

**FEEDBACK ON BETTER SOONER MORE CONVENIENT PRIMARY
HEALTH CARE PLAN
JULY 2010**

Response to BSMC feedback from the Steering Group:

We thank those people who took the time to respond to the 'Better, Sooner, More Convenient' (BSMC) plan. We acknowledge the points raised, and below provide a summary of our response to the feedback received.

- There are many examples of well integrated services being provided on the West Coast and we want to enhance and support these services.
- One of our main ongoing issues is attracting and retaining appropriately qualified doctors, nurses and allied health staff
- Being able to share information across health providers through IT integration is important to enable better services to be provided, and is one of our priorities going ahead.
- The models of care as set out are not 'set in stone' and will be refined as we further develop and implement the plans
- Clinical leaders on the West Coast who are also involved in the direct delivery of services will drive the development and implementation of the plans
- We will involve the community and health providers as we implement the plans as we flesh out the detail
- We think there is potential to improve the quality of our current services and there have been a number of good suggestions made on ways to do this
- Better integration of what happens outside hospital with what happens inside hospital is key to providing high quality sustainable health services for the West Coast
- As we look at different ways of doing things, our goal is to make sure that people (both health providers and patients) are better off as a result of the changes
- The heart of the BSMC plan is a change in **how** we do things, not a change in **where** we do things. Before we can talk about buildings we need to be clear on what we want to do inside those buildings. – whether they be existing ones, or new ones.
- There is a need for financial sustainability of the health system on the Coast which needs to be taken into account. This means that rather than seeing more funding as the solution to all of our problems, we need to focus on how to live within our means and make the best use of the funding we already have.
- We acknowledge that the involvement of the community in developing the initial plans for this proposal was limited, due to the tight time frames we needed to meet. We will welcome further input from the community as we put these preliminary plans in place, and intend to establish ongoing community input as we develop and implement service improvements.

SUMMARY OF FEEDBACK RECEIVED

Have We Correctly Identified The Main Problems?

General Comments

- I support the integration of all mental health services even though I do not agree it will lead to "better sooner more convenient" services, largely because as a secondary service we do not have waiting lists or delays in responding to any referral at present
- Having Community Nurses, Midwives, Allied Health & Maori Providers associated with a particular practice makes a lot of sense
- Some of the problems identified sound much more severe than they actually are, there are many things identified within this report that the staff of the WCDHB are currently doing

Finance

- The Board sees the main problem as a financial one, in that they consistently overspend due to factors out of their control. Consumers see the problem as one of difficulty in employing and retaining qualified GP's and allied health professionals to provide consistent quality health care

Health Promotion

- I also would like to see more emphasis on mental health prevention/promotion, there is reference in the document to mental health promoters, but in all honesty I have not seen evidence of what they actually do here in Westport

IT/Information System

- The most urgent ask is to integrate the IT system to allow all health professionals access to lab results & radiology images for the same patient
- There are some good ideas contained within the proposal, such as some degree of integration for IT & information storage, networking & patient convenience

Recruiting

- Yes there are difficulties recruiting Doctors to work on the West Coast. However under this IFHC system those Doctors that are left will have added burdens not less. If we cannot get the required number of Doctors needed, why would we think that we could then get the required number of skilled nurses to come to the West Coast?

Will The Proposals For Fixing The Problem Work?

General Comments

- The model of health provision as set out is fine, but the availability and retention of qualified staff is the greatest variable
- It certainly has merit as a basis to start consultation with the staff and people for the West Coast, we recognise that this is at the early stages of development and the voice of the people and staff may provide extra value and we are sure it will.
- There are many processes working well and sometimes struggle with the concept of "fixing something that isn't broke".

Staffing

- Don't believe ratio of GP: population is correct – might be suitable for urban environment but doesn't take into account unique demands of rural practice (such as travel times, after hours on-call commitments)
- There is an adequate number of GPs on the Coast with the ratio of 1:2000
- There is a need for more GP available consultation slots – by providing extra appointments with nurses (who inevitably will need to consult with GPs) extra work

will fall to GPs – may need more “protected-time” for GPs

- The increased demands on the wider primary healthcare workforce and support multidisciplinary teams will see them becoming increasingly overworked

Relationship With Secondary

- Need to develop working relationships with the Hospital consultants for increased assistance/supervision, which could enable GPs to develop areas of special interest e.g. diabetes management / women’s health where they could run their own outpatient clinics
- The potential for Practice Nurses to inappropriately refer to Hospital Specialists overloading the Hospital service

Resourcing

- Need to have adequate resources e.g. severe LVF/COPD could be managed if same nursing set up was available as for unstable cardiac patients, also the provision of a bipap/cpap machine
- Mental Health Services currently have the ability to see people anywhere at all, so integration will not make us any more convenient.
- While the proposal identifies that complex patients will need to be seen by GPs, it is often difficult to determine in advance which patients are complex
- Main issue in Buller is the need to have better ability to diagnose medical illnesses, with more intensive monitoring and nursing care. E.g. Access to longer courses of IV broad spectrum antibiotics to manage patients with suspected neutropenic sepsis; On site laboratory or at least capability of accessing lab results over the weekend; dedicated higher dependency room with one nurse in the room at most times

Facility

- A Facility by itself will not solve the current problems

Staff Training/Education

- Currently only a limited number of nurses can order laboratory tests and only then a limited range e.g. Smear takers. Under this proposal will ordering tests be opened up to more nurses? This raises the potential for inappropriate requests which incurs additional financial costs

Is there anything we have missed?

IT/Information System

- Will there be an opt-off or opt on process for patients medical notes to wider health services?

Relationship With Secondary

- How are you going to reduce a gap developing between Secondary Primary – this is of concern - How will this be managed?
- District Nurses feel they need to be attached to the hospital as most of their referrals are generated from here; they have rapport and connection with Specialists, which means fast response to their questions around patient care.

Work Load

- The District Nurses service is currently 7/7 if a Practise is not on call what happens to the patients for that District Nurses, will the other on call team pick it up? Will the District Nurses be working the same weekend as the GP on call?
- What will happen to the Palliative, Stoma, Continent patients currently with in the WCDHB service, will the GP on call take calls for Palliative patients over the weekend if needed, how will this work?

- Patient makes an appointment; and is seen by a nurse. If she considers the patient needs to be seen by a GP does that happen at that appointment, in a timely manner, or does it mean another appointment? If the former, how is that managed?
- Don't see any reference to casual patients – perhaps their fees need to be subsidised as well?
- There are concerns that there will be double ups, in areas, currently cases are handled by area with one person covering, there is potential for 3 Practises to all have District Nurses in the same street this is a valuable waste of resources.

Model of Care

- How is the Buller A&E function of the GPs embedded in this concept?
- Does the model include or exclude Karamea?
- Midwives are diagrammatically attached to the centres; but no further information is given. How is that to work?

Change Mngt

- How you plan to get staff and Communities “buy in” into this project. How will you prepare staff and Communities for this proposed change?

Costs

- What is the cost of employing a variety of locums for a year, as opposed to a GP on a fulltime salary?

Is There Anything In The Proposal That Worries You?

- **Ownership/Responsibilities**

- Sounds like the Board is abandoning some of its healthcare responsibilities to an unknown provider (maybe Private)

- **Finance**

- That historically free services become fee paying ones in the future
- The 2 big issues that will get in the way are: Payment to G.P's and practice nurses for all that will be required for full integration, and, IT systems which I believe need to be fully in place before integration so all are accessing the same client info.
- It is an unrealistic expectation to consider implementation of this plan and expect the redundancies to be covered by the WCDHB

- **Scopes of Practice**

- The feeling that the IFHC proposal is trending more towards shrinking the health service to the absolute bare minimum, creating opportunities that only Generalists will want

- **Customer Service/Focus**

- With all the time and expertise that has gone into this impressive discussion document and will continue to do so in the near future, do not forget the patient who fronts up to the service asking for help. Whether complicated or simple, the patient's request for help should always be in the forefront of the minds of the people who have the power to make these decisions.
- Bureaucracy in a one stop shop may be cumbersome & counter-productive

- **Feedback/Consultation Process**

- The lack of time for providing feedback is very disappointing
- The list of problems is very one sided and only from a current PHO perspective
- There is a serious lack of stakeholder consultation evident in this proposal / business case.
- There is lack of recognition of what is working well.

- **Resourcing/Workload**

- The concern I have is that due to the numbers of the current PHO type milder referrals, we could risk diverting resources away from the more severely mentally unwell in order to address the demands on services of the less severely unwell. There is also a risk that the new model becomes over medicalised with the expectation that all staff are seeing people within IFHC's when CMH staff tend not to work in an office
- Nurses taking on more care and feeling uncomfortable with higher levels of responsibility, for patients plus the additional demands placed upon them in terms of education/upskilling
- Doctors seeing only complex presentations will be consistently exposed to the stresses that come with this type of work.
- Doctors work load will be increased initially until they build up their confidence in the Nurses who will be working at an advanced level of practice

- **Facilities**

- Proposal seems to be too focussed on physical buildings – which is very expensive and not always the answer
- The one stop shop facility can only function with the provision of Pharmacy as an essential stakeholder – the current Pharmacies all have large and fixed commitments in terms of physical location – relying on Hospital Pharmacy is not an option as patients have developed relationship & loyalty to a Community Pharmacy over time

Relationship With Secondary

- The implication that links are weak between all Community Service Groups (CNS, DN, RNS, PHN etc) and GP's is incorrect, excellent work continues and huge inroads have been made and this will certainly continue to evolve as we all work together in the best interests of those in our care and the shared patient records will only enhance this process and improve patient outcomes and care.