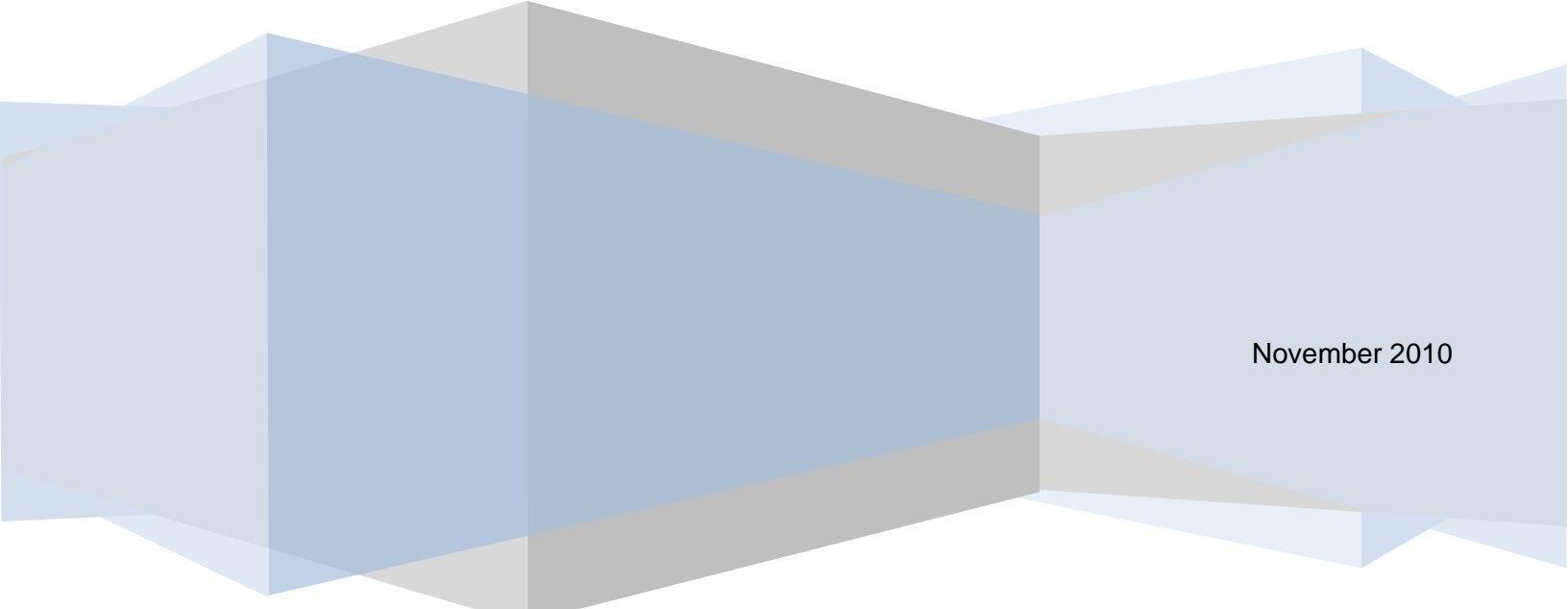


Consultation Document

Ophthalmology Service Development



November 2010

ACKNOWLEDEMENT

To the staff of the Ophthalmology Service – This document proposes some changes to the service and its future direction. It is intended as a basis for discussion not as a criticism of current service delivery. NMDHB appreciates the work you do for the people of Nelson Marlborough district and recognises that when change is proposed it can be difficult. Please participate in this process so that we can further improve the service already provided.

PURPOSE OF THIS DOCUMENT

This document is written as a consultation document to gain feedback on the proposals for the future development of Ophthalmology services put forward by the Rutherford Initiative review and being considered by NMDHB.

We are seeking your feedback on the proposals prior to NMDHB making a decision on these proposals and the future of Ophthalmology services.

Consultation feedback closes on 28 January 2011. Attached as **Appendix 1** are Questions and Answers. A response form is attached as **Appendix 2**. All feedback should be addressed to:

Karen Lindsay
NMDHB
Private Bag 18
Nelson 7042

EXECUTIVE SUMMARY

Rutherford is a DHB initiative under the ownership of the Chief Executive. The purpose of Rutherford is to provide recommendations to the Chief Executive gained through interaction and work with a range of people in reviewing the service. The Rutherford Initiative team has expert advice available to it and has worked with staff in the service including clinicians, analysts, service experts and customers/consumers/service users. Rutherford Initiative members actively seek ideas from managers, clinicians and frontline staff as well as subject matter experts.

The review of the Ophthalmology dept has been completed by the Rutherford Initiative group and a report presented for consideration. At the time the report was completed Ophthalmology was the responsibility of the District Manager Surgical Services who reported to the Chief Operating Officer. Under the new ELT structure ophthalmology will be part of the Medical/Surgical Directorate.

The Ophthalmology Service has departments based at both Nelson and Wairau Hospitals and provides a wide range of Ophthalmology services for the Nelson Marlborough region. Some treatments are also referred to Wellington or Christchurch.

In carrying out this review the Rutherford Initiative team has had numerous meetings with the Ophthalmology service management, the SMOs, some of the nursing and clerical staff; and

investigated the different DHB Ophthalmology service delivery models and had discussions with clinical personnel at Northland, Bay of Plenty and Southland DHBs.

This consultation document has been developed after considering the Rutherford Initiative report to the Chief Executive.

Essentially two options were proposed with regard to the future development of the service after analysis of the last four years volume and financial information:

1. Outsource all or part of the Ophthalmology services; and
2. Maintain the provision of the service in house but with changes to models of care.

The Organisation has decided to consult with staff and other key stakeholders on the two options proposed by the Rutherford Initiative review on the basis that both options have significant merit.

Option One Outsourcing

Benefits would be:

1. Strongly supports the government objective of “Better, Sooner, More Convenient”;
2. Avoiding the need to spend \$2.5m on facility redevelopment in surgical outpatients;
3. Avoiding the need for investment in expensive Ophthalmology equipment and the need to have same in both in public and private facilities, thus ensuring optimum usage of that equipment;
4. Avoiding downtime between public and private service provision caused by moving from one facility to another;
5. Streamlined patient flows and the consequent consistent meeting of government elective services targets; and
6. This initiative is in line with the strategy of moving secondary services into the primary sector at no cost to the patient.

It has been concluded that contracting out all or part of the NMDHB Ophthalmology service has significant merit. However the critical factor in determining whether or not this is achievable is the SMOs. Obviously there needs to be one or more SMOs willing to lead this initiative and tender for the contract. From discussions with the SMOs it is believed that there is an interest in this option however the outcome of any discussions cannot be guaranteed and in any event will take time to implement.

Whilst it is not possible to quantify the operational cost savings associated with **Option One** until the terms of a contract have been agreed it is expected that the arrangement to be at least cost neutral for NMDHB in comparison to the current position. By Outsourcing there would be Capital Expenditure Cost Savings as there would be no need to carry out the substantial Surgical Outpatient extensions included in the Nelson Hospital site redevelopment proposal being an overall saving in capital expenditure of \$2.5 million.

OPTION 1 - ESTIMATED TOTAL "CAPEX" COST SAVINGS	COST/BENEFIT ANALYSIS		
	2010-2011	2011-2012	2012-2013
OPTION 1 - ESTIMATED TOTAL "CAPEX" COST SAVINGS	-	\$2,500,000	-

If this option becomes the preferred option for the Organisation then a decision would need to be made on how the outsourcing would be managed (tender process, or contract current SMOs).

Option Two – Maintain the Provision of the Service In House but with Changes to Models of Care

Benefits would be:

1. Better targeting of SMO skills;
2. Utilisation of other clinical staff (nurses, optometrist) skills to allow SMOs to focus on procedures/consultations that only they can do;
3. District wide approach to service planning/provision that ensures equity of access for the people of Nelson Marlborough; and
4. Ongoing annual operational and capex cost savings of approximately \$440k.

In carrying out the review for **Option Two** (continuing to provide the NMDHB Ophthalmology service in-house) an alternative Service Delivery Model has been proposed that will reduce the pressure on the SMOs, deliver contracted volumes, and address ESPI wait list issues. It is proposed that:

It is proposed in Option Two:

Ophthalmology Service Model of Care

- The proposed fifth SMO is not appointed;
- A permanent full time district-wide Clinical Nurse Specialist position is created;
- The House Surgeon (currently on contract from August 2010 to February 2011) and thereafter the Clinical Nurse Specialist (or a Optometrist or Locum until one can be appointed) should hold three (or whatever number is required) clinics a week for Follow-Up Attendances at the same time as one of the SMO clinics and review the diabetic photography results in Nelson instead of contracting the GP (0.1 FTE);
- The House Surgeon can carry out the Avastin procedures until his contract ends in February 2011. At that stage other alternatives can be put in place. It may be possible to train the Clinical Nurse Specialist to carry out these procedures. Alternatively the SMOs may have time to do the Avastin treatment again now that the Acute and Elective Procedure Volumes have been reduced and pressure has been taken off the Clinics with the additional Follow-Up clinics being held by the Clinical Nurse Specialist/Optomtrist/Locum;
- The House Surgeon/Clinical Nurse Specialist be used to support the SMOs more on call;
- A single wait list is established to assist in reducing ESPI pressures;
- The SMOs are job-sized to address any imbalances in work loads;
- SMO Job Sizing - That the SMOs be job-sized and that the NMDHB should involve ASMS in carrying out the job-sizing process;
- Cost of Call - That Call is managed on a district-wide basis with the four SMOs (three in Nelson and one in Wairau) covering call one night a week Monday to Thursday and then rotate 1:4 to provide cover Friday to Sunday. The permanent appointment of a Clinical Nurse Specialist will also provide call support for the SMOs during the week;
- Theatre Cataract Trolleys - That the trolleys are purchased as part of creating additional future capacity and potentially reducing the current SMO requirement;

- District Wide Service Planning Including Clinical Leadership - One of the four SMOs is appointed as the Clinical Leader of the Ophthalmology service;
- Nursing Staff –
 - The FTE configuration for the ophthalmology service is reviewed to include a permanent full-time Clinical Nurse Specialist position with a clinical oversight responsibility across the district;
 - Position descriptions are reviewed to align key responsibilities with service requirements; and
 - Nurse led clinics are formalised in District-wide service plan. Supporting rosters are captured on the Actor payroll system.
- Nelson Clerical Staff –
 - Hours of work are changed to reflect the operational needs of the service. Job rotation is re-introduced;
 - Adequate desk files are created for each position;
 - “5S” methodology should be used to clear debris, archive and reorganise desks for better access and flow in the office; and
 - Pre-admission packages set up which are clearly marked and pre collated to improve efficiency.
- Discharge Policy – That FSA/follow up ratios are investigated as part of reviewing discharge policy;
- Outsourced Contractual Rates - That a review of all outsourced contractual rates is undertaken to determine what the current market rate is and whether or not NMDHB is obtaining a sufficient margin to cover corporate overheads at the rates that are currently being used;
- Outsourced Services Procurement Processes - That purchase orders are generated for these services through TechOne;
- House Surgeons - That the House Surgeon budgets are reorganised so that:
 - Their budgeted salary is allocated to the areas that they have been assigned to;
 - Actual salary costs are recognised against the cost centre where they have spent their time as per Actor;
 - Other costs associated with the House Surgeon programme (e.g. the House Surgeon co-ordinator, training costs, travel and accommodation etc) should remain in the Nelson and Wairau House Surgeon cost centres which can be combined into one cost centre; and
 - Consideration should also be given to whether or not it is better to share the House Surgeon with another similar sized specialty such as ENT rather than Orthopaedics, or to have the House Surgeon working full-time in one specialty for a fixed period and them moving to another specialty.
- Oracare Reporting and PVS Volume Recognition - The identified issues are investigated, and processes and procedures put in place to address them where appropriate;
 - The Oracare codes and categories are reviewed as part of preparing the Service Plan to ensure that in future information is being captured in a way that provides management with the information that they need to monitor the operations of the service;
 - Data rules be established to ensure consistency of data/information obtained from Oracare;
 - The CSR reports that are currently on the intranet be removed so that people do not use them for carrying out any volume analysis or trends. Copies of the monthly reports

published should be archived but clearly marked “superceeded”. Up-to-date versions of accurate and reliable historical data should be published each month so that the latest data is accessible on the intranet. Extra resource will be required to enable the Reporting Team to carry out this initiative; and

- A separate Oracare field is established for Outpatient volumes so that the medical condition driving the attendance, minor or laser procedure can be recognised e.g. macular degeneration, glaucoma, cataracts etc so that this information is available for Service Planning purposes.
- EyeNZ Website - That these arrangements be reviewed to determine the most appropriate way forward to include this web site as part of the NMDHB web/communication strategy;
- IDFs and SI Regional Plan - That the opportunities to complete congenital cataracts and a number of some complex ocuplastic work is considered once the South Island Health Services Plan has been finalised and there is more certainty around the Ministry of Health review of the IDF system which is also being undertaken currently; and
- Training Registrar - That consideration be given to the Registrar Training programmes as part of the future medical personnel planning for the Ophthalmology service.

The total Operating and Capital Expenditure Cost Savings from **Option Two** recommends the three years ending 2012-2013 amount to:

OPTION TWO	COST/BENEFIT ANALYSIS		
	2010-2011	2011-2012	2012-2013
ESTIMATED TOTAL OPEX COST SAVINGS	\$298,366	\$447,063	\$458,240
ESTIMATED TOTAL CAPEX COST SAVINGS	\$94,350	-	-
ESTIMATED TOTAL SAVINGS	\$392,716	\$447,063	\$458,240

The outsourcing of **Option One** will take time to implement and for the reasons outlined in the document may or may not happen. Therefore it is proposed that **Option Two** commence immediately to alleviate the pressure that the service is currently under and support it in the future.

Irrespective of the decision to choose to outsource or not there is a need to commence exploring option two as soon as possible.

Associated with the two options (particularly option two) are a number of proposals that need to be carefully considered.

This consultation document gives an overview of each aspect of the Ophthalmology service, identifies issues and makes proposals to resolve the issues.

Feedback is sought from affected staff and other key stakeholders to assist us to make the final decision regarding the provision of Ophthalmology services.

SERVICE OVERVIEW

The Ophthalmology Service has departments based at both Nelson and Wairau Hospitals and provides services for the Nelson Marlborough region. Whilst it is a district-wide service there is very little interaction between the two Hospitals and the service effectively runs as two separate operations.

OPTION ONE - OUTSOURCING

Ophthalmology as a medical service is becoming more reliant on equipment and technology and influenced by new developments in those areas. Consequently the cost of setting up a new consultancy practice and replacing or investing in new technology is significant. Therefore to ensure the most efficient use of the health dollar there are good economic reasons why public/private models may become more attractive and appropriate for specialty areas such as Ophthalmology.

Already around New Zealand DHBs, many different models are evolving which range from continuing to provide all services in-house using employees or locums, to contracting out just the Outpatient services, or contracting out the whole of the Ophthalmology service. For example:

- Southland currently has no Ophthalmologist employed and whilst recruiting for two positions is using locums from around the country to assist;
- Timaru has one Ophthalmologist and uses locums as required;
- Northland has four Ophthalmologists;
- Rotorua has a joint venture with private Ophthalmologists where it contracts out its Outpatient service and performs the Inpatient service at the Hospital; and
- Bay of Plenty has contracted out the whole of its Ophthalmology service for more than five years.

From the review of this Ophthalmology service and the review of the other DHBs there are clear reasons why it may be advantageous to consider contracting out all or part of the Ophthalmology service:

- **Equipment Costs** – As discussed Ophthalmology is becoming more dependent on expensive equipment and it would be more economic if one machine is bought in a region rather than two (e.g. one public and one private). For this very reason NMDHB is already contracting out some parts of the Ophthalmology service in Wairau as it does not have its own OCT scanner and Yag Laser and contracts the SMOs private rooms to perform these services;
- **Space issues** – Nelson and even Wairau (which is just going through a redevelopment) have space issues. Ophthalmology departments require more space than most speciality services because of the large amount of equipment required and the nature of the equipment e.g. some eye tests require sufficient space in the consultancy room to judge the patients ability to see at a distance;
- **Juggling private practices** – None of the Nelson or Wairau SMOs work full-time for the DHB and therefore because they are typically spending time at each location they are not able to use their time as efficiently as they would if they were spending it in one place.

Effectively they are also juggling two lists, one public and one private, which must also cause inefficiencies; and

- **Succession issues** – Where there is only one Ophthalmologist in a location such as Wairau, when that Ophthalmologist leaves or retires it may not be easy or even possible to replace them as working as a sole practitioner at a DHB is not typically as attractive as joining a team.

It is proposed that NMDHB investigates contracting out some or all of the Ophthalmology service with possible options being:

1. The District-wide Ophthalmology service;
2. The Nelson and or Wairau Inpatient (Acute, Elective and Minor Procedures) and Outpatient (FSAs and Follow-ups Attendances and Laser Procedures etc) service; and
3. The Nelson and or Wairau Outpatient service.

The preference would be to contract out the whole of the Ophthalmology service (Inpatient and Outpatient). It may be possible to contract with one part or there may need to be two parties – one in Nelson and one in Wairau.

Option One – Operational Cost Savings

It is not possible to quantify the operational cost savings associated with this Option until the terms of an agreed contract have been agreed. However based on the Consolidated Financial Results provided in the Financial Overview section it is expected the arrangement to be cost neutral for NMDHB.

Option One – Capital Expenditure Cost Savings

If the Ophthalmology service was outsourced then additional space would be created on the second floor of the Percy Brunette Building in Nelson Hospital to accommodate the other speciality service Surgical Outpatient requirements.

In which case there would be no need to carry out the substantial extensions included in the Nelson Hospital site redevelopment proposal. The New Build Business Plan quantifies the cost of the Surgical Outpatient re-build to be \$2.75 million. Should this not proceed it is estimated that \$225k of this amount would still be required to convert some of the existing rooms to clean rooms and therefore there is an overall saving in capital expenditure from Outsourcing of \$2.5 million.

Initiative Number	COST SAVING INITIATIVES - CAPEX	COST/BENEFIT ANALYSIS - CAPEX		
		2010-2011	2011-2012	2012-2013
1	Option 1 - Outsourcing			
	Costs			
	- Refurbishment	-	(\$225,000)	
	Benefits			
	- Surgical Outpatient new building development	-	\$2,725,000	-
	Total estimated Capex savings	-	\$2,500,000	-

OPTION TWO – CONTINUING WITH INHOUSE OPHTHALMOLOGY SERVICES

Option Two - Opex Cost Saving Initiatives

Ophthalmology Service Model of Care (Opex Savings)

Background

In 2008/2009 the Ophthalmology department struggled to achieve the Ministry ESPI Wait Time measures. The Ophthalmologists communicated to management that they were feeling the pressure of rising demands both from NMDHB and in their private practices and were concerned that this will only get worse given the forecast future increase in volumes due to the demographic effect of the aging population. Some of the SMOs believe that the current call arrangements are onerous and thus the appointment of a fifth SMO would assist in addressing this.

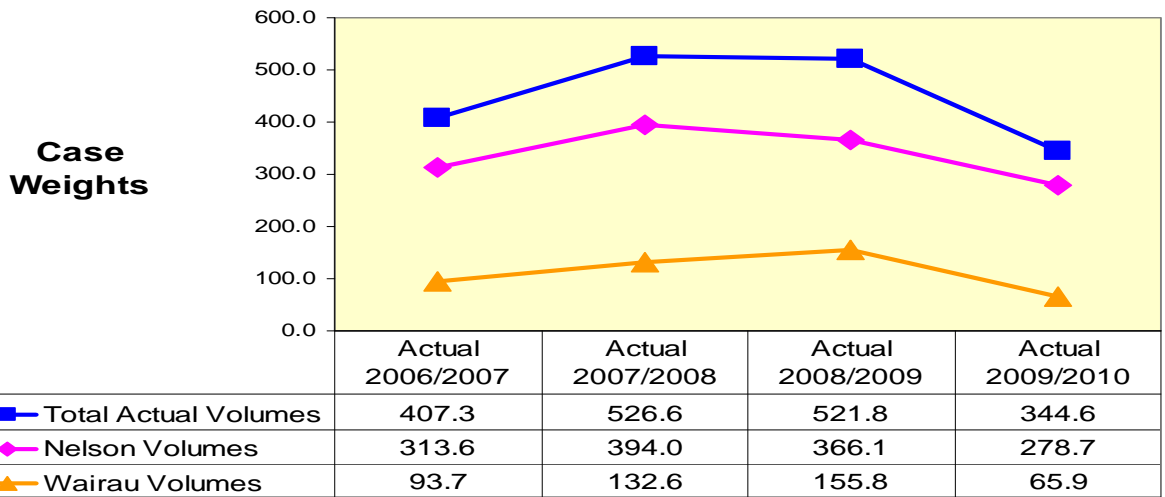
A business case was developed in April 2009 to support the appointment on the basis that volume levels had increased due to the level of work involved in the cataract initiative¹ and the introduction of the Avastin Procedure. The business case was approved and a recruitment process commenced and an additional SMO was included in the 2009/2010 for half of the year but no appointment was made.

The Nelson SMO 2010/2011 budget has an increased 0.8 FTE to allow for an additional SMO to be Nelson based but work across the district for the full year.

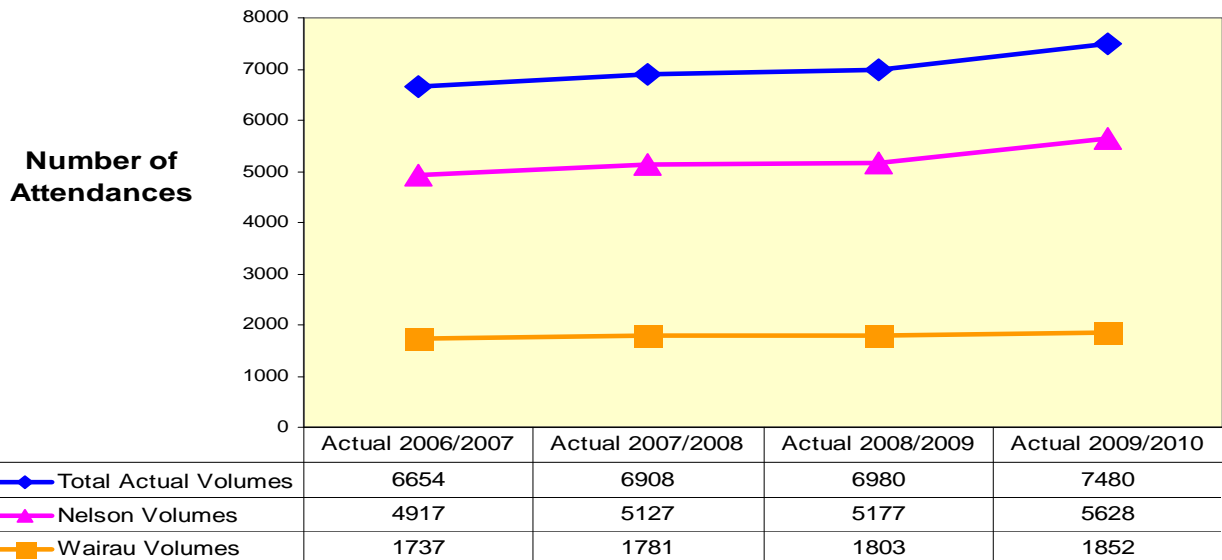
After reviewing the Procedure and Attendance volumes over the past four years it was found that whilst Avastin Procedures and the First and Follow-up Attendance volumes have increased, Acute and Elective Procedures volumes have not (refer below and to the body of the report).

¹ New Cataract assessment tool which has been introduced in Nelson but not in Wairau to date.

Ophthalmology Acute & Elective Procedures



Ophthalmology FSA and Follow-Up Attendances



The reason for the drop in case weights is that Avastin was originally counted as a case weight. Now it is counted as a minor procedure. At current staffing and service delivery models it is forecasted that the Nelson Ophthalmology service will not be able to meet planned First and Follow-up Attendances.

The Ophthalmology service is required to perform a total of 1,445 FSAs in 2010/2011 of which 954 (2/3rds) relate to Nelson. Currently three SMOs are holding eight Clinics for 42 weeks of the year (on average) in which they are currently booked to perform two FSAs per clinic. In addition to this other medical personnel (Optometrists/GPS etc) are carrying out some FSA attendances (42 in 2009/2010). As shown below with no change in service delivery model this would result in a shortfall of 240 Attendances for 2010/2011.

Nelson FSA Attendances	Patient FSAs	Clinics	Weeks	Total Attendances
SMO existing Clinics	2	8.0	42	672
2009/2010 Non-SMO attendances				42
Total Attendances				714
Contracted Attendances				954
"Shortfall" Attendances				(240)

Similarly the Ophthalmology service has planned to perform a total of 6,000 Follow-ups in 2010/2011 of which 4,680 (2/3rds) relate to Nelson. Currently three SMOs are holding eight Clinics for 42 weeks of the year on average in which they are currently being booked to perform ten Follow-up Attendances per clinic. In addition to this other medical personnel (Optometrists/GPS etc) are carrying out some Follow-up attendances (288 in 2009/2010). As shown below with no change in service delivery model this would result in a shortfall of 1,012 Attendances for 2010/2011.

Nelson Follow-Up Attendances	Patient Followups	Clinics	Weeks	Total Attendances
SMO existing Clinics	10	8.0	42	3,360
2009/2010 Non-SMO attendances				308
Total Attendances				3,668
Contracted Attendances				4,680
"Shortfall" Attendances				(1,012)

If all of the SMOs were holding three clinics a week (currently one SMO is only holding two) and an additional SMO was appointed in Nelson who also held three clinics a week (delivering 2 FSAs and 10 Follow-ups) then Nelson would over deliver by 96 FSAs (10.1%) and 668 Follow-up Attendances (14.3%) as shown below. The highlights in the tables reflect the changes from the previous tables.

Nelson FSA Attendances	Patient FSAs	Clinics	Weeks	Total Attendances
SMO existing Clinics	2	8.0	42	672
2009/2010 Non-SMO attendances				42
All SMOs doing 3 Clinics a week	2	1.0	42	84
New SMOs 3 Clinics a week	2	3.0	42	252
Total Attendances				1,050
Contracted Attendances				954
Attendance Overdelivery				96
% Overdelivery				10.1%

Nelson Follow-Up Attendances	Patient Followups	Clinics	Weeks	Total Attendances
SMO existing Clinics	10	8.0	42	3,360
2009/2010 Non-SMO attendances				308
All SMOs doing 3 Clinics a week	10	1.0	42	420
New SMOs 3 Clinics a week	10	3.0	42	1,260
Total Attendances				5,348
Contracted Attendances				4,680
Attendance Overdelivery				668
% Overdelivery				14.3%

Otago and Northland DHBs which have larger populations than NMDHB (177,000 and 150,000 respectively compared with 140,000) have only four SMOs and thus have found ways of meeting their contractual volumes without appointing an additional SMO. There are alternative Models of Care that could be adopted to support the SMOs to achieve contracted volumes without appointing a fifth SMO.

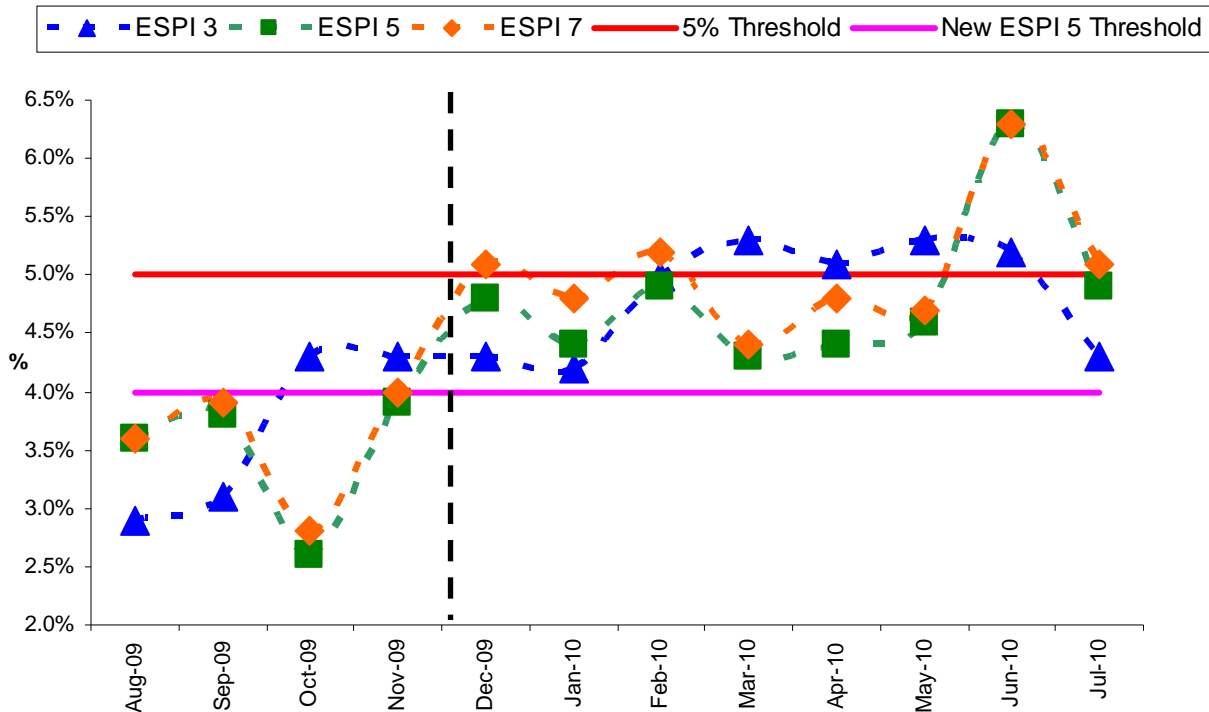
Personnel Options

Below are the alternative personnel options.

Permanent House Surgeon Position

The Nelson service had access to a House Surgeon last year with an interest in Ophthalmology who developed a competence in Avastin injections and thus was able to reduce the workload of the consultants in this area. The House Surgeon left in November 2009 (refer black dotted line on the chart below) and there has been no replacement until August 2010. The effect of losing this resource is reflected in the deterioration in the Elective Procedure ESPI measures.

Patient Flow Indicators - Ophthalmology - Inpatients



House Surgeons are able to deliver Avastin treatments and assist the SMOs who are on Call. The new House Surgeon (Post Graduate Year 2 Level) is scheduled to use Theatre 6 on a Friday to carry out the Avastin procedures. This is not an ideal situation as Theatre 6 is reserved for emergency Caesarean Sections and thus the Avastin treatments would need to be cancelled if an emergency Caesarean Section presents. However should option two be implemented the proposed refurbishment to the Surgical Outpatient rooms on Level 2 of the Percy Brunette Building of Nelson Hospital including the provision of some sterile procedure rooms would accommodate this procedure.

Using the House Surgeon in this way frees up time for the SMOs to carry out other procedures e.g. one additional cataract procedure per SMO theatre session. The House Surgeon is also able to assist with Clinics, the Call process and carry out some Minor Procedures such as Temporal Artery Biopsies or Eyelid Cyst removal procedures.

The disadvantages of having a permanent House Surgeon position (in comparison to other options) is that they typically only stay for a year and thus for one or two months of every year they are not fully productive as they require some training which also takes up SMO time. As a minimum the House Surgeon would need to be a Year 2 Post Graduate.

Permanent Medical Officer Position

An alternative to establishing a permanent House Surgeon position is to establish a permanent Medical Officer position. Medical Officers are more versatile than a House Surgeon, as they have greater stability and experience, and thus require less supervision and are able to prescribe and undertake a number of surgical procedures that a House Surgeon would not be able to carry out. Theoretically a Medical Officer should also stay longer than a House Surgeon as they are not on a fixed term training cycle. However it may be more difficult to recruit one, as there is not a large pool of specialist Medical Officers with the level of experience and knowledge of Ophthalmology that would be required.

Permanent Clinical Nurse Specialist Position

Southland currently has no Ophthalmologists. Locum SMOs come in weekly on Thursday and Friday to perform elective procedures. A number of different Ophthalmologists are used on a roster to cover different specialty areas e.g. paediatrics, corneal, retina, cataract and glaucoma conditions.

Southland does have a Clinical Service Leader, a Clinical Nurse Specialist (“CNS”), who is assisted by two Registered Nurses and a Health Care Assistant (who performs the Visual Field Tests).

The CNS and her team carry out cataract scoring, glaucoma tests, pre and post operative checks, cataract reviews, handle all FSAs, and decide who goes on the waiting list and who is discharged. The CNS discusses her findings with one of the visiting locums on a “virtual clinic” arrangement. The nursing team manages around 700 FSAs and 3,300 Follow-Ups per annum.

The CNS triages Ophthalmology patients from 0800 to 1700, has standing orders to administer a limited range of drugs but is unable to independently prescribe, and performs minor surgical procedures such as the removal of foreign bodies and rust rings, incision and drainage of myobian cysts, and minor lesion removal. Avastins are currently done by the locums but Southland is looking into having the CNS also perform this procedure. The Southland CNS completed her specialist training at the Sydney Eye Hospital where there is a six month in-house Post Registration Nursing Course.

Northland DHB also uses Clinical Nurse Specialists. They have two nurses comprising 1.0 CNS FTE in addition to one full-time Ophthalmologists and three part-time Ophthalmologists (two of which spent more time privately than in the public service).

The Northland CNS travels to Kaitaia once a week with one of the Ophthalmologists and holds a clinic. In Whangarei the CNS carries out pre and post operative cataract reviews, follow-up inflammatory conditions and manage acute presentations for removal of foreign bodies amongst other tasks. These CNS’s completed their training at Auckland University.

Auckland DHB has a number of CNS positions and has established sub-speciality CNS roles such as pre-operative assessment of cataract patients.

If NMDHB had a CNS they could also lead the nursing personnel, and oversee other operational aspects of the Ophthalmology service such as clinic rosters, and clerical and

administration staff. Again it may be difficult to recruit a CNS for Ophthalmology as there are very few currently practicing in New Zealand. However there will be more practicing in Australia as the Sydney Eye Hospital alone has 6 to 8 nurses at a time attending its six month Post Registration Nursing course.

Other non-SMO Medical Personnel in Clinics

The Ophthalmology service is fortunate to have other specialists that it can use to assist with Clinics. Currently the NMDHB service uses the following personnel: Orthoptist (0.6 FTE), GP (0.1 FTE), Optometrists (0.3 FTE), Nursing personnel (2.3 FTE) and Medical Photographer (1 FTE). A locum has also been used recently to clear the FSA backlog.

- **Locum SMOs** - NMDHB has used **locums** on a sporadic basis to remain within ESPI targets. Other DHBs are also contracting in locums on a more regular rostered basis, for example:
 - Southland currently has no Ophthalmologist employed and whilst recruiting for two positions is using locums around the country to assist;
 - The West Coast have no Ophthalmologists employed and rely on Canterbury DHB and locums from around the country to assist; and
 - Timaru has one Ophthalmologist and uses locums as required.
- The **Optometrist** is the most useful of the other Non-Medical Personnel (discussed below) as they have a higher level of Ophthalmology training and can also prescribe;
- Whilst the **Orthoptists'** particular skill is the diagnosis and management of binocular vision problems (defective eye movement and coordination) they are used for wider purposes in the UK where there are more practicing Orthoptists. There are very few Orthoptists in New Zealand;
- **Registered nurses** would require more training and supervision although some work is already being done. An SMO is currently training nurses in Nelson to do Goldman pressure Glaucoma checks as there are a large number of patients requiring these checks. The Southland nursing team perform these checks and hold diabetic screening clinics in the evenings; and
- **Health Care Assistants** are being used by Northland and Southland DHBs to carry out Visual Field Testing.

Increasing the use of non-SMO Medical Personnel in Clinics

The Wairau SMO and one of the three Nelson SMOs use Optometrists to run clinics whilst they are holding their own clinics. For example Wairau has its Optometrist hold alternating paediatric, glaucoma and pre-diabetic clinics on a Friday at the same time as the SMO is holding one of his clinics. Any patients that have symptoms that require the review of the SMO, or that the SMO wants to see specifically for clinical or professional reasons; can then be seen by the SMO during their clinic. The benefit of this is that the Optometrist can be seeing 16 Follow-up patients and of those typically only two or three may need to be also seen by the SMO. An example of how this works is provided below.

SMO Clinic	Patients	Mins	Total Mins	Optometrist Clinic	Patients	Mins	Total Mins
FSAs	2	20	40	FSAs	0	20	0
Follow-ups	12	10	120	Follow-ups	16	10	160
Total Minutes			160	Total Minutes			160
Time in Hours			2.7	Time in Hours			2.7

Note: The SMOs use the surplus time at the end of clinics to see Acute presentations and to carry out Laser Procedures. Two of the Nelson SMOs pay a fee to the DHB to enable them to also carry out Laser Procedures on private clients.

If three additional non-SMO clinics were held seeing 16 Follow-ups a clinic of which four patients (more than the estimated two to three patients discussed above) also needed to see the SMO then an additional 1,500 Follow-up patients could be seen by a non-SMO.

Nelson Follow-Up Attendances	Patient Followups	Clinics	Weeks	Total Attendances
SMO existing Clinics	10	8.0	42	3,360
2009/2010 Non-SMO attendances				308
Additional non-SMO Clinics	12	3.0	42	1,512
Total Attendances				5,180
Contracted Attendances				4,680
"Surplus" Attendances				500

As shown above in comparison to the Contracted Follow-up Attendances there would be a Surplus of 500 Attendances which could be taken out of the SMO Clinics and replaced with FSAs to cover the 240 Shortfall in Attendances discussed earlier and illustrated below.

Nelson FSA Attendances	Patient FSAs	Clinics	Weeks	Total Attendances
SMO existing Clinics	2	8.0	42	672
2009/2010 Non-SMO attendances				42
Total Attendances				714
Contracted Attendances				954
"Shortfall" Attendances				(240)

Additional non-SMO Clinics could also be scheduled to enable the SMOs to hold more Theatre sessions if required.

Whilst the example of the Optometrist above has been used, these clinics could also be held by a House Surgeon, Medical Officer, Clinical Nurse Specialist or Locum. It may also be possible to use an Orthoptist or Registered Nurse but additional training would be required.

It is proposed:

To address the current capacity issues that:

- NMDHB does **not** appoint a fifth SMO in Nelson;
- For the next six months whilst NMDHB has a House Surgeon on a six month contract, that the House Surgeon is used to carry out the Avastin treatments, hold three Follow-Up clinics a week and provide support to the SMOs on call;
- NMDHB recruits a Clinical Nurse Specialist with appropriate Ophthalmology clinical education and background who would form part of the nursing personnel FTE. Nelson currently has three registered nurses who are Specialty Clinical Nurses but none currently have the appropriate Ophthalmology specific post-graduate qualifications to step into the CNS role. Our preference is for a CNS over a Medical Officer or House Surgeon because this person could also lead the nursing team, oversee all clinic rosters district-wide, and provide the “glue” for the Ophthalmology service (something that is currently missing with only one full-time FTE in the whole service who is one of the clerical staff) and form part of the management/clinical leadership team;
- The Clinical Nurse Specialist when appointed should hold three clinics for Follow-Up Attendances a week at a minimum at the same time as one of the SMO clinics and reviews the diabetic photography results in Nelson instead of contracting the GP (0.1 FTE). To accommodate the appointment of the Clinical Nurse Specialist and the additional clinics (0.3 FTE) and diabetic photography reviews (0.1 FTE) the Nursing Personnel FTE in Nelson will need to change from 1.6 FTE Registered Nurses to 1.0 FTE Clinical Nurse Specialist and 2 x 0.5FTE Registered Nurses;
- Once the House Surgeon completes his six month contract in February 2011 consideration is given as to who is the best person to carry out the Avastin procedure. It may be possible to train the Clinical Nurse Specialist to carry out these procedures; and
- If a Clinical Nurse Specialist has not yet been recruited when the House Surgeons contract expires in February 2011 then a locum or Optometrist should be engaged on a suitable fixed term contract to carry out the three Follow-Up clinics per week until a Clinical Nurse Specialist can be recruited and/or trained. It may also be possible to extend the House Surgeons six month contract.

	<i>Estimated cost savings for this model of care - Opex</i>	COST/BENEFIT ANALYSIS		
		<i>2010-11</i>	<i>2011-2012</i>	<i>Total</i>
		\$211,356	\$269,563	\$480,919

SMO Job Sizing

The service employs three consultant ophthalmologists at Nelson Hospital (2.35 FTE) and one (0.8 FTE) in Wairau. With the exception of one in Nelson (0.75 FTE) all of the other SMOs are 0.8 FTE each.

The SMOs are rostered for one four-hour Theatre session, and three three-hour Clinics per week with the exception of one who is only holding two of the three individual Clinics. The Nelson SMOs also have a Joint Clinic on a Wednesday afternoon when monthly management meetings are held, referrals are triaged and some patient attendances are held. The Wairau SMO travels to Wellington or Christchurch monthly for collegial meetings.

	MON	TUE	WED	THU	FRI
AM	D Theatre Su Clinic	D Clinic	S Theatre Su Clinic	S Clinic Su Theatre	Su Clinic
PM	S Clinic	S Clinic	Joint Clinic	D Clinic	
WAIRAU SMO CLINIC					
	MON	TUE	WED	THU	FRI
AM					Clinic
PM		Clinic	Theatre	Clinic	

One SMO carries out corneal transplant operations and also the more complicated paediatric cataract procedures. These procedures typically require more follow-up attendances.

It is proposed:

That the SMOs be job-sized and that the NMDHB should involve ASMS in carrying out the job-sizing process.

District Wide Call

Current Arrangements

NMDHB Call is not managed district-wide – Nelson and Wairau hospitals have separate rosters:

- Nelson Ophthalmologists 1:3 and 1:4 weekend cover for the District; and
- Wairau Ophthalmologist covers 1:1 on weekdays and 1:4 weekends. The other three weekends are covered by the Nelson Ophthalmologists 3:4.

The Wairau call arrangements date back prior to the current specialist's appointment in 1996. Sharing call across the district was discussed when two specialists were appointed in 1996. However no changes were made as one of the other SMOs was concerned that it would disadvantage people in Tasman on the days that call was being covered from Wairau due to the greater distance.

Call Volumes

A review of the number of Acute Procedures and Acute clinic attendances over the past few years. The actual patient volumes that NMDHB has treated as an acute procedure are shown below together with a volume per month and for Nelson (where there are three SMOs) a volume per month per SMO:

Patient Volumes	2006/2007	2007/2008	2008/2009	2009/2010
Total Actual Volumes	51	81	141	57
Nelson Volumes	40	55	53	45
Wairau Volumes	11	26	88	12
Actual Volumes per month:				
Total	4.3	6.8	11.8	4.8
Nelson	3.3	4.6	4.4	3.8
Wairau	0.9	2.2	7.3	1.0
Nelson per SMO	1.1	1.5	1.5	1.3

The number of acute referrals being seen in clinics in Nelson over the past few years is shown below. This information is not captured for Wairau, and the trend in the Nelson data shows that it is only recently that it has been reliably captured in Nelson. Therefore the 2009/2010 numbers will have more validity than prior years. For 2009/2010 the 355 Attendances equates to 30 patients a month in total and 10 patients per Nelson SMO per month.

Nelson Acute Clinics	2006/2007	2007/2008	2008/2009	2009/2010
FSA Acute Clinic	0	48	109	169
Follow-Up Acute Clinic	0	38	54	186
Total Acute Attendances	0	86	163	355

Other DHBs

Consideration was given to how call is being handled in other similar sized DHBs. Southlands acute patients are currently being triaged by the Ophthalmology Clinical Nurse Specialist 0800 to 1700 who assesses patients and consults with the specialist on call in Otago (as Southland currently does not have its own Ophthalmologist). Southland then treats if appropriate or refers the patient through to Otago. The after hour acute service is provided by Otago.

Northlands Ophthalmologists are based in Whangarei and provide acute call for Kaitaia Hospital whose emergency department serves a scattered population of approximately 21,000.

Whakatane call is handled by Tauranga.

Nelson Call Issues

The Acute Procedure and Clinic Attendance volumes discussed above are not excessive and other DHBs are managing call across a wider population with less SMOs than Nelson. However some of the Nelson SMOs state that the current call arrangements are onerous, and this is one of the reasons why they have requested a fourth SMO in Nelson, to have someone else to assist in covering call.

In contrast to this the Wairau SMO does not find the Wairau call arrangements onerous and is not asking for a change to the call arrangements.

From discussions with the Nelson SMOs the main difficulty with the current call arrangements has been the lack of support during the week as there is no one to assist them in managing patients around their scheduled Public and Private clinic and theatre time. For example having someone they can use to organise blood tests, MRI scans, patient travel requirements etc. This is not such an issue on weekends as the SMOs do not have to work around clinics and theatres and typically only need to see one or two patients. The appointment of a full-time Clinical Nurse Specialist will address the support issue.

Cost of Call

From a NMDHB perspective in 2009/2010 the total cost of these allowances was \$165k. Applying 2009/2010 volumes to the 2010/2011 PVS prices does not leave much of a margin to cover other related costs such as the cost of the theatres, inpatient rooms, clinical supplies.

PVS Contract Line S40001	10_11 Volumes	10_11 Price	Total 10_11 \$
Acute Procedures	30	\$ 4,280.90	\$ 128,427
FSA Acute Clinics*	254	\$ 197.48	\$ 50,159
Follow-Up Acute Clinics*	279	\$ 165.27	\$ 30,740
Total Revenues			\$ 209,326

It is proposed:

That Call is managed on a district-wide basis with the four SMOs (three in Nelson and one in Wairau) covering call one night a week Monday to Thursday and then rotate 1:4 to provide cover Friday to Sunday. This arrangement would also reduce the safety risk issues around being on call whilst in Theatre if SMOs are scheduled to be on call on the days that they are not in theatre for their public or private practices. The permanent appointment of a Clinical Nurse Specialist will also provide call support for the SMOs during the week.

	COST SAVING INITIATIVES - OPEX	COST/BENEFIT ANALYSIS - OPEX		
		2010-2011	2011-2012	2012-2013
District-Wide Call				
Costs (estimated)				
<i>Nil</i>		-	-	-
Benefits (estimated)				
<i>Availability Allowance saving</i>		\$9,085	\$18,534	\$18,998
	Total estimated savings	\$9,085	\$18,534	\$18,998

The Cost Savings assume that the change in Call arrangements would take effect from 1 January 2011.

Note: If all of the Call was managed from Nelson on a 1:3 basis the full year saving in 2011/2012 is estimated to be \$31,891 (an additional \$13,357 per annum). This is not proposed as the additional cost savings are insufficient to outweigh other negative aspects of the arrangement.

Total Cost Saving Initiatives

The total operational cost saving from these initiatives over the next three years is estimated to be:

OPTION TWO - ESTIMATED TOTAL "OPEX" COST SAVINGS	COST/BENEFIT ANALYSIS		
	2010-2011	2011-2012	2012-2013
OPTION TWO - ESTIMATED TOTAL "OPEX" COST SAVINGS	\$298,366	\$447,063	\$458,240

Procurement and Contracts Report Cost Saving Identification

In the Financial Overview it was identified that the Wairau budgeted expenditure for Theatre Consumables and Ophthalmic Implants/Lenses for 2010/2011 totalling \$95k was significantly higher than actual expenditure in 2009/2010 of \$75k and prior years. This was discussed with the Manager Surgical Services and have agreed that the budget is higher than necessary. It is proposed that the budget be trimmed back to \$75k and that the saving of \$15k in budgeted costs is recognised.

Initiative Number	PROCUREMENT REPORT - COST IDENTIFICATION	COST/BENEFIT ANALYSIS - OPEX		
		2010-2011	2011-2012	2012-2013
6.0	Establish a Clinical Products Co-Ordinator Role			
	Costs (estimated)			
	- Nil	-	-	-
	Benefits (estimated)			
	- Reduction in Ophthalmology Theatre Consumables budget	\$10,000	\$10,200	\$10,404
	- Reduction in Ophthalmic Implants/Lenses	\$5,000	\$5,100	\$5,202
	Total estimated savings	\$15,000	\$15,300	\$15,606

Option Two - Capital Expenditure Cost Saving Identification

Ophthalmology Service Model of Care (Capex Savings)

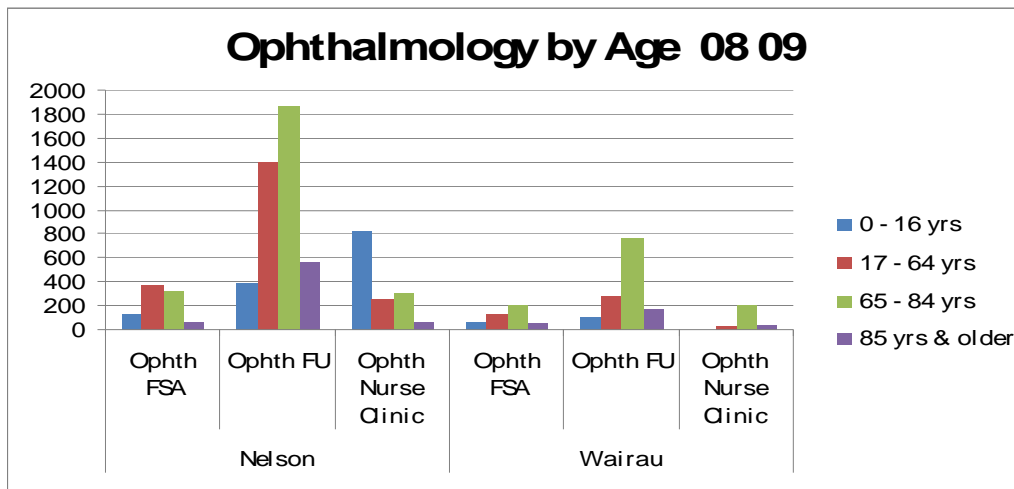
Set out below is the Capital Expenditure cost savings related to the proposals made in the Operating Cost Savings above.

Initiative Number	COST SAVING INITIATIVES - CAPEX	COST/BENEFIT ANALYSIS - CAPEX		
		2010-2011	2011-2012	2012-2013
2	Ophthalmology Service Model of Care			
	Costs			
	- Theatre Trolleys	(\$50,000)		
	Benefits			
	- Building costs to accommodate 4th Nelson-Based Ophthalmologist (based on the lower Business Plan option)	\$84,350	-	-
	- Estimated equipment costs to accommodate 4th Nelson-Based Ophthalmologist	\$60,000	-	-
	Total estimated Capex savings	\$94,350	-	-

Theatre Cataract Trolleys

The existing Nelson theatre beds are not considered "best practice". There are some specifically designed cataract trolleys that have adjustable heights that make it easier for the Ophthalmologists to carry out procedures and speed up the movement of patients in/out of

theatre. Given that a large proportion of patients are over 65 (refer below) and therefore tend to be slower moving in and out of theatre and getting on and off the theatre bed, cataract trolleys can provide substantial productivity gains.



A review of improved efficiencies from having these cataract trolleys was carried out by the Clinical Service Improvement Facilitator (Organisational Development) which estimated that turnaround time in the Ophthalmology Theatres could be improved by 23%. One SMO has used cataract trolleys and estimates that cataract procedures could be increased from six to nine per theatre session with the support of an additional nurse to prepare one patient whilst another is being operated on. We have not factored in another nurse in this model. This will again free up time for the SMOs to carry out other procedures and meet the anticipated growth in volumes over subsequent years driven by the aging population.

Two trolleys would be required so that one patient can be set-up whilst the previous patient is being operated on. Cataract operations take around 30 minutes and therefore sufficient time would be available to prepare one patient whilst the previous patient is being operated on. The cost per trolley ranges from \$15k for a manual to \$25k for an electronic trolley.

It is proposed:

That the trolleys are purchased as part of creating additional future capacity and potentially reducing the current SMO requirement.

Accommodating a fourth Nelson-based SMO

A Capital Expenditure Business Case was developed in December 2009 to expand the Ophthalmology outpatient facilities at Nelson Hospital to accommodate a new consultant (the fourth Nelson-based SMO) and an additional clerical secretary. The Business Plan identified two options ranging from \$84,350 (excluding GST) to \$96,850 (excluding GST). Previously the Ophthalmology service had gained approval to spend \$53,000 (excluding GST) and therefore was applying for the shortfall. These building construction costs do not cover the equipment cost of fitting out the consultants' room which we estimate to be in excess of \$60,000 as the Ophthalmology examining chairs alone cost around \$20,000.

This process has now been superseded by the Nelson site development work which is looking at the whole of the Surgical Outpatients area on the second floor of the Percy Brunette Building of which Ophthalmology is just one component. The site development Business Plan does not contain any specific costings for accommodating the additional SMO, or for the Ophthalmology share of extending the Level 2 Floor Plan over the AT&R facilities on Level 1 to include sterile Procedural rooms which Ophthalmology could use to carry out the Avastin Procedures.

It is proposed:

A fourth Nelson-based SMO would not be required then the additional consulting room will also not be required. Currently the Nelson SMOs do not need to hold their clinics at the same time and thus the SMOs could use the consulting room containing the laser machines and the House Surgeon, Optometrist or Clinical Nurse Specialist assisting them could use the adjacent consulting room.

If space issues are still an issue it may be possible to enter into a contractual arrangement with one of the SMOs to use a privately owned facilities which have specialist area fully equipped for Ophthalmology clinics and a room suitable for Avastin injections.

Process Initiatives

District-Wide Service Planning including Clinical Leadership

The Ophthalmology service departments in Nelson and Wairau operate as two separate services and there is no formal Clinical Leadership structure for the SMOs, Nursing staff or Clerical staff. This in our view puts unnecessary pressure on all personnel including management.

Two Separate Services

Nelson and Wairau operate separate wait lists, the Wairau SMO and staff are not included in the Nelson departmental meetings, peer review and audit activities. Joint meetings used to take place but a change of meeting time made it inconvenient for the Wairau SMO to attend. The new cataract screening tool and monitoring programme has been established in Nelson but not in Wairau. Thus the only District-wide focus is at a management level.

As Wairau is the smaller service its staff are not benefiting from the clinical and collegial support that they should receive in a larger service. The Wairau consultant addresses this by participating in peer meetings in either Christchurch or Wellington but there is no comparable opportunity for nursing and clerical personnel.

Clinical Leadership

The need for greater Clinical Leadership has been identified as a DHB wide issue and has been recognised in the NMDHB restructure of the Senior Leadership Team and the Clinical Leadership project that is being undertaken.

Ophthalmology is also struggling from a lack of formal Clinical Leadership:

- (a) Ophthalmology does not have a Clinical Director and there is no formal clinical leadership structure or one nominated SMO to assist the Manager of Surgical Services in leading and managing the Ophthalmology Service. Any leadership/management of the Ophthalmology department has to be achieved through consulting with all four SMOs;
- (b) Whilst the Nelson Ophthalmology service has monthly meetings involving management, SMOs and staff, Wairau is not involved in these meetings and thus it is difficult to manage the service on a district-wide basis;
- (c) The Nelson nurses do not report to a Charge Nurse Manager and do not have a designated clinical leader;
- (d) Wairau does not have a specialist eye nurse position. It is covered by nurses who work within Surgical Outpatients and has one nurse who assists the SMO with his clinics. This nursing position reports to the Charge Nurse Manager Outpatients, District Nursing and Oncology but does not have any interaction with the Nelson nursing personnel who have some specialty-specific training and skills; and
- (e) The administration staff report to the District Manager of Clinical Support Services and thus have a different reporting line to all of the other staff in Ophthalmology service.

Wait Lists

Currently not only is there a separate wait list for Wairau, but each of the Nelson SMOs has their own wait lists. Whilst this may not be a patient care issue when a service has plenty of surplus capacity this is not the case currently in the Ophthalmology service which is having difficulties achieving a number of its ESPI measures.

Having multiple wait lists makes it more difficult to schedule patients to achieve ESPIs and increases the risk that patients may be disadvantaged as a patient with a higher clinical need may be waiting longer than a patient with a lesser need.

A number of reasons have been put forward why wait lists should not or can not be merged but these are not insurmountable issues. For example Oracare does not enable Nelson and Wairau lists to be merged and the software supplier, I-soft, has refused to assist with the merger of the lists. To address this NMDHB IT believes it can write a programme to prepare one waitlist from the data contained within Oracare.

There is a practice at NMDHB that if a SMO has carried out an FSA then they should also carry out any surgical procedures or Follow-ups for that patient. In the past NMDHB resources and high levels of staff retention enabled this to happen but with rising demand and limited resources this is no longer possible. NMDHB is now in a position that many other public hospital services have been in for a number of years, of not being able to guarantee that patients will be dealing with the same SMO throughout their treatment. Therefore it will need to put processes and procedures in place to deal with this e.g. appropriate consent forms enabling informed consent as near to the procedure as possible (ideally within one month) and enabling a different consultant to be appointed. This change will require a significant cultural change and appropriate policies and procedures would need to be established around continuity of care.

Service Planning

Carrying out the review of the Ophthalmology service area was very time-consuming due to a lack of management information systems, and policies and procedures around service planning. As a result the financial and volume information needed for the review was generated by a number of different sources.

There are many contributing factors to why these difficulties exist but in our view the main reasons are:

- The Ophthalmology service has evolved over the years to its current configuration of nineteen people working as employees or on contract. They comprise a total of 12.5 FTE of which only one person is a full-time 1.0 FTE. Because there is no formal District-Wide Service Plan detailing what services are being provided, by whom and when, staff structures have developed over time;
- Lack of clinical leadership and as a result:
 - There are too many people reporting directly to the Surgical Services;
 - Medical, Nursing and Clerical personnel are organising their own rosters and do not all ultimately report to the same Manager. The four clerical personnel, being 3.75 of the total 12.5 FTE report to the Director Clinical Support Services; and
 - Rosters are not currently formally captured on any of the DHBs reporting systems e.g. Actor, Trendcare etc.
- The financial and business analysis support received by the Manager Surgical Services is inadequate and as a result the Manager is not receiving robust information on which to make informed decisions;
 - A profit and loss report for just the Ophthalmology service does not exist. Ophthalmology related revenues are captured in one cost centre and the associated costs are spread over a large number of other cost centres. Summarised are some of these cost centres in the Financial Analysis shown above but other related costs of using the Theatres, the Outpatient rooms and other Clinical and Administrative support services have not been captured;
 - The Reporting Team is under-resourced and as a result can only provide data to management as it does not have time to analyse the data and convert it to information that can be used by management; and
 - The finance and business support functions lack the time and leadership to adequately support management. For example the Business Case prepared to support engaging a fourth SMO in Nelson was too narrow in its focus as it did not consider why volumes were increasing, whether or not the revenues currently funding the service could support the significant costs that would be incurred, or what alternative options were available.

It is proposed:

- One of the four SMOs is appointed as the Clinical Leader of the Ophthalmology service. This would equate to a 0.2 FTE requirement and have included the costs associated with this appointment. The responsibilities of the Clinical Leader would be to work with/assist the District Manager Surgical Services and/or the new Medical/Surgical Services Directorate in:
 - Provide clinical leadership to the other personnel including outsourced Medical personnel;
 - Establishing the service budget, output and quality targets;

- Monitoring performance against budget, output and quality targets; and
- Holding the service accountable for performance against budget, output and quality targets.
- The monthly Nelson management meeting is replaced with a monthly District-wide meeting. A suitable time for all participants would need to be established. The meeting could be held by video conference to reduce travel time;
- There is a single point of entry for electives and a single wait list so that priorities can be managed as one;
- A District-Wide Service Plan is developed incorporating the information contained in this report and formalising:
 - Clinic and Theatre rosters including hours of work;
 - Acute and Elective Planning Activity – good work on this has been done by the Elective Services Manager;
 - Managing wait lists;
 - Clinical Leadership;
 - District-Wide Collegiality and CME;
 - Succession Planning; and
 - Other Operational areas deemed appropriate by management and the Clinical Leader.
- Key performance indicators are identified, monitored and reported against;
- An Ophthalmology service financial summary is prepared monthly incorporating volumes and analysis of the interrelationships, trends and variances to budget be completed, so that the leadership team is able to monitor operational performance. Combining the cost centres as done in the Financial Analysis section including transferring the Wairau nursing personnel and all clerical personnel to the new cost centre would help to achieve this.

Additional proposals related to District-Wide Service Planning and Clinical Leadership specific to Nursing Personnel and Clerical staff is provided below.

Proposals have already been made on improving the business support services and will address the budgeting and Business Case issues raised in this document.

Nursing Staff

The Nelson Ophthalmology service has three Registered Nurses who are Specialty Clinical Nurses (SCN), and have undertaken post graduate study to support them in these designated senior nursing roles. Currently none of these nurses work a full FTE. Contracted hours are 0.6, 0.6 and 0.4 FTE. The Rutherford Initiative Team has identified that there is a greater cost per nurse hour of employing any nurse for less than 0.5 FTE as sick leave and training entitlements are not determined on a pro-rata basis below a 0.5 FTE but are accrued at the same level as a 0.5 FTE. There is also a policy in place that no nurses are to be employed for less than 0.5 FTE without prior approval by the DONM. The service needs to have one person working full-time or at least a 0.8 or 0.9 FTE as part of the total contracted hours.

Currently the Nelson nurses do not have a Charge Nurse Manager to report to and there is no senior nurse or one of the three nurses designated to lead the nursing team. Ophthalmology is

not the only service where this is an issue. Orthopaedics, Urology, ENT and the Medical and Surgical outpatient departments do not have a Charge Nurse Manager. This issue has already been identified by the DONM and the Nursing and Midwifery Service Development Team (“NMSDT”) in their review of Senior Nursing roles within the Outpatient department (as part of the Rutherford Initiative implementation process) and they are preparing a separate report with proposals to address this issue.

The Wairau Ophthalmology service is supported by a Registered Nurse (0.7 FTE). This nurse reports to the Wairau Charge Nurse Manager Outpatients, District Nursing and Oncology but does not have any interaction with the Nelson nursing personnel who have specialty-specific training and skills. The Wairau Ophthalmology service would also benefit from staff having specialist nursing Ophthalmology training and taking on more clinical responsibility.

All of the nurses are currently working with an older position description and there is “role creep”, where clerical duties and other technical tasks are becoming a key part of their area of responsibility. This is professional waste which defuses clinical impact.

The Nelson Specialty Clinical Nurses do not have any reach into the community nor a contribution to developing the capacity of nurses working out in primary health care to support patients in the community. There is also limited capacity to provide education and mentoring of nurses within the inpatient areas or Wairau when dealing with ophthalmology patients. These two components are considered to be key responsibilities of nurses with identified specialist skill and knowledge.

It is proposed:

- The FTE configuration for the ophthalmology service is reviewed to include a permanent full-time Clinical Nurse Specialist position with a clinical oversight responsibility across the district;
- Position descriptions are reviewed to align key responsibilities with service requirements; and
- Nurse-Led Clinics are formalised in the District-Wide Service Plan and supporting rosters are captured on the Actor Payroll system. A project is currently underway to capture all Outpatients Departments nursing hours on the Actor system and is expected to be completed by September 2010 which will enable this proposal to happen.

Nelson Clerical Staff

Until recently Nelson has had four Clerical staff working 2.8 FTE. One clerical staff member is full time the other three part-time. Tasks were allocated between the four staff members as follows:

Personnel	Responsibility	FTE
Staff Member 1	Outpatients	1.0
Staff Member 2	Procedures for 2 SMOs	0.55
Staff Member 3	Procedures for 1 SMO & Avastins	0.7
Staff Member 4	Diabetic Clinics and Typing	0.5
Total		2.8

In addition to these tasks the Surgical Outpatients receptionist processes all Outpatients seen in the Clinics.

Over the past few weeks a resignation and longer term staff sickness have left the Ophthalmology department short-staffed. What compounds this difficulty is the way in which jobs are shared between staff members and as a result no one staff member has a complete oversight of the full clerical process for Ophthalmology.

Concerns have also been raised in relation to theatre and clinic bookings with a number of errors being reported and clinics being reportedly either over or under booked. As well as causing inconvenience for patients this has resulted in a waste of resources e.g. patients being placed on theatre lists and arriving at theatre without having had their pre-operative assessment performed. Inadequate time between posting of appointments and scheduled appointment times has also resulted in a number of DNAs.

The hours currently worked by staff members do not fit the operational activities of the department. The main duty of the clerical staff is organising patient appointment times. One staff member works 7.30 to 4.30 another works 4 to 6pm. The critical hours for the service are 9 to 12 and 2 to 5.

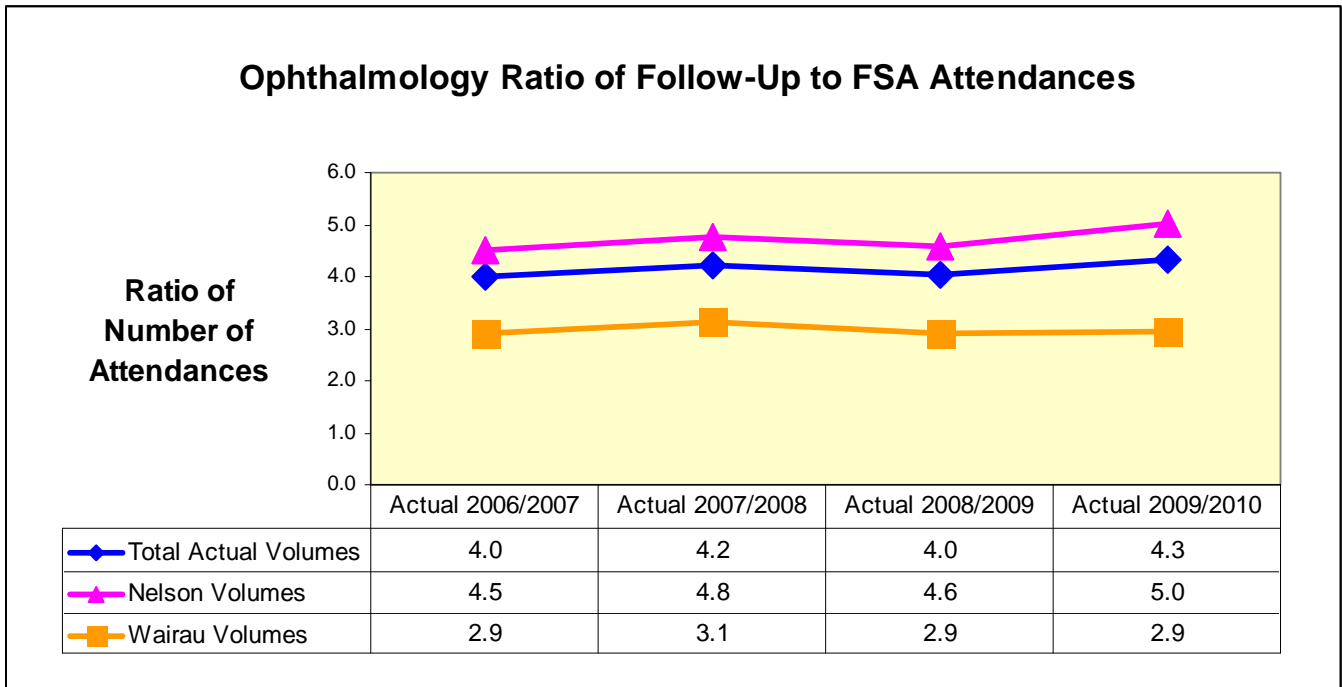
The Wairau clerical and secretarial duties are in the process of being split as part of the change to the clerical model of care in Wairau. Typical secretarial duties such as typing will occur in a shared office space with other secretarial staff with departmental cross-cover arrangements between staff members. Clerical duties such as theatre and clinic bookings will be performed by a separate group of generic clerical workers.

It is proposed:

- Hours of work are changed to reflect the operational needs of the service. Policies and procedures are put in place through the Service Planning process to ensure that in future all clerical staff are contracted for a minimum of 0.5 FTE and work between the hours of 8am to 6pm;
- Job rotation is re-introduced;
- Adequate desk files are created for each position to enable jobs to be interchangeable so that if someone leaves, or is on leave, someone else can easily cover their job;
- “5S” methodology should be used to clear debris, archive and reorganise desks for better access and flow in the office area and assistance with this obtained from the O&D Service Improvement Team if required; and
- Pre-admission packages should be set up which are clearly marked and pre collated to improve the efficiency of this process.

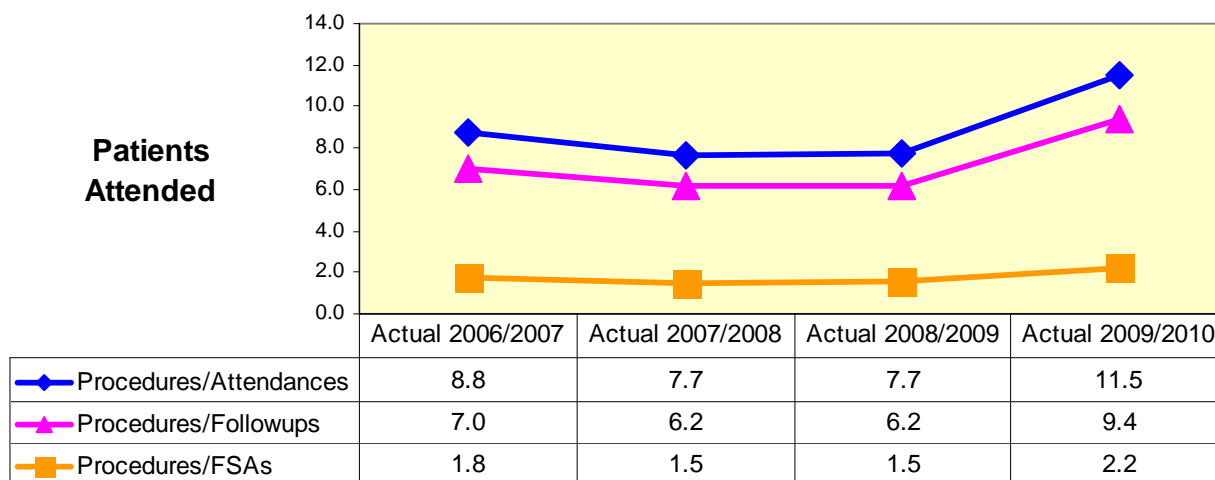
Discharge Policy

There are no set rules for how many Follow-ups should occur for a particular diagnosis or treatment, and the numbers do vary depending on the Clinicians personal judgement. For example some Ophthalmologists are more comfortable discharging patients sooner than others and thus reducing the number of subsequent follow-ups required.



The ratio of First to Follow-up Attendances above shows that the discharge rate in Wairau is considerably higher than the discharge rate in Nelson. Over the last four years Wairau has had less than three Follow-up Attendances for every FSA whereas Nelson has over four.

Ratio of Patient Procedures to FSA & Follow-Up Attendances



As shown above the ratio of First and Follow-up Attendances to the number of Patients undergoing procedures is very high. For 2009/2010 the numbers show that on average for every procedure undertaken there were 2.2 FSAs and 9.4 Follow-Ups totalling to 11.5 FSA and Follow-Up Attendances.

Whilst the number of Follow-ups for Ophthalmology may be higher than for other specialities (as a number of the eye conditions need to be reviewed every six months) it is not known what a suitable ratio would be. It is proposed that these ratios are investigated as part of reviewing the discharge policy. A discharge policy should be established and a suitable ratio of First to Follow-up Attendances should be set reflecting the policy and monitored as part of the Key Performance Indicators.

Review of Outsourced Contractual Rates

During this review two anomalies/issues with contractual rates were noted:

- NMDHB is currently paying optometrists lower than the current market rate which can result in precluding NMDHB from accessing the level of Optometrist support that may be required in the future. Optometrists are a useful resource and more cost effective than locums or medical personnel; and
- In Wairau part of the clinic is carried out in the Hospital but the Yag Laser Clinic is carried out at the SMOs private rooms, Marlborough Ophthalmic Services Limited (“MOSL”), as Wairau Hospital does not own a Yag Laser. The rate paid is effectively the same rate as the

Provider receives for carrying out Laser Procedures and so there is no margin to cover Corporate Overheads.

It is proposed:

That a review of **all** outsourced contractual rates is undertaken to determine what the current market rate is and whether or not NMDHB is obtaining a sufficient margin to cover corporate overheads at the rates that are currently being used.

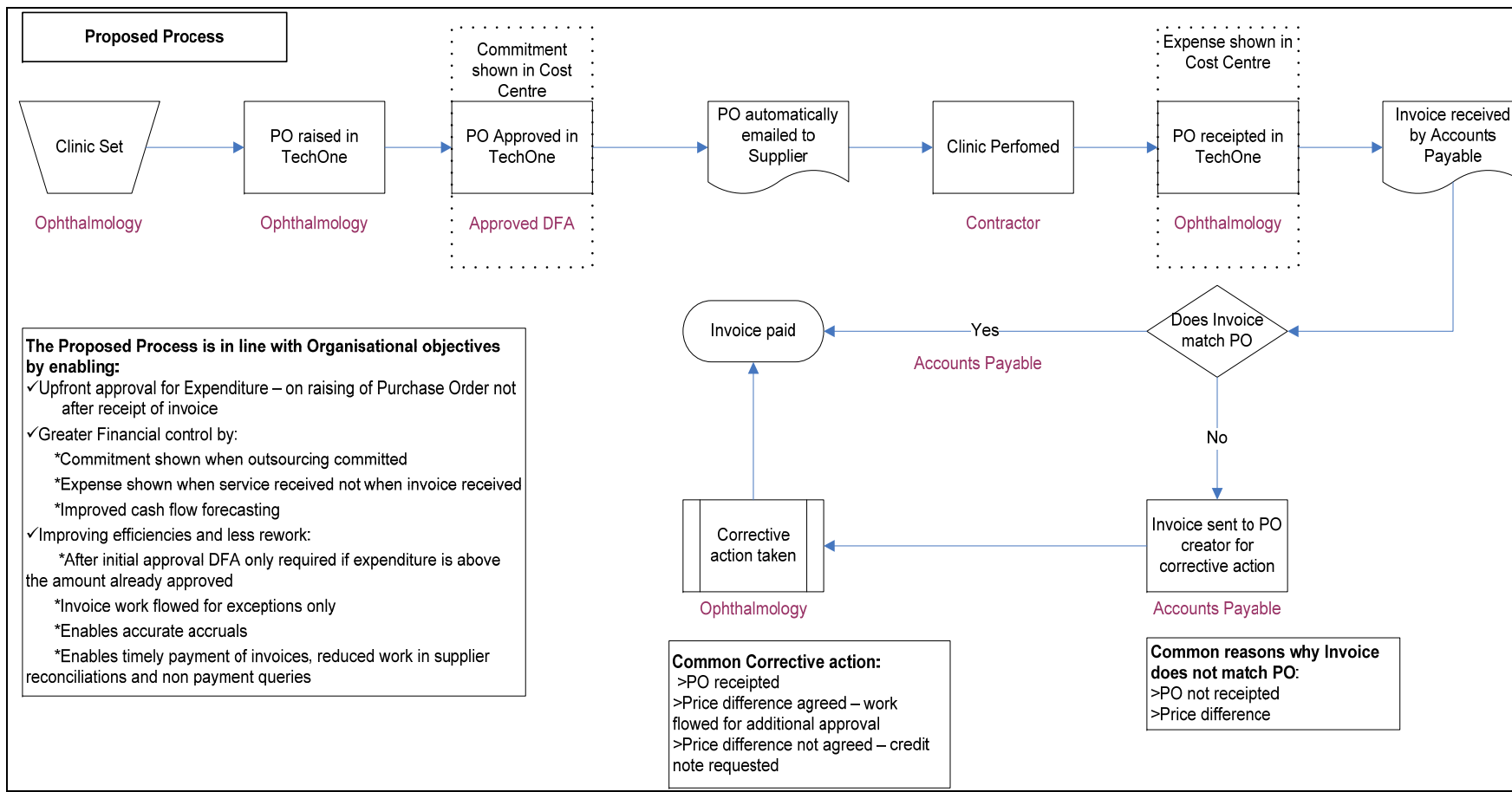
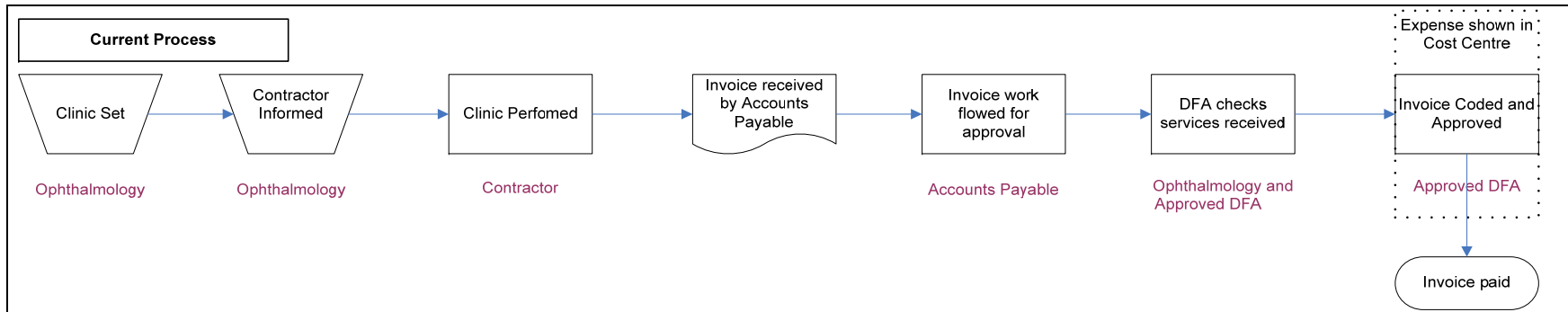
Outsourced Services Procurement Process

Ophthalmology uses outsourced medical personnel (Optometrists and Locums) who send in invoices for work performed. The contracted hours for most of these services seldom vary and are included in the budget at a set amount per month.

The current process of processing outsourced invoices requires the District Manager of Surgical Services to review and sign-off every invoice received. A summary of the Current Process is provided below.

It is proposed:

That purchase orders are generated for these services through TechOne as outlined in the Proposed Process diagram below. This will ensure up front approval of the clinic, reduce the District Managers administration time, reduce month-end accrual processing and assist with better financial control as outlined below.



House Surgeons

NMDHBs House Surgeons are allocated to various service areas but their associated costs are captured in two Cost Centres – one for Nelson (1094) and one for Wairau (2110).

Currently Ophthalmology shares a House Surgeon with Orthopaedics. 25% of that House Surgeons time is supposed to be spent in Ophthalmology and the balance in Orthopaedics. Currently it is not easy to see where the House Surgeons are spending their time and therefore if the various services are making the best use of the roles or if some specialties are monopolising the House Surgeon's time.

House Surgeons have commenced recording their time in Actor. This will enable their time to be charged to a specific specialty so it will be easy to monitor where they are actually spending their time.

It is proposed that the House Surgeon budgets are reorganised so that:

- Their budgeted salary is allocated to the areas that they have been assigned to e.g. 0.75 FTE Orthopaedics and 0.25 FTE Ophthalmology;
- Actual salary costs are recognised against the cost centre where they have spent their time as per Actor;
- Other costs associated with the House Surgeon programme (e.g. the House Surgeon co-ordinator, training costs, travel and accommodation etc) should remain in the Nelson and Wairau House Surgeon cost centres which can be combined into one cost centre; and
- Consideration should also be given to whether or not it is better to share the House Surgeon with another similar sized specialty such as ENT rather than Orthopaedics, or to have the House Surgeon working full-time in one specialty for a fixed period and then moving to another specialty.

Oracare Reporting and PVS Volume Recognition

There are a number of discrepancies in the way in which various activities have been coded or other anomalies:

PVS Contract Line MS01001 – Ophthalmology Nurse Clinics

- Until recently only clinics held by the Ophthalmology nurses were being included under PVS Contract Line MS01001. In the last year this has been extended to include the Visual Field Testing clinics carried out by the nurses and also the Orthoptist and other non-Nurse clinical staff. For an Ophthalmology clinic volume to be recorded under PVS Contract Line MS01001 it needs to be captured in Oracare under the "Ophthalmology Nurse Clinic" contract line description. However whilst the Nelson Visual Field Testing volumes are being captured correctly, the Wairau Visual Field Testing volumes are being captured under the "Diagnostic Clinic" contract line description. "Diagnostic Clinic" volumes are not recognised against PVS Contract Line MS01001 or any other PVS Contract Line and thus no revenue is attributable to

the Ophthalmology service for this activity. However there is a cost associated with the activity as NMDHB contracts this testing out to the private rooms of the Wairau SMO;

- Prior to the inclusion of Vision Field Testing Nelson recorded Nurse-Led Clinic activity under the “Eyes - Nurse Only Clinic” category which is recognised under the “Ophthalmology Nurse Clinic” contract line and thus counted under PVS Contract Line MS01001. However whilst these clinics are still taking place for the last two years no volumes have been recorded against the code. For example the nurses hold four diabetic clinics a week where they typically see 13 diabetics a clinic;
- Wairau “Care and Review” volumes have been included under the “Ophthalmology Nurse Clinic” contract line and therefore recorded as a volume against PVS Contract Line MS01001 but they shouldn’t be. “Care and Review” involves reassessing patients in the active review treatment list as to their eligibility for certainty of treatment and this activity does not meet the National Standards Framework for a “Nurse Led” Clinic;
- Cataract Assessments carried out in Wairau by the Optometrist are being included under the “Ophthalmology Nurse Clinic” contract line and therefore recorded as a volume against PVS Contract Line MS01001. However it is not clear whether these should be recorded against PVS Contract Line MS01001 for Nurse Led Clinics or if in fact they should actually be recorded as a Follow-Up Attendance or as a Diagnostic Clinic; and
- The Medical Photographer keeps records of all attendances. However NMDHB has been unable to determine where the Ophthalmology related volumes are captured.

Diagnostic Clinics

- The “Diagnostic Review” contract line description captures the clinic performed in Nelson by one of the Optometrists who assists the Orthoptist assessing children and carries out active reviews. Items with a “Diagnostic Clinic” contract line description in Oracare are not recognised against a PVS Contract Line. As discussed above Active Reviews do not meet the National Standards Framework for a “Nurse Led” Clinic or any other PVS Contract line and therefore should be treated as a Diagnostic Clinic in Oracare. However NMDHB has not been able to ascertain whether all of these volumes relate to Active Reviews or if some relate to the child attendances and it may be that these attendances should be captured as a Nurse-Led Clinic or a FSA or Subsequent Attendance and thus linked to a PVS Contract line; and
- The “Retinopathy – Not Diabetic” contract line description is used for some Wairau clinics. It is currently classified as a Diagnostic Clinic in Oracare and therefore is not linked to a PVS Contract line. NMDHB has been unable to ascertain who is carrying out these reviews or why, and therefore do not know if it is correctly included in Oracare as a Diagnostic Clinic or not.

Pre-Admission Clinics

- Whilst not directly linked to a PVS Contract Line (as it is considered to be part of delivering the Elective Procedure PVS Contract Line) Nelson records volumes of patients seen in the Nurses Pre-Admission Clinic but Wairau does not. These attendances should be recorded as it assists in assessing and monitoring nurse activity levels and service planning.

Laser Procedures

- Laser Procedures are often carried out during a First or Follow-Up Attendances. This is good practice as it is efficient and also means that the patient does not have to come back subsequently to have a Laser Procedure. In these instances volumes should be recognised for both the Laser Procedure and the First and Follow-Up Attendance however this is not always happening in practice.

First and Follow-Up Attendances

- For Procedures Oracare has a “proc_1_desc” code that provides information on the type of procedure. However Oracare does not appear to have a similar field for providing information on the nature of First and Follow-Up Attendances e.g. macular degeneration, glaucoma, cataracts etc. As a result from a Service Planning perspective it is difficult to see what is driving volumes. Wairau has resolved this to some extent by describing some of the clinics in the “APPT_CINP_TITLE” field e.g. paediatric eye, diabetic eye, glaucoma overflow patients. But not all of their clinics are captured by these descriptions and so like Nelson there are many attendance volumes for which the medical condition is unknown. Therefore it is believed that a better option would be for an additional Oracare field to be created which would capture this information; and
- The Orthoptist activities appear to only be included in the Visual Field Testing line. However from what is understood the Orthoptist is carrying out FSA and Follow-up Attendance on children which raises the question of whether some of these attendances should be recognised as a FSA or Follow-Up Attendance.

CSR Reports

- In obtaining volume information for this report we found that the CSR reports that are currently available to personnel on the intranet are not up to date. At the time that the CSR reports are published following month-end the supporting data has not been finalised and may still contain coding errors;
- In analysing the Ophthalmology data significant variances were found between the latest data available and the volumes reported in the CSR reports. Also as data capture had changed over the four year period adjustments needed to be made to the data to get a true picture of year-to-year trends; and
- Therefore the CSR data reports published on the web should not be relied upon or used for carrying out any volume or trend analysis.

It is proposed:

- The issues discussed above are investigated, and processes and procedures put in place to address them where appropriate;
- The Oracare codes and categories are reviewed as part of preparing the Service Plan to ensure that in future information is being captured in a way that provides management with the information that they need to monitor the operations of the service;
- Data rules be established to ensure consistency of data/information obtained from Oracare;
- The CSR reports that are currently on the intranet be removed so that people do not use them for carrying out any volume analysis or trends. Copies of the monthly reports published should be archived but clearly marked “superceeded”. Up-to-date versions of accurate and reliable historical data should be published each month so that the latest data is accessible on the intranet. Extra resource will be required to enable the Reporting Team to carry out this initiative; and
- A separate Oracare field is established for Outpatient volumes so that the medical condition driving the attendance, minor or laser procedure can be recognised e.g. macular degeneration, glaucoma, cataracts etc so that this information is available for Service Planning purposes.

EyeNZ Website

A website www.eyenz.co.nz or www.eyenz.com has been developed by one of the Nelson Ophthalmologists and the hosting fees are currently being paid by NMDHB. However there is no direct reference to NMDHB on the website nor is it linked in any way to the NMDHB website.

It is proposed:

That these arrangements be reviewed to determine the most appropriate way forward to include this web site as part of the NMDHB web/communication strategy.

Further Analysis Initiatives

IDFs and the South Island Regional Plan

NMDHB is able to perform a significant proportion of Ophthalmology procedures but the following treatments are referred to other regions (usually Canterbury DHB): vitreo-retinal surgery, complex oculoplastics and orbital surgery, intraocular tumours, some corneal treatment e.g DSEK, some paediatrics and the Wairau corneal transplants. IDFs totalled \$180,274 for the nine months ended 31 March 2010.

Some initiatives have been undertaken recently and other opportunities identified that will enable more procedures to be performed by NMDHB thus reducing the IDF cost and in doing so the total cost of the Ophthalmology service²:

- NMDHB installed some new equipment in June 2010 which will enable some patients to have lesions lasered in Nelson rather than needing to be transferred to Wellington or Christchurch. The equipment is a new Laser Indirect Ophthalmoscope which is a headset used for the treatment of people who are too short or elderly to be placed on the slit-lamp or for those with vitreous haemorrhages where the view is poor through the slit-lamp; and
- Until recently retinal detachments were referred out of the District. NMDHB is now able to perform about 20% of retinal detachments in Nelson following replacement of the cryopexy unit. If NMDHB had access to a SMO with vitreo retinal subspecialist training (either in-house if there was a change in personal or as a locum) it could do all of the vitreoretinal work which includes: Retinal Detachments, Epiretinal Membrane Peeling (increasing in numbers), Macular Hole repairs, some penetrating eye injuries and some severe intraocular infections.

One of the four NMDHB SMOs, is able to perform Corneal Transplants (Penetrating Keratoplasty) and is carrying out these procedures for Nelson patients but Wairau Corneal Transplants are currently being transferred out of the district due to capacity issues. If the SMO was able to do

² By reducing IDFs the total cost of the Ophthalmology service should reduce as the costs of an IDF (including patient travel costs) are likely to be higher than the marginal cost of carrying out the procedure at NMDHB.

these transplants it would make the service more sustainable as the SMO would be more able to achieve the minimum numbers of the procedure to maintain the skill level required. Alternatively NMDHB could see if one of the Wellington or Christchurch Corneal subspecialists was willing to come to Nelson to operate periodically.

- Similarly NMDHB is sending away Congenital Cataracts in Nelson and Wairau because only one of the four SMOs can carry out this procedure and does not currently have time in either theatre or clinic to do so. If work is able to be reconfigured the SMO could do both the Nelson and Wairau congenital cataracts; and
- NMDHB sends away a number of complex oculoplastic work eg Paediatric Ptosis, Eyelid and Orbital tumours, Severe Thyroid Eye Disease etc. One of the Auckland Oculoplastic Surgeons visits Nelson monthly and does private clinics and operations and may be interested in being contracted to do some Public work. Alternatively in future if there was a change in SMO personnel it may be possible to recruit an SMO with an Oculoplastics interest.

Whilst a number of opportunities have been identified above it is noted that Ophthalmology is one of the areas under review in the recent draft South Island Health Services Plan. The areas that will be considered is what procedures should be undertaken by secondary versus tertiary hospitals.

It is proposed:

That these opportunities are considered once the South Island Health Services Plan has been finalised and there is more certainty around the Ministry of Health review of the IDF system which is also being undertaken currently.

Training Registrars

A future opportunity for reducing the cost of the Ophthalmology department would be to utilise the services of a Training Registrar. To do this the Ophthalmology department would need to meet College training requirements but would receive contribution for each Registrar trained.

The MOH also has a training scheme available where a DHB or a group of DHBs can apply to Health Workforce NZ to have 100% funding for a single registrar position over three years plus a further two years of overseas experience. The DHB in return has to promise to employ the person on their return from overseas. The new scheme is to be piloted in Northland and Waikato.

It is proposed:

That consideration be given to the Registrar Training programmes as part of the future medical personnel planning for the Ophthalmology service.

APPENDIX 1 – Questions and Answers

In the service redevelopment how will the new models of care be introduced?

A user group will develop the new models of care based around the model of having some parts of what is currently delivered by SMOs delivered by other trained staff. There may be further consultation in conjunction with HR processes for clinical, nursing and admin staff regarding job structures.

How will a decision be made between the two options?

We will wait for feedback from staff and other stakeholders in the service. Depending on this feedback a decision will be made. It may be that there is no support for outsourcing of the service or we may not be able to reach agreement on an outsourcing contract which will lead to Option 2 being implemented (or parts) with new models of care and a focus on processes for staff.

Is outsourcing a step toward privatisation of the public health sector?

The proposal to outsource Ophthalmology services to the private sector is in line with “Better, sooner, more convenient health care”. The patient doesn’t have to pay for these services and there will certainly be no co-payment. This will be the same public service provided in the private sector.

Are Ophthalmology public patients currently treated at specialists’ private consulting rooms?

The DHB does from time to time use private specialist capacity to complete contracts and lists

Is this outsourcing model of delivering a secondary public service in the private sector applied anywhere else in New Zealand?

There are several examples of DHBs who have this model working in their district. Bay of Plenty, for example, has contracted out all of its Ophthalmology services for more than five years.

Is there a danger that putting this service into the private sector will raise the price of delivery to the DHB?

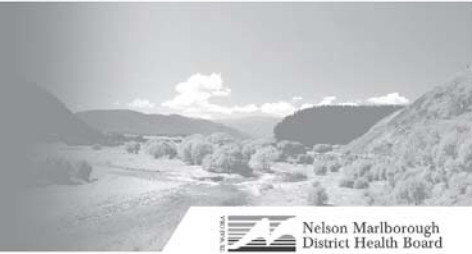
There will be clear parameters in the contracts on costs. There is an expectation that outsourced services will be delivered within national pricing.

Are more hospital services likely to be recommended to be delivered in the private sector?

This is something that is not known at present. We are always considering new models of provision in an attempt to work more efficiently and provide better health outcomes to our patients. Rutherford will look at all clinical areas and may make similar recommendations for other services.

APPENDIX 2 – FEEDBACK FORM

OPHTHAMOLOGY SERVICES PUBLIC FEEDBACK FORM



Information about you: (Optional)

Name: _____

Address: _____

Phone: _____

Organisation represented: (if applicable) _____

Option 1: What do you think about the proposal to outsource Ophthalmology Services?

Option 2: What do you think about the proposal to maintain Ophthalmology inhouse but with changes to the models of care?

Additional comment (you may like to include an insert with your returned form)

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SUBMISSIONS CLOSE AT 5 PM ON WEDNESDAY, 15 DECEMBER 2010

Thank you for your input. Please note that all submissions will be made available for public inspection unless you specifically request that yours remain private to the Board. However, you do need to be aware that even a private submission may need to be made available under the Official Information Act. All submitters who have provided contact information will be informed of the final outcome of this consultation.

If you would like more information or would like a speaker to address your group please contact:

Karen Lindsay – Phone: 03 546 1998 or Email: karen.lindsay@nmdhb.govt.nz

The consultation document on Ophthalmology Services for Nelson Marlborough and an electronic version of this form is available on www.nmdhb.govt.nz

Please fold this sheet, seal it and post before **15 December 2010**.

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Free Post Authority Number 255



Karen Lindsay
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