

FREQUENTLY ASKED QUESTIONS

What is the background to this project?

The past two years have seen C&CDHB steadily putting in place a different model for home and community services. The model started in response to the 2002 Health of Older People strategy. The approach arose out of many workshops including staff and consumers. There was a public consultation in 2004 on the model which largely supported the model and it was subsequently endorsed by the C&C DHB Board.

What are we attempting to do?

To develop, over time, a more patient focussed and integrated way of caring for people at home, trying to resolve the following problems that patients (and staff) told us that they experience:

- Confusion over boundaries between services – who does what?
- Fragmentation of services resulting in a lack of coordination between services – people fall through the gaps
- Duplication of services, referrals (different people turning up on different days to do the same thing)
- People not sure who to refer to or where to go to get services
- Clinical staff not always aware that other services are involved with someone
- Only being involved at crisis points and working on the back foot, not being proactive

Where are we up to?

Key aspects of the model and approach are now in place, this has included the establishment of the Care Coordination Centre, Care Managers who have the ability to assess, plan and establish care across a range of services and the development of a different way of funding and delivering care into the home based more on need rather than ‘what service someone fitted into’, as has been the case previously. We are though very much in a transition stage. The last two years has also seen developments in other areas such as:

- Palliative care - funding to expand the hospital palliative care team and to develop community based education and liaison roles from the hospice
- Stroke care - establishment of the rehabilitation arm of the stroke service and the soon to be established acute arm of the stroke service
- Residential care - training and developing residential care nurses in palliative care and care of the elderly
- Supporting carers - developing our options on how best to support carers

What are the next steps?

The next steps are about the development of community nursing and community allied health within the overall model to. We have therefore established a sector wide working group to think about and come up with some options that we will further develop and consult on. This will process will occur over the next few months.

Q: Which services are affected by the change?

A: The directly affected services are the HHS based Community Nursing, Community Allied Health and Capital Support.

Q: Is CCDHB considering taking district nurses out of its direct employment and having them employed by external agencies instead?

A: We have only just started to think about the different options that are available for the delivery and integration of community nursing and allied health with primary and community care. A sector wide working group has been established to discuss the issues that community health are facing and any options that may be suitable, which will then be consulted upon. This may mean that in the future, community nursing and community allied health may be delivered through a mix of primary and community care providers, the hospital and others. Any changes could involve a tender process.

Q: If services are delivered by another provider, will that mean we have to pay for services or that access to services will change?

A: No, service users will not have to pay anymore than they might do today and access to services will be at least as good as they are today, if not better. The DHB contracts with a large variety of 'not for profit', 'for profit' and 'Charities/Incorporated Societies/Trusts etc', many of who provide, and have provided for many years, a range of services to the community. Whatever options are developed, services will still be as free to patients as they are now. If any change of providers occurs in the future, the DHB will need to make sure that services will be at least as good as they are today and that people don't fall through the gaps. If this isn't the case, there will be no change.

Q: Where are these plans at? When is a decision being made? When would any changeover happen?

A: We are still at the very early stages of the process. The working group has only just had its first 'meet and greet' session. No decisions will be made until all options have been considered, consulted on and finally approved by C&C DHB Board.

Q: How will decisions be made on this?

A: The working group will develop an 'options paper', outlining the potential options that are suitable for community health services, this paper will be available for consultation, at which point we envisage that stakeholders can make any submissions regarding the options. The options and submissions will be presented to the Acting Chief Operating Officer/Director of Quality & Integrated Care and the Director Planning & Funding. A recommended direction will then be presented to C&C DHB Board and sub-committees for approval. Their advice and recommendations will then define what happens next.

Q: The working group contains people from primary health care and other agencies, why is that?

A: As much as possible we have always and continue to involve the whole sector in the design of health services through a collaborative approach. For people who may be directly affected by any potential changes this may feel uncomfortable, however we need to take a collaborative approach to ensure that all stakeholders are represented.

Q: Are jobs under threat? Are you planning to reduce the size of the service?

A: The aim of the integrated home and community care programme, (that started back in 2003/2004), has always been focussed on developing, over time, a more integrated and proactive approach to services delivered into someone's home, not job losses. This remains the case. C&C DHB primary/community based services need to develop capacity, capability and comprehensiveness to meet the growing number of older people who will need care over the coming years. This requires us to retain, develop and build our workforce to meet the needs of older people and especially those with chronic disease and palliative needs. We need to turn our focus more and more to supporting chronic care, restorative care and palliative approaches to care. We also need to look at similar 'journeys' that people take through our health system and see what models/services and processes can support or expedite those journeys e.g. admission avoidance services, discharge packages.

This requires changing what we do and the way we do it. This process is very much concerned with development and we believe that it will offer more opportunities for staff in the longer term.

However, options that might be developed through this process may not suit some people for a number of very good reasons. In this case, (just like in any other development), normal change management processes apply and where possible alternative arrangements will be found. Redundancy is always the last option and is only considered when all other alternatives for redeployment have been exhausted. As part of any change process it is important that information is shared and staff are able to participate throughout the process. If the final option creates a staff surplus, both staff and unions will be informed as soon as possible.

To re-iterate, to care for more people with chronic disease and palliative needs in their own homes, primary/community based services are growing in C&C DHB, (and internationally). Growing services need staff.

Q: Who can I contact to find out more?

A: Email communitynursealliedhealth@ccdhb.org.nz or call Anushiya Ponniah (project manager) on 04 385 5999 ext 4118