

TO Hospital Advisory Committee

FROM Lyn Horgan
Operations Director
Hospital Services



MEMORANDUM

DATE 28 June 2010

SUBJECT Under 65 Rehabilitation Inpatient Service
Review – Proposed Service
Reconfiguration

1. PURPOSE

MidCentral District Health Board no longer achieves budget, which is largely due to rising cost structures within the Hospital Division, MidCentral Health. The year end position 2009/2010 is forecast to be a deficit of \$9.8 million.

A number of financial service reviews are already underway within MidCentral Health. In addition five areas where there is potential over-servicing and/or duplication are being reviewed, including the Under 65 Rehabilitation Inpatient Service. There was an estimated identified saving of \$600k for the service review of <65 Rehabilitation Inpatient Service.

2. SUMMARY

A staff consultation and community engagement process has been completed, including discussion with the Ministry of Health.

The <65 year Rehabilitation Service is different to most services provided by MidCentral Health in that it is provided under contract to the Ministry of Health. The Ministry, not the DHB, is responsible for planning and purchasing health and disability services for the young disabled, including Rehabilitation Services.

The contract between the Ministry of Health and MidCentral Health is for six beds. In addition, MidCentral Health has a contract with ACC for two beds, given a total contractual requirement to provide an 8-bed inpatient rehabilitation service for people aged less than 65 years.

MidCentral Health has traditionally provided services in excess of the Ministry of Health's contract and has established local capacity of 12 beds (STAR Ward 3, Palmerston North Hospital). All costs associated with this over delivery are met by MidCentral Health.

COPY TO:

**Operations Director
Hospital Services**
MidCentral Health
PO Box 2056, Palmerston North Central
Palmerston North 4440
Phone +64 (6) 350 8825 Fax +64(6) 350 8830

It is proposed that MidCentral Health continue to provide Rehabilitation Services under contract, and that it reduce its capacity in line with contracted levels (including ACC), ie an 8-bed inpatient unit.

MDHB are in discussions with the Ministry of Health and these are likely to improve the services financial position.

This proposal is supported by the service, MCH Clinical Board, MCH Senior Management Team, and Funding Division.

This report sets out the findings of the review process.

4. RECOMMENDATION

It is recommended:

- *that MidCentral DHB align its inpatient Rehabilitation Unit (STAR 3, Palmerston North Hospital) to contract level effective immediately, noting that current contract level is eight beds;*
- *that medical and administration staffing levels be reduced by 0.45 and 0.56 FTE (\$78,000) respectively by 10 December 2010;*
- *that the STAR 2 and STAR 3 shared nursing leadership and roster proposal be further progressed and the outcome reported to the Hospital Advisory Committee by October 2010;*
- *that a post event audit review of the Rehabilitation Service reconfiguration be conducted in May 2011.*



Rehabilitation Inpatient Service Review

Proposed Service Reconfiguration

June 2010

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1. Executive Summary

MidCentral District Health Board (MDHB) has entered into a period of financial constraint and must reduce costs in line with revenue and/or increase revenue.

Five areas have been identified where there is potential over-servicing and/or duplication. One of which is the Rehabilitation Service for people aged less than 65 years (<65 years), which MidCentral Health (MCH) provides under contract for the Ministry of Health (MoH).

(Note: Rehabilitation Services for people aged <65 years are distinct to, and separate from, assessment, treatment and rehabilitation services provided to people aged 65 years and over. This paper relates to the Rehabilitation Service for <65 years only.)

The <65 year Rehabilitation Service is different to most services provided by MidCentral Health in that it is provided under contract to the Ministry of Health. The Ministry, not the DHB, is responsible for planning and purchasing health and disability services for the young disabled, including Rehabilitation Services.

The contract between the Ministry of Health and MidCentral Health is for six beds. In addition, MidCentral Health has a contract with ACC for two beds, given a total contractual requirement to provide an 8-bed inpatient rehabilitation service for people aged less than 65 years.

MidCentral Health has traditionally provided services in excess of the Ministry of Health's contract and has established local capacity of 12 beds (STAR Ward 3, Palmerston North Hospital). All costs associated with this over delivery are met by MidCentral Health.

A staff consultation and community engagement process has been completed, including discussion with the Ministry of Health.

It is proposed that MidCentral Health continue to provide Rehabilitation Services under contract, and that it reduce its capacity in line with contracted levels (including ACC), ie an 8-bed inpatient unit.

MDHB are in discussions with the Ministry of Health and these are likely to improve the services financial position.

This proposal is supported by the service, MCH Clinical Board, MCH Senior Management Team, and Funding Division.

This report sets out the findings of the review process.

2. Recommendation

It is recommended:

- *that MidCentral DHB align its inpatient Rehabilitation Unit (STAR 3, Palmerston North Hospital) to contract level effective immediately, noting that current contract level is 8 beds;*
- *that medical and administration staffing levels be reduced by 0.45 and 0.56 FTE (\$78,000) respectively by 10 December 2010;*
- *that the STAR 2 and STAR 3 shared nursing leadership and roster proposal be further progressed and the outcome reported to the Hospital Advisory Committee by October 2010;*
- *that a post event audit review of the Rehabilitation Service reconfiguration be conducted in May 2011.*

3. Purpose

MDHB no longer achieves budget, which is largely due to rising cost structures within the Hospital Division, MidCentral Health. The year end position 2009/2010 is forecast to be a deficit of \$9.8 million.

As a result, a Financial Recovery Programme working towards a break-even budget in 2011/12 was required to be prepared by the MDHB for the Minister of Health (January 2010), and this is now in place. This plan includes continuation of cost saving initiatives implemented by 30 January 2010, and an ongoing requirement to achieve efficiencies.

Productivity within the hospital continues with higher levels of activity across most services. However, the costs associated with this increased activity have exceeded our income. It is imperative that we live within budget.

A number of financial service reviews are already underway within MCH. In addition five areas where there is potential over-servicing and/or duplication are being reviewed, including the <65 Rehabilitation inpatient service. There was an estimated identified saving of \$600k for the service review of <65 Rehabilitation Inpatient Service.

Note: This service re-configuration only involves the Rehabilitation Inpatient Service, and is exclusive of the outpatient service unless there is a consequential impact.

4. Service Description

At its core rehabilitation is about a multidisciplinary health care team, involving medical, nursing and allied health professionals working together with the patient and their family to maximise a person's abilities and independence, restore lost function and prevent new or further functional loss. Rehabilitation is 'what happens next' after a person suffers a disabling injury or illness.

The rehabilitation process aims at restoring functional loss and improving a patient's quality of life. Specialist rehabilitation staff (medical, nursing and allied health) assess and treat a range of physical, cognitive and social needs for people with a wide range of diagnoses including stroke, head injury, amputation, musculoskeletal and spinal cord injury etc, in the post-acute stage. Allied Health staffing levels need to be high due to a younger patient group with high rehabilitation potential. There is a greater demand for this patient group to return to the workplace, requiring more intensive rehabilitation.

Rehabilitation Services have been offered at MCH for many years. In 1972 a purpose built Rehabilitation Centre was opened at the Palmerston North hospital. This was considered a New Zealand first, featuring an interdisciplinary approach across inpatient and outpatient rehabilitation programmes. In 2002 the Rehabilitation Services were relocated to the then newly-commissioned STAR Centre, with inpatient provision based in STAR 3. STAR 3 is a 12 bed Specialist Rehabilitation Unit providing assessment, treatment and rehabilitation for the under 65 population.

The Rehabilitation Service is seen as a Centre of Excellence, with a number of New Zealand's rehabilitation specialists having been trained here at Palmerston North under Dr Jurriaan de Groot who is one of a limited number of Rehabilitation Specialists in New Zealand. It is also an accredited Australasian Faculty of Rehabilitation Medicine registrar training post.

In the 1990's there was a change in the purchase units that the Ministry of Health funded. Services for Elderly and Rehabilitation were no longer purchased separately, instead being jointly purchased under Disability Support Services (DSS) to encompass both under 65 and over 65 age spectrums.

Two years later (2003/2004) the MoH devolved the over 65 funding to District Health Boards, but retained the under 65 services. Due to an anomaly in the counting methodology, MCH received a significantly reduced volume target from 7,830 for inpatient, outpatient and community volumes to 5,949 (equating to a dollar variance of approximately \$340k at the time). This volume has not changed since devolution.

MCH's <65 Rehabilitation Service provides care for people after an acute illness or injury with the primary focus on, but not limited to:

- Stroke
- Amputation
- Brain injury
- Spinal cord injury
- Neurological Conditions
 - multiple sclerosis, muscular dystrophy, Guillain-Barre syndrome, spina bifida, etc

STAR 3 promotes a move away from an illness model of care where patients remain in bed with staff doing a majority of daily activities for patients to an alternative wellness and restorative model approach where people are functionally stimulated and are encouraged to “do for themselves”. STAR 3 inpatients are encouraged to dress in day clothes, eat meals out of bed and are encouraged to attend to their own personal care needs, to mobilise safely and regularly where appropriate.

The New Zealand branch of the Australasian Faculty of Rehabilitation Medicine is currently developing a National Rehabilitation Strategy for New Zealand. This is closely modelled on the Australian National Rehabilitation Strategy¹ - Rehabilitation is “What Happens Next”. The Executive Summary taken from this strategy is Appendix 1.

5. Service Profile

The MCH Rehabilitation Service is able to provide readily accessible expertise to the acute hospital, is able to assist with patient flow issues, as well as providing advice and support with physical disability issues earlier than is experienced in other DHBs, who may not have access to a Specialised Rehabilitation Physician.

5.1. Funding Stream

The <65 Rehabilitation Service is funded by the MoH under Disability Support Services (DSS) and via the Crown Funding Agreement. The MoH sets our contracted volumes and the purchase price for these volumes. For the last six years (since devolution in 2003/2004) volumes have remained unchanged, having been originally set too low, and MCH is delivering more service than we are being paid for.

MoH funding of Rehabilitation inpatient services (\$432 per bedday) has not kept in line with either the ElderHealth purchase units (currently at \$717 per bedday) or ACC bedday rate (\$561). Current funding is also lower than similar specialist rehabilitation units provided at other DHBs, eg one provider received \$673.51 per bedday in 2008/2009 – 56% more than MCH is funded for similar service delivery.

National pricing for DSS purchase units is set at a higher level (approximately 36% more for Inpatient services) than the Ministry of Health are able to fund.

Table 1: DSS Funding Received from Ministry of Health

DSS 214	ATR Inpatient	\$432.64
DSS 215	ATR Outpatient: clinics	\$161.41
DSS 217	ATR Outpatient: domiciliary assessments & education sessions	\$161.16

Table 2: DSS National Prices

DSS 214	ATR Inpatient	\$678.51
DSS 215	ATR Outpatient: clinics	\$185.25
DSS 217	ATR Outpatient: domiciliary assessments & education sessions	\$238.98

In March 2010 the MDHB wrote to the Ministry of Health requesting consideration for both an increase in funding and an increase in volumes.

Key points from the response are:

- The Ministry of Health recognises that the rate paid to MDHB under this contract is less than the national price. It also recognises that MDHB has, at its own cost, traditionally provided services in excess of contract levels.
- The Ministry of Health’s disability services budget is stretched and it does not have the ability to increase funds and/or volumes on sustainable basis.
- The Ministry of Health recognises the dilemma this causes MDHB, but would like the DHB to continue as a service provider of rehabilitation services for people aged <65 years.
- The Ministry of Health accepts MDHB’s right to reduce its capacity (beds) to contracted levels.

MDHB are in discussions with the Ministry of Health and these are likely to improve the services financial position.

5.2. Entry Criteria

Patients accepted into STAR 3 are under the age of 65, however some patients over the age of 65 will be considered if appropriate. Patients should be able to benefit from intensive rehabilitation, eg have problems that if over come would allow increased independence, or decreased carer support requirements. Priority is given to patients with stroke, injury, neurological problems, and amputees, with a view to provide rehabilitation that will facilitate a return to work, social and family function as close to pre illness

condition as possible. Patients who are medically or surgically unstable are not accepted into STAR 3.

Patients are transferred from the Medical or Surgical wards once their acute episode is over, and a referral is made from the consultant.

5.3. Bed Availability / Utilisation

Contractual arrangements between MCH and the MoH and ACC are for eight beds. Currently MCH has an established capacity of 12 beds. Actual utilisation is equivalent to slightly under 10 beds. The MoH contract is capacity funded, with MCH meeting any cost of over delivery.

	Purchased Beddays (Target)	Purchased Beds (Target)	Forecast Yr End Actual Beddays (May)	Utilised Beds
Available Beds		12		
MoH Purchased Beddays DSS	2305	6.32	2854	7.82
ACC (Average useage)	456	1.25	456	1.25
	2761	7.56	3310	9.07
Unfunded Beds		4.44		2.93

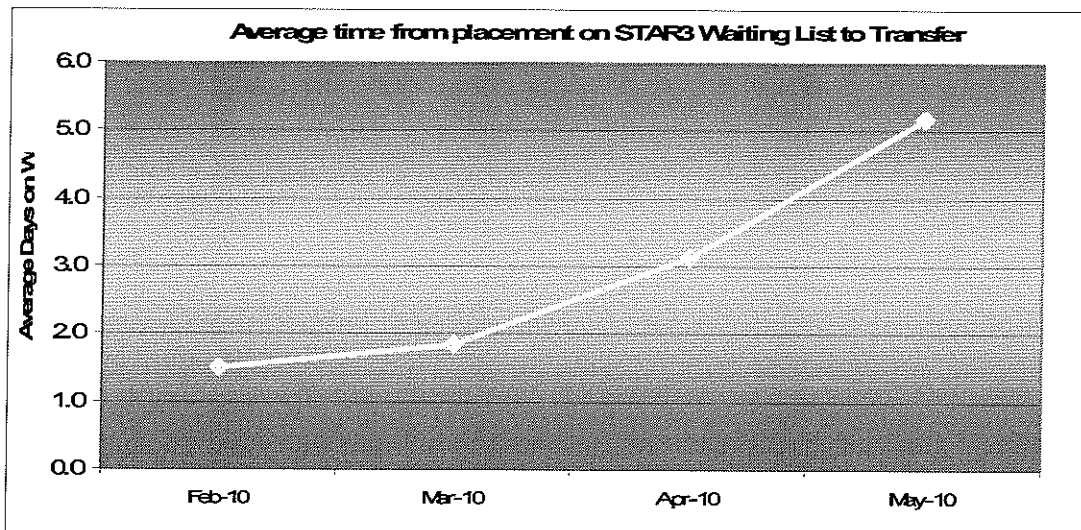
Over delivery of inpatient services for the 2009/2010 year end is forecast to be 549 beddays, or \$237k.

5.4. Actual Beds and Waiting Time

Due to there currently being limited Senior Medical Officer cover, the beds have been reduced to eight as at the end of March 2010. Prior to this reduction the waiting time from referral to STAR 3 until transfer was 1.86 days. Currently the waiting time is 5.18 days – the increase being the impact caused due to reduced beds.

In March there were 7 patients waiting a sum of 13 days before being transferred to STAR 3 (1.86 days per patient). This has increased to 11 patients waiting 57 days for transfer (5.18 days per patient) in May 2010.

Table 3: Waiting Time from Referral to Transfer to STAR 3 - February to May 2010



5.5. Occupancy

On average slightly over 9 of the 12 beds are utilised, resulting in occupancy of 82%.

Table 4: STAR 3 Occupancy - 2009/2010

Utilised beddays	3310
Average Bed Utilisation	10
Average Occupancy	82%

Occupancy has been impacted over the past 12 months due to limited nursing resource and inequitable skill mix. Also impacting currently is limited Senior Medical Officer cover.

5.6. Length of Stay

The average length of stay (ALOS) in STAR 3 is slightly over 22 days, which is below the target of 23. Impacting ALOS is the difficulty in funding and placing 'personal health' patients (eg bariatric) and/or patients who require residential care placement as discharge options are very limited.

Table 5: STAR 3 Length of Stay - 2009/2010

Minimum LoS	0
Average LoS	22.25
Maximum Los	94

5.7. Discharges

Approximately 185 patients will have been discharged from STAR 3 at 2009/2010 year end.

Table 6: STAR 3 Discharges per financial year

2006/2007	189
2007/2008	192
2008/2009	187
2009/2010	185

5.8. Age Profile

The average age for patients in STAR 3 is 52 years. The Rehabilitation Service will care for patients outside of the <65 age spectrum where clinically appropriate as evidenced by the 99 year old patient that was appropriately admitted to STAR 3 for rehabilitation.

Table 7: STAR 3 Age Profile 0 2009/2010

Minimum Age	17
Average Age	52
Maximum Age	99

5.9. Benchmarking

The NZ Role Delineation Model was developed for the Ministry of Health to differentiate complexity between services within, and across District Health Board providers. The levels of complexity usually extend from community based services through to the most complex setting. The most complex services are Level 6 which means the service usually has the capability to provide after hours for the most complex care for the most complex patients. The service's infrastructure demands are greatest and the risks of under-utilised capacity are significant. At the other end of the spectrum, services rated a one are the least complex and are usually community based services. Role Delineation for MCH Health of Older Adults and Specialist Rehabilitation combined reflects a complexity level of 5 out of 6, eg Major Specialist Services.

The below benchmark information is for similar sized DHB's to MDHB, eg medium sized. Currently MCH has slightly over 7 <65 rehab beds per 100,000 population, the proposed change will provide slightly under 5 beds per 100,000.

Table 8: Number of Actual <65 Rehabilitation Beds per medium sized DHB – 2010

Anonymised as DHBs have not been consulted re release of information.

DHB	No. of <65 Beds	DHB Population	Beds per 100,000 Population	DHB bedday price
DHB 1	26	184600	14.085	717.15
MidCentral Health - <i>current</i>	12	163790	7.326	432.64
MidCentral Health - <i>proposed</i>	8	163790	4.884	
DHB 2	7	200810	3.486	433.49
DHB 3	4	140940	2.838	717.15
DHB 4	3	133635	2.245	437.30
DHB 5	2	152600	1.311	439.03
DHB 6	2	152650	1.310	442.00

DHB 1 has significantly higher beds than other similar sized DHBs. DHB 1 has a 26 bed ward, providing DSS and respite care to the <65 population.

DHB 1 and 3: The MoH bedday price is subsidised to this level by their Funding Division to align with the Health of Older People bedday rate.

There are slight variations on the funding that the remaining DHBs receive. The reason for this is unclear, however it is assumed that these variations are due to the individual DHB Funding Divisions funding methodologies.

It is largely recognised that the level of Rehabilitation Services provided at MCH are equivalent to those provided at Rehab Plus (Auckland DHB) in Auckland. As this is classified as a large DHB it is not benchmarked in the above table. Comparing the two services (Rehab Plus and MCH Rehabilitation Services), based on beds per population, is difficult as Rehab Plus services the wider Auckland area, covering the three DHBs of Auckland, Counties Manukau and Waitemata.

5.10. Staffing

The following budgeted FTE are involved in the inpatient service of STAR 3.

7.125

Table 9: Current Staffing - 2009/2010

	Budgeted Inpatient FTE	Budgeted Outpatient FTE	Clinical Director
Medical Personnel			
SMO	0.6	1	0.2
Registrar	0.5	0.5	
HO	0.5		
			3.3
Nursing			
Charge Nurse	1.13		
RN	5.02		
EN	3.26		
HCA	4.84		
Admin			
Ward Clerk	0.56		
	16.41		
Allied Health			
Social Work	0.6		
Physio	2.5		
OT	2		
Psychology	0.4		
Speech Language Therap	0.2		
Recreational Therapy	0.8		
Total	22.91		

The outpatient component of the Rehabilitation Service, delivered by the medical personnel, is shown in the above table to give an overall view of FTE as medical personnel work in both areas.

5.10.1. Senior Medical Officer

There is 1.8 Senior Medical Officer FTE in the <65 Rehabilitation Service. This FTE is split between 0.20 FTE Clinical Director duties, 0.60 FTE dedicated to inpatient and the remaining 1.00 FTE for outpatient services.

A 0.60 FTE vacancy arose last year, following the resignation a Senior Medical Officer. This position has been temporarily filled by a senior Registrar who is awaiting vocational registration, working 1.00 FTE. The temporary contract will end in December 2010.

5.10.2. Registrar

Currently the <65 Rehabilitation Service has 1.00 FTE Registrar. This is an Australasian Faculty of Rehabilitation Medicine accredited training post, and receives clinical training revenue of \$32k per annum. The role is shared across inpatients and outpatients with 0.50 FTE dedicated to each.

5.10.3. House Office

STAR 3 currently has a 0.50 FTE House Officer, which is shared between <65 Rehabilitation Services and the Stroke Service. This position also contributes to the MCH after-hours roster.

5.10.4. Nursing

There is 14.25 FTE of nursing staff (Charge Nurse, Registered Nurses, Enrolled Nurses and Health Care Assistants) budgeted to resource STAR 3.

Prior to the commencement of the <65 Rehabilitation Inpatient Service Review, a review of nursing requirements between STAR 2 and STAR 3 was progressing. This was to ascertain the nursing leadership, nursing and administrative requirements, with the potential for the two wards to have a combined roster. The nursing review was put on hold, pending the outcome of the <65 Rehabilitation Inpatient Service Review.

5.10.5. Administration

A ward clerk is employed for appropriate administrative duties in the ward for 20 hours per week.

6. Feedback from Staff Consultation and Community Feedback

An internal MCH consultation process has been completed, with submissions being received on the two options proposed:

- Option 1) Eight beds remain open for <65 Rehabilitation. The remaining four beds would be closed and be physically removed from STAR
- Option 2) Six beds would be dedicated to <65 Rehabilitation, with the remaining six beds utilised for either <65 or >65 ACC Non-Acute patients as appropriate.

Option 2 was proposed to assist bed management in the event that ATR patients could not be transferred to STAR 4, Horowhenua, when it became a rural inpatient ward only. Due to the service review of STAR 4 not progressing at this stage, Option 2 is no longer applicable.

6.1. Submission Summary

The consultation process included staff (in accordance with the Management of Change requirements in Collective Agreements), and feedback received from the community was also considered prior to making the final recommendations.

Twenty-four submissions were received, in addition to a petition with over 400 signatories opposing the possible closure of STAR 3 and STAR 4.

Submissions from the community (including patients) gave considerable focus to the value to patients and their quality of life that the rehabilitation services currently brings, and their concerns about the impact of these people not being able to access appropriate rehabilitation services in a timely manner.

Staff submissions included concerns about the impacts for patients, and also commented on the impacts for staff and the STAR wards of the proposed changes, as well as identifying consequential impacts for the wider hospital, eg reduced availability of rehabilitation beds could result in longer patient stays in the acute medical/ surgical beds.

Key themes included:

- Concern regarding impact on consumers – noting the benefits of access to the service in a timely manner; and concerns about the impact of inability to access services at all.
- Support for MCH pursuing appropriate level of funding from the Ministry of Health.
- Retention of 12 beds generally supported.
- Potential adverse impact for outpatients through reduction in the team of professionals (who cover both inpatients and outpatients).
- Impact on medical/ surgical beds through reduction of availability of STAR 3 beds and increasing waiting list, eg discharge delays and timeliness of rehabilitation intervention for patients.
- Return to a five-day ward not supported – issues with bed availability in acute areas and disruptive for patients and their rehabilitation time.
- Reduced resources would mean less availability of specialist support/ advice to other areas/ hospitals.
- STAR 3 model of care reflects the needs of their patient group (different from elderly patient rehabilitation model).
- Reduction in staffing levels could compromise patient care.
- Essential to retain the registrar training post for recruitment, retention and succession planning – and contribution of the role to outpatients and covering the consultant.
- Possibility of withdrawing the house surgeon role.
- Concern regarding the proposal to disestablish the Charge Nurse role and establish a CNS role – would an Associate Charge Nurse role be better (insufficient detail provided re the proposed CNS role)?
- Concern re reduction in Care Assistant Hours, given their input and assistance in the rehabilitation process.
- Disestablishment of Ward Clerk position – not supported by STAR 3, although patient throughput would indicate that one position could cover both STAR 2 and STAR 3.
- Consider increasing Social Work hours to assist with discharge planning.
- Concern about one person on night shift; support for having RN cover every night (currently EN cover for three nights).
- The potential impacts for STAR 2 of a reconfiguration of STAR 3 – service delivery model, nursing management and leadership (while

STAR 2 was not a part of this review, the proposal includes recommended leadership changes for that area).

An alternative staffing configuration based on eight beds was proposed by the STAR 3 staff for consideration.

A detailed summary of the submissions is attached as Appendix 3.

7. Recommended Service Re-Configuration

Following consultation, an amended version of Option 1 is the recommended option. This proposal would see a reduction in beds to align with the bedday volumes via the Ministry of Health (MoH) DSS214 purchase unit and Accident Compensation Corporation (ACC).

7.1. Recommended Option

Recommendations are:

- It is proposed that the number of beds be reduced from 12 to 8 to align with the bedday volumes purchased by the Ministry of Health - 6 (purchase unit code DSS214) and by the Accident Compensation Corporation (2).
- By reducing beds to contract levels, the cost of the service would reduce by \$78,000 in the first instance being a reduction in medical staff establishment (0.45 FTE senior medical officer) and 1 ward clerk.
- It is proposed that the STAR 2 and 3 nursing review be completed to enable shared nursing leadership and staffing across the two wards. This would provide further efficiencies.
- It is proposed that the STAR 3 ward clerk position be disestablished. Administrative requirements will be ascertained as part of the STAR 2 & 3 nursing review.

7.2. Proposed Staffing

Table 10: Proposed Staffing

	Inpatient/Outpatient	
	Current	Proposed
SMO	1.83	1.39
Registrar	1	1
House Officer	0.5	0.5
	3.33	2.89
	Inpatient Only	
Nursing	to be decided by the STAR 2 & 3 nursing review	
Ward Clerk	0.54	0

- The overall medical staffing will decrease from 3.3 FTE to 2.9
- Nursing staff will be decided upon completion of the STAR 2 and STAR 3 nursing review.
- Allied Health staff are outside the scope of this project, as there is an organisational wide service review scheduled this year.
- Ward Clerk will be dis-established – a reduction of 0.54 FTE.

7.3. Support for Proposals

There is general support for the proposal of:

- Reducing STAR 3 beds from 12 to 8 in line with contracted volumes
- Dis-establishing the ward clerk position
- Completing the STAR 2 and STAR 3 nursing review

Support is given by:

- MCH Clinical Board
- MCH Senior Management Team

8. Impact of Reconfiguration

Patients will continue to receive specialised assessment, treatment and rehabilitation in a dedicated environment, with ready access to a fully equipped rehabilitation gymnasium, patient lounge, ADL (activities of daily living) kitchen, etc.

This re-configuration will require strong commitment from staff, and a change in service delivery to ensure the service delivery remains effective and appropriate to the vulnerable patient group.

Changes to nursing staffing levels are proposed which would impact on current staff. The actual impact will not be known until a final decision is made following the outcome of the STAR 2 and STAR 3 nursing review. The implementation of any changes will be planned in consultation with the relevant unions, and staff will be kept informed of plans and progress. There will be compliance with the management of change provisions in relevant employment agreements, including working through options with those affected on an individual basis, together with their chosen representatives.

9. Financial

9.1. Current

Currently STAR 3 is forecasting a 2009/2010 year end deficit of \$511k, which is slightly below target by \$44k. Impacting this deficit is the funding received by the Ministry of Health for Specialist Rehabilitation beddays which does not meet the costs of the service.

	ACTUAL	BUDGET	VARIANCE
Current state as at 31 May 2010:	(\$468)	(\$477)	\$9
Forecasted bottom line at 30 June 2010:	(\$511)	(\$554)	\$44
Surplus/(Deficit)			

9.2. Proposed Savings

Revenue

All Ministry of Health, Accident Compensation Corporation and Clinical Training Agency (received for the Registrar position) revenue would be retained.

Expenditure

Costs would reduce with the reduction in Senior Medical Officer FTE and the dis-establishment of the ward clerk position by \$78k.

Until the outcome of the STAR 2 and STAR 3 nursing review is known it is not possible to accurately calculate the nursing savings, however it is anticipated that this will be no less than \$100k.

Table 11: Proposed Savings

Medical	61,173
Nursing (unknown quantity until completion of the STAR 2 & 3 nursing review	?
Ward Clerk	17,021
	<hr/>
	78,194



Lyn Horgan
Operations Director
Hospital Services

10. Appendix 1: Australian National Rehabilitation Strategy

Executive Summary

Rehabilitation is “what happens next” after a person suffers a disabling injury or illness. Rehabilitation does not save lives, but makes the saved life worth living.

Ms Andrea J is a 17 year old woman who sustained a stroke. She needed help for walking, talking, showering, and feeding herself. Three weeks after her stroke her parents were advised to place her in a nursing home, but they refused. After three months of rehabilitation she returned home with her family. After a further 12 months ambulatory rehabilitation at home, she returned to school and is now at work as a teacher.

Stories like this reveal the benefits that rehabilitation can give the individual and society. The individual achieves personal goals of independence and self-worth. The community avoids costly nursing home placements and gains the economic benefits of workforce participation.

Rehabilitation is a Human Right enshrined in the UN Convention on the Rights of Persons with Disabilities, Article 26, a Convention ratified by both the Australian and New Zealand Governments.

The consequences of a lack of effective Rehabilitation Services are human and economic. This includes:

- increased disability in Australians
- additional demands placed on community resources and long term care
- reduced participation in society
- reduced participation in the workforce

Over the past four months a national Alliance of leaders of major national bodies representing those health professionals who provide Rehabilitation has united to develop a Strategy for Rehabilitation within Australia. Out of this collaboration a consensus was reached regarding the following proposals for Rehabilitation in Australia.

A National Rehabilitation Strategy is required to:

1. Place Rehabilitation firmly on the national health agenda and close the missing link between hospital and community services
2. Obtain national information about Rehabilitation
3. Improve integration of Rehabilitation with other elements of the health system (acute care, community care, primary care, aged care and disability services)
4. Develop the national multi-disciplinary Rehabilitation workforce
5. Establish National Rehabilitation Service Provision Standards

- 45 Rehabilitation and Geriatric Evaluation and Management (GEM) beds per 100,000 population
 - 10 - 15 hours of allied health therapy per week for each patient
 - Develop nursing care models and optimum nursing hours per patient day
 - Commencement of Rehabilitation in the acute care setting
 - Comprehensive ambulatory, outpatient and community Rehabilitation programs
 - National reporting and benchmarking of access to Rehabilitation
6. Focus on the specific Rehabilitation needs of our Indigenous communities

¹: National Rehabilitation Strategy. Working towards a clear and united Rehabilitation Strategy for Australia, Alliance of National Rehabilitation Professional Organisations, 8 March 2010

11. Appendix 2: District Nursing Service Re-Configuration Reference Group
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The following Reference Group members have been involved in the <65 Rehabilitation Inpatient Service Review process.

<i>Team Member</i>	<i>Role</i>
Maggie Oulaghan	Project Manager
Lyn Horgan	Operations Director
Sue Wood	Director of Nursing
Jurriaan de Groot	Clinical Director, Rehabilitation and Therapy Services
Kim Fry	Allied Health Director
Colleen Bary	Service Manager, ATR, Therapy & District Nursing
Mark Beale	Clinical Director, Internal Medicine
Louise Angus	Acting Charge Nurse, STAR 3
Lee Hefford	Social Worker
Boris Mak	Rehabilitation Registrar
Donna Ryan	NZNO Representative
John Bourke	ASMS Representative
<i>(none nominated)</i>	PSA Representative
<i>(none nominated)</i>	NZRDA Representative
<i>(none nominated)</i>	APEX Representative
Viv Laurenson	HR Representative

12. Appendix 3: Submission Summary

<p>MIDCENTRAL HEALTH REHABILITATION INPATIENT SERVICE REVIEW SUMMARY OF SUBMISSIONS</p>
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1.0 EXECUTIVE SUMMARY

FEEDBACK FROM STAFF CONSULTATION AND COMMUNITY FEEDBACK

The consultation process included staff (in accordance with the Management of Change requirements in Collective Agreements), and feedback received from the community was also considered prior to making the final recommendations.

Twenty-four submissions were received, in addition to a petition with over 400 signatories opposing the possible closure of STAR 3 and STAR 4.

Submissions from the community (including patients) gave considerable focus to the value to patients and their quality of life that the rehabilitation services currently brings, and their concerns about the impact of these people not being able to access appropriate rehabilitation services in a timely manner.

Staff submissions included concerns about the impacts for patients, and also commented on the impacts for staff and the STAR wards of the proposed changes, as well as identifying consequential impacts for the wider hospital, eg reduced availability of rehabilitation beds could result in longer patient stays in the acute medical/ surgical beds.

Key themes included:

- Concern re impact on consumers – noting the benefits of access to the service in a timely manner; and concerns about the impact of inability to access services at all.
- Support for MCH pursuing appropriate level of funding from the Ministry of Health.
- Retention of 12 beds generally supported.
- Potential adverse impact for outpatients through reduction in the team of professionals (who cover both inpatients and outpatients).
- Impact on medical/ surgical beds through reduction of availability of STAR 3 beds and increasing waiting list, eg discharge delays and timeliness of rehab intervention for patients.
- Return to a five-day ward not supported – issues with bed availability in acute areas and disruptive for patients and their rehabilitation time.
- Reduced resources would mean less availability of specialist support/ advice to other areas/ hospitals.
- STAR 3 model of care reflects the needs of their patient group (different from elderly patient rehabilitation model).
- Reduction in staffing levels could compromise patient care.
- Essential to retain the registrar training post for recruitment, retention and succession planning – and contribution of the role to outpatients and covering the consultant.
- Possibility of withdrawing the house surgeon role.
- Concern re the proposal to disestablish the Charge Nurse role and establish a CNS role – would an Associate Charge Nurse role be better (insufficient detail provided re the proposed CNS role)?

- Concern re reduction in Care Assistant Hours, given their input and assistance in the rehabilitation process.
- Disestablishment of Ward Clerk position – not supported by STAR 3, although patient throughput would indicate that one position could cover both STAR 2 and STAR 3.
- Consider increasing Social Work hours to assist with discharge planning.
- Concern about one person on night shift; support for having RN cover every night (currently EN cover for three nights).
- The potential impacts for STAR 2 of a reconfiguration of STAR 3 – service delivery model, nursing management and leadership (while STAR 2 was not a part of this review, the proposal includes recommended leadership changes for that area).

An alternative staffing configuration based on eight beds was proposed by the STAR 3 staff for consideration.

2.0 SUBMISSIONS

Submissions received in response to the Proposal for Consultation:

- Inpatient Rehab Team (STAR 3)
- New Zealand Nurses Association
- Brigid Fay, Professional Advisor, Speech-Language Therapy
- Erica Henderson, Professional Advisor, Social Work
- STAR 2 Nursing Staff
- Dr Kirsten Holst, Clinical Director, ElderHealth
- Dr John Bourke, Physician/ Geriatrician
- Dr Syed Zaman, Consultant Physician, Internal Medicine/ Elder Health
- Jan Mathews, Duty Nurse Manager
- Max Adamson, Professional Advisor, Clinical Clerical Services

Submissions directed to the Chief Executive Officer, Chairman, or via Communications:

- MS Central Districts – Ethel Robinson, Secretary
- Petitions (co-ordinated by MS Central Districts): “We the undersigned, object to the possible closure of the Rehab facilities in Palmerston North Hospital (STAR 3) and Levin Hospital (STAR 4)” were sent to the Chief Executive Officer, MDHB” – over 400 signatories.
- The Board of Brain Injury Association Central Districts Incorporated
- Stroke Foundation of NZ Ltd, Manawatu Sub-Region (President & Hon Secretary)
- Stroke Foundation of NZ Ltd, Manawatu Sub-Region (General Manager)
- The Ryder-Cheshire Foundation (Manawatu) – Chief Executive Officer
- Staff of STAR 3
- Seven patients of STAR 3
- Chairman, Physicians Committee

The remainder of this summary is a collation of information from individual submissions.

3.0 IMPACT OF THE PROPOSAL (SERVICE DELIVERY)

3.1 STAR 2

Process concerns

- Consultation/work stream process regarding STAR 2 and 3 process discontinued, but in this document it is taken as a completed exercise that there was to be one charge nurse/team across STAR 2 and 3

- In the initially set up group reviewing the merging of the wards we agreed that it was MDT approach, and should include all team members
- With a small service it is impossible to make changes to one aspect of the service without impacting on the other aspects. The same clinicians work across community/outpatient and inpatient services
- The details of the service provided by STAR 2, the stability of medical, nursing, allied health staff, the model of service delivery and the effectiveness and efficiency of the assessment, treatment and rehabilitation is not considered in this proposal. The assessment in Star 2 is that the patient outcome and “staff risk” situation is high if the current ward flow is changed. There is an implication that the changes in Star 3 will alter the focus of the service in Star 2 and impact on service delivery model, nursing management and leadership in Star 2.
- It is unclear if the changes that would be required by Star 2 to promote efficiency of the Star 3 are due to the wards’ location or to a view that rehabilitation of all ages should occur in one place and under one model of care.

Star 2, the neighbouring ward to Star 3, provides a service for patients over 65 years of age. This area had been informed that it was not under review, however, the impact of Star 3 reconfiguration will have significant effect on patient care, service delivery and staff working environment. For the proposal to be considered credible, it must consider the needs of each ward collectively, not the efficiencies of Star 3 in isolation.

3.2 Outpatients

Given that the in and outpatient workload is undertaken by the same team of rehabilitation professionals, we are concerned that the potential negative implication of this proposal on the outpatient services is not considered. The MOH DSS 2.15 outpatient services contract requires us to produce 2000 outpatient contacts. With the significant reduction in team composition, this target is unlikely to be met resulting in significant loss of revenue (as well as ACC revenue). There are two types of outpatients: those who have graduated from their inpatient stay, but still require follow up including medical review and/ or therapy provided by an Allied Health member of the team, and those referred directly from the community by ACC and GPs.

3.3 Beds

It would appear short-sighted to not admit patients from the Surgical wards (often trauma or head injury patients) and obtain the ACC revenue which is significantly more than Vote Health. Patient flow from surgical wards to the Rehab ward will allow elective surgery to continue uninterrupted.

NZNO members note that this prevention of bed block potentially assists with the identified Ministry of Health Target “Shorter Stays in Emergency Departments” (MOH, 2010).

It is noted that approximately 3,000 bed days/ year are currently allocated to the Rehab Unit and there are likely to be significant implications for other services if these bed days are to be allocated elsewhere within the hospital system.

3.4 Discharges/ Length of Stay/ Waiting List/ Referrals

AT&R services in PNH have evolved to deal with patients that other groups have difficulty dealing with, particularly with respect to difficult discharge planning. Other services are not set up to deal with this so lack of available beds will lead to discharge delays (negative impact on length of stay efficiency), without significant up-skilling, and repeated learning of the management of the complex pathways for multiple physicians and teams. A decrease in bed numbers or loss of nursing staff will also have an impact for community admissions direct to the ward. There have also been cases where patients are discharged acutely having not been referred/had access to appropriate rehab services/advice, eg head injuries.

Reducing bed numbers in STAR 3 will have some impact on the acute medical/surgical wards referring patients down and the timeliness of their Rehab intervention.

Since the beginning of 2010, we utilised maximum bed capacity (currently 8 beds) and (unfortunately) have a waiting/referral/advice list which is growing due to lack of bed availability. This is disheartening to the team who have always provided excellent clinical care and outcomes; knowing our client group don't have appropriate access to specialist health care.

3.5 Five-Day Ward

Returning to a five day per week ward is just cost shifting as some of the patients would need to be weekend housed on medical/ surgical wards (although a five day week option would be better than no Rehab ward at all). There could also be issues with weekend bed availability in the acute areas.

Moving at weekends can be disturbing for patients, especially those with varying levels of cognition impairing orientation – and not conducive to “Optimising the Patient Journey”. This also cuts rehab time by a day, as movement in and out takes a half a day minimum at each end (based on previous experience doing this), and ties up much nursing staff in co-ordinating the moves.

3.6 General

The STAR 3 service acts also as a resource for satellite health providers, including Wanganui and Masterton, where their expertise is not duplicated in these hospitals. This also reduces the potential for out-of-area admissions in relation to complex cases.

The rehab team are always working towards ways of improving communication channels within MCH and the referral system/advice network, and are always happy to offer what advice/input they can as staff resources allow. Their ability to provide this advice would be limited with less resources.

Loss or reduced services/resources to our service impact negatively on our client group individuals, potentially creating lowered levels of functioning and participation, not to mention the psychological effect when they are already coping with life changes/disability adjustment issues. Holistically, and from an MDT view – this is unacceptable, and not productive to the service, organisation and wider community.

Although there is an aging population, the <65yr age range are experiencing multiple co-morbidities, which, with specialist input such as ours, will ensure more manageable outcomes in the future (i.e. >65). For example, approx. 35% of STAR 3 admissions are CVA/neuro-related conditions. The service needs to continue to provide patient-centred (specific) care to this population. STAR 3 utilise national guidelines (eg Stroke Foundation best practice) to ensure this is efficient and accessible to all who should require it.

4.0 MODEL OF CARE

Nursing Model – Star 3 operates a Team Nursing Model; Star 2 operates Primary nursing. The two models are different but meet the needs of the different ages.

Multidisciplinary Team

The needs of the under 65s are well met by the current model of care which is team nursing. This model is supported by the current Multidisciplinary team. The current team is unaware of patient dissatisfaction or patient safety concerns with this current model of care. By maintaining this model, staff welfare and retention are key factors and essential to long term viability of an extremely knowledgeable staff group, and the MDT staff strength.

The multidisciplinary rehabilitation team approach cannot be duplicated in its current form elsewhere within MidCentral Health. The current setting provides a safe and therapeutic

environment from a physical, clinical and psychological perspective. There is internationally well documented evidence, particularly for stroke rehabilitation patients that clinical outcomes are superior in the general rehabilitation ward as compared to rehabilitation provided in a medical ward (Langhorn, P: Stroke Trialists Collaboration, 1995).

The proposed options will impact on the functioning of the MDT and on the discharge process and the patient's reintegration into the community.

STAR 3 patients have very different needs to older people – with respect to rehab goals, employment, driving, personal relationships etc; and have different pathologies (e.g. severe head injury) requiring specialised rehab programmes from highly skilled professionals with profound knowledge and extensive experience of these conditions. Staff on the general medical wards do not have the necessary training or expertise to manage these patients, and patient outcomes will be impacted. Lengths of stay and readmission rates will increase.

Complexity of assessment

The patient under 65 years of age has special needs for assessment, planning of care and discharge. They are often still participating in vocational and social activities and have family commitments that require different assessment and management from the aged population. This client group has funding from Ministry of Health and ACC – these funding streams are more complex.

An example is a spinal patient in another Rehabilitation setting (eg. >65yrs) who required significant support from Star 3 staff for their specialty knowledge. This is becoming a more common situation, with advice sought from our service. Again, demonstrating that Star 3 service is not duplicated anywhere in MCH region.

5.0 STAFFING

5.1 General

At current staffing level and bed numbers, any change in current staffing level would compromise patient care. Internationally it is recognised that this patient group requires a minimum of three hours of active therapy input a day, in order to optimise their rehabilitation outcomes. With the significant reduction in staffing levels across all disciplines as part of options one and two, this objective will not be met. This will result in sub-optimal rehabilitation outcomes such as increasing length of stay, potential failed discharges, more patients requiring residential care, lower return to work rates and higher long term requirements. It is also expected that performance will drop in the AROC benchmarking data set.

STAR 3 already has beds capped from 12 to 8 beds, and appears to be “breaking even” according to information from Hospital accountants. Since this capping of beds, staff cuts have occurred (including allied health and nursing), all relative to patient acuity. The Rehabilitation Outpatients Service pays approximately 10% of costs. The Allied Health and Doctors proportion a significant amount of time to this service which is not really included in total personnel figures.

5.2 Medical Staff

A fulltime rehabilitation consultant (with high standing in the Rehab medical community, nationally and Australasian-renowned) and fulltime rehabilitation registrar (a long-standing training position – with CTA revenue) is essential to the continued function of the rehabilitation service both for inpatients and outpatient services, and to assist with recruitment, retention and succession planning. The registrar undertakes outpatient clinics, provides consultation to other departments and GPs and can assist in cover of leave for the consultant. The registrar is also involved in co-ordinating AROC (benchmarking, outcome measures in-patient setting).

Assuming that patients for rehabilitation are medically stable with a 22.25–day length of stay, the house surgeon role could be withdrawn.

5.3 Nursing

Disestablishment of Charge Nurse Role

The Charge Nurse of STAR 3 has a co-ordination role in discharge planning - additional pressure has been placed on the role with the social worker only covering 4 days. The lack of Charge Nurse and reduced social work cover will have a negative impact upon discharge planning and communication with patients, family and external agencies.

There is an assumed “Nursing leadership one model approach across Star 2 and 3 with one Charge Nurse covering both wards”. The load for one charge nurse in Star 2 with the increased legislative, Health and Safety, increased technology and increased reporting requirements have increased. Further load would make it unmanageable without appropriate associate support to assist with the existing role in discharge planning, patients referrals, ward round of two consultants, MDT and patient flow from the acute wards together with HR requirements of staff, and twenty five patients.

Establishment of CNS Role

We fully support the establishment of a senior nursing position but are concerned about the effectiveness of this role combined with the demands of a clinical load and wonder whether an Associate Charge Nurse may better serve the service.

The proposed role of a CNS is not clearly defined. The role has reportedly been unsuccessful in the acute wards and reportedly there is no CNS taking a clinical load in the hospital. It is noted that the proposal suggests that the role covers both Star specialities, but the FTE of staff would not increase despite a four-bed increase in option 2. This then would indicate that the clinical load is based in Star 3. It is difficult to assess the role as it applies to Star 2 and 3, incorporating the special focus of each area

This is not favoured by the nursing staff and as the CNS would have a 50% clinical work-load it would be sensible to reallocate this as a Associate Charge Nurse position for STAR 3. They could be involved in staffing and nursing administration of STAR 3. The Charge Nurse position in STAR 2 is already full-time and often works over-time without penalty to the organisation. There is a risk that if the proposal of an increased workload to the STAR 2 Charge Nurse was made, the current incumbent exits the organisation from burnout.

The proposed role of the CNS needs to be clearly defined – notes for consideration:

- The role has reportedly been unsuccessful in the acute wards, as the expectation of a clinical load together with other responsibilities of MDT and ward rounds is not manageable.
- It is difficult to assess the role as it applies to Star 2 or 3, incorporating the special focus of each area.
- The existing role of the STAR 2 Charge provides a significant influence in discharge planning, ward rounds of two consultants, MDT, patient assessment and patient flow from the acute wards together with HR requirements of staff and 25 patients.
- An Associate Charge Nurse, covering ward rounds/family meeting/discharge planning, would be required.

Both proposals (Options 1 and 2) in terms of senior nursing staffing provide insufficient detail about the duties that would be undertaken by this person. The rehabilitation model requires that a senior member of the nursing team fulfils a co-ordinating role in supporting the patient model of care. This includes monitoring the nursing staff performance, overseeing rostering, attendance to various meetings, including family meetings, core team meetings, service improvement meetings and case conferences. The role also includes assessing patients for suitability of transfer to STAR 3 from other wards and the community in conjunction with the rehabilitation medical staff. Given the complexity of our patients, this co-ordinator role

requires a significant amount of time in the discharge planning, liaising with both internal and external agents and keeping up to date with current rehabilitation based knowledge.

Currently this role is fulfilled by the Charge Nurse. Neither option one or two provides a designated charge nurse and although a CNS position is specified in both options, given the small size of the nursing team, it is highly likely the CNS will end up carrying a patient load which is incompatible with the co-ordinator role. This would result in inappropriate transfer of patients, delayed transfers, loss of specialist knowledge and increasing length of stay.

The current Charge Nurse role is a more effective and safe role than that of a Clinical Nurse Specialist role for Star 3. We see this as a Coordinating role, especially in implementing the model of care. This is because the Charge Nurse role includes

- A staff management role, ie performance development and ongoing appraisals, competence
- Resource person
- Liaison and coordination with the Multidisciplinary team for care planning and complex discharge planning
- Performing to strengthen a collaborative relationship with other teams within MCH and external agencies.
- Significant discharge planning input (internal & external)

The one Charge Nurse across both areas would not be sustainable to achieve the above in a timely manner.

The introduction of a CNS with an overview of all patients in the ward would be desirable.

5.4 Reduction in Care Assistant Hours

Often the care assistants provide supervision for patients needing feeding assistance/guidance and they also often provide a lot of the oral cares for patients. Reducing their overall numbers – particularly over meal times would mean some increased clinical risk.

Under supervision from registered staff, care assistants undertake duties such as assistance with showering and dressing, mobilising and helping at meal times. All of which foster and support the patients to maximise their independence. The care the assistants provide is to motivate and enable the patients to work towards their rehabilitation goals. Their presence frees up more time for the other health professionals for other work and it is therefore far more cost effective. The care assistant is trained in monitoring patients for sleep study overnight and this service is partially funded by respiratory services.

Some patients require two assistants for cares. A morning care assistant (0700-1100), not a full shift, would cover this.

5.5 Disestablishment of Ward Clerk Position

There will be a resultant increase in admin for social work and allied health staff, eg data entry for AROC (submitting data on every patient), provision of patient information pack, dissemination of family meeting minutes, assessment and discharge summary – and the position provides valuable frontline support for the service.

Clerical support is being under valued. Ward clerks on other wards may have more beds, but their range of skills and responsibilities in STAR facilities is much wider, and this allows other members of team to concentrate on more vocationally specialised jobs. We are well aware that when one is away things fall over. Our ward clerks have a more general PA job than those working in acute service.

The proposal to reduce to one Ward Clerk across STAR 2 and STAR 3 seems reasonable based on the throughput of other wards; it is assumed that one ward clerk could cover both areas.

5.6 Social Work FTE

Historically the social work department has dedicated up to 1.1 FTE to the Under 65 Rehabilitation service. Generally this has been shared between 2 social workers who have provided 5 day per week cover.

Currently only 0.6FTE is being utilised over 4 days which impacts on the inpatients and potentially interrupts /communication flow and discharge planning.

Recommend that the social work hours be increased to assist with patient discharge planning in a climate where access to resources and funding options for patients is severely reduced, eg Access to ACC funded services, IFP through Supportlinks MOH funding to the Stewart Centre.

5.7 Therapies

Intensive therapy is essential to the patient in rehab, and we acknowledge and support the other therapies that make up the MDT; Speech language therapy, occupational therapy, physiotherapy, psychology and recreational therapy.

5.8 Night staff rostering

NZNO members believe that the reduction in night shift staff for STAR 3 to one RN is a health and safety issue for the following reasons:

- Security
- Lifting

This will be raised via the Health and safety Representative for STAR 3, following MidCentral DHB's Policy processes.

Night cover in STAR 3 will be covered by a Registered Nurse (RN) seven days a week in each proposal. This is a change from the present four nights per week RN cover and three nights per week Enrolled Nurse cover supported by STAR 2 at night. This is a positive and addresses a major current concern in safety. There is once again an indication that support for one nurse is required to facilitate meal breaks and to assist in patient care.

6.0 CONSUMER PERSPECTIVE

The current inaccessibility of specialist care for our client group is disheartening to the team, and community as a whole and we are proud to state that local, regional and national support from these groups for our unit is valuable and shows the importance of such a service not able to be duplicated at regional level.

NZNO notes that the Health and Disability Services Standard 13.4 states *"Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner"*.

NZNO members note that patients have commented on Star 3 service provision through their correspondence with Hospital Management, and letters to the Editor of the Manawatu Standard. We note the comments by MS Central Districts Field Officer P.Russell stating concerns about cuts to Star 3 services (Manawatu Standard, 2010).

Seven patients testified to the positive outcomes of their treatment/ experiences – and support the continuance of STAR 3 rehabilitation services.

Potential for longer hospital stays (further congestion of acute beds) – and patients placed on wards not equipped to provide the specialist rehab services they require. While PNH has an acute stroke unit, upon becoming medically stable, survivors are moved quickly to STAR rehabilitation services.

Concern that the reduction in beds will compromise the people from Ryder-Cheshire to access them on a regular basis when they require a rehabilitation assessment.

Benefits of STAR 3 Rehab for people with MS include:

- Access to a trained, highly skilled multi-disciplinary rehabilitation team of Doctors, Neuro-Physiotherapists, Occupational Therapists, Social workers, Speech language Therapists and Neuro-Psychologists
- Early intervention for People with MS experiencing an exacerbation of their symptoms is an essential part of their treatment.

If the well-functioning rehab service was lost, how would these services be maintained so that people with disability in MDHB can continue to have a better chance of rehab leading to a better quality of life?

7.0 FUNDING

Support for MCH action to align the MOH Rehabilitation funding for bed-days in Star 3 (no increase in the last six years) to the acceptable market rate annually, and in so doing, prevent front-line clinical changes.

8.0 OPTIONS

A number of submissions expressed support for Option 2:

- We feel that there is the necessity to retain 12 beds within the service if at all possible (6-8 Ministry funded beds and 4-6 non-acute ACC contracted beds)
- One of the questions that arose during our discussion was around the occupancy rate of 84% (just over 10 of the 12 beds being filled) - it was asked whether this was a reflection on the lack of staffing resource for STAR 3 or a lack of referrals into the service?
- Will allow retention of registrar and HCAs, and retain 7-day week opening.

Given the fact that the funding under Personal Health is to be limited to only 6 beds, propose an increase in bed numbers if patients (<65) were under the ACC contract (flexi-beds).

NZNO members do not support either option presented, and request that the current structure is retained.

9.0 ALTERNATIVE OPTIONS

9.1 Proposal 1

Although our team would prefer to continue to provide a 12 bed service, should we be forced to reduce to 8 beds out of economic necessity, then our view could be summarised as follows:

To maintain clinical viability, a minimum team composition is required to maintain team functioning and to ensure the unique nature of the rehabilitation service is not lost. Such a team composition would consist of the following to cover an eight bed rehabilitation inpatient unit, plus the rehabilitation graduate requiring outpatient input. This would also enable us to continue to discharge patients at the earliest opportunity and provide their further rehabilitation as an outpatient. This approach optimises the patient's outcome and minimises the length of stay as much as possible with obvious benefit for the organisation.

The service would comprise:

- Rehabilitation Consultant – 1.0 FTE
- Rehabilitation Registrar – 1.0 FTE
- House Officer – 0.5 FTE

- Nursing Staff
 - Charge Nurse – 0.8 FTE
 - Registered/ Enrolled Nurses – 8.28 FTE
 - Health Care Assistants – 4.87 FTE
- Physiotherapy
 - FTE Physiotherapist
 - 0.75 Physio Assistant
- Occupational Therapy
 - FTE Occupational Therapist
 - 0.5 FTE Occupational Therapy Assistant
- Social work – 1.0 FTE
- Psychology – 0.4 FTE
- Recreational Therapist – 1
- Speech Language Therapist – 0.5 FTE (covering STAR 1,2, 3 and including outpatient follow up) (*Noted SLT input into STAR 3 not acknowledged in consultation document*)
- Ward Clerk – 0.4 FTE

(The staffing is proportionally less as we are basing on eight beds rather than 12 beds.)

9.2 Proposal 2

With appropriate funding and staff – utilise 12 beds and continue to admit a proportion of patients over 65 whose rehabilitation needs meet STAR 3 referral criteria. This would improve the patient flow and add to the elder health bed day volume. This would be of benefit to the whole organisation.