COMMUNITY WORKSHOP: QUESTIONS & ANSWERS MARCH 2019

A commitment to excellence underpins everything we do. Whether this be related to clinical or non-clinical services, this needs to be at the forefront of our thinking. Our staff are our most important asset and in order to keep our patients and our staff safe we must have staff that have the right skill mix, at the appropriate staffing levels working within a workplace that lives up to our organisational values. The people requiring services are our reason for being here, as such their needs are central to our decision making.

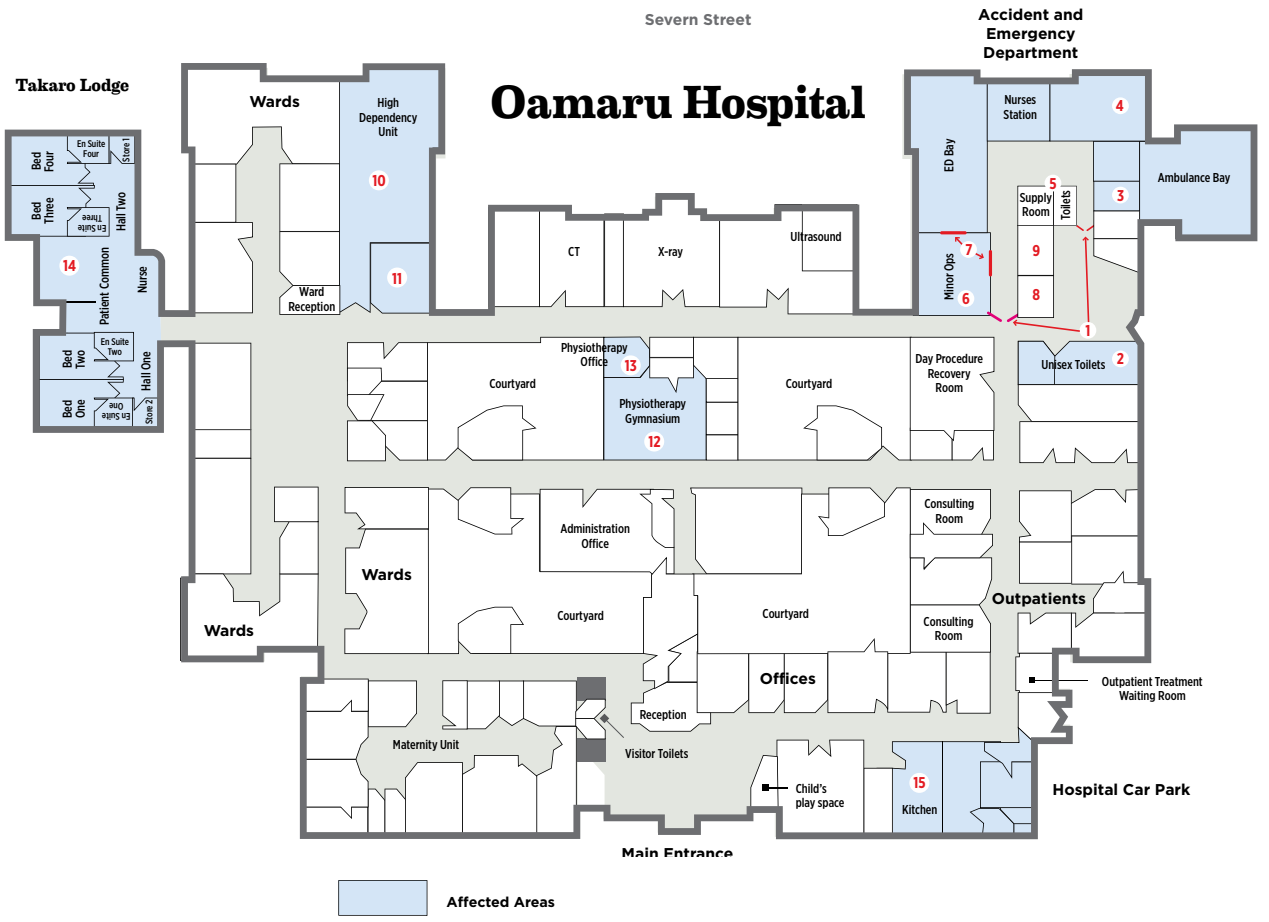
We are currently embarking on a period of change where we are working to use our building more effectively which includes reconfiguration of how we deliver our services within the building footprint.

Four community workshops were held last week and approximately 160 people attended. Physical layout changes were presented and the proposal for change was discussed at the workshops.

The purpose of this publication is so those who could not attend have the opportunity to be part of the community conversation.

The presentation and the series of questions are also available on the Oamaru hospital website.

PROPOSED LAYOUT CHANGES



EMERGENCY DEPARTMENT

1. Install doorway so anyone cannot "wander" into department.
2. Triage area (and room for distressed persons)
3. 4 La-z-boy chairs for treatment of those not needing to be lying on trolley. Current: Poorly utilised space in ED.
4. Dedicated resuscitation room
5. Wheelchair accessible toilet. Current: Toilet and supply room
6. Two bedded ED observation/stabilisation space. Current: Minor operations room
7. Windows into ED and corridor
8. Wet area shower and toilet. Current: One room
9. Divide into a clean an diry room. Current: One room

CURRENT HDU

10. Transform into rehabilitation gymnasium for all allied health. Three walled cubicles and two curtained areas. Current: HDU space
11. Transform into an assessment bathroom. Current: HDU bathroom

CURRENT PHYSIO

12. Education/meeting room. Current: Physiotherapy gym (empty)
13. Interdisciplinary student office. Current: Physiotherapy office

TAKARO LODGE

14. Takaro Lodge: New entrance for Centre of Excellence for Allied Health and Community Services. Create assessment kitchen and dining for inpatients. Current: Four bedrooms with ensuites

KITCHEN

15. Resize to far end of room. create a new minor operations theatre at closest end of the room. Current: Kitchen

Questions & Answers

Physical Layout:

1. **What timeframe is in place for the physical changes to the hospital layout?**
   The exact timelines are still to be worked on, but the staged approached to the changes are below;
   Stage One
   - Emergency Department: Bathroom, clean/dirty, move monitoring system

   Stage Two
   - Emergency Department: Increase ED Toilet size, shift ED stores, self-closer on staff door, new doors
   - Current HDU: Create 3 cubicles, 2 plinth areas
   - Ward: Move medicines cupboard
   - Outpatients reception

   Stage Three:
   - Ward: Transform bathroom into store room
   - Current Physio area: Create door into passage

   Stage Four:
   - Takaro Lodge / New Rehabilitation Gym: Create OT Assessment kitchen and bathroom
   - Kitchen: Reduce size and create minor operations room
   - Red Cross: Transform into staff accommodation
2. **There were 32 beds at Oamaru hospital in 2017. Why are there now less beds even if the population is growing? Are you cutting bed spaces?**
   In December 2018, between the Inpatient Area, HDU and ED there were 28 clinical spaces. With the proposed changes, there would be 32 plus more in our Outpatients Department for day procedures.

   The funding of 32 beds included some long stay beds for older persons, this contract ended with the opening of the Observatory Village.
3. **How many beds will be there?**
   20 inpatient beds and in the acute care area that is proposed, a further 12 treatment spaces.
4. **How did that plan come together?**
   This has come through reading some historical papers about service layout, a facilitated session late in 2018 with an architect, staff groups offering advice and solutions and we are working with a Quantity Surveyor currently.
5. **Would a new building be more practical than the proposed alterations?**
   It would be a lot more expensive and not achievable at this time.
6. **Would the layout changes still be needed if there hadn't be financial deficits?**
   Yes, clinical safety and safe staffing would require us to still make these changes. People who worked at the hospital on the hill, reportedly identified layout issues when the move was made.

Proposal for Change:

1. **Timeline for changes?**
   The consultation period will conclude on 25th of March. It is planned that on the 8th of April a decision on the proposed changes will be delivered to staff. It is intended the changes will be presented to the public in a series of workshops in May.
2. **Why is there the need for a Human Resources consultant? Is the current person in HR not qualified for this task?**
   There are different forms of Human Resources specialists resource into any organisation. In small companies such as ours, it is usual to have a 'transactional' human resource person available for the day to day human resource management and planning. For significant work such as transformational change, which we are embarking on, it is usual practice to engage specialist HR support with experience and expertise in change processes.
3. **How will the alterations be paid for?**
   Funding from alternative sources, trust applications, community funding etc
4. **What is the timeframe for financial sustainability if the proposed changes are implemented?**
   Mid 2019
5. **Will the rural hospital concept help with the financial position? Are we up for this?**
   Yes, because it allows for doctors to work across the whole hospital system and not specialise in one particular medical field.
6. **Where is the increase in income coming from?**
   Primary Care, ACC and private funding streams
7. **What's the long term vision for the hospital?**
   To become a progressive, positive and caring organisation delivering a responsive, accessible and modern health service.
8. **How much has the hospital saved from closing the kitchen?**
   Approximately $250k
9. **A Health Hub – How will this be set up? How will this be communicated?**
   This will require extensive community input and an understanding of our current and future health needs.
10. **Have other rural hospitals in the SDHB region made these types of significant changes?**
    Yes, this happened when funding changed a few years ago. They moved to the rural hospital model with expanded services.
11. **How will you manage patients while the alterations are being carried out?**
    Sound planning, and experienced project management.
12. **Was an Allied Health Consultant approached about Occupational Therapy reduction?**
    No, but we have significant expertise within our Allied Health team who are intending to provide feedback

Nurses & Allied Health:

1. **How will these changes effect staffing levels?**
   At this time, we do not know as we are currently in consultation with staff & unions and no decisions have been made.
2. **How will you work efficient with the same level of staff if you can't provide safe staffing levels now?**
   By bringing patients with the highest health needs together, we can ensure no staff are working in isolation. Our modelling has suggested that we may not have the most appropriate mix of staff to meet our needs at present.
3. **How many patients do you see in ED?**
   Every year we see 7000 people through our Emergency Department.
4. **How many are we funded for?**
   We see approximately 7,000 people, and we are funded for 3,500 contacts per annum.
5. **How can we utilise a GP funding contract?**
   A GP funding contract would mean we would have a contract with WellSouth, the Primary Health Organisation within the Southern region. Holding such a contract would enable us to claim primary care funding and hold additional ACC funding contracts.
6. **Combining HDU and ED. How will mental health patients, upsetting unwell patients be managed in the acute area?**
   We are looking to set up a dedicated area for persons attending the ED who are mentally unwell. This room could also be used for distressed families or private triage of all health needs.
7. **What is the staff mix going to be like on the inpatient ward?**
   At this time, we do not know as we are in consultation with staff & unions and no decisions have been made.
8. **Who was consulted about the nursing model? Why would one do away with EN's when the EN training has only been recommenced in the last few years?**
   There have been no decisions made on enrolled nurses. The proposal was based off staffing mixes in other rural hospitals in NZ.
9. **Are exit interviews conducted for every staff member that leaves?**
   All staff that leave are offered an exit interview.
10. **How will the Nurse Education role continue? How will the professional development of nurses continue?**
    The administrative function of professional development is proposed to sit with the Human Resources Officer, working in conjunction with the clinical leaders. The Nurse Leader will be responsible for working with the nursing clinical practice groups to ensure that there is adequate education opportunities available to meet the needs of our staff.
    It is proposed that the hands-on clinical education will come from a variety of sources with an increased focus on interdisciplinary training which will be led by senior staff, Simulation training, visiting health professionals, mobile surgical bus are just some examples. In addition, on-line training could be accessed as this is available and used by other rural hospitals.
11. **What changes will there be for district nursing?**
    At this time, we do not know as we are in consultation with staff & unions and no decisions have been made.
12. **Do staff need to reapply for their jobs. What happens if they don't?**
    We don't know the process until the final decision is made. At that point we will determine what that plan needs to look like. We acknowledge that this is a risk and we have considered our response should this occur.
13. **Do admin staff also have to reapply?**
    We don't know the process until the final decision is made. At that point we will determine what that plan needs to look like.
14. **Support to staff. What has been happening?**
    The following communications has been carried out with all staff and is ongoing
    - Union meetings
    - Story boards
    - One on one meetings
    - Independent HR person available.
    - Resource to assist staff to see how they might re-engineer
    - Employee Assistance Programme has been on site
15. **What will happen if skilled staff leave before the end of the consultation period?**
    We acknowledge this a risk and have considered our response if this is to occur.
16. **How will the upskilling of staff be carried out?**
    We will look at the skills required for each area, and then working with individual staff, ensure that we have opportunities for staff to upskill in the relevant area.

Funding:

1. **SDHB funding – What influence do they have over funding for the hospital?**
   SDHB are our major funder of services. Approximately 85% of our funding currently directly comes from the DHB. It is our intention to work towards accessing funding from other sources so that we may, like other rural hospitals reduce our dependency on the DHB.
2. **How are we working in with SDHB to optimize IT across the hospital?**
   Where ever possible and practical we utilise regional IT solutions. Such as Medchart which is being introduced in May.
3. **How is the board interacting with the SDHB to continue funding and services into Oamaru?**
   Ongoing discussions
4. **Has the board looked at getting direct funds from Ministry of Health?**
   Not at this time as the current funding mechanisms, goes to DHB's directly.
5. **What is Waitaki District Councils link to hospital?**
   We are a Council Controlled Organisation and they're our 100% shareholder.

Communication:

1. **Why is the communication on the proposed changes only to staff and not the wider community?**
   We need to consult with community on changes of services, but where it is an internal HR change about how we operate the hospital the consultation needs to be with staff.
2. **Why can't staff currently speak publicly about the restructure / social media?**
   Restructures are internal Human Resource processes. It is usual business practice that staff do not talk publically about the detail of such processes. Social media however is governed by the professional bodies such as medical and nursing. These professional bodies are clear on the use of social media and our policies reflect this Furthermore it is about protecting other staff. We have already had some staff personally 'hurt' through information that has identified them personally being out in the public arena, when final decisions have not been made.
3. **Did the staff members get a similar presentation to the one received tonight?**
   Yes
4. **What education/communication is provided to the community on knowing what health needs are seen at the hospital or what should be send by a GP?**
   This is an area that needs further work. We will work with the appropriate communities to provide education on emergency department services and what a GP can provide.

Doctors:

1. **Are you cutting back to one doctor across all services?**
   No
2. **How many doctors work in the hospital on a daily basis?**
   In the daytime hours there are 3+ doctors on during the week day. Currently there is one doctor at nights. And there is backup for this doctor.
3. **How many doctors do we have that live currently in Oamaru?**
   We currently have 6 residing in Oamaru. Our budget is for 8 doctors. We look to recruit more permanent doctors who will live and reside in Oamaru in the immediate future.
4. **How are you going to recruit new doctors?**
   This is an ongoing process utilising our rural hospital networks, word of mouth and normal recruitment channels.
5. **What were the reasons for letting named senior doctors (WDHSL deemed it not appropriate to publish their names here) go?**
   No doctor's employment has been terminated.
6. **What happened with the previous Emergency Department Physician?**
   This matter predates the current management structure so no comment can be made
7. **The cost of locums is high. There seems to be a big gap between costs of health care specialist across the spectrum.**
   The costs for locums is high and we are intentionally actively trying to recruit permanent employed doctors. Collective employment agreements dictate pay structures across the whole health system. This is not driven by Oamaru hospital in isolation.

Services:

1. **Has the service of the Cardiology Specialist been cut**?
   No
2. **What does HDU stand for?**
   High Dependency Unit
3. **Why is there such a long wait for people who have surgery in Dunedin to return to a bed in Oamaru?**
   Health is predominantly demand driven. All hospital's experience times where they're 'bed blocked' due to higher than predicted demand.
4. **Will the outpatient administration area change?**
   At this time there are no plans for change, but this may come up in the consultation period with staff.
5. **Who is going to do the cleaning & orderlies work?**
   The Cleaning FTE is proposed to increase. There has been no decision about the orderlies, and we are expecting feedback as part of the consultation.
6. **What happens when helicopters can't fly to Dunedin for urgent cases? (for example, in winter)**
   Other sources of transport will be considered. The weather patterns are out of hospital control and this situation has occurred in the past and has been dealt with efficiently.
7. **Is there a community vehicle/driver to get patients to Dunedin? Could costs be claimed back for transport?**
   We do have a hospital van that is used for this propose. There is a real opportunity for collaborative work to improve this system. For example: volunteer drivers, fundraising for a new van.
8. **Minor Ops room: Will this house HDU patients?**
   Yes
9. **How will triage operate?**
   Triage is a function for all nurses who are skilled to work in emergency departments. There will be lead triage nurses on each shift.
10. **Maternity- Will that stay at the same location in the hospital?**
    Yes
11. **Where are acute maternity patients going to be housed under this proposal?**
    During afterhours if it is a complicated case the midwife may have cause to bring the patient into the acute area to access other medical staff and equipment support. The midwife will remain the lead in these cases.
12. **How are we going to achieve excellence for orderlies, healthcare assistants etc.?**
    Achieving excellence by implementing smart systems and process to meet the needs of the internal customer, working within the code of rights and their qualifications.
13. **Mobile surgical bus – is that going to stay?**
    Yes
14. **How often is it coming?**
    It is onsite every five weeks
15. **And where do people recover?**
    People currently recover in the outpatient area in a dedicated recovery room and there are no planned changes here..

General Topics:

1. **Waitaki District Health Services Ltd owns the old pipe band hall. What do they intend to use this building for?**
   At this stage we do not know.
2. **Is there regular monitoring by an independent nutritionist on the Standards of nutritional value & "tastefulness" of food provided for patients?**
   Yes, this is in place.
3. **Is there security onsite after 6 pm?**
   Currently the security function is carried out by our orderly team.
4. **How are we going to deal with security issues going forward?**
   There have been no decisions, but we need to ensure operating as a good employer that we are not putting staff at undue risk. There are changes to our population and those people accessing health services. We are seeking comment and feedback from staff as to how best to meet this need going forward.
5. **We have 4 large factories close by. Under these changes how will the Oamaru hospital be able to manage a major crisis?**
   Surge management is part of our planning system with unexpected increases in demand.
6. **Why was there the need for a picket march when all these changes are positive?**
   This will probably be best answered by those who organised the picket. The reality though for both staff and our community is that change can create fear and concern. People experience a range of emotions and all respond differently. Some staff are looking forward to working with us to address areas of concern that they have harboured for some time.