

The Buller Health Report

October 2005

Achieving Excellence through Integration

Executive Summary

This report presents the recommendations of the Buller Health Steering Group regarding the proposed formation of “Buller Health” as a Business Unit within the WCDHB.

The original objective was for Buller Health to include Buller Medical Services, Buller Hospital, Community Services and Community Mental Health Services.

Key findings include;

- The steering group unanimously supports the integration of health services in Buller into one unified management and leadership structure, Buller Health.
- This unanimous support is tempered by the realisation that Allied Health and Community Mental Health services need to maintain management links to services in Greymouth due to the unique challenges (small scale and clinical isolation) that these services face in Westport.
- There should be a Manager of Buller Health, with clear leadership responsibility for health services in Buller. The Practice Manager for Buller Medical Services should report to the Manager of Buller Health. Reporting structures within Buller Hospital should be clarified so that one person is responsible for its operations. This person should also report to the Manager of Buller Health.
- The Manager of Buller Health should have a degree of autonomy within the West Coast DHB. They should have budget holding responsibility for Buller Health and should have delegated authority for minor items of capital expenditure.
- Processes and procedures should be standardised so that staff and patients can move between services with as little disruption as possible.
- Staff induction processes should be reviewed, in order to ensure that staff are aware of where and how to access clinical support. There also needs to be a focus on improving informal communication networks within the Buller site.
- Health services in Westport should be re-branded as “Buller Health” so that it is clear to both patients and staff that they operate as one combined organisation.
- A clinical governance structure should be established for Buller Health, with a lead medical and a lead nursing practitioner appointed to provide advice to the Manager of Buller Health on clinical issues.
- The Buller Health steering group does not support the formation of a separate community governance structure for health services in Buller.

Table of Contents

Executive Summary	2
Table of Contents	3
Directory.....	4
Introduction.....	5
Project Scope.....	6
Planning Process	7
Strategic Context – West Coast DHB	8
Strategic Context – Buller Region	9
Buller Health – A Vision for the Future	10
Environmental Scanning	11
Internal Analysis	14
Key Strengths	14
Key Weaknesses.....	14
Strengths and Weaknesses - Buller Medical Services.....	15
Strengths and Weaknesses - Buller Hospital	16
Opportunities for Improvement.....	17
Threats to the successful implementation of Buller Health	21
Leadership Structure	24
Recommendations	27
Strategic.....	27
Leadership Structure	28
Community Governance	32
Management Processes	32
Financial Considerations.....	33
Staff Induction and Socialisation.....	34
Clinical Governance.....	34
Clinical Processes and Procedures.....	36
Community Recognition	36
Implementation Plan	37
Management of Change.....	37
Implementation Timeline	38
Appendix 2 Buller Health Project – Initial Instructions.....	41
Appendix 3 Roles - Manager of Buller Health	45
Appendix 4 Overview of the Grafton Report.....	46

Directory

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Introduction

In 1995, the West Coast DHBs predecessor organisation (Coast Health Care Ltd) entered into a collaborative arrangement with Dr Bird, effectively forming Buller Medical Services (as we now know it), in order to achieve clinical and financial benefits through the integration of primary and secondary care services.

Anticipated benefits included the sharing of administrative overheads, the sharing of clinical rosters, combining of clinical staff, shared responsibility for patient care and a multi-disciplinary approach to health service provision.

Buller Medical Services was relocated on to the Buller Hospital site, with contractual arrangements implemented, whereby the GP practice provided after hours medical cover for the Hospital.

When Dr Bird left the West Coast, the DHB bought the rest of Buller Medical Services, in order to further facilitate its integration objectives.

Some integration has occurred, mainly in the area of shared corporate services (HR, finance and procurement). Co-location has also had some advantages, in terms of shared facilities costs and the development of informal networks between staff. However Buller Medical and Buller Hospital were never actually integrated into one service and so the full potential for improved health outcomes has never been achieved. Instead the two services, Buller Hospital and Buller Medical Services operated with independent management structure, reporting through to different managers within the DHB.

The West Coast DHB is now the sole provider of primary health services in the Buller region. The DHB still operates both services as separate business units, Buller Hospital and Buller Medical Services, with Community Nursing, Community Mental Health and other services in Buller also run as independent business units within the DHB.

The Buller Health Steering Group, was set up by the Chief Executive Officer of the West Coast DHB in order to investigate and make recommendations regarding the formation of "Buller Health" as a Business Unit within the WCDHB.

The original objective was for Buller Health to include Buller Medical Services, Buller Hospital, Community Services and Community Mental Health Services.

This report documents the findings and recommendations of the Buller Health Steering Group.

Project Scope

The Buller Health project specifically avoided re-litigation of the Grafton Group's recommendations regarding the structure and format of health facilities in Westport.

Instead, the steering group considered that the integration and improvement of management structures and systems should proceed regardless of whether or not the Grafton Groups recommendations that services be co-located into a modern, closely integrated facility were to be adopted.

The West Coast DHB's own public consultation process on the Grafton Groups recommendations (required by the New Zealand Public Health and Disability Act) was already underway at the time that the Buller Health project was initiated. We now know that the West Coast DHBs consultation process found considerable community support for the redevelopment and re-configuration of health services in Westport, including the recommendation that services be co-located into a modern, closely integrated facility.

The Buller Health project has also sought to not re-litigate the Vause report, a detailed report outlining opportunities for operational improvements within the Buller Medical Services GP practice. Many of the opportunities outlined in the Vause Report are already being implemented by the West Coast DHB and will be of value regardless of whether or not the DHB proceeds with the Buller Health initiative.

Planning Process

The Buller Health Steering Group followed a standard strategic planning process in order to arrive at the recommendations outlined in this report.

Only recommendations that the Steering Group consider likely to improve the integration, co-ordination and delivery of health services in Buller have been included as recommendations in this report.

Vision and Mission for Buller Health

Internal Analysis

- What currently works well, what doesn't? (Strengths and Weaknesses, possibly for each of Buller Medical, Buller Hospital, various Allied Health services, Community Services and Community Mental Health).

Environmental Scanning

- What are the external factors that affect Health Services in Buller and how? (Opportunities and Threats of SWOT analysis possibly for each of Buller Medical, Buller Hospital, various Allied Health services, Community Services and Community Mental Health).
- PESTE (Political, Environmental, Societal, Technological and Economic) factors affecting Buller Health – what might the future look like?

Options Analysis

- What do we need to change in order to adapt for the future, what different options are available?
- What are the potential implications of changing? Do the options improve on the status quo?
- How do the options impact on the SWOT of Buller Health?
- What are the financial implications of the options being considered?
- What is the preferred option(s) and why?
- Are there scenarios where a different option(s) would be preferable.

Write Report

- Document logic and recommendations.

Review Report and Recommendations – Can we improve it.

Strategic Context – West Coast DHB

Health services on the West Coast have suffered through 12 years of financial deficits. During this time, considerable management effort was lost to funding negotiations and a drive for financial efficiency. Recruitment and retention of both management and clinical staff has suffered through bad publicity and concern about the viability of health services on the West Coast and due to international shortages of health professionals.

At times the DHB was under extreme financial pressure, with different business units within the organisation actively competing against one-another in order to look profitable, even if they were actually acting to the detriment of the organisation as a whole in order to do so (described as a “silo mentality”). Against this context, it is obvious that there will have been times of angst, with Buller Medical, Buller Hospital, various Allied Health services, Community Services and Community Mental Health) all operating as separate services within the DHB, competing against one-another for internal resources.

At the same time, there has been uncertainty over the DHBs commitment to primary health, leading to confusion and staff dissatisfaction, which has contributed to shortages of GPs. This has required the DHB to enter into expensive cover arrangements, which have created increased financial pressure and led to additional uncertainty about the DHB’s continued involvement in primary practices, a vicious circle of inaction that the DHB has struggled to break.

This issue has only recently been tackled, with the West Coast District Health Board passing a series of resolutions, confirming its commitment to an ongoing involvement as an owner and provider of primary health practices.

On the financial front, the West Coast DHB has now secured additional funding (at least for the next two financial years) and so has overcome its deficit funding situation. This is in recognition of the fact that the national population based funding formula does not fit the West Coast’s unique geography, rurality and population dynamics. The West Coast DHB is in a position where it can now work to improve health services (whilst maintaining financial performance) where as it’s previous motive was to try to improve financial performance whilst maintaining health services.

To this end, the DHB has re-defined its mission statement;

To become a centre of excellence in Rural Health

Achieving excellence in Rural Health involves the integration of services, a shared culture of quality improvement and the alignment of services and resources to meet the West Coast population’s health needs.

The timing is now right to look for opportunities for service improvement opportunities, including the improved co-ordination and integration of health services in Buller.

Strategic Context – Buller Region

In 2004, the Buller District Council engaged the Grafton Group to investigate options for the future configuration of health services in the Buller Region. The project included investigations and rigorous community consultation around management structure, governance structure, ownership structure, models of care and physical infrastructure requirements.

The Grafton process was well received by the Buller community, with clear support for improved integration of services (models of care, facilities and management). However, support wasn't as strong for different ownership and governance options.

Key recommendations from the Grafton process include the recommendation that Buller Medical Services and Buller Hospital be merged and integrated, with the Buller Hospital facility reconfigured or reconstructed so that services are centred around the GP practice, with GP level observation beds and maternity beds. Grafton recommended that the West Coast DHB look to exit aged care services, should an alternative private provider be interested in providing them. A detailed summary of the Grafton Group reconfiguration options is presented in Appendix 4.

In its 2005 District Strategic Plan consultation process, the West Coast DHB consulted with the Buller community on a selection of the Grafton recommendations (all of the recommendations relating to health services in Westport except for those relating to Governance and Ownership), confirming community support for improved integration and co-ordination of health services.

As outlined in the introduction, health services in Buller are already co-located on the Buller Hospital site. Informal communication systems between staff in Buller are well established and some models of care have developed around this, however integration of the two services has never actually been formalised and so the two services are still operated as independent business units, with separate management structures, reporting through to different managers within the DHB.

The formalised integration of Buller Health into one business unit will enable improved co-ordination of services, facilitate the continued development of multidisciplinary models of care and will allow health services in Buller to achieve a state of readiness for changes from the other Grafton recommendations when or if they are eventually adopted.

The timing is right to finish off the job that was originally initiated back in 1995.

Buller Health – A Vision for the Future

Buller Health will be a business unit within the West Coast DHB and a key component in our goal of developing WCDHB as a

“Centre of Excellence in Rural Health”.

Within this vision for the future of the West Coast DHB, the Buller Health Steering Group has developed a separate mission statement for Buller Health.

“Buller Health is a team of dedicated professionals applying available resources to the health needs of our community through effective delivery and promotion of quality holistic health care”.

It is anticipated that Buller Health will have a degree of autonomy from the rest of the West Coast DHB, with its own management structure and separate budget holding, decision making and strategic planning processes, all of which will contribute to the West Coast DHB’s overall planning and management processes.

For example, it has been suggested that there should be a Health Plan for Buller, outlining the community’s health needs, health priorities and strategies for meeting these.

Environmental Scanning

Any decision regarding the future structure of Health services needs to bear in mind trends in population demand, treatment methodologies and in the political and funding environment.

The Buller Health Steering Group used “PESTE” as a framework for considering future trends and issues affecting health services in Buller. (PESTE stands for Political, Economic, Societal, Technological and Environmental).

Key factors affecting the future of health services in Buller include;

- The risk of changes to DHB funding formulas, especially as the West Coast DHB currently sits outside of the national population based funding formula. This risk includes the risk that political imperatives will change regarding health rationing and with it the will to maintain or boost existing health services.
- Potential changes in DHB boundaries or the merging of DHBs. The Buller region currently contains 1/3 of the West Coast DHB’s resident population, so is a real priority for the West Coast DHB. Changes in DHB boundaries could conceivably see the Buller District serviced by Nelson Marlborough DHB or the West Coast DHB merged with Canterbury DHB.
- Either of these changes would affect the level of managerial priority given to the Buller region, although there may also be compensating benefits (Nelson Marlborough is currently a well funded DHB for example).
- Health services in Westport are small in scale and rely on other centres (currently Greymouth and Christchurch) for clinical advice, collegial support and professional development. Even minor disruptions to these external relationships, such as changing staff members at either location can disrupt the smooth operations of health services in Buller.
- Health professions are becoming more and more specialised over time, due to new technologies, changing legal frameworks (such as the introduction of the Health Practitioners Competency Act) and overseas trends (often driven by litigious environments in other health jurisdictions).
- As health practitioners become more specialised in their practice, more staff will be required in order to provide existing levels and ranges of service. Specialised staff will need to maintain minimum levels of practice in order to maintain their competency, so it will become increasingly difficult for small rural communities to attract and retain a full range of health practitioners, especially whilst living within a fixed operating budget. Increasing co-operation between facilities and

innovative solutions (such as job rotations between sites) will be required in order to meet the needs of small communities whilst allowing specialist staff to maintain their competency requirements. This is an especially pertinent issue in Westport and for other West Coast communities (including specialist services in Greymouth) as the level of isolation and population dispersion on the West Coast is uniquely challenging.

- The development of specialised nurse practitioners is an emerging trend which may have potential for implementation within Buller Health.
- The Buller community is ready for changes in the way health services are delivered. The Grafton process has achieved high level of community participation and has created an environment where the residents of Westport understand what their basic health requirements are and are realistic about the fact that they could be delivered more efficiently and effectively from a modernised facility that is right-sized for their needs.
- The Grafton process does not advocate a reduction in Health services in Buller, but does advocate improvements in the integration and co-ordination of health services through improved physical co-location. The creation of Buller Health is a key step toward this as physical co-location will lead to frustration and confusion unless systems are aligned and management structure integrated at the same time.
- The West Coast PHO has recently decided to change management services organisations. Most of the PHOs funding initiatives (Care Plus, Health Promotion and Services to Improve Access funding) are national initiatives, however, the way they are implemented and interpreted locally may differ between management services organisations. (Positively or negatively).
- The Maori population in Buller is younger and is expanding more rapidly in Buller than in other areas of the West Coast. This is of concern, as Maori in Buller have higher socio-economic deprivation that in other areas of the West Coast and because there aren't the same support systems in place for Maori in Buller as there are in other West Coast locations.

A summary of the PESTE analysis undertaken by the Buller Health steering group follows.

POLITICAL	ECONOMIC	SOCIETAL	TECHNOLOGICAL	ENVIRONMENTAL
<p>National Change of Government funding formula</p> <ul style="list-style-type: none"> Decentralised health planning. DHB funder / provider <p>Change in Government but no change in health needs. Centralised v decentralised</p> <p>Current Government big on health.</p> <p>DHB boundaries may change</p> <ul style="list-style-type: none"> Same issues Same health problems <p>International Global unrest</p> <ul style="list-style-type: none"> Demand for safe countries International travel opportunities decline <p>Local Responsiveness to local demands Internal politics Interest in health by local Government Loss of ward system STV misunderstood</p> <p>Access to internal resources DHB - Elected members & Appointed members Clinical Health Background Unsophisticated processes</p>	<p>National Health biggest Government spend Government has surplus What happens to health funding when it doesn't have a surplus? Government currently fully funding West Coast DHB</p> <p>Local Healthy local economy</p> <p>Economics of scale / structure Centralised – rebuild cheaper</p>	<p>National Make up of population ethnic diversity</p> <ul style="list-style-type: none"> Patients Staff Obesity, diabetes, cardiac illness, stress related illness as well, lack of exercise <p>International Shrinking world globalisation</p> <ul style="list-style-type: none"> Communication of diseases Lifestyle / location World unrest? <p>Longer working life – mix of workers (gender) Family unit – breakdown</p> <p>Local Ageing population</p> <ul style="list-style-type: none"> Patients Staff <ul style="list-style-type: none"> Dedication Acceptance of new technology and treatment <p>Community expectations Less community and personal responsibility Dependant society Pockets of unwell</p> <ul style="list-style-type: none"> E.g. Is Buller currently a socio-economically disadvantaged “pocket” Availability of alcohol and drugs <p>Public transport</p>	<p>National Broadband internet communications</p> <ul style="list-style-type: none"> Cheap communications Access to resources Ability to work remotely Remote locations easier to live in <p>Local Specialisation of Health Services / specialists</p> <ul style="list-style-type: none"> Hard to get and maintain competencies Need to have technology and volume of patients to maintain <p>Patients can become experts in rare conditions through independent research via the internet</p> <p>No one has invented (all weather) helicopter rotors</p> <p>Internal Pressure for what others have access to Ability to forge links with other areas / services Availability of health information online – real time Travel costs down travel up Get second option Travel for special services</p>	<p>National Climate Change Wet / warm / control erosion</p> <p>Local Geography 650 km in length 50 km wide 1/10 of NZ are population density. Population dispersed in “pockets” – lots of small communities</p> <p>Fault line</p> <p>Southern Alps</p> <ul style="list-style-type: none"> Isolation re weather <ul style="list-style-type: none"> Snow Rain Terrain – slips Roading –transport

Internal Analysis

In order to recommend improvements to services, we first need to determine what (if anything) is wrong with them. What areas need to be changed and what areas need to be preserved in order to ensure that they continue to operate effectively into the future. A common way of analysing this is through the “Strengths and Weaknesses” part (S & W) of a SWOT analysis.

The Buller Health Steering Group undertook a separate S & W analysis for each service area of the Buller Health site, including Buller Medical, Buller Hospital, Community Nursing, Allied Health and Community Mental Health.

Key Strengths

The key strength identified for all health services areas was the professional, dedicated and experience of their staff.

Professional links to colleagues elsewhere in the DHB were also seen as a key strength in all areas. **In Allied Health and Mental Health, this strength was seen as an absolute that must be maintained at all costs**, due to the risks involved in the clinical isolation of one staff member departments.

Key Weaknesses

A key weakness identified for all health services areas was ineffective internal communication both with-in the Buller site (which seems to have good informal communication but poor formal communication) and difficulty communicating the urgency or importance of needs to key decision makers within the DHB.

Some of the other weaknesses that were identified are symptomatic of this first weakness. For example, Telephone issues, Computer issues and aged or outdated equipment are considered to be symptomatic of a lack of effective two way communication about the urgency or importance of needs to key decision makers rather than symptomatic of a wise funding or resource issue.

A summary of the Strengths and Weaknesses for Buller Medical and Buller Hospital are presented below. Other areas were also analysed but have been omitted from this report in order to keep it concise.

Strengths and Weaknesses - Buller Medical Services

Strengths	Weaknesses
<p>Staff friendly welcoming Staff experienced and dedicated team</p> <p>Will to implement change Track record Adaptable (in crisis)</p> <p>Spacious modern facility</p> <p>Population well served (in terms of access)</p> <p>Nurse led clinics/appointments</p> <p>Are all on one site GPs work in both services (1^o and 2^o) Opportunity to integrate Co depending with other services well developed</p> <p>Monopoly Provider</p> <p>Treat people well</p>	<p>Telephone system (not enough lines) Swamping by telephone triage system Only one answer phone Easy accessible(too easy)</p> <p>Communication of needs / urgency of need (this is changing) Public to take more responsibility for our health needs We need to educate them Community expectation</p> <p>Communication (distance) between health Services on the Buller Campus</p> <p>Continuity of GPs</p> <p>Links generally informally rely on individuals</p> <p>Struggle to staff all possible initiatives Out of the loop – communication with WCDHB And WCPHO And SouthLink (now replaced by PHOCUS)</p> <p>Manage people – staff are often too accommodating, reinforcing unrealistic patient expectations.</p> <p>Access to Equipment</p>

Strengths and Weaknesses - Buller Hospital

Strengths	Weaknesses
<p>Sole provider</p> <p>Staff – wide range of abilities</p> <ul style="list-style-type: none"> - Adaptable - Quality of care <p>Relationships within Buller Hosp (Seamlessness)</p> <p>Range of services</p> <p>Links to Grey Hosp –Training</p> <ul style="list-style-type: none"> - Collegial support <p>Links to Tertiary Hospital</p> <p>Excellent quality nursing care</p> <p>Integration of services on Grey Hosp campus including non clinical</p> <p>Access to services (where they are available eg x-ray)</p> <p>Community structure – people know their patients</p> <p>Building in good condition (especially when refurbished)</p>	<p>Sole provider</p> <p>Orientation for clinicians</p> <p>Compliance with regulations -legislation</p> <p>Recognition of the availability of staff</p> <p>Staff don't know what the \$\$ are → do they meet the patients needs</p> <p>Access to (Clinical) Medical staff</p> <p>↕</p> <p>Internal Communication within Buller Campus when short staffed</p> <p>Equipment outdated / Access to equipment</p> <p>Communication of needs – Greymouth</p> <p>Speed of IT network - Citrix 2-3pm</p> <p>Lack of cover for small (sole staff) services</p> <p>Community expectations</p> <p>Security / Alarms</p> <p>Patient Transport System</p> <p>Difficulty to recruit</p> <p>Building inefficient</p> <p>Hard copy notes disappear with patients (to Greymouth)</p> <p>Reception/Admin community services?</p>

Opportunities for Improvement

Building on the internal analysis, a number of opportunities were identified for Buller Health.

Communication and Co-ordination

Many of the issues identified when analysing the strengths and weaknesses of the various health services in Buller are related to poor communication, both between services in Buller and key decision makers in Greymouth.

A dedicated manager of Buller Health could act as a conduit for communication. Having a central person in charge overall would also simplify communication between health services in Buller as there would be a single escalation point for any issues that need to be resolved between services.

Responsiveness to Community Health Needs

As mentioned earlier in this report, one of the key aspects of Buller Health will be the development of a Health Plan for Buller, outlining the community's health needs, health priorities and strategies for meeting these.

The Buller Health plan would have a 5-10 year time horizon and would be updated 3-yearly, linking into the West Coast DHB's District Strategic Plan, which has the same time horizon and which is also updated 3-yearly. As with the District Strategic Plan, the Buller Health Plan would be operationalised through the West Coast DHBs' District Annual Plan (DAP), which sets annual operating objectives for the DHB.

The aim of the health plan is to provide a mechanism for proactive health intervention by identifying and responding to the communities changing demographics and health needs, in order to customise and co-ordinate responses both directly, in terms of the application of existing health resources and potentially indirectly, by measuring and potentially demonstrating the need for additional health resources in order to meet the unique health needs of the Buller community.

The Health Plan for Buller will become a key pillar of communication, identifying objectives and strategies for co-ordinated implementation by staff within Buller Health.

Integrated Continuum of Care

The West Coast DHB already provides a full range of health services in Westport, from Maternity and Birthing through to Palliative Care. However, these services aren't co-ordinated effectively and are poorly integrated.

By standardising protocols and procedures across services, staff and patients will be able to better understand what to expect and which processes to follow when interacting with different services within Buller Health. Informal communication already works well within the Buller campus, such that

standardising systems should enable greater responsiveness to patient needs, simply by allowing staff and patients to intervene and advocate for individual needs across the whole spectrum of health services.

There will also be improvements in quality and patient safety by standardising systems so that staff can move between areas with as little disruption as possible (at the moment GPs from Buller medical provide medical cover to Buller Hospital and emergency cover for Maternity services in Buller, for example. Also, in times of short staffing or extreme emergency, staff might work in areas that they do not normally cover).

Integrated Systems

Further advances could be made by integrating health information systems across the spectrum of health services, so that lab tests, drug prescriptions, contra-indicators, patient preferences, alerts and even 'do not resuscitate' instructions are available where ever patients come into contact with health services.

Currently health services in Westport are on the same computer network, but information is spread over three different patient administration systems, with no sharing of medical information between systems. (IBA for hospital information, Coast Care Community for Community Services and Mental Health information and Medtech32 for GP practice information).

The West Coast DHB is currently engaged in the implementation of a new hospital patient information system (iSOFT), which will provide a platform for improved sharing of patient information between systems and which may also replace the Mental Health and Community system. Messaging of information between two systems will always be a clumsy integration option, but will provide a stable integration platform for the DHB as a whole, with a best of breed system (iSOFT) for secondary services and a best of breed system (Medtech32) for primary health.

Zooming in from this 'DHB as a whole' view to consider Buller Health as a stand alone entity, there would seem to be obvious advantages if all of Buller health were to adopt one of these two systems as a whole of Buller Health system. Theoretically, either system has functionality that would support the internal management of the full spectrum of health services provided by Buller Health. However, it is unclear whether either would perform the full range of reporting and claiming required by both primary and secondary health services. Both systems are going to be integrated to the West Coast DHB's other patient information repositories via messaging.

Patient Responsiveness

Ideally, Buller Health should adopt one single patient administration system. If this is not practical, data collection process, appointment booking processes and other systems need to be improved so as to be more patient friendly by improving messaging between systems and by giving staff access to different systems. Ideally, GPs should be able to book outpatient appointments

(including appointments at other West Coast DHB facilities) for patients during patient consultations.

Staff Induction Process

With a wide range of relatively small and isolated services, health professionals in Buller rely on one-another for back up and support, as well as relying on distant services such as those based in Greymouth and Christchurch for clinical advice.

Moving to a small, relatively remote community can be daunting, especially when adapting to a new job and learning new systems and processes. Education of new staff members is a critical aspect of rural health, because there is no one who can cover for staff while they're learning the ropes.

Policies and procedures that differ between services along with an over-reliance on informal communication systems make this a key area of clinical risk for Buller Health, especially given the high staff turnover. There needs to be a Buller specific orientation process for all clinical staff, along with a concerted effort to standardise processes and procedures between services.

The induction process needs to go beyond teaching new staff about processes and procedures, to introduce them into the informal social network that supports the current integration activities between health services in Buller. Further more, existing informal processes that work well should be formalised and maintained by including them in staff orientation processes.

Staff will still need to attend formal organisation wide training and induction processes so that they know about DHB wide systems and procedures.

The increasing Maori population in the Buller region and the fact that the support services for Maori aren't as strong as they are in other regions of the West Coast will mean that mainstream (non "by Maori for Maori") services in Buller will need to strive to be accessible and responsive to the need of this growing population, which is know to suffer from inequalities in health status and socio-economic deprivation. Induction and staff training need to include training in Maori Health and Maori customs and protocols. Examples include, Treaty Training, Inequalities training (non Maori specific) and training in and adoption of Te Kanga recommended best practice.

Relationships with Secondary Services

The Buller region makes up approximately 1/3 of the Greymouth Hospital's patient catchment.

Buller Health relies on Greymouth Hospital for clinical advice, back up and support, visiting outpatient's clinics, patient referrals and clinical training.

Both sites fall within the provider arm of the West Coast DHB and together they are the DHB's two biggest and most complex sites. They are also the

biggest sites on the western side of the Southern Alps and so it is conceivable that staff could be dispatched from either site to support the other in the case of a major disaster, especially if the availability of local clinical staff has been compromised.

It is therefore logical and indeed imperative that staff from both sites be encouraged to train together, socialise together and work together. That systems and procedures are streamlined and that common processes are used, in order to eliminate barriers and improve communication and co-operation between the sites. A common DHB wide induction, orientation and socialisation process is required, in addition to location specific induction processes recommended in this report.

Specialist staff in Greymouth should support and mentor staff in Buller. For example, clinical education sessions held in Greymouth should be shared around DHB sites.

Clinical governance groups from the two sites should work collaboratively on projects that jointly affect both, including a review of the clinical documentation sent between sites in the case of patient transfer and subsequent discharge.

Achieving Excellence

Buller Health has a very real opportunity to become a recognised centre of excellence in the provision of integrated and co-ordinated rural health care.

While this sounds exciting, it is actually a mission critical requirement. Failure to achieve excellence and to become recognised as a centre of excellence in rural health will mean that health services in Buller continue to be subjected to recruitment and retention woes. They will struggle to even be responsive to community health needs.

Threats to the successful implementation of Buller Health

The Buller Health Steering group has identified a number of key threats to the potential for successful implementation of the Buller Health concept.

(Unrealistic) Community Expectations

The Westport region currently enjoys a very high level of access to health services. Many similar sized communities no longer have resident X-ray, physiotherapy, occupational therapy or maternity services.

The main reason for retaining these services in Buller relates to the necessity brought about by geographic isolation from other services and due to minimum service provision requirements. However, the flexibility and accommodating nature of staff in Buller also creates unrealistic expectations such as the expectation that someone will turn up to operate the X-ray machine, regardless of the time of day or night that it is needed.

Residents of Westport have come to expect the availability of these services at short notice as the norm and don't appreciate that access to these services is much more difficult, even in metropolitan areas throughout New Zealand.

Residents of the Buller region have also come to expect that a wide range of visiting specialist outpatient clinics and some (mobile) surgical services are available to them in their own community, where as residents of similar sized communities elsewhere in New Zealand generally have to travel for these services.

One of the biggest threats to the future of Buller Health is the risk that community expectations might not be able to be met due to factors that are beyond their direct control (for example, due to rationing of funding or due to an inability to recruit or attract staff with the required health competencies – both factors affecting all other small communities in New Zealand) and that Buller Health will be blamed and criticised for this.

(Negative) Media Coverage

The Buller community is unique amongst small New Zealand communities in the fact that it continues to maintain its own local daily newspaper. This contributes to a strong sense of community identity, but has disadvantages when the media runs out of meaningful news stories and so looks to sensationalise the mundane goings on of public organisations in the region in order to try and sell newspapers.

This potential for sensationalism amplifies the risk that external changes affecting the ability to meet community health expectations (regardless of whether or not their continuation is in the best interests of the whole community) will be misinterpreted and blamed on local decisions.

Funding Stability

As mentioned above, the residents of Westport currently enjoy access to a number of health services that is (often) better than elsewhere in New Zealand.

This level of access is required due to Westport's geographic isolation from the nearest alternative service and is also related to the fact that there are minimum service requirements required in order to even have a service.

As a hypothetical example, you would need a radiation technologist and an X-ray machine even if you plan to only ever take one X-Ray. Having made the decision to get the machine and employ the technologist, it costs very little to take the next and subsequent X-rays and in fact, the staff member will need to take a certain number of X-rays each year in order to retain competency.

When operating at minimum service volumes, there is very little opportunity for financial rationing, short of exiting a whole service.

Ability to Recruit & Retain Specialist Staff

New Zealand currently has very low unemployment. There are worldwide shortages of nurses, doctors and skilled business leaders. Furthermore, safe minimum operating standards require that a certain number of each must be in place in order to operate a health service.

The success of the Buller Health concept depends on the ability to locate, employ and motivate a skilled leader, capable of motivating and managing Buller Health.

It also depends on the ability to attract and retain the right mixture of clinical staff, with the right mixture of health competencies.

As outlined above, one of the biggest threats to the successful implementation of Buller Health is the risk that community expectations might not be able to be met due to factors that are beyond their direct control such as due to an inability to recruit or attract staff with the required health competencies to provide the current mix of health services in Buller.

Further to this, one of the key drivers for the formation of Buller Health is a belief that health services can become more forward thinking and pre-emptive in their goal of servicing their communities' health needs.

Time delays in attracting new staff and an inability to retain staff with the required skill sets will create inertia, delaying change processes that are required if health in order adapt and respond to the populations changing health needs.

Ability to Predict and Meet Changing Community Needs

Health services need to predict and adapt to changing community needs as they occur. This includes changing population dynamics, responsiveness to different groups within the community and addressing health inequalities.

Buller Health will need a planning and prioritisation system that facilitates these as well as having a culture that is adaptable and willing to change to meet changing health demands, such as the aging population and the changing ethnic composition of the population.

Motivation and Reward Systems

One of the key strengths identified in our study was the motivation, commitment and loyalty of staff.

Motivation levels within health services in Buller are often diminished in times of increased work pressures by negative media commentary regarding health services in Buller and about the West Coast DHB in general.

There is a lack of intrinsic rewards within the organization and a lack of appreciation of the workloads and excessive hours / time employees are investing in the organisation.

Employees are commonly driven not only by extrinsic rewards, such as pay, but also by factors such as a “thank you”. This is obviously easier to achieve where staff report to managers located in the same town as them, as it is best achieved face to face and with a personal touch.

There is a strong sense of community in Westport and one of the potential advantages of the Buller Health concept is improved recognition and self esteem for staff, as health services become more co-ordinated and more responsive to community needs.

The West Coast DHB is currently reviewing its DHB wide performance management and reward systems. Improvements from this review should be implemented DHB wide, including Buller Health.

Leadership Structure

Different services within the Buller Hospital campus currently report to a myriad of different management positions within the West Coast DHB.

The Practice Manager for Buller Medical Services reports to the GM Primary Health, the Manager of Buller Hospital reports to the GM Operations, Allied Health services all report to different Heads of Department in Greymouth, some of whom report to the Operations Support Co-ordinator and some of whom report directly to the GM Operations. Community Nurses report to a Clinical Nurse Leader, who reports to the GM Primary Health. The Manager of Community Mental Health reports to the GM Mental Health while Trades staff report to the Facilities Manager in Greymouth.

With such a complex management structure, some staff are likely to be uncertain about who reports to whom. This could be a real issue if a staff member is acting in a clinically unsafe manner.

Some staff report that this issue is currently overcome by effective informal communication within the Buller site. This may be so, however, the physical / structural layout of premises does not allow for staff assimilation and communication or social involvement as long corridors separate services from one-another. Different groups of staff have different tearooms, creating pockets of internal communication, but also limiting opportunities for communication between services.

With such a complex management structure, and competing leadership input from different managers throughout the DHB, there is bound to be a disconnect between the strategies and initiatives implemented by different health services in Buller and in the allocation of workload and resources between competing health priorities. Resource allocation will be skewed by the differing professional preferences of different managers, leading to ineffective utilisation of staff and resources.

We want Buller Health to be strategically focused. We want health practitioners to be inspired by their work and we want Buller health to address health issues in an integrated and co-ordinated manner.

Diagram 1: Current Management Structure – Buller Medical Services & Community Nursing

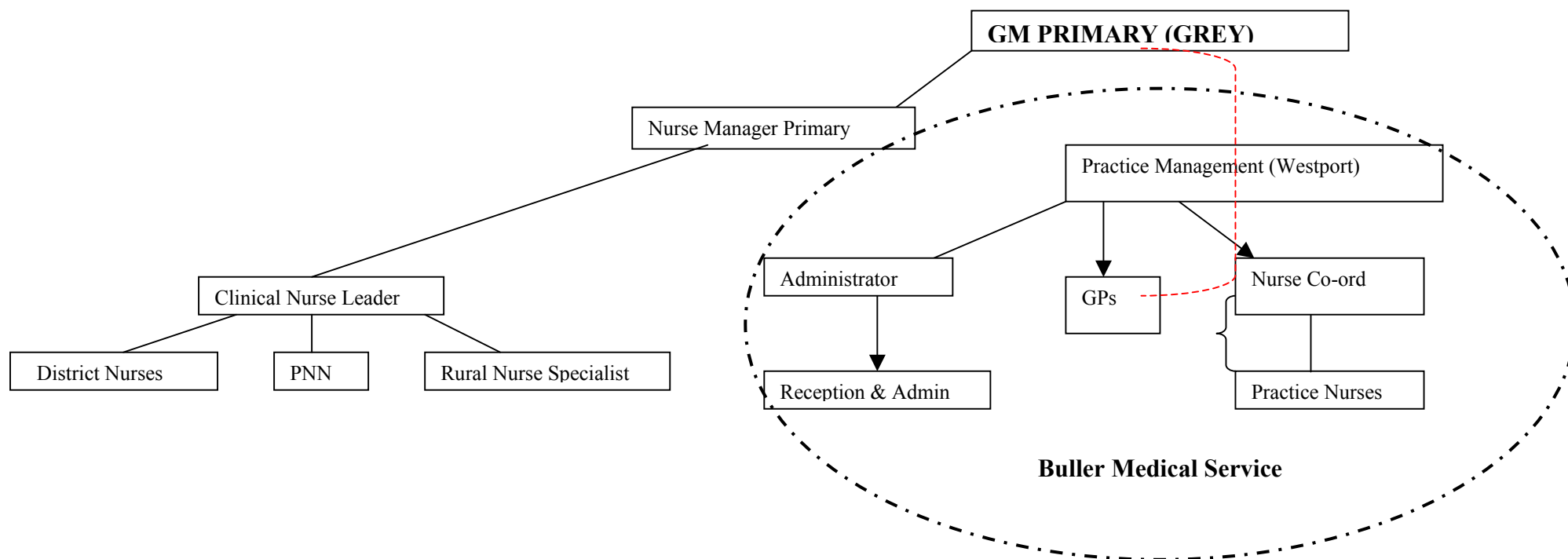
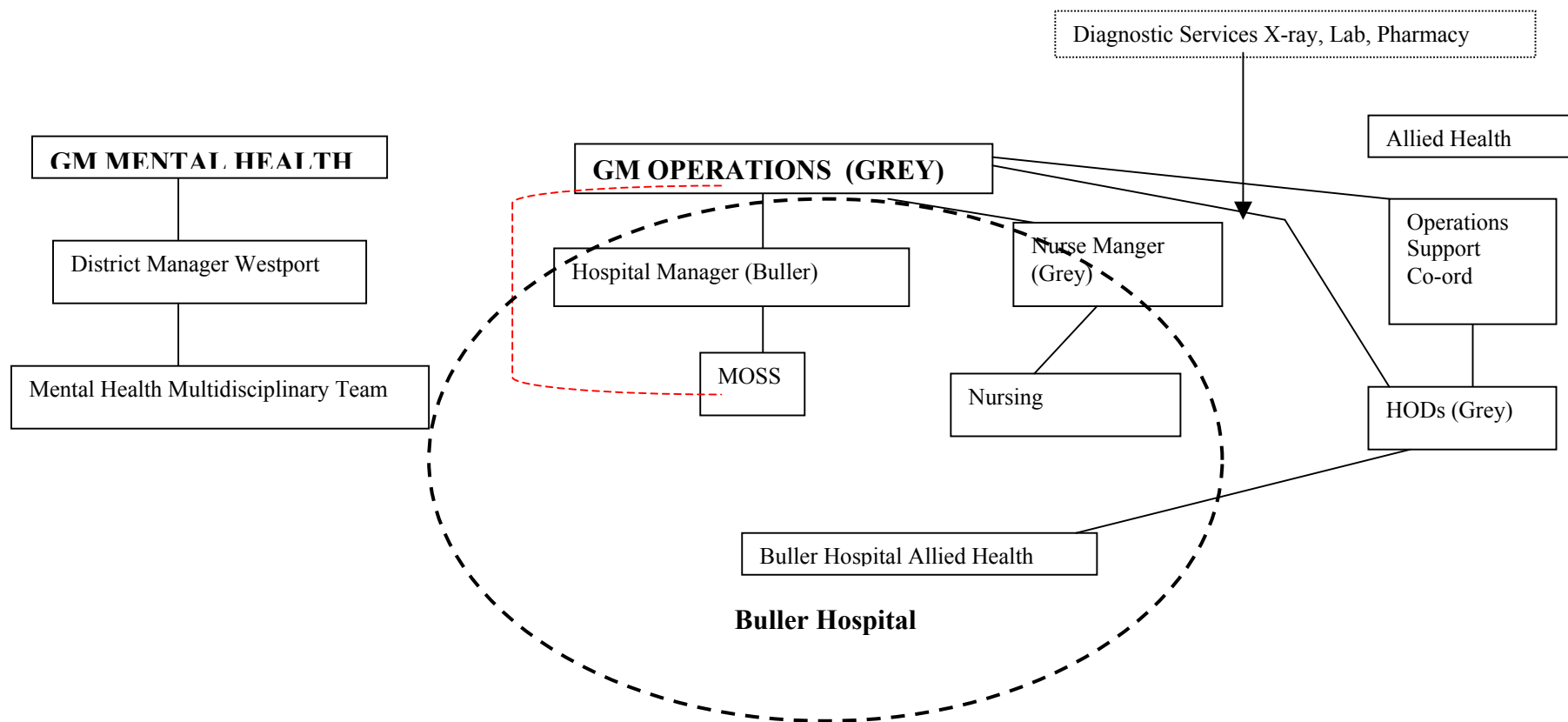


Diagram 2: Current Management Structure – Buller Hospital & Community Mental Health



Recommendations

The steering group unanimously supports the integration of health services in Buller into one unified management and leadership structure, Buller Health.

The challenge is to allow local autonomy under a unified / integrated model but at the same time ensure this doesn't lead to increased isolation of services in Buller.

Key recommendations include;

- The Buller Health business unit should have its own manager, who will be responsible for strategic planning, budget management and all operational matters relating to Buller Health, operating as a senior departmental manager within the West Coast DHB.
- Centralised business functions such as accounting, payroll, and human resources will continue to be provided centrally within the DHB.
- Buller Health will be a division within the West Coast DHB (much the same as community services or mental health services are currently a separate division within the West Coast DHB).
- The manager of Buller Health will report to the GM Primary Health.

Strategic

Buller Health needs to be holistic in its approach to health care provision, incorporating and co-ordinating the full range of health services that the West Coast DHB provides in the Buller region. Examples of how this concept could be applied include the concept of Whanau Ora (Ministry of Health Maori Health Strategy, He Korowai Oranga) and the West Coast DHB's Neighbourhood Nursing primary health innovation project, which encourages health services to work with families and communities as well as individuals.

One of the roles of Buller Health should be to develop a Health Plan for Buller. This will be a key strategic document, linking planning processes around service delivery, service structure and planned interventions to the communities current and anticipated health needs.

As outlined earlier in the report, it is intended that the Buller Health plan would have a 5-10 year time horizon and that it would be updated 3-yearly, linking into the West Coast DHB's 3-yearly District Strategic Plan.

As with the District Strategic Plan, the Buller Health Plan would be operationalised through the West Coast DHBs' District Annual Plan (DAP) and Statement of Intent (SOI) which sets annual operating objectives for the DHB. The DHB's regular performance management processes (the setting Key Performance Indicators, DAP and SOI performance reporting and the Statement of Service Performance (SSP) in the DHBs annual accounts) should be used to report and manage performance against the objectives in the Buller Health Plan.

The aim of the health plan is to provide a mechanism for proactive health intervention by identifying and responding to the communities changing demographics and health needs, in order to customise and co-ordinate responses both directly, in terms of the application of existing health resources and potentially indirectly, by measuring and potentially demonstrating the need for additional health resources in order to meet the unique health needs of the Buller community.

Leadership Structure

The key to improving the integration, co-ordination and responsiveness of health services in Buller is improved leadership capability and the simplification of what is currently a complex and ambiguous leadership structure.

Central to this is the creation of a new role, Manager of Buller Health, which will report to the GM Primary Health. Responsibilities will include;

- Overall management responsibility for health services in Buller.
- The development of a Health Plan for Buller, outlining the community's health needs, health priorities and strategies for meeting these. This will involve liaison with community groups (including Maori), public consultation, and working with the West Coast DHB Planning and Funding team in order to determine health needs and priorities.
- Maintaining relationships with the local community, including Maori.
- Achieving the services delivery targets and health outcomes targeted in the Buller Health Plan.
- The Practice Manager for Buller Medical service will report to the Manager of Buller Health.
- Who ever is responsible for the operational management of Buller Hospital (there seems to be some ambiguity between the roles of Manager of Buller Hospital and Clinical Nurse Leader – this needs to be sorted out with the establishment of Buller Health) will report to the Manager of Buller Health.

- A clinical governance group should be developed with lead clinicians informing the Manager of Buller Health on relevant clinical issues. Membership should include a senior nurse, a senior medical officer and lead Allied Health staff from within Buller Health.

Mental Health services within the West Coast DHB operate a complex multi-disciplinary service using a matrix structure that integrates mental health services across the West Coast. This structure has developed over time and has adapted to meet the unique needs of the West Coast's scattered population. Clinical processes and procedures, support structures and escalation routes need to be maintained in support of this structure and in recognition of the fact that clinical processes in mental health can differ from other health services. Community Mental Health Services in Buller should be incorporated into Buller Health, but will need to maintain strong structural linkages with other Mental Health Services on the West Coast.

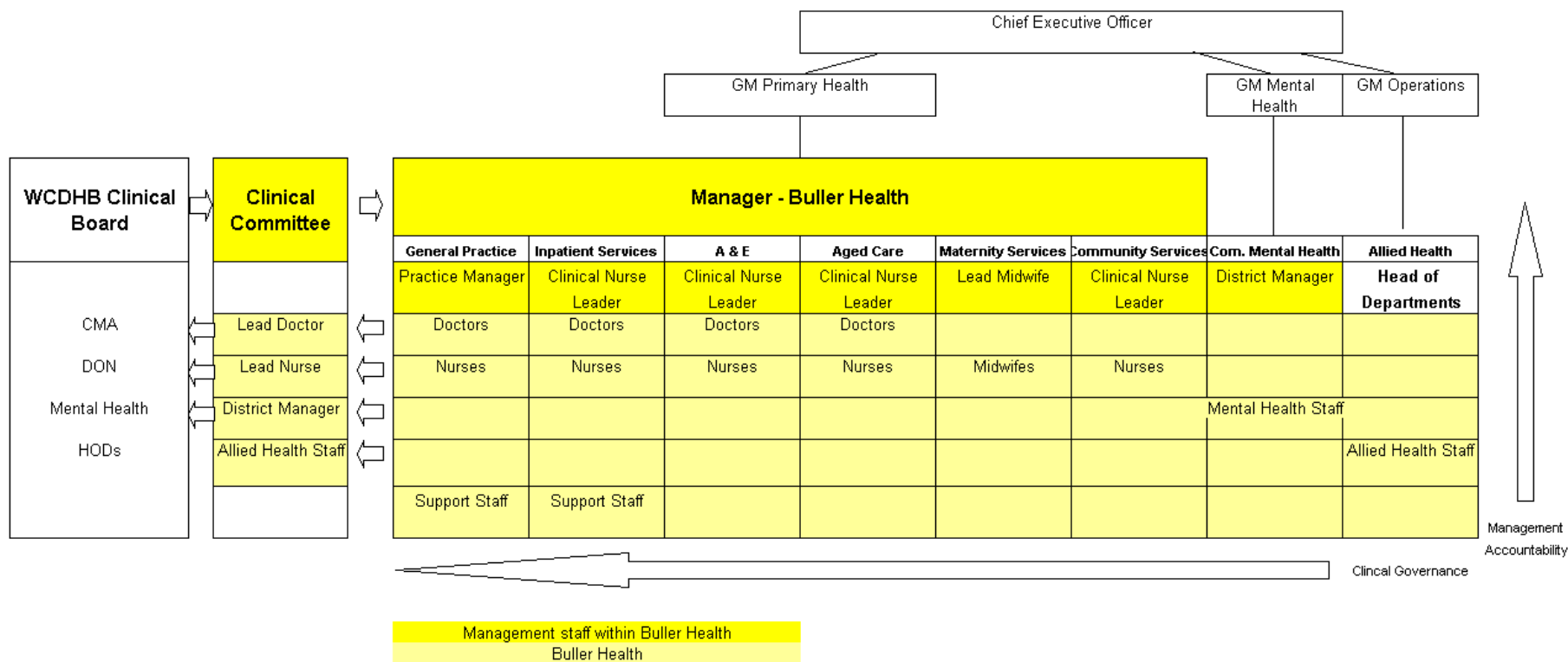
- The Manager of Community Mental Health Services should be a member of the Buller Health Management Team and the Buller Health Clinical Advisory Committee, in order to ensure that Community Mental Health services are fully integrated into Buller Health. For example, they will be responsible for the Mental Health component of the Buller Health Plan.
- However, there is a strong need to maintain existing structural and service linkages in order to ensure that services in Buller continue to benefit from the integrated, multidisciplinary West Coast wide service structure. The Manager of Community Mental Health Services should therefore continue to report to the General Manager – Mental Health.

Allied Health services should continue to report to their respective departmental colleagues in Greymouth, in order to maintain the current structure around “must keep” professional and collegial links that support small “sole practitioner” services in Buller.

- Heads of Department for allied health services (based on Greymouth) should continue to have budget holding responsibility for these services in Buller, with separate cost centres maintained for the Buller portion of their operations (as currently occurs).
- There will be a need to educate some Heads of Departments about the role and responsibilities of the Manager of Buller Health, so that they can operate in a constructive and collaborative manner regarding the funding and operations of Allied Health services in Buller.
- It is noted that Allied Health services have generally already achieved a degree of local autonomy in Buller due to orientation to the needs of internal customers (Buller Health) and due to their isolation from Greymouth.

- The Manager of Buller Health should meet regularly with this peer group (monthly) in order to discuss matters relating to health services in Buller.
- The Manager of Buller Health should consider the possibility of having a lead Allied Health staff member on the Buller Health management committee.

Diagram 3: Proposed Management Structure – Buller Health



The key changes are the implementation of a Manager of Buller Health and the establishment of a Clinical Committee.

Community Governance

The Buller Health Steering Group investigated several different governance options for Buller Health. Overall it was felt (most fervently by the Community representatives on the Buller Health Steering Group) that the Governance of Health Services is actually a DHB responsibility. The DHB has a well established governance structure and processes, which promote community participation (including Maori) within the Board and its advisory committees as well as through regulations requiring consultation on major planning documents and on any major service changes.

This finding is consistent with the Grafton Groups finding regarding different governance and ownership options, especially for hospital services in Buller.

That said, there is support for the establishment of a health consumer group for Buller Health, to act as a focus group for service improvement. Membership could include representatives from a range of community interest groups, such as Plunket, disability support organisations and local Maori.

Management Processes

Management processes within the West Coast DHB need to be revised, in order to facilitate increased autonomy of services.

The Manager of Buller Health should be delegated authority to undertake minor capital purchases (up to \$5,000 per item) without the need to seek approval from Management in Greymouth (a fixed budget of \$25,000 should be delegated for this¹).

- This same level of delegation should be made available to other senior managers within the West Coast DHB. (Currently items of capital expenditure are presented to the West Coast DHB's Executive Management Team for approval, regardless of their dollar value).

The West Coast DHB should continue to operate different cost centres for different services within Buller Health, so that the Manager of Buller Health can devolved Budget management responsibility to departmental managers within Buller Health.

- It is envisaged that GP services and hospitals services will continue to have separate line managers, who will report to the Manager of Buller Health.

¹ Equipment depreciation for Buller currently amounts to \$38,000 per annum. This total is mixed between high value and low value items. The suggested \$25,000 is in addition to any major capital items that are planned for Buller.

As mentioned earlier in the report, there would be clear advantages if health services in Buller could migrate to one shared patient administration system. Medtech32 is a sophisticated GP practice management tool, which is also used in some acute hospital settings. It is unclear whether or not it can deliver all of the reporting and data extract functionality required to meet the West Coast DHB's external reporting requirements for inpatient hospital services. (It is known that iSOFT does not meet New Zealand GP practice reporting requirements).

- The West Coast DHB should investigate whether or not Medtech32 could be used as a single patient information system for all of Buller Health.

One key concern raised regarding the formation of Buller Health was that there might no longer be an imperative for Grey Base Hospital to provide visiting outpatient clinics in Westport as it may not have the budget or influence required to buy services from Grey Base Hospital. (This concern points to the 'silo' issue noted earlier in this report).

- The West Coast DHB's Funder Arm should buy visiting outpatient clinics for Buller off the West Coast DHB provider arm. By specifying a set number of clinics for Buller when purchasing services, the Funder Arm can moderate any arguments about the relative priorities between clinics in Greymouth and Clinics in Westport, linking strategic influence with an understanding of DHB wide prioritisation requirements.

Financial Considerations

Buller Health needs to be properly resourced and incentives need to reward the improved effectiveness and efficiency that it aims to generate.

A budget needs to be established for the establishment of Buller Health. We suggest a budget of \$10,000 for communication, community consultation, advertising and sign writing. (Re-branding and marketing).

The manager of Buller Health needs to be adequately remunerated and the two clinical advisor roles may also need to be remunerated.

These are new costs to the DHB and will need to be offset by improved efficiency, both elsewhere within the organisation and within Buller Health.

There will be compensating improvements in efficiency and effectiveness in Buller as a result of the improved integration and co-ordination of health services, however these are 'soft' savings as they are likely to be reinvested into service and process improvements rather than directly realised as a financial saving to the DHB.

The proposed changes to delegated expenditure and financial reporting processes will not change the DHBs overall budget, only the way that expenditure is authorised.

Staff Induction and Socialisation

With a wide range of relatively small and isolated services, health professionals in Buller rely on one-another for back up and support, as well as relying on distant services such as those based in Greymouth and Christchurch for clinical advice.

- There needs to be a Buller specific orientation process for all clinical staff, which needs to focus on how and where to get clinical advice and collegial support .
- The induction process needs to go beyond teaching new staff about processes and procedures, to introduce them into the informal social network within Buller Health.

Whilst this informal social network has been heralded as a strength of services on the Buller campus, it is important to note that the current facilities in Buller do not readily encourage social interaction between services, with long corridors separating different services from one another and with each service having its own staff lounge and cafeteria areas.

Some thought also needs to be given to the idea of re-organising cafeteria and coffee break arrangements so that staff from different services within Buller Health socialise with one-another. Social sporting events, quiz nights and a staff social club may also improve informal communication systems and support structures within Buller Health.

There also needs to be a process for teaching staff about the health needs of the Buller population, how they are expected to change over time, understand where inequalities exist and what can be done to redress them and understand how Buller Health is planning to respond to them. (i.e.: The Buller Health Plan).

This process should include a re-orientation process for existing staff in Buller.

Clinical Governance

A clinical advisory committee should be established in Buller, consisting of two new clinical advisors (nursing and medical) as well as the manager of community mental health services, a lead community nurse and allied health staff in Buller. This advisory group should meet monthly to discuss issues relating to clinical practice, the allocation of workload between services in Buller and any operational issues affecting clinical practice.

The lead medical and lead nursing clinician roles are new to Buller Health and should be selected as clinical advisors to the Manager of Buller Health.

It is envisaged that these positions will be selected from staff members within the Buller health business unit and that one day a week of their time will be committed to clinical governance activities and therefore unavailable for normal clinical and non-clinical workload. There may also be a need to remunerate them for this responsibility.

Responsibilities include;

- Provide support and advice to the Manager of Buller Health on matters affecting clinical practice.
- Review processes and procedures so as to standardise them across Buller Health and to synchronise processes and procedures in Buller with those elsewhere in the DHB.
- Promote continuing education opportunities for clinicians in Buller. This will include getting clinicians from elsewhere with the DHB (and some external speakers) to give presentations and training sessions in Buller, as well as promoting opportunities for staff to attend training elsewhere within the DHB and external training opportunities.
- To oversee clinical credentialing and accreditation processes in Buller and (where appropriate) to participate in them.
- To provide a liaison between primary health services (Buller Health) and secondary health services (Greymouth Hospital) by reviewing referral and discharge systems, being represented on the West Coast DHB clinical board and participating in DHB wide quality and system improvement initiatives.
- To liaise with other clinical governance structures within the WCDHB on clinical governance matters affecting Buller Health. It is intended (for example) that the lead medical clinician would liaise with the Chief Medical Advisor, the lead nursing clinician would liaise with the Director of Nursing, the Manager of Community Mental Health Services would liaise with Mental Health services in Greymouth, and so on, regarding clinical governance matters.
- To promote the adoption of evidence based clinical best practice throughout Buller Health (for example, baby friendly hospital and Te Kanga recommended best practice).
- To conduct a re-orientation of existing staff to keep them up to date with the latest ideas and practices in rural health, promoting excellence in evidence based clinical practice.
- With the growing proportion of Maori in the community there will be a need to tailor existing services to suit customary models, such as the Whare Tapa Wha model of holistic health care. (The whare tapa wha model of health (Durie1994) comprises four cornerstones that are the integration of Wairua (spiritual essence) Hinengaro (emotions) Tinana (body) and whanau (family) acknowledging that all affect the other and that balance is required. It requires an interconnectedness and balance to achieve and maintain health.

Clinical Processes and Procedures

As noted earlier in the report, different parts of Buller Health currently have different processes and procedures.

Processes and procedures need to be standardised across Buller Health (and the rest of WCDHB) so that staff and patients can move between different services as seamlessly as possible. They also need to be based on evidence based clinical best practice.

This will also simplify and standardise credentialing and accreditation processes.

Standardising policies, procedures and practice across services will take time. The clinical advisory committee (and in particular the lead medical and lead nurse roles) will lead this process.

Community Recognition

Health services in Westport should be re-branded as “Buller Health”, so that Buller Medical, Buller Hospital, various Allied Health services, Community Services and Community Mental Health services are all seen to be the one entity.

Sign writing, letterheads, etc should be updated accordingly. A public relations campaign could also be conducted, introducing the change.

This is also an opportunity to improve signage on the Buller campus and to re-decorate, so as to make services more welcoming and culturally appropriate. (Strategically placed artwork for example, including Maori art, Maori language on signage).

Buller Health needs to be marketed as an integrated and co-ordinated health service, working to pro-actively meet the health needs of the Buller community.

The creation of a Buller Health consumer focus group will give a mechanism for feedback about the success of this re-branding exercise, as well as a forum for recommending service and quality improvements).

Opportunities for the promotion of the Buller Health brand include, running health promotion events (eg a men’s health and a woman’s health night), the distribution of health promotion fliers, advertising for the recruitment of staff, as well as signage on buildings and facilities.

Implementation Plan

A two phased implementation plan is proposed for the formation of Buller Health.

Phase one involves appointing the Manager of Buller Health.

Initial implementation activities will include;

- The development of the first ever Health Plan for Buller.
- Re-branding of health services in Buller into the Buller Health brand.
- Customise and streamline processes and procedures across health services in Buller.
- A site Master Planning exercise for the Buller Hospital site, including an investigation of options for the re-configuration or re-construction of health facilities into a more efficient facility that is “right-sized” for current and future levels of health services. Note that there is no intention to reduce the level of services delivered in Buller through this process.
- Motivate and inspire staff within Buller Health.

Phase two involves bedding down the systems and procedures developed in phase one, ideally inheriting an updated and reconfigured facility that has been right sized for the Buller community’s health needs.

The role and scope of Buller Health will be well defined by this stage and Buller health will be firmly established as the provider health services to the Buller community.

Management of Change

The West Coast DHB has policies and procedures in place for the management of changes which may affect the employment of individuals within the DHB.

Before implementing the changes recommended in this report, the West Coast DHB will engage in a consultation process with unions and staff representatives in order to work through the implications of the recommendations in this report for individual employees.

From an employment relations perspective, most of the changes recommended in this report are minor in nature, involving changes in reporting lines but not affecting job functions.

If possible, the DHB will fine tune the way in which the recommendations are implemented so as to minimise any negative impacts on staff. However, it is possible that some employees may be affected by the proposed changes.

Implementation Timeline

October 2005	Buller Health Report finalised and released to the CEO and EMT
November 2005	Report recommendations accepted - Management of Change process is initiated. - Recruitment begins for a Manager of Buller Health. Re-branding project is initiated. Clinical advisors (lead clinicians) appointed. Clinical advisory committee starts meeting.
January 2006	Manager of Buller Health Appointed.

Appendix 1 Buller Health Steering Group - Terms of Reference

West Coast District Health Board

Project Title:

“Buller Health”
Establishment of Business Unit

TERMS OF REFERENCE

Background:	West Coast District Health Board is proposing to establish “Buller Health” as a Business Unit within the WCDHB Buller Health would include Buller Medical Services, Buller Hospital, Mental Health Services and other Community Services
Sponsor:	Wayne Champion, Chief Financial Manager
Stakeholders:	WCDHB, WCPHO, Buller GPs, Nursing Staff, Allied Health Workers, Community of Westport and Ngakawau
Objective:	To establish Buller Health as a Stand Alone Business Unit by December 2005
Project Steering Group:	Chief Financial Manager, WCDHB General Manager Operations, WCDHB General Manager Primary Services, WCDHB Lead GP representative, WCDHB Lead Hospital representative, WCDHB Lead Mental Health representative, WCDHB Lead Community Health representative, WCDHB Maori Health representative, WCDHB Community representative Other practice representative
Process: May 6th May 20th July 31st	WCDHB acknowledgement Project Steering Group Work plan developed – reference to scope of work
Scope of Work:	<ul style="list-style-type: none"> ▪ Investigation of governance structure ▪ Establishment of vision for Buller Health ▪ Development of models of care ▪ Structure and processes developed ▪ Development and emphasis on teamwork, defining roles

	<ul style="list-style-type: none"> ▪ Recognition of Te Tiriti and Waitangi ▪ Maori Health Plan developed, cultural competence training ▪ Development of performance indicators that reflect the vision of Buller Health ▪ Establishment of ongoing planning process for Buller Health with involvement of staff and community ▪ Identification of policies that should be developed or reviewed. These to include: <ul style="list-style-type: none"> - Recruitment and retention of general practitioners - Orientation - all staff, education - all staff - Linkages with community key groups, Mental Health ▪ Recommendations to Executive Management Team, WCDHB ▪ Throughout emphasis on <ul style="list-style-type: none"> ┌ patient satisfaction ├ job satisfaction for staff └ community involvement
Reference:	<p>Grafton Report, "Improving Care" a report for improving the performance and functionality of Buller Medical Services. A report by Ruth Vause, Jim Vause, Waverney Grennell. (Summary Board agenda 6 May). Consultation process with Primary Care March & April 2005. District Strategic Plan and Annual Plan WCDHB</p>
Outcome:	<p>An efficient and patient focused model of services is in place and that the service is positioned to meet the needs of staff and the population in implementing the Primary Health Strategy</p>

Appendix 2 Buller Health Project – Initial Instructions

(Initial) Objective

- To make recommendations to the West Coast District Health Board regarding the proposed Buller Health concept - The establishment of one combined health service for Buller, including Buller Medical Services, Buller Hospital and Community and Mental Health Services, within the West Coast DHB.

Deadline

- End of July 2005.

Buller Health Project – (some) Potential Benefits

- Improved integration of health services in Buller.
- Implementation of a strategic vision for health services in Buller.
- Introduction of ongoing strategic planning processes in place for health services in Buller.
- Improved representation for Buller Health Services in DHB decision making (one unified voice rather than two voices with competing priorities).
- Streamlining of management processes.
- May identify other options for improving health services in Buller.
- Learning may be transferable to other DHB owned facilities or to other DHBs.

Buller Health Project – Key Risks

- Risk of political interference by DHB Board, Council, or Government (given that it is an election year) while project is being undertaken.
- Confusion with or duplication of the Grafton and Vause processes.
- The need to follow a proper process.

Buller Health - Key Risks

- Risk of clinical isolation for specialised staff, who rely on professional and collegial support from Greymouth and from other West Coast DHB sites.
- Buller Health will still need to compete for (limited) DHB resources.

Final Recommendations May Involve

- Changes to WCDHB structure so that Buller Health operates as one combined Business Unit reporting through to one executive manager.
- Changes to management processes including financial reporting systems and policies and procedures.
- Changes to models of care and operating processes.
- Changes to the governance structure for health services in Buller.

Items specifically excluded from the Scope of this Project

- Ownership structure of Buller Health.

- Changes to the quantity or range of health services that are provided in Buller.

Buller Health – Project Principles

Project Structure

The Chief Executive Officer of the West Coast DHB has appointed Wayne Champion (Chief Financial Manager of the DHB) as project sponsor for this project.

A multi-disciplinary steering group has been established in order to progress this project. The project team includes two community representatives, one selected by the Buller District Council and one selected by the West Coast DHB.

Additional advice may be sought from other sources.

Confidentiality

Unless specifically agreed, all project discussions are confidential to the project steering group, until published in the final report with recommendations for consideration by the West Coast District Health Board.

The project needs to maintain a safe environment, so that project participants can contribute to debates, without fear of reprisal.

Principles

It is intended that the steering group will agree most items by consensus through logical debate and discussion.

Where consensus is not achievable, a majority vote may be held, at the discretion of the project sponsor.

Representation

The project sponsor will be the spokesperson for the project.

Buller Health – Project Priorities

- Complete work plan in a timely but complete manner.
- Maintain confidentiality, so that project participants can speak freely during project meetings.
- Maintain a climate that is conducive to change, should the project recommend it.

Buller Health – Project Work Plan

Vision and Mission for Buller Health

Internal Analysis

- What currently works well, what doesn't? (Strengths and Weaknesses, possibly for each of Buller Medical, Buller Hospital, various Allied Health services, Community Services and Community Mental Health).

Environmental Scanning

- What are the external factors that affect Health Services in Buller and how? (Opportunities and Threats of SWOT analysis possibly for each of Buller Medical, Buller Hospital, various Allied Health services, Community Services and Community Mental Health).
- PESTE (Political, Environmental, Societal, Technological and Economic) factors affecting Buller Health – what might the future look like?.

Options Analysis

- What do we need to change in order to adapt for the future, what different options are available?
- What are the potential implications of changing? Do the options improve on the status quo?
- How do the options impact on the SWOT of Buller Health?
- What are the financial implications of the options being considered?
- What is the preferred option(s) and why?
- Are there scenarios where a different option(s) would be preferable.

Write Report

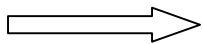
- Document logic and recommendations.

Review Report and Recommendations – Can we improve it.

Appendix 3 Roles - Manager of Buller Health

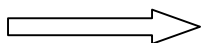
Position Description

Manager of Buller Health

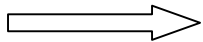


Strategic Planning the “Buller Health” Plan
Skills, vision, passion, communicator, listener
Possible issue – takes time to learn about Health

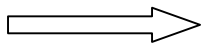
Quality



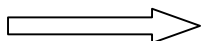
Developing and enhancing relationships



Represent Buller Health
For External & Internal Stakeholders



People Manager rather the Process Manager



Managing Diversity (of range of services)

Implementation

Consultation - Feedback loop

Write “Buller Health Plan”

Create Manager of Buller Health role

Establish Clinical Advisor Roles and Clinical Advisor “Team”

Links with the DHB

Consumer Reference Group

Communication Strategy for Implementation

Change Agent for Initial
Appointment

Appendix 4 Overview of the Grafton Report

The Grafton Group was contracted by Buller District Council, to review options for primary care in Westport and Reefton. The West Coast DHB offered financial support for the Grafton process and the scope of the project was extended to cover all health services in the Buller.

The process involved consultations with staff from both primary and secondary services, District Council and DHB management, and the community by way of a community steering group. All of these four sectors were consulted over the geographical area of the Buller District Council, Karamea, Westport / Northern Buller and Reefton sites and communities.

Periodically the process produced reports for consideration and analysis framing the development of the final report. These reports included a Situational Analysis, Recruitment and Retention and, Community health ownership models.

The final report proposed a matrix of four options for Reefton, Westport and Karamea, encompassing primary and secondary care. This final draft was then released as the Models of Care document for consultation and framing the final report and recommendations.

Reaction to the models of care draft was mixed with different communities reacting in different ways. In Reefton a community meeting resulted in an action group, which chose to deal directly with the DHB over previously unresolved issues and those contained in the report. While in Westport a mix of sessions lead by steering group members and a community meeting provided community feedback. The Karamea community chose the status quo as during the period of the project they had recruited a GP and wished to consolidate his presence.

The final report generally recommended that all services be retained but aligned better for improved integration, take advantage of changes in physical proximity, and implied improved communication and co-ordination. While some of the options indicated exit of services on the part of the DHB, this was primarily in ownership rather than that of service delivery. Some services were recommended to be enhanced.

The Final Report was tabled at the Buller District Council meeting on the 8th of December 2004. Reaction at that meeting was not overly supportive of the report itself, however the report was passed to the West Coast DHB Board for their consideration, which has occurred in the first quarter of 2005. A consultation round being aligned with the DHB strategic plan consultations occurred in the 2nd quarter of 2005.

The matrix over leaf shows the four options for each site and the service mix proposed for each option.

	Status Quo	8 Beds + Maternity (New)	8 Beds + Maternity (Reconfig)	4 Beds + Maternity (New)
GP Services	<ul style="list-style-type: none"> BMS practice 	<ul style="list-style-type: none"> BMS practice 	<ul style="list-style-type: none"> BMS practice 	<ul style="list-style-type: none"> BMS practice
Inpatient Services	<ul style="list-style-type: none"> 8 medical inpatient beds 1 palliative care bed Medical cover provided by MOSS/GPs 	<ul style="list-style-type: none"> 8 medical inpatient beds – incl. palliative Medical cover provided by MOSS/GPs 	<ul style="list-style-type: none"> 8 medical inpatient beds – incl. palliative Medical cover provided by MOSS/GPs 	<ul style="list-style-type: none"> 4 medical inpatient beds – incl. palliative Medical Cover provided by Moss/GPs
Aged Care	<ul style="list-style-type: none"> 17 continuing care beds in Buller Hospital 27 rest home beds in Kynnersley Rest Home 	<ul style="list-style-type: none"> 23 continuing care beds – private provider 27 rest home beds – private provider 	<ul style="list-style-type: none"> 23 continuing care beds – private provider 27 rest home beds – private provider 	<ul style="list-style-type: none"> 23 continuing care beds – private provider 27 rest home beds – private provider
Maternity Services	<ul style="list-style-type: none"> 4 maternity beds LMC midwives (2.0 FTE) Core midwives (1.2 FTE) 	<ul style="list-style-type: none"> 2 Maternity beds LMC midwives (1.6 FTE) Core midwives (1.0 FTE) 	<ul style="list-style-type: none"> 2 Maternity beds LMC midwives (1.6 FTE) Core midwives (1.0 FTE) 	<ul style="list-style-type: none"> 2 Maternity beds LMC midwives (1.6 FTE) Core midwives (1.0 FTE)
Community Nursing Services	<ul style="list-style-type: none"> District Nursing Public Health Diabetes Educator 	<ul style="list-style-type: none"> As per current levels Creation of generalist nursing roles as per Neighbourhood Nursing 	<ul style="list-style-type: none"> As per current levels Creation of generalist nursing roles as per Neighbourhood Nursing 	<ul style="list-style-type: none"> As per current levels Creation of generalist nursing roles as per Neighbourhood Nursing
Emergency Services	<ul style="list-style-type: none"> St John – mix of paid/volunteer staff Trauma stabilisation Level II A&M 	<ul style="list-style-type: none"> St John – current configuration Trauma stabilisation Level II A&M – instigate patient charges for triage levels 4 and 5 	<ul style="list-style-type: none"> St John – current configuration Trauma stabilisation Level II A&M – instigate patient changes for triage levels 4 and 5 	<ul style="list-style-type: none"> St John – current configuration Trauma stabilisation Level II A&M – instigate patient changes for triage levels 4 and 5
Outpatient Clinics	<ul style="list-style-type: none"> Orthopaedic Anaesthetics Audiology Diabetes General Medicine General Surgery Gynaecology 	<ul style="list-style-type: none"> Retain current range Investigate expansion of private clinics 	<ul style="list-style-type: none"> Retain current range Investigate expansion of private clinics 	<ul style="list-style-type: none"> Retain current range Investigate expansion of private clinics

	<ul style="list-style-type: none"> Nutritional Services Obstetrics 			
Outpatient Clinics (cont.)	<ul style="list-style-type: none"> Ophthalmology Paediatric Medical Podiatry 			
Allied Health	<ul style="list-style-type: none"> Radiology - Plain Film OT Physio Social Work Field Worker/Needs Assessment 	<ul style="list-style-type: none"> Teleradiology (digital) Other Allied Health services at current levels 	<ul style="list-style-type: none"> Teleradiology (digital) Other Allied Health services at current levels 	<ul style="list-style-type: none"> Teleradiology (digital) Other Allied Health services at current levels
Mental Health	<ul style="list-style-type: none"> Community Mental Health Alcohol & Drug Child, Adolescent and Family Service 	<ul style="list-style-type: none"> Same as current 	<ul style="list-style-type: none"> Same as current 	<ul style="list-style-type: none"> Same as current
Other Services	<ul style="list-style-type: none"> Domestic Assistance/Personal Care Meals on Wheels Surgical Bus 	<ul style="list-style-type: none"> Domestic Assistance/Personal Care – current levels Meals on Wheels Surgical Bus 	<ul style="list-style-type: none"> Domestic Assistance/Personal Care – current levels Meals on Wheels Surgical Bus 	<ul style="list-style-type: none"> Domestic Assistance/Personal Care – current levels Meals on Wheels Surgical Bus
Facility	<ul style="list-style-type: none"> Buller Hospital Internal Kitchen 	<ul style="list-style-type: none"> Closure of Buller Hospital Greenfield's development of an Integrated facility incorporating primary and secondary care Collocation of BMS, dentist, private physio, pharmacy and St John No kitchen – meals outsourced 	<ul style="list-style-type: none"> Reconfiguration of current hospital buildings, integrating primary (GPs) and secondary care Possible collocation of dentist, private physio, pharmacy and St John Meals may be outsourced 	<ul style="list-style-type: none"> Closure of Buller Hospital Greenfield's development of an integrated facility incorporating primary and secondary care Collocation of BMS, dentist, private physio and St John No kitchen – meals outsourced

