

# *Next Steps* - Integrated Home and Community Care

## *Supporting Document to the Options Paper*

PROPOSAL FOR  
DEVELOPING COMMUNITY NURSING AND ALLIED HEALTH  
SERVICES IN CAPITAL & COAST DISTRICT

---

*Developing Community Focused Integrated Care Teams*

OCTOBER 2007

## DOCUMENT HISTORY

VERSION NUMBER	CHANGES MADE	DATE
1.0	Released to CPHAC	16/08/2007
2.0	Released to the Board	03/10/2007
3.0	Released for print on website (sections 3.1, 3.2, 3.3 and Appendix 1 some information withheld to maintain confidentiality)	25/10/2007

## Abbreviations used in this document:

ACC	Accident and Compensation Corporation
AT&R	Assessment Treatment and Rehabilitation. This is a hospital based service comprising of multi disciplinary teams that provide rehabilitation for people following an injury or disease.
A&E	Accident and Emergency
C&C DHB	Capital and Coast District Health Board
CCC	Capital and Coast Care Coordination Centre
CHF	Congestive Heart Failure
CHS	Community Health Services. This is the hospital based service that provides community nursing, some home care and community therapies.
COPD	Chronic Obstructive Pulmonary Disease
CPHAC	Community and Public Advisory Committee
DAP	District Annual Plan
DHB	District Health Board
DSAC	Disability Services Advisory Committee
DSP	District Strategic Plan
ED	Emergency Department
FTE	Full Time Equivalent
HHS	Hospital and Health Services
MECA	Multiple Employment Collective Agreement
MDT	Multi Disciplinary Team. They are a mixture of nurses, doctors and therapists for example physiotherapist, occupational therapist, dietician.
NASC	Needs Assessment Service Coordination. In this district this is the Capital Support which is part of the hospital based in Porirua. It assess people for their disability related needs and organises relevant services for people who are under 65 and have a life long disability to support them at home.
NGO	Non Government Organisations
NZNO	New Zealand Nurses Organisation
PHO	Primary Health Organisations
PSA	New Zealand Public Service Association
PVS	Price Volume Schedule
SWOT	Strengths, Weaknesses, Opportunities and Threat
TLA	Territorial Local Authority
WINZ	Work and Income New Zealand

## Acknowledgements

This document was compiled with the help from the following people.

Data supplied by:            Pirom Tawngdee (C&C DHB)  
    Steve Newby (C&C DHB)  
    Kit Wong (C&C DHB)  
    Capital and Coast Care Coordination Centre

## TABLE OF CONTENTS

<b>1. PURPOSE OF DOCUMENT.....</b>	<b>5</b>
<b>2. PROFILE OF OUR CURRENT SERVICES.....</b>	<b>6</b>
2.1. COMMUNITY HEALTH SERVICES.....	6
2.1.1. CHS SERVICES.....	6
2.1.2. CHS LOCATION.....	7
2.1.3. CHS HOURS OF SERVICE.....	7
2.1.4. CHS MODEL OF SERVICE.....	7
2.2. ALLIED HEALTH SERVICES (THERAPIES) .....	7
2.2.1. THERAPIES SERVICES .....	7
2.2.2. COMMUNITY THERAPIES LOCATION .....	8
2.2.3. COMMUNITY THERAPIES HOURS OF SERVICE.....	8
2.2.4. COMMUNITY THERAPIES MODEL OF SERVICE.....	8
2.3. OTHER HOME AND COMMUNITY BASED SERVICES.....	8
2.4. CURRENT PROCESS AND FLOWS.....	9
2.5. SERVICE DESCRIPTIONS .....	10
<b>3. BACKGROUND ANALYSIS .....</b>	<b>12</b>
3.1. LEVEL OF FUNDING.....	12
3.2. STAFF DETAILS.....	12
3.3. CURRENT FINANCIAL PERFORMANCE .....	12
3.4. REFERRAL PATTERNS.....	12
3.5. SERVICE UTILISATION.....	14
<b>4. APPENDIX 1 - FEEDBACK ON DISCUSSION DOCUMENT “FUTURE OF HOME      COMMUNITY CARE” .....</b>	<b>16</b>
<b>5. APPENDIX 2 - SUMMARY OF WORKSHOP DISCUSSION.....</b>	<b>22</b>
<b>6. APPENDIX 3 – INTEGRATED HOME AND COMMUNITY CARE MONITORING AND      EVALUATION PLAN.....</b>	<b>40</b>
<b>7. APPENDIX 4 – BOARD AND COMMITTEE MINUTES ON ORIGINAL INTEGRATED      HOME AND COMMUNITY CONSULTATION .....</b>	<b>44</b>

## TABLE OF FIGURES

<i>Figure 1: Mix of HHS and other home and community care providers .....</i>	<i>9</i>
<i>Figure 2: Referral Patterns through CCC.....</i>	<i>12</i>
<i>Figure 3: Referral patterns through CCC by TLA.....</i>	<i>12</i>
<i>Figures 4: Referral Patterns and client contacts through CHS &amp; Therapies .....</i>	<i>13</i>
<i>Figure 5: CHS Referral patterns by Ethnicity by TLA .....</i>	<i>13</i>
<i>Figure 6: Client ethnicity by TLA and district.....</i>	<i>13</i>
<i>Figure 7: Utilisation of CHS one or more services .....</i>	<i>14</i>
<i>Figure 8: Top 7 combinations of three or more services accessed .....</i>	<i>14</i>
<i>Figure 9: Top 7 combinations of two or more services accessed.....</i>	<i>15</i>

## **1. PURPOSE OF DOCUMENT**

This document provides supporting information for the draft options paper on developing community nursing and allied health services.

Information included in this section should be read in conjunction with the options paper as it relates to relevant and detailed information that has been used to develop the options paper for the CPHAC and C&C DHB board.

## **2. PROFILE OF OUR CURRENT SERVICES**

Home and community health services are currently delivered through a mix of NGO providers and the Hospital and Health Services.

The C&C DHB provider arm (otherwise known as Hospital and Health Services or HHS) provides community health services through its Allied Health Services (Therapists) and Community Health Services.

### **2.1. COMMUNITY HEALTH SERVICES**

Capital and Coast Community Health Services (CHS) along with the Capital and Coast Therapies Service, provide home support services to patients living in their own community. Patients require acute, short and long term care and palliative care in the home setting. A broad range of competencies is required to respond to patients who are critically ill, dying, post-acute, frail, disabled or rehabilitating.

CHS provides a collaborative practice model in which specialist nurses work along side generalist district nurses. The district nurses work exclusively in the community while the specialist nurses work across both the community and inpatient settings facilitating the continuum of care.

An initial assessment is made in the home where the nurse determines and negotiates with the client (and carer), the best plan of care to meet their needs. Clients who require complex assessment may initially be assessed by a Care Manager from the Care Coordination Centre using the InterRAI-MDS tool.

#### **2.1.1. CHS Services**

Services provided by the district nurses include:

- Acute nursing care following hospital discharge
- Assessment and treatment of complex and chronic wounds
- Home Intravenous Therapy
- Palliative care services
- Personal Care services (through Health Care Assistants)
- Enuresis programme
- Stoma therapy
- Continence management
- Domiciliary Oxygen
- Pulmonary rehabilitation programme (led by respiratory nurse)
- Continence, stoma and oxygen consumables supply services

Services provided by the specialist nurses include:

- Breast nurse services
- Oncology nursing services including home based chemotherapy
- Respiratory nursing services
- Stoma therapy
- Continence management

Clinics are also provided at each base for individual clients (e.g. wound, stoma, and enuresis). Clinics are usually open in the morning and weekends prior to the nurse visits to patients in the community.

Community Health consumables are managed through materials management services.

Mary Potter Hospice also provides palliative care coordination services along with CHS district nurses.

Following are the internal linkages that will need to be maintained with any change introduced. They are primarily related to the specialist nursing services provided by the CHS.

- Capital Support to facilitate linkages in care delivery for those who have a life long disability and are less than 65 years of age.
- Capital and Coast Rehab services with input from AT&R specialist services.
- Child Health Service for the delivery of specialist services for 0-15 year age group.
- Medical services and infectious disease for IV.
- Respiratory physicians and physiotherapists in relation to pulmonary rehabilitation and patients requiring specialised respiratory nursing services.
- Surgical services for Stoma patients requiring specialised stoma nursing services.
- Wellington Blood and Cancer Centre to facilitate shared care between the centre and the community cancer/ oncology nurses for patients requiring oncology district nursing services and plans for future changes in relation to cancer care in the community.

CHS estimates 18% of its service delivery relates to ACC funded services.

#### **2.1.2. CHS Location**

There are three bases for the CHS, Wellington, Keneperu and Kapiti.

#### **2.1.3. CHS Hours of Service**

Service hours are currently 8:00 hours to 16:30 Monday to Friday. Reduced services are available in the evening (until 22:00) and the weekends between the hours of 08:00 and 22:00. An on-call nursing service is available between the hours of 22:00 and 08:00 for patients who already receive district nursing services.

#### **2.1.4. CHS Model of Service**

CHS describes its model of services as a collaborative practice model in which specialty nurses work along side generalist district nursing services.

The introduction of the Integrated Home and Community Care Service model has influenced changes to the referral process of CHS. However there have been no changes to the models of service delivery as the systems, funding and structures of the service have not changed.

At an individual nurse/ health professional's level there is an emphasis and recognition of effective care. However the service model reflects an acute care model where it is disease-centred, symptom driven, hospital/specialty based with a focus on individual patient needs.

There has been a lack of investment in the community health service that has led to a poorly supported service with no clear vision that links with the agreed Integrated Home and Community Care programme.

## **2.2. ALLIED HEALTH SERVICES (THERAPIES)**

For purpose of this report the allied health service group that is included is the community therapies services

### **2.2.1. Therapies Services**

Therapies comprises of following five allied health disciplines:

- Dietetics
- Occupational Therapy
- Physiotherapy
- Social Work
- Speech Language Therapy

Services provided are assessment, treatment and intervention in inpatient, outpatient and community settings. This report considers the 'community setting' component of the service. Therapies services also include assessment for housing modification, complex wheelchair setting, equipment assessment, younger person rehabilitation, palliative care, disability management and community education.

Key linkages for the service include:

- Inpatient therapies
- AT&R
- CHS and other community providers
- Capital Support
- Mary Potter Hospice
- ACC
- Care Coordination Centre

Assessments for short term equipment loans e.g. walking frames, crutches, drip stands are usually completed as part of the clinical process and are provided from the centrally managed short term equipment pool based at Wellington & Kenepuru. Short term loan forms are completed and equipment management is managed through a materials management system. Replenishment of local stocks of equipment, e.g. A&E or therapies for frames etc, occurs as required. Stock is returned to the central store for cleaning etc from several 'drop off' sites.

Assessments for long term equipment have to be completed by accredited assessors and are managed through ENABLE. For equipment this may require a second assessment to be completed and additional visits to replace short term hospital pool equipment with long term equipment (a lot of times of the same make and model) by HHS and ENABLE personnel.

### **2.2.2. Community Therapies Location**

The service is co-located with the CHS team in all three bases Wellington, Kenepuru and Kapiti.

### **2.2.3. Community Therapies Hours of Service**

Community Therapies hours of service are Monday to Friday from 08:00 to 16:30.

### **2.2.4. Community Therapies Model of Service**

The service is operated in a multi disciplinary team, which is co-located with the CHS in all three bases. The community therapy service is resourced by a very small team (see background information section). The service has an underlying philosophy of team approach.

## **2.3. OTHER HOME AND COMMUNITY BASED SERVICES**

C&C DHB has a number of NGO community providers including three packages of care providers and Mary Potter Hospice who provide a range of home and community care services.

There are seven PHOs in the Capital and Coast region and they provide a range of primary and community health services (see section 2.2)

## 2.4. CURRENT PROCESS AND FLOWS

The majority of referrals for home and community based services are sent to the Care Coordination Centre where they are screened and forwarded onto the relevant service. The CCC receives up to 120 referrals a day; with referral sources for the majority of the services from primary and community care (see referral pattern figures in background information section)

On receipt of referral from the Care Coordination Centre, each provider opens appropriate events on their client management systems and closes them on completion of service (HHS uses IBA and is awaiting implementation of the community health module). Individual services arrange appointments with clients.

Notification is then sent to the Care Coordination Centre when service provision has finished. This may not happen on all occasions with HHS services but does for NGO providers as this is linked to their payment. The Care Coordination Centre manages invoice validation for payment for those services contracted through the package of care approach. Payment for HHS services is managed through the Price Volume Schedule (PVS).

The table below shows the current services provided by a mix of HHS and other providers based on service type.

Service	Provider			
	HHS	NGO	PHO	Enable
Allied Health Out-patients (excludes women's health)	<input checked="" type="checkbox"/>			
PUVA	<input checked="" type="checkbox"/>			
Short term <ul style="list-style-type: none"> <li>- District Nursing including palliative, home oxygen, IV, enuresis</li> <li>- Short term community personal care</li> <li>- Allied health (community therapist)</li> </ul>	<input checked="" type="checkbox"/>			
Specialist nursing including <ul style="list-style-type: none"> <li>• Oncology</li> <li>• Stoma Service</li> <li>• Continence</li> <li>• Respiratory</li> <li>• Breast care</li> </ul>	<input checked="" type="checkbox"/>			
Package of care approach (nursing, home support, allied health)		<input checked="" type="checkbox"/>		
Long term home support/personal care (transitioning to package of care 06-08)		<input checked="" type="checkbox"/>		
Primary care based clinic including some chronic care programmes			<input checked="" type="checkbox"/>	
Short term Equipment management	<input checked="" type="checkbox"/>			
Long term equipment management				<input checked="" type="checkbox"/>

**Figure 1: Mix of HHS and other home and community care providers**

## 2.5. SERVICE DESCRIPTIONS

Following table provides the service descriptions.

Service	Notes
Specialist Community Allied Health	<p>Funding: Personal Health</p> <p>Service: Full range of professional inputs from: Physiotherapy, Occupational Therapy, Social Work, Speech Therapy, Dietetics</p> <p>Referral by medical practitioner, qualified nurse/allied health, NASC and self referral.</p>
Community Nursing Including: Home IV Therapy Specialist wound service	<p>Funding: Personal Health</p> <p>Services: include generalist nursing and specialist nursing including complex wound care including IV therapy and enteral therapy. People with palliative care needs (where these patients do not meet the criteria for entry into the specialist palliative care service i.e. they do not need specialist symptom control) and those with tracheotomies or gastrostomies</p> <p>Referrals: By medical practitioner, a practice nurse, or other appropriate health professional. Clients referred for IV therapy require must be referred by a specialist physician or surgeon.</p> <p>Exclusions: Clients resident in a rest home or continuing care hospital, unless their personal health need has arisen as a result of recent major surgery.</p>
Home O2 Therapy	<p>Funding: Personal Health</p> <p>Services: for chronic respiratory insufficiency as identified by a respiratory/ designated Physician only. Can include therapy for clients with cardiac insufficiency resulting in prolonged hypoxia.</p> <p>Referrals: by respiratory/ designated Physician</p> <p>Exclusions: If clients are receiving short-term therapy oxygen following an acute inpatient episode where the inpatient service is currently responsible for the patient's oxygen</p>
Incontinence Services	<p>Funding: Personal Health</p> <p>Services: Provided for clients who have a demonstrated urinary or faecal incontinence that affects daily living and who are not being seen as part of an integral part of a medical specialist clinic.</p> <p>Referrals: Referral by a primary medical practitioner, a practice nurse or appropriate health professional, if the client has a six month history of ongoing continence problems which have been unresponsive to treatment on specialist medical referral for an acute medical or surgical incontinence problem on self-referral if the person meets eligibility criteria.</p>

	<p>Exclusions: Those being seen as part of a specialist medical clinic specialist symptom management for a progressive terminal illness, from which they are reasonably expected to die within twelve months.</p>
Stomal services	<p>Funding: Personal Health</p> <p>Services: Provided post-operatively for those people who already have a stoma, which is either temporary or permanent or pre-operatively, for those people with a potential for ostomy following surgery when the services do not form an integral part of a medical specialist clinic.</p> <p>Referrals: A medical practitioner or a stoma therapist may refer clients to the service. Clients who have a stoma arising from a colostomy, ileostomy or urostomy operation can self refer.</p> <p>Exclusions: Clients who are being seen as part of an integrated service from a medical specialist clinic.</p>
Home help personal cares	<p>Funding: Personal Health</p> <p>Personal care: Assistance with activities of daily living e.g. washing, dressing, feeding</p> <p>Home help: Assistance with household tasks e.g. cleaning, shopping</p> <p>Referred by: medical/surgical specialist service, general practitioners, other health professionals and Needs Assessment and Service Coordination (NASC) and CCC agencies. Self-referral for assessment may also occur.</p>
Meals on wheels	<p>Funding: Personal Health</p> <p>Service: prepare and deliver hot meals to people living at home, and who, because of their age, illness or disability, are unable to prepare their own meals and thus maintain their nutritional status.</p> <p>Referral: Can be from primary care, secondary care or self referral Needs Assessment Service Coordination service (NASC) or CCC</p>
Palliative care - community	<p>Funding Personal Health</p> <p>Service: This service is the domiciliary non-medical part of the New Zealand Palliative Care Strategy (2001) provided in the community through nursing and allied health staff. It is the active care of people with advanced, progressive disease which is no longer responsive to curative treatment, and whose death is likely within 12 months. Can include end stage organ failure and HIV/AIDS.</p> <p>Referrals: By hospital-based specialist palliative care service or a general practitioner</p> <p>Exclusions: People receiving domiciliary palliative services from a hospice. Those in residential care are limited to assessment only.</p>
Note: mental health funded service descriptions not included.	

### 3. BACKGROUND ANALYSIS

#### 3.1. LEVEL OF FUNDING

Section removed

#### 3.2. STAFF DETAILS

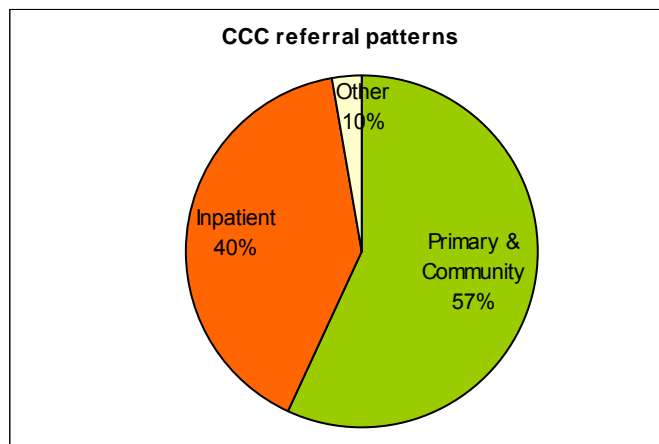
Section removed

#### 3.3. CURRENT FINANCIAL PERFORMANCE

Section removed.

#### 3.4. REFERRAL PATTERNS

Nearly 60% of the referrals received through the Care Coordination Centre are from Community and Primary Care referrers with 40% relating to hospital and health facilities.



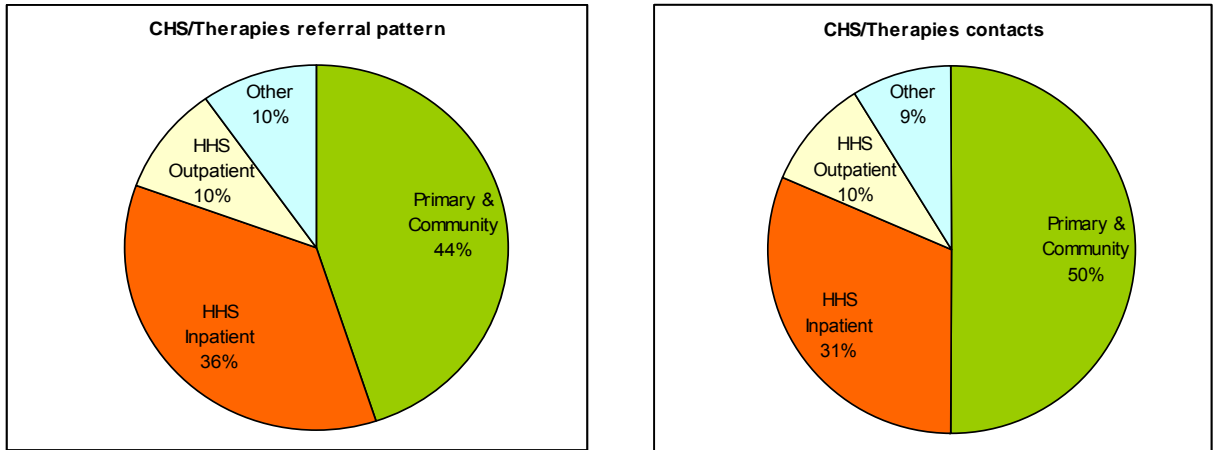
**Figure 2: Referral Patterns through CCC**

Half of the referrals received through the Care Coordination Centre are for clients domicile in Wellington, 32% relate to Kapiti and 16% relate to Porirua regions. Referrals received in relation to Kapiti clients have a higher proportion (63%) through primary and community care referrers which is expected given the population demographics and facilities available.

CCC referral (01 Sep 05 - 17 Mar 07)	Primary & Community			Total	%
	Inpatient	Other			
Kapiti Coast District	4,714	2,685	179	7,578	32%
Porirua City	1,937	1,642	97	3,676	16%
Wellington City	6,640	5,097	363	12,100	52%
<b>CCDHB Total</b>	<b>13,291</b>	<b>9,424</b>	<b>639</b>	<b>23,354</b>	<b>100%</b>
%	57%	40%	3%	100%	

**Figure 3: Referral patterns through CCC by TLA**

The following two graphs relate to referrals and clients contacts through the Community Health Services and Therapies. While the referrals received from primary and community care services is at 44%, the actual client visits in relation to the referrals source being primary and community care services is 50%.

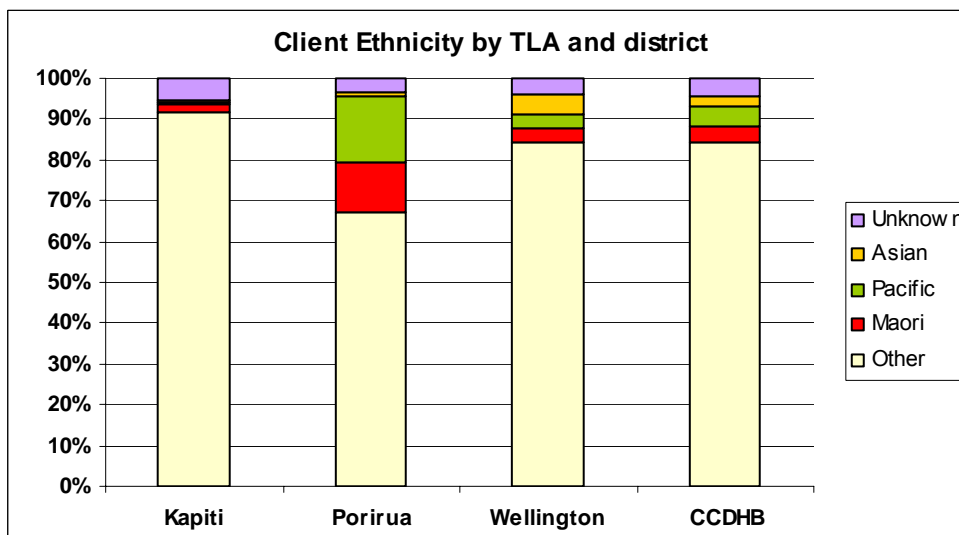


**Figures 4: Referral Patterns and client contacts through CHS & Therapies**

The following table shows the ethnicity as identified by the client referred through the Care Coordination Centre. These relate to all age group except younger persons with life long disability. Porirua region has a higher Maori and Pacific people. Majority of the people under 'Other' are NZ European.

CCC Ethnicity	Asian	Maori	Other	Pacific	Unknown	Total
Kapiti	0%	2%	92%	0%	6%	100%
Porirua	1%	12%	67%	16%	3%	100%
Wellington	5%	3%	85%	4%	4%	100%
CCDHB	3%	4%	84%	5%	4%	100%

**Figure 5: CHS Referral patterns by Ethnicity by TLA**



**Figure 6: Client ethnicity by TLA and district**

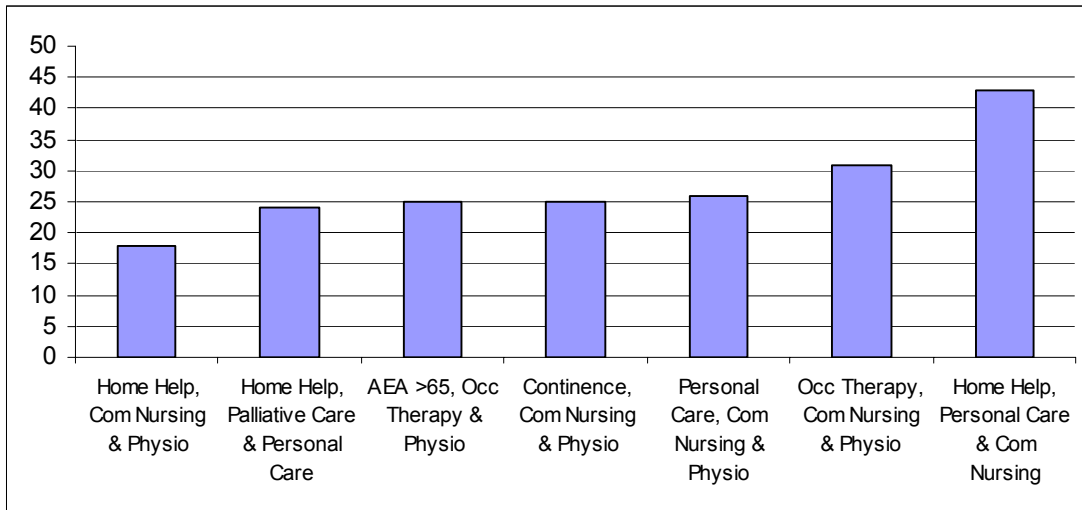
### 3.5. SERVICE UTILISATION

This section provides information on C&C DHB community health services utilisation by clients over 50 years of age. Over 42% of the clients receive more than two services and 18.8% receive three or more services.

Utilisation of HHS Community Services 50+ Age Group		
No. of services utilised	Number of Clients	Percent of Total Clients
1 Service	2,538	57.7%
2 Services	1,033	23.5%
3 Services	513	11.7%
4 Services	198	4.5%
5 Services	79	1.8%
6 Services	29	0.7%
7 Services	7	0.2%
	<b>4,397</b>	<b>100.0%</b>
2 or more services	1,859	42.3%
3 or more services	826	18.8%

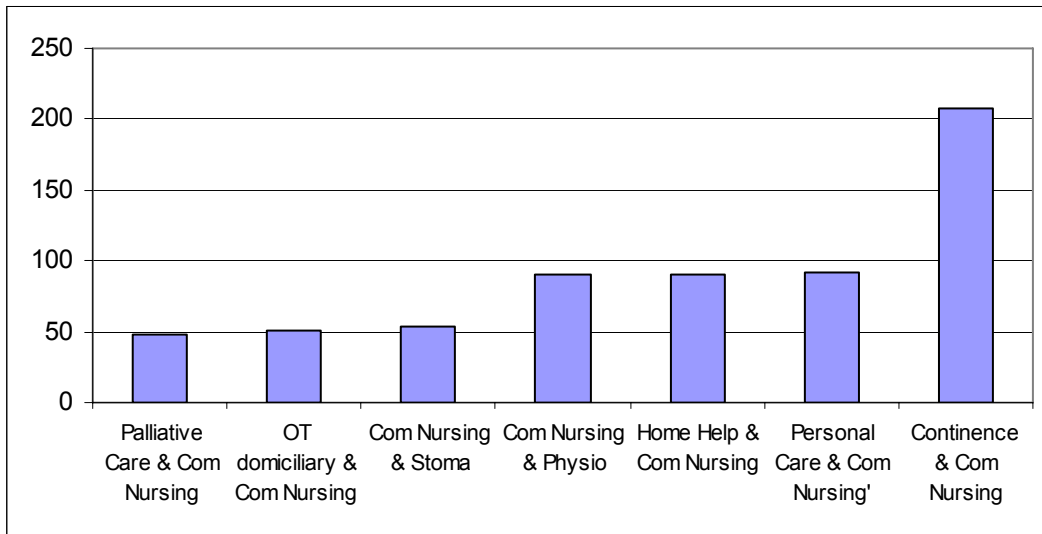
**Figure 7: Utilisation of CHS one or more services**

Following graph shows the top seven mixes of services that people who receive three or more services. Most number of clients receives a combination of community nursing, personal care and home help.



**Figure 8: Top 7 combinations of three or more services accessed**

Following graph shows the top seven mixes of services that people who receive two or more services. Most number of clients receives a combination of community nursing and continence followed by community nursing and personal care service combinations.



**Figure 9: Top 7 combinations of two or more services accessed**

#### 4. APPENDIX 1 - FEEDBACK ON DISCUSSION DOCUMENT “FUTURE OF HOME COMMUNITY CARE”

##### SUMMARY

In all 8 items of feedback were received in relation to the discussion paper.

- 3 were from sub-board committees
- 2 were from primary care practitioners
- 1 was from a community nurse
- 1 from Primary care management services on behalf of three PHOs
- 1 was from a secondary care nurse (in response to the recommendation that the Patient Care Coordination Service should be moved to be delivered from the Capital & Coast Care Coordination Centre – note that this recommendation is excluded from the project).

The feedback (anonymous) is included as full below.

##### 1) CPHAC minutes.

[http://www.ccdhb.org.nz/Meetings/CPHACpapers/2007\\_03\\_15/Final\\_Draft\\_CPHACmins\\_14December06pub.pdf](http://www.ccdhb.org.nz/Meetings/CPHACpapers/2007_03_15/Final_Draft_CPHACmins_14December06pub.pdf)

The Committee resolved to recommend that the Board:

1. Note the contents of the report.
2. Note that the report is being forwarded to interested parties for discussion.
3. Note that the report will form the basis of engagement with key stakeholders regarding further development of community based health and care services in the new calendar year.
4. Note that engagement will follow a consultative process of design and analysis and will report back to the C&C DHB Board towards the end of 06/07 with options for approval.
5. Note that CPHAC members can provide feedback to the project manager for use in the development of the project.
6. Requested that this topic be referred to the CPHAC meeting in March when PHOs are on the agenda, enabling the committee to hear about the cross links with health system changes.

The Committee resolved to recommend to the Board that it note that CPHAC supports the over-riding paradigm shift that this paper purports which is a reversal of the current situation. The suggested end-state would put primary and community care providers at the centre of service provision and community wellbeing.

The Committee discussed the paper and made the following points:

1. The development of community support workers is essential.
2. There is disparity regarding family members who are registered nurses or those qualified in health care that do not get paid, whereas someone who is less qualified can be brought in as a provider and does get paid.
3. Ethnic and minority communities who may have high health needs may not have much background information on available services, nor the organised structures to address this. The Board is currently reviewing the Community Engagement policy for the whole organisation and this will be taken into

account.

4. The flow chart could use Maori, Pacific and low income families as an example and assess the impact on these groups.
5. Chronic illness is a growing issue and needs to be addressed and incorporated in the overall plan.
6. Need to look at needs of consumers through the whole life cycle from birth through to the end of life.
7. The model provides progress in the ability to measure how our services meet the needs of our community.

## **2) DSAC Minutes**

([http://www.ccdhb.org.nz/Meetings/DSACpapers/2007\\_03\\_13/Final\\_Draft\\_DSAC\\_mins12Dec2006.pdf](http://www.ccdhb.org.nz/Meetings/DSACpapers/2007_03_13/Final_Draft_DSAC_mins12Dec2006.pdf))

The Committee recommended that the Board:

1. Note that DSAC has discussed the paper and benefited from the excellent comments from Margaret Guthrie. Margaret's comments are to be included as an information only paper.
2. Note that the report is being forwarded to interested parties for discussion.
3. Propose that the C&C DHB Board and committees' comments and suggestions can be most effectively incorporated into this process by the officials using the material in preparing the next version of this paper.

The Committee highlighted the need for clarifying and strengthening the relationships between NGOs and PHOs. In addition workforce issues with respect to those working in the community need to be resolved. Standards setting and contract management is key and we need a staged approach ensuring that what is decided fits into our integrated care model and the need for early diagnosis. A firm plan for what we are going to consult on is required and this will be covered by C&C DHB review of consultation and engagement.

## **3) DSAC Committee Member**

This otherwise forward looking paper is marred by its omissions. In writing that I am aware that it was done in a short time frame while Benedict was back NZ. The logic of the paper is sound, so far as it goes. It is just incomplete, and what is not in it is important if we are to improve well-being as people age and, thereby lessen the impact on both the health services and peoples' lives.

Looking at both the text and the references there is frequent mention of the InterRAI MDS assessment tool but no actual reference to the publication which resulted in its being piloted in five areas of NZ including at C&C DHB's Care Coordination Centre (CCC), namely the NZ Guidelines Group Assessment Processes for Older People, October 2003. Perusal of that Guideline should also have led to some mention of Proactive Assessment with the 'aim of detecting problems at an early stage in order to initiate interventions designed to improve health, reduce disability and functional decline...an improve the older person's quality of life.

Because of the increasing impact of chronic disease on both the health system and the lives of sufferers and their families there is emphasis on improved management, including self management and the centering of care in the primary sector. That is important: but equally important should be simultaneous, parallel efforts to reduce the rates of chronicity. That is why a combination of Proactive Assessment, subsequent follow through and really effective engagement of people affected should also have received direct mention in the paper.

How to engage people effectively has been exercising many, especially as research shows that many who have ongoing diseases, either are diagnosed too late, Or become 'non

compliant'. John Wellingham, until recently Chronic Care Manager at Counties Manakau presented a paper at the November RNZCGP Quality Workshop which showed that 50% were lost to follow up after diagnosis and only 12.5% actually were fully engaged in ongoing treatment. His recent studies in the UK led him to social marketing through 'twilighters' ie; someone who grows up in a low socio-economic area and becomes middle class but does not lose their roots. They are only one step away from the front line people and can connect with them. Another UK initiative stems from a paper by Harry Cayton, 'The Flat-pack Patient'? Creating Health together. Which compares the partnership between manufacturers and buyers of self assembly furniture and patients who create their own health services. Cayton argues that it is not just health systems which need patient engagement, but individuals increasingly want partnership and co-creation of health.

Yes the paper mentions self management but gives no indication that so far we have a great deal to learn about how to really engage people in that process, which should begin much earlier than when people are really ill. In fact, though recent initiatives are due to concern about the impact of chronic ill health, the principles should begin much earlier than when people are really ill, the principles should hopefully one day be applicable from infancy.

Other related work is to be based at the University of Auckland where identification of ways for health providers to stay in contact with aging clients is an effort to identify risk and reduce disability. The Maximising Health for Older People Programme, is a series of projects funded by the Health research Council, designed to look at maintaining the independence of older people, including how Primary care practitioners can stay in contact outside of scheduled visits so that potential problems can be identified and treated early. Dr Ngaire Kerse of the Faculty of Medical and Health sciences is one of those involved with this research which will be underway in early 2007 among practices in both Auckland and Wellington.

The key to effecting real change in these areas may well lie in research within NZ, taking account of our specific cultural solutions, while acknowledging collaborative exchanges between New Zealanders and largely UK based parallel research outcomes.

1 NZGG 2003, Assessment Processes For Older people

2 Wellingham, John, GP Apolo and wai Health, Primary care Advisor Waitemata DHB

3 Cayton, Harry. The Flat pack Patient? Creating Health Together. June 2006. Elsevier Ireland Ltd All Rights Reserved.

**4) Secondary care nurse**

Removed to maintain anonymity

**5) Primary Care Practitioner**

Removed to maintain anonymity

**6) Community Nurse**

Removed to maintain anonymity

**7) Primary Care Practitioner**

Thank you for the opportunity to respond to the document *Future Delivery of Community Based Health and Care Needs*

In interested of time and brevity, I shall highlight my feedback in bullet points

- I agree with the emphasis on moving health care services into the primary health care environment
- I agree this needs a different approach to the use of existing and future workforce

- The strength of primary health care is in its ability to complement the different skill sets; this is implicit in primary health care philosophy. The emphasis on ‘substitution’ within this report is concerning. The implication is that professional groups such as nurses will be required to assume expanded roles, which move into general practitioner medical care delivery.
- Ensuring roles are complementary roles makes better use of both sets of skills than substitution. Nurses are not mini-doctors nor doctors maxi-nurses; both disciplines offer different roles and work best when used together. There is an assumption made in this report there is a nursing workforce ready-and-waiting to take on substitution roles. This is not so. Primary health care nursing is a diminished and not overly well-prepared workforce. It has suffered from no vocational training, limited availability of continuing and higher education and when available, limited financial support (no CTA funding). General Practice being set-up as small business interests has not systematically supported continuing or higher education and many primary health care nurses have been disempowered by the employer-employee relationship (although not exclusively).
- There is a limited focus in the report on Nurse Practitioners and how they might be used and Nurse Practitioners applicants being actively supported by DHBs to ‘grow’ the workforce, however, they too will want to work allied to general practitioners.
- The terms ‘self management’ and ‘self caring’ appear to have been confused in the report. Self management is the promotion of self efficacy which is the belief that one can effectively manage ones long term illness (and has the wider skills to manage it). It is an evidence based construct and is supported by (scripted and validated) self management courses a la Kate Lorig, Stanford University (and the Lorig offshoot used by the NHS - Expert Patient Programme) and run in NZ by Arthritis NZ. Self-management support on the other hand, is provided by a validated Flinders University course for health care professionals to maximise their ability to work effectively with patients and involves the use of standardised assessment and goal setting tools and motivational interviewing. ‘Self care’ in itself is not the end point of self management and gives the impression of cost saving. (The recommendation re Chronic Care Management (CCM) on pg 8 does not reflect the need to make self management and self management support widely available in C&C DHB.)
- The Congestive Health Failure Project is noted within the report. This project has been running for some time by Janet Dunbar and colleagues. It is an excellent programme with robust data collection, excellent patient/family outcomes and integrated palliative care provision for those at end-of-life. It is well overdue to be replicated in other CC&C DHB areas, not just with Congestive Health Failure but with other long term conditions such as Chronic Obstructive Pulmonary Disease (where CCM integrated with palliative care approaches are essential).
- I would dispute that the chronic care management (CCM) programme is as well activated in C&C DHB’s it could be (pg 7). As you will be aware, Wagner’s CCM model<sup>1</sup> incorporates 6 pillars of action. Not all are developed in C & C DHB particularly patient self-management (as discussed), community support and delivery system design. Integration of the community support via the NGO sector is very limited and the PHO structure generally excludes NGOs (should be added to recommendations on new ways of working pg 9). Delivery systems are not making best use of the differing skill sets of health professionals and there is still extremely limited integration of care; it is rare to find secondary specialist input into primary care and there are no contemporaneous electronic records for both sectors
- There continues to be a (funded) disease silo-ed approach and this is demonstrated through the assessment process (pg p8) whereby, for example patients with mental

---

<sup>1</sup> Wagner, E Glasgow, E Davis, C Bonomi, A Provost, L McCulloch, D Carver, P & Sixta C. Quality improvement in chronic illness care: a collaborative approach 2001 J Qual Impr. 27(2)63- 80.

health needs are assessed via a different agency and do not appear to access the same resources.

- Palliative care is not as widely available as is required (*Grow the home and community services* (pg 8). Moving the availability (funding) of palliative care back into the primary care sector would maximise accessibility (see the MidCentral DHB Palliative Care Partnership model).
- Managing change is crucial. Judicious use of PDSA cycles should be added to *Effectively managing the transition*. Also the need to support staff through change should be emphasised. Human resource is the most important resource!

Once again thanks for the opportunity to comment. Please contact me if you wish to discuss this.

## **8) Primary care management services on behalf of three PHOs**

### **Re: Submission on Future Delivery of Community Based Health and Care Services**

Thank you for the opportunity to provide comment on Capital & Coast District Health Board's (CCDHB's) report for "Future Delivery of Community Based Health and Care Services". We would like to congratulate the DHB on the comprehensiveness of the paper presented and its recognition of the importance of the primary health care sector.

#### **1. Grow and extend the scope of the primary & community sector**

- Whilst we endorse the concept of primary health and community care providers being supported to deliver a wider range of community based services, we would expect that the services being delivered were appropriately funded and that funding was maintained at a sustainable level over the longer term.
- It is not clear what the small number of community services to be provided by the HHS would be and why there would be a necessity for this? The patient journey we believe begins and ends in primary care and if the approach to this change is on an in-reach basis to hospital as suggested throughout the report, then all community services should be based in the community
- The need for specialist support to primary care providers was raised at the PHOAG strategic planning workshop held in November 2006 and so we would certainly endorse strengthening/formalising this type of support.

#### **2. Further integrate processes and systems**

- The Care Coordination Centre (CCC) has not yet fully established itself within the community/primary care setting. We have had a recent experience of meeting with care management staff aligned to one of the PHOs who had no idea of what the PHO was or what services it provided? If the service was to be expanded, we would suggest that it needs to first understand its current role and establish the necessary relationships in a way that works for the wider sector. However, we would also like to raise the possibility of incorporating the CCC or at least some of its functions such as care management within primary care/PHOs. This would achieve better integration of primary care services, especially with further development of chronic care management models.
- The interRai tool is currently utilised by the CCC, however, the issue with this tool is that it was designed for those with very high health need and therefore does not adequately assess those who sit outside this relatively small population group. The linkages to the Care Plus wellness assessment process as suggested would need to be carefully considered before any changes were made.
- Discharge planning should be embedded within primary care/PHOs. This would be in line with the concept that the patient journey begins and ends in primary care. PHOs would be

better able to ensure that their enrolled population was linked back into the services required and linked to the CCC's services if appropriate.

### **3. Develop chronic care management programmes**

- The PHOs have responded separately to the DHB's proposed framework for chronic care management/long term conditions via PHOAG.
- This organisation would welcome the opportunity to work closely with the CCDHB and with the PHOs to develop Chronic Disease Management programs which integrate with and build on existing initiatives both in CCDHB and in the Wairarapa and Midcentral DHBs. Both the latter DHBs have recently invested heavily in this area and this organisation is leading the co-ordinated implementation of these programs across all five PHOs. CCDHB also can build on existing successful local initiatives eg PHO Outreach services, Retinal Screening and Care Plus, to further the development in this region. Chronic Disease Information Management tools are important but also need to integrate with existing PMS systems and make use of the skilled information analysis skills in this organisations IM team. They also need to look ahead to the use of telecommunications technology to enable home based self assessment linkages.

### **4. Grow and extend home & community care services**

- We strongly support the further development of restorative and palliative home and community care packages through joint/shared arrangements across NGOs, PHOs and the HHS. We would like to see stronger linkages across the services provided by/objectives of the various organisations and their initiatives, for example, Care Plus wellness goals.
- Primary care has always endorsed the importance of a rapid response for services particularly in an after hours scenario as this has always been a service gap. The use of the paramedic workforce as part of the continuum of care should be explored.

### **5. Enable new ways of working**

- Developing the workforce and using people resources in the most effective ways, as you are aware, is a high priority for PHOs. We would support further development in this area but would support an approach that was inclusive of the professional bodies and education/training agencies, as this we believe is more likely to provide a more sustainable outcome.
- Developing and entrenching "new ways of working" also takes an enormous amount of time, in training, supporting change processes, evaluating impact and implementing subsequent quality improvement approaches. Investment to support this process is very important. Back filling of key leaders to enable them to lead the change is important. We cannot expect real change unless it is recognised as such and resourced appropriately.
- Such development of course would need to take into account the Health Practitioners Competence Assurance Act 2003.

Thank you once again for the opportunity to comment on the future development of community/primary care.

## **5. APPENDIX 2 - SUMMARY OF WORKSHOP DISCUSSION**

### **Background**

C&C DHB has commenced the next steps (2007 onwards) in continuing the development and implementation of our Integrate Home and Community Care programme introduced in 2004/2005.

As outlined in the project approach document (available on [http://www.ccdhb.org.nz/planning/homecommunity/home\\_community.htm](http://www.ccdhb.org.nz/planning/homecommunity/home_community.htm)) a wide sector working party was formed in March to look at the criteria for developing options for the next stages of community nursing and allied health (community therapies) C&C DHB is currently holding workshops with the working party to enable the development of an options paper for consultation.

Detailed notes of the team presentations can be found on the above webpage.

### **Working Party**

The working party consists of 55 participants. This is made up of two union organizers, 31 participants from the C&C DHB community health services (health care assistants, district nurses, specialist oncology, stoma, continence nurses, physiotherapists, occupational therapists, speech therapists, dieticians, social workers and administration staff) 12 from Primary Health Organisations and six other participants (Care Coordination Centre, Mary Potter Hospice, Package of care providers).

### **Meetings and Workshops**

#### Workshop One

Initial meeting was held on 19 March 2007 which focused on the introduction and orientation to the development of community nursing and allied health services. Relevant materials in relation to this project was circulated and a presentation to provide context to the Integrated Home and Community Care programme.

#### Workshop Two

The working party met on 24 April for a workshop. The group was formed into four teams with representation from the wide community health and primary care sector. Four real case scenarios were provided prior to the workshop. The case scenarios included end of life palliative patient, an older persons requiring long term support care, chronic leg ulcer patient, a young diabetes patient. Each team worked through the assigned case scenarios.

All case scenarios identified acute and chronic components, medical and social requirements, myriads of health practitioners involved in the care of the patient with multiple funders, setting and services in place.

There were a number of common themes and concepts that emerged from the workshop groups which could form the basis of options, as related to this project, for potential future development. They are as follows:

### **Common Emerging Themes and Concepts**

- Options for co-location
- Concept of a lead agency
- Care Pathways
- Prompt response service
- General Practice/primary care having the capacity to start early treatment e.g. IV
- Discharge planning

- understanding how allied health's requirement to support secondary in-patient care influences developments
- Case management in primary care setting

The case studies also highlighted the role primary care could play beyond 'normal' general practitioners, for example, the ability to start early treatments at the general practice level which could avoid hospital admissions for short stays.

Other issues discussed at the workshop, (many of which are outside the scope of this project), were around communication, electronic health information, common assessment and care planning, transport and ambulance service, rapid response versus emergency services, access to services after hours, provider capability, capacity and competency.

### Workshop Three

The third workshop focused on formulating concepts from those emerging themes. Following the real case scenarios of workshop in April a set of questions/ requirements was presented in a matrix format for each of the identified groupings of services. The four groupings of identified services were:

- Allied Health: relates to physiotherapy, occupational therapy, speech therapy, dieticians and social work within community therapy services
- Palliative Nursing: relates to palliative aspects as part of district nursing service
- Specialist Nursing: Continence, Stoma, Oncology, Respiratory, Breast Care
- District Nursing: relates to all other aspects of nursing and also consider services provided by health care assistants

The working party met on 22 May for a workshop. The group was formed into four teams with representation from the wide community health and primary care sector. The groups identified the most appropriate concept/ theme for their assigned service and worked through the set of questions and requirements as presented in the matrix. Please see matrix below.

Questions/ Requirements	Ref	A	B	C	D	E	F
Will it support flexibility service delivery? If yes, How? If no, Why?	1	<i>Colocation with primary or community</i>	<i>Develop Care Pathways</i>	<i>Lead Agency</i>	<i>Early treatment in General Practise</i>	<i>Discharge Planning</i>	<i>Rapid Response</i>
Will it support responsive service delivery?	2						
Could it support 24/7 cover and after hour access?	3						
Would this contribute to achieving the best balance between primary/community and secondary care? What do you believe that could be?	4						
Will it streamline current services?	5						
What are the issues that are local specific (Wellington, Keneperu, Kapiti)? Will it address those issues?	6						
What risks are could there be in terms of staff coverage during leave/ holidays? I.e. annual leave, sick leave, stat holidays	7						
Will this support improved continuity of care and communication?	8						
Will it minimize duplication of elements of services?	9						
Will it strengthen and integrate primary care services to patients with chronic illness? Will it support a case management approach in a primary/community care setting?	10						
Green field thoughts	11						

### Summary of Workshop Three group presentations

The following fundamental infrastructure were identified as necessities in formulating option from the emerging themes and concepts

- Competency
- Capacity including 24/7, leave cover, ability to lead and deliver
- Ease of access
- ability to detect issues early
- Multi Disciplinary approach

### Other common discussions related to

- Involvement of multiple providers depending on the patient journey and therefore multiple answers to take including geography
- Electronic Health Record , ability to share good information
- Improved communication and tools of communication
- Prevention of admission
- Care Pathways
- Combined Education

### Workshop Four

This last workshop was dedicated to looking at workforce development and drew from national workforce programmes and current C&C DHB programmes as presented by

- Nursing Workforce by Cheyne Chalmers, Director of Nursing and Midwifery, CCDHB
- Allied Health Workforce by Margaret Sanders, Social Work Advisor, CCDHB
- Unregulated Workforce by Shereen Moloney, Manager Older Persons Health, Planning and Funding, CCDHB

Following the presentations the working group discussed the following three questions in the context of developing community nursing and allied health workforce and taking a sector wide approach,

**Questions One:** What do you believe are the future requirements in terms of ensuring continued service delivery through high quality workforce?

**Questions Two:** What are the workforce initiatives that we can develop in partnership across the sector?

**Questions Three:** How can community nursing and allied health workforce support the development of community support worker roles in delivering a home and community care services?

### Summary of Workshop Four group presentations

Following the team presentations, Eldred Gilbert Director of Nursing Primary Care summarised the session and identified the following fundamentals.

- That we needed to look at the total community health workforce. It was noted that this was one of the few times that we had come together as a group across sector to discuss our common workforce issues.
- The need to start now given the national challenges ahead by 2012
- Grapple with the difficulties and then move to action
- Appropriate communication across sector

We need:

- Capacity, Capability, Leadership, Information
- Population focus across sectors is needed
- New models within existing systems will not work



## **Further Thoughts and Comments Received**

Further thoughts were received from the following person/ services

- Mary Potter Hospice
- Nurse Maude Association
- Wellington Blood and Cancer Centre, C&C DHB
- Community Health Service, C&C DHB
- Jen Boryer, Physiotherapy Team Leader Wellington Therapies, C&C DHB
- WIPA

### **1) Comments received from Mary Potter Hospice**

#### **Workforce Issues**

The presentation by the District Health Board on workforce development confirmed our own experience around the need for capacity building for a future workforce, particularly nursing and home support workforce.

For nursing staff, the aging of the workforce is a real concern for future workforce capacity. In our own workplace, recruiting nursing staff is an ongoing activity and we face the retirement of some of senior experienced nursing staff over the coming few years. This year we plan to consider a capacity/capability plan to ensure that we are building a future workforce as well as continuing our ongoing education and support for our current staff.

The DHB is in the position to take a facilitated approach to developing 'regional workforce project(s)', particularly in nursing, that traverse the community/NGO sector as well as the hospital/institutional workplace. I would strongly support the DHB consider this in their planning.

Although this submission is focused on the District Nursing Service, Mary Potter Hospice also has concerns about the consistency and continuity of home support through our community providers. We would also support the intention of DHB to consider how training and development facilitated through the DHB can assist the home support workforce.

#### **District Nursing**

Mary Potter Hospice service cannot run a service without a full community nursing service that is also available (on-call) over the weekend and evenings.

On average we have 150 patients at any one time, with an inpatient unit of 18 beds. Most of the patients therefore are based in the community with their care being coordinated through the PCC (Palliative Care Coordinators). This coordination includes the family, caregivers, District Nurses, local PHO (mostly GPs), rest homes, private hospitals, and our inpatient unit.

Increasing patient complexity is a trend that is placing some tension on our capacity to service needs those patients in our care. Patient numbers and acuity are reported as increasing (and we want to establish more clearly the patterns involved in this and whether it is short or longer term trends). Uncertainty about the District Nursing service has the potential to further strain our ability to deliver quality palliative care.

The possible options for the district nursing staff that could be considered by the DHB in their final presentation to their Board include:

- status-quo of continuing the service as a 'nursing outreach' with the hospital as the base;
- devolution of (some/all) positions/funding to PHOs (and other possible providers);
- devolution of (some) positions/funding to Mary Potter Hospice, or
- a combination of the above.

### **Issues for Mary Potter Hospice**

Developing a multiple set of relationships to ensure patients in our service would have the care they need (and when they need it) becomes more complex if the 'nursing staff' is spread over multiple providers. Unfortunately the distribution of PHO services is not even throughout the region (with a particular shortage of GPs in the Kapiti region) nor is after-hours GP availability. This option would require agreements between Mary Potter Hospice and those providers 'allocated' district nurses, and the development of processes and protocols to practically implement such an approach.

One concern would be the eligibility or access of our patients to appropriate nursing care if that care is conditional on being registered with a GP or PHO. We have had a number of patients, particularly in the Kapiti region, that were listed as 'casuals' with PHOs rather than as registered members. If nursing care was dependent on registration then a number of patients would not receive the care they need.

While the Hospice is able to offer phone advice (24 hour/ 7 days), the after-hours service is mainly 'triaged' through the District Nurses (in some cases the calls are received by the PCC and then referred to a District Nurse). This practice would need to be reviewed with any changes to the district nursing base.

The delivery of District Nursing service is supplemented through using the 'end-of-life' care available on recommendation through Care Coordination Centre, and is dependent on the availability of agency nurses. (In the event that this is not available to families or care-givers, patients are often admitted to the in-patient unit or hospital, despite the desire of families for such care to be provided at home.) Referral and management for the 'end of life' nursing, is carried out between the District Nurses, GPs and/or the Hospice PCCs, separately or together. Multiple providers of District Nursing service adds more complexity to this process, but does not add value to the care of patients.

Mary Potter Hospice is aware of the ongoing need for collaborative work between the District Nurses and our community teams (regardless of where that nursing team is placed). Our current projects include improving the process of 'sharing of notes' between the teams and the need for continued communication for patient benefit.

The development of a Mary Potter Hospice full community nursing service is an attractive option for us but would still require time and careful planning to build such a service from our current base. A phased approach could be introduced through the development of the evening/weekend on-call service. This service could then be enhanced with a full working service, (either in collaboration with other providers or within the Mary Potter Hospice framework). This option would allow services to develop to meet patient/family need more coherently without the risks of gaps appearing in the service that are inherent in a service being operated from a number of different providers.

Our intention in attending the workshop sessions was to gain some insight in the possible implementation of the review. However the session did expose the complexity of the potential options and the potential for even greater fragmentation.

We have a commitment to increasing the knowledge and awareness amongst the wider range of primary and community health providers of palliative care. The recent establishment of the 'Community Liaison-Palliative Care position by Mary Potter Hospice is a commitment by Mary Potter Hospice and the DHB of finding new ways of working and sharing knowledge and experience on palliative care.

The 'community and allied health' workshops were an opportunity for the wide range of health and community providers to come together to consider the issues highlighted in the review. We appreciated that opportunity

## **2) Comments from the Nurse Maude Association**

### **Development of Community Nursing Health and Allied Health Services**

Thank you for the opportunity to comment on this important issue before the preparation of your options paper. The Nurse Maude Association has followed with great interest the workshop discussions and written material to date. We have, at the same time, given some thought to the question of what is the most appropriate model of community nursing and allied health service for the Capital & Coast District Health Board.

The following represents our current thinking based on our own experience as a provider of community based services and our knowledge of your current situation.

#### **Givens**

In responding to your letter we have taken some time to consider what we believe to be the givens for this project and the future model. These givens underpin the ideas and approached discussed below:

- Some change is necessary. Whatever change comes from the process it must reflect an appropriate balance of service provision between the DHB and the community.
- While change is necessary, the positive components of current service provision must be protected and safely transitioned into the new model.
- The new model must work in synergy with the Home and Community Integrated Care service framework established to date, including the role of the Care Coordination Centre and Care Management.
- The model must provide a framework for future growth and development.

#### **Approaches**

We believe that an options paper needs to consider a range of approaches in order to generate robust debate across the sector. We recommend the following approaches and options be included for debate:

##### ***Pick up and move***

This approach would recommend that the current structure and framework be shifted into the community under a community provider in its entirety, with no change to the model. This option would allow minimal disruption to services and staff in the short term while retaining the opportunity to evolve into a new model at a later date through a controlled, evolutionary change process. This is a conservative approach that would not generate the true rewards in the short term, but would allow change over time to respond to the community needs.

##### ***Compartmentalisation***

This approach fundamentally assumes that not all service components need to be shifted into the community. It allows debate around some service components continuing to be provided by the DHB with others moving into a community setting. The workshops identified that specialist nursing is a group that some would see valuable to retain within the DHB environment due to the interface with hospital based services, with generalist district nursing moving out under a community provider.

Our experience has shown the value of providing a service where specialist nursing sits with the Generalist team in the community. This allows for improved access and continuity for consumers and enhances supported role extension of the generalist as the “episode of care” case manager. The colocation of specialists with generalists contributes to better access to scarce resources for the community. Basing specialist nurses in the community has not reduced access by hospital based services. Should this approach be preferred we would recommend testing through a robust consultation process in order to determine its appropriateness, or lack thereof.

##### ***Change the model***

This approach assumes that all services considered under this project will move into the community under an alternative provider to the DHB. There are two main options that we believe could be considered as part of an options paper:

1. *The multidisciplinary cluster model*

Services are located in clusters throughout the community. While the clusters could be colocated with PHO's the management of the teams would sit with a single organisation; this promotes the effectiveness, efficiency and resource management of the service. The organisation would provide a comprehensive service model that meets the needs of the region based on the development of systems that support effective, modern health care delivery.

A focus on rapid response to service delivery requests would be central to the model with a team approach to complex care provision in the community.

The core staff of each cluster would consist of generalist district nursing, health care assistants and allied health staff, supported by allied health professional advisors and specialist nurses.

Benefits of this model include locating services close to the community of care, a multidisciplinary approach and aligning the service with General practice.

2. *The hub and spoke model*

This model would see the establishment of a centralised base for all district nursing, specialist nursing and allied health services. Resources would then be deployed across the district in direct response to demand and need. This model enhances collegial support, professional development, team work and effective allocation of scarce resource. It also supports the introduction of a case management model where each client is assigned a case manager who then coordinates the response for the episode of care from across the MDT and with external service providers such as hospice providers, the Care Coordination Centre and package of care providers.

### **Key Priorities**

The Nurse Maude Association believes the right approach is to change the model as outlined above. However, for this to be a successful change there are some key priorities that any new model must incorporate. These are outlined below:

#### ***IT infrastructure***

In order for community services to be fully supported and to best utilise time available to clinical teams, IT infrastructure is paramount. Community services must have comprehensive access to information databases and be in a position to capture data in real time. This can only be achieved through comprehensive agreements with the DHB for access to Clinical Records, Concerto, InterRAI and any other appropriate clinical databases. Further, equipment needs to be provided that allows effective undertaking of clinical work in the community. This is a significant investment, but provides an invaluable opportunity for great gains.

#### ***Communication and networking***

Any new model must emphasise the requirements for, and establish an infrastructure to support, effective communication and networking across the sector. The networks must include:

- The Care Coordination Centre
- Primary Health Organisations
- Community Service providers
- Package of Care providers
- Secondary and Tertiary hospital services
- Hospice/palliative care services

### ***Training and development***

The movement of increasingly complex patients from the hospital to the community is resulting in new workforce development requirements. Role development and extension is necessary for the community health workforce to meet the needs of this client group.

Access to appropriate post graduate level education and training for nurses and allied health staff, along with opportunities for the non regulated support workforce is required.

Enabling the workforce to access education will require investment in cost of study, release time and role backfilling. Resultant benefits will include role flexibility, improved patient outcomes and appropriately trained staff.

### ***Discharge planning***

The model must recognise the importance of liaison with the secondary and tertiary services and support effective integrated care across the continuum. Specialist community services must be made readily available to hospital services in order to support discharge planning. It is also pivotal that a rapid response solution is established within the community model from the outset. There is an opportunity to address this issue through a dedicated rapid response team in the community, utilising the role of the health care assistant as part of that team.

### ***Equity of access***

The model must support equitable access to services across the district. This issue is twofold:

- Clients in Kapiti should be able to expect the same level of support and service as clients living in Wellington. This is of particular concern in relation to access to specialist nursing services.
- Services need to be made appropriate and available to Maori and Pacific peoples. This may require some targeted responses in certain areas to ensure that needs are being effectively met for these populations.

### **Framework for future growth**

The options paper being developed provides the DHB with an opportunity to explore options that will provide a framework for future growth. As we are all aware, services in the future will continue to move out of the hospital environment and into a community setting to support aging in place and to recognise the increase in population of people over 65.

The options paper needs to present models that will allow this shift to occur in a smooth and controlled manner. It is for this reason that the Nurse Maude Association would strongly support the development of options relating to the change model approach outlined above. It is our view that the other options, while needing to be considered and debated, do not provide the necessary framework to future-proof growth and development in community based health services over the next 10 years.

In conclusion, we believe that the development of a more integrated and responsive community based health service is one of the most important challenges facing health planner's to-day and we congratulate the Capital & Coast District Health Board on its decision to pursue this. We have valued the opportunity to contribute to your efforts in the past and look forward to continuing this in the future.

### **3) Wellington Blood and Cancer Centre**

#### **ONCOLOGY DISTRICT NURSE ROLE AND REPORTING LINES UNDER THE REVIEW OF COMMUNITY SERVICES.**

Prepared June 2007 by: Helen Costello, Emma Mold & Matthew Callahan in consultation with the CHS Senior Nursing Team

### **Background**

The Wellington Cancer Centre offers high calibre cancer care in an inpatient, ambulatory and community setting as a secondary and tertiary regional service. The geographical area

covers the greater Wellington region (Capital & Coast DHB, Hutt DHB), Nelson Marlborough and Wairarapa DHBs. Future projections are that oncology and haematology speciality practice will grow exponentially as the number of cancer patients increases. This growth will increase demand for flexible ambulatory and community based care including increased clinical assessment, treatment interventions and management. Cancer therapy is becoming more complex and dynamic in its clinical application.

Community oncology nurses are integrally involved in facilitating safe, predictable and non-routine oncology care for cancer patients. They work as solo practitioners in the community but work closely and collaboratively with the Wellington Cancer Centre and Community Health Nursing Services. Their role in the community includes education, advanced assessment, active symptom management especially with those receiving chemotherapy, radiotherapy and combined modality treatments and individualised patient care. Key to this role is the ability to anticipate actual and potential needs and promote early intervention to positively influence patient outcomes.

This innovative practice continues to assist with the management of the finite physical and capital resources of the C&CDHB. Active support and management in the community is fundamental in ensuring patients have the access to care and timely support and interventions. Potential also exists for increasing use of community interventions and therapies (including administration) either at home or satellite clinics, where patients could receive therapies. This type of nurse-led ambulatory community treatment would relieve some of the Wellington Cancer Centre pressure by reducing the throughput of patients as well as improving services to benefit the users and providers.

The ability to liaise effectively with clinicians, volunteers, and other personnel to facilitate access to support and services beyond those provided by the Regional Cancer Centre, is essential in guiding the coordination of appropriate care for patients. This collegial support and input extends to General Practitioners and practice nurses, who cannot be expected to be familiar with the many treatment modalities and related complications of specialist oncology.

Safe patient care is of paramount importance, and the integral links with Wellington Cancer Centre medical team cannot be underestimated with this model of community care. Community based oncology nurses are key clinicians with potential to further extend services in the community.

### **Proposal**

It is proposed that if there is to be a change in service alignment that the CCDHB community oncology nurses would be more appropriately positioned in the Blood and Cancer Centre. This would provide these nurses professional development and support from within the speciality. This would enhance the ability to maintain current knowledge of best practise in oncology and haematology. The nursing collegial over lap will enhance all services within Blood and Cancer reflecting continuity of care and contributing to provision of holistic care. This alignment would ensure that the roles were able to be developed to their full potential within a specialist MDT environment. Current service is provided over three sites of differing geographical access. The roles would continue to be community based and community focussed, this will not be affected by the change in reporting lines.

Structures and processes to maintain the current collegial working relationship with the generalist community nurses will need to be supported to ensure that this unique relationship continues.

The service currently provides a 24/7 advisory telephone service which is valued by the patients and all professional groups. Telephone triage assists in reducing the number of unnecessary admissions to hospital.

The New Zealand Cancer Control Strategy 2005-2010, supports the introduction of more community based care and support. This DHB has been the leader in this area nationally in providing the community based specialities nurses in oncology since 1990

In proposing the alignment to the inpatient ambulatory speciality it is recognised that this group of nurses have developed a well functioning community based service that is known and respected in the primary arena. Care would need to be taken to ensure that this practise model continues to be supported and developed as it has many proven benefits. It would be anticipated that the model of shared care would continue and processes to ensure that to continue seamlessly would be put in place.

A significant aspect of the oncology community nurses role is in education of both patients and their families along with all professional colleagues. The continuation of education to support primary and secondary professional groups would be seen as critical to the model under a new reporting structure.

**Recommendation:**

- If alignment of services is to change, that the community Oncology District Nurses align with the WBCC.
- That these roles report to the Team Leader WBCC.

#### **4) Community Health Services**

##### **Community Nursing: Re-thinking the Future**

##### **An opportunity to build Community Health Services capacity and grow services, to better support an integrated approach to patient care in the community**

###### **Introduction**

There is much about the existing Community Health Services (CHS) that models excellent delivery of comprehensive services, which meets a range of community patients' needs. Our service works closely with Hospital Health Services (HHS) to deliver specialist complex care in the community. As a C&C DHB service the nursing workforce of CHS work effectively across the care continuum to provide and facilitate care for patients referred from primary, secondary and tertiary sectors. Knowing and using community resources to complement health care is the speciality skill of the community health nurse. Nursing people at home enables access to care which supports people to retain control with disability and illness, allowing them to spend as much time as possible in their own environment. This submission is structured around five key areas of CHS services delivery. In light of the current community nursing and allied health services project, these key areas are described to highlight the opportunities for developing the future direction of CHS.

Increasing current capacity of community nursing is constrained by limited integration between services in the community, contractual arrangements and communication between primary and tertiary providers. CHS have the foundation and expertise to deliver a responsive service that works more effectively with all health care providers. To achieve this CHS nursing services needs to maximise strengths, streamline current referral criteria and intersectional links. This submission proposes service change that addresses the new expectations for delivery of community based health and care services (Hefford, 2006).

This submission uses SWOT Analysis, a strategic tool, to evaluate the **Strengths**, **Weaknesses**, **Opportunities**, and **Threats** of developing CHS to further improve "...health outcomes, reducing disparity, providing an 'intergrated continuum of care' and delivering alternatives to institutional care" (Hefford, 2006, p.5).

###### **Community Health Services Functional Relationships**

CHS currently operates across a care continuum that involves many disciplines and services in the community and inpatient settings as detailed in Figure 1. District nurses work

collaboratively with speciality nurses and allied health within CHS to provide care. This care can be complex as patients may need support from a number of different services. The liaison and coordination facilitated by CHS works well but could be strengthened to better provide a seamless continuum of care. Building on these existing functional relationship CHS must seek to improve the often complex care arrangements for people with chronic conditions. There is potential through reformed models of care to improve integration of community-based services to enhance patients, family and whānau's experience of health care. The intersectoral delivery of primary care (Figure 1) shows the important multidisciplinary linkage of existing services. The needs of the patient directs, which services are involved and to what capacity. Reform must address the need for patient-centred records that potentially could facilitate seamless care across the continuum.



Figure 1. Community Health Services Functional Relationships. The arrows show the constant interface of community relationships.

### Community Health Services Provisions

Patients require both acute, short and long term care, as well as palliative care in the home setting. CHS nurses employ a broad range of practice competencies that are responsive to patients needs. Nurses are required to be adaptable, resourceful and competent in a wide range of settings. Nursing is well supported by proactive leadership from senior nurses. Leadership is essential in providing specialist assessment, consultation and quality review. As a nurse-led service this leadership underpins the autonomy of current service provisions.

Services include:

- Acute nursing care (post hospital discharge)
- Oncology nursing services/ home-based chemotherapy
- Assessment and treatment of complex and chronic wounds
- Home intravenous therapy
- Domiciliary oxygen and respiratory nursing services

- Stomal therapy services
- Continence services
- Palliative care services in partnership with Mary Potter Hospice (MPH )
- Breast nurse services
- Enuresis programme
- Pulmonary rehabilitation programme
- Consumables supply services: Continence, stomal and oxygen

### 2006 CHS Service Provision Data

Data for the four month period July- November 2006 (last available due to new C&C DHB IT system) provides a snapshot of CHS service provision in Figure 2. This data is based on number of nursing visits, which correlate to nursing volume contracts. This data does not capture the acuity or time spent in the delivery of nursing care. Of note complex wound care makes up the majority of ACC and clinical activities.

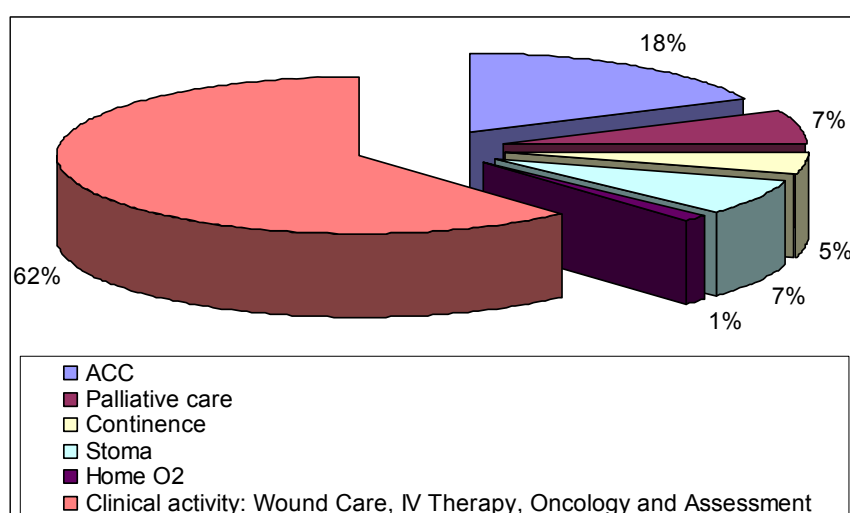


Figure 2. CHS Service Provision Data for July- November 2006

Increasing current capacity of CHS nursing services is difficult due to following the reasons:

- Existing contract obligations
- Historical obligation to accept referrals on current criteria which is ill defined
- Palliative care contacts set on current volume are unsustainable and effects other service provision

### SWOT Analysis of CHS Provision

This SWOT analysis draws on the strengths of the CHS nursing service and considers current weaknesses to identify the opportunities for developing our service to address the changing needs of community health services. Current and potential threats to securing this change are considered within the current context of our own and other services.

### Wound Care

Management of acute and chronic wounds in the community supports early discharge and reduced readmission. This wound care is often provided in the context of recent diagnostic and urgent surgery, complex lower limb pathophysiology, as well as progressive and palliative (non-curable) conditions. In all of these situations advanced assessment and management is often the key factor in overall patient outcomes. District nurses provision of complex wound

care involves a multidisciplinary team approach. Recognition of this specialty area of practice supports referrals from a wide range of primary providers as well as tertiary level care.

### Wound care can account for up to 70% CHS volume

<p><b>Strengths</b></p> <ul style="list-style-type: none"> <li>• Extensive district and specialist nurse wound care expertise</li> <li>• Skilled in assessment, Doppler and complex management</li> <li>• Implementation of best practice guidelines</li> <li>• Accessible service</li> <li>• Ethic of care</li> </ul>	<p><b>Weaknesses</b></p> <ul style="list-style-type: none"> <li>• Chronicity weighted service</li> <li>• Historical obligation to provide wound care</li> <li>• Referral and contract model outdated</li> <li>• Inconsistent practice</li> <li>• Timely discharge</li> <li>• ACC revenue collection and administration support</li> </ul>
<p><b>Opportunities</b></p> <ul style="list-style-type: none"> <li>• Potential for new consultancy and shared care models using service expertise to improve patient outcomes - specialty practice in wound care</li> <li>• Negotiate new care pathways with PHOs &amp; NGOs for patients with 'non-healing wounds'</li> <li>• To be the 'Specialty wound care service' for the patients within our DHB</li> <li>• Continuous quality of improvement</li> </ul>	<p><b>Threats</b></p> <ul style="list-style-type: none"> <li>• Volume of contacts impact on quality of wound care</li> <li>• Ad hoc ACC referral (typically referral after prolonged non healing time – earlier referral for specialist input improves patient outcomes)</li> <li>• Invisibility of strength of service</li> <li>• Outsourcing could reduce revenue and impact on standard of patient care</li> </ul>

### Summary

CHS would like to further develop speciality wound services maintaining close relationships with the HHS vascular service. There is potential to negotiate with a range of primary care providers a new shared care model to support greater involvement in chronic non-healing wound management. This model could provide specialist assessment and support, and management of consumables. The shared care focus of this model will support continued implementation of best practice guidelines, better integration of existing services to meet the ongoing needs of patients. By refining the volume of non-healing chronic wounds currently managed by district nurses the service would have more capacity for continuous quality improvement in wound care. Patient's needs would still be met but the reconfiguration of wound care services would enable greater capacity for developing other areas of wound care practice.

### Early Discharge - Increased Capacity and Volume Opportunity

CHS currently provide a responsive and flexible service that supports HHS to reduce the need for admission and early discharge. C&C DHB is working towards expanding the model of ambulatory care and early discharge that CHS currently supports. The generalist and specialist expertise of staff within CHS underpins the work they do with patients and families to ensure safe and optimal recovery. This area for service delivery could be strengthened. The CHS recognise the value of working closely with Health Care Assistant (HCA) to increase team capacity. With good liaison and early consultation with the multidisciplinary team CHS is a key provider in the ambulatory care model.

<p><b>Strengths</b></p> <ul style="list-style-type: none"> <li>• Responsive &amp; flexible service</li> <li>• Existing workforce expertise</li> <li>• Team comprises of HCA, Specialty and DN working together</li> <li>• Secondary and Tertiary HHS linkages are strong</li> </ul>	<p><b>Weaknesses</b></p> <ul style="list-style-type: none"> <li>• Under developed Multi Disciplinary Team approach</li> <li>• Communication across the continuum of health care providers - needs to improve</li> <li>• Duplication of services</li> </ul>
---	--

<ul style="list-style-type: none"> <li>• Embedded practice development</li> </ul>	<ul style="list-style-type: none"> <li>• Equipment resource</li> </ul>
<p><b>Opportunities</b></p> <ul style="list-style-type: none"> <li>• Grow &amp; improve after hours service</li> <li>• Improve support &amp; resources for nurses A/H</li> <li>• Develop advanced assessment skills</li> <li>• Enhance shared care model with HHS to improve pt outcomes</li> <li>• Maximise HCA role in team nursing</li> </ul>	<p><b>Threats</b></p> <ul style="list-style-type: none"> <li>• Cope with increased capacity</li> <li>• Under resourced currently</li> <li>• After Hours Medical access</li> <li>• Communication between inpatient and community services</li> <li>• Equipment resource</li> <li>• Loss of allied health</li> </ul>

### Summary

Our current capacity to build our early discharge service requires a reformed model of team care. We envisage a short-term team approach that addresses high acuity of need, supportive and rehabilitative needs. The nature of our existing shared care nursing model between generalist district and speciality nurses provides comprehensive clinical assessment and care planning. Current levels of liaison and negotiated care interventions are effectively managed between tertiary, secondary and primary care. However, intersectorial communication and pathways could improve to ensure patients, families and whānau experience less fragmented healthcare.

### Palliative Care

CHS are the main direct providers' palliative care in the community. District nurses are the health professionals providing this care. This care is provided along with the support of the shared care model with Mary Potter Hospice (MPH). The CHS meets the vision of the NZ Palliative Care Strategy [NZPC] (2001) in providing a service that ensures dying patients, family and whānau benefit from access to quality palliative care.

As the key provider of community-based palliative care, nurses work to meet the often unpredictable and increasing acuity associated with patients end-of-life care. It is well documented in the palliative care literature that accuracy on predicted death is difficult to estimate, as is, the complexity of care requirements and ongoing symptom management issues with unstable patients.

District nurses in the current Care Model work alone after hours and may be providing direct care for a number of actively dying patients. Current acuity models contrast markedly between inpatient and community-based palliative care. Most patients admitted to the MPH service will receive the majority of the nursing care in the community. In accordance with the NZPC strategy, CHS works with patients and families to provide care that enables them to have the choice to remain in their homes, with increasing acuity. More MPH patients die at home than in inpatient settings.

### A Volume Range of 7-10%

<p><b>Strengths</b></p> <ul style="list-style-type: none"> <li>• Commitment &amp; passion and expertise</li> <li>• Responsiveness to acuity</li> <li>• CHS team work</li> <li>• Shared care model to support provision of specialist community Palliative Care</li> </ul>	<p><b>Weaknesses</b></p> <ul style="list-style-type: none"> <li>• Palliative Care contract - capacity, volume &amp; funding doesn't 'fit' with current service</li> <li>• Its 'fit' with all other service provisions</li> <li>• Communication with providers</li> <li>• Workload and time commitment</li> <li>• Under resourced</li> <li>• Lack of recognition</li> <li>• Team nursing outsourced</li> </ul>
---	---

<p><b>Opportunities</b></p> <ul style="list-style-type: none"> <li>• Contract changes to improve better 'fit'</li> <li>• Funding recognition to support capacity</li> <li>• Better shared care model</li> <li>• Negotiate new care pathways for Palliative Care patients</li> </ul>	<p><b>Threats</b></p> <ul style="list-style-type: none"> <li>• No opportunity to increase capacity</li> <li>• Imbalance between capacity &amp; volume</li> <li>• Access to medical support</li> <li>• Lack of team care After/Hours</li> <li>• Outsource Palliative Care</li> </ul>
---	---

### Summary

To meet the increasing acuity of the palliative population receiving end of life care, CHS currently provides nursing input well in excess of set Relative Value Unit (RVU) time ratio. As shown in figure 2 recorded at 7% volume of nursing visits. This does not reflect the actual time spent providing palliative care. Estimates from within the service would place palliative care as second to wound care in actual nursing time. CHS is not funded in a way that recognises that a district nurse may care for a number of actively dying patients and also be required to manage other patients' diverse needs. With reduced staffing after hours this workload places increased pressure on services. The disparity of RVU for palliative care services urgently needs contractual recognition to enable an important part of district nurses practice to be sustainable.

While providing an excellent responsive service throughout the C&C DHB region, the current funding provision for CHS to deliver palliative care has a direct impact on all other CHS nursing services. This occurs because the needs of patients, carers and families managing the terminal phase of illness demands nurses' prioritise this work above less urgent but important needs of their other patients.

To continue to provide a palliative care service which is flexible and responsive to patients needs a reformed model of shared care with RVU recognition is required.

### Specialist Nursing Services

District nurses work collaboratively with specialist nurses that have strong linkages to specialist hospital services. The shared care model enhances the specialty services capacity to support patients across the care continuum. The collaboration between generalist and specialist nurses is fundamental in ensuring patients have access to optimal care through timely support and interventions. The co-ordination of an often complex care trajectory ensures a seamless approach to ongoing assessment, intervention, care planning and evaluation of outcomes with patients.

### Specialist nursing care can account for up to 18 % CHS volume

<p><b>Strengths</b></p> <ul style="list-style-type: none"> <li>• Expertise &amp; advanced assessment experience in specific specialties</li> <li>• Enable early discharge for HHS</li> <li>• Monitor usage and standardization of products</li> <li>• Intersectorial Communication</li> <li>• Responsive</li> <li>• Shared care model WORKS</li> <li>• Team work</li> <li>• Complementary nursing view (generalist/specialist)</li> </ul>	<p><b>Weaknesses</b></p> <ul style="list-style-type: none"> <li>• Access</li> <li>• Communication</li> <li>• Service curtailed by limited FTE</li> </ul>
<p><b>Opportunities</b></p> <ul style="list-style-type: none"> <li>• To expand service provision</li> <li>• To build primary nursing expertise</li> </ul>	<p><b>Threats</b></p> <ul style="list-style-type: none"> <li>• Loss of speciality nurses to HHS</li> <li>• Weakened shared care model impacting directly on responsiveness</li> </ul>

	and flexibility of patient care
--	---------------------------------

**Summary**

The innovative practice of nurse-led care in the community ensures a patient-centred approach to care delivery. Building on this practice CHS have the skills to address the expanding ambulatory service of C&C DHB. Effective shared care models provide a template for further development within the primary healthcare setting. The CHS shared care models that works well currently, continue to ensure responsive intervention support and rehabilitation in the acute and ongoing care of patients with illness and disability.

**Health Care Assistants (HCA)**

The HCA employed by the CHS to provide household tasks and personal cares are valued members of the CHS team. This service supports early discharge, short-term disability and end of life care. The current team model is well supported through a strong delegation and supervision framework. This provides an integration of safe care delivery between registered nurses and HCAs. Such linkage is important for effective team work that currently supports CHS capacity. Patients and families respond well to this team approach. There is potential to build on the strength of this approach to reframe a model of care that is responsive to new expectations of C&C DHB e.g. early discharge and palliative care.

<p><b>Strengths</b></p> <ul style="list-style-type: none"> <li>• Skilled &amp; reliable workforce</li> <li>• Strong delegation and supervision model between DN/HCA</li> <li>• Education programme</li> <li>• Team work WORKS</li> </ul>	<p><b>Weaknesses</b></p> <ul style="list-style-type: none"> <li>• Current contracted hours limiting</li> <li>• Current contract</li> </ul>
<p><b>Opportunities</b></p> <ul style="list-style-type: none"> <li>• Potential to develop this with early discharge model improving responsiveness</li> </ul>	<p><b>Threats</b></p> <ul style="list-style-type: none"> <li>• Outsourced</li> </ul>

**Summary**

There is a need to remove CHS commitment to providing home help provided by HCAs to allow targeted increased HCA involvement in delivering personal cares and involvement in supporting a new model of early discharge. CHS have the infrastructure and resources to support an appropriately skilled HCA team. The value of HCAs could be better utilised with some reform in the current service structures. Targeted development of this part of the CHS team will support the development of some current services.

**Conclusion**

The nurse-led service provisions of Community Health Services are an asset in the current health care environment. The potential to build greater partnerships with other primary care providers will require some reform in the way CHS currently provides services. CHS has a key role in providing specialist nursing in the home environment.

This submission describes five key service areas of CHS that can be developed to improve our capacity and integration in primary health care. To realise the opportunities for development, current contractual arrangements must better reflect service provision. CHS must maximise the specialist nature of our nursing and HCA workforce. The CHS team want to further build on our strengths to consult, liaise and provide shared care with other providers. With greater flexibility in funding arrangements CHS will have greater capacity to reduce disparities and the impact of chronic illness in the community.

**References**

- National Health Committee. (2007). *Meeting the needs of people with chronic conditions*. Wellington: Author.

- Peplau, H. (2003). Specialisation in Professional Nursing. *Clinical Nurse Specialist* 17 (1), 3-9.
- Hazelbaker, C. (2006). The SWOT Analyses: Simple, yet effective. *Clinical & Corporate perspectives*, 11(6), 53-55.
- Hefford B. (2006). Future delivery of community based Health Care Services. *Report for Margot Mains, CEO Capital Coast District Health Board.*
- Ministry of Health. (2001). *New Zealand Palliative Care Strategy*. Wellington: Author.

#### **5) Jen Boryer, Team Leader Wellington, Therapies**

I would like to acknowledge the strategic focus of this work and can envisage areas where work could better be managed if moved to the community and primary health organisations. Major work around co-ordination principles and workforce development will impact the successful implementation of any changes proposed,

My submission will be based on Physiotherapy, in Therapies and the opportunities and risks related to community provision of the service within our current service provision requirements.

- Links with the Care Co-ordination Centre will be vital to maintain a link between primary, secondary and tertiary physiotherapy services and community organisations. We need to improve the development of assessments that can be transferable and used by multiple users, thus preventing the constant requirement to reassess patients for information that may be easily obtained.
- Need to be able to access information easily around what supports and disciplines are involved with a patient at any one time – whether this be via an electronic system or phone number to call for questions etc. This will allow notification of patients who have been admitted or discharged to ensure the appropriate follow up or treatment.
- Access to flexible community services to aid in quick discharge home with the appropriate supports – physiotherapy may be required to check safety of mobility in the home environment, other services may be required to support discharge e.g. personal cares, equipment. This will assist in timely discharge from inpatient wards i.e. not having to wait until Monday, or after public holiday, and straight from A&E or SSU to prevent the requirement for admission. I would like to see a rapid response team – including other disciplines (Nursing, Occupational Therapist, Social Worker etc) that is responsible for this work and has access to the appropriate equipment in order to facilitate this work e.g. transport, Occupational Therapy equipment, walking aides etc.
- Economies of scale is an important limitation of physiotherapy services being “distributed” amongst primary health/community organisations. In Therapies we currently employ approximately 4FTE to cover the Wellington Region (Wellington to Kapiti). Should this service be distributed amongst the PHOs or other community organisations, these positions will be split a number of ways possibly rendering them inefficient and ineffective.
- Workforce Development – due to the variety of community work, staff need to maintain a wide variety of skills to manage their patient loads. They often access the specialist knowledge of physiotherapists working in other areas of the HHS to advise them e.g. physiotherapists. Although this would still be possible if staff worked in PHOs, the relationships would not be so well developed to promote this type of professional development and support. In the HHS we already have regular inservice forums set up to assist in staff development. If staff were based with PHOs/community organisations, access to these forums would be possible, an agreement (including funding) would need to be formalised.
- Recruitment – would be very difficult to a number of small, part time positions, thus risking that positions in any particular area may be vacant for a long period of time. If staffing was centralised, there is more likelihood of physiotherapist looking for work being in contact with a Physiotherapy Team Leader in the HHS, than individual PHOs/community organisations.
- Equity of Service to all areas of the district – with staffing centralised in the HHS, cover strategies enable us to ensure equitable cover of all areas throughout the district. Access

to a particular level of service can also be equitably managed to prevent one area having different access to other areas e.g. availability of assistants, number of treatments per week etc

## **6) WIPA**

### **Re: Community Nursing and Allied Health**

Thank you for the opportunity to provide further comment on this project. As mentioned in our letter to the DHB dated 18 June we wish to provide some high-level feedback on a proposed service model. Unfortunately it was not possible for us to meet your deadline of 29 June.

We have discussed this project with our nursing staff and general practice, and would suggest that an option to achieve the DHB's objectives would include:

#### ***Specialist Nursing***

Specialist nursing positions (eg community cardiac nurses) need to stay in hospital. Movement of these nurses from the hospital would be dependent on additional FTE being funded and a workable model that integrates specialist secondary nursing with specialist primary and practice nursing teams. We suggest that MidCentral DHB's (MDHB's) Disease State Plan implementation model may be a useful framework the DHB could consider.

MDHB's model keeps the specialist nurse(s) (at an Expert level) employed within the hospital. Primary specialist nurses are employed at (or expected to be trained to) one level below expert competency – ie a Proficient level in one specialist area. It is expected that once they have attained a Proficient level in their core area that they be trained to an Advanced Competent level in the other core disease state areas (specifically cardiovascular respiratory and diabetes). Therefore over time we would have a highly skilled workforce that would be focused in one core area but able to work with patients in a community setting who have one main illness, but also other common comorbidities.

#### ***District Nursing***

We believe that District Nursing should definitely be shifted to primary care and contracted through PHOs. We do not favour the DHB contracting directly with each individual practice as this would be inefficient and may not be workable with all practices. We suggest that District Nurses could be linked closely to general practices and some relating to home support providers. This will promote integration and provide for more consistent and proactive patient care across the district. We are currently aware that the integration/linkages of district nursing services with general practice services are very variable. In some regions this is working well, but in other areas the district nurses are mostly invisible.

#### ***Allied Health Staff***

Allied health services (for example physiotherapy, occupational therapy, speech therapy etc) should stay in hospital. This is because we believed there is little efficiency gains to be made through shifting these services from outside the hospital setting.

#### ***Provision of After Hours Care***

The provision of after hours care, especially the rapid response team, could be provided through a new model integrating paramedic, GP after hours services and community nurses. If this is feasible the PHOs may wish to respond in a joint proposal with the Wellington Free Ambulance, although these discussions have not yet taken place.

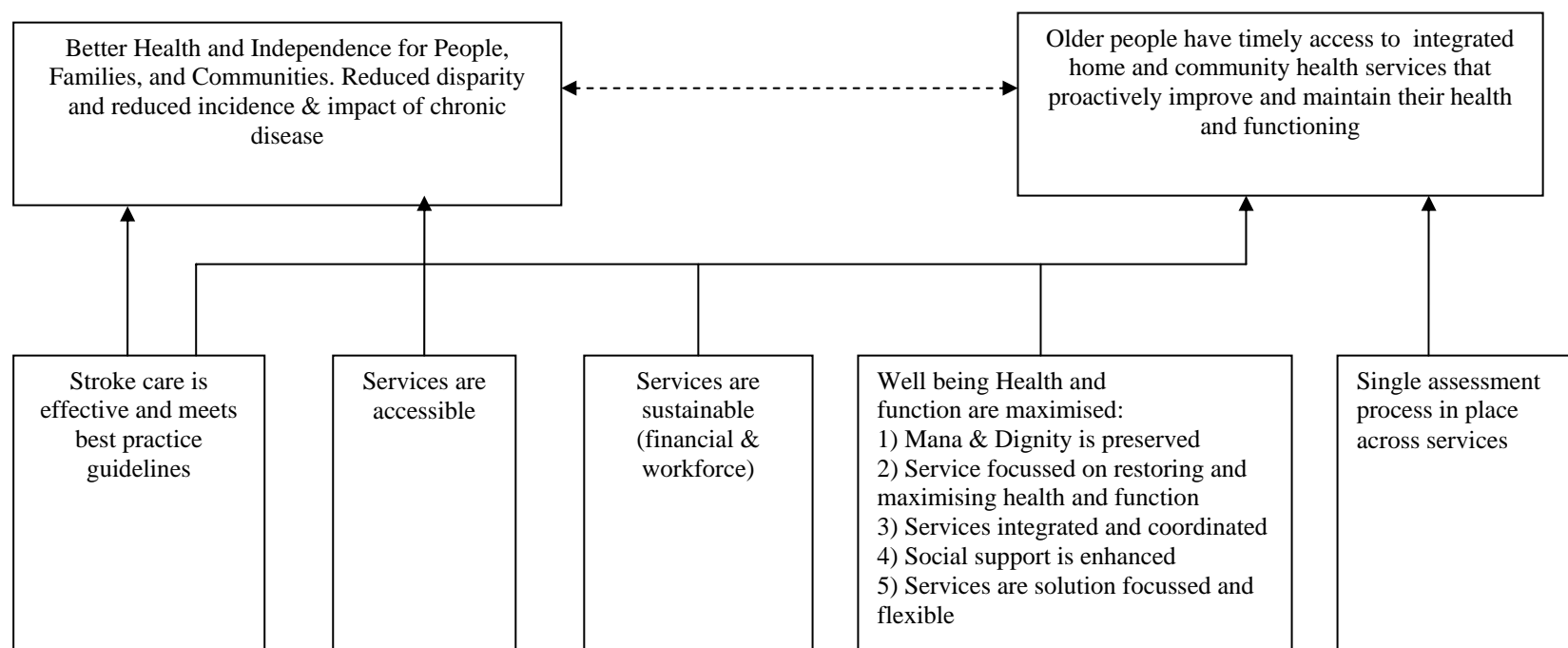
We look forward to working constructively with the DHB to further develop this important piece of work. Please do not hesitate to contact me if you wish to discuss this further.  
End.

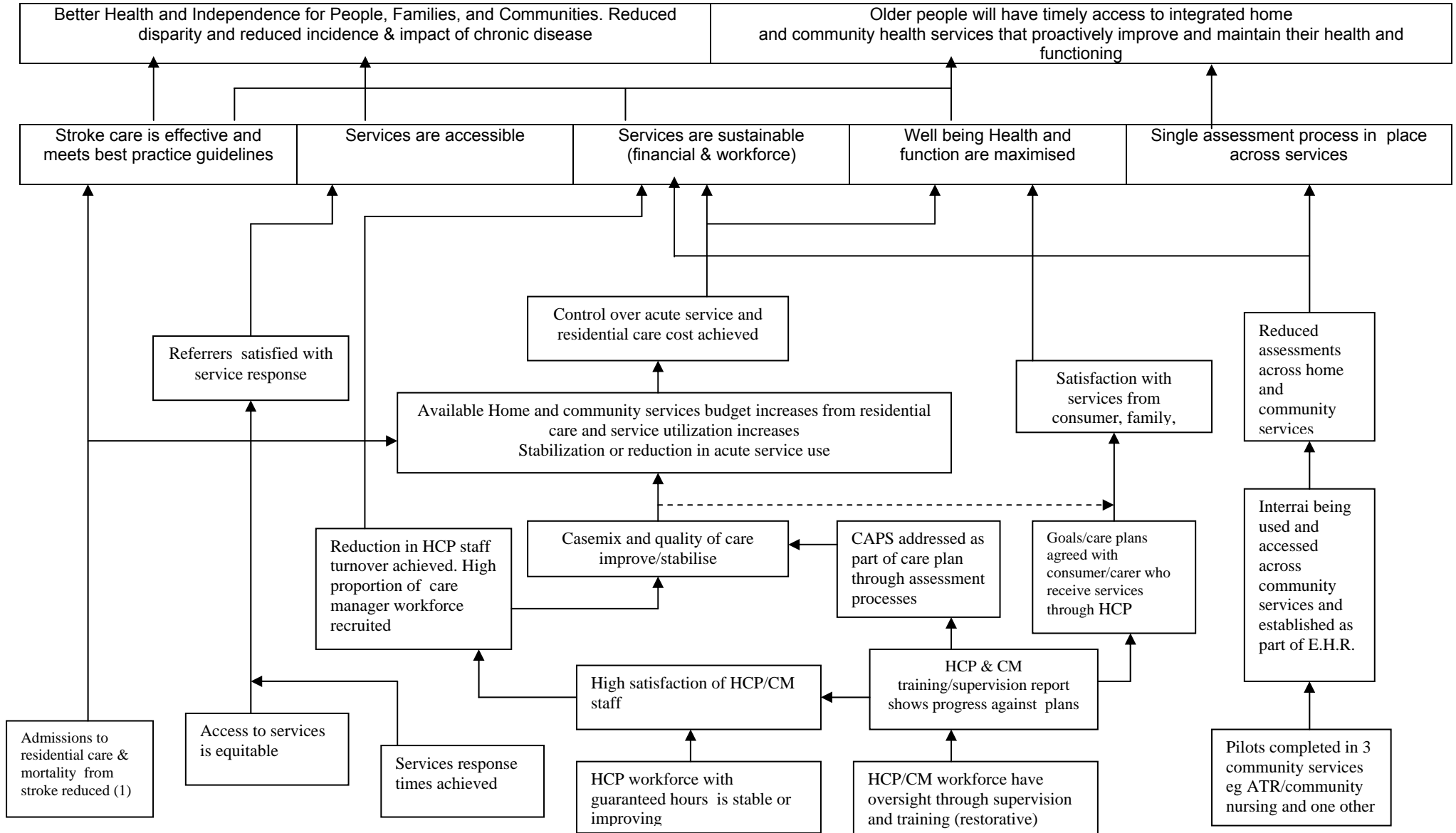
## 6. APPENDIX 3 – INTEGRATED HOME AND COMMUNITY CARE MONITORING AND EVALUATION PLAN

Following is an extract from the Integrated Home and Community Care programme monitoring and evaluation plan that is in place.

### Overall Outcome Chart

The relationship between the policy context of the Health of Older People Strategy and the C&C DHB context is depicted below. The high level programme outcomes are noted in the first diagram, intermediate ones in the second.





Note that the majority of outcome in the central portion of the diagram relate to the CCC, Care Managers and Home Care Package providers. Together these establish 'Restorative' approach to home based services. These measurements will be expanded to include any changes proposed to the home and community care services.

Intermediate outcomes	Measure	Monitoring method	Frequency
Admissions to residential care & mortality reduced for stroke <sup>(1)</sup>	20 fewer people admitted to residential care following acute stroke Between 20 and 30 fewer people die following acute stroke As per stroke SLA and service KPIs	Trends of discharge destination from HHS Mortality rate of stroke Through SLA for stroke service <sup>(1)</sup>	Annual Annual See SLA for stroke service <sup>(1)</sup>
Access to services is equitable	Referral rates comparable to C&CDHB ethnicity ratios Referral rates comparable to C&CDHB deprivation distribution	Report from CCC	6 monthly
Services response times achieved	% of response times achieved as per service specifications	Report from CCC Report from providers	6 monthly
Referrers satisfied with services (CCC) Clients satisfied with services	85% of referrers satisfied according to surveys 85% of clients satisfied according to surveys	Report from CCC	Annual
Reduction in HCP staff turnover achieved	10% improvement from 06/07 baseline	Report from providers on staff turnover	Annual
High proportion of care manager workforce recruited	90% recruited at any one time	Report from CCC on staff turnover	Annual
High satisfaction of HCP staff	85% of staff satisfied according to surveys	Report from providers	Annual
HCP workforce with guaranteed hours is stable or improving	% of HCP workforce with guaranteed hours is stable or improving	Report from providers	6 monthly
HCP/CM workforce have oversight through supervision and training (restorative/goal setting) and work within team approach (5)	100% occurrence	Report from CCC/providers re: progress against supervision and training plans	Annual
Control over acute service and residential care cost achieved	5% control over acute service cost achieved 5% control over residential care cost achieved	Tracking of unplanned acute services use by clients seen through the programme <sup>(2)</sup> Tracking of residential care expenditure over period of programme <sup>(3)</sup>	Annual
Available Home and community services budget increases from residential care and service utilization increases	Evidence of available home and community services budget and service utilisation increasing independent of external funding <sup>(4)</sup> primarily via use of residential care funding	Analysis of home and community budget and internal transfer from residential care budget	Annual

Intermediate outcomes	Measure	Monitoring method	Frequency
Stabilization or reduction in acute service use (4)	Evidence of stabilization/reduction in acute use % changes to HCQI W31 (Prevalence of hospitalisation/visit to ED since last assessment)	Tracking of unplanned acute services use by clients seen through the programme <sup>(2)</sup>	Annual
		Tracking HCQI W31	Quarterly
Casemix and quality of care improve/stabilise	RUG groupers remain static or trend towards lower casemix overall HCQI indicators remain static or trend towards better quality	Tracking RUG groupers and HCQI's	Quarterly
CAPS addressed as part of care plan through assessment processes	100% achievement	Interrai software analysis	6 monthly
Satisfaction with services from consumer, family, whanau achieved	85% Satisfaction with services consumer/family/whanau	CCC/HCP provider consumer satisfaction survey.	Annual
Goals/care plans agreed with consumer/carer who receive services through HCP	100% of goals/care plans agreed with consumer/carer who receive services through HCP	Interrai software analysis	Annual
Reduced assessments across home and community services	20% reduction in assessments across home and community services	See note (6)	Annual
Interrai being used and accessed across community services and established as part of E.H.R	Numbers of services/users who use interRAI as core tool	Post implementation review	End 07/08
Pilots completed in 3 community services + one other	Completed pilots	Project closure reports	End 06/07

## 7. APPENDIX 4 – BOARD AND COMMITTEE MINUTES ON ORIGINAL INTEGRATED HOME AND COMMUNITY CONSULTATION

CAPITAL AND COAST DHB  
MEETING OF THE BOARD HELD IN THE BOARD ROOM  
54 CAMBRIDGE TERRACE, WELLINGTON  
ON WEDNESDAY 6 APRIL 2005 AT 9.15AM

PUBLIC SECTION

### PRESENT:

Bob Henare (Chair)  
Judith Aitken (Deputy Chair)  
Brendon Bowkett  
Ken Douglas  
Margaret Faulkner  
Ruth Gotlieb  
Kiri Parata  
Fuimaono Karl Pulotu-Endemann  
Helene Ritchie

### IN ATTENDANCE:

Margot Mains (Chief Executive Officer)  
Fiona McTavish (Director, Strategic Community Relations)  
Calum Laurie (Director of Finance)  
Win Bennett (Director, Planning & Funding)  
Sandy Dean (Executive Coordinator, Governance)  
David Bratt (Primary Care Advisor)

**APOLOGY:** Helene Ritchie for lateness, Ruth Bradwell, Peter Dady

Jack Rikihana opened the meeting with a karakia.

### 1982 RESOLUTION TO EXCLUDE THE PUBLIC

The Board **resolved** that the public be excluded from the following parts of the proceedings of this meeting, namely:

- for the Agenda items and general subject matter to be discussed as set out in the first column in the table below,
- on the grounds under clause 34 of Schedule 3 to the New Zealand Public Health and Disability Act 2000 as set out in the second column in the table below and
- for the reasons set out in the second column of the table below (including reference to the particular interests protected by the Official Information Act, where applicable.)

### TABLE

**The following Agenda items are recommended for consideration in public exclusion section under under clause 34 of the Health and Disability Services Act: paragraph (a) i.e. the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982**

Agenda item and general subject of matter to be discussed	Reason for passing the resolution in relation to each matter, including reference to OIA where applicable
Confirmation of minutes of Board meetings 2 <sup>nd</sup> March 2005 (public excluded section) and matters arising from those minutes.	OIA, section 9(2)(ba) to protect information which is subject to an obligation of confidence where the making available of that information would be likely to prejudice the supply of information from the same source, and it is in the public interest that such information should continue to be supplied. OIA, section 9(2)(j) to enable this organisation to carry on, without prejudice or disadvantage,



**The Board agreed that workforce issues related to this project should be included in the Workforce Planning workshop.**

### **Background**

The Board:

1. **Noted** that on 6 October 2004, after extensive consultation with the public, the Board:
  - approved a change programme for home and community care services, including an implementation process with some shifts in revenue and service delivery over 2005/06
  - delegated to the CEO financial decisions necessary to implement the new services
  - approved the implementation plan (which had been considered and recommended by the Disability Support Advisory Committee) for the next two implementation phases of specification and establishment, but asked the CEO to report back with recommendations for the roll out phase, including establishment of the Care Coordination Centre.
2. **Noted** that analysis has demonstrated the expected benefits of the service changes outlined in the home and community care programme, and that this analysis is outlined in full in a supporting document.
3. **Noted** that progress with implementation of the changes is on schedule.

### **Establishing the Care Coordination Centre**

The Board:

4. **Noted** that the Care Coordination Centre is a core service in the Integration of Home, Community, Primary and Specialist Services, and is the service that is central to the success of the new programme.
5. **Noted** that a Registration of Expressions of Interest (REOI) for the Care Coordination Centre was released on 28 November 2004 and five expressions of interest were received by the closing date of 1 March 2005.
6. **Noted** that a nine member evaluation panel fully evaluated the EOIs against the criteria and reached consensus agreement to recommend that Planning and Funding Directorate work with Nurse Maude Association to establish the Care Coordination Centre service by 1 July 2005.
7. **Agreed** that management consult with union representatives and potentially affected staff, including ascertaining their preferences, and take their feedback into account prior to making final decisions about the provider of the Care Coordination Centre.
8. **Agreed** that, following the consultation above and more detailed discussion with Nurse Maude Association, the CEO decide on the Care Coordination Centre provider and work with that provider to establish the Centre within the available budget of \$1.5 million per annum and the target commencement date of 1 July 2005.

### **Establishing Home & Community Care Packages**

The Board:

9. **Noted** that the development of home and community care packages is a key part of the roll-out stage of implementation in the home and community programme.
10. **Agreed** that Planning and Funding undertake a comprehensive process of specification, establishment, development and monitoring of the new community care package approach, using a request for proposal process to identify appropriate providers.
11. **Noted** that establishing these services is a developmental process that will take place over a period of years and Planning & Funding will work with each preferred provider to develop their capability over time.

### **Financial Implications**

The Board:

12. **Noted** that the home and community care programme largely involves a re-distribution of current revenue and resources, and that specific revenue changes for 2005/06 are being finalised as part of developing the 2005/06 budget.

