improve funding allocation to maximise value for money <ul style="list-style-type: none"> ➤ Utilise prioritisation tool and process to inform future funding decisions ➤ Review access to elective services to ensure equity with other DHBs ➤ Review configuration of dental services to maximise access for high needs groups ➤ Review efficiency of WDHB mental health services
Ensure funding/contracting arrangements promote/support improved service performance <ul style="list-style-type: none"> ➤ Develop new ways of funding services to provide new models of care

Process for change established

Realising the Triple Aim is as much about achieving transformational change over the medium and longer term as it is about achieving immediate gains. The Steering Group and Working Group have proposed significant change in the way services are structured and delivered and but more importantly, in attitudes, and have taken steps themselves towards achieving the attitude changes required. The work of both groups has created a process in which individuals work together to discuss and resolve difficult issues, to find positive ways of moving forward.

The recommended actions and proposals for service redesign included in this Clinical Services Action Plan have all been developed bottom-up, from suggestions from steering group members and the consultation process. The engagement and commitment of clinicians has ensured that the recommendations of the Steering Group not only reflect but were generated by those directly involved in the delivery of health care in Wairarapa.

Active involvement of a wide range of clinicians from across Wairarapa in both the Steering Group and Working Group has resulted in wide understanding of the need for change, and commitment to supporting it. Steering Group members are keen to promulgate, lead and participate in implementing the changes proposed. They will continue to meet as a Joint Clinical Forum to encourage and monitor progress. This creates an excellent base for the next steps.

This plan is just the beginning. There is much to be done to ensure that the recommended actions are realised and our goals are met. This project has created a process that provides a strong platform on which to build the capability of the DHB to respond to the certain challenges it will continue to face. The process needs to be nurtured and developed into the future.

Introduction

Plan Structure and Status

This plan draws together the findings of the Wairarapa Clinical Services Action Plan project. There is a companion document, an appendix to this plan “Current Service Status” which 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 Clinical Services Action Plan consists of the following sections:

Introduction	Outlines scope, objectives and approach of the project.
CSAP Planning Environment	Describes the planning environment in which the Clinical Services Action Plan was developed and will be implemented. Highlights service delivery issues and challenges
Roadmap for Change	Outlines where changes are needed over the next 5 to 10 years
Wairarapa DHB Overview	Describes the context of the Wairarapa including demographic profile, overview of current services and the DHB’s strategic context.
Appendices	<ul style="list-style-type: none">• IT projects• Glossary and definitions

Plan Status

This is the final version of the Wairarapa Clinical Services Action Plan and presents the findings of the work completed to date.

The plan reflects the approved direction of the Wairarapa DHB and provides an overall framework for decisions about future service configuration and delivery. It identifies options for immediate change as well as issues which require further analysis and discussion.

The dynamic nature of the health context means the DHB needs to constantly review and adjust to changing demands and initiatives. This plan should be viewed as a foundation document which will need to be continually reviewed and updated.

Project Scope and Objectives

This Clinical Services Action Plan has been developed to provide a strategic framework that identifies the clinical services required to meet current and future demand of the Wairarapa population.

The primary focus of the plan is to determine how best to utilise Wairarapa DHB resources to meet the increasing demand for clinical services. It presents a set of actions the Wairarapa DHB can take to create a set of services that are sustainable clinically and financially and that provide for safe quality care.

The plan provides the overarching context, core requirements, and linkages needed to guide development of more detailed plans for each of the services that will be provided by the Wairarapa DHB through Wairarapa Hospital and Community Health Services over the next ten years, and the other services the DHB will fund through service agreements with the PHO, NGOs, and other providers.

The Clinical Services Action Plan has taken into account

- What services will be provided in Wairarapa
- The levels at which they will be provided
- The linkages and clinical networks required to support effective delivery of the services in Wairarapa
- Which services the Wairarapa population will access outside the district

The Clinical Services Action Plan scope includes:

- Stock take of current services – what and how delivered
- Consideration of environmental factors –disease drivers, changing demographics, future funding path, workforce, technology changes
- Consideration of Regional Clinical Services Plan (RCSP)
- Consideration of the broader environment e.g. primary care strategy , inter district flows, Long term System Framework, “Better, Sooner, More Convenient” and other government policy
- Models of care – which organisations may deliver which services

Key project deliverables include:

- Stock take/overview of current clinical services
- Assessment of ‘fit’ with Regional Clinical Services Plan
- Role delineation (DHB provider arm services)
- High level models of care, workforce, IT and infrastructure planning implications

Project Approach

The project to develop the Clinical Services Action Plan consisted of three phases over four months of intensive work.

Phase 1: May	Phase 2: June	Phase 3: July/September
Information gathering <ul style="list-style-type: none"> • Data extraction • Capacity & demand projections • Service stock take meetings • Role delineation 	Options development <ul style="list-style-type: none"> • Stakeholder input workshops • Analysis of what needs to change & how. • Triple Aim analysis 	Agree options and actions Submit report <ul style="list-style-type: none"> • Develop “roadmap” & draft plan • Submit plan to Board
<p>A scan of clinical services was undertaken to determine the current model of care, issues related to service delivery and strategic drivers and trends which impact on service delivery.</p> <p>Population projections and data extracts were sourced. Volume and capacity projections were sourced where available.</p> <p>Stock take meetings were held with each clinical specialty group to gather information on issues, challenges and opportunities for each service.</p> <p>Role delineation data was sourced.</p>	<p>Clinical staff provided extensive input at this stage to assess options, identify recommendations, and determine the implications of preferred options.</p> <p>NGOs and community groups were invited to participate through a written survey, individual meetings and/or stakeholder workshops.</p> <p>Proposals for change were assessed against the Triple aim using Benefits Criteria.</p>	<p>A road map was developed showing key recommended actions over the next 5 years.</p> <p>The final draft of the Clinical Services Action Plan was submitted to the Wairarapa DHB</p> <p>The final version of the Plan was endorsed by the Board.</p>

Consultation Process

A survey and interview schedule was developed to align with the Vulnerable Services Project which arose out of the Regional Clinical Services Plan. The same questions were used to gather information from clinical services and community providers in Wairarapa.

The questions related to the issues, challenges and opportunities for each provider or service with respect to: workforce, model of care, infrastructure, clinical and financial viability. Following each meeting or interview, data was collated and summaries were returned to the participants for verification and amendment as required.

The Patient Voice

Views and experiences of patients and their families/whanau were obtained through individual interviews and patient advocate/support focus groups. This information was invaluable in providing true accounts of patient journeys from across the continuum of care. The stories used in the plan are based on those accounts with names and other identifying details changed to protect the privacy of individuals and their whanau.

Clinical Services

Individual meetings were held with each clinical service and qualitative data was collected using the standardised interview schedule. 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 clinical staff involved in the formal consultation process is provided on the following page. In addition to those listed input was received from a number of GPs and other primary health staff.

NGOs and Community Groups

A broad range of non-government organisations (NGOs) and community groups were invited to participate in development of the Clinical Services Action Plan 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
- Whaiaora

Clinical service involvement

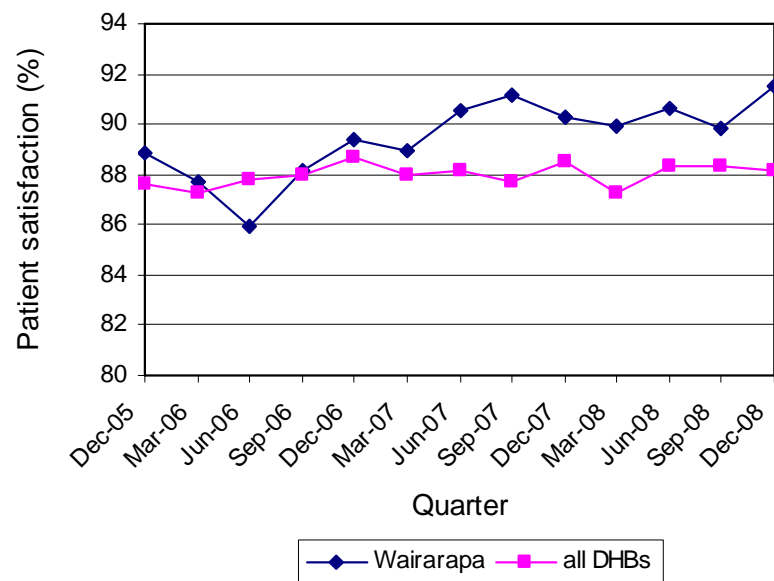
Several General Practitioners from a number of practices	
Mr Alan Shirley	Medical Adviser
Dr Andre Smith	O & G Consultant
Andrew Curtis-Cody	Community Psychiatric Nurse
Anna Reed	Clinical Nurse Specialist
Anne McLean	GM, Hospital Services
Aynsle O'Reilly	Clinical Nurse Manager, Rehabilitation
Mr Bob 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	Emergency Department Consultant
Danielle Farmer	Nurse Coordinator Clinical Training Agency (CTA) Programmes
Deb Severn	Nurse, Medical-Surgical ward
Debi Lodge-Schnellenberg	Manager, Public Health & Ambulance
Donna Purvis	Clinical Midwife Manager
Eileen Fahy-Teahan	Whaiora
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 Cross	Maori Health Directorate
Janet Saunders,	Medical Officer, Rehabilitation
Jill Perry	Whaiora

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
Moira 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, Medical –surgical ward
Dr Sharon English	Urologist
Sharon Woods	Unit Manager
Mr Steve Martyack	General Surgeon
Sue Willoughby	Clinical Nurse Manager, Child & Adolescent mental health services
Susan Reeves	Clinical Nurse Manager, Medical-surgical ward
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

Wairarapa Clinical Services Planning Environment

Productivity and Performance

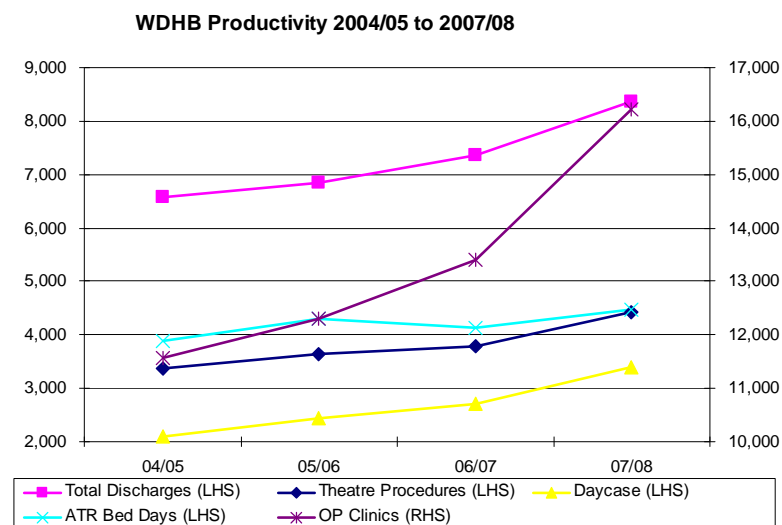
Nationally Wairarapa DHB is seen as a leader in developing creative strategies for the provision of health services. Ministry of Health data¹ show that Wairarapa is one of the highest performing DHBs for achievement of 15 non-financial performance indicators. This high performance is reflected in relatively high levels of patient satisfaction as seen in the following graph.



The high performance has also been reflected in significant gains in hospital productivity. In contrast to many other DHBs across the country, the productivity of Wairarapa hospital has increased

¹ Ministry of Health. Report on Indicators of DHB Performance (IDP) for Quarter Two 2008/09. Report Number 20082474

significantly over the past five years. This is illustrated in the following graph which shows growth in activity at Wairarapa Hospital over the past five years. Growth in hospital outputs has greatly exceeded growth in funding and staff numbers have remained largely flat.

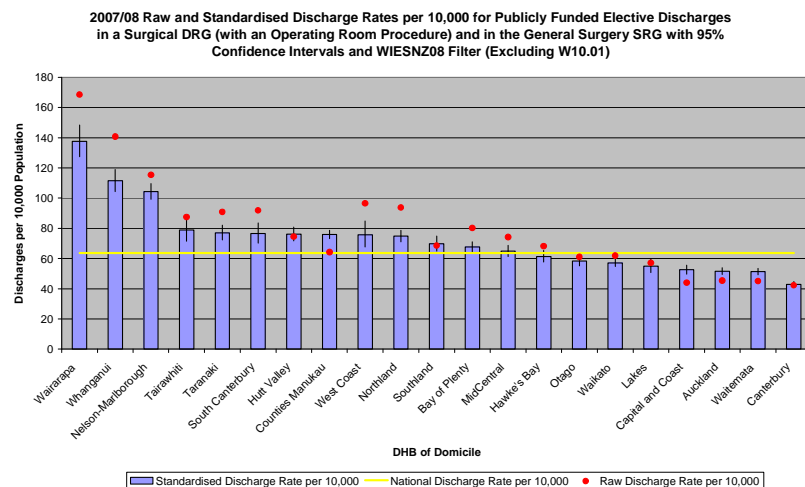


These productivity improvements have led to significant output above contract. In 2008/09 the DHB provider is over-delivered against contract by about 5%. Wairarapa people have better access to hospital services than elsewhere in New Zealand.

As shown by the following graph, Ministry of Health data indicates that the Wairarapa DHB is providing elective surgical procedures at

Planning Environment

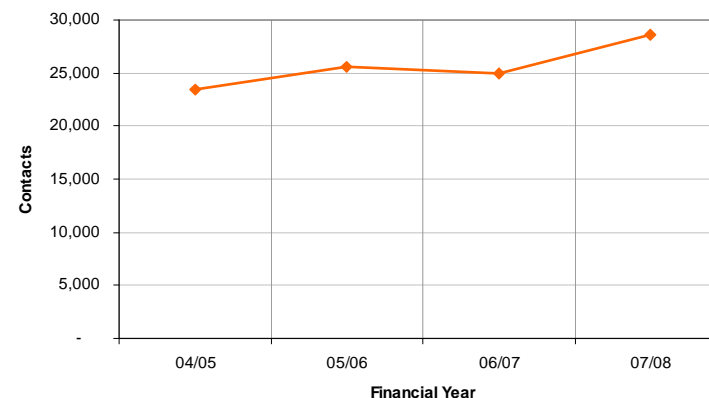
a much higher rate than the national average. The table below shows which procedures are provided above the national average.



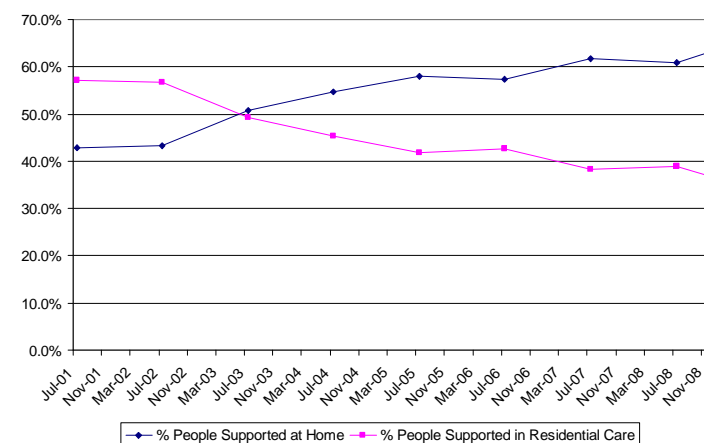
Surgical procedure	SDR 2007/08
Grommets	1.01
Repair of Hernia	1.27
Cholecystectomy	1.28
Tonsils and Adenoids	1.35
Cataract	1.36
Hysterectomy	1.47
Total Hip Replacement	1.67
Total Knee Replacement	1.72
Carpal tunnel procedure	1.72
Tubal Ligation	3.08

Community services activity has also increased, as illustrated by the increase in Community Nursing contacts in the following graph. These contacts are for services such as wound care, IV therapy in the home, palliative and oncology services

Wairarapa DHB Community Nursing Activity
Professional Services Contacts



A significant trend in community services is the increased ratio of older people being supported at home compared to those supported in residential care. This data relates to older people assessed as needing support services (not the total population of older people in Wairarapa.)



Why we need to change

Wairarapa DHB's current funding and provision of services is unsustainable. During 2008/09 the DHB has moved from financial breakeven to deficit as growth in outputs and costs has outstripped growth in funding. Government has made it clear that DHB deficits will not be supported and that in 2010/11 and beyond Vote: Health will grow much more slowly.

There is growing recognition around the world that expenditure on healthcare cannot continue to grow as it has over recent years. In New Zealand the latest Treasury forecasts indicate government will be able to afford only very minimal growth in health funding for the next decade. Health services also face increasing workforce constraints. Forecasts indicate the health workforce cannot grow fast enough to meet the projected demands for services in the future.

We must move quickly to reorganise how we work so as to regain financial breakeven, manage within workforce constraints, and continue to improve health outcomes, whilst addressing changing demands and increasing needs of an aging population. Wairarapa DHB must reduce its annual expenditure by \$4M.

At the same time there is increasing focus nationally and internationally on the quality and safety of health services, with recent legislation requiring certification, credentialing and audit, and reports of the Health and Disability Commissioner (HDC) placing increasing demands and expectations on the provision of care. Added to this are the statutory requirements on DHBs to improve health outcomes and reduce inequalities.

Finding a better way

Albert is 82 and lives in Masterton with his frail wife. He receives a letter advising him that he would be having long awaited hip replacement surgery in three weeks. The letter also advises him that he has two appointments at the outpatients department the following week. A couple of days later he receives another letter advising him of an appointment with the Surgeon, also next week. As he no longer drives, Albert's family and friends rearrange their schedules to transport him to and from the hospital.

At the pre-assessment clinic the nurse tells him that he needs to have an x-ray and blood test done before going home, that he needs an ECG on Thursday, half an hour before his anaesthetic clinic appointment, and that he needs to come in for another blood test 2 or 3 days before the day of his surgery. That afternoon he receives a telephone call from the physiotherapist advising him that on Thursday he will also need to see the physiotherapist and occupational therapist.

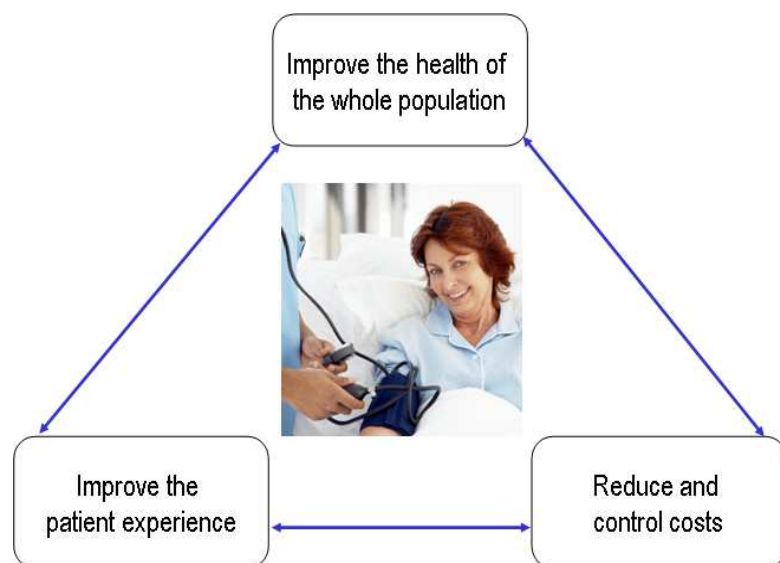
By the end of the week Albert has made 3 trips to the hospital and been to 7 different appointments or departments. It has taken him 7 hours. He is tired and bewildered by all the information he has been given, both verbally and in numerous sheets of paper and leaflets.

This plan has identified actions to streamline journeys like Albert's as a priority.

The Triple Aim: what we must achieve

Wairarapa DHB has adopted the Triple Aim approach as its guide for the way forward. The Triple Aim was developed by Don Berwick at the Institute for Health Improvement (IHI) in the USA. It is based on the belief that focusing on three critical objectives simultaneously can lead to better models for providing healthcare.

The Triple Aim puts the patient at the centre of all endeavours and says patient needs will be served best when we simultaneously provide the services which make the most difference to health overall, in ways which provide the best possible experience for the patient, and provide them at the lowest cost.



Strategic Direction

Our Vision for Health Services

Wairarapa will have one integrated, patient centric, co-ordinated system of health services working to common goals, pathways and protocols across the continuum; in which:

- Individual team, agency and professional roles and linkages are clearly identified and understood by both staff and patients and their whanau;
- Patients know their “medical home” and that this “home” will ensure their health care needs are well communicated and met seamlessly.

Key Principles for Service Design

Health services in the Wairarapa will be:

Patient centred

- sensitive to individual's needs and preferences
- supporting self-care and independence

Collaborative

- provider agencies and professional groups working together in interdisciplinary teams to provide a fully integrated model across the continuum of care

Effective

- evidence based, providing care that works, based on the best available scientific information
- able to demonstrate improvements in clinical outcomes – health gain
- culturally effective, able to demonstrate reductions in inequalities

Efficient

- continually seeking reductions in waste (of time, supplies, equipment, ideas and information)

Sustainable

- Funding and resource needs (including workforce) can reasonably be expected to be met over the longer term.

The Planning Context

We expect that the health sector of the future will be very different from how it is today. In 2009 we face a convergence of issues that make change imperative. The need for change is urgent and ongoing. Key factors driving change are:

1 The Global economic recession

The worldwide recession has led to reduction in growth of funding for health services. Reduced funding is likely to continue for the next ten years. New Zealand cannot afford to continue to provide health services in the way they are provided and configured currently.

2. Worldwide recognition of the need to increase the value obtained from expenditure on health

Governments around the world are questioning the value of increasing expenditure on health services, and whether this leads to improvements in health status. International comparisons indicate diminishing returns as per capita expenditure increases. New Zealand reports indicate falling productivity.

3. Workforce issues

New Zealand faces shortages and gaps in all parts of the health workforce. This will worsen soon in Wairarapa as our workforce is mostly older than elsewhere. The average age of nurses at Wairarapa hospital is the highest across all DHBs. We also have predominantly older specialists and general practitioners, many of whom expect to retire within 10 years. National forecasting indicates the professional health workforce growth requirements outstrip the current rate of new entrants to health professions. The clinical workforce cannot be grown quickly due to the years of training required. We must find new ways of boosting workforce numbers and new service delivery paradigms so as to optimise our use of increasingly scarce health professionals.

4. Quality and safety issues

The introduction of the Health and Disability Commissioner, and recent legislation such as the Health Practitioners Competence Assurance Act and Health and Disability Services Safety Act bring increasingly stringent compliance requirements for systems,

practices, and individual practitioners. This limits the complexity of treatment that can be provided at Wairarapa hospital and means more complex procedures will increasingly be provided only at larger centres.

Cultural competency and cultural responsiveness, particularly in regard to Maori, are of growing importance, as is patient choice, and ensuring access to whanau ora services.

5. The National Government – *Better Sooner More Convenient*

The government has signalled major change for the health sector. The principles government will use to guide the changes are:

- Putting patients first
- Care close to home
- Integrated care
- Trusting health professionals
- Working together for better care
- Healthier lifestyles

A larger proportion of health services will be provided in primary care, rather than in hospitals. There will be greater regionalisation of service planning and funding and greater use of regional clinical networks to guide service delivery, and a strong focus on clinical leadership.

6. Population changes and disease trends

Continual change in the demand for, and delivery of, health care is inevitable. The population is ageing and ethnic diversity is increasing. Disease trends, such as increasing rates of diabetes, cancer and cardiovascular disease will compound pressure from demographic changes.

All of the above are taken into consideration in this plan.

Service Delivery Challenges in Wairarapa

As well as preparing for a different future, the Clinical Services Action Plan needs to take into account current challenges to service delivery and where possible, make provision to progressively address them. Meetings were held with clinical specialty groups to gather information on the key issues and challenges facing each service. From the collated data the challenges are summarised as follows.

Models of Care

- Rising volume growth from an aging population with increasingly complex health needs
- Increasing demand arising from diabetes, cancer, cardiovascular disease and depression.
- Creating standardised assessment and clinical pathways across systems
- Improving communication and integration between primary and secondary care.
- Supporting a Maori world view and whanau ora
- Redesigning processes that are wasteful
- Managing limited capacity in some services to meet additional demand growth
- Reducing multiple patient pathways and patient handovers
- Providing a seamless continuum of care for patients with complex needs through case management and interdisciplinary teams.
- Improving support for patients to manage their own health
- Improving the support given to primary health care by secondary services.
- Creating more partnership based service delivery models across the region

Workforce

- An aging workforce creating critical workforce shortages
- Recruiting and retaining an appropriately skilled workforce
- Developing a workforce that can effectively deliver services to Maori
- Continuing investment in professional development
- Providing an appropriate workforce to meet roster commitments
- Providing adequate clerical/administrative support to clinicians
- Managing resources across the sector, district and region.
- Determining the best use of the non vocationally registered medical workforce
- Achieving a balance between specialist and generalist expertise
- Enabling peer support and interaction for clinical specialists
- Providing excellent clinical oversight and leadership

Infrastructure

- Replacement of a legacy Patient Administration System
- Inability to electronically record and share information which impedes shared patient care.
- Multiple systems which are not integrated, do not provide a single patient view and delay access to information
- Limited ability to support clinical audit, administrative processes and workflow.
- Overly bureaucratic processes which contribute to disjointed pathways and inefficient administrative systems.
- Appropriate resourcing and regular maintenance of clinical equipment

Our vision 10 years on

Patients

- Actively participate, to the level of their ability and preference, as partners in their care and as integral members of the care team.
- Receive healthcare that is respectful of and responsive to individual cultural traditions, their personal preferences and values, their family situations, and their lifestyles.
- Have health professionals who work closely with them and their families/whanau to develop treatment goals and plans, monitor progress, and assess results.
- Experience communications based on their level of understanding, and are fully informed about all aspects of their condition and care.
- Have trust and confidence in health care professionals and believe that they are working as a coordinated team.
- Receive accurate, relevant and comprehensive information which enables them to make informed decisions about their health. The information is presented in a format appropriate to their condition, language, culture and abilities.
- Family/whanau are involved in the patient's care and made to feel welcome in the care environment.
- Are encouraged to be independent and are supported to manage and monitor their own health.
- Are given choices and schedules that are tailored around their needs when possible.
- Have access to necessary healthcare services, regardless of their condition, ethnicity or socio-economic status.

Delivering health care

- Well designed care pathways provide a streamlined patient journey across the continuum of care. This is enabled through:
 - A culture of continual quality improvement which identifies and addresses bottlenecks and redundancies in patient journeys.
 - Seamless transitions between providers and health care settings that are respectful, coordinated, and efficient.
 - Care pathways in key areas such as child health, chronic care management and elective surgical services, developed by practitioners from primary and secondary
 - Key workers and case managers supporting the transition of care.
 - In-reach and outreach services facilitating closer relationships between specialist services and primary health care providers
 - Appropriately resourced clinical support services

Healthcare at Wairarapa Hospital

- Only the most complex and acutely ill patients are admitted as inpatients. Most health care is delivered in outpatient, community and home based settings, including care for long term conditions and rehabilitation following discharge from hospital.
- Services are delivered for complex, chronic and acutely ill patients and for those who meet the thresholds for elective services.
- Low priority services are provided when resources allow or where there is a strong public imperative to do so
- Well designed systems and processes facilitate
 - Effective front door management for primary health care referred patients and self referrals
 - Efficient management of surgical and day procedure patients, including fewer diagnostic, assessment and treatment visits.
 - Effective discharge planning, initiated at admission and including primary health care input.

Our vision 10 years on

Health Care in the primary setting

- An expanded range of health problems are dealt with in Primary Health Care (PHC) settings
- There are fewer referrals to hospital based services; those that are made are for serious clinical problems, specialist interventions, care and procedures.
- PHC delivery is underpinned by a patient/whānau-centred approach that meets cultural needs and supports independence and self-care.
- PHC practitioners work in inter-disciplinary teams.
- Some PHC practitioners have developed competencies in specialist areas of interest such as palliative care.
- Maori providers deliver an expanded range of services.
- GPs and other PHC practitioners have enhanced access to specialist services for “virtual” consultations.
- An electronic patient record facilitates the timely and efficient sharing of patient information between primary and secondary health care.
- Some PHC providers have direct access to facilities such as outpatient appointments, community referral requests, and diagnostic results.
- Effective partnerships in key areas such as long term conditions management, aged care, palliative and rehabilitation services support residential and home based care for patients who would have previously been admitted.

Workforce and infrastructure

- Our workforce is multi-skilled, flexible and adept at working as members of multi-disciplinary teams across care settings.
- Strong clinical governance ensures there is clarity about the types and acuity of patients managed by each level of service, and the respective responsibilities and accountabilities of each service.
- Specialists do the work only they can do.
- Increasingly specialist nurses and allied health professionals work in specific specialities.
- Clinical services are supported by strong information technology systems, including patient, bed and other management systems, and service specific systems such as PACS and theatres.
- The most critical patient information flows seamlessly between care settings in a timely way through a shared electronic patient record.
- Our workforce have widespread access to desktop computers, and where appropriate, wireless and portable devices and are trained in the use of the IT systems.
- Telemedicine capability has an increasing role in the provision of specialist care in our region.

Health Care across the region

- Collaboration with other DHBs ensures the delivery of effective, efficient and high quality services.
- A regional CSP is implemented which ensures workforces and resources are aligned to deliver services locally where it is viable or regionally where it is beneficial for the population.
- Common predefined pathways support consistent management of patients across the region.
- Close liaison with other hospitals ensures support for credentialing and training for specialist staff.
- An effective IT system facilitates the provision of specialist advice and clinical support from other hospitals.

Roadmap for change

Regional Clinical Services Plan

The six central region DHBs have developed a Draft Regional Clinical Services Plan (RCSP)² to guide their collaborative planning efforts over the next 5 to 10 years. The plan presents a vision of “Connected Communities,” a regionally coordinated system of health planning and delivery leading to sustainable improvements in access, quality and affordability of services.

The regional plan proposes a new service model which envisages more health care being provided at home and in the community, including care for long term conditions and rehabilitation following discharge from hospital. Community health centres will be developed to meet a wide range of health needs without resorting to hospital care. The RCSP proposes that while the existing public hospitals in the central region remain, there will be a greater co-operation between them, and more differentiation between the services they provide.

Under the proposed RCSP model, Wairarapa hospital would be a Local Hospital, continuing to provide:

- non-complex, inpatient and day case services to the local population
- an excellent emergency department providing care to all. The most severe emergency cases will be stabilised and transported to a major Acute Hospital.
- high dependency unit (HDU) for non-ventilated patients
- on-site maternity services, including secondary obstetrics on a 24/7 basis by working in collaboration with a neighboring major Acute Hospital
- high throughput elective surgery for local and regional populations

² Regional Clinical Services Plan (2008) Central Region's Technical Advisory Services Ltd (on behalf of Central District Health Boards) FINAL DRAFT www.rcsp.org.nz

An overview of the hospital types proposed in the RCSP is presented below³.

● Local Hospital

- Core services (including ED) open 24/7: other reduced hours
- Serve local population of 50-150k
- Offer ED services and non-complex acute medicine and surgery
- Provide high throughput elective surgery

● Major Acute Hospital

- Open 24/7
- Serve sub-regional population of 300-400k
- Offer complex acute and elective medical and surgical services, ICU and specialist diagnostics.

● Tertiary Referral Service

As major acute (or within major acute) plus:

- Provide advanced diagnostic and treatment services, usually for medical and surgical subspecialties.
- Linked to academic health science centre

● Specialist Hospital

- Regional centre of excellence for a particular service (e.g. reconstructive surgery: GI surgery: cardiac services)
- Linked to academic health science centre

While the types of services provided by Wairarapa Hospital will be largely unchanged, there will be significant changes in the way in which they are delivered and to the degree which DHBs work together. There is already an increasing amount of collaboration between some DHBs but the RCSP recognises that a united approach is required and real commitment to make the changes necessary to meet the challenges now and in the future.

³ Ibid.

All hospitals will need to work together across the facilities to enable greater coordination and standardisation of care. The central region currently has five networks: cancer, cardiac, mental health, plastic surgery, and renal. In future there will be increased linkages through clinical networks with common predefined disease pathways to support consistent management of patients across the region. There will be an increasing need for DHBs to share the clinical workforce to ensure clinical viability across all hospitals and specialist services.

The greatest changes will occur in primary care. Under the future model most health care will be delivered in outpatient, community and home based settings, including care for long term conditions and rehabilitation following discharge from hospital. Hospital services will cater for only the most serious clinical problems, specialist interventions, care and procedures.

Primary health practitioners will have a key role in the case management of patients with complex needs and be vital in ensuring that effective partnerships exist between providers.

The RCSP notes that to achieve a single integrated health system will require significant changes in how and where care is delivered and by whom.

Viability Issues

Since the Final Draft RCSP was completed in mid 2008 the world wide recession has arrived, health service funding is increasingly constrained, and the long term affordability of the RCSP model is still to be assessed.

A dilemma

Tamati is a 78 year-old who lives alone since the death of his wife 6 months ago. He is independent and enjoys reasonable health. Recently Tamati has been thinking about what would happen if he was to become ill. He hates the thought of being “hooked up to a machine, having a long drawn-out death”. He tried to talk to his family about his thoughts but it only upset them.

Tamati has now had a stroke. He is unconscious and requires assistance to breathe. His doctor calls the family together to talk about his condition and explains that even if Tamati regains consciousness, he will be unable to speak or manage the most basic personal tasks, such as feeding himself. She explains that it may be in Tamati's best interests if they remove the life support machines and provide comfort care, so that he may die peacefully. Tamati's family face a difficult decision. His daughter wants everything done but his son is sure that his father would not have wanted his life prolonged in this way.

How it could be

After the death of his wife, Tamati realised that he didn't want his children to be in the situation of having to decide whether or not he should have invasive procedures or be kept on life-support. He gathers his family together and tells them what he has been thinking about. They are upset that he is talking about death but he insists that he is only being practical and that he wants to ensure that there is no doubt about his wishes should he not be in a position to make them known himself.

Together they discuss a brochure on Advanced Care Planning which he picked up at the local Health Care Centre. It includes questions which guide Tamati and his family through the process of creating an Advance Care Plan. Tamati now has a clear record of his preferences about future medical care and his family is reassured that if they need to make decisions on his behalf, they will be based on a clear understanding of their father's wishes.

The need for integration

The Steering Group agrees that Wairarapa people will be served best by a single integrated system of local services, encompassing all service provider organisations across Wairarapa, with clear access pathways to more specialised services in other DHBs, supported by regional clinical networks. Better integration has the potential to improve patients' experience of care, improve health outcomes and lower costs. Effective integration relies on participants being clear about their roles and responsibilities for the various integration functions. The lack of this in the past has resulted in limited integration. It is also important that all individuals in the system are aware of how their actions, or inactions, impact on others in the system.

System integration

The DHB as funder needs to step up and take full responsibility for the system level integration - ensuring there is effective linkage between all provider services/organisations across the whole continuum of care; and working with them to encourage and support co-ordinated service delivery within the single linked system. A joint clinical forum is needed to act as a key driver for system integration.

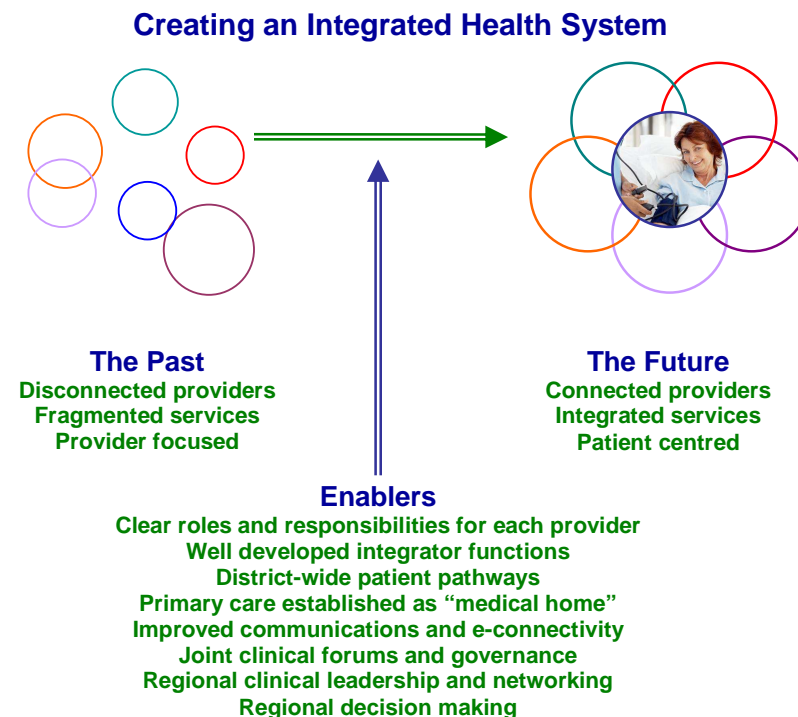
Patient level integration

Integration or coordination at the patient level means taking responsibility for ensuring individuals and families/whanau receive the best and most appropriate care for their specific needs. A patient's primary care practice or medical "home" is usually the team most able to fulfil this role.

Integrated Family Health Centres

The Minister of Health has signalled the focus from 2010 will be on establishing Integrated Family Health Centres (IFHCs) and shifting some secondary services to primary care settings. Many general practices already have on-site (or close-proximity) allied health professionals, laboratory collection services, pharmacy services and access to other medical specialties. Masterton Medical, for example, has pharmacy, physiotherapy and laboratory services on-

site. Successful integration, however, requires more than co-location of services. *"Whilst some may feel that integration can only be achieved by co-location, integration is as much about systems for innovation, communication, clinical collaboration and shared learning as it is about bricks and mortar"*⁴



To develop an IFHC model in a rural DHB such as Wairarapa presents unique challenges due to small scale and population spread.

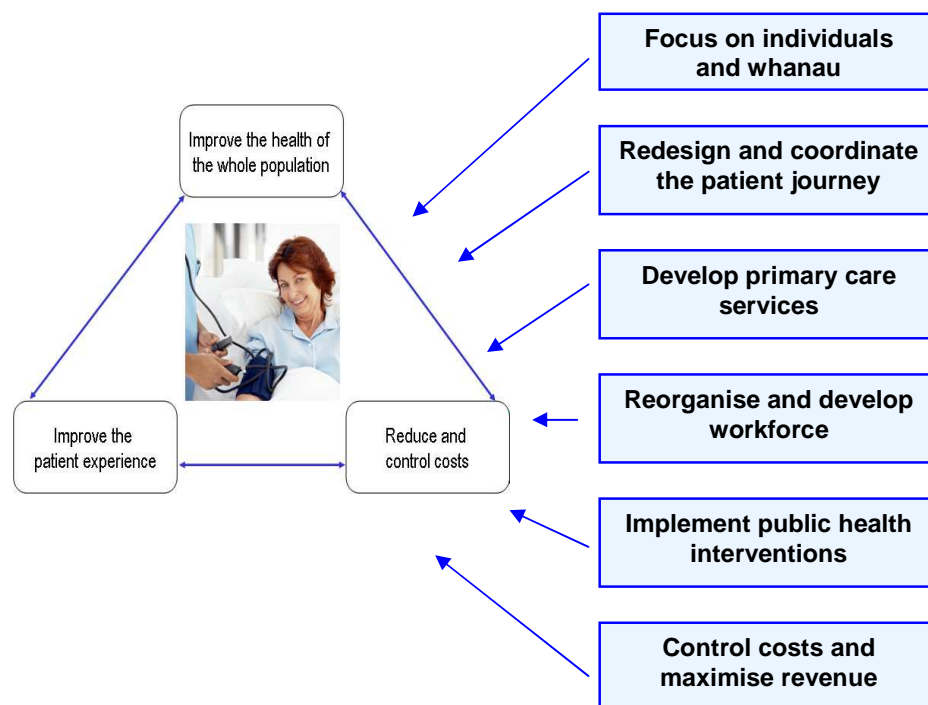
⁴ Royal College of Physicians, Royal College of General Practitioners, Royal College of Paediatrics and Child Health, 2008, pg 9.

Roadmap for change

Experience has shown, for example, that there is insufficient local demand to support a second radiology facility. Close proximity and easy access to Wairarapa Hospital for most residents means the co-location of a radiology service in primary care is not warranted. For Wairarapa the challenge will be to develop a “virtual integrated family health centre” model which establishes a well integrated network of primary and secondary health care services across the district

The steering group’s advice

The Steering Group has identified six system components or areas in which actions are required to achieve the Triple Aim. These are illustrated in the following diagram.



Across the six components three types of actions will be needed:

- A. Improvements in service delivery
- B. Realise opportunities to maximise revenue
- C. Reshaping services to increase value for money

A. Improvements in service delivery

The Steering group identified that there is considerable scope for improving the delivery of services across the whole continuum. Better co-ordination and integration of services, and more streamlined patient pathways will reduce costs and improve patient experiences. The Steering Group recommends that several projects are established (and where relevant, existing projects completed). Recommended actions are presented on pages 25-30.

B. Revenue maximisation

Increasing revenue is another important part of ensuring financial viability. Most of the DHB's revenue is provided by government. The DHB's funding allocation from government's Vote:Health is determined according to a population based formula. The only way of increasing Wairarapa DHB's share would be to increase the local population very fast. Obviously this is not a realistic option.

About 17% of Wairarapa DHB's funding allocation is paid to other DHBs for use of their services by Wairarapa residents, and Wairarapa receives about 2.8% additional funding per annum for services provided at Wairarapa hospital to residents of other DHBs. There is scope to improve management of referrals of Wairarapa patients to other DHBs to control costs, and to maximise revenue from referrals into Wairarapa through improved address coding.

Another important funding stream is provided by ACC. Some of this funding is paid on a fee for service basis. Specific recommendations for actions to maximise revenue are included in the recommended actions.

C. Re-shaping services to increase Value for Money

The Steering Group advises that service improvements and efforts to maximise revenue will be insufficient to provide the savings required and that some changes are required in the services that are provided. The Steering Group developed a tool, process and framework to assess the relative value/benefit of expenditures on different services and activities.

The tool is based on the Triple Aim and may be used to assess and rank the values of changes in expenditures on both types of services/activities and amounts of services. For example assessment of the benefits of offering one more or less of a particular type of specialist clinic, and assessment of the benefits of having or not having that specialty at all.

A working group, comprised of a subset of steering group members, plus two community representatives, was set up to review proposals for making savings through changes in service provision. The benefits assessment tool was used to guide discussion, and recommendations made to the Steering Group. It was only possible to consider a limited set of proposals due to time constraints. However the working group process was considered very valuable and is recommended to be used for regular review of all future proposals.

"The district nurses are marvelous. If they didn't come in every day I couldn't stay here. It means so much being in my own home. It's nothing special, just a little flat but I'd hate to have to go someplace else."

Dorothy, 76

Features of the future model

- Strong confident clinical leadership and collegial co-operation
- Collaborative services
- Continuous care that anticipates needs
- Supported self-care and independent patients
- Knowledge is shared and information flows freely
- Co-ordinated connected providers – individuals and organisations
- Strong interdisciplinary teams (which may be virtual)
- Clear decision making structures that enable and support difficult decisions (evidence based)
- Strong e-connectivity with shared Patient Administration System (PAS) and Electronic health Record (EHR) across all providers

Recommended Actions for Achieving the Triple Aim

Achieving each of the recommended actions will, in most cases, require an interdisciplinary approach and clinical champions from both primary and hospital services. Project or implementation teams will be needed for each action, including relevant stakeholder and provider representatives. The details of how the work will be accomplished and who will do it are yet to be finalised.

Focus on individuals and whanau	
Objective	Actions
Put the patient at the centre of all endeavours	<ul style="list-style-type: none"> ➤ Promote WDHB values across the organisation and to other health providers. Align the values with employee performance planning and development. Incorporate the values into contract negotiations. ➤ Hold workshops for staff on what being patient centred means ➤ Add session on patient focus to DHB staff induction programme
Support patients as active participants in planning their own care	<ul style="list-style-type: none"> ➤ Promote whanau ora – Maori families supported to achieve their maximum health and wellbeing ➤ Implement an Advanced Care Planning programme
Manage patient and community expectations of ever-increasing access to health services	<ul style="list-style-type: none"> ➤ Work to increase community understanding of the DHB's resource limits and options

Early Targets: 2009		Mid-term targets: 2010-11		Long-term targets: 2012-15
	Create platform to promote & align WDHB values			
	Implement Advanced Care Planning			
	Patient focus in staff induction		Staff workshops - being patient centred	
Increase community understanding of the DHB's resource limits and options				
Promote whanau ora – Maori families supported to achieve their maximum health and wellbeing.				

Roadmap for change

Redesign and coordinate the patient journey	
Objective	Actions
Streamline patient pathways encompassing all providers	<ul style="list-style-type: none"> ➤ Develop district-wide care pathways and guidelines, and reduce service duplication for common conditions, such as diabetes, CVD, palliative care, wound care, COPD and asthma ➤ DHB takes responsibility for system-wide integration across all providers
Collaborate effectively with other DHBs, including shared staffing	<ul style="list-style-type: none"> ➤ Participate in regional clinical networks ➤ Regular senior executive meetings with CCDHB, HVDHB and MCDHB ➤ Develop shared staffing of clinicians with other DHBs to optimise use of specialist resources.
Increase capacity and capability of aged residential care (ARC) services to manage their own patients	<ul style="list-style-type: none"> ➤ Provide advisory nurse support to aged residential care facilities ➤ Provide training for registered and enrolled nurses in aged residential care facilities ➤ Implement GP support and supervision for aged residential care facilities facilities in Masterton
Achieve good communications and easy communications pathways between GPs and specialists	<ul style="list-style-type: none"> ➤ Develop processes for virtual GP consults with specialists ➤ Establish a joint clinical forum to support, advise, and monitor progress in implementing the Clinical Services Action Plan
Improve processes and pathways within Wairarapa Hospital	<ul style="list-style-type: none"> ➤ Streamline patient pathways, e.g. for pre-operative assessment ➤ Improve admission to discharge planning ➤ Increase the range of patient focus groups and facilitate patient input into process redesign ➤ Redesign outpatient services to reduce face-to face clinics and support virtual GP consults
Create effective integrated IT/IS systems	<ul style="list-style-type: none"> ➤ Implement Wairarapa DHB's Information Systems Strategic Plan (ISSP) and the multi-DHB Health Management System Collaborative (HMSC) projects (see appendix 1)

Early Targets: 2009		Mid-term targets: 2010-11		Long-term targets: 2012-15	
	Establish joint clinical forum	Develop shared staffing of clinicians with other DHBs			
	Prioritise ISSP & HMSC projects	Implement GP support & supervision for Masterton ARC facilities			
	Develop virtual consults & reduce clinics	Advisory nurse support to ARC facilities Provide ARC nurse training programme			
		Increase patient focus groups and patient input to system redesign			
		Streamline patient pathways			
		Develop care pathways & guidelines; reorganise resources; reduce service duplication			
		Participate in regional clinical networks & Regular inter-DHB senior executive team meetings			
		DHB takes responsibility for system-wide integration across all providers			

Roadmap for change

Develop primary care services	
Objective	Actions
Establish general practices as the “medical home” for each patient	<ul style="list-style-type: none"> ➤ Support practices to develop case manager/key worker roles in primary care ➤ Develop primary health care teams including providers external to the PHO ➤ Establish case management for patients with complex and/or long term conditions, including a review of the Care Plus programme
Re-orient services to support self care and independence from medical services	<ul style="list-style-type: none"> ➤ Increase linkages and referrals between primary / secondary care and NGO and voluntary / community services
Create one virtual Integrated Family Health model for Wairarapa incorporating primary and secondary services	<ul style="list-style-type: none"> ➤ Develop GP and nurse specialists working across practices ➤ Develop referral pathways between practices and between practices and other primary care providers (e.g. Maori providers and pharmacists)
Ensure acute first contact care occurs in the most appropriate setting for best use of health service resources	<ul style="list-style-type: none"> ➤ Review and implement After Hours Plan to ensure optimal use of GP and ED services ➤ Investigate use of advanced paramedics as first response providers in the home ➤ Extend Community Nursing support into general practice. May include wound care and IV antibiotics.

Early Targets: 2009		Mid-term targets: 2010-11		Long-term targets: 2012-15	
	Review and implement After Hours Plan		Investigate use of advanced paramedics		
	Extend Community Nursing support into general practice.				
	Develop primary health care teams			Develop GP and nurse specialists working across practices	
	Support practices to develop case manager/key worker roles in primary care				
	Establish case management for complex patients				
	Increase linkages & referrals between primary/secondary care and NGO and voluntary / community services				
	Develop more comprehensive referral pathways				

Roadmap for change

Reorganise and develop the healthcare workforce	
Objective	Actions
Ensure tasks are allocated to maximise the use of the skilled workforce	<ul style="list-style-type: none"> ➤ Review the composition of the hospital clinical team, including the role of RMOs and investigate alternative workforce roles e.g. hospitalists, advanced care pharmacists and physician assistants. ➤ Implement recommendations from the Clinical Administration Review to support frontline clinicians. ➤ Implement <i>The Productive Ward: Releasing Time to Care</i> ➤ Review use and placement of Clinical Nurse Specialists (CNS) and Clinical Nurse Educators (CNE) ➤ Review maternity services and use of maternity workforce
Strengthen clinical leadership	<ul style="list-style-type: none"> ➤ Establish clinical lead for each sub specialty at Wairarapa Hospital ➤ Increase regional peer support for SMOs
Develop a culturally competent clinical workforce	<ul style="list-style-type: none"> ➤ Implement cultural competency framework, Te Arawhata Totika in Wairarapa Hospital and offer to all other providers.
Provide relevant and accessible training programmes	<ul style="list-style-type: none"> ➤ Create an annual calendar of training programmes to support skills development across the DHB and service providers. Subjects may include, for e.g: <ul style="list-style-type: none"> ○ Communication / Financial management / Quality improvement ○ Creating and working in interdisciplinary teams ○ Leadership (consider <i>The Productive Leader</i>)

Early Targets: 2009		Mid-term targets: 2010-11		Long-term targets: 2012-15
	Investigate alternative workforce roles			
		Implement <i>The Productive Ward</i>		
	Implement clinical administration support	Increase regional peer support for SMOs		
	Create annual calendar of training programmes			
		Review CNS & CNE roles		
	Establish clinical subspecialty leads			
		Review maternity services & workforce		
Implement cultural competency framework, Te Arawhata Totika				

Roadmap for change

Public Health interventions	
Objective	Actions
Improve quality of life and reduce morbidity and mortality through improved understanding of the determinants of health	<ul style="list-style-type: none"> ➤ Review actions and functions of Healthy Lifestyles oversight and governance groups ➤ Clarify and streamline health promotion actions between the PHO, Public Health Unit and NGOs ➤ Embed <i>Keeping Well</i> priorities into public health planning and contracting ➤ Continue <i>Go 4 Your Life</i> and Healthy Lifestyles programmes ➤ Further develop tobacco control and smoking cessation programmes ➤ Complete and implement suicide prevention plan ➤ Support Masterton East project ➤ Targeted programmes in high needs communities

Early Targets: 2009		Mid-term targets: 2010-11		Long-term targets: 2012-15
	Review actions & functions of Healthy Lifestyles groups			
	Clarify/streamline health promotion actions			
	Support Masterton East project			
	Create an overarching public health plan			
	Embed <i>Keeping Well</i> priorities into planning and contracting			
Continue HEHA programme				
Further develop tobacco control and smoking cessation programmes				
Targeted programmes in high needs communities				

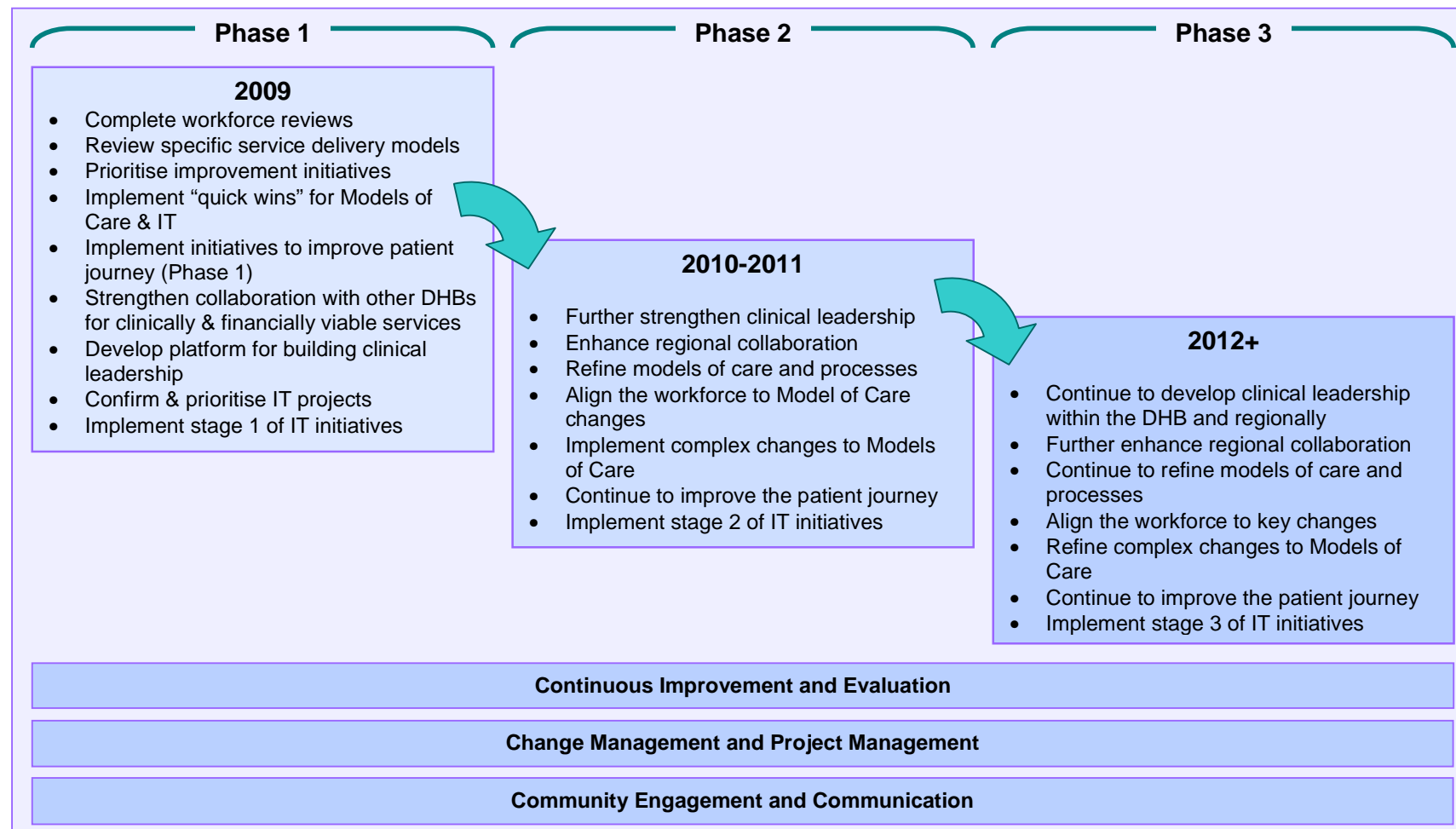
Roadmap for change

Control costs and maximise revenue	
Objective	Actions
Maximise revenue generating opportunities	<ul style="list-style-type: none"> ➤ Improve clinical coding and ACC claiming processes ➤ Capture all revenue for IDF inflows through improved address coding
Reduce expenditure outflows	<ul style="list-style-type: none"> ➤ Reduce referrals to other DHBs for services available at Wairarapa hospital ➤ Review referral patterns to other DHBs and introduce prior approval policy if appropriate
Use all resources more efficiently	<ul style="list-style-type: none"> ➤ Rationalise use of diagnostics ➤ Investigate sharing back office support functions between DHBs ➤ Continue/expand projects to improve use of pharmaceuticals ➤ Share specialist staffing with other DHBs
Increase efficiency of hospital services	<ul style="list-style-type: none"> ➤ Implement recommendations from perioperative service review ➤ Introduce hospital capacity planning
Improve funding allocation to maximise value for money	<ul style="list-style-type: none"> ➤ Utilise prioritisation tool and working group process to inform future funding decisions ➤ Review access to elective services to ensure equity with other DHBs ➤ Review configuration of dental services to maximise access for high needs groups ➤ Review efficiency of WDHB mental health services
Ensure funding/contracting arrangements promote/support improved service performance	<ul style="list-style-type: none"> ➤ Develop new ways of funding services to provide new models of care

Early Targets: 2009			Mid-term targets: 2010-11		Long-term targets: 2012-15	
	Improve address coding for IDF		Rationalise use of diagnostics			
	Implement perioperative service review recommendations			Share back office functions between DHBs		
	Introduce hospital capacity planning		Expand pharmacy synchronisation project			
	Improve coding & ACC claiming processes		Review dental services			
				Review access to elective services		
		Review efficiency of mental health services				
	Review IDF referral patterns; introduce prior approval policy		Reduce referrals to other DHBs			
Utilise prioritisation tool and process to inform funding decisions						
Develop new ways of funding services to provide new models of care						










































Implementation Roadmap

An indicative implementation roadmap has been developed for the key activities required to achieve the triple aim. The roadmap consists of three phases of work, each underpinned by strong project management and change management. Each phase builds on the achievements of the previous phase and reflects an iterative approach. To work within the funding constraints, activities and initiatives within each phase will need to be prioritised and implementation timeframes agreed.



How the key changes impact on services

The Clinical Services Action Plan maps out an overall direction for health services in Wairarapa over the next 5-10 years and beyond. Consultation has occurred widely with clinical services to ensure that service specific issues have been considered in the development of the plan and that the impact of recommended actions is well understood. Through the consultation process data was gathered on the issues, challenges and opportunities for each service. This process identified key areas where action is likely to occur or is needed, including many suggestions for improving service delivery and efficiency. This information was taken into consideration along with the recommended actions to create the following table. The symbols indicate the level of impact that is likely to result from change within each service relative to others across three dimensions. Those with most impact are services in which significant actions or changes have been identified. It is envisaged, for example, that in future most health care will be delivered in outpatient, community and home based settings with less referrals to hospital based services. This will impact significantly on the models of care for primary care and medicine in particular.

	Models of care	Workforce	IT & other Infrastructure	Key
Primary Care				 Least Impact  Most Impact
Public Health				
Emergency Medicine				
Clinical Support Services (Laboratory, Pharmacy, Imaging)				
Medicine				
Surgery				
Pediatrics / Neonatal care				
Maternity				
Mental Health / Drug & Alcohol services				
Rehabilitation / support				
Community Nursing				
Palliative care				
Elder Health				

Where change is most needed

Models of care

Change is most needed in:

- Primary care to create a “medical home” for each patient and re-orient services to support patient self care and independence
- Primary care to lead chronic disease management and create effective referral pathways between providers.
- ED and medicine to manage the increasing rate of ED attendances and to reduce the incidence of high frequency repeat presentations.
- Medicine to improve the flow of patients through the hospital and back into primary care.
- Medicine to provide greater support to primary care practitioners and to develop common care pathways.
- Surgery to manage the demand for elective surgery and to streamline the pathways for surgical and day procedure patients.
- Extend Community Nursing support in primary care and further develop in-reach and out-reach services.

Workforce

Key workforce issues need to be addressed in:

- Primary care to develop GP and nurse specialists working across practices
- Medicine and surgery to develop a model based on shared clinical resources across DHBs to ensure clinical viability of services
- Medicine, ED and Surgery to provide support for credentialing and training for specialist staff.
- Rehabilitation, support services and elder health to manage significant growth in demand
- All services to align workforce and work practices to changing models of care

IT and other infrastructure

Significant change is needed to create an effective, integrated IT system to support:

- Clinical services with strong IT systems, including patient, bed and other management systems
- Improved access and greater sharing of patient information between services
- The provision of timely access to critical information to support clinical decisions through a shared patient record
- Out-reach and community based services with remote access

Wairarapa DHB Overview

The Wairarapa DHB Catchment

This section provides an overview of the Wairarapa DHB. All population figures are based on 2006 census data.

Wairarapa DHB provides health services to a wide geographical area. The Wairarapa district is located in the southeast of the North Island and includes three Territorial Local Authorities (TLA's) Masterton, Carterton and South Wairarapa. It extends from the Rimutaka Hill in the west to Ocean Beach in the south and Mount Bruce in the north, a total of 5,936 square kilometres.

Masterton is located in the heart of the Wairarapa region of New Zealand. It is about an hour and a half's drive from both Wellington and Palmerston North.

Masterton comprises one large urban town with a population of some 18,000 people and a diverse rural district totalling some 5,000 people. Rural districts include the coastal resorts of Castlepoint and Riversdale.

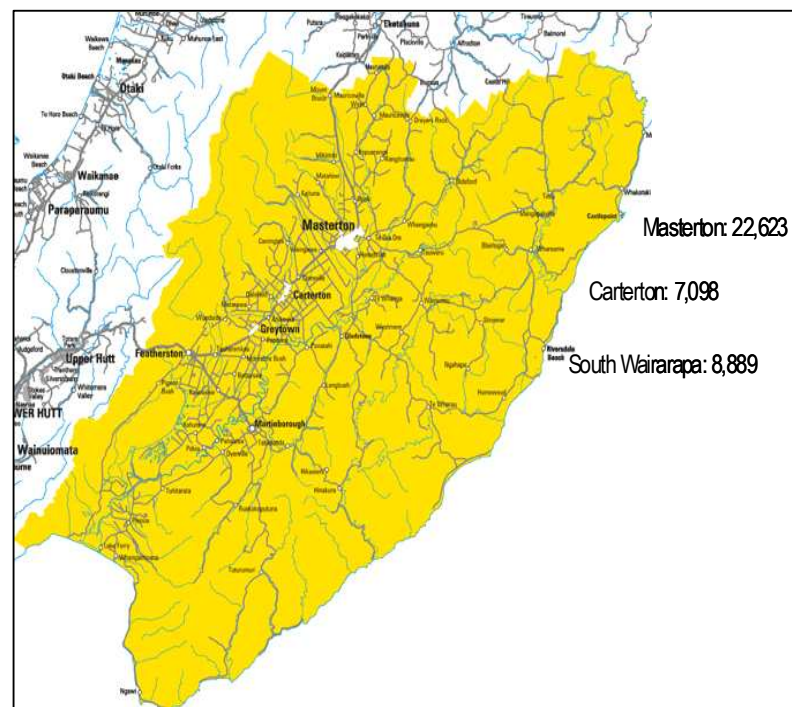
Carterton is located south of Masterton and covers an area of 1,145 square kilometres. Carterton is bounded by the Waiohine River to the south and the Waingawa River to the north and stretches from the Tararua Ranges to the west and to the Pacific Ocean to the east.

South Wairarapa is situated at the southern most corner of the North Island and has an area of approximately 2484 square kilometres. The boundary follows the coastline from the western end of Palliser Bay in Cook Strait to Honeycomb Rock, east of Martinborough. The western boundary follows the main divide of the Rimutaka and Tararua Ranges to Mount Hector, from which the boundary runs southeast across the Wairarapa Plains to the coast.

South Wairarapa includes the towns of Featherston, Greytown and Martinborough which are the main population centres.

Rangitane and Kahungunu are the principal Maori Iwi in the Wairarapa.

Wairarapa DHB Catchment Area

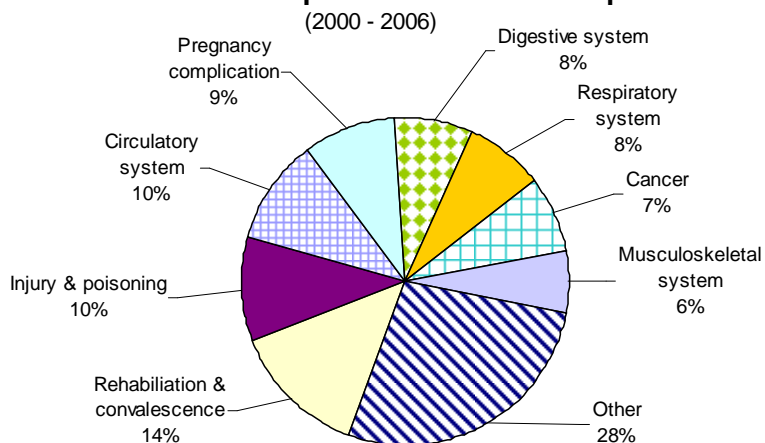


General Health Status

Overall the health status of the Wairarapa population does not differ greatly from that of New Zealand. For most conditions the morbidity (illness) and mortality (death) rates are similar to the rates for New Zealand. Wairarapa has a slightly higher death rate from respiratory disease and Maori and Pacific population groups have a higher rate of death due to external causes. The breast cancer rate is 13% higher for Wairarapa than nationally

The three main causes of hospitalisation for people in Wairarapa are procedures related to rehabilitation and convalescence, injuries and poisonings and circulatory system condition.

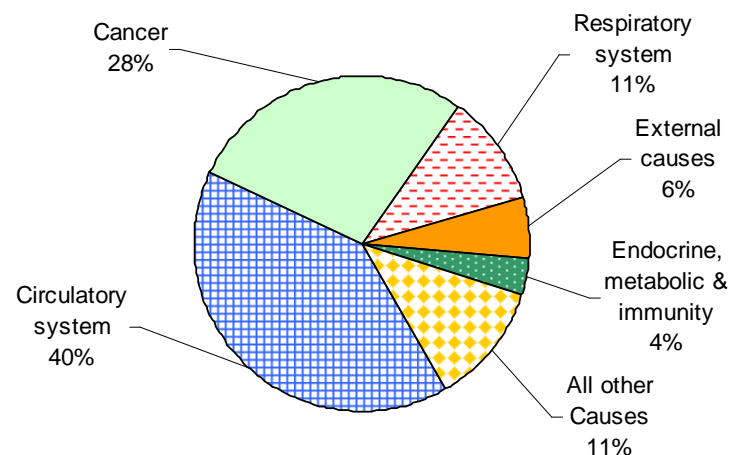
Causes of Hospitalisations - Wairarapa



The three main causes of death of Wairarapa people between 1994 and 2004 were diseases of circulatory system, cancers, and diseases of the respiratory system.

Causes of Death - Wairarapa

(1994-2004)



Cancer: includes all cancers

Circulatory system: Primarily heart disease, stroke & aneurysm.

Digestive system: for example, oral disease, hernias, appendicitis, and diseases of the gallbladder, intestine, pancreas and liver.

Endocrine, metabolic and immunity: Includes diabetes and renal disease
External Causes: Includes accidents, falls, drowning, suicide and homicide.

Injury & poisoning: all poisonings and toxic effects and injuries including fractures, burns, dislocations etc.

Musculoskeletal: conditions related to muscle, bone and tissue such as arthritis, osteoporosis and joint displacement.

Pregnancy complications: complications during or related to pregnancy and delivery.

Rehabilitation & convalescence: Care involving use of rehabilitation procedures, convalescence and other follow-up care

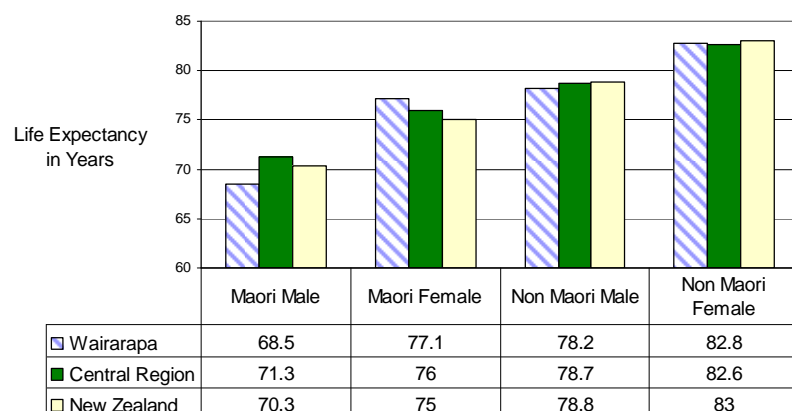
Respiratory system: For example, Chronic Obstructive Pulmonary Diseases (COPD), emphysema, asthma and pneumonia.

Wairarapa DHB Overview

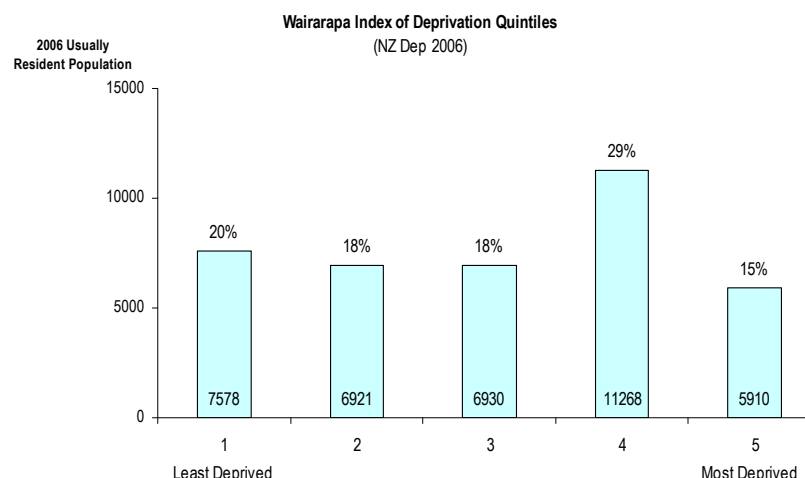
Life expectancy

Except for Maori females, Wairarapa people have a slightly shorter life expectancy than the New Zealand average. Overall, Wairarapa men live on average to the age of 77.1 years and Wairarapa women to the age of 82.6 years.

**Life Expectancy at Birth by Ethnicity and Gender:
Wairarapa, Central Region and NZ (2004-2006)**



people in the least deprived group and 10% fewer people in the most deprived group. The largest population group in the Wairarapa live in deciles 7 and 8 (decile 10 is the most deprived) which is disproportionate to New Zealand rates. This means reducing financial and social barriers to accessing health services must remain a high priority for Wairarapa.



Key Issues for the Wairarapa

Aging Population

By 2026 the population aged 55 years and over is projected to increase by 14.6%. Wairarapa has 4% more people aged 65 years and over than the national average. The Wairarapa population aged 65 years and over is projected to increase by 78% by 2026, increasing from 16.4% of the Wairarapa population to 29.8%.

Socio-economic status

Socio-economic status variables such as income, education and employment are major indicators of health. Deprivation levels have changed in Wairarapa over the last 10 years. There are 57% more

The deprivation indexes are further grouped into quintiles where deprivation quintile 1 refers to least deprived areas and quintile 5 the most deprived areas. There is some variation across the region with 85% of Wairarapa's most deprived people (those in quintile 5) living in Masterton.

Long-term (chronic) conditions

Heart disease, diabetes, renal failure and kidney disease, respiratory disease and cancer were the top five causes of admissions to hospital of Wairarapa people from 2000–2006. Many of these conditions are preventable through lifestyle choices such as being smoke-free, physical activity and healthy eating.

Lifestyle factors affecting health

Lifestyle factors such as physical activity, nutrition, tobacco smoking, alcohol intake and obesity are choices people can make to prevent chronic or long term conditions and improve their health and well being. Statistics for Wairarapa include:

- **Smoking:** Maori women have the highest smoking percentage (47.4%) in Wairarapa.
- **Nutrition:** more males than females do not have adequate fruit & vegetable intake. More Maori than non-Maori do not have adequate fruit & vegetable intake.
- **Obesity:** obesity levels for both males & females are worse in the Wairarapa than New Zealand as a whole, with Maori being more obese than non-Maori.
- **Physical Activity:** Wairarapa people have similar levels of physical activity to the rest of New Zealand.
- **Drug and Alcohol Misuse:** Wairarapa has a higher prevalence of hazardous drinking than the New Zealand average.

Maori Health

Demographics

Key characteristics of the Maori population in the Wairarapa show:

- Maori make up 14% of the total Wairarapa population.
- 16.5% of the Masterton population identify as Maori, which is 2.5% higher than the national figure.
- The population growth rate for Wairarapa Maori (20%) is less than that projected for New Zealand Maori overall (28%).
- Maori have a higher proportion of young people and a smaller proportion of older adults (65+ years) than non Maori

Health Status

- Maori have poorer health than Non-Maori, both in New Zealand and the Wairarapa.
- Wairarapa Maori males have a shorter life expectancy than the New Zealand average for Maori males.
- The leading causes of death for Wairarapa Maori are diseases of the circulatory system and cancers.
- Levels of obesity for Wairarapa Maori are higher than for New Zealand as a whole.
- Maori women have the highest smoking percentage in Wairarapa (47.4% smoke).

Wairarapa Maori Health Initiatives

Wairarapa DHB strives to deliver health services that ensure better health outcomes for Maori residing in the Wairarapa. The overall aim is whanau ora – Maori families supported to achieve their maximum health and wellbeing.

Increasing recognition and understanding of the cultural determinants of health is of specific relevance to the DHB. Service developments for Maori must support whanau ora and Maori models of health. The DHB is guided by He Korowai Oranga, the National Maori health strategy, and utilise the four strategic pathways within He Korowai to support the achievement of Wairarapa whanau ora.

Maori participation in the provision and development of health services in Wairarapa will continue to be underpinned at governance level by the relationship between the Board and Te Oranga O Te Iwi Kainga our Maori relationship Board. The relationship between governance and Iwi will continue to be strengthened and Māori leadership will be encouraged at all levels of the organisation.

Iwi Kainga led the development of a Cultural Competency Framework - Te Arawhata Totika which was completed during 2008.

Wairarapa DHB Overview

This is a significant achievement for Wairarapa as the framework articulates the values relating to hauora that the tangata whenua o Wairarapa have identified as being central to health and wellbeing. The framework can be used to improve health practice and increase responsiveness to Maori across all WDHB services.

There is a continued focus on increasing Maori access to health services and on increasing service responsiveness for Maori across primary, secondary and tertiary services. In the past this task has tended to be left to those in dedicated Maori health roles; however it is time for all health providers to take responsibility for developing and delivering appropriate services for Maori.

We should courageously look forward to a time when everyone takes responsibility for successfully engaging with Maori and effectively meeting Maori health needs.
Community Health Provider

Ensuring and actively engaging Maori participation and the incorporation of Maori worldviews and values across all levels of service planning and delivery continues to be a focus for WDHB. Some of the clinical priorities identified for action in 2009/10 and 2010/11 include:

- Continued development and provision of mainstream provider policy development, guidelines and training
- Maori pathways of care programme continues to identify areas of Maori patient need across hospital services:
- Roll out of the Cultural Competency Framework - Te Arawhata Totika across hospital services and engage with primary health and other community services.
- Development and implementation of a training programme for WDHB staff on Cultural Competency

- Continue to assist Maori Provider development, capacity and capability
- Increase Maori workforce development initiatives
- Utilise all opportunities and forums to build and maintain strong relationships within and between mainstream and Maori health providers, other agencies and the wider community

Hone and Maria are in their fifties and have both smoked for over thirty years and have tried to quit many times without success.

During the World Smokefree Day promotion "Give it a Go" Whaioira profiled a prominent local Maori male in the media who shared his successful smokefree journey. Enthused and motivated Hone and Maria enrolled with Aukati Kai Paipa (Smoking Cessation)

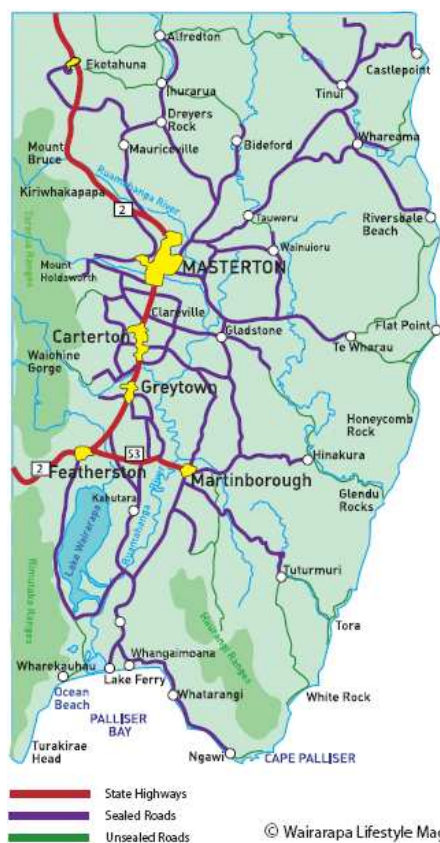
The nature of their work means it is difficult to make routine appointments so the flexibility of the programme allowed them to be coached and mentored either by phone or text, fitting in their face to face appointments when it was convenient.

Three months later Hone and Maria are both smokefree. The improvement in their health and their appearance in this short time frame has been remarkable with many of their whanau now enrolling so they can take the same journey.

"We are so grateful for this service. We haven't been able to quit before. It was the kanohi te kanohi way of Aukati Kai Paipa and the coach talking whakapapa with us that really made the difference" Hone

Transport

A key component of a safe and high quality health system is the ability to transport patients to hospital, and between hospitals, in appropriate timeframes, so that the patient receives the medical treatment they need when and where they need it.



It is commonplace for Wairarapa residents to travel to receive health services. Mostly this is within the region, however many patients and their families/whanau need to travel outside Wairarapa to access specialist services.

Although a national travel assistance policy provides limited assistance if specific criteria are met, transport and accommodation can be a significant problem for those needing to travel to other DHBs.

Travel costs for patients and for inter-hospital transfers are expected to increase as fuel costs increase and as more patients are transferred to specialist centres for complex health care.

Ambulance

The Wairarapa Ambulance Service is one of only two ambulance services owned by a DHB in New Zealand. The DHB is committed to providing a sustainable ambulance service for the population of the Wairarapa, with a vision of expert pre-hospital care, and timely transport to the relevant facility.

Ambulance services are available 24 hours a day, 365 days a year. Wairarapa Ambulance Service attends upwards of 4500 calls and travel on average 220,000km per year. This includes transfers to our neighbouring tertiary hospitals in Wellington and Palmerston North. Wairarapa ambulance service achieves 93% of urban urgent calls within 20 mins which is just outside the target of 95%. Calls to remote areas such as Castlepoint or Ngawi take more than 60 minutes on average.

Road travel times and distances within the Wairarapa

From	To	Distance	Time
Masterton	Martinborough	56 kms	40 mins
	Featherston	38 kms	33 mins
	Greytown	25 kms	22 mins
	Carterton	16 kms	14 mins

Road travel times and distances within the Central Region

From	To	Distance	Time
Masterton	Wellington	102 kms	1 hr 30 mins
	Lower Hutt	86 kms	1 hr 15 mins
	Palmerston North	108 kms	1 hr 15 mins
	Wanganui	179 kms	2 hrs 20 mins
	Hastings	215 kms	3 hrs

Public Transport

A bus service is provided by Tranzit operating during week days, with some connections to Wairarapa Hospital. A daily bus service operates between Masterton and Palmerston North. A train operates between Wairarapa and Wellington for the benefit of commuters. A direct airline service between Masterton and Auckland operating six days a week was introduced in early 2009. Comprehensive airlines services operate out of Palmerston North and Wellington.

Wairarapa Community Transport Service

Wairarapa Red Cross operates two volunteer driven vans which transport patients to and from health appointments, including facilities in Wellington and Lower Hutt at no cost to patients.

Reviewing Patient Transport

During 2007/08 the cost of patient transport across all modalities increased significantly for Wairarapa DHB.

A review is underway to assess how best to manage patient transport. At present it is managed through three different areas, creating confusion and inefficiencies. The review will determine if these functions should be co-ordinated through a central office and will examine both road and air transport to identify factors that influence cost and appropriateness of patient transport modalities.

"I was so frightened when they told me that I would have to go to Wellington – what if I had my baby on the way? But once the helicopter arrived and I saw how well trained the staff were I felt much safer. I was upset though that my husband couldn't come with me"

Angela, in labour at 29 weeks

The patient experience now

David is a 52 year old farmer. He is working with his son in the woolshed when he feels a crushing pain in his chest. His son calls the ambulance and the crew, suspecting a heart attack, take him on the 1 hour trip to hospital.

Tests at the hospital confirm that David has had a heart attack and needs to be referred to a cardiologist. To receive the procedure as an inpatient and avoid a lengthy wait, David remains in hospital for five days until a bed is free in Wellington. David is transferred by air ambulance to Wellington Hospital and undergoes the angioplasty and has a stent inserted.

David is discharged after a few days and informed that he will need to arrange his own travel. He waits for his wife to collect him and they make an uncomfortable three hour journey back to the farm. At home David slowly improves but has no contact from any health professional. Three months later he has another heart attack.

Future scenario

The ambulance crew, suspecting a heart attack, use a clinical predictive tool to determine that David would benefit from specialist cardiology intervention. In line with the regional treatment protocol, David is transferred by air ambulance directly to Wellington Hospital where he has an angioplasty and stent insertion.

Feeling better after a night in ICU, David is transferred back to Wairarapa Hospital for step-down care and rehabilitation. Using a telemedicine link, the Wellington cardiologist reviews David's condition and provides advice to the medical team at Wairarapa Hospital. After a few days David is discharged home where he is visited by a specialist cardiology nurse.

Services Funded and Provided by Wairarapa DHB

Wairarapa DHB's hospital and community health services are provided primarily from Wairarapa Hospital and Choice Health. Services are also delivered from out-reach clinics, including several held at schools and Marae.

The Wairarapa DHB's provider arm delivers outpatient, community, day programmes, and inpatient services across the following services:

- Medical Services
- Surgical Services
- Child Health
- Oral Health Services
- Obstetrics and Women's Health
- Mental Health Services
- Rehabilitation Services
- Public Health Services
- Community Health Services
- Palliative Care Services
- Ambulance
- Clinical Support Services – laboratory, pharmacy, imaging and allied health service

PHO

The Wairarapa Community PHO takes a lead role in delivering primary health services to their catchment population from Mt Bruce in the north to Cape Palliser in the south. The PHO receives 6.3% of the DHB's total funding to provide a range of health care services (see appendix to the CSAP "Current Service Status" for details). The Wairarapa is serviced by 7 medical centres.

The DHB has contracts with other NGOs and independent providers, including Maori providers, to deliver a wide range of primary care and community based services. These include:

Access Homehealth Limited	Rideshop
Dentists(13)	Salvation Army
Foot mechanics	Selena Sutherland private hospital
Healthcare New Zealand	SF Wairarapa
Hearing Care	Support in the Community Service
King Street Artworks	Te Hauora Runanga o Wairarapa
Medlab Central	Te Omanga Hospice
Mental Health Consumers Union	Te Whare Atawhai Society
NZ Red Cross	Wairarapa Addiction Service Inc
Rangitane o Wairarapa Inc	Wairarapa Care Network
Rest Homes & hospital level care (422 beds provided by 13 facilities)	Wairarapa Parents Centre
Retail pharmacies (8)	Wellington Regional Diabetes Trust
Richmond Fellowship	Whaioara Whanui Trust

The DHB also works in partnership with a number of non-health agencies and voluntary community groups who provide vital support and/or advice services. Some of these organisations are:

Advocacy Network Services	Post Polio Support Group
Arthritis Foundation	Plunket
Alzheimers Wairarapa	Royal NZ Foundation for the Blind
Barnardos	Strengthening Families
Cancer Society	Stroke Foundation
Diabetes Wairarapa Society	Wairarapa Asthma Society
Hearing Association	Wairarapa Victim Support
Heart Foundation	Department of Child, Youth & Family
Multiple Sclerosis Society	Masterton Truancy Service
CCS Wairarapa	Ministry of Education
NZ Society IHC	Ministry of Social Development
La Leche League	Work and Income
Parkinsonism Society	

Role delineation

Role delineation is a process of health services assessment that enables consistent categorisation of hospitals and services according to their assessed level of complexity. The role delineation model sets out the clinical staff profile, (including hours available and qualifications), and support services required for the safe provision of diagnosis, treatment and care at different levels of clinical complexity. Role delineation has been completed for all hospitals in New Zealand to assist regional and national service planning. It supports more co-ordinated planning for provision of hospital services across DHB boundaries.

The New Zealand Role Delineation Model delineates across six levels of complexity within seven categories of service. The levels of service complexity are generically summarised in the table below. For each specialty the model provides an explicit description of the key determinants and support services required to attain each level of role delineation (RDL).

The RDL of a service is determined by assessment of the service against three sets of information:

- The key service provider elements within the service speciality;
- The level of clinical and patient support services available within the facility to support the service speciality;
- For medicine, surgery and paediatrics the level of the inter-speciality support available within the facility or DHB at the more complex service level.

RDL	Level Descriptor	Description
1	Primary Services	Community based services provided by primary practitioners. May be in a rural, provincial or urban setting.
2	Community (General & convalescent) Services	General and convalescent services, sometimes in rural communities, providing sub-acute care and access to acute services.
3	Acute & Elective Specialist Services	Specialist services providing acute and elective care to communities.
4	More Specialised Services	Large services with some subspecialisation
5	Major Specialist Services	Large services with multiple subspecialties and subspecialty support.
6	Supra Specialist & Definitive Care Services	Most complex service of any subspecialty. Will be a provider of definitive care (does not transfer to another centre)

Support services

There are eight support services separated into Clinical Support and patient support. The RDL of any service category is constrained by the level of support services available to it. It is not possible to have a more complex service than the available level of support service will allow. The clinical support services are: pathology, pharmacy and diagnostic imaging (excluding interventional radiology). The patient support services are anaesthetic services, operating theatres, interventional radiology, critical care services (ICU/HDU) and coronary care units.

Wairarapa DHB Overview

Role delineation results

All services at Wairarapa hospital have been assessed and found to be at RDL3 – specialist services providing acute and elective care to communities. Other hospitals with emergency and medical services at this level are: Lakes, Tairāwhiti, Taranaki, Whanganui, Hutt Valley, West Coast, South Canterbury and Southland.

The inter-speciality collaboration or networking required in surgery is greater than for other services. RDL3 surgical services are provided by Wairarapa, Northland, Lakes, Tairāwhiti, Whanganui, Hutt Valley, Nelson Marlborough, West Coast, South Canterbury and Southland.

Maternity services aim to achieve a balance between local access to services and the safe provision of care for mother and baby. The role delineation model covers the spectrum of care from community based lead maternity care to complex obstetrician led care. RDL3 maternity services providers are Wairarapa, Tairāwhiti, South Canterbury and Southland.

Services Provided by other DHBs

As a small DHB, Wairarapa is highly dependent on other DHBs for provision of tertiary and more complex secondary services and spends around 17% of its funding on such services.

No single DHB is able to provide all the services its residents may need. Some services are very highly specialised and available only at one place in New Zealand, such as Starship Children's hospital in Auckland. Other tertiary level services such as renal transplantation or cardiothoracic surgery are provided at a small number of locations only.

Wairarapa residents make extensive use of services at other DHBs. About 60% of their outpatient attendances occur at Wairarapa hospital, and the other 40% at hospitals in other DHBs. For inpatient care, about 70% by value occurs at Wairarapa hospital and 30% at other hospitals.

In 2007/08 Wairarapa residents used other DHBs' services to the value of \$18.7m. Around \$8.3m was spent on 2,216 case weighted

discharges (inpatient services) delivered by other DHBs for 1,431 Wairarapa residents. The remaining \$10.4m was spent on outpatient services at other DHBs, such as emergency department attendances, radiotherapy, chemotherapy, renal dialysis and specialist clinics. Mostly these services were accessed at Wellington, Hutt Valley, and Palmerston North hospitals.

Outflows by DHB

DHB	Total \$	%	CWD \$	Outpatient
Capital & Coast	\$10,845,824	58%	\$5,462,230	\$5,383,594
Hutt Valley	\$2,992,391	16%	\$1,342,162	\$1,650,229
MidCentral	\$2,558,273	14%	\$695,729	\$1,862,544
Other	\$2,369,237	13%	\$790,130	\$1,579,107
Grand Total	\$18,765,725	100%	\$8,290,251	\$10,475,474

In addition Wairarapa hospital is served by many visiting specialists from other DHBs who by holding clinics at Wairarapa hospital, provide Wairarapa people with local access to a wide range of specialties as shown in the table on the next page.

Wairarapa DHB Overview

Summary of clinical services provided to the Wairarapa population by provider DHB

Clinical Service	Provider DHB					Clinical Service	Provider DHB				
	Wairarapa	Capital & Coast	Hutt Valley	MidCentral	Other Contract		Wairarapa	Capital & Coast	Hutt Valley	MidCentral	Other Contract
Primary Care	C					Surgical Services					
Public Health	C					General Surgery	C	●		●	
Community Nursing	C					Cardiothoracic		●			
Mental Health, Drug & Alcohol	C	●	●	●		Dental Surgery	R				●
Rehabilitation/Disability Support	C					Maxillofacial Surgery			●		
Emergency / AAU / HDU	C					Neurosurgery	V	●			
Medical Services						Ophthalmology	V	●			●
General Medicine	C					ORL Head & Neck	RV	●	●	●	●
Cardiology	R	●				Orthopaedic Surgery	C				
Dermatology			●			Plastic Surgery	RV		●		
Diabetes	C	●	●			Urology	V				●
Endocrinology	V	●				Vascular Surgery		●			
Gastroenterology	R	●				Non-surgical cancer services					
Infectious Diseases		●				Medical & Radiation Oncology	V	●		●	
Neurology		●				Haematology	V	●		●	
Palliative Care	C					Women's and Children's Health					
Psychogerontology	V				●	Gynaecology	C				
Renal		●				Maternity	C				
Respiratory Medicine	RV			●	●	Paediatric Medicine	C	●			
Rheumatology (incl. immunology)	V		●			Paediatric Surgery	V	●			●
						Neonatal Intensive Care	R	●			

Key

R	Partial service provision
C	Comprehensive range of service
V	Includes some visiting services at Wairarapa Hospital
●	Provided at another facility

Appendices

Appendix 1: Proposed IT projects

The Information System Action Committee (ISAC) is working through a prioritisation process to identify the key IT projects for the organisation. As the prioritising of the projects is an ongoing process, the following list must only be considered as a draft. The projects are listed alphabetically; the order does not imply any ranking of priority.

- AMS Actor (Rostering)
- Asset Management
- Capacity Planning & Demand Forecasting
- Clinical Audit
- Clinical Documents: ECG images to CDV
- Clinical Documents: ED Discharge Summaries
- Clinical Documents: New templates
- Clinical Documents: PDF to GPs
- Clinical Documents: Word to PDF to CDV (Clinical document viewer)
- Community Nursing solution
- Concerto in Primary Care
- DHB wide Wireless network infrastructure
- Electronic Document and Records Management
- Electronic referrals - Level 1
- Enterprise-wide risk management system
- FMIS (Financial Management Information System)
- HMSC (Health Management System Collaborative)
- Identifying deceased patients in Concerto
- Intranet upgrade
- Medications List from GP systems
- Oral Health system
- Primary care information in Concerto
- Procurement and Supply Chain
- Redesign Concerto Episode List
- Regional PACS Repository/Archive
- RSD messages to Concerto
- Videoconferencing/Telemedicine

Health Management System Collaborative (HMSC)

Recently, there have been separate initiatives underway to replace ageing computerised patient management systems at a number of DHBs. The Health Management System Collaborative (HMSC) represents a convergence of initiatives involving MidCentral, Whanganui, Wairarapa, Nelson/Marlborough, South Canterbury, Canterbury and Northland DHBs

The goal of the HMSC is to establish an individual-centric health information management system built around the individual rather than the provider. The system will enable greatly improved shared access to an individual's health information by all the clinicians involved in their care as well as by the individuals themselves.

The vision is for a system that will allow people to be fully informed about their health and have improved ownership and participation in their own care. The vision expands the traditional view of a PAS system and Clinical Support Systems to be more integrated, more interactive, wider in scope and much richer in functionality.

Appendix 2 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	MMHA	Maori Mental Health, Adult
CCDHB	Capital & Coast District Health Board	MOH	Ministry of Health
CNE	Clinical Nurse Educator	MOSS	Medical Officer Special Scale
CNS	Clinical Nurse Specialist	MSW	Medical Surgical Ward
CSAP	Clinical Services Action Plan	NASC	Needs Assessment and Service Co-ordination
CWD	Case Weighted Discharge	NGO	Non-Government Organisation
DHB	District Health Board	NZNO	New Zealand Nurses' Organisation
DRG	Diagnostic Related Groups	O&G	Obstetrics and Gynaecology
ED	Emergency Department	OPD	Outpatients Department
ENT	Ears, Nose and Throat	PACU	Post Anaesthetic Care Unit
FTE	Full Time Equivalent	PHO	Primary Health Organisation
FU	Follow up Visit	RCSP	Regional Clinical Services Plan
HDC	Health and Disability Commissioner	RMO	Resident Medical Officer
HDU	High Dependency Unit	RN	Registered Nurse
HEHA	Healthy Eating Healthy Action (programme)	SCBU	Special Care Baby Unit
HVDHB	Hutt Valley District Health Board	SDR	Standardised Discharge Rates
GP	General Practitioner	SMO	Senior Medical Officer
ICU	Intensive Care Unit	WDHB	Wairarapa District Health Board
IDFs	Inter district Flow(s)	WIPA	Wellington independent Practitioners Association
IT	Information Technology		

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	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.
Medical Home	A medical home is not a building or facility, but rather a team approach to providing comprehensive primary care that facilitates partnerships between individual patients and all involved health care providers.
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.