PRACTICE-BASED REFLECTION:

CONSIDERATIONS FOR RE-ENGINEERING

SECONDARY HEALTHCARE IN

NEW ZEALAND

by

Anita F. Bamford

A thesis submitted to the Victoria University of Wellington
in partial fulfillment of the
requirements for the degree of
Master of Arts (Applied)
In Nursing and Midwifery

1997

ABSTRACT

Re-engineering is the "buzz" word of the nineties. Re-engineering has been successful in industry. Now the principals of re-engineering are being applied to healthcare. Considerations for re-engineering secondary healthcare in New Zealand will be examined in this literature review, which is divided into two sections.

The first section provides the aims of the literature review, my background interest and knowledge of the topic, it's relevance to nursing practice, plans for addressing the literature review, and proposed sources of information.

Section two illustrates the learning contract to manage the task of conducting the literature review. It identifies timelines for managing the project and agreed arrangements for communication with my mentor.

Finally, a report will address my progress in relation to my learning contract articulating insights gained and hopes and dreams for successfully incorporating process re-engineering in my area of nursing and midwifery practice in the future.

ACKNOWLEDGMENTS

Johnson University Hospital [R.W.J.U.H.], New Brunswick, New Jersey. Marguerite has been leading the re-engineering programme at R.W.J.U.H. for the last five years. Of all the hospitals I visited in the United States in 1995/96, this was a leading light. Many hospitals had taken a slash and burn approach to re-engineering. R.W.J.U.H. had really taken care of it's people and had adhered to their "Guiding Principals". This impressed me very much and was in sharp contrast to what I had seen elsewhere. I had the opportunity and privilege to workshop with Margeurite at Lakeland Healthcare in February 1997.

I am grateful to the Directors of Lakeland Healthcare for sending me to the Master Classes in Re-engineering with the Leicester Royal Infirmary, March, 1997 and giving me the opportunity to chair the Leading Edge 2000 [L.E.2000] Sub-Committee of the Board. L.E.2000 is responsible for process re-engineering at Lakeland.

To Mary Smith, who is the Change Leader for L.E.2000 and Tony Phemster from Coopers and Lybrand, Auckland, thank you for all you continue to teach me and for insights gained. This literature review would not have been complete without the application to Lakeland Healthcare.

To Cheryle Moss, my mentor for this paper, thank you for your support and encouragement. I valued our monthly meetings and your feedback.

Finally, to my community, family and friends who have supported and walked with me over these two years of study, my heartfelt thanks for sharing such a wonderful opportunity with me.

CONTENTS

List of Tables

PREFACE

It must be considered

that there is nothing

more difficult to carry out,

nor more difficult of success,

nor more dangerous to handle,

than to initiate a new order

of things.

For the reformer has enemies

in those who profit by the old order

and only lukewarm defenders

in all those who would profit by the new.

Machiavelli: The Prince.

PART I.

Introduction and Proposal to Conduct a Literature Review

Part 1 consists of Chapters One and Two. Chapter One provides an introduction, the aims of the literature review, my background interest and knowledge of the area, and it's relevance to the practice of nursing. Chapter 2 looks at plans for addressing the topic, proposed sources of information, the Learning Contract to manage the task of conducting the Literature Review and agreed arrangements with my mentor.

CHAPTER 1.

INTRODUCTION.

"A deliverable is the invisible that becomes the intangible

and achieves the impossible."

Ann Driver, Team Leader, Leicester Royal Infirmary, 1996.

Healthcare throughout New Zealand is in various stages of "re-engineering" using a number of different approaches. The different approaches are of concern. For the approach determines the outcome. Three approaches that I am aware of are: imposing the Business Process Re-engineering model onto healthcare, the slash and burn approach which apparently has the same effects as dieting i.e. you loose it quickly and put it back on just as quickly, and an adaptation of Business Process Re-engineering to a healthcare setting as at the Leicester Royal Infirmary in the United Kingdom.

Re-engineering is a key area of healthcare and nursing in particular in today's environment. It is for this reason that I have chosen this area in which to do my literature review.

This assessment will identify the aims of the literature review, explain my background interest and knowledge of re-engineering before exploring it's relevance to healthcare and nursing in a New Zealand setting. Plans for addressing the topic and proposed sources of information will be explained within the boundaries established with my academic mentor. This will be accompanied by a Learning Contract which will identify a timeline for managing the project.

1.1: The Aims of the Literature Review

- To identify healthcare issues in New Zealand that have created the impetus for process re-engineering in the secondary sector.

- To analyze international trends in re-engineering so as to determine their appropriateness for the New Zealand healthcare environment.

- To examine the distinguishing characteristics of business versus healthcare approaches to process re-engineering.

1.2: Background

My Own Story

"Re-engineering" has become the buzz word in healthcare in the 1990's. It is often used very loosely and has a number of meanings depending on the context. I first became interested in "re-engineering" in healthcare in the early 1990's. At that time my main interest was in the valuing and costing of nursing and I read extensively in this area. It was on reading an article by Dominick Flarey "A Methodology for Costing Nursing Service" in the Journal of Administration Quarterly 1990,14 [3], 41-51 that I first became aware of the word "re-engineering" in nursing. As I was unable to work out Flarey's methodology, I decided to ring him in Ohio to discuss it .

Over the years we had many a conversation on matters related to nursing as Flarey has written two books: "Redesigning Nursing Care Delivery" and "Re-engineering Nursing and Healthcare". Each time he has sent me a copy of his book. I was fortunate to spend a day with Dominick December 1995 in Chicago.

Flarey's books opened my eyes to the fact that 40% of all that nurses consider to be "nursing" can be delegated to care assistants. Upon this realization I began to examine nursing in my work environment and quickly realized that Flarey was in fact correct in his estimation. I

clearly remember bringing the topic up with the Nurse Unit Managers and the whole idea was bounced off the wall. They would not hear of it. Of course all that they did was nursing!!!

I waited for a year before broaching the subject again and in the meantime continued to read about "re-engineering" and have my conversations with Dominick Flarey. On raising the subject with the Nurse Unit Managers for the second time they welcomed the idea with open arms. I could not believe it. Here was the same group of people accepting a concept which a year earlier they had very definitely thrown out. It was wonderful. Obviously the timing was right.

We set about looking at what nursing could give away and soon had a job description drawn up. A pilot was run on a thirty bed surgical ward Monday to Friday 7am - 3pm. This person soon became indispensable and the nurses had much greater job satisfaction. This role is now on all wards and covers morning and afternoon shifts.

December 1995 and January 1996 I had five weeks looking at "re-engineering" and how nursing had been reshaped as a result, in the United States and visited the following hospitals: The Evanston Corporation, Chicago; The John Hopkin's University Hospital, Baltimore; Beth Israel, New York; Beth Israel, Boston; The Robert Wood Johnson University Hospital, New Brunswick and the Civic

Hospital, Ottawa. Each organization had approached the subject for different reasons i.e. as the result of a nursing shortage, withdrawal of the level reimbursement from insurance companies and an increasing difficulty in covering costs because of the escalating costs of healthcare. The hospital that really impressed me the most was the Robert Wood Johnson University Hospital. They had managed the process themselves and been very successful. They had not used outside consultants at all. What made them very successful was the fact that they had re-engineered without making a single person redundant. Staff had been given this guarantee and so there was staff buy in from the outset. Instead they had reduced staffing by attrition and had upskilled staff for their new roles as roles changed within the organization. When they had embarked on the project they had formed a set of "Guiding Principles" to be used in decision making which really impressed me for here was an organization that had values and people mattered. It was very refreshing!

July 1996, I was appointed as Clinical Director to one of the Crown Health Enterprises at a time when the C.H.E. had been given six months to improve. The whole organization was mobilized with what was known as Project 96 and in that time the organization learnt much about itself. There was a strong commitment to the project throughout the organization and it engendered considerable enthusiasm to take the organization forward. Four key developments from the project were the

7

formulation of the vision, mission, values and guiding principals for the organization [Appendix 1], and the implementation of the Clinical Services Model [Appendix 2], the development of the Strategic Direction of the organization and Leading Edge 2000. In order to carry over from the good work that was done through Project 96 the Board formed five sub-committees one of which I am the chairperson - known as Leading Edge 2000. As we did not believe that Business Process Re-engineering could be uplifted from the business world and applied directly to a healthcare setting, we called it Leading Edge 2000. For it is about Patient Processes and who is at the heart of the patient processes but the nurse! Our decisions will all be made in the context of the vision, mission, values and guidelines of the organization.

Leading Edge consists of four key strategies:

1. Shareholder Strategy

2. Funder / Purchaser Strategy

3. Internal Strategy

4. Community / External Stakeholder Strategy

There are four sections to the Internal Strategy:

1. The implementation of the Clinical Services Model

2. Cost reduction - Efficiency gains

3. Clinical Services Re-engineering

4. Continuous Quality Improvements.

My responsibility lies with the Clinical Services Re-engineering which we have defined as "the fundamental thinking and radical redesign of clinical and business process to achieve dramatic improvement in performances, such as quality, service, speed and cost."

There are four phases to the Clinical Service re-engineering:

Phase 1: Develop and implement the Clinical Services Model - October 1996 - February 1997. Completed.

Phase 2: Preparation of services for Clinical re-engineering - March - June 1997.

Phase 3: Implementation July 1997 - 2000.

Phase 4: Continuous quality improvement of the re-engineering processes 2000+.

We are currently in Phase 2. People I have spoken with, who have embarked on this journey emphasize the importance of adequate preparation time and how that impacts on "the flow on" effect for the

success of the project. From my short experience I would wholeheartedly endorse this. Ensuring that the composition of the board sub-committee and the operational committee is right is critical if the processes are to cascade through the organization. There needs to be a bottom up and top down approach simultaneously.

The other big decision has been whether or not to involve external consultants. After much deliberation we decided to interview four consultancy firms to see what they were able to offer to the process. Consultants commented that we used a rigorous process for the interview. The interview took the form of the consultants presenting to us how they would go about assisting us. The presentation was one aspect of the interview. We were also looking for the right person fit for the organization. This was very important to us as staff have had more than their fair share of "the men in suits" as they call it and felt no benefit of such previous visits at the coal face. We decided to go with a firm who has the ability to assist with the analysis work and benchmarking nationally and internationally.

From my reading on the subject, it was obvious that we also needed our own internal leader for Leading Edge 2000. We choose the best of the nurse consultants to be this leader. [Job Description - Appendix 3]

17th - 26th February, 1997, Dr Marguerite Schlag from Robert Wood Johnson University Hospital in New Brunswick, New Jersey, came and introduced the concept of healthcare reengineering and shared her ten years experience with us. Marguerite workshopped with staff across the organization asking each group the following questions: "What's being done? Who's doing it? Should it be done? Who should do it?

The quality of work was looked at by asking the following questions: "Are we doing the right work? Is it being done by the right person, in the right place, at the right time, for the right reason, at the right cost?"

The quality of service was examined to see if it is "accurate, timely, expert, responsible, sensitive, thorough and co-ordinated."

It was an excellent eight days. Staff really began thinking about their work and how it could be undertaken differently which affirmed a belief I have in the internal wisdom of an organization. The staff hold all the answers.

10-14th March the internal leader and myself attended Masters Classes on Re-engineering conducted by a team of three from The Leicester Royal Infirmary in the United Kingdom [Programme- Appendix 4]. We learnt an enormous amount from the workshop which gave us the tools to take the whole process forward. We have now formed within the

organization what is known as Leading Edge 2000 - Best Practice Initiatives for this undertaking. [Appendix 5].

The workshop clearly demonstrated that the imposition of the business model of reengineering usually fails because healthcare staff cannot readily identify with this model. For healthcare staff respond better to leadership than to management as is demonstrated in the following Table 1:

Table 1

MANAGER	LEADER
Administrates	Innovates
Maintains operations or systems	Develops new systems or approaches and identifies new areas to explore
Relies on systems	Relies on trust
Does things right	Does the right thing
Aims for acceptable comprise	Seeks out new approaches despite possible risk.

Source Unknown

In summary , the above diagram clearly shows the difference between the radical top down [imposed] approach of the business model and the team bottom up, inside out approach that appears to be more successful in the healthcare environment. Health is also far more complex than business. For it has hundreds of processes within

processes, in addition to the specialty dimension, with all that that entails

1.3: The Relevance for Nursing Practice

The workshop demonstrated how nursing is key to the whole redesign. Nursing also came out incredibly strong, in that nurses were upskilled and were now undertaking procedures that have traditionally laid with the medical profession i.e. nurses performing routine endoscopy procedures!

The greatest challenge for nursing will be to let go of what has become tradition and to be able to start with a blank piece of paper and trust the process. Nurses need to be encouraged to develop a new way of thinking. The Leicester Royal Infirmary experience found that there were greater career opportunities, greater accountability for practice, increased decision making within the process framework and a professional development that reflects the requirements of the process team. If we are able to fully realize this initiative it will have revolutionary implications for nursing in New Zealand.

CHAPTER 2

PLANS FOR ADDRESSING THE TOPIC.

I will systematically work my way through the identified aims and accompanying timeline. Therefore there will be four sections to the project. As I continue to gain more practical experience in the application of process re-engineering this will bring another dimension to my understanding and analysis of the literature.

Today I came across a reflection which is so applicable in approaching this paper and in the application of Process Re-engineering. It is titled:

2.1: The Journey is more Important than the Goal

"Focus on the journey itself rather than on the goal or the dream. In this way you will get to experience the joys that abound in each step of the journey......

The steps in the process are what bring new growth and understanding, which in turn deepens and expands the dream. The journey that leads to the dream is more important to the growth of the soul than the actual

achieving of the goal..... When the dream becomes more important than the process required to achieve it, the wisdom and integrity may be lost..... Take the journey one step at a time, allowing yourself the joy to be in the present moment..... Always make the journey more important than the goal, and your dreams will be achieved effortlessly." [Jordan, 1995:140-143].

2.2: Proposed Sources of Information

I have an abundance of information on this topic as follows:

Blancett, S. S. and Flarey, D.L. Reengineering Nursing and Healthcare Aspen Publication, 1995

Bridges, W. Transitions

Flarey, D.L. Redesigning Nursing Care Delivery   J.B. Lippincott Company, 1995

Goldratt, E.M. and Cox, J. The Goal North River Press, Inc. 1992

Hammer, M. Beyond Reengineering Harper Business, 1996

"Managing Today While Creating Tomorrow" Helen Bevan's Ph.D. thesis on Re-engineering at the Leicester Royal Infirmary

Robert Wood Johnson University Hospital Pro- Act References. [Appendix 6]

The Leicester Royal Infirmary's Reading list [Appendix 6]

The Leicester Royal Infirmary's Toolkit on Re-engineering

The New Zealand First / National Coalition Health Policy Agreement [Appendix 7].

There will be other sources that currently I am not aware of but will discover in the course of the literature review.

2.3: Learning Contract To Manage The Task Of Conducting The Literature Review

Aims of the Literature Review	Learning Resources and Strategies	Evidence of Accomplishment	Criteria and Means of Validating Evidence
1. To identify issues in New Zealand healthcare that have created the impetus for process reengineering in the secondary sector.	To undertake a literature review in this area. To meet monthly with my mentor to discuss progress.	To obtain adequate relevant information to enable identification of the issues in New Zealand healthcare that have created the impetus for process reengineering in the secondary sector.	To be able to write a clear and succinct account of the issues and there-by provide the context for process reengineering in the New Zealand healthcare setting by the end of April.
2. To analyze international trends in reengineering to determine their appropriateness for the New Zealand healthcare environment.	To undertake a literature review in this area and to visit a renowned hospital in the U.S. who has implemented hospital wide reengineering. To meet monthly with my mentor to discuss progress	To obtain adequate information to enable me to make an analysis of international trends and their appropriateness for New Zealand	To clearly determine an appropriate way forward for a New Zealand healthcare setting after analysing international trends in reengineering. This will be completed by the end of May
3. To examine distinguishing characteristics of business versus a healthcare approach to process reengineering.	Read Hammer and Champy, the authors of Business Reengineering. Examine the U.S. literature and compare with the Leicester Royal Infirmary experience which is an adaptation of the business approach.	The ability to identify the distinguishing characteristics between business verses a healthcare approach to reengineering.	The creation of a model appropriate for a New Zealand Healthcare setting. To be completed by the end of August.

17

2.4: Agreed Arrangements with my Mentor Cheryle Moss

PROCESSES	DATES
Monthly meetings	Wed 9th April 1.30-3.30pm
Phone in if you get stuck	Wed 14th May 1.30-3.30pm
Send in material to Cheryle as I finish each section	Tues 3rd June 5-6pm
Prepare a brief report for each meeting	Wed 30th July 11-1pm
Visit Mercy Hospital-San Diego in June	Mon 11th August 1.30-3.30pm
Talk to Joanna Harper	Wed 17th Sept 1.330-3.30.pm
Participation in I.C.N.	

PART II.

THE LITERATURE REVIEW

Part 2 consists of Chapters Three and Four. Chapters Three and Four are the first section of the literature review. Chapter Three considers issues in New Zealand healthcare that have created the impetus for process re-engineering in the secondary sector. Chapter Four will discuss "Why Process Re-engineering?".

CHAPTER 3

3.1: Section 1 of the Learning Contract

Aims of the Literature Review	Learning Resources and Strategies	Evidence of Accomplishment	Criteria and Means of Validating Evidence
1. To identify issues in New Zealand healthcare that have created the impetus for process reengineering in the secondary sector.	To undertake a literature review in this area. To meet monthly with my mentor to discuss progress.	To obtain adequate relevant information to enable identification of the issues in New Zealand healthcare that have created the impetus for process reengineering in the secondary sector.	To be able to write a clear and succinct account of the issues and thereby provide the context for process reengineering in the New Zealand healthcare setting by the end of April.

3.2: Introduction

This section of the learning contract is to identify issues in New Zealand healthcare that have created the impetus for process reengineering in the secondary sector. Before I am able to embark on this, the stage needs to be set in terms of where we have come from since 1991. This section is rather lengthy but necessary, because the background provides a sharp contrast in practice to the emerging environment of process reengineering. The background will clearly demonstrate how, unconsciously, it has provided the impetus for radical change to patient centered care with an emphasis on processes across an organization.

3.3: Background

The New Zealand Health Reforms were announced in 1991, with implementation over a three year period 1992-1994. The health reforms were among the most market orientated following the competitive model which has been applied across the public sector. The basis of the reforms was the purchaser [4 Regional Health Authorities] provider [public and public] split which was designed to encourage competition amongst providers and encourage cost minimization. The Regional Health Authorities [R.H.A.'S.] are able to choose between public and private hospitals according to the cost of providing specific services. The health reforms have been greatly influenced by the work of the economists. The

economists have advocated that care should be allocated on the basis of need and that efficiency of resource be improved by the explicit measurement of costs and outcomes. With cost minimization, quality of service is an issue. As contracts have been usually given to the cheapest contender, competition has driven some unrealistic prices at times, for the sake of obtaining a contract over their competitors. This model gives providers the incentives to be cost minimizes, so as to maximize the market share [Boron and Maynard, 1993: 243].

However, in many situations there has been / still is an adversial relationship between the C.H.E'S. and the R.H.A'S. with no common aim apparent between the two organizations. Instead, it has become a mechanistic, competitive process which has had the effect of killing any plans for a joint agenda of service innovation and productive change which meets the health needs of the local community.

Alternatives for healthcare are only available in the bigger centres. Where public hospitals have no competition, there may be no incentive for cost minimization. In these situations, hospitals may utilize their monopoly powers to extract surpluses to spend on unnecessary services. This may be due to unrealistic expectations of the public or empire building on the part of management.

Accompanying and integral to corporatisation is "managerialism" which is an ideology with two distinct claims as given by Rees [1995:17] in Table 2:

Table 2: Two Distinct Claims of the "Manageralism" Ideology

Efficient management can solve almost any problem.	Practices which are appropriate for the conduct of the private sector enterprises can also be applied to the public sector.

There are plenty of managers who haven given substance to these images, with their toughness and efficiency, their willingness to disparage old professional practices and traditions in the interest of a new corporatism. For with corporatism, came managers from the private sector, who had no understanding of the complexities of healthcare. Because few of these managers could come to grips with healthcare complexities, they changed frequently, bringing a sense of instability, to what had previously been a stable environment.

Page, Wilson and Kolb [1994] have conducted a study of New Zealand [N.Z.] management competencies. They find that N.Z. managers are perceived as being much stronger on the "hard" competencies. They are perceived as being good at utilizing techniques of administration and control rather than the "soft" competencies of openness, sensitivity and creativity.

Page, Wilson and Kolb [1994] also found that their respondents did not place much emphasis on organizing the organizational culture. The lack of awareness of the importance of managing culture fits with N.Z. managers concentration on hard-nosed management techniques at the expense of the development of the awareness of others and their cultures.

Aligned with corporatism is masculinity. Feminine values, in a masculine defined market and management style is fraught with difficulties of representation. The power is being maintained by both the management bureaucrat and the strongest male dominated professional group - medicine. As a result, nursing and patient care have been oppressed and powerless in this environment.

This approach is in conflict with good business principles where the emphasis is on developing the organizational culture with strong leadership and a shared vision. Teams and the professional development of staff are integral to the organization, as staff are seen to be the organization's greatest asset. Customers, service and quality are part of the culture. managers "walk the talk" and it's all about empowerment. To date, this has been a major gap in the N.Z. managers repertoire of competencies in managing healthcare.

The prescription of the corporate model is to do more with less. The attempt to label healing as a product to be purchased at the cheapest price, ignores the fact that health is more than a disease absence. Health is influenced by physical, emotional, mental and spiritual factors. Jenkinson [1995:3] refers to this "denial of the holistic nature of people" as a key factor in the imposition of the corporate culture. Human costs are not allowed to cloud the efficiency equation as is demonstrated by the following:

"The other day I went to ask my boss for another nurse on the ward. What I got was a speech about zero funding options, performance outcomes, funding buckets, downsizing of inflexible manning systems and service level agreements. I didn't get another nurse, so I guess all that meant was No. I'm not dumb, but it's like another language. Just a fancy way of saying No".

<div align="right">Staff Nurse 1996.</div>

The language that has become everyday uses words such as inputs, outputs, variance analysis, contracts, cost variance analysis, productive and non-productive time - to name but a few. "Language is a powerful mechanism by which to shape perception" [Radsma: 1994:445]. The interesting thing about all this is that one rarely hears the word "patient" because the patient is now a "consumer". Because the word "patient" is rarely heard neither is the word "nurse" even though it is estimated that

nurses' deliver 80% of the care. Is it because corporatisation is aliened with masculinity. Masculine logic, by definition, fears, denies and controls bodily needs, emotions and interdependencies seeking to control them in the private sphere [Davies: 1995 in Antrobus: 1997]. With the corporate model of healthcare, has come the corporate offices and all their bureaucracy, in new buildings with corporate colours and consultants. Staff, at the grass roots, have come to despise the "men in suites" as they call them because they do nothing to improve the lot of the patient / client or the nurse. Jenkinson [1995:22], in Table 4, finds that the clue to the corporate takeover is to be found in the parallel colonization of New Zealand in 1840. Table 4 and Table 4 clearly show that there are direct comparisons of the takeover of New Zealand by the Pakeha culture, and the takeover of a hospital, in the new healthcare environment.

Table 3: THE GRIEF PROCESS OF CORPORATISATION IN NEW ZEALAND By Robert Jenkinson [1996:23]

COLONISATION OF THE HOSPITAL BY BUSINESS ORIENTATED PEOPLE	COLONISATION OF N.Z. BY SETTLERS IN 1840
Upon entry, promises of consultation, collaboration and improved conditions.	Treaty of Waitangi signed. Promises made. Benefits for all.
Cite examples of bad management, primitive service, etc = *need for change.*	Cite rumours of cannibalism, misuse of land and warfare = need for change.
Begin the bureaucracy, set up committees, claim they are too slow, draft in more experts. claim the situation is worse than you thought. Produce a barrage of paper work. Call *for more experts.*	Produce a civil list. Local committees. Ignore their findings. Call for more troops. Situation worse than thought.
Change the name of the buildings. Select suitable eminent people to name things after. Change people's uniforms, letterheads, paint everything, distribute new procedures. Bring in a new language.	Change the names of places. Forbid speaking in Maori. Ignore old customs, produce a new style of European clothes. Select eminent people e.g. Cameron, Hamilton, Victoria etc to name streets after.

Table 4: THE GRIEF PROCESS OF CORPORATISATION IN NEW ZEALAND by Robert Jenkinson [1996:24]

AGENCY	NEW ZEALAND
Demonise previous leaders. Point out faults. Reward those willing to be an advocate for the new system. Create a climate of division. Separate and rule.	Label some leaders as rebels. Reward tribes that co-operate. Punish others.
Blame resistance on negative thinking, not moving with the times.	Blame resistance on rebels, savages and malcontents.
Disregard all happenings prior to the new culture as irrelevant and primitive.	Disregard all happenings pre-1840 as primitive.
Structure the system in new teams, cut people of from their colleagues and professional links. Give individual, not collective contracts.	Introduce new institutions, relegate past as quaint. Pronounce old culture is dying. relocate tribes. Cut people off from elders.
Ensure followers of the new system are highly paid. Encourage training in new ways. Abolish all other training.	Confiscate land and give to loyal followers. Start Pakeha schools for new training.
Claim space is wasted. Give the biggest desks to followers.. Move people without asking. Draft in more analysts, public relations to vet all statements.	Claim land is wasted. Give to more progressive owners. Relocate people without consultation.

Unfortunately these diagrams clearly illustrate what has been part of everyone's experience who has been involved in healthcare over the last seven to ten years. The side effects have left people with feelings of powerlessness, low self esteem, demoralization and indifferent to another's pain in an attempt to protect themselves. How can healing take place in such an environment?

October 1996, saw the development of New Zealand's first Coalition Government with the National Party and New Zealand First. The Coalition Health Policy document sets out guidelines for Providers and their relationships with Funder / Purchasers for the future. The impact on the Crown Health Enterprises [C.H.E'S.] can be summarized in **Table 5.** Even though the Coalition Document gives the general policy direction, there is still quite a degree of uncertainty in the sector, as to how it will really work and what will be the implications. Overall the health sector has be in turmoil for a number of years now and one has to wonder how we are going to emerge from this mess?

Table 5: The Coalition Policy Document

C.H.E. will be replaced with the Regional Hospital and Community Services which will deliver those services currently delivered by the C.H.E.	C.H.E. will report through the Ministry of Health to the Minister of Health rather than a minister of Crown Health Enterprises	The competitive profit focus will be removed for the Regional Hospital and Community Health Services.	C.H.E. will be required to function in a businesslike manner.
The new focus will be on achieving health outcomes and improving the health status of those we serve.	Private sector involvement in services usually provided by the public sector will be limited and subject to Ministerial approval.	Co-operation and collaboration rather than competition to be encouraged.	From 1 July, 1998, there is an expectation that there will belong term contractual agreements for services, rather than the one year R.H.A. process.
By July 1998, there will be one funding body which will be separate from the Ministry of Health.	R.H.A'S. will also report through to the Minister of Health until such time as the National Funding Agency is in place and R.H.A'S. as we know them disappear.	The Structure replacing R.H.A'S. will undertake monitoring, auditing and reporting functions to enhance health gain and financial accountability.	Hospital part-charges are to be removed.
Recommendations from the Mason Report on Mental Health are to be fully funded and implemented.	Vote Health funding will be increased and extra funding will be available to reduce waiting times.		

CHAPTER 4

Why Process Reengineering?

What are the issues in New Zealand healthcare that have created the impetus for process reengineering in the secondary sector?

The healthcare system is a malfunctioning system which is a consequence of a number of years of poor management. To date it has been treated with first aid instead of surgery. Because many internal and external factors were not adequately managed, the organization and the delivery of care has become the business of everyone. Healthcare providers are coping with competition, a global marketplace, radical technological innovation and major attitudinal shifts about work, employees and leadership.

In spite of the market model of healthcare, the bureaucratic structures have and still do contribute to waste and economic insufficiency. In the market model, the business of hospitals - patient / client care has become separated from the financial structure. This has further encouraged the development into a highly labour intensive segmented business.

31

Dramatic changes in science and technology have hastened changes in healthcare. The rate of change is unprecedented. The change and the challenge we are about to face in healthcare will be intensely different from those confronted in the past. Such change is causing healthcare organizations to scramble for reengineering initiatives that will help ensure viability. Three major indicators for reengineering initiatives are: increasing difficulty to achieve / maintain viability, customer dissatisfaction with the present system and difficulty competing for managed care contracts.

Flarey [1995] identifies the four hallmarks of reengineering as being: reduced length of stay, at minimal cost, with maximum reimbursement and optimal clinical outcomes.

Along with the imperative to decrease costs comes the changing expectations of the New Zealand public. People are better educated and informed and want a more active role in the management of their care. The public want to know what they are getting for their health care dollar. This has brought pressure to bear on accountabilities and subsequent internal pressure to eliminate inefficient work processes. Better educated staff feel entitled to find personal fulfillment in their jobs, as the bureaucratic fragmentation of work processes has not been satisfying. The government has also been looking at ways to slow the rising costs, and in effect, is trying

to place a ceiling, on what is spent providing healthcare for New Zealanders.

I believe that we are about to embark on a totally new direction in healthcare delivery. Flarey [1995: 10] has identified the following changes that will drive the need to reengineer the delivery of healthcare:

4.1: Care Delivery

- Third party players will force a massive shift of care delivery away from the acute care setting and into the home, sub-acute care facilities and outpatient centres.

- Homecare will become the largest deliverer of care with clinic services been the second largest.

- Hospitals will become triage centres with the primary focus of making a rapid diagnoses and stabilizing patients.

4.2: Reimbursements

- We are moving into a world of managed care. Health maintenance organizations and preferred provider organizations will become commonplace.

- Fixed payment structures will prevail.

4.3: Medical Practice Patterns

- Doctors will be active participants in some type of integrated care delivery system. Partnerships between the hospitals and the medical staff will developing order to negotiate the delivery of care with managed care networks.

4.4: Physician Extenders

- We are beginning to see and will see develop further, the role of the nurse-practitioners and midwives in community clinics providing care independently.

4.5: Practice Patterns

- Clinical pathways which are beginning to develop will become standard. These pathways will major financial initiatives in a capitated payment system, because the length of stay and use of resources will be reduced.

- A major focus will be on quality and outcomes will prevail.

- The driving force for care delivery will be based on nationally accepted patient outcomes and quality indicators.

4.6: The Continuum of Care

- An overwhelming emphasis on a full continuum of care services will be the driving force for the formation of group practices, integrated delivery systems, and organizational and system affiliations and mergers.

Today, the recipe for the future of any organization is anticipation, innovation and excellence. Anticipation is about the gathering of information to allow the organization to be in the right place at the right time for innovation and excellence. This is the recipe for successful reengineering and will take any organization, in New Zealand, into the 21st century.

PART III.

INTERNATIONALTRENDS

Part 3 consists of Chapters Five and Six. Chapters Five and Six cover section two of the literature review. Chapter five analyses international trends in re-engineering and their appropriateness for New Zealand. Chapter Six suggests a way forward for a Crown Health Enterprise.

CHAPTER 5.

5.1: Section 2 of the Learning Contract

	Aims of the Literature Review	Learning Resources and Strategies	Evidence of Accomplishment	Criteria and Means of Validating Evidence
2.	To anlayse international trends in re-enginereing to determine their appropraiteness for the New Zealand healthcare environment.	To undertake a literature review in this area and to visit a renowned hospital in the US who has implemented hospital wide re-engineering. To meet monthly with my mentor to discuss progress.	To obtain adequate information to enable me to make an analysis of international trends and their appropriateness for New Zelaand.	To clearly determine an appropriate way forward to a New Zeland healthcare setting after anlaysing interntional trends in re-engineering. This will be completed by the end of May.

International Trends in Re-engineering

5.2: Introduction

The first section of the literature review described my interest and experience with reengineering, before identifying issues in New Zealand healthcare, that have created the impetus for process reengineering in the secondary sector. Spiraling healthcare costs are forcing providers to investigate new approaches to patient care delivery which will enable them to do more within a limited resource and to gain greater efficiencies.

I will now analyze international trends in reengineering to determine their appropriateness for the New Zealand healthcare environment.

5.3: International Trends

In America, back in 1983-1986, the impetus for reengineering was the introduction of the prospective payment system and the national nursing shortage. This resulted in an escalation in redesign in nursing , in particular, because of the rising costs of employing agency staff, the development of recruitment and retention programs and the rapid increase in nurses wages

[Flarey: 1995]. As a result, it was nurse leaders in the United States who pioneered the redesign of patient care delivery systems initially.

Today, the impetus for redesign / reengineering is different, as are the critical issues we now share internationally. Our common critical issues are: the increasing expense of the professional workforce; a consistent decline in the length of stay; a shift to outpatient services; increasing deficits; mergers; a move towards a primarily managed care system; and capitated payment system.

Flarey [1995] believes that the need for redesign is more critical today, than ever before. Flarey suggests, we have yet to fully maximize our resources and integrate services appropriately into the delivery of care. Many inefficiencies and system problems still exist that prevent the delivery of high quality, cost effective service and innovations in healthcare delivery. I fully support this notion. For, in spite of the move to corporatisation and the introduction of managers from the private sector, this has still not been achieved in New Zealand healthcare. In fact, it appears that with each wave of change has come some degree of empire building. The trouble is, as I see it, none of the waves of change have totally dismantled the previous empire [nursing would have to the exception here], which means in many places there is a bulky middle management. I believe that reengineering

will address this, for it contributes to inefficiencies and is very costly to maintain.

Flarey [1995] acknowledges that understanding the current delivery systems provides a solid foundation for all successive planning. The following are a few current realities that are / were shared internationally, as cited by Flarey [1995: 5]. They are but a few of the signs of a healthcare system in trouble.

United States Examples

The following are American examples for which there are correlation's in N.Z.:

Registered nurses [R.N.s] spend the majority of their time on indirect care activities. One comprehensive study demonstrated that only 42% of nurses time is spent providing direct care [Quist: 1992].

Only 16 cents of every health dollar is allocated for patient care; 14 cents in every dollar is spent for scheduling and co-ordinating services and 29 cents is spent on documentation [Brider:1992].

In today's hospital, direct care foe patients accounts for less than 25% of hospital personnel expenditures [Lathrop: 1992].

Healthcare staff today are not multiskilled; rather they are over specialised.

During an average four day hospital stay, one patient may interact with approximately 60 different employees [Lathrop:1992].

In most care delivery systems, patient is designed around various specialised departments. Services are centralised and far removed from the patient [Sheer: 1993].

Most healthcare organisations have traditional pay and reward systems that are not linked to customer expectations [Eubanks: 1992].

Up to 65% of non-nursing tasks currently performed by nurses could easily be reallocated to more technical personnel [Henderson & Williams: 1991].

Patients perceive the healthcare delivery system much differently than do the healthcare providers [Gertis, Levitan, Daley & DelBanco: 1993].

The average hospital requires four hours to process and deliver a routine service [Lathrop:1993].

Hospitals are overburdened with management staff. A typical 300 bed hospital has on staff at least eighty department heads and senior managers [Lathrop: 1993]

A large number of our hospitals are having serious financial difficulties. Costs are out of control and are not being effectively managed [Wilson:1992]. These symptoms could have been written for New Zealand healthcare, which is also a healthcare system in trouble.

In 1993, Leicester Royal Infirmary National Health Services Trust, in conjunction with Leicestershire Health, Trent Regional Office, N.H.S. Executive, and the University of Leicester, Faculty of Medicine, pioneered the introduction of process reengineering into the United Kingdom healthcare. They undertook an initial Scoping Study to identify opportunities for Trusts to achieve quantum leap performance improvements. Three patient processes were identified and were Clinical Crisis Management, Patient Diagnostic Efficiency and Personalised Patient Care [Leicester Royal Infirmary Manual: 1997]. And so their process reengineering began making remarkable headway in three years.

The Leicester Royal Infirmary Experience

An aspect of the Leicester Royal Infirmary model that is very valuable and that has not been a feature of the American literature, was their

42

understanding / management of change / transition, with special emphasis on the transition phase. Transition is defined by Bridges [1995:3] : *Change is not the same as transition. Change is situational: The new site, the new boss, the new team roles, the new policy. Transition is the psychological process people go through to come to terms with the new situation. Change is external, transition is internal.*

Bridges [1995] asserts that a major reason why change projects fail is the failure to take into account the impact of transition. Change can be planned and its timescales predicted, but transition is an individual process which cannot be planned with precision.   The Leicester Royal Infirmary found that *large scale change initiatives strain an organisation's attention span. If it takes too long, staff cannot sustain the required high level of focus and achievement orientation. The velocity of change needs to be fast* [The Leicester Royal Infirmary, January 1994:49].

This approach suggests that time scales should be contained to take account of the reality of the human aspects of change. At Lakeland Healthcare we have set a timeframe of three years, considering that to be a realistic timeframe.

5.4: Change Management

According to Pascale [1993], popular change management methodologies go through definite life cycles, emerging as a panacea to cure organisational ills eventually declining as fads. Some authors already argue that reengineering has already been discredited and is in decline due to its association with brutal cost cutting exercises and its failure to take into account the human implications of radical change [Davenport: 1995; Katz: 1995].

So where to from here? Planning is the cornerstone for reengineering and is a major undertaking [it has taken us six months at Lakeland]. Currently there seems to be little published about this aspect of reengineering, yet it is critical to the ongoing success, as I see it. Lack of adequate planning could also be a factor in the failure of reengineering in some areas. For after all, a house built on sand, will not be able to withstand the elements!

However, Flarey [1995: 6-7] cites a method of planning supported by Ackoff [1981], which regards the past, present and future equally and is rooted in the system's age. This is so important, because often the past is devalued, in light of the new approaches, rather than been seen as a building block. The interactive concept of planning may be described as *the design of a desirable future and the intervention of ways to bring it about* [Ackoff: 1981].

44

What strikes me is that these words of wisdom were written in 1981. Why are they not more widely known and adhered to? May be it is expediency, because any interactive process takes time and people skills. As change agents we need to be interactivists, so as to be proactive.

Ackoff [1981] describes the beliefs and attributes of interactivists in the following way:

They rely on experiments rather than on experience to seek out solutions.

They rely on experience to reveal problems.

Their major is on improving performance over time.

They believe that planners often fail to address the right problems because they are not fully aware of what they are striving for.

They engage in normative planning, with an emphasis on the selection of goals, objectives and ideals.

They assert that planning is indefinite.

To plan effectively we must undergo a radical shift in our thinking from an emphasis on parts to systems thinking. For too long now the major components of care delivery have been compartmentalised, segregated and centralised into department with poor interrelationships and integration. As a result , there have been [still are] critical inefficiencies within the system, such as poor control of costs and productivity, substandard quality, and customer and employee dissatisfaction [Flarey 1995: 6].

A lack of integration provides the ideal opportunity for redesign / reengineering. Ackoff [1981] offers five phases of interactive planning which are illustrated in Table 6:

Table 6: Ackoff's Phases of Interactive Planning

Phase 1. Formulate the Mess:
Identify systems of threats and opportunities facing the organisation.

Phase 2. Ends Planning:
Determine the ends to be pursued; envision the desired future.

Phase 3. Means Planning: Determine the means by which the ends are to be pursued; invent the means to your desirable future.

Phase 4. Resource Planning:
Determine what resources will be needed and how to obtain them for your desired future.

Phase 5. Design of Implementation and Control:
determine who is to do what, when and how to manage the implementation.

An adaptation by Flarey [1995: 7] from Ackoff, R. [1981] *Creating The Corporate Future.*

NewYork: John Wiley.

From the foundation of Ackoff's [1981] five phases as illustrated in the table, comes a solid methodology for the planning of systems redesign / reengineering. The best way to plan successfully for an integrated systems redesign is to include those who work in the service. Drucker [1974], acknowledged that workers' knowledge, experience and needs are critical resources to planning. They must be involved form the start and integrated into the process. This still requires an attitudinal shift as most managers see it as their prerogative. An organisation's staff and customers can

provide insights into the threats and opportunities that face the organisation.

I believe that the wisdom of any organisations resides in the staff.

CHAPTER 6.

A Way Forward.

6.1: Introduction

At Lakeland Healthcare, although not aware of Ackoff's five phases of Interactive Planning, the planning has followed this format as will be illustrated in Figure 5.2.

I will now discuss Phase 5. in greater detail because, that is the stage that we are embarking on currently. As already mentioned there are three stages to this phase communication, project identification and best practice initiatives.

6.2: Communication

The objectives for this stage include the fact that all Lakeland staff will understand the rationale for L.E. 2000 Best Practice and its effects on them.

49

They will also understand why the change is needed and their involvement in the change process.

Table 7: Ackoff's Phases of Interactive Planning as Applied to Lakeland Healthcare

Phase 1. Formulate the Mess: Identify systems of threats and opportunities facing the organisation.	**Phase 1. Formulate the Mess:** Project 96: August-November 1996 a major self analysis of the organisation, identifying strengths and weaknesses.
Phase 2. Ends Planning: Determine the ends to be pursued; envision the desired future.	**Phase 2. Ends Planning:** The vision, mission, values, guiding principles and strategic direction were formulated and shared with staff and external stakeholders
Phase 3. Means Planning: Determine the means by which the ends are to be pursued; invent the means to your desirable future.	**Phase 3. Means Planning:** There were five Board Sub-Committees formed to determine the means by which the ends are to be pursued and they are Leading Edge 2000 [L.E.2000], Healthcare Opportunities, Risk Management & Finance
Phase 4. Resource Planning: Determine what resources will be needed and how to obtain them for your desired future.	**Phase 4. Resource Planning:** Change leader was appointed full time to Leading Edge 2000. The Change Leader and the Chairperson of L.E.2000 attended Master Classes in Reengineering. An outside consultant was appointed to undertake the Scoping Study and to assist with timelines and benchmarking nationally and internationally.

Phase 5. Design of Implementation and Control: determine who is to do what, when and how to manage the implementation.	Phase 5. Design of Implementation and Control: There are three stages to this phase: communication, project identification and best practice initiatives.

As part of the strategies for this stage target groups will be identified throughout the organisation and meeting times with them will be scheduled. We will ensure that all management personnel understand L.E.2000 so as to obtain their buy in to the process and to be able to be a resource to staff. A booklet has been developed to support the transfer of information. A page will be dedicated to Best Practice Initiatives in the Leading Edge newsletter. Four Leading Edge notice boards will be strategically placed, to provide information and notification about progress. Any change must add value.

6.3: Project Identification

L.E.2000 Sub Committee will identify projects, following the Scoping Study undertaken by Coopers and Lybrand, and consideration of the Process and Identification form. Staff will be encouraged to submit Process Identification forms for any project they fell would benefit the patient processes and / or the organisation.

6.4: Best Practice Initiatives

Projects that are endorsed by the Board Sub Committee will then proceed to the establishment of a team and team briefing. A scoping study will identify opportunities, potential benefits, constraints and commitment. The objectives of the Scoping Study will be to define measures of value and success; set program goals; identify terms of reference and scope of the program; agree on a timescale and resources. The question underpinning the Scooping study will be **WHY?** not how or what?

In conclusion, this section of the literature review has analysed international trends in reengineering in the U.S.A. and Great Britain to determine their appropriateness for New Zealand healthcare. I have found there are aspects of both approaches that are applicable to our environment. Leicester Royal Infirmary, in Great Britain, in particular highlighted the necessity of giving due attention to the period of "transition". From the U.S.A., insights were gained from Ackoff's five phases of interactive planning, which were then applied to the process at Lakeland Healthcare.

This section prepares for the discussion on distinguishing characteristics of business versus a healthcare approach to reengineering, which will enable the creation of a model appropriate to a New Zealand healthcare setting.

PART IV.

BUSINESS VERSUS A HEALTHCARE APPROACH TO

RE-ENGINEERING

Part IV consists of Chapters Seven and Eight. Chapters Seven and Eight cromprise the third and final section of the literature review. Chapter Seven examines the distinguishing characteristics of business versus a healthcare approach to re-engineering. Chapter Eight will illustrate a New Zealand model for process re-engineering in action in a Crown Health Enterprise.

53

CHAPTER 7

7.1: Section 3 of the Learning Contract

Aims of the Literature Review	Learning resources and strategies	Evidence of Accomplishment	Criteria and Means of Validating Evidence
3 To examine distinguishing characteristics of business versus a healthcare approach to process reengineering	Read Hammer and Champy, the authors of Business Reengineering. Examine the U.S. literature and compare with the Leicester Royal Infirmary experience which is an adaptation of the business approach	The ability to identify the distinguishing characteristics between business verses a healthcare approach to reengineering.	The creation of a model appropriate for a New Zealand Healthcare setting. To be completed by the end of August.

54

7.2: Introduction

This is the third and final section of a literature review which has identified issues in New Zealand healthcare that have created the impetus for process reengineering in the secondary sector. Building on this was an analysis of international trends in reengineering to determine their appropriateness for the New Zealand healthcare environment. Finally, distinguishing characteristics of business versus a healthcare approach to process reengineering will be examined, with the intention of creating a model appropriate for a New Zealand healthcare setting.

Hammer and Champy are the champions of business reengineering, publishing their first book "Reengineering the Corporation" in 1993. For six months, the book was on the New York Times bestseller list. It has since been translated into fourteen languages and is a bestseller around the world. Numerous companies have applied their principles in order to become lean, nimble, flexible, responsive, competitive, innovative, efficient customer focused and profitable. [Hammer & Champy: 1994]. There are three forces, separately and in combination, that are driving today's companies in an environment where nothing is predictable, and they are *customers, competition and change* [Hammer & Champy: 1994].

7.3: Re-engineering Methodologies

Exploration of the distinguishing characteristics of business versus a healthcare approach to process reengineering revealed that little academic research is available which demonstrates the practical application of reengineering methodologies [Corrigan: 1996]. However, in exploring the texts on reengineering, it is possible to identify clear methodological trends over a period of time and chart how the "leading edge" of methodological advice has evolved.

Between 1990-1993, publications characteristically emphasized generalized methodologies for radical process redesign. Recipes for reengineering comprised of linear sequences and technical and situational change [Hammer and Champy:1993].

Stoddard, Jarvenpaa and Littlejohn [1996] refine concepts of business process reengineering by comparing and contrasting Pacific Bell's reengineering experience, a project perceived to be successful, to the five assumptions of reengineering that are frequently touted by the early writers on reengineering. Table 8. will develop a set of assumptions that more closely reflect the implementation of Pacific Bell and my experience to date.

Texts between 1994-1995 emphasize the human dimensions of reengineering. They include the requirements of a visionary leadership to lead the cultural and behavioral change necessary to bring about and sustain the change process [Hammer & Stanton]. They also believe that a focused strategy, effective leadership and widespread participation by staff affected by change will lead to a sense of shared values and the fundamental cultural change that is required for reengineered processes to be embedded.

Table 8: Reengineering Results in Radical Change:

Reengineering Assumptions: Early Writers	Reengineering Assumptions: Pacific Bell's Experience
Reengineering results in radical change	Reengineering design may be radical, but implementation is incremental
Reengineering assumes clean slate change.	Reengineering design assumes clean slate change. However, implementation will be limited by those constraints that management cannot or will not remove.
Reengineering focuses on end to end processes.	Reengineering design focuses on end-end process redesign. Reengineering often focuses on the perceived most broken pieces.
Reengineering is top-down directed.	Reengineering is top-down directed but implementation must be owned from the bottom up.
Rengineering is information technology enabled.	Reengineering design is information technology enabled but implementation might initiate without much of the assumed I.T. capability.

Pacific Bell's experience would be true of a number of organisations in business and in healthcare that have embarked on reengineering.

More recently, there has been an emphasis on the critical importance of understanding the political context and the impact of reengineering on organisational power bases. This has been my experience already, in the early stages of preparation and implementation of reengineering, especially with the medical staff. Even though the clinical directors [who are all doctors] were present and participated in conversations and discussions about the implementation of the model, when it came to actioning any aspect of the model, they were there with their sabotage. Eventually, in order to win them over, we had to adapt our model, so that they thought they would be able to maintain their power base. Personally, I believe the process will sought that aspect, and that the clinical directors will come to see themselves as team members eventually. Grint and Willcocks [1995] cite difficulties in reengineering initiatives, as a possible misrecognition of power. How true! Reengineering success is ultimately dependent on persuading people to act in different ways.

7.4: The Complexity of Re-engineering in Healthcare

It is becoming evident that, in healthcare organisations dominated by professional groups, it is a difficult environment in which to implement radical organisational change. Phillips [1996] suggests that

reengineering in a healthcare environment is a significantly more complex task than reengineering in a "typical industrial organisation". Phillips defines complexity along two axes: *the uniqueness of customer segments served* [characterized by the number of product lines times the number of major customer groups] *and political complexity,* defined as the number of stakeholding communities with unaligned objectives impacted by the reengineering project as in Table 9.

Table 9: Relative Complexity Of The Task Of Re-Engineering In Healthcare

Political Complexity [number of communities with unaligned objectives]	High		Typical healthcare organisation
		Typical industrial organisation	
	Low		

Low

High

Uniqueness of segments
[number of product lines x number of

customers]

Source: Adapted from Philips [1996].

Uniqueness of segments is the key issue as it determines the extent of which a small number of generic processes can be identified, redesigned and "rolled out" across the organisation in a hospital context. By definition,

process re-engineering implies that an organisation's processes have enough elements of consistency [i.e. similar inputs and outputs] and are repeatable enough to justify designing common processes which cross the organisation [Davenport:1993]. It is questionable the extent to which such core processes can be defined in healthcare.

The high number of product lines [diagnostic and treatment protocols] and the unique characteristics of each patient group, limit the potential for uniformity of process and generic solutions within a reengineering program [Philips:1996]. An example of this would be in reengineering

outpatients, where due to specific characteristics and requirements of the patient groups who use the services, each outpatient clinic will have to be redesigned to a unique specification.

"Political complexity" is a characteristic both internal and external to a healthcare organisation. Klien [1995] identifies a series of tensions and contradictions in the relationship between central government and the organisations which actually deliver healthcare, between the R.H.A.'S and the clinical professions, and between the requirements of public accountability and professional autonomy. The position of a Crown health Enterprise [C.H.E.], as part of a wider politically determined healthcare system, leads to external constraints which limit flexibility and autonomy.

In an internal context, the nature of professional power is such that clinicians are able to exercise an monopoly over the provision of specialist services whilst enjoying relative freedom from external intervention. Doctors have always been able to rely on their professional autonomy to avoid carrying out policies with which they as a group do not agree. Previous initiatives to institutionalise major changes in the medical staffs attitudes and behaviour have failed. They are always the exception!

Ackroyd [1996] explains that many managers recognise that they will never make headway unless they achieve the tacit support of a high

proportion of the senior doctors, because it is through the action of the senior doctors that the aims of management can be realized.

This scenario suggests the requirement of a reengineering approach which enables clinicians to determine and lead their own radical change process, rather one that is managerially set and imposed, a "bottom up" approach the change through individual clinicians, rather than the "top down" approach suggested by reengineering commentators. These factors illustrate the enormous complexities of reengineering in a healthcare environment.

The literature review has highlighted the different approaches that are possible towards healthcare reengineering. There is the business approach as given to us by Hammer & Champy. There are numerous variations on the theme. Then there is the Leicester Royal Infirmary application which was adapted specifically for healthcare with the supervision of Hammer himself. These are all excellent resources. From my own short experience, I believe once a broad knowledge of reengineering is obtained, one draws on that knowledge to develop a methodology, which is process based, and tailored for a specific organisation. For the power base and the political complexity are unique to each organisation.

CHAPTER 8

A New Zealand Model in Action.

8.1: Lakeland Healthcare's Experience To Date:

It is against this background that I will illustrate a model which has been developed for a Crown Health Enterprise - Lakeland Healthcare - in New Zealand. The model is known as "Leading Edge 2000 [L.E.2000] - Best Practice Initiatives" [Table 4].

After six months of preparation, gaining a common understanding of what we meant by reengineering; determining our approach; preparation of a brochure for staff explaining what is meant by L.E.2000 and how they will be involved [Appendix 7]; timing the launch; and assistance that may be required by an external consultancy firm, we were ready to begin. We engaged the external consultant to "scope" the organisation for us to assist in determining project priorities. L.E.2000 was launched on 12th May, 1997. The L.E.2000- Best Practice Initiatives Model is integral to the Clinical Services Model / Structure, which has been in place since December, 1996. Table 4 illustrates the model and the place of Whakaruruhau [the cultural perspective] in Lakeland Healthcare which is a core component of any

undertaking there. Whilst the diagram looks as though the teams will arise out of the services and be service specific, it is intended that the teams will be cross functional and multidisciplinary i.e. the perioperative project as in Appendix 8.

Reengineering consists of project work and the development of selection criteria for projects must be suitable to run with by the multidisciplinary teams. It was agreed that the selected projects must exhibit potential for improvement either in terms of a clinical outcome or financial savings; encourage buy-in by key players by addressing issues that are currently a cause of frustration with in the organisation; raise the profile of the L.E.2000 Project by demonstrating that L.E.2000 can get things done and make a difference; place emphasis upon process not task and so encourage multidisciplinary approaches; recognise the need for staff development to assist staff to understand the concepts and practices; develop a natural progression of project work so as to allow lessons from one project to benefit another; and spread the project workload.

Using these criteria four key projects have been chosen which are outpatient services, surgical services perioperative model, improving the Health Record Information flows and reviewing the length of stay / discharge process [Appendix 9].

A simple generic process to undertake each suggested project has been designed. Various feedback loops will be required to validate findings and reach the optimum solution.

Once a project has been approved by the L.E.2000 Sub-Committee of the Board, a multidisciplinary team is appointed and terms of reference are drawn up for the particular project. The initial research and analysis is done and options are identified. The options are then assessed and a report on the project is drawn up. Then we come to the implementation phase.

The terms of reference for each approved project contain the following headings: *Definition of the project* which includes what the project is about and what it hopes to achieve; a description of *the current situation* and reasons for the project; *project goals* highlighting key issues that the project will appraise; *project outputs or deliverables* by which the quality of the project will be assessed; *project structure* explaining who will be involved and reporting procedures; *project parameters* with timelines and milestones; *cost* meaning resources available to the project; *quality* covering who was consulted and what if any where the restrictions on the project; *impacts and benefits* explaining what the project will contribute; *threats* meaning what possible obstacles currently exist in the way of the project?

Coopers and Lybrand have designed a five steps model to process redesign for Lakeland [**Tables 8.1 & 8.2**]. The five steps are mobilse, analyse, innovate, engineer and commit. **Tables 8.1 & 8.2** flesh out the processes to each of the five steps. We have yet to work with these steps.

How Will L.E. 2000 Be Achieved?

Significant work will be achieved this year by the multidisciplinary project teams and staff will be consulted on a range of issues. Formal structures will be developed to consult with staff on the projects and other developmental work. These structures will be piloted during Phase One projects and incorporated into a communication plan.

Once the redesign process has been validated as appropriate for implementation, action will follow. There are three stages to the implementation phase: *act* where tasks are undertaken, controlled against the plan and progress is communicated to staff; *measure* against target specifications, including the cost benefit analysis; *sustain* on going management and key performance measures.

Process Redesign Steps

Table 8.

Step 1: Mobilise	Step 2: Analyse	Step 3: Innovate	Step 4: Engineer	Step 5: Commit

1.1 Build Team
 	
 • Confirm team
 • Confirm way of working
 	
 1.2 Project
 	
 • Work plan development
 • Resource assignment
 • Meeting schedules
	2.1 Map Process
	
	 • Define process boundaries
	 • Develop extended process definition
	 • Deline activities
	 • Identify 'value adding' steps
	
	 2.2 Develop Information Base for Decision
	
	 • Data collection
	 • Performance Indicators
	
	 2.3 Evaluate Change Readiness
	
	 • risks
	 • change methods
		3.1 Vision
		
		 • New process visions
		
		 3.2 Filter Options
		
		 • Select improvements
		 • Devise alternatives
		 • Construct new proces vision
		 • Simultaneous consideration of vision with implementation factors
		 • Model and simulate short-listed scenarios
		
		 3.3 Link with Process Vision and Options
		
		 • Cultural goals
		 • New process
		 • Supporting changes
		 • Benefits
			4.1 Specify Process
			
			 • Model and simulate short-listed scenarios
			 • Refine models adjusting parameters
			 • Refine cost, quality, service, time metrics
			 • Select final resource specifications
			 • Specify information systems
			 • Set target improvements
			
			 4.2 Specify Performance Measures
			
			 • Design monitoring system
			   - quality
			   - time
			   - cost
			   - service
			 • Design organisational learning monitoring system
			
			 4.3 Plan Change Management Actions
			
			 • Teamworking
			 • Leadership development
			 • Training
			 • Reward
			 • Supporting Changes eg management practices
				5.1 Commitment Workshop
				
				 • Develop consensus
				 • Build outline plan across all scenarios
				 • Commit

67

Table 8.2

THERE ARE FIVE REDESIGN STEPS THAT WILL BE FOLLOWED IN EACH RE-ENGINEERING PROJECT - (THE IDENTIFIED MAY NOT NEED TO BE COMPLETED IN ALL CASES)

Process Redesign Module Activities

Step 1 Mobilise	Step 2 Analyse	Step 3 Innovate	Step 4 Engineer	Step 5 Commit
Build Team 1.1	Map Process 2.1	Vision 3.1	Specify Process 4.1	
Plan Project 1.2	Develop Information Base 2.2	Filter Options 3.2	Specify Performance Measures 4.2	Commitment Workshop 5.1
	Evaluate Change Readiness 2.3	Link with Vision and Options 3.3	Specify Change Management Actions 4.3	
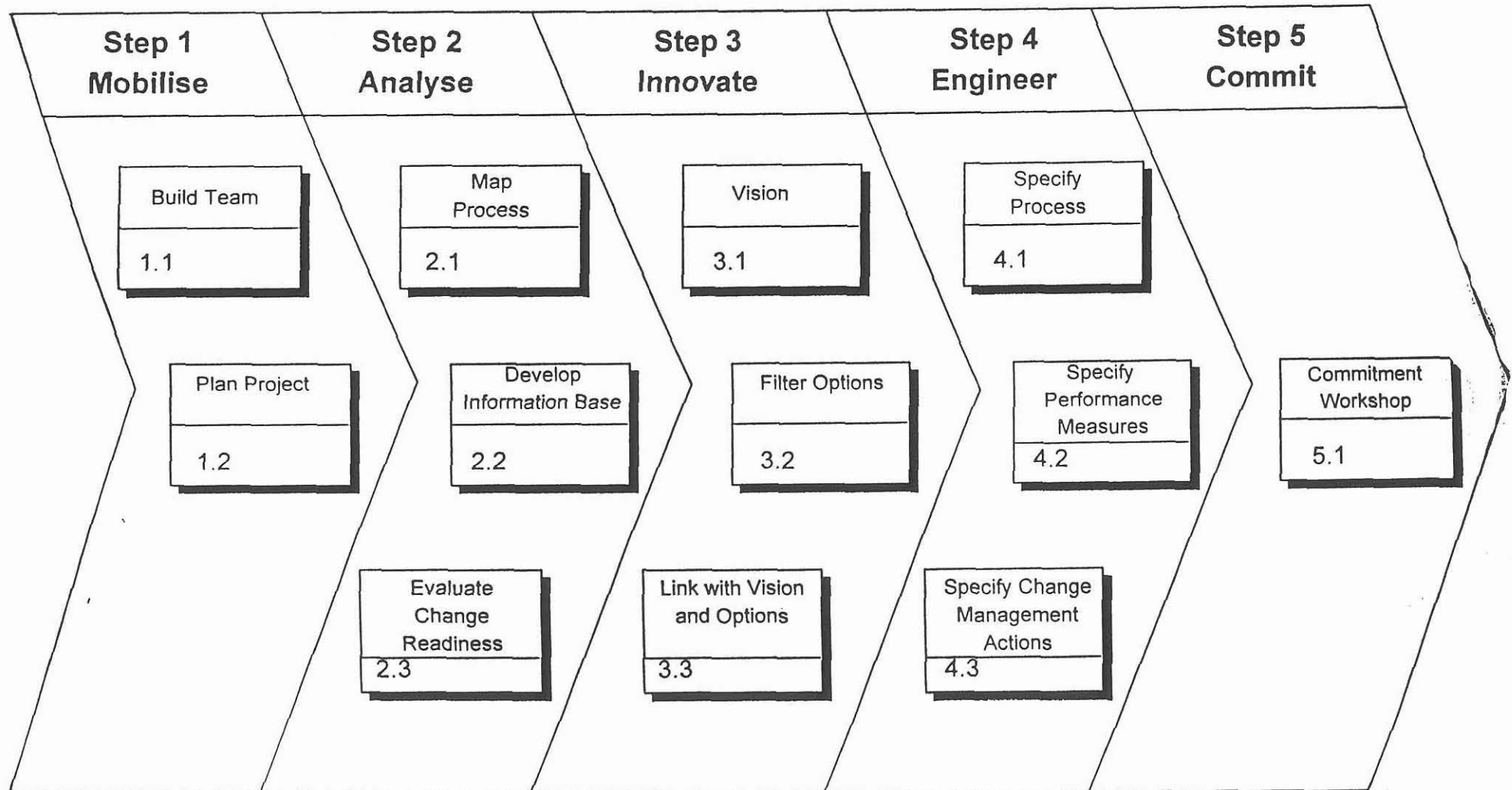
The implementation will fail if staff have not had an opportunity to understand the rationale for change, validate the vision plan and it's impact, or to contribute to the redesign of the process.

PART V.

Insights and Dreams for the Future

This concluding section is a report on progress in relation to the Learning Contract and the goals for the course. It contains insights gained on the journey and draws on the relationship between theory and practice of creating a literature review. Finally, it expresses some hopes and dreams for nursing in the future.

8.2: A Vision for the Future

When we get through with reengineering, the new managerial jobs that will remain will have three flavours - none of which has anything to do with a traditional manager. One I call a process owner.....The second is a coach - teaching, developing people. The third kind is the leader, who primarily motivates - creates an environment where people get it done.

Hardly any existing managers have the ability to do any of these things, or the inclination. Michael Hammer, The Wall Street Journal, 1995.

8.3 Conclusion

Reengineering healthcare is one of the most ambitious undertakings yet. This literature review began by identifying the issues in New Zealand healthcare that have created the impetus for process reengineering in the secondary sector. The real impetus being to do more with less.

An analysis of international trends in reengineering was undertaken to determine their appropriateness for the New Zealand healthcare environment.

Finally, distinguishing characteristics of business versus a healthcare approach to process reengineering was examined before concluding with the presentation of a process reengineering model suitable for a

Crown Health Enterprise to achieve it's goal of becoming "Leading Edge" by the year 2000.

CHAPTER 9

Self Assessment of the Learning Contract and Goals, plus Hopes and Dreams for the Future of Nursing.

There have been a number of insights gained in the course of this literature review on *Considerations For Re-engineering Secondary Healthcare in New Zealand*. Whilst *identifying issues in New Zealand [N.Z.] healthcare that have created the impetus for process re-engineering in the secondary healthcare* [Aim: 1] what occurred to me was the enormous complexity of the healthcare environment and the impact of politics on the day to day operation. The political environment operates at two levels i.e. external and internal. Externally, there is government, who determines where, how, how much [volumes / case mix] and what type [primary / secondary / tertiary] of healthcare will be delivered to the population of New Zealand. Since my involvement at Lakeland, I have discovered that this is like walking on shifting sand. There seems to be two levels of accountability / control and that is between the Crown Health Enterprise [C.H.E] and the Regional Health Authority [R.H.A.] who really holds the C.H.E.'S. to ransom whist there seems to be no forum where the R.H.A.'S. are held to accountability for there dysfunctional organisation. Then, there are

the internal politics of any organisation. It seems to me that the internal politics can be more crippling to the delivery of healthcare than the politics of government. In healthcare, there has been a degree of "kingdom building" especially amongst the medical staff. The review has highlighted for me how healthcare delivery is primarily serving those who deliver it first and the patients / clients second. This is the main reason why process re-engineering in healthcare is so difficult. In process re-engineering the focus shifts from the health professional and their department [kingdom] to the patient. This also means that the walls of the various "kingdoms" have to broken down in the interests of the patient. Instead of working as individuals, the new environment requires health professionals to work in multidisciplinary teams. This can be / is very threatening for the medical staff in particular.

The new environment created by process re-engineering truly has the interests of the patient at heart and requires a different type / process of communication amongst the health professionals.

The shifting sand of government politics is a great threat to making any progress in process re-engineering or healthcare delivery. Process re-engineering requires an organisation to be very focused about the processes in order to make headway. From my experience, because of the shifting nature of the external political environment, it is very easy indeed, to get distracted by the latest storm and not have time for the business of process re-engineering of patient care delivery

74

systems. Once again projects are put on hold. Hence progress is hindered. I believe that it is not until we develop the ability to cope with the storms and at the same time have the ability to keep our eyes on the horizon, that any headway will be made.

The analysis of the international trends in re-engineering [Aim: 2] clearly demonstrated that there area number of ways of going about process re-engineering. *When examining the distinguishing characteristics of business versus a healthcare approach* [Aim: 3] the business approach can be applied to healthcare - not that well I believe, or an adaptation of the business model which has been proven to be more appropriate i.e. the Leicester Royal Infirmary and the Robert Wood Johnson experiences. One of my goals for this paper was to visit Mercy Hospital, San Diego, as they are leaders in the United States in Patient Focused Care. That is a fine example of what can be achieved, in spite of external pressures. I also had the privilege of attending the Master Classes with the Leicester Royal Infirmary. In considering what is an appropriate way forward for the New Zealand healthcare environment, we decided on a mix of the best from the three and that is still be rolled out.

In May, I visited the two "demonstration units", one medical and the other surgical, at Hawkes Bay. Structural changes had been made to these wards, in order to implement the model of Patient Focused Care as had been implemented at Mercy Hospital, San Diego. The model

had been running for two weeks at that time and was still being developed. However, it looked very promising.

The final goal for this paper was to the International Council of Nurses meeting in Vancouver, in June, 1997. This was a wonderful experience. One of the highlights for me was the keynote address by Gloria Smith Ph.D. The title of her address was *Sharing the Challenge: Health is Greater than Healthcare.* It was a powerful address. The theme was living and working in a world of scarce resources. We tend to think of scarce resources, predominantly, in terms of dollars. However, in healthcare, we still have a vast resource that has not reached it's potential and that is our staff. Gloria Smith's key message was that staff need to be empowered. When this happens, there is no longer a shortage of resources. This especially true for nurses. We have a valuable resource that needs empowering. I found this address to be inspirational and hopefully will soon have an opportunity to empower the nursing staff in my place of work. That is the future of nursing and healthcare. The fact of the matter is that there will never be enough dollars to deliver all the healthcare that is needed. But, we do have within our power, the opportunity to empower each other and maximize every dollar spent on health.

I see the future and strength of nursing in the empowerment of each other, providing mentoring and clinical supervision / support of practice. We have an obligation to society, to try and reach our own potential, in

terms of who we are as persons and professionally. Only then, can we truly benefit those we serve.

In conclusion, *Consideration for Re-engineering Secondary Healthcare in New Zealand,* has been thought provoking, stimulating and informative. It has enabled me to pull a number of strands together. Strands that up until now have stood on their own. It is only when the strands stand side by side, that each is enhanced and reflects light on the other.

TABLE OF APPENDICES

Appendix 1: Lakeland Healthcare's Vision, Mission, Values and Guiding Principles

VISION

THE LEADING EDGE IN HEALTHCARE

MISSION

EXCELLENCE IN HEALTH - PARTNERSHIP WITH PEOPLE

MOVING FORWARD TOGETHER

VALUES

- RESPECTING ALL PEOPLE
- HAVING INTEGRITY
- WORKING TOGETHER
- TAKING PRIDE IN WHAT WE DO
- BEING PROUD OF WHO WE ARE

GUIDING PRINCIPLES

The direction of Lakeland health is based on the following guiding principles:

1. The Company Vision, Mission and Values integrated throughout the organisational process, structure and relationships.

Appendix 2: Lakeland Healthcare's Vision, Mission, Values and Guiding Principles

2. Services based on the Lakeland Health clinical Services Model delivering Clinical and Commerical Best Practice.

3. Consumer focussed service delivery [with optimum Clinical and CorporateSupport].

4. Understanding our business, our client's needs, and focussing on the required outcomes.

5. A facilitative and empowering style of clinical and management practice with highly competent and valued staff.

6. "Equal access for equal need" across Lakeland's Clinical Services.

LAKELAND CLINICAL SERVICE MODEL

LAKELAND : THE LEADING EDGE IN HEALTH CARE

81

LAKELAND HEALTH LTD

Mai I Maketu Ki Tongariro

LHL CLINICAL SUPPORT [2]

LHL CLINICAL SERVICES [1]

LHL CORPORATE SUPPORT [3]

WHAKARURUHAU [7]

Vote Health [9]

Other Public Sectors [14]

Midland - Iwi Joint Venture Boards [6]

Minister of Health [10]

Ministry of Health (M.O.H.) [11]

Midland RHA [4]

Mana Whenua Services [8]

CCMAU / Treasury [5]

Other Revenue Streams [12]
e.g. Clinical Training Agency
ACC
Other RHA's
Joint Ventures
Integrated Care Networks
Budget Holding
Independent Purchasers
(Private Sector)
Research Funding
International

[13] COMMUNITY
Healthcare Sectors
(Primary, Secondary, Tertiary)

Appendix 4: The Programme for the Masters Classes in Re-engineering with the Leicester Royal Infirmary 10-14th March, 1997.

OBJECTIVES:

The aim of the Masters Class is to equip participants with sufficient tools, techniques and methodologies to undertake re-engineering in their own organisation.

PROGRAMME:

The programme is very intensive, based on Leicester Royal Infirmary's RE-ENGINEERING TOOLKIT - a step by step reference guide to healthcare re-engineering. Changes may be made according to participants needs. Sessions are divided into three categories:

1. TEACH-INS - aimed at equipping participants with a range of re-engineering tools, techniques and analytical models with proven applicability to healthcare.

2. PARTICIPATIVE CASE STUDIES - based on actual re-engineering scenarios at the Leicester royal Infirmary, offering participants the opportunity to apply and practices healthcare process redesign.

3. PRESENTATIONS - on key aspects of re-engineering by clinical and managerial leaders of the Leicester Royal Infirmary.

Appendix 5: Leading Edge 2000 Best Practice Initiatives Terms of Reference

PURPOSE:

The redesign of processes to achieve best practice within resources.

The Membership is composed of team leaders of Process Teams and core support members.

OBJECTIVES:

1. To be Leading Edge in Healthcare delivery by Year 2000.

2. To improve current level of patient and staff satisfaction.

3. To monitor progress of purpose.

STRATEGIES:

1. Develop process maps for identified projects.

2. Organise process teams.

3. Establish benchmark based on data.

4. Design new systems and roles.

5. Development implementation plans.

6. Evaluate results.

MEETING STRUCTURE:

Meetings are initially scheduled on a monthly schedule. Minutes are recorded and distributed to LE 2000 Best Practice Initiative team members. A monthly report will be forwarded to the Board Subcommittee.

Lakeland Health Limited

JOB DESCRIPTION

POSITION:	Best Practice Initiative - Change Leader
LOCATION:	Lakeland Health
RESPONSIBLE TO:	Chief Executive, Lakeland Health
FUNCTIONAL RELATIONSHIPS:	Leading Edge 2000 Board Subcommittee Members of Best Practice Initiative Team Clinical Directors Operational Managers Clinical Team Leaders All other Lakeland Health staff involved in patient and support processes Other health professionals (community based) who impact patient and support processes Users of the service (patients) and patient support groups
DATE:	April 1997

Organisational Environment

Lakeland Health Limited is a Government-owned company (Crown Health Enterprise) which provides both hospital and community-based health care. Currently the company provides health service at Rotorua Hospital, Taupo Hospital and numerous community based venues.

.Lakeland Health Ltd is strongly committed to service excellence as reflected through its · vision statement:

The Leading Edge in Healthcare

and

Mission Statement:

Excellence in Healthcare - Partnerships with People
He Tangata! He Tangata!
Moving forward together

Values:

- *Respecting all people*
- *Having integrity*
- *Working together*
- *Taking pride in what we do*
  - φ *Being proud of who we are*

In addition to service excellence, Lakeland Health has made a commitment to basing service delivery upon the   following guiding principles and strategic direction

GUIDING PRINCIPLES

1.   The Company Vision, Mission, and Values integrated throughout the organisational process, structure, and relationships.

2.   Services based on the Lakeland Health Clinical Services Model delivering Clinical and Commercial Best practice.

3.   Consumer focused service delivery (with optimum clinical and corporate support)

4   Understanding our business, our client's needs, and focusing on the required outcomes.

5.   A facilitative and empowering style of clinical and management practice with highly competent and valued staff.

6.   "Equal access for equal need" across Lakeland's Clinical Services.

STRATEGIC DIRECTIONS

1. Lakeland Health's purpose is to deliver and support clinical services.

2. Lakeland Health will be driven by the Clinical Service delivery Model.

3. Lakeland Health will develop its strengths in secondary services.

4. Lakeland Health will develop the appropriate skills and relationships in order to lead an intergrated health network(s).

5. Lakeland Health will strengthen delivery of clinical services in the community.

6. Lakeland Health will accept and manage risk by meeting our financial requirements, meeting quality standards, and evaluating clinical outcomes.

7. Lakeland Health will increase market share and build upon its existing customer base.

Person Specifications

Essential Skills/Attributes

- Understanding of principles of change management
- Skill in managing change process
- Sound understanding of Lakeland Health culture and internal environment
- Ability to understand company wide issues and funding process
- Clinical credibility
- Proven ability to lead and motivate health care teams
- Commitment to provision of quality patient care.
- Effective communicator
- Well developed interpersonal skills
- Self motivated and able to use initiative
- Proven ability to be flexible
- Commitment to staff development
- Facilitation and negotiation skills
-

Knowledge of

- Health and Safety in Employment Act (1992)
- Privacy Act (1993) and Health Information Privacy Code (1994)
- Treaty of Waitangi and its application to the health setting
- Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations (1996)
- New Zealand Health Care Standards

Primary Goal

To coordinate the review and development of patient and support processes and to achieve Quality Outcomes / Best Practice in line with available resources.

Key Performance Areas	Expected Outcomes
1. CHANGE LEADERSHIP	• Direct support is given as required to key change projects • Change programmes are facilitated and staff coached to ensure achievement of corporate goals • Connection is made to staff at all levels in all professional groups as appropriate • Advice and support is offered to organisational leadership to enable operationalizing of strategies • Change teams act to maximise value and build on the ideas of patients and other key stakeholders • Staff training in all aspects of change process is planned • Change efforts are linked to Quality Assurance programmes • Links with external bodies are developed and maintained in a manner consistent with fostering good working relationships with our community • Research and networking are used where appropriate to help achieve change objectives
2. BEST PRACTICE LEADERSHIP	• Staff are supported to ensure integration of best practice into all apects of the hospital's work • Analytical skills are used appropriately to evaluate options • The role of the Best Practice Initiative team is continually developed and evaluated • Strategies are developed in line with current Best Practice

Key Performance Areas	Expected Outcomes
Best Practice Leadership Cont'd	• Evidence Based Care philosophy permeates newly designed or redesigned processes • Links between strategy, process and the organisation are clearly articulated • External dissemination strategies are developed (in collaboration with communications officer) and delivery is ensured • Materials are developed for use to support the change process
3. PROFESSIONAL DEVELOPMENT SUPPORT	• Opportunities are sought to promote current thinking on professional development within a re- engineered, process managed organisation • All aspects of professional development are to align to corporate goals. Professional development leaders are advised and supported
4. TEAMWORKING	• Organisational changes toward a team based (self managed team unit) organisation are built in to all change projects • The Best Practice Initiatve support team will be developed to integrate into project teams as required • All change management staff will have team skills • In line with clinical services model clinical staff will be considered in all project teams • Change teams will recognise the need to achieve objectives through other teams

Key Performance Areas	Expected Outcomes
5. CORPORATE LEADERSHIP SUPPORT	• Others are supported to lead and develop organisational strategy • Advice is offered on Best Practice Leadership • Advice is offered on alignment of corporate and clinical/process objectives • A positive image of the organisation is proactively promoted • Change options which satisfy the future medium and long term goals of the organisation are developed along with short term ones • Appropriate relationships are built inside and outside the organisation

Appendix 7: Robert Wood Johnson University Pro-Act References

Brett, J.L. and Tonges, M.C. Resource Allocation in Managing the Shortage. American Hospital Association and American Nurses Association, 1990.

Brett, J.L. and Tonges, M.C. "Restructured Patient Care Delivery: Evaluation of the ProACT Model." Nursing Economics, 8(1): 36-44, 1990.

Brett, J., Bueno, M., Royal, N. & Sengin, K.K. "PRO-ACT II™ - Integrating Utilization Management, Discharge Planning and Nursing Case Management Into Outcomes Manager Role." Journal of Nursing Administration, (in press).

Bueno, M. McC. and Hwang, R-F. "Understanding Variances in Hospital Stay." Nursing Management, 24(11): 51-57, 1993.

Bueno, M., Cavanaugh, P., and Schlag, M. "Case Presentations Increase Nursing's Contribution to Financial Integrity of the Institution." Aspens Advisor for Nurse Executives, 9(11): 3-4, August, 1994.

Dveirin, G. and Adams, K. "Empowering Health Care Improvement: An Operational Model." Journal on Quality Improvement, 19(7): 222-233, July, 1993.

Elting, C. and Stewart, E. "Unit-Based Case Management Benefits Patients and Nurses." ONS News, 8(8): 5, August, 1993.

Fralic, M.F. and Schlag, M.K. "Case Management Helps University Hospital Cope With Reimbursement Challenges: An Interview." Hospital Case Management, 1(7): 117-123, 1993.

Fralic, M.F. "Creating New Practice Models and Designing New Roles: Reflections and Recommendations." Journal of Nursing Administration, 22(6): 7-8, 1992.

Fralic, M.F. "The Nurse Case Manager: Focus, Selection, Preparation and Measurement." Journal of Nursing Administration, 22(11): 13-14, 46, 1992.

"An Interview at Robert Wood Johnson University Hospital: ProACT Model." Orthopedic Nursing, 9(1): 41-44, 1990.

Jacobson, Erika. "Three New Ways to Deliver Care." American Journal of Nursing, 24-26, July, 1990.

Ritter, J. and Tonges, M.C. "Work Redesign in High Intensity Environments: ProACT For Critical Care." Journal of Nursing Administration, 21(12): 26-35, 1991.

Ritter, J., Fralic, M.F., Tonges, M.C. and McCormac, M. "Redesigned Nursing Practice: A Case Management Model for Critical Care." Nursing Clinics of North America, 27(1): 119-128, 1992.

Ritter, J. and McCormac Bueno, M. "Quantitative and Qualitative Measurement of Unit-Based Nurse Case Manager Performance." American Organization of Nurse Executives, 2(1): 2, 4, 1993.

Service, R. "A Winning Team (editorial)." R.N., 52:4, April, 1989.

Shendell-Falik, N. and Soriano, K. "Outcomes Assessment Through Protocols." In Flarey, D. and Blancett, S. Handbook of Nursing Case Management, (pp. 136-169) Gaithersburg, Maryland: Aspen, 1996.

Shendell-Falik, N. "Perinatal PRO-ACT®: Work Redesign and Case Management." The Journal of Perinatal and Neonatal Nursing, 8(4): 1-12, 1995.

Shendell-Falik, N. "ProACT for Pediatrics: Work Redesign and Nursing Case Management." In Flarey, D.L. Redesigning Nursing Care Delivery: Transforming Our Future, (pp. 162-172) J.B. Lippincott, 1995.

Tonges, M.C. "Redesigning Hospital Nursing Practice: The Professionally Advanced Care Team (ProACT) Model, Part 1." Journal of Nursing Administration, 19(7): 31-38, 1989.

Tonges, M.C. "Redesigning Hospital Nursing Practice: The Professionally Advanced Care Team (ProACT) Model, Part 2." Journal of Nursing Administration, 19(8): 19-22, 1989.

Tonges, M.C. "ProACT: The Professionally Advanced Care Team Model." Patient Care Delivery Models. Edited by G. Mayer, M.J. Madden and E. Lawrenz. Aspen Publishers, Inc., 1990.

Tonges, M.C. "ProACT: A Positive Response to the Nursing Shortage." Echo, 26-27, March, 1990.

Tonges, M.C. "Work Designs: Sociotechnical Systems for Patient Care Delivery." Nursing Management, 23(1): 27-32, 1992.

Vogel, D.P. "Patient-Focused Care." American Journal of Hospital Pharmacists, 50: 2321-2329, 1993.

Weber, David O. "Six Models of Patient-Focused Care." Healthcare Forum Journal, 21-31, July/August, 1991.

1/97

Appendix 8: The Leicester Royal Infirmaries Reading List

Advisory Board Company (1992), *Re-engineering the hospital: Clockwork surgery*, Washington DC, The Advisory Board Company.

Aghassi, H. (1994), "Organisational structures, people and technology", Coulson-Thomas, C. (ed), *Business process re-engineering: Myth and reality*, London, Kogan Page.

Ahmed, P. (1996), "Conceptualising business process re-engineering", *Business Process Re-engineering and Management Journal*, Vol 2, no 2, pp73-92.

Ahmed, P. 1996), "Viewpoint: Moving beyond re-engineering: Integrated process management", *Business Process Re-engineering and Management Journal*, vol 2, no 2, pp3-7.

Argenti, J. (1993), *Your Organisation: What is it for?*, Berkshire, McGraw-Hill.

Ashburner, L. (1996), "The role of clinicians in the management of the NHS", Leopold, J., Glover, I., Hughes, M. (eds), *Beyond reason? The National Health Service and the limits of management*, Aldershot, Avebury, pp207-225.

Ashburner, L., Ferlie, E., Fitzgerald, L. (1996), "Organisational transformation and top down change: The case of the NHS", *British Journal of Management*, vol 7, pp1-16.

Bartlett, C., Ghoshal, S. (1995), "Rebuilding behavioural context: Turn process re-engineering into people rejuvenation", Sloan Management Review, Fall, pp11-23.

Bashein, B., Markus, L., Riley, P. (1994) "Preconditions for BPR success", *Information Systems Management*, Spring.

Beer, M., Eisenstat, R., Spector, B. (1990). *The critical path to corporate renewal*, Boston, Harvard Business School Press.

Beer, M., Eisenstat, R., Spector, B. (1990), "Why change programmes don't produce change", *Harvard Business Review*, November/December, pp158-166.

Belmonte, R.W., Murray, R.J. (1993, "Getting ready for strategic change: Surviving business process redesign", *Information Systems Management*, Summer, pp23-29.

*Bevan, H. (1996), "Managing today while creating tomorrow: The paradox of a re-engineering journey", *Henley Working Paper Series*.

Bevan, H., Homa, P. (1995), "Re-engineering healthcare: The potency of process", *Focus on Change Management*, November, pp3-6.

Blumenthal, B., Haspeslagh, P. (1994), "Toward a definition of corporate transformation", *Sloan Management Review*, Spring, pp101-106.

Braganza, A., Myers, A. (1995), Issues and dilemmas facing public and private sector organisations in the effective implementation of BPR, *The Cranfield School of Management Working Paper Series*.

*Bridges, W. (1995) *Managing transitions: Making the most of change*, London, Nicholas Brearley.

Brindle, D. (1996), "Back to basics of the bar", *The Guardian*, Society supplement, 2th July, p11.

Buchanan, D., Boddy, D. (1992), *The expertise of the change agent*, Hemel Hempstead, Prentice Hall.

Buchanan, D., Wilson, B. (1996), "Re-engineering operating theatres: The perspective assessed", *Leicester Business School*, occasional paper, no 34.

Caron, J.R., Jarvenpaa, S.L., Stoddart, D.B. (1994), "Business re-engineering and CIGNA Corporation: Experiences and lessons from the first five years", *Management Information Systems Quarterly*, September, pp233-250.

Carr, D., Johansson, H. (1995), *Best practices in re-engineering*, New York, McGraw-Hill.

Champy, J. (1995). *Re-engineering management - the mandate for the new leadership*, Harper Collins.

Clarkson, P. (1995) *Change in organisations*, Whirr.

Clemons, E. (1995), "Using scenario analysis to manage the strategic risks of re-engineering", *Sloan Management Review*, Summer, pp61-71.

Clemons, E., Thatcher, M., Row, M. (1995), "Identifying sources of re-engineering failures: A study of behavioural factors contributing to re-engineering risks", *Journal of Management Information Systems*, Autumn, Vol 12, no 2, p9-36.

Cobra. (1995), "BPR case study: The single visit neurology outpatient clinic. The Leicester Royal Infirmary", *CCTA/Cobra.*

Corrigan, S. (1996), "Human and organisational aspects of business process re-engineering", *Institute of Work Psychology, University of Sheffield.*

Coulson-Thomas, C. (1994), *Business process re-engineering: Myth and reality,* London, Kogan Page.

Coulson-Thomas, C. (1996), "BPR and the learning organisation", *The Learning Organisation,* Vol 3, no 1, p16-21.

Council of International Hospitals, (1994), *Special research lesson: second generation lessons on critical care paths.*

Cross, K., Feather, J., Lynch, R. (1994), *Corporate renaissance,* Oxford, Blackwell.

CSC Index (1994), *State of re-engineering report, North America and Europe,* Boston, Massachusetts, CSC Index.

Dale, M. (1994), "The re-engineering route to business transformation", *Journal of Strategic Change,* vol 3, pp3-19.

Davenport T. (1995), "Will participative makeovers of business process succeed where re-engineering failed?", *Planning Review,* January/February, vol 28, no 1, pp24-30.

Dawson, S. (1994), "Change in the distance: Professionals reappraise the meaning of management", *Journal of General Management,* Vol 20, no 1, pp1-21.

Dawson, S., Mole, V., Winstanley, D., Sherval, J. (1995), "Management, competition and professional practice: Medicine and the marketplace", *British Journal of Management,* vol 6, pp169-181.

Dixon, R., Arnold, P., Heineke, J., Kim, J., Mulligan, P. (1994), "Business process re-engineering : Improving in new strategic directions", *Californian Management Journal,* Summer, pp93-107.

Easterby-Smith, M., Thorpe R., Lowe, A. (1991), *Management research: An Introduction,* London, Sage.

Eden and Huxham (1996), "Action research for management research", *British Journal of Management,* vol 7, pp75-86.

Ferlie, E., Pettigrew, A (1996), "Managing through networks: Some issues and implications for the NHS", *British Journal of Management*, vol 7, Special Issue, March, pp581-599

Ferlie, E., Pettigrew, A. (1996b), "The nature and transformation of corporate headquarters: A review of recent literature and a research agenda", *Journal of Management Studies*, vol 4, July, pp495-523.

*Ferlie, E., Pettigrew, A., Ashburner, L., Fitzgerald, L. (1996), *The new public management in action*, Oxford University Press.

Fitzgerald, B., Murphy, C. (1994), "The practical application of a methodology for business process re-engineering", Coulson-Thomas, C. (ed), *Business process re-engineering: Myth and reality,* London, Kogan Page, pp166-173.

Gouillart, F., Kelly, J. (1995), *Transforming the organisation*, New York, McGraw-Hill.

Grint, K. (1995), "Utopian re-engineering", Burke, G., Peppard, J. (eds), *Examining business process re-engineering*, London, Kogan Page, pp82-106.

Gummeson, E. (1991), *Qualitative methods in management research*, Newbury Park, Cal, Sage.

Hackman, J., Wageman, R. (1995), "Total quality management: Empirical, conceptual and practical issues", *Administrative Science Quarterly*, no 40, pp309-342.

Hall, G., Rosenthal, J., Wade, J. (1993), "How to make re-engineering really work", *Harvard Business Review*, November/December, pp119-131.

Hammer, M. (1990), "Re-engineering work: Don't automate, obliterate", *Harvard Business Review*, July/August, pp104-112.

*Hammer, M., Champy, J. (1993), *Re-engineering the corporation: A manifesto for business revolution,* New York, Harper Collins.

Hammer, M., Stanton, S. (1995), *The re-engineering revolution: A handbook*, New York, Harper Collins.

*Harrington, J. (1991), *Business process improvement*, New York, McGraw Hill.

Harrison, A. (1996), "Structural change in hospitals: The implication for research", *Journal of Health Services Research and Policy*, vol 1, no 1, pp44-50.

Harrison, B., Pratt, M. (1993), "A methodology for re-engineering businesses", *Planning Review*, March/April, vol 21.

Harrison, S., Hunter D., Marnock, G., Politt, C. (1992), *Just managing: Power and culture in the National Health Service*, Basingstoke, MacMillan.

Harrison, S., Small, N., Baker, M. (1994), "The wrong kind of chaos? The early days of an NHS Trust", *Public Money and Management*, January/March, pp39-46.

Harvey, D. (1994), *Re-engineering: The critical success factors*, Business Intelligence.

Healthcare Advisory Board (1992), *TQM: The second generation*.

Hewitt, F., Yeon, K. (1996), "BPR perceptions, practices and expectations - a UK study", *Business Change and Re-engineering*, vol 3, no3, pp47-55.

Homa, P., Bevan, H.(1995), "If your hospital did not exist, how would you create it?" *Hospital Management Handbook*, London, Kogan Page.

*Hout, T., Carter, J. (1995), "Getting it done: New roles for senior executives", *Harvard Business Review*, November/December, pp133-145.

Hughes, D. (1996), "NHS managers as rhetoricians: A case of cultural management", *Sociology of Health and Illness*, vol 18, no 3, pp291-314.

*Hutt, M., Walker, B., Frankwick, G. (1995), "Hurdle the cross-functional barriers to strategic change", *Sloan Management Review*, Spring, pp22-30.

Inns, D. (1996), "Organisation development as a journey", Oswick, C., Grant, D. (eds), *Organisation development, metaphorical explorations*, London Pitman, pp20-32.

Jackson, B. (1996), Re-engineering the sense of self: The manager and the management guru, *Journal of Management Studies*, vol 33, no 5, September, pp573-590.

Jackson, D. (1994), "BPR: Hype or reality?", *The TQM Magazine*, vol 6, no 6, pp19-22.

Johansson, H., McHugh, P., Pendlebury, J., Wheeler, W. (1993), Business process re-engineering, Chichester, John Wiley.

Joss, R., Kogan, M. (1995), *Advancing quality: Total quality management in the National Health Service*, Buckingham, Open University Press.

Judson, A. S. (1991), *Changing behaviour in organisations; minimising resistance to change*, Cambridge, Mass Blackwell.

Kanter, R., Stein, B., Dick, T. (1992), *The challenge of organisational change*, New York Simon and Schuster.

Keen, M.(1995), "BPR: Managing the change process - or the process of change managing BPR?", Burke, G., Peppard, J. (eds), *Examining business process re-engineering*, London, Kogan Page, pp262-276.

Kennedy, C. (1994), "Re-engineering: The human costs and benefits", *Long Range Planning*, vol 27, no 5, pp64-72.

Kiely, T. (1995), "Re-engineering, it doesn't have to be all or nothing", *Harvard Business Review*, November/December, vol 73, no 6, pp16-17.

Klein, M. (1994), "The most fatal re-engineering mistakes", *Information strategy: The Executive Journal*, Summer, pp21-28.

Kotter, J. (1995), "Why transformaton efforts Fail", *Harvard Business Review*, March/April, pp59-67.

Langley, A. (1995), "Between 'paralysis by analysis' and 'extension by instinct", *Sloan Management Review*, Spring, pp63-76.

Lawler, E., Galbraith, J. (1994), "Avoiding the corporate dinosaur syndrome", *Organisational Dynamics*, pp5-16.

McHugh, P., Merli, G., Wheeler, W. (1995), *Beyond business process re-engineering*, Chichester, John Wiley.

*Majchrzak, A., Wang, Q. (1996), "Breaking the functional mind-set in process organisation", *Harvard Business Review*, September-October, pp93-99.

Marshak, R. (1993) "Managing the metaphor of change", *Organisational Dynamics*, vol 22, no 1, pp44-56.

Merry, P. (1996), "Back to the drawing board", *Medical Interface*, August, pp15-18.

Meyer, A., Goes, J., Brooks, G. (1995), "Organisations reacting to hyperturbulence", Huber, G., Van de Ven, A. (eds), *Longitudinal field research methods: Studying processes of organisational change*, Thousand Oaks, CA, Sage, pp299-350.

Newman, K. (1994), "The single visit clinic: A case study in process re-engineering", *The Journal of Corporate Transformation*, vol 2, no 2, pp10-18.

*Noer, D. (1994), *Healing the wounds*, San Francisco, Jossey-Bass.

Nutt, P., Backoff, R. (1993), "Transforming public organisations with strategic management and strategic leadership", *Journal of Management*, vol 19, pp299-347.

Obeng, E., Crainer, S. (1994), *Making re-engineering happen*, London, Pitman.

Obeng, E. (1995), "Beyond the petronius principle: Achieving results through virtual teams", *Project Manager Today*, June, pp22-24.

Oblensky, N. (1994), *Practical business re-engineering - Tools and techniques for achieving change*, London, Kogan Page.

Oram, M. (1996), "Five stars guide the way forward", *People Management*, 2nd May, p29.

Oram, M., Wellins, R. (1995), *Re-engineering's missing ingredient: The human factor*, London, Institute of Personnel and Development.

Padulo, R. (1995), "Using business process re-engineering to build a double loop learning organisation", *Management Research Paper*, 95/2, Templeton College, Oxford.

Palmer, C. (1995), "British healthcare reforms: A hospital manager's view", *Business Strategy Review*, Autumn, Vol 6, no 3, pp41-50.

Peppard, J., Preece, I. (1995), "The content, context and process of business process re-engineering", Burke, G., Peppard, J. (eds) *Examining business process re-engineering*, London, Kogan Page, pp157-185.

Petrazzo, D., Stepper, J.C. (1994), *Successful re-engineering*, New York, Van Nostrand Reinhold.

Pettigrew, A., Whipp R. (1994), *Managing change for competitive success*, Oxford, Blackwell.

Pettigrew, A., Ferlie, E., McKee, L. (1992), *Shaping strategic change; making change in large organisations, the case of the National Health Service*, London, Sage.

Pichault, F. (1995), "The management of politics in technically related organisation change", *Organisation Studies*, vol 16, no 3, pp449-476.

Price Waterhouse Change Integration Team (1996), *The paradox principles*, Chicago, Irwin.

Quinn, R., Cameron, K. (1988), *Paradox and transformation: Toward a theory of change in organisation and management*, Cambridge, Mass, Ballinger.

Reger, R.K., Gustafson, L.T., Demarie, S.M., Mullane, J.V. (1994), "Re-framing the organisation. Why implementing total quality is easier said than done", *Academy of Management Review*, vol 3, pp565-584.

Remenyi, D. (1995), Some typical phases of a business transformation project, *Henley Working Paper*, Henley Management College.

Remenyi, D., Heafield, A. (1995), Business process re-engineering: Some aspects of how to evaluate the risk exposure, *Henley Working Paper* 95/18, Henley Management College.

Remenyi, D., Whittacker, L. (1994), "The cost and benefits of BPR", *Business Change and Re-engineering*, Vol 2, no 2, pp51-65.

Senge, P. (1990), *The fifth discipline*, London, Century Business.

Shaw, R., Walton, A. (1995), "Conclusion: The lessons of discontinuous change", Nadler, D., Shaw, R. (eds), *Discontinuous change*, San Francisco, Jossey-Bass.

Slack, N., Chambers, S., Harland, C., Harrison, A., Johnstone, R. (1995), *Operations management*, London, Pitman.

Stoddard, D., Jarvenpaa, S.L., Littlejohn, M. (1996), "The reality of business re-engineering: Pacific Bell's centre provisioning process", *California Management Review*, vol 38, no 3, pp57-76.

*Sylvester, K. (1996), "It's the system that's causing the problem, doctor!", *Clinician in Management*, January.

Sylvester, K. (1996), "To go with the flow", *Clinician in Management*, April.

Talwar, R. (1994), "Re-engineering - A wonder drug for the 90's?", Coulson-Thomas, C. (ed), *Business process re-engineering: Myth and reality*, London, Kogan Page, pp40-59.

Teng, J.T.C., Grover, V., Fielder, K.D. (1994), "Business process re-engineering: Charting a strategic path for the information age", *California Management review*, Spring.

Tinaikar, R., Hartman, A., Nath, R. (1995), "Rethinking business process re-engineering: A social constructionist perspective", Burke, G., Peppard, J. (eds), *Examining business process re-engineering*, London, Kogan Page, pp107-116.

Tuckman, A. (1994), "The yellow brick road", *Total Quality Management and the Restructuring of Organisational Culture*, vol 15, pp727-751.

Van de Ven, A., Poole, M. (1995), "Explaining development and change in organisations", *Academy of Management Review*, vol 20, no 3, pp510-540.

Vince, R., Broussine, M. (1996), "Paradox, defence and attachment: Accessing and working with emotions and relations underlying organisational change", *Organisation Studies*, vol 17, no 1, pp1-21.

Willcocks, S. (1994), "The clinical director in the NHS: Utilising a role-theory perspective", *Journal of Management in Medicine*, Vol 8, no 5, pp68-76.

Willmott, H. (1995), "Will the turkeys vote for Christmas? The re-engineering of human resources", Burke, G., Peppard, J. (eds), *Examining business process re-engineering*, London, Kogan Page, pp306-315.

*Willmott, H. (1995b), "The odd couple?: Re-engineering business processes: managing human relationships", in *New technology, work and employment*, September, vol 10, no 2, pp89-99.

Wood, J., Vidgen, R., Wood-Harper, A., Rose, J. (1995), "Business process redesign: Radical change or reactionary tinkering?", Burke, G., Peppard, J. (eds) *Examining business process re-engineering*, London, Kogan Page, pp245-261.

M nday, 9 December 1996 4.30pm

GENERAL POLICY DIRECTION

a) Government is committed to providing a flexible, modern, properly funded, accessible health service that meets changing public needs and expectations. The Coalition Government's health policy has the overriding goal of ensuring principles of public service replace commercial profit objectives for all publicly provided health and disability services.

b) The Coalition Partners are committed to publicly funded health care that encourages cooperation and collaboration rather than competition between health and disability services.

c) By July 1998 there will be one funding body separate from the Ministry of Health which will carry out functions determined after consultation with the health sector and a review of the current system.

d) Public health providers (CHE Services) will be required to function in a businesslike manner. The new focus will be on achieving health outcomes and improving the health status of the populations they serve. Private sector involvement in services usually provided by the public sector will be subject to criteria set by Government.

c) Every effort will be made to minimise disruption to the health sector by progressively introducing any changes to health service referred to in this document. In most circumstances current arrangements will continue until 1 July 1998 when new policies add legislation will be in place.

KEY POLICY INITIATIVES

1. General:

a) The Minister of Health will be responsible for the whole publicly funded health sector and the publicly owned health providers.

b) Vote Health funding will be increased. Extra funding will be available to reduce waiting times for hospital treatment. Guaranteed maximum waiting times for various procedures will be introduced.

c) Health and disability services for children will be boosted to ensure children receive the care and protection they need for the best possible start in life.

d) Equity of access to health and disability services across generations will be assured
by removing income and asset testing for older people needing long stay geriatric public hospital care services and asset testing for long stay geriatric private hospital Care.

e) By 1999/2000 introduce an exemption of $100,000 on the family home on the income and asset test on rest home care for single people and for married couples where both are in care.

f) Increased resources will be made available to address major issues in delivery of mental health services.

g) In recognition of,Government's commitment to improving the status of Maori health, increased resources will be made available to provide Maori leadership within the health sector, and to enable the continuing growth and development of Maori health service provision by Maori.

---

2. Changes to CHE Health and Disability (Regional Hospital and Community) Service Provider:

a) replacing Crown Health Enterprises with Regional Hospital and Community Services which will deliver those services currently provided by CHES. They will report directly to the Minister of Health through the Ministry of Health.

b) Removing the competitive profit focus for Regional Hospital and Community Services, replacing it with a requirement to carry out its activity in a businesslike fashion The principal goal will be achieving improved health outcomes to contribute to the health status of the populations they serve. Legislative and administrative arrangements that will achieve these goals will be completed during 1997.

c) A commitment will be demonstrated to publicly provided health and disability services, with long term contractual agreements with Regional Hospital and
Community Services for a range of services with the intention of providing the

Community Services for a range of services with the intention of providing the maximum mount of health care to patients for the taxpayers' funds available. Services will cover the following range:

community and rural health
mental health
Maori health
dental health
public health (including health protection and promotion)
intellectual, age related, physical/sensory disability support services
maternity (including pregnancy and childbirth services)
wellchild services
A&E
secondary/tertiary medical and surgical services diagnostic services

d) i) Publicly provided health and disability services are complemented by a wide range of non-government health service providers. ~~Regional Hospital and Community Services may form joint ventures with these non-government providers, or other Crown providers, working collaboratively with them when this is consistent with health gain priorities and within the criteria in d) ii).~~

ii) Current contractual arrangements involving the private sector in CHE based services will continue. However, any new joint venture, subcontracting or private work undertaken, or involvement by private companies in CHE based services will be limited. Private sector involvement must result in improvements as defined in health outcomes, pose no increase in financial risk to the Crown assessed over the next ten year period, and must be approved by the Minister of Health after consultation with Coalition Partners.

e) ~~Regional Hospital and Community Services will be required to develop initiatives in partnership with Maori, which lead to demonstrable improvements in Maori health status.~~

f) The Coalition partners have agreed to make minor amendments to the Commerce Act as it relates to some parts of the Health sector.

g) Ensure accountability and performance of Regional Hospital and Community Services receive high priority in their funding agreements.

h) Review after consultation the number of Regional Hospital and Community Services adjusting service boundaries to the optimum configuration to achieve health outcome goals.

i) Elected community representation will be considered by a joint working party of Coalition MPs as to the most appropriate place for public representation in the health sector.

j) The health sector will be consulted on changes to current arrangements in administration and legislation, governance mid reporting.

k) In the case of general practice any GP budget holding beyond GMS, primary laboratory and pharmaceutical budgets must result in improvements in defined health outcomes, pose no increase in fiscal risk to the Crown assessed over a ten year period, and must be approved by the Minister of Health after consultation with the Coalition Partners.

l) Reconsider the decision to unbundling ACC funding from CHEs for acute and some elective surgery.

---

3. Funding Arrangements:

a) By July 1998 there will be one funding body separate from the Ministry of Health which will carry out functions determined after consultation with the health sector and a review of the current system.

b) Public health services will no longer be competitively purchased by RHAS. Providers of public health services will be required to comply with stringent contractual funding agreements with clear health outcome goals.

c) A review of the most appropriate structure to carry out these changes in policy will be conducted and concluded by May 1997. The Coalition will consider all significant developments and agree on all aspects of implementation arising from the review.

d) Implementation of the changes necessary to meet the policy objectives will be completed by March 1998 in order to minimise the disruption to health services delivery to New Zealanders and to manage a smooth transition to the new arrangements.

The six principles below we agreed as non-negotiable:

I. Retaining the separation between the structure that replaces RHAs as funder and all health service providers including CHEs/Regional Hospital and Community Services, IPAS, GPs, Disability Services, rest homes etc.;

II. Limiting bureaucracy where possible;

III. Removing the 'for profit focus' from the CHEs but require them to work in a businesslike fashion.

IV. Giving greater emphasis to health gain.

V. ~~RHA purchasing from providers on a competitive price volume basis will be replaced with contractual funding agreements between the structure replacing RHAs and all providers based on historic funding information and levels, benchmarking information, changes in technology and comparative data to provide a cost effective health system that delivers the maximum amount of healthcare to patients for the taxpayers funds available.~~

VI. The structure replacing RHAs will undertake monitoring, auditing and reporting functions to enhance health gain and financial accountability.

---

4. Increase health sector resources and remove financial barriers to people needing to access health and disability services including:

a) Increase baseline funding to Vote: Health after full consideration is given to the sustainable funding work being undertaken.

b) Increase the waiting time fund by $5OM in 199718.

c) Establish guaranteed maximum waiting times for surgical and specialist treatment.

d) Remove hospital user part-charges.

e) Providing free doctors visits mid prescription medicines for children 5 years and under.

f) Remove income mid asset testing for long stay geriatric public hospital care services and asset testing for long stay geriatric private hospital cue.

g) By 1999/2000 introduce an exemption of $100,000 on the family home on the income and asset test on rest home cue for single people and for married couples where both are in care.

---

5. Pilot a community based family health team approach for the delivery of some primary healthcare services by Regional Hospital and Community Services:

a) Regional Hospital and Community Services family health teams coordinate and in some instances integrate primary healthcare with the delivery of the following services:

community health
mental health
Maori health
dental health (including school dental services) public health (including health protection and promotion) intellectual, age related, physical/sensory disability support services maternity (including pregnancy and childbirth services) wellchild services
hospital secondary and tertiary services

b) Family health teams will facilitate access for people needing hospital care taking responsibility for their transition through health and disability services. Family health teams will be involved in providing some child health and disability services. They will act as a referral agency for other child health service providers monitoring service delivery for at risk children.

---

6. Maori Health

a) Development of competent Maori Health providers is a critical requirement to support improvements in Maori health status. The following initiatives will be undertaken:

I. accelerated development of the professional Maori workforce

II. development of administrative add organisational expertise

III. Maori leadership within the Ministry of Health with dedicated provider approval, monitoring and evaluation functions

IV. increased public health resources for Maori provider development both directly to Maori providers and w a service obligation of Regional Hospital and Community Services

b) referred Maori service providers who meet minimum standards as set by the

Ministry will be funded to provide a comprehensive range of primary healthcare, community based health and disability services and identified secondary health and disability services.

---

7. Child Health

a) In order to ensure a greatly enhanced focus on the health and protection of children the Ministry of Health will be required to appoint a senior person whose responsibility it will be to oversee, coordinate, motivate and lead in the area of health gain priority areas, i.e.:

child health
Maori health
mental health (Commissioner and Director of Mental Health already in place)
waiting list/waiting times

These people will report to the Director-General and Minister on progress or the lack of it in these areas.

b) During 1997 all child health programmes currently in operation will be reviewed with a view to building on those that deliver the best health gain and improved family function thus reducing risk to children.

---

8. Mental Health

a) The recommendations of the Mason Report are to be fully funded and implemented.

LEGISLATIVE IMPLICATIONS OF THIS POLICY AGREEMENT

a) Significant amendments to Health and Disability Act.

b) Minor amendments to the Commerce Act as it relates to the health sector.

FISCAL IMPLICATIONS

	Over and above current baselines		
	97/98	98/99	99/20
Likely increased baseline funding based on current information	$156m	$291m	$490m
Additional resources for elective hospital treatment	$50m	$50m	$50m
Remove hospital area part charges	$7m	$7m	$7m
Free doctor's visits and prescription medicines for children 5 years and under	$65m	$65m	$70m
Remove income and asset testing for continuing care in public and the asset test for private hospitals	$45m	$40m	$40m
In 1999/2000 exempt house to $100,000	-	-	$67m (est)
Establish "safety net". child health and disability services	$30m	$30m	$30m
Maori health provider development	$10m	$10m	$10m
Additional Mental Health funding	$15m	$30m	$45m
	$378m	$523m	$809m

Ministry of Health Homepage

Last updated: 12 December 1996

LEADING EDGE 2000

LAKELAND

HEALTH

MAI I MAKETU KI TONGARIRO

BEST

PRACTICE

INITIATIVES

What is this about?
How will it affect you?
Why are we doing it?

MAY 1997

LAKELAND HEALTH
MAI I MAKETU KI TONGARIRO
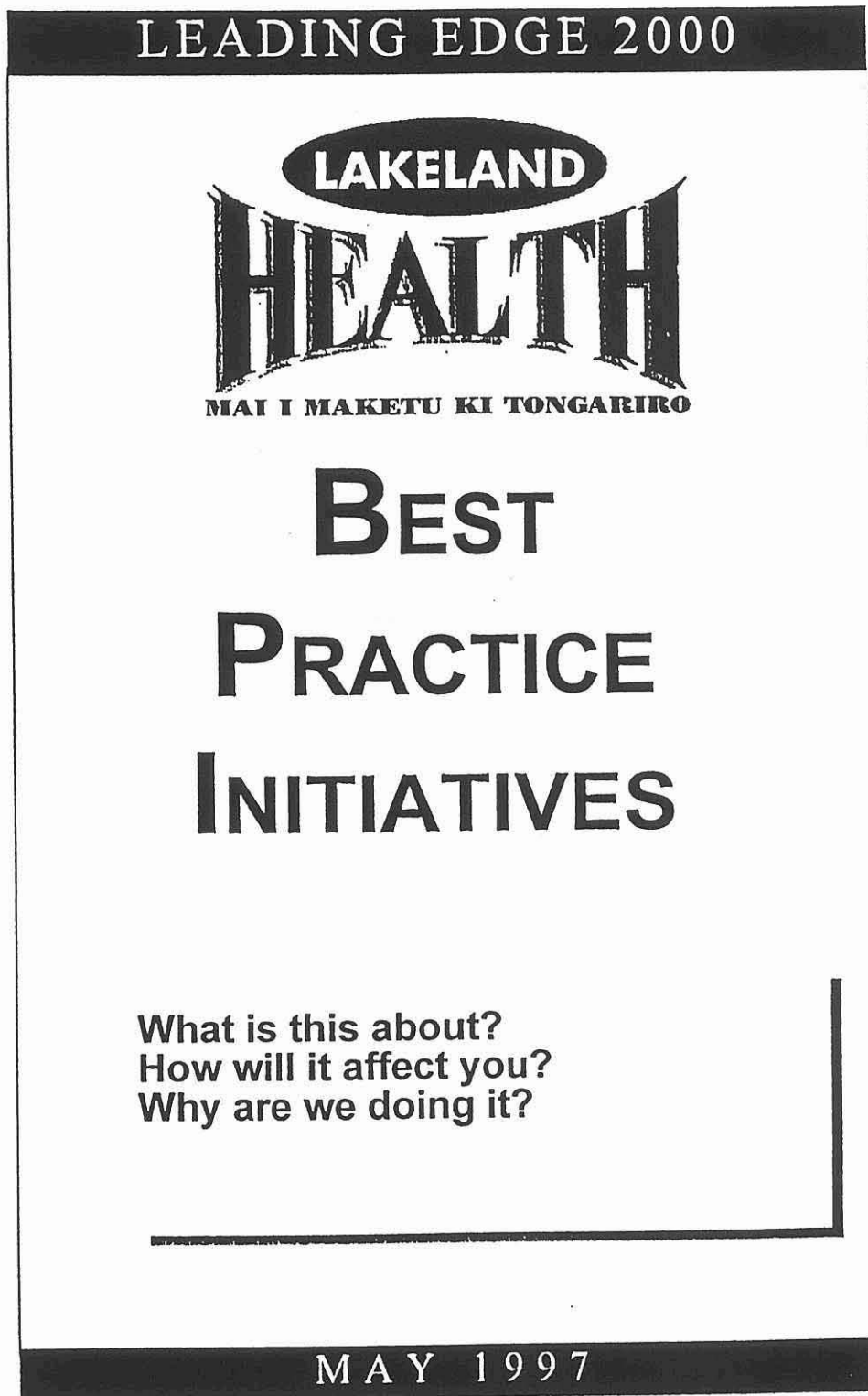
BEST PRACTICE INITIATIVES

WHAT IS IT ABOUT?

Best Practice Initiatives are part of Lakeland Health's strategy to be the *Leading Edge* in healthcare delivery by the year 2000.

The purpose of the Best Practice Initiatives Team is to assist you to fundamentally rethink and redesign healthcare processes, so that, in line with our new Clinical Service Model, we achieve dramatic improvements for our patients.

In streamlining our systems and clinical processes we will use our resources more efficiently.

The key performance areas we wish to dramatically improve on are:

* **Valuing patients' time**

* **Valuing resources - staff, facilities, equipment**

* **Clinical outcomes**

* **Patient and General Practitioner satisfaction**

LAKELAND HEALTH
MAI I MAKETU KI TONGARIRO

112

1

2

How will this affect you?

Process Redesign involves ALL Lakeland Healths' employees - Including YOU!

Best Practice Initiatives will involve *organisation wide, patient process focussed* simultaneous redesign of patient care, support and management processes.

The Initiatives will be *clinically led* .

The Best Practice Initiatives team will consist of core support members who will integrate into service teams and resource them as required.

Core members and Clinical Team leaders from the processes being worked on will meet regularly and progress will be reported to a Sub-committee of the Lakeland Health Board. This sub-committee, called the Leading Edge 2000 Board Sub-committee, has Board representatives on it.

The model on the next page shows how the change process will operate.

Table 3.

LEADING EDGE 2000
BEST PRACTICE INITIATIVES

BOARD

LE2000 BOARD SUB-COMMITTEE

TEAM LEADER

TEAM LEADER

TEAM LEADER

TEAM LEADER

TEAM LEADER

TEAM LEADER

LHL CLINICAL SUPPORT SERVICES
Initiatives

MEDICAL & DIAGNOSTIC SERVICES
Initiatives

SURGICAL SERVICES
Iniatives

WOMAN, CHILD & FAMILY SERVICES
Initiatives

MENTAL HEALTH SERVICES
Initiatives

LHL CORPORATE SUPPORT
Initiatives

IT SUPPORT
FACILITIES SUPPORT
FINANCIAL SUPPORT
STRATEGIC HEALTHCARE DEVELOPMENT
CLIENT RELATIONSHIP

LE2000 CO-ORDINATOR

WORKGROUPS

Redesign focuses on all aspects of change

PROCESS	defining the process according to patient needs
PEOPLE	training and developing for skills and competencies according to process needs
PERFORMANCE	managing individual and team performance within the process
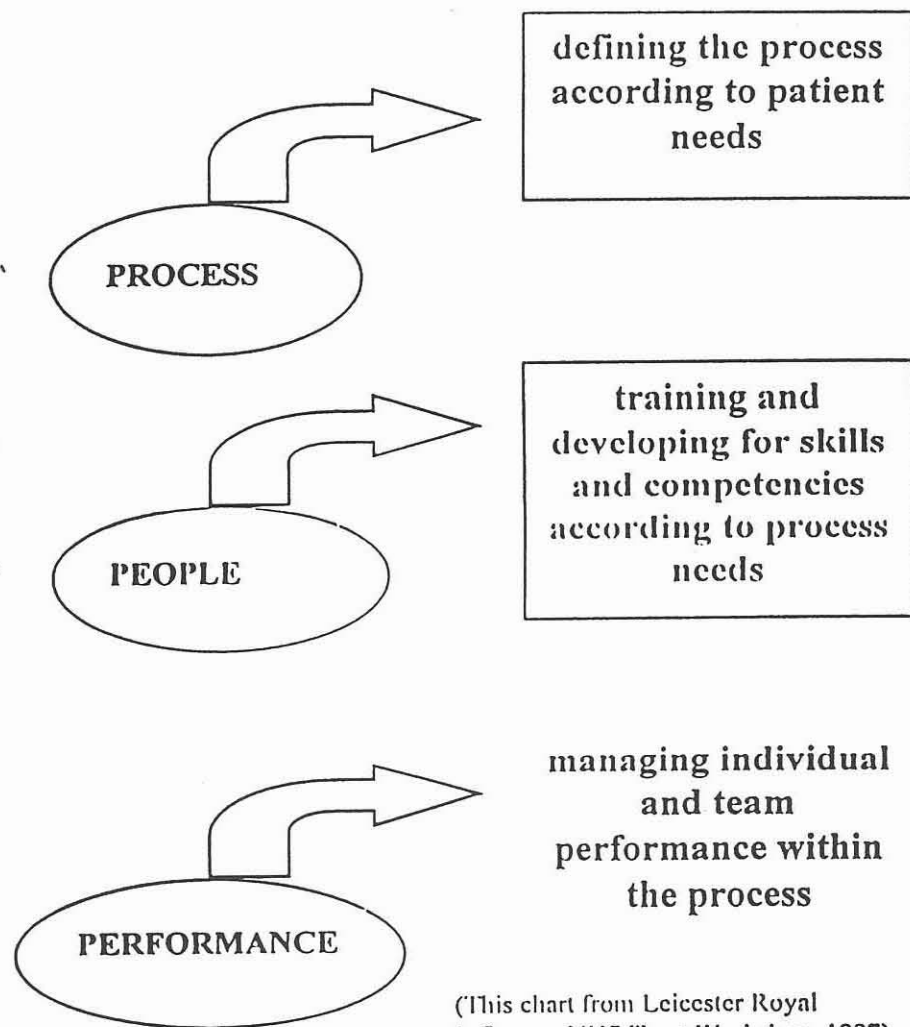
(This chart from Leicester Royal Infirmary NHS Trust Workshop, 1997)

Successful process redesign must happen from the "bottom up and from the inside out" -

This means every single staff member at Lakeland Health will need to be involved

YOU can:

Think seriously about your own job and what changes could be made to improve it

Think about what other people could do to support you to do your job better

Think about what you could do to support others to do their jobs better

Pass on your ideas to your Service Best Practice Leader, or to the Leader of the Best Practice Initiatives team

LAKELAND HEALTH

HEALTH

MAI I MAKETU KI TONGARIRO

BEST PRACTICE INITIATIVES

LAKELAND HEALTH'S BEST PRACTICE INITIATIVES TEAM WELCOMES YOUR IDEAS!

Nurse Consultant Mary Smith has been seconded to lead the Best Practice Initiatives Team. Reporting directly to the Chief Executive Officer, Ray Watson, Mary will liaise with team leaders from within each of the services, assisting with process definition, co-ordination resourcing and establishment of new teams to work on particular processes where necessary.

Phyllis Tangitu will be responsible for ensuring Whakaruruhau (cultural safety) permeates all patient and support processes.

Redesign requires ALL of us to contribute to change.

Process Redesign aims for complete integrated patient processes. It involves an integrated view of outpatient, inpatient and discharge roles and activities and identified care and treatment pathways (Clinical Pathways)

The Leading Edge 2000 Initiatives will be linked to the Lakeland Health Quality Framework Development

LEADING EDGE 2000

The key performance areas we wish to dramatically improve on are:

* **Valuing patients' time**

* **Valuing resources - staff, facilities, equipment**

* **Clinical outcomes**

* **Patient and General Practitioner satisfaction**

LAKELAND HEALTH
MAI I MAKETU KI TONGARIRO

2

Appendix 11: The Perioperative Project

1.0 Introduction

Surgical Services at Rotorua wish to implement the perioperative service model by September 1st 1997.

The concept, tried and tested extensively in Australia involves a change of philosophy, and therefore as a consequence, a change in medical and administrative workpractices.

The concept is as follows:

Elective inpatient surgery has traditionally been a staged process: - the patient is seen by the surgeon, clerked through the hospital admission office, admitted to a ward, reviewed by an anaesthetist, has an operation (usually the next day) and is then discharged at some time afterwards.

Perioperative care involves combining all the above stages into one process that is planned in advance so that actual inpatient time occurs with maximum efficiency and highest quality. Hence anaesthetic assessment, nursing care planning, and discharge arrangements are all performed before admission.

Rather than admitting patients to a surgical ward, patients are admitted from home to an area adjacent to the operating theatres (the perioperative unit) shortly before surgery.

Patients are (administratively) admitted to a ward bed on admission, but do not occupy the bed until 3 - 4 hours later. During this time, the bed may still be occupied by a patient who is about to go home. This allows a virtual bed occupancy rate greater than 100% ("Hot Bedding").

Patients do not enter the surgical ward until after surgery. This reduces preoperative hospital stay, minimises patient transfers (portering), and improves surgical ward efficiency.

Planning discharge prior to admission minimises delays on discharge, as community nurses, GP transport and ancillary services are arranged in advance.

The concept of perioperative care thus plans elective surgery as a unified process with highest quality of care, and maximum efficiency in the use of hospital resources.

2.0 Philosophy

The organisation of a Perioperative Service incorporates some important
* philosophical principles

1   Patients should be treated outside of hospitals as much as possible. Hospitals should be seen as acute care areas, only providing services that require such facilities.

2   Patient management for elective surgery should be limited to providing the surgery as expeditiously as possible. Management of intercurrent or long-term health problems that do not affect patient management during the elective surgery episode should be left to community based health services (eg General Practitioners).

3   Teaching within hospitals should not distort the organisation of clinical services. Activities that have traditionally been justified "for teaching purposes" may have to be reviewed, if this interferes with providing clinical services of optimal quality, patient convenience and efficiency.

The **rationale** is:

1   <u>Quality</u>
        The quality of patient care is improved if there is an organised system for preadmission screening, collation of patient results and other data, and planning of perioperative care.

2   <u>Cost</u>
        The existence of a perioperative system facilitates the planning of elective surgery with a minimum length of inpatient stay and maximum efficiency of patient care during that stay. Thus the costs of care for elective surgery patients are minimised while maintaining quality of patient care.

3   <u>Patient Preference</u>
        Patients prefer to spend as little time as possible in hospital. An organised perioperative service facilitates this preference.

4   <u>GP focus</u>
        A perioperative care system brings the focus of long term health care onto the General Practitioner, and recognises that hospitals are appropriately seen as places for short term acute care only.

3.0   <u>Components of a Perioperative Service</u>

The fundamental idea of a perioperative service is to organise elective surgery as a single planned event, consisting of multiple steps rather than a sequence of separate events. Elective Surgery is thus seen as starting at the time of the patients booking for surgery (in the surgeon's rooms) and ending when the patient is returned to their place in the community.

The components of a Perioperative Service thus include:

1   A booking system with the hospital or hospitals.

2   A system for screening patients to ensure appropriate preparation before their surgery.

3   A Clinic or Clinics for assessment and preparation of the patient prior to surgery.

4   A system for collating patient records, assessments, and admission details, prior to the patient's admission.

5   A bed management system to plan the availability of beds for inpatient stay.

6   A preoperative area for the patient to be admitted to hospital and to be prepared prior to surgery.

7   An Operating Theatre/Recovery and second stage Recovery area.

8   Inpatient Wards.

9   A Discharge Planning and Support Service.

10   A management structure to co-ordinate all the components of the service.

At Rotorua, we have already achieved many of these objectives, but some of them need fine tuning.

1   **Booking Service**
         In place

2   **System for Screening Patients**
         In place, but needs modifying

3   **Clinic for assessment and preparation of the patient prior to surgery**
         In place, but needs moving physically.

4   **System for collating patient records, etc**
         In place but needs rationalisation.

5   **Bed management system**
         Probably not applicable in a hospital of our size and is now successfully managed by CNL's and Operations Manager (Non-Acute).

6   **Preoperative area for the patient**
         In place (Ward 8) but needs modifying.

7   **An Operating Theatre/Recovery and second stage Recovery area**
         In place, but no second stage Recovery area (This may not be necessary).

8   **Inpatient Wards**
         In place.

9   **A Discharge Planning and Support Service**
Not in place.

10   **Management Structure to co-ordinate all components of the service**
Currently being reviewed and recruitment process commenced.

4.0   Action Plan

See attached Business Plan 1997/2000 (Appendix 1).

5.0   Perioperative Working Party

A multidisciplinary working party was established in April '97 consisting of:

Mr Ross Bohm	Clinical Service Director, Surgical Services
Dr David Laidlow	HOD, Emergency Department / Specialist Anaesthetist
Helma van der Lans	Manager, Surgical Services
Beth Lang	Clinical Nurse Leader, Ward 8
Monica Blaser	Nurse Consultant
Greg Vandergoot	Operations Manager - Surgical
Merle Amos	Admissions Clerk
Waiora Rogers	Admissions Clerk/Outpatients Coordinator
Mary Smith	Nurse Consultant, Leading Edge 2000
Derek Roser	Manager, Medical & Diagnostic Service
Brent MacDonald	Manager, Clinical Support Service
Lyn Groot	Social Worker
Ian Shaw	Manager, Works Departmnt
Lorraine Hartley	Coordinator, Operating Theatre
Dr Sam Hill	GP representative

This core group meets weekly to monitor progress of delegated projects and coordinate staged development.   Additional representation will be sought on an if and when required basis to ensure all aspects relating to perioperative support are included in service planning.

6.0   Facility

Ideally, the perioperative unit should be in the immediate vicinity of theatres to achieve maximum efficiency and patient flow, eliminating dependency on "outside" attendants for transfer of patients (one of the biggest factors in theatre delays), and facilitating sharing of staff between areas and pre-operative access to patients by anaesthetists.

Option 1
The ideal site, which would be the area presently occupied by ICU/CCU and theatre rest room, (Appendix 2) has been investigated and costed.

However, current financial constraints may impact on an early progression of this preferred option which includes relocation of ICU/CCU.

Option 2

As an interim solution it has been decided to implement the service, and the philosophy at minimal cost, by adapting the current Day Unit (Ward 8) (Appendix 3).

To achieve this the following issues need to be resolved before formal implementation of the system:

1   **A perioperative clinic**, consisting of the Specialist Anaesthetist, a clinic nurse, and a booking clerk situated in or near the ward.

As there is no space on the ward, the offices used by the dietitian, social worker and oncology have been identified as ideal without major reconstruction being required.

2   **A reception area for ward 8**.   The newly-built reception area between Wards 7 and 8 can be utilised.   Extension into the next room may be necessary and needs further investigation.

3   It is logical to develop an entrance and drop off / pickup area at the ground floor entrance next to the lifts going up to the Day Unit as these lifts open into the reception area (see 2 above).   There are two options to be considered.

   1   Utilisation of the existing Ward 10 entrance and staff car park (ideal solution).

   2   The entrance on the west side currently used for entrance to the kitchen area.   While feasible, this grim looking entrance with the kitchen rubbish bins parked outside it is not considered to be an acceptable solution in its present state as the "gateway" to Rotorua Hospital and the portals for major surgery. Consideration also needs to be given to the ability to shield patients and public from inclement weather conditions.

The working party firmly supports Ward 10 entrance as the preferred option.

4   A "transit lounge" for patients to wait for their transport after discharge, in order to free up beds.   This facility exists both on Wards 7 and 9.

5   Exact staffing levels are not known at this stage.   The Business Plan (Action Plan) has identified a working party to be established in May '97 to assess and implement staffing requirements.   The implications of this have to be worked through if FTE's in excess of Business Plan are identified.   Site development will be crucial to achieving staffing efficiencies.

7.0 Financial Implications

Option 2 has been costed as a practical compromise to get the perioperative service established within the planned timeframe. (Appendix 4)

This involves:

- Establishing Pre-Assessment Clinics in Perioperative Unit by moving Oncology / Dietitian offices and treatment space to alternative site.

- New entrance (ground floor Ward 10) entrance or kitchen entrance,

- Minor alterations to Ward 8 to improve Ward utilisation, bed transport and reception facilities.

- Possible initial additional staffing costs cannot be ruled out until the system has been firmly "bedded in". A purpose-built facility (eg current ICU/CCU area), ward rationalisation and re-engineering of admission process will achieve staffing efficiencies long term.

8.0 Site Review

The site development plan should also include resiting of Ward 7 to current CSSD and adjacent vacant old ECG area, resulting in one surgical/orthopaedic ward and establishment of high dependency nursing area. Rationalisation of wards will result in staffing efficiencies and improved bed utilisation.

Vacated Ward 7 to be utilised for Surgical Services Management Team, HOD's and SMO office space, RMO facility, meeting / lecture rooms (currently situated on CSB third floor), clinical support services (secretarial / typing).

An option worth consideration would be resiting of ICU (and CCU?) to the space currently occupied by the cafeteria and possible resiting of cafeteria to groundfloor Edward Guy building. This would optimise CSB utilisation for valuable clinical activities.

9.0 Savings

- Reduction in bed nights.

- Reduction in preoperative investigations (quantity unknown). These will be requested by a senior anaesthetist and not a junior house surgeon.

- Hot bedding.

- Less theatre delays.

- Less last minute cancellations.

- Improvement in the quality of service to our patients.

The implementation of the perioperative system will be developmental and processes / documentation reviewed and refined as practical experience of the system becomes more transparent.

However, there is no reason to assume that a tried and tested system, already in place elsewhere, and PROVEN TO BE EFFICIENT and economical, should be any different at Rotorua.

To achieve the best possible long term result, the Working party welcomes input into and challenges of the planning process to date.

In the meantime, a newsletter will be prepared to inform LHL staff of this exciting initiative. Your agreement to distribute this at the earliest opportunity would be greatly appreciated.

David Laidlow
SPECIALIST ANAESTHETIST

Helma van der Lans
SERVICE MANAGER, SURGICAL

15 May, 1997

THE IMMEDIATE PRIORITY IS TO MAKE THINGS HAPPEN, TO GET SOME EARLY "WINS" AND TO GET STAFF BEHIND LE2000. WE RECOMMEND FOUR AREAS OF FOCUS FOR PHASE TWO WORK:

Phase Two Projects

Project	Type & Benefits	Comments (why?)
Leading Edge Outpatient Services	Process redesign & implementation: • improved efficiency • improved practice	Ideal pilot study: Service sits in a management 'gap' Identified opportunities for efficiency/effectiveness gains Common processes cross functional "silio's" Need for change recognised within services
Surgical Services: Building a business case for the Perioperative Service	Process redesign: Specification to • improve efficiency • improve practice	High profile project Recognised need for change (surgical services are high cost but low profit) Service already holds project "champions" (some overlaps with outpatient study)
Improving the Health Record information flows : Admission to Discharge (general medical patients)	Process redesign/effectiveness and efficiency study: Specification to identify the roles, responsibilities and information system requirements	Weaknesses and inefficient practices associated with current information systems High organisational risk associated with current systems High level of frustration with current practice Allows introduction of key process re-engineering concepts to clinical staff (some overlaps with 'clinical pathway development')
LOS: potential to improve the discharge process?	Process review: • efficiency gains through effective discharge process, • improved information for decision-making	Possible opportunities for reductions in LOS identified Significant cost savings opportunities if LOS can be reduced Introduces clinical pathways as a tool, challenges current practice

125

BIBLIOGRAPHY

Ackroyd, S. [1996] Organisation contra organisations: Professions and Organisational Change in the United Kingdom. Organisation Studies, vol 17, no 4, pp 599 - 621.

Antrobus, Sue. [1997] An analysis of nursing in context: the effects of current health policy. Journal of Advanced Nursing, 25, 447 - 453.

Blancett, S.S; & Flarey, D.L. [1995] Reengineering Nursing and Health Care. Aspen Publication.

Boston, J. [1991] The Theoretical Underpinnings of Public Sector Restructing. In Boston, J., Martin, J., Pallot, J., & Walsh, P. [Eds], Reshaping the State [pp 1 - 26]. Auckland Oxford University Press.

Borren, P., & Maynard, A., [1994] The Market Reform of the New Zealand Healthcare System searching for the Holy Grail in the Antipodes. Health Policy, 27, 233 - 252.

Bridges, W. [1996] Transitions: Making Sense of Life's Changes. Nicholas Brealey Publishing, London.

Coopers and Lybrand [1997] Draft Document for Lakeland Healthcare Leading Edge 2000: Phase 1.

Corrigan, S. [1996] Human and Organisational aspects of Business Process Reengineering. Institute of Work Psychology, University of Sheffield.

Davenport, T. [1995] Will Participative Makeovers of Business Process Succeed Where Reengineering Failed? Planning Review, May / June 1993, pp 6 - 13.

Flarey, D.L. [1995] Redesigning Nursing Care Delivery. J.B. Lippincott Company

Grint, K. & Wilcocks, L. [1995], Business process reengineering in theory and practice: Business paradise regained? New Technology, Work and Employment, vol 10. no 2. September, pp 99 - 109.

Hammer, M. & Champy, J. [1994] Reengineering The Corporation: A Manifesto for Business Revolution, Harper Collins, New York.

Jenkinson, R. [1996] The Grief Process of Corporatisation in New Zealand. A paper.

Jordan, S. Inspired by Angels Blue Dolphin Publishing, 1995.

Katz, R. [1995] Is Reengineering already Dead? Quality Digest, January.

Leicester Royal Infirmary Manual 1994. Unpublished

Phillips, A. [1996], Reengineering in Healthcare. A presentation by A. T Kearney Ltd, April, unpublished.

Radman, J. [1994] Caring and Nursing: a dilemma. Journal of Advanced Nursing 20, 444 - 449.

Rees, S. [1995] The fraud and the fiction. In S. Rees, & G. Rodley [Eds.], <u>The human costs of managerialism</u> [pp. 14-27]. Sydney: Pluto Press Australia.

The Coalition Policy Document on Healthcare: <u>Guidelines for Providers.</u> [1997]

Stoddard, D., Jarvenpaa, S.L. & Littlejohn, M. [1996] The reality of business reengineering: Pacific Bell's centre provisioning process. <u>California Management Review,</u> vol 38, no 3, pp 57-76.

The Coalition Policy Document on Healthcare: <u>Guidelines for Providers.</u> [1997]