



Development of Community Nursing and Allied Health Services – Including Capital Support

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February 2007

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Introduction & Background

In 2002 the Ministry of Health released the 'Health of Older People Strategy'. In C&C DHB the major programme of work that developed as a response to this was the Integrated Home and Community Care programme. This programme was designed and progressively implemented through a consultative process that started in 2003 including, but not limited to:

- Consumer advisory and focus groups held during 2003/04
- Combined service development groups held during 2003/04
- Initial staff representative presentation (early stages of model development)
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- Full public consultation during 2004
- Staff/staff representative pre release consultation
- Public forums for submissions – written/oral
- Involvement of DHB senior management (Integrated Care Steering Group) in approving and finalising the model subsequent to public consultation
- Final approval through C&C DHB Board and DSAC committees
- Staff/staff representative presentations post Board decision presentations
- Communications and presentations of model to numerous groups – PHOs, community groups etc
- Communications, presentations, newsletters on an ongoing basis e.g. Integrated care newsletter, CCC communiqué

The Implementation of the model commenced in 2004 and has been ongoing for the past two years. Thus C&C DHB is currently in a 'transition phase' from the 'traditional' model of home and community services to a more integrated model. This phase also relates to the original consultation document where the following was noted on page 29:

In future we expect the new arrangements will allow us to develop services that prevent or reduce the need for acute hospital care and delay entry to residential care. Other options being considered for future development include:

- Rapid response teams
- Hospital in the home
- Enhanced primary care
- Home support services and/or residential services that have a slow stream rehabilitation component and emphasis

Through the Integrated Home and Community Care programme, C&C DHB has commissioned and established a new model for home and community services. Some of the key elements of this model are:

- Care Manager service
- Care Coordination Centre
- Developing more flexible home and community services including nursing, allied health, restorative home based 'packages of care'

- Development of a single assessment process supported by the roll out of the InterRAI MDS suite of tools.

The model as a whole follows international trends towards more integrated services.

During the 'Integrated Home and Community' public consultation a key principle was to establish the right mix of providers for home and community based services. This noted that future providers may include a combination of primary and community care providers, the hospital and others and could involve tender processes.

The restorative support component within the packages is delivered based on a support plan developed from an InterRAI assessment and the consumer's goals. It is delivered by trained support workers who are supervised by registered health professionals as part of a multidisciplinary team. The registered health professional also maintains oversight of the consumer and regularly reviews the support plan. The approach is flexible, responding to changes the consumer makes as they regain function.

With the introduction of the care coordination services and through the packages of care approach, C&C DHB has now developed a new way to contract and deliver home and community services that under pins the integrated model.

Note that linked initiatives to this are the ongoing implementation of the 2004 Palliative Care review and the Supporting Carers project.

Strategic Alignment

This initiative is linked to and incorporates the development of the 2006/07 DAP initiatives noted in sections 2.3.1 and 2.4.4 as per the tables below.

2.3.1

What	Embed the restorative 'package approach' to home and community services.
Who	Manager Aged Care & Disability
How	◆ Continue to increase the 'package approach' to home and community services.
When	Quarters 1-4 ◆ Increase the expenditure on packages, increase capacity of community providers to provide packages.

2.4.4

What	Repositioning of community health nursing and community therapies to achieve the appropriate balance between community and DHB provision.
Who	Director Integrated Care
How	Develop and implement a plan to achieve an optimal balance for ownership of community nursing and allied health services between C&C DHB and the community and primary care sector Use the restorative 'package approach' in a planned, staged and managed way. Ensure planning covers off risk to after hours service delivery and potential fragmentation of specialist and training services.
When	Quarter 1: <ul style="list-style-type: none"> ◆ Scope, develop draft plan Quarter 2-Quarter 3: <ul style="list-style-type: none"> ◆ Consult and finalise Quarter 4: <ul style="list-style-type: none"> ◆ Commence transition of services.

Governance

Lead committee: Community & Public Health Advisory Committee
Sponsor: Chief Operating Officer/ Director of Quality and Integrated Care

Funding & contracting responsibility: Director Planning & Funding
Joint planning responsibility: Chief Operating Officer/ Director of Quality and Integrated Care, Director Planning & Funding
Project Management: Integration & Change team
Working group: HHS/ Hospice/ NZNO/ PSA/ Package Providers/ Primary Care/ CCC /Planning & Funding
 To develop options for development/consultation

Contracting to establish services - Health of Older People Team

Principles for next phase of development

- Integrate service provision, processes and funding across C&C DHB and with ACC/WINZ
 - Development of services and processes will support care pathways/programmes for clients with similar characteristics and who follow similar processes/patterns eg supporting admission avoidance and discharge pathways
 - Community and Primary and care will be viewed as the first and main point of contact, providing a more comprehensive range of quality services for clients and their carers, that:
 - Are flexible and accessible
 - Focus on prevention, supporting chronic care and palliative approaches to care
 - Minimise avoidable admissions (acute and residential)
 - Hospital services will support, through advice, education, consultation and liaison, the provision of quality community based care services by primary & NGO providers
 - Workforce development will draw from national workforce programmes (Future workforce) and current C&C DHB programmes eg secondary and primary nursing workforce development. Workforce development will focus on:
 - Supporting chronic care
 - palliative approaches to care
- through:
- clinical role expansion
 - sustaining community support worker development
- Partnership arrangements will be supported and developed

Future Givens

There are some givens in terms of the future development of this model:

- The Care Coordination Centre is the central point of budgetary oversight, the single point of entry for the majority of services and the service that provides oversight and access to an increasing menu of home and community services.
- The 'package' approach, (which includes funding, contracting, service delivery and supporting processes), is seen as the model of service delivery that will best meet the future needs of many people requiring home based services in the community.
- C&C DHB will grow and extend home and community services to achieve the appropriate balance between primary/community and DHB service provision. More comprehensive 'packages' of care will develop through this process and will include chronic care support, after hours care and support the community model of palliative care
- C&C DHB will seek proposals as part of ensuring the best quality and flexibility of services/providers
- C&C DHB will continue to progress single assessment process (InterRAI) using C&C DHB supported tools and processes.
- Careful consideration is required for services that; support a secondary specialty or clinic, require specific 'high end' or unique products and specific protocols to be used or followed, by nature are small and require a critical

mass of staff and volumes to maintain expertise i.e. stoma care/oxygen, IV therapy.

- Any changes will occur in a phased and controlled approach and standard management of change protocols will be followed.
- Electronic Health Record will be used wherever possible as the basis for clinical records

Directly Affected Services

The directly affected services are the HHS based Community Nursing, Community Allied Health services and Capital Support Needs Assessment service.

Phase 1 (February to April). Development of options paper for consultation with affected services

Output from this phase will be:

- Completed initial communications as per change management protocol
- A small options paper for consultation with affected services and providers/PHOs.
- Summary of responses against options
- Decision for preferred direction – Chief Operating Officer/ Director of Quality and Integrated Care, Director Planning & Funding

Process

Four workshops will be held with a small working group, based around a set of questions and scenarios. Recommendations will be used where appropriate from Future Delivery of Community Based Health and Care Services (Benedict Hefford, November 2006) paper to guide discussion. Comments received in response to the paper will be circulated and those made by the C&C DHB Board and DSAC/CHPAC.

It is anticipated that this working group will have representation from Hospital and Health Services, NZNO, PSA, Hospice Services, Package of care Providers, Primary Care, Care Coordination Centre and Planning & Funding.

1st workshop:

Reflect on programme to date, original aims, progress to date, confirm principles, givens, review the Future Delivery of Community Based Health and Care paper and feedback received. Any constraints? Purpose of workshops i.e. Produce an options document.

2nd workshop:

What 'fits' in the package approach, what type of packages/pathways/programmes could be developed? What would work well for general palliative care services and after hours? What could we do to integrate processes, planning and service delivery more, for example discharge coordination?

3rd workshop:

How would we get closer integration with primary care and after hours? How can we integrate chronic care support more into the model?

4th workshop:

How do we support and share the development of quality and safety across providers? What could we gain by taking a DHB-wide approach, if so how could we do that?

Workforce development? What skill sets and competencies should a clinician and community support worker have in the future? What types of roles could be developed to support development of the model? What are the priorities? What is available now to build on? What could we gain by taking a DHB-wide approach, if so how could we do that?

Following consultation (mainly with directly affected services) an options paper will be submitted to Chief Operating Officer/ Director of Quality and Integrated Care, Director Planning & Funding for decision on preferred directions.

Phase 2 (May) - Service planning & specification

Outputs

- **Service specifications**
- **Relevant Board and committee papers**

Process

- **Analysis, modeling & specification**
- **Development and approval of service specification(s)**

Phase 3 (June/July onwards) – Development path

Timeline and plans to be developed.

Working Group – TOR

TERMS OF REFERENCE – Community Nursing and Allied Health services Working Group	
Objectives	To provide the Chief Operating Officer/Director of Quality and Integrated Care, Director Planning & Funding with an appraisal of the options available to further develop services and processes in line with the Integrated Home and Community Care programme and the recent ‘Future Community Health and Care Services’ discussion document.
Expected out puts	An options paper for consultation with predominantly with directly affected staff and services that builds on current strategies to: <ul style="list-style-type: none"> • Continue to improve the integration of primary, secondary, community services • Develop effective partnerships and networks between providers • Build capacity of consumers, communities, and providers
Accountability	The working/reference Group is accountable to the Chief operating Officer/Director of Integrated Care and Quality
Communication processes	Communications related to the working/reference Group activities will be through the Project Manager, unless agreed otherwise
Meetings	Four workshops will be held to discuss and develop options to be scheduled through February / March 2007
Constraints & Challenges	The planning process will need to focus on key issues developed through the four workshops and will assume that any options developed will be established through current DHB funding and planning processes.