A Concept Plan

For a

Model of Care

For

Waitaki District Health Services Ltd.

‘Shifting the Focus”

July 2017

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EXECUTIVE SUMMARY

The WHSL Model of Care initiative stems from the review of the health care system within the Waitaki District.
These reviews were:

- Patient Centric Model of Nursing Care Proposal
- The Waitaki District Health Services Review: a review of the Health Services in the Waitaki District
- The Waitaki District Health Services Review: a review of the Employed Caseloading Midwife Service in Oamaru

Chronic shortages of healthcare professionals, the ever-increasing costs to provide care and the increasing demands on the health system underline the need for continually reviewing and redesigning the way healthcare services are provided to patients.

The key to moving forward as a single system is the need to develop processes and systems of care delivery that reach beyond traditional borders such as hospitals or home care and link the care delivery teams through a revitalized focus on care planning and coordination.

The newly designed model of care envisions a strong focus on these processes and systems, embedding them into the care processes in the home and community settings and linking care partners from primary care right through the continuum including hospital services to better meet the needs of the patients being served.

Emerging from the reviews which were undertaken was a consensus that patients and families should be at the centre of care and have a role to play in the delivery of care. Additionally, care should be available and delivered closer to home and community; communication and the availability of information is paramount and all members of collaborative care teams need to practice to their applicable full scopes of practice.

Creative thinking and keeping the welfare of the patient at the forefront guided the development of the model and will continue to be an important tenet as the district implements the new model of care.

A change in the delivery system will necessitate a change in the way each healthcare professional functions within that new delivery model. Each provider's function should be clearly defined, and each provider will be aware of the others' roles. Re-thinking as to how nursing and medical staff, allied health professions, in primary and community based care and in the homecare will function and interact will help in providing quality care closer to home.

The review teams identified issues relating to people, processes, information-sharing and technology which need to be addressed in order to assist in the transition. In order for the change to succeed, a commitment to collaboration and coordination, effective communication, ongoing education, and strong and effective leadership are needed.

A summary of the Model of Care is as follows:

- Oamaru Hospital will still be an integral part of the Waitaki District health system
- People are enabled to provide more of their own care for themselves;
- When support is needed, the goal is to keep the person in their own homes for as long as possible, leveraging support in the local community as needed;
- Access to services will be streamlined through the use of consistent tools and processes;
- Telemedicine and electronic communication will be used more extensively to enable care planning, conferencing, interventions and follow-up;

- The Clinical Healthcare Hub in conjunction with Community based providers will drive coordination, with additional resources being provided as the complexity of coordination increases;
- Services within local communities will be enhanced as appropriate and be consistent with the goals of high quality, sustainable and affordable patient care delivery; and
- When people need to travel to access services, these too will be coordinated and focused on enabling access and timely return to their home community for follow-up care as required
  The workforce in all departments of Oamaru Hospital will co-ordinate the services provided to enhance the objectives of the Model of Care.

A People, Process, Information and Technology change management framework will be applied to guide the work required to implement the Model of Care across the Waitaki district for which the services are designed.

To transition from a Model of Care "Plan" to the actual deployment and realization of benefits, a mobilisation (Roll-Out) plan is essential to ensure necessary planning, design, training, communicating and overall preparation of all care providers across the continuum.

INTRODUCTION, BACKGROUND AND CONTEXT

National Strategic Context

It is well established that New Zealand's health care system needs to significantly increase its investment of time, energy and resources in primary care. For well over a decade, the Treasury, the Ministry of Health, District Health Boards and Primary Health Organisations have consistently identified a need to drive investment towards better models of care. The proposal outlined in this Model of Care will specifically support the following strategic priorities outlined in the Ministry's Statement of Intent 2014-18:

- Maintain wellness for longer by improving prevention - New Zealanders are living longer but are also more likely to spend a period of their later years managing a long-term condition. It is important that the government invests in new models of care to help people stay well for longer and prevent the onset of these conditions.
- Making services more accessible, including more care closer to home – delivering better, timely, more convenient care is an ongoing focus for the Ministry. More effective and integrated models of care are a key supporting component of this vision.
- Supporting the health of older people - the Government is committed to improving the well-being of older New Zealanders by providing health services that support independence. Person-centric models of care, such as this one being proposed, have been proven internationally and within New Zealand to address the priority health needs of older people in consistent and integrated ways[1]
- Making the best use of information technology to ensure the security of service user records is a priority. A central component of enhanced models of care is improving patients' access

[1] Examples include providing care closer to home through the provision of wraparound home care services for older people, and improving collaboration at regional and national levels by establishing a regional approach to implementing dementia care pathways.

2 Patient portals support and enhance primary care delivery, change the way care is delivered and enable people to take more control of their own care. Portals are a self-care tool for individuals, with the addition of a shared care plan for more complex health needs if required. Provider portals also provide the potential for emergency departments and after-hours practices to view a patient's primary care summary record.

to their electronic health information via patient portals[2].

Strategic Context

Southern DHB is currently considering service delivery models as it works towards a health system that will meet the needs of its dispersed population in 21st century New Zealand. This strategic level thinking is informed by the DHB's Southern Strategic Health Plan which has six (6) identified priorities.

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

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

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

Local Strategic Context

Southern District Health Board (SDHB) and Waitaki District Health Services (WDHS) have jointly undertaken reviews to explore how best to provide sustainable health services for the Waitaki community.

The review team of clinicians and management from the organisations as well as community representation, pharmacy and primary health (GP's) participated in a series of workshops and community engagement meetings held between May 2016 and July 2016.

The full review document has details of the review process and findings (see attached as appendix)

The Waitaki District Health Services Board and Southern District Health Board Commissioners endorsed the recommendations below in the last quarter of 2016.

Strategic Recommendations are:

1. **Community based services:** Establish a community clinical care hub as a local point of entry with the aim of keeping people well and safe at home.
2. **Coordinated urgent care:** Implement a streamlined first response system to ensure people get the right care in the right place when they have urgent health needs.
3. **Improved post-hospital discharge:** Improve processes for post-hospital discharge to reduce delays, avoid patient readmission and support return home.
4. **Services closer to home:** Increase specialist outpatient services provided locally to ensure access to care is as close to home as possible and people only travel when they need to.
5. **System communication and coordination:** Improve systems for communication and coordination to provide patient centred care through better use of technology and enhancing relationships within the healthcare provider community.
6. **Workforce enhancement:** Develop and maintain a workforce that will meet the needs of future service delivery

Measures of Success:

Adopt the following measures in the implementation phase as overall measures of success:

1. Decreasing numbers of ED presentations.
2. Decreasing numbers of occupied bed days
3. Decreasing readmission rates.
4. Increasing numbers of outpatients appointments completed locally.
5. Increasing levels of patient satisfaction.

The Implementation Process:

Agree an implementation process as follows:

1. A working group to be established to implement the recommendations of this review. A formal process will be undertaken for membership of this group.
2. Provision will be made for dedicated project management resource.
3. A prioritised work plan be developed allowing time for further consultation with staff, unions, Māori, Pasifika, and other key stakeholders. The work plan will include assigned responsibility for managing any proposed changes and timeframes.
4. Detailed service models to be produced including the framework for funding.
5. A collaborative and alliance approach to decision making be taken, including upholding the principle of 'best for patient, best for system'. (reference South Island Alliance principle)

THE WAITAKI DISTRICT MODEL OF CARE

What Is A Model Of Care?

A Model of care is the framework for delivering health care for the Waitaki District.
It identifies:

- the services that will be delivered
- how those services will be delivered
- how those services will operate
- forms the basis for planning for and responding to the health events within the district of Waitaki

At the centre of the new model is the Patient and all decisions about change must be grounded first and foremost in how it will improve care to the population as a whole.

In the future, care will be delivered through:

- A single, integrated system of care
- One grounded in evidence-based decision making
- Focused on improving health and enhancing access; and
- Refocusing the emphasis of the care delivery system on primary health care and services that can appropriately and safely be provided locally

The result will be:

- A system that ensures patients/consumers receive the services they need and need the services they get;
- A system that is safer, more responsive and timely;
- A system that meets the needs of all patients/clients/consumers equitably;
- A system that uses its resources as effectively as possible; and
- A system that is sustainable and here to meet the needs of future generations of the Waitaki District

Model of Care Summary

A summary of the Model of Care is as follows:

- People are enabled to provide more of their own care for themselves;
- The goal is to keep the person in their own home for as long as possible, utilising support and services locally available;
- Access to services will be streamlined through the use of consistent tools and processes;
- The use of Telemedicine and electronic communication will be increasingly utilised for the benefit of the patient;
- The Clinical Healthcare Hub in conjunction with Community based providers will drive coordination, with additional resources being provided as the complexity of coordination increases;
- A desire to reduce the need for patient travel to access services
- Hospital services will be responsive to the changing needs of the community i.e. focussing on a patient centric model

Attributes of the Model

Using the People, Process, Information and Technology, the key attributes of this model are:

People

Patients and Families will be at the Centre of Care and as such, all care planning, coordination and delivery will be grounded in what is best for the patient and their family and these decisions, where possible are based on individual capacity, will be made by them. The role of the patient in the care team should also be valued and the patient should be actively involved in appropriate elements of some aspects of his/her own care.

Care will be structured around populations of patients, whether the patients are in a community-based clinic, long-term care homes and acute care hospitals or in the patient's own home. Teams will be deployed to meet the needs of the defined populations and will range in size depending on the needs and number of people being served and the partnerships required to fully meet those needs. Care will leverage an inter-professional care model, where all providers work to their defined scopes of practice.

Under the emerging model, every team member will have the opportunity to work to his or her full scope of practice in a clearly defined role. Teams may include different types of providers, including both professionals or licensed staff and unlicensed personnel.

Staff development will focus upon mutual trust and respect for each member of the team. Teams will be supported to understand each other's roles and scopes of practice; contributing both individually and collectively to the development of integrated care plans in accordance with those scopes of practice. Various members of the team will be utilised more effectively as a core requirement, as will the need to consider how unlicensed care providers will be more consistently and effectively integrated to support care delivery when appropriate.

The Community Services Manager will be accountable, in conjunction with the Healthcare Hub personnel for care planning and navigation;

- either by the patient themselves (self-care), or
- through the efforts of the Primary Care Provider, or
- by an assigned home & community care coordinator
- other appropriate personnel

The concept would be a tiered response model whereby additional resources would be called in to support coordination as required.

The home and community providers, including the important involvement of the patient's GP, will perform a valuable role in coordinating care and support.

Coordination within care sectors would continue to be done by staff within the applicable setting.

Processes:

Care co-ordination is a major focus of the process change needed to realise the benefit of the model.

Core processes such as care planning, coordination, communication and discharge management will all need to be restructured to enable change.

The concept of enabling transitions becomes a major focus, with an overall goal of ensuring ease of access across the system and within individual care delivery sites. Within this context, intake and assessment processes must be a priority.

Information and Technology:

As part of ongoing SDHB & WDHSL commitment to improving communication appropriate information will be easily accessible to providers and patients.

To achieve this, all sectors will be linked together using technology which is presently available and updated technology in the future, enhancing processes and information to ensure patients receive the care they need, in a timely manner.

Patients, families, public health providers and other professional providers will have improved access to informational resources through a mix of modalities including user information guides and web-based tools.

There are potential outcomes from increased use of electronic systems, for example:

- Telehealth and video conferencing to facilitate care
- The use of health information technology (HIT) solutions
- Innovative technologies being introduced to support care of patients with chronic diseases (e.g. remote diabetes monitoring and consultation)
- Enhancing the utilisation of technologies having a positive impact, in particular in remote rural communities

Potential Changes to Roles

Fundamental to the Model of Care is the impact that any changes will have on roles that people currently perform. There are some common principles related to roles which need to be considered. These include:

- Each provider's role will be very clear and how roles work together well defined. Trust will be a foundation of a newly defined team philosophy for care.
- Generalist doctors, nurses and allied health professionals will provide the majority of health care to the local health system, well supported by specialist practitioners
- The unlicensed workforce will be integrated more fully into the care environment.
- Innovative staffing approaches will be utilised to ensure services are around the patient when they are required.

While much more work is required to confirm specific roles changes, there are potential changes which need to be considered based on comparable Models of Care in other organisations as well as feedback from the present workforce. Below is detailed some of these potential changes:

(a) General

- It is important to tailor medical care delivery to the needs of the local population and create awareness programmes and clear communication between the community and organisations is essential and highly required.

- To assist in the necessary changes consideration should be given to a comprehensive analysis of clinical work flows delving into everything from when and where labs were drawn, to how medical assistants, nurses, administrators etc. were used to support physicians and more.

- If staff understand the current situation processes can then be redesigned to ensure work flows that are not only optimised, but consistent and sustainable.

- Quality and other measures, for example, can be tracked consistently from location to location. Teams can then control validated clinical and business work flows with an eye toward long-term clinical and financial improvement.

- It is important to tailor medical care delivery to the needs of the local population and create awareness programmes and clear communication between the community and the organisation is essential and highly required.

- To keep the organisation functioning according to plan, the knowledge and skills of all managers and employees' should be upgraded; necessary training on the changes in technology must be provided.

(b) Nursing:

- Nursing care roles may need to be redesigned to leverage professional/registered staff more directly in core processes related to care planning, management and coordination as well as patient/family/whanau teaching and ongoing reassessments of a patient's progress.

- There is the possibility of nursing staff filling multi skilled roles e.g. being able to move into the various departments within the hospital setting to assist where the need is greatest. Basic nursing skills could be enhanced by training in additional skills to suit the various departments.

- District Nurses could consider taking on a more holistic approach to patients dealing not only with the health aspect of a patient but also the living conditions which may need to be adapted to prevent future safety issues.

- The ability to record information electronically would assist the receiver of the information (i.e. the GP) in identifying the needs of the patient.

- To accomplish these changes, staff will require the opportunity to enable them to focus effectively on the new priorities and be supported to work to top of scope to develop multi skilled integrated staff in a rapidly changing environment.

(c) Allied Health

- The examination of roles to enable staff to have the time to complete adequate assessments, define individualised care plans and support specialised care delivery. Examine the inefficiencies which include clerical work, inappropriate screening of referrals supporting routine care delivery which could be done by others and equipment preparation and cleaning.

- Investigate the opportunity to build a flexible and efficient team.

- The ability of a trained staff member (a co-ordinator) to undertake assessments by phone or a preliminary questionnaire to start the process of preparing a plan for the patient would be a worthwhile consideration e.g. St. John's system for collecting information.

- Work that was identified as possibly being able to be transferred to other members of the care team includes: general ambulation and exercise; routine therapeutic interventions, accessing funding sources in the community and general administrative or clerical tasks.

(d) Hospital Medical Staff

- The medical staffing model must be appropriate to a rural hospital, staffed by vocationally registered Rural Hospital Medical Doctors, with trainee doctors (RHM registrars) imperative.

(e) Primary Health Care / Community Based Care:

- There is significant potential to develop collaborative working relationships with primary health care providers to redesign how planned & unplanned patient care is provided in community settings.

- Consideration needs to be given as to how public health, home care and other community-based resources could be utilised and integrated more effectively.

(f) Clerical & Support Staff

- The clerical & support staff could consider some focus areas worth exploring as ways to increase support staff effectiveness and efficiency; examples:
  - Induction and training of support staff
  - Role definition,
  - Guidance & support from other staff members within the organisation (one Team)
  - Right person/right job specialisation
  - Teamwork and culture
  - Productivity through effective systems and relationships
  - Capability for change i.e. flexibility
- Identify attainable workforce change initiatives that will improve the effectiveness and efficiency of the support staff workforce
- Clerical and support staff will be more integrated in the hospital/organisational functions
- Consider improved productivity as "collectively making resources count".

Issues to consider:

Key issues being considered as these new models are implemented; some examples are listed:

1. The need to support management and leadership at each department level
2. The need for team building and change management strategies to be in place to reduce stress associated with the move to new models;
3. The need for some high priority processes to be redesigned in parallel (e.g. care coordination, care planning and discharge management);
4. The need for access to more consistent information regarding the patient's needs across multiple care settings;
5. The need for ongoing engagement with all stakeholders.

Introduction to Recommendation 1:Community Based Services

Objective: To establish a Clinical Healthcare Hub to focus on keeping people well and safe within their home and avoiding admission to hospital wherever possible.

Ideally the Hub will be staffed by a mix of allied health, nursing and mental health workers. Staff will work as part of an inter-professional team where the different professions and occupations with their varied and specialized knowledge, skills, and methods communicate and work together, as colleagues, to provide quality, individualised care for patients.

The Hub will deliver services in three main areas:

1. **Services in an outpatient setting**
    a. The goal is that Clinical Needs Assessment and Service (CNAS) will be predominantly undertaken/delivered at the location most suited to the patient.
    b. Referrals for acute and rehabilitation services will be received using a single process and be reviewed by an MDT focussing on understanding complexity of need. Services available through the MDT will include medical review, community nursing assessment and review, allied health assessment and review, NASC, and community mental health team assessment and review

2. **Services delivered in an inpatient setting**
    a. Effective and efficient discharge planning commencing on day one of admission
    b. Rehabilitation that cannot be delivered in the patient's home

3. **Services aimed at keeping people out of hospital**
    a. Rapid response services for people who may otherwise require an acute inpatient stay.
    b. Referrals could come from GPs, Ambulance services or rest homes
    c. Early supported discharge and intensive rehabilitation services designed to support a rapid transition from hospital to home
    d. Rapid assessment, treatment and planning in the Emergency Department to prevent unnecessary admissions

Achievements for 17/18

1. Inter-professional practice and the seamless coordination of services delivered in an outpatient and inpatient setting will be fully implemented by June 2018.
2. Pilot projects should be put in place for services aimed at keeping people out of hospital i.e. decentralisation of Care Co-ordination Centre (CCC)

First Action for Implementation

A Workshop to be held with all current community-based and allied health staff, focussing on how current referrals are handled, and how this might change in line with the objectives for a Clinical Healthcare Hub.

Actions Associated with Recommendation 1: Community Based Services

Objective: To establish a Clinical Healthcare Hub to focus on keeping people well and safe within their home and avoiding admission to hospital wherever possible.
The Allied Health Department within Oamaru Hospital will be the integral department for the establishment of and be known as the Healthcare Hub.

Systems: Referrals will be made into the Healthcare Hub from a variety of sources.

Clinical Needs Assessment and Service Coordination (CNAS) services will be delivered in people's homes predominantly.

Internally:

An Allied Health Leader has been employed (3 days per week) on a fixed term contract until October 2017 to facilitate the work to be accomplished in this department.

1. Under the proposed Model of Care it is recommended that a Community Services Manager be appointed to build alliances with all the community groups within the Waitaki District to ascertain the services available to the community and will undertake the following:
    - initiate procedures and processes with the community to enable the Healthcare Hub to link with the appropriate care services to allow the parties to plan and provide the appropriate patient care and meet the measurements outlined in the Model of Care
    - work towards a closer collaboration between medical services and services the community can provide to reach the level required for Mental Health Support as necessary with the increase in mental health issues
    - investigate the use of CAPA within the Healthcare Hub; a clinical system that brings together the active involvement of young people and their families, demand and capacity ideas and a new approach to clinical skills and job planning
    - update the data base collated in April 2017 as to community based organisations & services
2. Consideration will be given to inserting tasks relating to case coordination into an appropriate role to enable the screening of incoming referrals to gather the fundamental relevant information to then be examined by the Assessment Team.
3. Information will be recorded electronically to commence the one patient/consumer/one record process.
4. Exploration of the possible extended use of InterRAI assessments tools will be undertaken not only for assessments but also for communicating between health professionals/community providers.
5. The Healthcare Hub will investigate a rapid access process for short term loan equipment with the objective of providing the necessary equipment within a reasonable time frame.
6. The Healthcare Hub will collate data on rehabilitation & recovery at home in order to improve the ability for this to occur more effectively.
7. Ensure that Individual Care Plans in an electronic form are in operation through HealthOne by the end of 2017.
8. Consideration will be given to have a triage expert as part of the Healthcare Hub.
9. The availability of Advanced Care Planning for patients with no family support will be re-emphasised within the training plans for all relevant staff.
10. It is recommended that the Healthcare Hub be housed in premises configured for the services offered; an empty building on site building has been identified as potential premises allowing for a physical presence of a Healthcare Hub for the community.
11. Data on hospital readmissions will be collated to identify the reasons for readmissions and the ability to reduce these; identification of missed interpretation of presentations.
12. Data will be collated as to the reasons for repeat visits to ED of 'frequent user' patients to identify the trends and the reasons why patients/consumers present repeatedly.
13. The adoption of the Calderdale Framework will be considered as a development tool to standardise patient care and achieve service efficiencies.
14. The assessment waiting list will be audited to identify issues i.e. inefficiencies hindering the

ability to process more assessments;

15. MBIE will be invited to educate and train staff in cultural competencies with all parties associated with the Model of Care.
16. Undertake the education of staff on cultural advice of all cultures represented within the community.
17. Collaboration with Mental Health Services will occur in order to understand and be better equipped to manage mental health and dementia issues as appropriate.
18. The Human Resources Manager will link into the training organised by Safer Waitaki Alliance as part of his/her organisation development role.

Externally:

On the appointment of a Community Services Manager the following will be undertaken:

- assist in the education of the community groups and residents as to the services the Hospital can provide and the new procedures to be followed
- work collaboratively with all community providers and residents for whom they advocate as to the availability of optional services available in the district other than the GP's & Hospital
- form an alliance with Safer Waitaki Trust to liaise with the initiatives being undertaken by the Trust i.e. Family Violence, Suicide Prevention, Alcohol Harm, mental Health, Older People, Family/Whanau
- ensure staff are aware of the availability of all services in the community e.g. Women's Clinic
- investigate with the caring agencies for enhanced services for the mutual benefit of all parties
- with the Nurse Manager liaise with the Rest Home sector to formulate a plan to up skill the nursing staff & carers in procedures which, with training, the staff can accomplish at Rest Homes to reduce the presentations of minor cases at ED and the possible use of hospital beds

  with the Nurse Manager, form a close liaison with the GP's in the Waitaki District to ensure an effective and efficient working relationship with a clear understanding of what services can be provided by the Hospital
- connect with rural practices which have practices that can assist in certain presentations being initiated at the rural practice e.g. Kurow (use of ultra sound)
- investigate enhanced services for carers in conjunction with Health Care Hub
- investigate the process of the flow of information between Hospital Doctors, GPs & community services; identify where improvements could be made for a more effective system particularly in relation to care plans for patients who frequently require urgent care thus reducing duplication where possible
- procure funding sources other than the SDHB
- investigate the opportunity for service augmentation other than with the SDHB i.e. alternative options in care provision
- investigate the provision of local education where possible with emphasis on:
  - the ageing patient
  - rehabilitation in the home
  - preventing ED presentations & possible hospital admission

1. Discuss with the Allied Health team and Unit Manager of the Care Co-ordination Centre (CCC) in Dunedin potential approaches to ensuring local ownership of as much of the needs

assessment process as possible in order to reduce any current delays in the identification of patients for assessment, allocation and service co-ordination.

2. Work with community providers with the objective of implementing a 'wrap around service' for patients/families who are the most prolific users of health services; a pilot scheme; funded from outside SDHB sources.
3. Investigations will occur relating to:
    - Quantifying placements, particularly the proportions of patients needing rest home placement, services to return home etc;
    - Short term support to enable patients to return home safely until full support was available;
    - The assistance available within the community for services in the Mental health area; communication with the Mental Health & Addiction Alliance
    - The ability of community based patients having a patient held record with all disciplines using this;
    - Examine the possibility of an Early Discharge and Rehabilitation Service (EDRS) for Oamaru provided either by the proposed Healthcare Hub at the hospital or a community group;
    - Follow up the request as to the reason for bottlenecks and seek clarification on the needs assessments process and access to service before discharge.

4. Consideration will be given to ' Clinical Governance by the Community' a Community Council formed in the way of an overarching clinical group to provide support for the Community Services Manger & the Health Care Hub; ensuring a clear distinction between management & reporting responsibilities. A Board Member could be considered 'ex officio' for clinical governance.
5. With the census occurring in 2018 a current statistical picture of the Waitaki District will be obtained as opposed to the last census. This will assist in identifying the diversity of residents i.e. Pacific Island community, child bearing families, the maturing (elderly) population.

Introduction to Recommendation 2: Co-Ordinated Urgent Care

Objectives:

- To ensure those with more serious or life threatening emergency needs are treated with the very best expertise to maximise the chances of survival and a good recovery.
- To meet patients' needs in the delivery of high-quality, high-value health care.
- To ensure that the patient's needs are known and communicated at the right time to the right people.
- To provide increasingly responsive, effective and personalised services outside of hospital for those patients needing urgent but non-life threatening needs.

People requiring urgent care present in various ways and can be grouped into three (3) Categories:

- People clearly requiring hospital admission
- People who are unwell and need investigation and/or social support assessment before being able to determine whether they require hospital admission
- People needing urgent care but who do not fit into the above two (2) categories

Urgent Care Category 1: These patients are currently dealt with by the Emergency Department at Oamaru Hospital or sometimes GP's may refer directly to Dunedin Hospital.

Urgent Care Category 2: It is proposed that care could be provided through a multidisciplinary 'rapid response' service. This could be based out of the Emergency Department location at Oamaru Hospital, with the sharing of the workforce, support services and space.

The ED doctor with the assistance of the community nursing and allied health rapid response service could provide the work up to determine if the person could return home with appropriate home-based and social support, in communication with the person's GP team. If necessary, the person would be admitted.

Specialist advice from physicians and geriatricians based at Dunedin Hospital (by phone or video conference) would enhance this service. Comprehensive packages of extra support, e.g. more intensive district nursing input, home based support for a few days, would allow more people to return home. Further work on determining how this service would work is planned.

***Urgent Care Type 3*:** Currently the Oamaru Hospital Emergency Department and the Oamaru GP's both provide twenty four (24) hour urgent care to urgent care type 3 patients. An opportunity exists to examine how services are currently configured and discuss if changes from the current configuration could improve patient access, staff experience and business processes.

Co-coordinated Urgent Care will involve the marshalling of personnel and other resources needed to carry out all required patient care activities and will be managed by the exchange of information among participants responsible for different aspects of care.

Co-ordinated Urgent Care will be achieved using the following approaches:

- using broad approaches that are commonly used to improve health care delivery and
- using specific care coordination activities

1. **The Broad Care Coordination Approaches:**
    - Teamwork
    - Care management
    - Medication management
    - Health information technology
    - Patient centred medical plans
2. **The Specific Care Coordination Activities:**
    - Establishing accountability and agreeing on responsibility
    - Communicating/sharing knowledge
    - Helping with transitions of care.
    - Assessing patient needs and goals
    - Creating a proactive care plan.
    - Monitoring and follow-up including responding to changes in patients' needs.
    - Supporting patients' self-management goals.
    - Linking into community resources
    - Working to align resources with patient and population needs.

Achievements for 2017/2018

a) To identify where there are disjointed systems and processes in the operation between primary care sites and speciality sites.
b) To ensure patients and their families understand procedures clearly; examples are:
    - why they are being referred from primary care to a specialist

- how to make appointments
- what to do after being treated

c) To ensure all parties involved in the a patient's care consistently receive clear reasons for the referral or adequate information e.g. on tests that have already been done
d) To streamline processes and gathered information to reduce the possibility of lost information resulting in inefficient care
e) To fast forward the introduction of technology to support the objectives listed above.

First Action for Implementation

1. A follow up meeting from that of 26 June 2017 will occur in August 2017 to progress the main objectives of improved Co-Ordinated Care.
2. To plan for and organise further meetings with GP's, community providers, Oamaru Hospital and St. John's on a regular basis to consider solutions and actions as the implementation of the Model of Care evolves.

Actions Associated Recommendation 2: Co-ordinated Urgent Care

Strategy: To provide a streamlined first response system to ensure patients get the right care in the right place when they have urgent health needs.
Structure: To be developed.
Systems: A streamlined first response system will consider both out of hospital options as well as in hospital options.

Internally

The Needs Assessment Procedures is under review to identify the gaps in the present procedure and continued improvement will be a priority of the Healthcare Hub.

1. The availability of non-acute beds to assist in Needs Assessment and service co-ordination for older patients will be investigated. This is to assist frail people to have an intensive day sorting out and then be discharged back home rather than be admitted for sorting if at all possible so as not to lose condition when out of their home environment.
2. The procedure for Discharge Summaries has been investigated and the anomalies discovered in the present programme are being eliminated to result in a more efficient and effective process; appropriate, timely and integrated.
3. ED will be open & staffed at all times i.e. twenty four (24) hours
4. A major objective will be effective communication between the GP's and the Community Services Manager & the Nurse Manager as to the services that will be provided by the Hospital in conjunction with the role of the patient's GP.
5. Investigate the methods for patients to access ED other than walk-ins:
   - People who needed hospital treatment
   - People who could be seen by a multi-disciplined team
   - People who could be seen by a GP
6. Investigate how to maximise income for ACC patients.
7. Finalise the establishment of the Waitaki Rapid Response Service Plan which has been formulated to provide patients with options to facilitate an earlier or more supported discharge from hospital or to help avoid admission to hospital by provision of care, assessment and treatment in the community.
8. Formulate a plan to develop a strong interdisciplinary focus within this team in order to operate within a locality model.
9. Consideration will be given to the instigation of referrals from ED directly to specialists to reduce duplication of information gathering from patients; the proposed use of technology will assist in this process.

10. Consideration will be given to having a GP co-located with ED to assist with triage.
11. Promote the speedy use of Telehealth with clinicians/specialists for appropriate clinics undertaken by the Hospital.
12. A sign will be put up at ED advising patients to go to their GP if it was not urgent, provide the name, phone number and address of the on-duty GP and advise that there will be a waiting time to be seen.
13. Training in de-escalation practice competencies will be organised for Orderlies working with the Non Clinical Support Services Manager in order to assist the nurses with the more abusive & agitated clients.

Consideration will be given to the following:

- The introduction of 'primary options in acute care' funding packages, planned to be introduced through WellSouth, which would allow GPs to provide 3 days of augmented services to keep people at home to prevent a hospital admission (and ED attendance).
- Exploring a pathway where GP's see more triage 4 and 5 ACC cases, which could include direct referrals to X-ray, with a GP review.
- Exploring St John transporting patients to the GP practice, (either the patient's own GP, or the on-call GP, depending on time of day), when appropriate, rather than transporting them to ED. This would involve giving the GP roster to St John Ambulance.
- Implementing an ongoing information campaign so that the local community is aware of how they should seek urgent care when they require it. It would include media, social marketing and linking in to community groups, through Safer Waitaki, including engaging with the Pacific community. This could be incorporated into the public relations work of the Community Services Manager within the community.
- GP's and the Oamaru Hospital consider GP's taking more ACC patients to ease the pressure on ED especially the under 13year old children who are full funded.
- The GP on duty roster to be provided to St John and to divert patients from ED to GP's, if that was suitable and safe.
- The use of ultra-sound by GP's to evaluate fractures etc., rather than sending to ED for access to radiology.
- The provision of one-on-one education/assistance to "frequent user patients" to change behaviour.
- To investigate the SDHB project to reduce unnecessary presentations to ED by having a person in ED who would look at services they needed to enable more people to stay at home safely.
- To investigate the work St John is doing with communities on Alternative Care Pathways to reduce entry to ED, depending on what will work best for individual areas; an example is having a rapid response nurse organising services for the patient to return home.
- Consider the results of several trials being undertaken at present e.g. addressing long term issues patients may have which, when added up, will help reduce hospital admissions, such as providing funding to GP's for falls, fragility, fractures trials, ambulance options for acute care by developing alternative care pathways.

Externally

- Planning will commence for the geographical configuration of Oamaru Hospital to allow for better usage of the building and the operation of future services; August 2017 is the tentative date for the start of this project.
- Early notification will be given to St. John's for travel time to Dunedin particularly with maternity cases.
- The Oamaru Hospital CEO will facilitate a meeting in August 2017 to progress these areas being considered and organise further meetings with GP's, community providers, Oamaru Hospital and St. John's on a regular basis to consider solutions and actions as the

implementation of the Model of Care evolves.

Introduction to Recommendation 3: Post Hospital Discharge

Objective:

- Discharge planning will address the social, cultural, therapeutic and educational interventions necessary to safeguard and enhance that person's health and wellbeing in the community and should involve the patient, family/whanau, the treatment team and other service providers. It is required when a patient leaves any inpatient facility and it is particularly important in the case of patients with mental health disorders (including substance abuse)
- Discharge planning commences at the time of admission.
- The DHB Advisory Board Guidelines will be examined and guidelines appropriate to Oamaru Hospital will be considered for implementation.

The principal aims of discharge planning will be to achieve:

- early supported discharge
- continuity and co-ordination of care and treatment
- provision and mobilisation of a level of support that will correspond to the assessed needs of the patient for community living
- early intervention during crises and relapse of illness
- optimal health and well-being for the patient
- working in partnership with patients
- with patient agreement family/whänau and caregivers may be jointly involved with the patient in developing a discharge plan and be subject to cultural, ethical and legal constraints
- the service to be responsible for the care of the patient after discharge must be involved in the planning; the objective being one patient, one plan

Post Hospital discharge planning will address the following areas: ·

- The adequacy of the services to meet post-discharge needs, including highest level of independent function and quality of life possible
- Individual level of functioning and response to treatment
- Compliance with the discharge treatment programme
- Appropriate modification in treatment programmes to reflect changes in the individual's condition with careful monitoring of medication side effects
- Appropriate support for family/whanau or other care providers

First Actions for Implementation

- To undertake the outcomes of the workshops recommended under: Recommendation 1: Community Services
- All teams involved in the care of a patient will work collaboratively.

Achievements for 2017/2018

The DHB Advisory Board resource will have been examined with the applicable guidelines implemented.

Actions Associated with Recommendation 3: Improved Post Hospital Discharge

Strategy: To improve Post Hospital Discharge in order to minimise readmission and to support the patient returning home.

Systems: To minimise readmission the information flow will be improved to enhance the handover between providers and those being discharged.

The actions outlined below will be amalgamated to produce streamlined systems in patient care:
Recommended Actions for 1: Community Based Services
Recommended Actions for 3: Improved Post Hospital Discharge

Internally:
Additional focus will be upon the following:

1. The following DHB Advisory Board Guidelines have been determined as the guidelines appropriate to be undertaken at Oamaru Hospital:
   - Review and enhance discharge date prediction processes
   - Monitor the patients' length of stay to identify any delays; recognise and remedy factors that prevent unnecessary lengths of stay
   - Review the Clinical Needs Assessment processes for discharge planning for complex, chronic patients requiring sophisticated discharge plans
   - Implement the use of an electronic whiteboard and patient bedside whiteboards to improve visibility and enable monitoring of discharge planning intentions

2. Packages of Care and local support for those discharged from both Oamaru and Dunedin Hospital will be implemented to support the return home. The role of the Healthcare Hub will perform an integral part in forging a clinical alliance with lead health professionals to facilitate collaboration and co-ordination.
3. A standardised handover tool e.g. ISBAR(R) (Identify, Situation, Background, Assessment, Request) and (Remember) will be used.
4. To address flow challenges in the hospitals through better triage and discharge processes to ensure that patients with less severe needs who are safe to return home without extra support can do so as quickly as possible

Externally

1. Personnel associated with the Post Hospital Discharge process will consult with Health Care Hub to co-ordinate services offered by the Hub.
2. Investigate the adoption of the Alliance South Long Term Condition Network recommendations.
3. Effective education for patients and their families/whanau will be provided about expectations when returning home from hospital. The use of Teach Back will be considered.

Introduction to Recommendation 4:Services Closer to Home

Objectives:

- To allow people to access health services and to work with local communities to provide tailored support on the ground to reduce the impact of patient's having to travel for medical care

Hospitals may be the most visible providers of health care, but most health care provision occurs in the community i.e. moving from 'hospital centric' to 'patient centric.' Community services include

GP surgeries, health visitors, community nurses, pharmacists, dentists, physiotherapists and social services.

The Model of Care has the following objectives:

- To provide care closer to where people live especially for the management of long term conditions
- To integrate health services and to improve connections with the public services available in the wider community
- To promote wellness and to prevent long-term conditions through population – based and targeted initiatives
- To invest on health and wellbeing in the early stages of life particularly children, young people and family/whanau

The aim is to integrate and build networks between public health institutions, community home care teams, day rehabilitation services and social care and private providers, especially general practitioners. This moves away from the silo institution-centric approach to facilitate cohesive integrated management of patients across the spectrum of health and social services.

First Actions for Implementation

Increase the access to imaging services locally

- To review outpatients services
- Use Telehealth to provide better access particularly in remote rural communities

Achievements for 2017/2018

- Notable reduction in patient's travel

Actions Associated with Recommendation 4: Services Closer to Home

Strategy: To ensure that access to care is as close to home as possible
To ensure patients only has to travel away from the Oamaru location where there is no other option than to do so.

Systems: To identify those services available within the Oamaru/Waitaki district and incorporate their usage as the primary objective in providing services to outpatients.

Internally

1. An investigation will occur to identify the predominant clinics required in Oamaru; which clinics are needed the least? Can clinics be undertaken in a different way e.g. the use of Telehealth ?
2. Outpatient services will be reviewed based on the services used the most by patients and the level to which these services are required by the patients e.g.
   * ENT (Ears, Nose, Throat) * Eye * Orthopaedics * Dietician *Diabetes
   * Chemotherapy * Respiratory * Surgical Bus * Other services
3. A review of the procedures used to schedule clinics will be undertaken; move to an electronic booking form and having clinics spread over the month; move towards a closer understanding between Dunedin specialists and Outpatients.
4. The following will be investigated:
   - The ability to undertake Pre Ops ECG's through ED
   - The ability of providing a direct access to the CT scanner service for GP's
   - The ability to utilise the CT scanner for efficiently by undertaking more in Oamaru but ensure a charge back if not covered by funding.
   - The ability to streamline the making of appointments when patients are required to

travel to Dunedin to reduce the necessity to travel on different days for multiple appointments.

- The trend of cancelled clinics to assist in planning for the reduction of cancelled Clinics.
- The ability to roster clinics over the whole month to assist in a more efficient work flow.
- Patients being able to access or be referred to specialist/outpatient clinics in Dunedin or Timaru, depending on the best/fastest/easiest (transport) access, efficiency and cost.
- The use of drivers to collect personnel from Dunedin airport for clinics, meetings etc. in Oamaru; hiring a car as an alternative?

5. Identify which clinics could effectively use the recently installed Telehealth system.
6. Improve the referral processes to ensure timely communication especially in e-referrals to all parties involved; special attention to those without electronic devices.

Externally

1. Better and more frequent utilisation of the mobile service, where appropriate, will be made.

2. Advocate for the use of systems at the rural practices in the Waitaki District:

- Increase the use of ultra-sound at a rural practice level to determine whether further radiology investigation is needed before a patient travels to Oamaru/Dunedin.
- Improve the use of technology such as Skype, TeleHealth/Video conferencing by rural GP's with the patient for initial diagnosis and if necessary in conjunction with a specialist, to determine what the patient needs

3. The following will be investigated

- Have a provision made for acute rural ED services, perhaps something similar to the First Response Team proposal but based in an area such as a first response which then determines where the patient should go from there.
- The ability to improve communication & negotiations with neighbouring health boards (particularly Central Otago, South Canterbury and Canterbury) to resolve boundary issues. This should ensure patients, especially emergency/acute/accident, being taken to the nearest hospital regardless of which DHB area in which they live.
- The ability of WDHSL to tender/contract out specialist services to Timaru or Dunedin based on the fastest and most economical access.

Introduction to Recommendation 5:Systems Communication and Coordination

Objectives:

- To establish Information Technology (IT) as a vital and integral part of the Model of Care and in particular Health Information Technology (HIT). HIT is the application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making.

Below is detailed some of the proven benefits of HIT which could be utilised in the Model of Care:

- The development of electronic medical records (EMR) which can convert medical information into a single database. This technology reduces paper costs and allows

healthcare providers to access pertinent patient information such as medical history, medications, insurance information etc.

- EMR has the ability to care for patients with a record that is integrated with laboratory and pharmacy information and provides point of service information regarding preventive services, diagnosis, treatment and follow up representing a dramatic advance in patient care
- Improving and measuring quality is a positive result of clinicians using EMRs
- Drug prescribing patterns of individual clinicians could be carefully evaluated and compared to established standards
- Improving communication with the use of computerised systems e.g. electronic prescribing

It is also vital that the organisation upgrade its IT systems to allow for more efficient and effective methods of communication to provide the services required of clients/patients and the community for the following reasons:

Communication:
The ability for staff to communicate both internally and externally in the Hospital's operations using some or all of the following:

* Online meeting tools * Video conferencing * Smart phones

Inventory Management
The organisation needs to have current information as to maintain equipment, supplies and plant to meet demand without investing in more than is required. Inventory management systems track the quantity and whereabouts of plant/equipment maintained by the organisation triggering the ordering of additional requirements or when plant needs maintenance.

Data Management
The storage of digital version of documents, patient files etc. on servers and storage devices allow documents to be instantly available to those requiring the information therein both internally and externally. This allows for the storage and maintenance of large amounts of historical data economically with respective parties able to have immediate access to the documents/information needed.

Management Information Systems (MIS)
The organisation can use stored data for the following:

- as part of the strategic planning process as well as the tactical execution of that strategy
- the ability to track expenses
- maximise return on investment

First Action for Implementation
A Workshop will be held with the Management Team in August 2017, to identify the priorities of upgrading the Systems Communication and Coordination internally within the organisation and externally in the community and with community providers.

Achievements for 2017/2018

- all telehealth training completed in appropriate departments by end of August 2017
- all laptops and desktops reviewed and plans for any upgrade completed by end of September 2017
- installation and upgrade of new phone system completed by end of October 2017
- bandwidth capacity completed by the end of 2017 financial year

Actions Associated with Recommendation 5: System Communication and Coordination

Strategy: To improve systems for communication and co-ordination to provide patient

centred care through better use of technology which should also result in developing more effective relationships within the healthcare provider community

Systems: Communication systems need to be available which enable users to access information/advice within a short time span without duplication of processes and reduce the risk of errors and misunderstandings in communication.

Internally

1. The Technical and IT Issues for Effective Communication will be addressed:
    - Investigate the ability of sharing information in an effective & efficient way keeping the care of the patient at the forefront
    - Alternative methods to accelerate the processes & ensure the correct & current information is sent to the appropriate person the 1st time e.g. GP to Midwife
    - Contact has been made with the SDHB IT department and agreement has been made to work on the following items:
        - Bandwidth capacity (scheduled for the financial year 2017)
        - Wifi capacity
        - Med Chart (scheduled for November 2017)
        - Electronic notes for both Ward & ED
        - Radiology Reports to the SDHB PACS system
        - Hardware audit (has been reviewed & upgrade required)
        - New phone system (installation& upgrade commenced)
        - Paging system (under review)
        - Mobile Phone system (to be reviewed)
        - PC s (desktops & laptops are under review)
        - Electronic notes for the Ward
2. Ensure all relevant parties make use of the Telehealth/Videoconferencing which has been installed at Oamaru Hospital and should improve the direct communication between senior clinicians.
3. Investigate the use of a suitable system which is compatible with any SDHB patient system with the possibility of the hospital using it as well.
4. Investigate the feasibility of moving towards electronic claiming for MMPO & electronic MMPO.
5. Update the desktop computer in maternity which is slow and access to HealthConnect is not available.
6. Consider the use of an electronic based system for recording patient data i.e. use of I-Pads and access to HealthConnect will be available.
7. Update the hospital website linking it to all websites in the district i.e. Council, Schools etc. Consider having a Package of Welcome to the Waitaki District with expressions of interest in Employment opportunities.

Externally

1. Ensure all electronically stored patient information is available during an emergency, such as a power cut, network or Wifi disruption; consider backed up information is off site e.g.to the cloud in order to ensure business continuity.
2. Ensure the integration between hospital and community such as GP's and community support groups to enable all details relating to a patient are recorded and available through tablets/I-pads.

Introduction to Recommendation 6:Workforce Enhancement/Development

Objectives:

- To support skills for quality improvement and business excellence, a commitment to an

organisational efficiency and productivity programme including the selection of key contributory measures that will support the delivery of the overall measures of success in the Model of Care. It necessitates a broad, comprehensive and multifaceted focus on the entire organisation.

- To transition towards a more generalist workforce model.
- To build capacity within the workforce to enable staff to work across clinical areas
- To investigate the development of a healthcare assistants (unlicensed) workforce

The proposed Model of Care will incorporate a wide range of key activities, strategies and policies with potential to impact on teams within Oamaru Hospital, the systems that surround them, as well as the community environment.

Using a holistic concept, workplace enhancement/development will include workforce analysis and planning, integrate human resource (personnel) management and capability development. It will also strengthen organisational success by aligning the workforce to both current and future service demands.

Workforce enhancement/development within the Model of Care will focus on the client/patient and make adjustments to systems in accordance with client/patient needs. There will be a focus on the policies and practices needed to support the whole of Oamaru Hospital not just selective departments.

The following three (3) key domains of workforce enhancement/development will be integrated:

- Human resource (Personnel)management
- Workforce capability development
- Workforce planning

Additionally there will be:

- Clarification of the relationship of professional development to capability development
- An alignment with a framework for excellence

Workforce Planning

- Workforce planning will identify both short term and long term workforce supply, demand issues and needs. It will involve workforce data analysis, profiling the current workforce, forecasting future needs, planning and evaluation
- An effective workforce planning process will be constantly updated to meet an ever changing environment. It will be integrated into the organisation's strategic plan.

Human Resource (Personnel) Management

- There will be a strategic and coherent approach to the management of people in order to enhance Oamaru Hospital's performance. It will include job design, attraction and recruitment, performance appraisal, career planning, retention and transition of staff.

Workforce Capability Development

- Building a strong, resilient and capable workforce is a key objective.

First Action for Implementation

A Workshop will be held in August 2017 with the Management Team to identify the priorities of the employment relations within the organisation and additionally the organisational training and development required to implement the Model of Care initiatives.

Achievements for 2017/2018

- Implementation of the Skill for Change Programme

- A Calderdale Framework for Skills Sharing across Allied Health workshop will be held.

Actions Associated with Recommendation 6: Workforce Enhancement

Strategy: To develop a workforce that meets the needs of future service delivery and to provide a culture to enhance the skills and opportunities for the 21st century employee in the health sector.

Systems: Ensure robust employment relations systems exist

Internally

1. A review the whole organisation structure of Oamaru Hospital has commenced. The Organisation Structure will be revised and an Organisation Chart will be composed which best reflects the communication and reporting channels to support the proposed Model of Care
2. Serious consideration will be given to employing an HR Manager to undertake a review of all departments most affected by the proposed Model of Care.
3. Serious consideration will be given to having the Maternity Department reporting to the Nurse Manager to become the Nurse and Midwifery Manager.
4. Due process will be followed for staff who will be affected by changes to organisational structure and undertake restructuring process offering redeployment.
5. The recruitment of staff for a casual pool of nurses, medical, security/drivers, cleaning, and administration will continue. A list of Medical staff locums has been compiled.
6. Possible retirements/resignations will be investigated so that succession planning is an integral part of planning for the future staffing in the Hospital; this could also be linked to career planning for employees. An age profile of staff has been compiled.
7. A cohesive Management Team will be built identifying each person's responsibility to the organisation and those who report to them.
8. Undertake a Needs & Skills Analysis of all departments to ascertain present and recommended resources required to undertake services.
9. Undertake a quality improvement/productivity programme for all departments to identify inefficient systems, customs and practices which hinder the progress towards a patient centred organisation.
10. Plans will be formulated for training to be offered to nurses to lift them to the level of skills required of nurse practitioner or advanced nurses, capable of nurse prescribing.
11. In association with the Nurse Manager investigate the Critical Review Process relating to the presentation of Critical Incidents by midwives.
5. In association with Quality Nursing Support/Clinical Nurse Education a plan will be formulated for a continuation of the quality improvement work Waitaki Health Services is undertaking following the Quality Improvement Workshop staged with the SDHB.
12. The HR Manager will undertake the following:
    - undertake all recruitment of new employees
    - orientation plans for all new staff and those who have been promoted to a new role
    - commence rectifying the annual leave situation by investigating the outstanding leave throughout the whole organisation & initiate a plan for staff to plan holidays in the future within the requirements of the Holidays Act i.e. yearly entitlements
    - implement a programme of Performance Reviews for all staff
    - undertake a skills & capabilities analysis of all staff so that a programme of up skilling can be formulated with the result of more flexible skills within teams

- upgrade all HR Management Policies and procedures
- formulate plans for training of personnel to up skill in electronic data communication and information data
- undertake a skills analysis of all volunteers to enable a productive use of their skills
- manage the team volunteers around the Hospital with duties assigned and clear rules about matters relating to the confidentiality of information e.g. files
- ensure all volunteers undertake the appropriate level of training as per a clear Job description

Externally

1. Market throughout NZ the long term desire for Rural Hospital Medical Specialist Doctors in the Waitaki District along with the benefits of working in this area, i.e. housing, schools, facilities, environment etc.; this will occur when a vacancy arises.
2. Advertising for expressions of interest from people wanting to work in the hospital i.e. to formulate a waiting list of potential recruits will be considered.
3. Extend the methodology of recruitment from the traditional to methods used into society today i.e. social media, networking etc. currently accessing SEEK, Linked-In & relevant websites for recruitment drives.
4. Promote ethnic group representation as a desirable attribute in recruiting personnel in all departments of the Hospital.

NEXT STEPS

To transition from a Model of Care "Plan" to the actual deployment and realization of benefits, a mobilisation (Roll-Out) plan will be essential to ensure necessary planning, design, training, communicating, and overall preparation of all care providers across the continuum.

To assist in the planning a four (4) phase plan is detailed below to support the process.

Key phases include:

Phase 1: Endorsement of the Model of Care Design. (Commences July 2017)

This is a critical step to ensure endorsement of the model. This includes approval from the WDHSL and the SDHB, with clear agreement for moving forward from each showcase unit including support from each participating site leadership.

Once this has been achieved, a communication effort must quickly be deployed to engage, inform and educate all stakeholders across the broader continuum.

Phase 2: Building Teams to Support Roll-Out. (Commences August 2017)

This phase reflects an important step to identify necessary resources and other critical success factors that must be present to begin. Some early considerations may be to ensure union support, project management and available expertise, engagement of regulatory bodies.

To support this planning, temporary Implementation Support "Build" Working Groups will be identified, staffed, and organized to work on specific deployment areas of focus.

The suggestion is to develop an appropriate number Working Groups or a Working Group to identify and complete a defined set of tasks/deliverables to support the deployment of the Model of Care, based on an approved timeline. Examples could be all or some of the following categories to be considered depending upon the decision as to the makeup of a working group(s):

Education Implementation Support provides overall direction for designing the education and development approach for staff on the showcase units and overseeing implementation to enable successful deployment of the Model of Care;

Change Management and Communication Implementation Support provides overall direction and oversight for the development of change management and communication support and strategies for the implementation and evaluation of the model of care on showcase units.
Finance Implementation Support provides overall direction and oversight to the financial management and measurement components of the new Model of Care;

Human Resource Implementation provides overall direction and recommendations for the Human Resource components;

Process Design Implementation provides overall direction and recommendations related to the process improvement and redesign needs for the successful implementation of the Model of Care;

Technology Integration Implementation Support provides overall direction and recommendations for Model of Care related technology needs to enable ongoing co-ordination with other technology projects within Oamaru Hospital and associated providers. To support this work, a project manager could be assigned to provide guidance and oversight to the process.

Phase 3: Performance and Evaluation Planning. (Commences September 2017)

The performance and evaluation phase reflects a critical need to clearly identify expected benefits and impact in advance of moving forward and to identify supporting data. It is expected that the ongoing rollout of the Model of Care will be based on a success of the working group(s); hence documenting the benefits will be critical.

Phase 4: Showcase Readiness. (Commences February – March 2018)

This phase is an important step to complete all necessary prework by Support "Build" Working Groups including job description changes, redesign efforts, technology alignment, education plans etc.
Depending on the activities, the pre-implementation phase may vary however the phase must be condensed and managed so as not to draw out this phase. Each Working Group will work in coordination with other groups, under the direction of a person nominated for this role.

This phase reflects an important pre-planning step to identify necessary resources and other critical success factors that must be present to begin. Some early considerations may be to ensure union support, project management and available expertise, engagement of regulatory bodies.

To support this planning, a Working Group or Project Team will be identified, staffed, and organised to work on specific deployment areas of focus.

The decision as to one (1) Major Team or several smaller groups needs to be contemplated taking into consideration the size of the hospital & the Waitaki District.

A suggestion would be to consider the six (6) recommendations of the Model of Care and determine under each category the priorities to determine what needs to be done in the early stages of implementation and what will need time over several months to implement. The objective would be the identification and completion of a defined set of tasks/deliverables to support deployment of the Model of Care, based on an approved timeline.

Definitions:

SDHB:	Southern District Health Board
WDHSL:	Waitaki District Health Services Ltd.
ED:	Emergency Department
GP'S:	General Practitioners
EMR:	Electronic Medical Record
Health Connect:	This provides clinical staff with a single repository for patient clinical records, streamlining and simplifying access to patient information. It captures patient documentation and stores it in a patient-centric way, giving clinicians a single overview of medical history within a secure environment.
PACS:	A picture archiving and communication system; is a medical imaging technology which provides economical storage and convenient access to images from multiple modalities (source machine types).
MedCh:	A medical chart is a complete record of a patient's key clinical data and medical history, such as demographics, vital signs, diagnoses, medications, treatment plans, progress notes, problems, immunization dates, allergies, radiology images, and laboratory and test results.
CNAS:	Clinical Needs Assessment and Service
MMPO:	Midwifery and Maternity Providers Organisation (New Zealand)
CAPA:	Corrective and preventive action also called corrective action/preventive action, or simply corrective action) are improvements to an organisation's processes taken to eliminate causes of non-conformities or other undesirable situations.
MDT:	Multidisciplinary Team is a group of health care workers and social care professionals who are experts in different areas with different professional backgrounds, united as a team for the purpose of planning and implementing treatment programs for complex medical conditions.
RHM:	Rural hospital medicine is determined by its social context, the rural environment, the demands of which include professional and geographic isolation, limited resources and special cultural and sociological factors. It is invariable practised at a distance from comprehensive specialist medical and surgical services and investigations. A broad generalist set of skills, knowledge and attitudes are needed to deliver optimum patient outcomes in rural hospitals.
MBIE:	Ministry of Innovation, Business and Employment
HIT:	Health Information Technology

IT: Information Technology

Telehealth: Telehealth is the use of information and communication technologies to deliver health care when patients and care providers are not in the same physical location. For example, illnesses can be diagnosed and treatment provided via secure video conference.

EDRS Unit: The Early Discharge and Rehabilitation Service for Older People (EDRS) delivers community-based integrated health services at home to patients who are medically stable but would otherwise have to remain in hospital, or who have high risk of readmission in the immediate future. This service will facilitate the safe transition of patients back to their own homes, where they will receive ongoing monitoring and same-day visits, as required.

CCC: Care Co-ordination Centre. The Aged Care Needs Assessment and Service Coordination is a district wide service that is based in Dunedin, Invercargill and the Rural Hospitals. The services provide assessment to identify the level of need for ongoing support in the home and community settings. Services are allocated based on this identified need. The service provides support for elderly people with an ongoing disability.

WellSouth: The primary health organisation, funded by the Southern District Health Board, providing healthcare service funding to medical practices and accredited Maori and Pacific Island agencies in Otago and Southland.

Pre Ops ECG's: Preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, and urinalysis) is often performed before surgical procedures.

Calderdale Framework: The Calderdale Framework (CF) is a clinically-led workforce development tool to facilitate a 'best for patient, best for system' approach. It provides opportunities to standardise patient care and achieve service efficiencies.

Alternative Care Pathways: A multidisciplinary management tool based on evidence-based practice for a specific group of patients with a predictable clinical course, in which the different tasks (interventions) by the professionals involved in the patient care are defined, optimized and sequenced either by hour (ED), day (acute care) or visit (homecare). Outcomes are tied to specific interventions.

CT Scanner: Detailed images of internal organs are obtained by this type of sophisticated X-ray device. CT stands for computed tomography. The CT scan can reveal anatomic details of internal organs that cannot be seen in conventional X-rays. The CT scan is also known as the CAT (computerized axial tomography) scan.

Ultra Sound: A method of diagnosing illness and viewing internal body structures in which sound waves of high frequency are bounced off internal organs and tissues from outside the body.

Rapid Response: A Rapid response Team (RRT), aims to provide patients with options to facilitate an earlier or more supported discharge from hospital or to help avoid an admission to hospital by the provision of care, assessment and treatment in the community.

Triage: 1: the sorting of and allocation of treatment to patients and especially battle and disaster victims according to a system of priorities designed to maximize the number of survivors.
2: the sorting of patients (as in an emergency room) according to the urgency of their need for care.

Frequent User: A habitual or regular user of the hospital services.

Teachback: The teach-back method is a way of checking understanding by asking patients to state in their own words what they need to know or do about their health. It is a way to confirm that the explanation given and the manner in which it is given to a patient is clearly understood by the patient.

ACC: The Accident Compensation Corporation is a New Zealand Crown entity responsible for administering the country's universal no-fault accidental injury scheme.

SEEK: A Recruitment Agency

Wifi: Wi-Fi is defined as an abbreviation for wireless fidelity, meaning a person can access or connect to a network using radio waves, without needing to use wires.

SKYPE: Free voice over internet protocol (VOIP) service that allows across internet connection by combining voice, video and instant messaging

Appendices:

Waitaki District Health Services Review Repo