FRANCIS GROUP

Liberating Opportunity: Health Board Collaboration for Better Health and Disability Outcomes

28 May 2009

Contents

1. Executive Summary

In April 2009, Francis Group was retained by West Coast District Health Board (WCDHB) to conduct an investigation into a potential shared services/clinical collaboration model between it and the Nelson-Marlborough District Health Board (NMDHB).

To ensure there is no confusion about the terminology, throughout this report, we will refer to Shared Services in relation to corporate, non-clinical functions. Alignment of clinical functions will be called Clinical Collaboration. When we refer to a DHB as an organisation, we will refer to it as a DHB. The governance of the organisation will be referred to as the Board.

The drivers for this investigation were the need to create efficiencies in non-clinical services, and a combination of efficiencies and better community health outcomes through the provision of clinical collaboration.

In undertaking the review, we have conducted a number of interviews with clinical and non-clinical staff, Board Chairs and members of both Boards. In addition, interviews were conducted with Canterbury District Health Board (CDHB) and Capital & Coast District Health Board (C&CDHB), with whom the two DHBs have existing collaborations (WCDHB/CDHB, and NMDHB/C&CDHB and CDHB).

Support for closer clinical collaboration and sharing of services between the two DHBs is mixed. There has been a real willingness to explore the potential at all levels, and benefits and risks have been identified. However, the compelling case that both Boards have asked for is not able to be made.

All the parties we have spoken to have identified the value of existing clinical networks. As a consequence, our work has focused on the barriers these networks face in addressing the viability and sustainability questions and the extent to which a different management structure or shared service arrangement might impact on these barriers.

There are certainly some benefits to be gained through shared services: more critical mass, the opportunity for better utilisation of resources, more clinical safety and quality, some marginal cost savings. However, critical mass, while improved by the combination of the two populations, is not really achieved, with the combined populations not exceeding 170, 000 people.

Each DHB has a larger, neighbouring DHB, and collaborative relationships exist already between each DHB and its larger neighbour. In the case of NMDHB, it has collaborative arrangements with both CDHB and C&CDHB. In conducting this review, we felt it was important to consider the options in this wider context, and interviews with WCDHB representatives in particular, reinforced the depth of collaborative activity at the clinical level. In addition there are shared services models at the non-clinical level as well, so it was important to discuss any potential alignment of WCDHB and NMDHB with representatives of CDHB.

In discussion with CDHB, we have identified a very strong commitment to further enhancing the very wide range of existing clinical collaborations which already exist between it and WCDHB. The CDHB has proposed a series of pilots which would involve the design of entirely new models of care, and would enable services to be maintained to the West Coast at a very high level of safety and quality, and would be based on patient-centric principles of treatment as close as possible to the patient's home.

If these pilots were to be successful, and it is CDHB's view that they could be set up in a relatively short period of time, then they would provide a model for further collaborations across a growing range of services.

The impact of this suggestion on the original proposal is mixed. It does not preclude WCDHB and NMDHB from continuing to pursue collaborative opportunities; indeed it may provide a blueprint for the two DHBs to find ways to share services without being hampered by the barriers of geography and distance. It may even lead to some very successful three-way collaborations, which address the needs of both DHBs in an innovative manner.

The case for an alignment of management functions between WCDHB and NMDHB is not clear-cut. Efficiencies would be marginal at best, and there would be some significant locational issues to be overcome. There is an argument that the two DHBs together could increase their critical mass to a point where they bring more strength to any further collaborative negotiations, but the increase in critical mass is not sufficiently large to warrant the disruption that a functional alignment of non-clinical functions would cause and, at a clinical level, the critical mass could be achieved in a different way, on a service by service basis, where demonstrable benefit could be achieved. We have concluded that management alignment will not, in and of itself, provide a solution but may be an outcome of the closer clinical collaboration that will address the underlying issues. Management commitment and support are required, however, to assist a combined clinical solution to succeed.

Accordingly, we are recommending that the DHBs consider a different approach to solving their sustainability and viability issues, an approach that would see collaborations happening where they are most likely to deliver benefit to the community and manage risk, and would involve re-thinking models of care in innovative and potentially very exciting ways.

This approach could provide a blueprint for future development of health services within the country, at a time when resources continue to be constrained, and an innovative approach is highly desirable.

The alignment of management is not precluded by this approach, but it does not form part of our recommendations. In the event that the DHBs wished to pursue such an alignment, they could do so and continue to pursue the approach outlined above.

2. Introduction

The West Coast District Health Board (WCDHB) retained Francis Group Consultants Ltd (FGC) to investigate the opportunities for collaboration between WCDHB and Nelson Marlborough District Health Board (NMDHB). This investigation was driven in part by the desire to achieve operational efficiencies, but more importantly to address issues of clinical viability of service provision, risk management and more sustainable quality outcomes for patients within its region. Francis Group was also asked to consider potential synergies with the Canterbury District Health Board (CDHB).

We outline here some of the contextual features which have influenced our investigation, and which inform the conclusions we have reached.

2.1 The Economy

In light of the challenges facing the New Zealand economy during the global recession which is occurring currently, the Government is facing increasing pressure through the impact on central funding. There is significant competition for resources, and the Government is committed to gaining efficiencies in organisational expenditure, in order to deliver better services to the community. The Health Sector is a major spender of government funds, and continues to face pressure in delivering quality health outcomes with stretched resources.

In addition, there is a shortage of many of the specialist skills required within the health sector. Many District Health Boards (DHBs) struggle to provide adequate resource to ensure safety and quality care for their population. This creates unacceptable levels of risk in some cases. In remote areas, this shortage can be even more acute, and DHBs need to think laterally about the ways they can provide the services required.

2.2 Shared Services and Clinical Collaboration in New Zealand

New Zealand has a somewhat patchy record in provision of shared services within the Health sector. There are collaborative relationships in existence (Otago-Southland, Bay of Plenty), and some shared services activities though independent agencies (SISSAL), and combined approaches (Health Alliance), but pooling of resources and rationalisation are not widespread. Some attempts to share services have failed (for example, the collapse of the Taranaki/Capital & Coast IT services).

The state of the economy, and the policy settings of the Government provide an opportunity to look at forms of collaboration within the sector, and we were asked to see if the WCDHB/NMDHB relationship has the potential to unlock value and opportunity through close collaboration.

2.3 South Island Clinical Services Planning

The drivers behind initiatives currently underway in the South Island (South Island Health Services Planning, the Sustainability Project) are as follows:

- Quality of care and safety of patients
- Clinical viability and sustainability
- Better utilisation of resources

The proposed collaboration between WCDHB and NMDHB needs to be set within the context of these wider strategic considerations, so that future developments and opportunities can be part of the long-term strategy for both DHBs.

A description of the Sustainability Project is attached at Appendix V.

3. Process and Methodology of Review

The review has been conducted over a four-week period, utilising three senior consultants from Francis Group: Stuart Francis, Managing Director; Dr Paddy Austin, Principal; and Trevor Read, Principal. Some background on these three consultants is included in Appendix III.

The brief for the review was to identify whether there was a compelling case for alignment of the two DHBs in a shared services/collaborative model.

Initial interviews were conducted with the Chairs of both Boards, followed by a series of interviews and workshops with a range of people. Each senior management team has been involved in two workshops to examine the current state, existing collaborations, opportunities for further collaboration, benefits, and risks. In addition, discussions have been held with senior doctors, nurses, community nurses, and Board members from both DHBs. A list of all participants in interviews and workshops is appended at Appendix I.

In recognition of pre-existing relationships and the need for ongoing cooperation, we have also interviewed representatives of Canterbury District Health Board (CDHB) and Capital & Coast Health (C&CDHB).

As the discussions and workshops have progressed, we have progressively refined our analysis of potential benefits, risks, and future collaborative models, as we consider a WCDHB/NMDHB model.

See Appendix I for a list of the people interviewed.

4. WCDHB and NMDHB: Current State

4.1 WCDHB

The West Coast District Health Board serves a population of approximately 32,000 people. This population is geographically very widely spread, with sparse populations in many areas. Travel and accessibility are significant issues for service delivery under current delivery models.

The DHB is projecting a $7.8m deficit for the 2009 financial year. There are a number of factors contributing to this result, including the cost of operating infrastructure, and the cost of locum provision within the region. The medium to long term financial viability of this DHB is under threat.

Recruitment and retention of clinical staff across the range of disciplines is challenging, particularly where people have to be recruited into the region. Many of the medical staff are close to retirement. The requirement for on-call cover and specialist services cover means there are staff who are under-utilised and this places pressure on budgets. While providing excellent services, without innovative approaches, the DHB is unsustainable clinically in the medium to long term.

The DHB has a particular strength in models of care around the primary/secondary interface, and in rural health. The DHB owns most of the primary practitioners, and has developed a very strong working relationship between primary and secondary practice. Many practitioners have a generalist experience, which is vital for good provision of care in this rural community.

It is fair to say that, for WCDHB, doing nothing is not an option, because it is facing significant and increasing difficulties in maintaining financial viability and clinical sustainability.

4.2 NMDHB

The Nelson-Marlborough District Health Board serves a population of 130,000, in a mixture of urban and rural environments. Some parts of the region feature similarly sparse populations to those on the West Coast.

While this Board is not under the same degree of pressure as WCDHB, there are some similarities between the two. Whilst the average age of Nelson Marlborough's medical workforce is somewhat younger than the West Coast's (42.9 vs. 51.6 years), all provincial hospitals will experience increasing difficulty in attracting and retaining clinical staff. There are also similarities in some areas of geographical isolation, the provision of on-call and specialist cover, and a worsening financial situation, which mean that longer-term sustainability and viability are an issue for this Board as well.

Areas in Marlborough, Murchison and Golden Bay provide a sound knowledge of rural health, and there are a number of remote areas analogous to those on the West Coast.

The Nelson Marlborough DHB is the result of an earlier (1989) full merger between the Nelson and Wairau Hospital Boards. There are long-standing cultural differences between these two geographic areas and this has been, to some extent, reflected in the bringing together of the two health services, with a strong sense of independence evident in both places. In recent times, however, there has been considerably greater rationalisation of services between the two locations than occurred in the earlier years of the merger, and there is little doubt that significant benefits for both areas have been achieved, through greater critical mass of population, the ability to share clinical and other resources, combined systems, clinical and financial viability and capital investment, including the new hospital currently under construction in Blenheim.

4.3 Economies of Scale

In discussions with both Boards and their senior management teams, it is clear that some economies of scale can be achieved, both in non-clinical functions and clinical service provision. Some savings may be achieved at the margin in aligning activities, but the more significant economies are around better utilisation of existing resource in both DHBs, sharing best practice models between DHBs, and creating more critical mass for both corporate and clinical functions.

4.4 Existing Shared Services and Clinical Collaborations

There is a history of some collaborations across the West Coast/Nelson Marlborough boundary. There have tended to be somewhat fitful in nature, dependent on personal relationships and the amount of time available for people to commit to them.

Both DHBs operate in relatively small provinces, with widely spread communities, so they have a number of demographic and geographical factors in common. Our impression from discussion with representatives of both DHBs is that there is a growing culture of collaboration, as there is with the larger DHBs which are their neighbours to the east and north.

Clinically, WCDHB currently operates a primary and low end secondary service, with around 70% of West Coast patients being treated at Grey Hospital.

For high-end secondary and tertiary services, West Coast patient referral is as follows:

- 25% to CDHB
- 5% shared over other District Health Boards, mainly Auckland DHB, C&CDHB and NMDHB

In contrast, NMDHB has a significantly more comprehensive secondary service, and currently there is little need for patients to travel outside of the region except for tertiary and some high end secondary services. For tertiary services, the referral volumes and cost are split approximately 50/50 between C&CDHB and CDHB.

A non-comprehensive but indicative list of the tertiary relationships is provided at Appendix II.

4.5 Other

There are some Planning and Funding functions, notably Health Needs Assessment and Audit & Monitoring, which are carried out by SISSAL on a regional basis, and CDHB offers some services to WCDHB, like payroll and some HR support, and Property Management assistance. Support services are also provided by the Southern Alliance for the iSoft patient management system. Public Health services for WCDHB are provided by Community & Public Health at CDHB. There are collaborative initiatives in Public Health being undertaken with both DHBs

5. Benefits and Risks of Shared Services and Clinical Collaboration

In considering a shared services and clinical collaboration model, we have identified benefits and risks of potential areas for alignment, right across the services of both DHBs.

5.1 General

5.1.1 Benefits

- Recognises the trends nationally and politically, and means being able to take a proactive approach rather than having structural change imposed.
- There is an argument for creating an alignment between the two organisations to strengthen them for further collaborations on a wider regional basis (top of the South Island, hub and spoke models).
- It would appear that, for WCDHB at least, doing nothing is not an option.

5.1.2 Risks

- Failure to gain community acceptance.
- Neither DHB is sufficiently robust to manage the cost and disruption of service alignment.
- Loss of community voice, or perceived loss of community voice.
- If there were one CEO leading the two DHBs, the Boards would need to adopt a higher profile to ensure that their communities felt their interests were being protected.

5.2 Clinical services

5.2.1 Benefits

- Potential to address quality and safety issues, ensuring that cover is available for vital services.
- Ability for greater rationalisation of capacity over a larger population.
- Opportunity to attract, develop and grow staff.
- Ability to share resources, both physical and human.
- Synergies across both areas in outreach to small and isolated communities, as well as rural nursing.
- Better capacity to collaborate over on call and overtime service.
- Potential for WCDHB to reduce locum costs.
- WCDHB can help NMDHB with theatre capacity.
- Potential to standardise credentialing.
- Both DHBs will achieve a bigger pool of specialists, thus creating a more attractive service for recruitment and retention.
- Pooling of resources will enable both DHBs to reduce intervention rates and therefore reduce costs.
- To capture economies of scale, the DHBs have the opportunity to develop new, innovative models of care.

5.2.2 Risks

- Will not create new models of care to address fundamental problems of sustainability and clinical viability, in that nothing will have changed, and the inherently unsustainable model will be maintained.
- The workforce flexibility will not be sufficient to support new models of care.
- Ability or desire to travel (staff).
- Ability or desire to travel (patients).
- Cutting across existing relationships may put some in jeopardy.
- WCDHB becomes the 'poor relation' (this is also a risk with any collaboration).
- Realignment of employment relationships to different situations.

5.3 Non-clinical

5.3.1 Benefits

- Risk reduction: ensuring that levels of professional service are consistent and support good clinical services.
- Combined investment: The ability to pool resources across the DHBs.
- Standardisation: Policies and procedures which are standardised across both DHBs can lead to better clinical outcomes, especially when patients or clinicians are crossing borders for treatment.
- Shared skills: There are complementary strengths and weaknesses in the DHBs, and synergies could be realised.
- Some cost efficiency, although this may not be significant in the short-term, if at all, given the already strong support and relationships that exist.
- Shared systems will lead to a seamless service provision through harmonised approach from the perspective of the clinicians practicing in both areas.

5.3.2 Risks

- Loss of jobs through rationalisation of some services
- Incompatible systems, resulting in conversion costs or delayed alignment of systems
- Need for "on the ground" services in some areas meaning that loss of expertise in either area may result in lower quality services.

6. Principles Underpinning the Review

- Any solution should have at its core increased safety and quality of care for the community served by the DHB.
- The concept of provision of care as close as possible to the patient's home as possible should underpin the design of models of care.
- Pre-existing relationships with Canterbury and Capital & Coast DHBs should not be cut across unless a demonstrable benefit in patient care can be established by changing those relationships.
- In considering clinical sustainability and financial viability, there should be separation of ownership & service provision to aid the development of alternative future states.
- Any change should fit within a longer-term strategy. At this point, sensible short/medium term changes should be instituted which pave the way for further shared services or regional integration.
- In this regard, this investigation should be seen as an opportunity to consider radical change to the way things are done, rather than another way of doing the same thing that is currently being done.
- Any change should recognise the importance of retaining control of population based funding in order to avoid community disempowerment, and this should be a fundamental part of the design.
- Form follows function, so the solution needs to be driven by the best way to deliver health benefits to the community rather than by a pre-conceived organisational structure.
- Focus should be on the areas of potential synergy of expertise and knowledge (rural health, rural medical training, primary/secondary interface).
- Models of care should take account of the geographical factors facing both DHBs, and utilise technology and innovation to overcome challenges where possible.
- Alignment of core business is essential. Management structure must enable and encourage any collaboration, removing barriers to new models of care which address some of the current concerns.
- Role delineation is crucial to determine how staffing, support services and standards of delivery are developed to ensure safe and appropriate service delivery in both facility-based and networked service provision.
- It would be a waste to move for change, but limit the scope to "what is" currently. The opportunities will be liberated if this initiative is seen as a chance to critically examine the whole picture, identifying the best way to achieve the stated objectives.
- The solution should be not only acceptable but attractive to the two communities, and should be based on what is best for those communities in terms of optimum clinical outcomes.
- Recognition of Maori issues is important, and consultation with Iwi vital, in designing new models of care and modes of delivery.

7. Issues and Considerations for Shared Services/Clinical Collaboration

- A programme will need to be designed that identifies desired levels of sharing across both organisations, and with the other partners, based on a map of collaborations currently underway, strengths and weaknesses in each area, and opportunities for enhanced services through collaboration. This programme will need to be prioritised and staged.
- Commitment to the implementation of new models of care must start at Board level and be reflected in contractual agreements and accountability mechanisms.
- The twin principles of patient/community choice, and patient/community voice will need to be considered in the planning process. Collaboration and shared services which clearly enhance these will be more likely to achieve community buy-in in the short-term.
- The need for clinician-led change with appropriate infrastructural support has been identified as a critical success factor. A shared services/clinical collaboration strategy will need to be underpinned by structures and systems which are aligned to, and supporting, service delivery. Emphasis will need to be on removing those barriers which impede progress towards better clinical outcomes.
- Local employment issues need to be taken into account in any change process. It would be preferable, where possible, to implement change in such a way as to use attrition as a means of reducing duplication.
- The change process needs to consider appropriate use of local facilities and skills of the workforce. There is an underlying fear, if there is a move towards shared services under one management structure, that one party to the agreement will be subsumed in the other, and thus lose influence. The most successful way to unlock the opportunities inherent in this proposed collaboration is to identify where the strengths are, and build on these, possibly even creating something new and more effective as a result.
- There is potential for technology to support and enable remote operation, thus dealing with one of the significant barriers which exist in the West Coast region, and to some extent in Nelson/ Marlborough: that of geographical isolation and sparse populations.
- This move to collaboration needs to be seen in the context of the potential for wider medium/long-term South Island configurations. Arguably, a united West Coast/Nelson Marlborough service, focused on the primary/secondary interface, and building on strengths in rural clinical practice, community medicine, and best use of both clinical and non-clinical resources, could be in a strong position to negotiate a place in the wider regional picture.
- It seems therefore sensible to focus on:
    - strengthening primary and secondary networks for greater sustainability;
    - taking the opportunity to develop a new model of care, based on the principles outlines above, utilising the best available visiting specialist services, and maintaining overnight capacity for assessment and post-surgical recovery; and
    - WCDHB maintaining the high-end secondary/tertiary focus with CDHB and NMDHB maintaining the tertiary focus with C&CDHB and CDHB.
- A simpler South Island configuration on a hub and spoke model will be possible longer term if CDHB systematically interfaces with neighbouring DHBs on a service by service basis

- There is potential for staged process-based sharing of generic processes in the future, including Finance, HR, Planning and Funding, Information Management, Property and Asset Management, with some sharing already in existence between WCDHB and NMDHB. Some of these services may well be provided on a wider regional basis over time, and planning of any new system introduction should take account of existing systems within potential partners for larger future collaborations.

8. Risks with a WCDHB/NMDHB Shared Services Model and Potential Mitigations

We have made a subjective assessment of the risks, based on our discussions with representatives of both DHBs, and our experience in organisational change and development. These risks, and particularly the metrics associated with them, will need to be validated further.

In assessing probability, we have adapted the risk framework used by DHBs. This is attached at Appendix IV.

Area of Operation	Risk	Probability	Impact	Mitigation
General	Failure to gain community acceptance for change	Likely	Moderate	Well-planned, consistent and thorough stakeholder engagement plan, showing demonstrable improvements in clinical safety and quality
	Neither DHB is sufficiently robust to manage the cost and disruption of service alignment	Likely	Moderate	Change planning and change management need to take this issue into account. Lessons to be learnt from other New Zealand collaborations
	Loss of community voice	Unlikely	Very High	Separate governance, and a coordinated approach by both Boards to CEO management and accountability DHBs will need to retain control of their own funding
	Currently, WCDHB delegates much of the stakeholder engagement to the CEO. This will be less viable if there is a joint CEO	Likely	Moderate	Boards will need to have a higher profile in the community rather than delegating this to the CEO
Non-Clinical	Loss of jobs through rationalisation of some services	Almost certain	High	If change is implemented over time, service by service, as a case is made for it, this will make it easier for attrition to deal with duplication Some duplication will be necessary in the transitional period, and possibly long-term
	Incompatible systems, resulting in conversion costs or delayed alignment of systems	Certain	Moderate	Immediate, 100% change not proposed. Roll-out of system alignment over time

	Need for “on the ground” services in some areas meaning that loss of expertise in either area may result in lower quality services.	Almost certain	Moderate	Identify where change is appropriate, and where it is not, over short, medium and longer term
Clinical	Difficulty in obtaining necessary workforce flexibility	Likely	Very High	There will be a need to negotiate new conditions of service where possible As new staff come on board, conditions should reflect the shared service responsibility
	Ability or desire to travel (staff) doesn’t meet the needs of the service delivery	Likely	High	As above Consider options for more attractive travel options, such as aeroplane charter
	Change is hampered by the lack of ability or desire to travel (patients)	Likely	High	Where possible, patient choice should be respected Where possible staff travel rather than patient, or services are offered through new models of care which may not involve patient travel Existing collaborative arrangements used where appropriate
	Cutting across existing relationships may put some in jeopardy	Unlikely	Very High	Existing relationships to be looked at on a case by case basis Where existing relationships are offering the best patient outcome, they should remain
	WCDHB becomes the ‘poor relation’ (this is also a risk with any collaboration)	Likely	High	The terms of engagement need to be clear (MOU or other) Each service to be examined on a case by case basis, with optimum outcomes for patients as the driver, as opposed to pulling capacity into one area at the expense of the other
	There is difficulty in achieving realignment of employment relationships to different employment expectations	Likely	High	Part of change management process as above

9. High-Level Cost Benefit Considerations

There has been no detailed cost-benefit analysis undertaken at this point, but the following points are an indication of where some costs may be saved:

1. Alignment of non-clinical functions may achieve modest savings at the margin. However, these may be offset by transitional and change costs.
2. There is potential for savings to be generated through better utilisation of existing clinical resources, and a consequent reduction in locum costs.
3. There is potential for some savings to be made through lowering of intervention rates through better critical mass within the shared services.

As far as a cost-benefit ratio is concerned, this will be difficult to articulate. There is a range of potential benefits identified in section 5, and as a result of our investigation, we conclude that the reasons for undertaking a move to shared services are not really to do with cost savings. Overwhelmingly they relate to the following:

1. Better clinical outcomes for patients.
2. A higher degree of patient safety.
3. Better utilisation of a scarce clinical resource.
4. Viability and sustainability for both DHBs.

After discussions with all parties, we conclude that the best way to achieve 1-4 above is to consider developing more proactive relationships on a wider basis than just between the two DHBs, particularly with those neighbouring DHBs with which there are existing relationships.

In the development of these collaborations, costs and savings can be identified on a case by case basis, and cost-saving should obviously continue to be a driver. However, if the DHBs are looking for a purely financial reason to move to shared services/collaboration, we do not believe that such a case can be made.

10. Case for Change

Given that, in the case of WCDHB, doing nothing is not an option and, given that NMDHB like similar sized provincial DHBs in New Zealand will increasingly face similar issues in the future, it is our recommendation that the Boards pursue a shared service/clinical collaboration model.

However, we do not recommend that each DHB confine itself to the pursuit of such collaborations just with the other, but rather more widely, depending on the clinical benefits that can be derived from such collaboration, and which comply with the principles and address the issues as laid out in sections 6 and 7 above.

The benefits of collaboration are compelling from a community perspective, providing that the barriers to effective implementation can be overcome: transport, communication, systems & procedures and information technology.

Given that some collaboration is occurring between the various DHBs already, it might be tempting to consider a "business as usual" model, where collaboration grows organically. The flaw in this argument is that such organic change is heavily reliant on personalities, sometimes serendipity, and time and energy on the part of the collaborators. At best, such change is likely to be too slow to create the benefits within the time available, and at worst, it will be patchy and possibly even reversible over time, according to situational factors. These factors are aligned to and reinforce the conclusions reached by John Ayling in his report earlier in 2009 on clinical collaboration.

If a shared services/clinical collaboration model is desired, therefore, we recommend that it be driven at the clinical level, but backed by an organisation or organisations whose mandate is to remove barriers to effective collaboration, and who are accountable to their Boards for execution of a progressive collaboration plan. If it is decided to achieve this by a single management and executive structure, some structural provision will be necessary to ensure that the CEO and team are enabled rather than hampered by the management/governance interface. One possible option is to have a number of joint appointments across both Boards. Another option is to have a joint Board governance group.

We would suggest that a staged approach be taken to identification of potential shared services. In the interests of liberating the opportunities inherent in a change of approach, we believe that a more creative approach needs to be taken than just moving to a shared services/clinical collaboration model between the two DHBs, utilising existing methods and operating principles. Such an approach will continue to be hampered by the barriers which have been identified through our consultation process: namely transport, communication, systems and processes, and IT, and also the relative weakness of both DHBs in terms of resources.

It is our view that this review offers the opportunity to go much further in unlocking the opportunities offered by a radical rethink of models of care which are based around service provision rather than ownership: in other words that both DHBs could benefit from thinking beyond the buildings and equipment that they own now or potentially in the future, to utilising new technologies and building on current collaborations to identify the most effective and efficient ways of delivering services to patients that:

- Allow them to be treated as near as possible to their home, or at least in a manner that keeps them from their home region for as short a time as possible.
- Ensure clinical safety and quality at a level unavailable to them under current circumstances.
- Build on the current strengths of the DHBs, but also enable staff from the DHBs to maximise their clinical experience and development by exchange with and exposure to larger populations like Wellington and Canterbury.
- Minimise expenditure and reliance on facilities that are unsustainable for the populations they serve.
- Develop and enhance existing relationships in a way that maximises the benefits gained over years of collaboration to one degree or another.

11. Recommended Approach: An Example

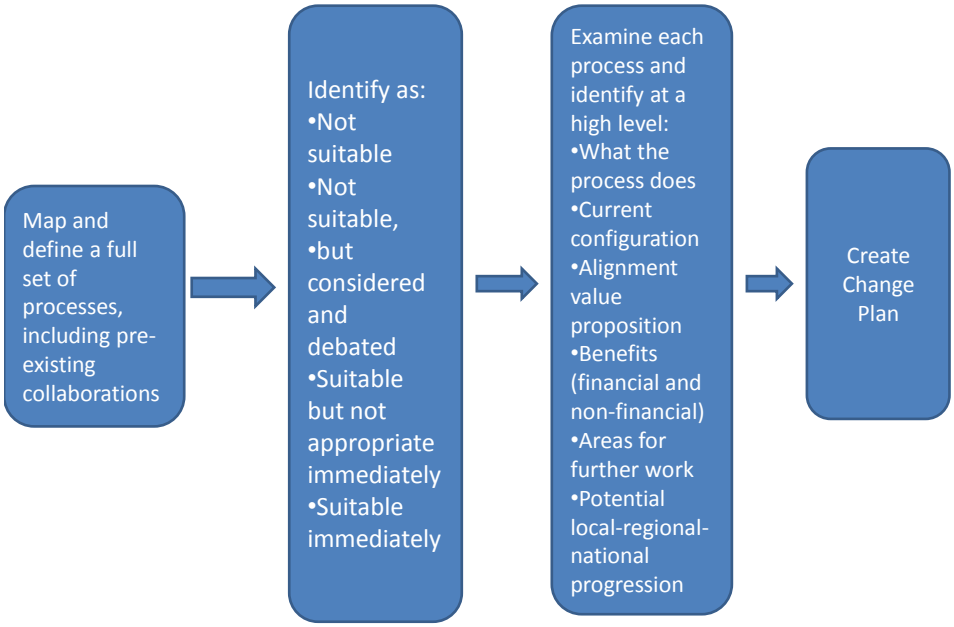
In recommending a wider and more creative approach to improving viability and sustainability for WCDHB, and for NMDHB for the future, we have referred to opportunities which arise through the implementation of the Canterbury Initiative, an approach to different models of care for patients across the primary-secondary interface. While there has been a somewhat variable approach to cross-border collaborations in the past, DHBs are being forced by economic and sustainability factors to reassess their approach to service provision.

We were asked by the Chair of WCDHB to discuss options with CDHB, and In discussion with CDHB, it became apparent that the senior management and Board are very keen to pursue a greater degree of collaboration with WCDHB, based on the use of Canterbury and West Coast resources in such a way that maximises the strengths of each.

They propose a pilot project to develop a shared services approach in ED/Acute care and Obstetrics. This would be achieved by using a proven set of facilitation/liaison steps used to get the primary/secondary /tertiary clinicians working together in a way that gets constructive results in a relatively short timeframe and could potentially be implementable in a relatively short time. Based on the results of such a pilot, other services could be set up in the future through the same process.

Proof of concept and early delivery will enable a quick and constructive start to the process. We understand discussions are underway already, and we support continuation, extension and acceleration of the process.

Following the approach with ED and Obstetrics, we would recommend an identification process similar to that below.



Adapted from EY report to Treasury: Shared Services in the Public Sector – Opportunity Assessment, 2000

The process should be aimed at early proof of concept, leading to relatively rapid benefit realisation. There is the ability for NMDHB to participate on a service by service basis as their clinical requirements dictate.

12. Impact on WCDHB/NMDHB Relationship

There is no reason why this wider, more radical approach to the concerns facing the DHBs could not be undertaken alongside a shared services/collaboration process between WCDHB and NMDHB. It is more a matter of scope rather than change of direction: Instead of looking to achieve the effectiveness and efficiency outcomes from within a group of two DHBs, the approach could be taken over three and maybe four DHBs.

The question remains as to whether there is a need for the combining of the two management teams under one CEO to achieve the outcomes of these wider collaborations. We do not believe there is a compelling case for such a change, given that the savings would be marginal at best. The question of whether such a combined structure would enhance progress towards this more radical change, or at least remove barriers to it, is a moot one.

In the event that the DHBs decide that they do want to pursue a single CEO and Executive team, we see no reason why it needs to be an impediment to the wider shared services approach. We would caution, however, that the DHBs would need to be very clear about the reasons for effecting that change, given the risks associated with it as detailed in section 8 above.

The alternative would be to establish a joint working team, drawn from both DHBs, to examine the potential for clinical collaborations with each other, and jointly with CDHB and C&CDHB. They may choose to develop some shared services between them, and others that they pursue independently, and then again there may be others where a three-way collaboration would be appropriate. Any structural change should follow the development of such a strategy, and should be designed to support that strategy.

The underlying principle remains, however, that these collaborations need to be viewed from a different perspective from 'business as usual'. As noted above, reliance on an organic approach to the development of clinical networks to deliver a sustainable solution will not work in isolation – there needs to be management and governance commitment to ensure its success. A critical success factor for the Canterbury Initiative has been the direct involvement of the CDHB Funding and Planning Division to provide both financial support and strategic focus to make it work.

There is an opportunity to develop models that are a first for New Zealand, that really address the desired patient outcomes, the sustainability and viability issues for the DHBs, and demonstrate new approaches to creating a sustainable health system within the country.

13. Conclusions

13.1 WCDHB and NMDHB should commit to a re-think of models of care and look for creative ways to deliver the best quality, safest care to their community, in collaboration with each other and with CDHB and C&CDHB.

13.2 The most effective approach is to develop specialty by specialty models of care and support the proposed models with workforce planning. The work currently the subject of an RFP by WCDHB would be a very appropriate place to start in reviewing models of care.

13.3 We conclude that WCDHB should consider shared services at a number of levels, with NMDHB and CDHB, with which they currently have relationships, and progress new initiatives with some urgency. This work should be undertaken under a clear mandate and commitment from all parties at both management and governance levels.

13.4 We suggest that WCDHB, CDHB and NMDHB develop a change strategy to address the essential enablers of service delivery: transport, communication, IT and Systems/Processes, between each DHB and those with whom it is collaborating.

13.5 As a result of this innovation strategy, it would then be appropriate to develop a common approach to recruitment and engagement that:

- encourages retention;
- promotes flexibility (especially geographical mobility);
- articulates the attractive lifestyle and career development opportunities available through clinical collaborations;
- forms a basis for international recruitment;
- develops professional development and clinical competence models utilising collaborations between DHBs; and
- sheets home responsibility and accountability for implementing clinical collaborations according to plans driven by the CEOs of the participating DHBs.

13.6 Consideration of alignment of corporate services should occur only if there is evidence that it will increase the likelihood of success in the above and/or significant cost savings or increase in effectiveness.

Appendix I: People Involved in the Review

WCDHB:

Rex Williams	Chair
Sharon Pugh	Board member
Elinor Stratford	Board member
Warren Gilbertson	Board member
Joel George	CEO
Vicki Robertson	Acting Chief Medical Adviser
Wayne Turp	General Manager Funding and Planning
Wayne Champion	GM Corporate Services
Gary Coghlan	GM Maori Health
Kim O'Keefe	Human Resources Manager
Jane O'Malley	Director of Nursing and Midwifery
Jude Bruce	Maternity Coordinator
Maureen Frankpitt	Nurse Manager Community/PHC
Janet Hogan	Clinical Nurse Leader – Community Nursing Service South
Terry Mixter	General Surgeon
Greville Wood	GP & Rural Immersion Student Coordinator
Rodger Mills	A&E Doctor
Mark Bowen	Quality Assurance and Risk Manager
Hecta Williams	GM Community, Primary and Mental Health Services
Phil Clarke	Laboratory Manager
Colin Weeks	Chief Financial Manager

Nurse Managers Group

Heads of Department, Allied Health

NMDHB

Suzanne Winn	Chair
Ian MacLennan	Board member
Sharon Brinsdon	Board member
John Peters	CEO

Strategic Leadership Team (SLT)

Nigel Trainor	CFO
Mike Cummins	Board Secretary
Dr Sharon Kletchko	GM Planning and Funding
Peter Burton	GM Primary and Community
Nick Lanigan	Chief Information Officer
Nicola Ehau	Director Maori Health
Dr Andre Nel	Chief Medical Advisor
Phillipa Molloy	Director of Nursing
Denise Hutchins	GM Organisational Development
Keith Rusholme	Chief Operating Officer

Senior Medical Officers

Nick Baker	Paediatrician
Clive Garlick	
Andrew Hamer	Cardiologist
Nick Fisher	Cardiologist
Bruce King	Physician
Andre Nel	CMO
Ed Shepherd	DM Surgical Services
Rosie Wilson	DM Older People and Rural Services
Robert Blackbeard	
Mike Ball	Geriatrician
Suzanne Beauker	Urologist
Lindsey Bates	DM Medical Services

Allan Panting	Orthopaedist

CDHB

Alister James	Chair
David Meates	CEO
Mary Gordon	Director of Nursing
Nigel Millar	Chief Medical Officer

C&CHDHB

Ken Whelan	CEO
Shaun Drummond	Chief Operating Officer

Appendix II Existing Collaborations

The following is a non-exhaustive list of clinical collaborations already in existence.

NMDHB/C&CDHB:	Cardiology and cardiothoracic
	Renal
	Neonates and at risk perinatal
	Oncology
NMDHB/CDHB:	Some Oncology
	Haematology
	Specialist surgery (orthopaedic, opthamology, ENT, neurosurgery)
	Psychogeriatric
	Forensic
	Adolescent Mental Health
NMDHB/Starship:	Pediatrics
WCDHB/CDHB:	Tertiary Orthopaedics
	Anaesthesia
	Respiratory
	Neurology
	Cardiology
	Haematology
	Nephrology
	Oncology
	Urology
	Range of secondary services
	Paediatrics
	Rehabilitation services
	Mental health services
	Hospital support and laboratories
	Nursing support services
WCDHB/NMDHB:	WCDHB/NMDHB:Maori Health – some collaborative work underway
	Orthopaedics
	Early discussions on General Surgery
	Clinical Audit and Support
	Private elective services through Churchill Hospital Trust, Blenheim
WCDHB/Otago DHB:	Occasional referrals from the Southern West Coast

Appendix III Francis Group

Established in 2002, Francis Group is a specialist social services public sector consulting firm comprising consultants in Wellington, Christchurch, Auckland, London and Birmingham. Francis Group has a proud record of successful engagement with and supply of services to the Health Sector.

Some of the projects Francis Group has undertaken in the Health sector include:

- Health Information Strategy for New Zealand: Ministry of Health
- Review of the Addressing Disincentives Pilots, Ministry of Health
- National Ambulance Strategies and Protocol Frameworks
- Mental Health Information Strategy: Ministry of Health
- Implementation Plan for the Mental Health Information Strategy
- Establishment of Patient Safety function at ACC
- Health Sector Address Validation and Geo-coding Information Strategy: Ministry of Health
- CCDHB costing project
- Lakes DHB Theatre Management Review
- Mid-Central DHB Costing Review
- High-performing team development – ACC

Stuart Francis

Stuart Francis is a senior management and health care consultant specialising in the government and health sector and is the Managing Director of Francis Group. He works at senior levels within the public sector in New Zealand and the United Kingdom, particularly facilitating multi-agency initiatives and national programmes. He is on the National Council of the New Zealand Institute of Health Management, is a Fellow of the Australian College of Health Service Executives and a member of the Institute of Directors.

Paddy Austin

Paddy Austin has a long history of governance and senior management, primarily in the public sector. Most recently, she has been Chair of Christchurch City Holdings Ltd, a company with assets exceeding $2b. Chairing this company for 6 years, she has been responsible for a significant improvement in governance policy and practice, as well as a major strategic review of the company's role in infrastructure provision for the Canterbury region. A significant part of this overview involved developing a culture to foster a shared approach to purchasing and management services within the Group.

Trevor Read

Trevor is a senior management consultant specialising in the area of ICT and process improvement in the health and education sectors. Trevor leads Francis Group's performance improvement practice. Until recently he has been teaching health informatics part time in the Faculty of Health and Science School of Nursing at the Christchurch Polytechnic Institute of Technology. For a number of years Trevor was a Director in the Health, Education and Public Sector consulting team of Cap Gemini Ernst & Young and Practice Leader of the clinical decision support and casemix costing service lines, responsible for sales and delivery of professional consulting services to clients in the health sector in Australia and New Zealand. A health professional by background, Trevor has had a major focus on specification development, evaluation, selection and cost benefit analysis of ICT systems and process improvement within health provider units. Particular skills include the provision of expert knowledge of financial and management reporting tools and applications, learning management systems/virtual learning systems (e.g. Blackboard, Moodle) and the use of system analysis to optimise service delivery performance.

Appendix IV Risk Matrix

Descriptor	*PATIENT SAFETY*	*SERVICE DELIVERY*	*FINANCIAL*	*REPUTATION*	*WORKPLACE SAFETY*
	Patient harm resulting from the process of health care, unrelated to the natural course of the illness & differs from the expected outcome to a patient's management.	Disruption to operational activities resulting in an inability to provide quality services.	Impact on expenditure or revenue, or capital availability, which results in an inability to operate within budget.	Impact on the reputation of the DHB in the public, government or regulatory environment.	Harm resulting from accidents within the workplace environment.
Extreme	Unanticipated patient death(s)	Non-delivery of a key service.	Cost overrun or reduction in revenue >$1 million	Major inquiry by external agency. Major threat to public confidence creating an impact at national level.	Death(s) of a staff member/contractor visitor.
Very High	Patient sustaining permanent disability or incapacity or requiring major additional medical or surgical intervention.	Significant ongoing disruption to a key service.	Cost overrun or reduction in revenue >$500,000	Major inquiry by external agency. Major threat to public confidence creating an impact at a regional level.	Permanent disability or loss of function to a staff member/contractor/visitor. Requires major additional medical or surgical intervention.
High	Patient injury requiring extended treatment.	Disruption to a key service.	Cost overrun or reduction in revenue >$ 200,000	Inquiry by external agency. Threat to confidence creating an impact at a local level.	Staff member/contractor/visitor injury requiring extended treatment.
Moderate	Patient injury requiring short term treatment.	Disruption to service.	Cost overrun or reduction in revenue >$50,000	Potential for negative impact at a local level or within DHB.	Staff member/contractor/visitor injury requiring short-term treatment.
Low	Minimal patient injury.	Minimal disruption to service.	Cost overrun or reduction in revenue <$50,000	Minimal impact on the reputation of the DHB.	Minimal injury to staff member/contractor/ visitor

⇩ CONSEQUENCES	LEVEL OF RISK				
Extreme	Moderate	Major	Critical	Critical	Critical
Very High	Moderate	Major	Major	Critical	Critical
High	Minor	Moderate	Major	Major	Critical
Medium	Minor	Moderate	Moderate	Major	Major
Low	Minor	Minor	Minor	Moderate	Moderate
Likelihood: ⇨	HIGHLY UNLIKELY	UNLIKELY	LIKELY	ALMOST CERTAIN	CERTAIN

Appendix V Sustainability Project

WEST COAST DISTRICT HEALTH BOARD SUSTAINABILITY PROJECT

Background

1. Over recent years the West Coast District Health Board (WCDHB) has increasingly experienced challenges in securing and retaining clinical staff of the right mix and volume to provide the current range of services that it provides on the West Coast. This, coupled with the changing population demographics, the geographical challenges, and parameters of the New Zealand health funding model, has resulted in an increasing pressure on services and funding pathways. In addition a recent building inspection of the Buller and Grey Base Hospitals and sites has indicated there are critical seismic and compliance issues that need addressing.

2. In 2007 WCDHB and The Ministry established a partnership project, the West Coast Sustainability Project, aimed at identifying and planning for a sustainable model of care and clinical services plan for the district. The four components of sustainability considered are services, workforce (clinical and managerial), facilities and funding models.

3. The sustainable model of care will guide service delivery, workforce (including training), facility and information technology requirements. This will work towards building on and sustaining the WCDHB's goal of being a Centre of Excellence for Rural Health. The project emphasises a commitment to ensuring safe and high quality services.

4. Development of a formalised sub-regional DHB network has been initiated as part of the project. This includes Nelson Marlborough, Canterbury and West Coast DHBs. There is agreement in principle by the three DHBs that the sustainable solution is likely to be for all of them to work together. This is supported by recent Ministerial direction that focuses on strengthened regional collaboration and the devolution of selected secondary services to primary care settings.

Current State of Play

5. The WCDHB has now examined options (reported in detail in a three-part report), all of which emphasise a shift to primary, community and home based services. The key issues have now been distilled into three questions:

a. Which acute services will be delivered on the Coast, and how?
b. Where not delivered locally, how will emergency and trauma needs of the West Coast population be met?
c. What ongoing support can be proved by neighbouring DHBs, for services delivered on and off the Coast?

6. Other key developments include:

a. A commitment by all six South Island DHBs to the development of a South Island Clinical Services Plan. Work on this is underway, facilitated by the South Island Shared Support Agency ('SISSAL').
b. West Coast DHB has had two capital cases referred back from the National Capital Committee for further work.
c. West Coast DHB has defined 'core services' which must be provided on the Coast.
d. There is an increasing willingness by neighbouring DHBs to work collaboratively to find mutually beneficial solutions to the WCDHB's health service and financial challenges.

Current Request for Options Analysis

7. WCDHB is seeking an Options Analysis of the three potential models of care including scenario development, workforce recommendations and costings (including capital) and the development of an engagement framework. The current target date for this work is 31 July 2009.