
*Next Steps: Integrated Home and
Community Care*

Developing Community Nursing
and Allied Health Services

Capital and Coast District Health Board

Response to Public Consultation

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Executive Summary

In 2003 Capital and Coast District Health Board (C&C DHB) began work on a proposal that that would fundamentally change the way in which home and community care services were delivered in the district. In July 2004, the Board consulted with staff and the public on the proposed Integrated Home and Community Care service model. The feedback from the consultation showed a high level of support from staff and the community for the Integrated Home and Community Care vision and service model.

Since 2004, C&C DHB has begun implementing the Home and Community Care services and continued planning for the next steps. From 17 October to 29 November 2007 the Board consulted with the public on proposals for further developing community nursing and allied health services.

1. Consultation process

The Board developed a consultation document that was widely distributed and available from the website.

The consultation process included opportunities for people to:

- Attend and express their view at any of the advertised meetings, hui and fono
- Request a special meeting with the Board
- Provide a written response. A submission booklet was provided by the Board.
- Present an oral a submission

In total there were 176 attendees at the meetings. Seventy-nine written submissions and one oral submission were also received.

This report is a summary and analysis of the meeting notes, written submissions and other feedback received through the consultation.

2. Options

Respondents were asked to identify their preferred option for developing community nursing and allied health services. The following table outlines the options outlined in the consultation document and the responses received from the written submissions.

Option	Description	%
1	Expand and develop Community Health Service by the hospital forming a partnership to deliver fully Integrated Care Services (acute and chronic).	45
2	Introduce a provider to deliver fully Integrated Care Services (acute and chronic).	8
3	Current packages of care providers to share provision of all Community Health Services and deliver fully Integrated Care Services (acute and chronic).	5
4	Deliver all home based service through a single (per district or TLA)	8

Option	Description	%
	provider that supports fully Integrated Care Services (acute and chronic).	
5	Continue existing model does not support fully Integrated Care Services.	25
Total		91%

Nine percent of the responses did not indicate a preference for option one to five.

The majority of respondents preferred option 1 and considered that this would support the development of fully integrated services.

The option had a sub question - whether a partnership to expand and develop Community Health Service should be not-for-profit. Eighty-five percent of the responses that preferred option 1 agreed this should be a not for profit partnership. Through the consultation, the Board was unable to provide details on the partner (as selection of a partner would have pre-empted the outcome of the consultation), the legal basis of the partnership and how it would work in practice. This appeared to limit support for the option.

The second most preferred option was option 5. Respondents with this preference often shared the view that the current district nursing service is effectively provided by C&C DHB and that this should continue. Changes in the structure or ownership of the service could threaten or disrupt the current workforce and the delivery of an essential service. These responses considered that C&C DHB has the foundations for an integrated team approach, and that these services are appropriately provided by public sector organisations.

3. Other options

Respondents were asked if there were other options they would like the Board to consider. Three alternative options for developing community nursing and allied health services were presented. They all proposed that C&C DHB should be responsible for the delivery of community nursing and allied health services.

1. C&C DHB develop community nursing and allied health services

The most common suggestion was to extend option 5 to include C&C DHB continuing to work towards an integrated care service by building on and developing the current district nursing and allied health services.

2. C&C DHB develop community health service

This option is similar to the one above, but takes a broader view of how community health services could be developed. Components of the option include close alignment and co-location of district nurses, specialist nurses, and complex care managers (currently located within the Care Coordination Centre).

3. C&C DHB establish a new publicly owned body

This body would report to and be the responsibility of the Board. It would be structurally separated from hospital-based services and responsible for delivering community nursing and allied health services.

4. Key themes

There was a high level of consistency in the key themes that emerged from the analysis of feedback received at the meetings and through the written submissions. The information may be useful for further planning the development of integrated home and community care services.

The key themes were:

- Improve processes, communication and coordination between primary, community and hospital services. This requires the development of systems (including information systems) that ensure that there is clear communication and pathways between services.
- Where possible services should be co-located as this supports working relationships and ease of communication.
- Develop a key worker or similar role. This suggestion recognises that the needs of some clients are complex and they will require a number of health professionals and support workers to be involved in their care. A key worker would be a single point of contact for the client and responsible for coordinating and liaising with all primary, community and hospital services.
- Increase the planning and coordination of hospital admissions and discharges.
- Extend the proposals to include primary care. This was considered important to improving the integration of home and community services with primary health care, and to meeting acute and long term age-related and chronic health needs.
- The emphasis on providing services in the home should recognise and support the roles of family/ whanau and carers. This should include consideration of their needs.
- Developing services into the home requires a corresponding increase in resources. This is necessary to meet the growing needs of an ageing population and prevalence of chronic illness, and an increasing expectation of community-based care and outcomes.

5. Additional to consultation process

A Kapiti based group of private individuals formed WeCare. The purpose of the group was *'to oppose any option by C&C DHB to disband the public district nursing service in the Kapiti and Wellington region'* (www.wecare.org.nz).

WeCare developed and distributed forms that supported no change to the district nursing service. There were different versions of the form and these varied in the level of detail and information provided. In total 1,586 forms were received. Submitters provided their address on the forms and these indicated that approximately 88 percent were from Kapiti, seven percent were from Wellington or Porirua and five percent were from outside the Capital and Coast district.

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1. Introduction

1.1 Background

In 2003 Capital and Coast District Health Board (C&C DHB) began work in a proposal that that would fundamentally change the way in which home and community care services were delivered in the district. In July 2004 C&C DHB consulted with staff and the public on the proposed Integrated Home and Community Care service model. The feedback from the consultation showed a high level of support from staff and the community for the Integrated Home and Community Care vision and service model.

Since 2004 C&C DHB have been implementing the Integrated Home and Community Care service model. Key achievements have included:

- Establishing a single point of entry for most referrals for home and community care services. This is provided through the Care Coordination Centre.
- Introducing comprehensive assessment for those clients with high needs.
- Establishing care management.
- Combining many funding streams to provide services that fit people's needs.
- Beginning to establish a specialist stroke service.
- Establishing restorative home and community care packages.
- Establishing a palliative care education and liaison role.
- Introducing a new approach to supporting carers based on early intervention and assessment of carers' needs.

C&C DHB also undertook planning for the next steps and in March 2007 a sector wide working group was formed. The working group identified a range of issues and requirements of home and community services. These informed the development of a series of proposals and options.

From 17 October to 29 November 2007 the Board consulted with the public on proposals for developing community nursing and allied health services. This report is a summary and analysis of the meeting notes, written submissions and the feedback received on the proposals.

1.2 Consultation process

The Board developed a consultation document that was widely distributed and available from the website.

The consultation process included opportunities for people to:

- Attend and express their view at any of the advertised meetings, hui and fono
- Request a special meeting with the Board

- Provide a written response. A submission booklet was provided by the Board.
- Present an oral a submission

1.2.1 Public meetings, focus groups and staff meetings

A range of meetings were held and these were an opportunity for attendees to hear representatives from the Board present the proposals for developing community nursing and allied health services, to ask questions and clarify any aspect of the presentation and present their views to the Board.

Four public meetings, two hui and one fono were planned as part of the public consultation process. In addition groups could request a meeting. One group, the Kapiti Community Health Group Trust, made a request and this was accommodated.

The following table outlines the meetings held and the number of attendees at each meeting.

Meetings	Attendees
Kapiti - public meeting	57
Porirua - public meeting	14
Wellington - public meeting	20
Johnsonville - public meeting	13
Porirua - hui	2
Waikanae – hui	38
Wellington – fono	14
Kapiti Community Health Group Trust	18
Total	176

Notes of each meeting were recorded and included in the analysis of the consultation.

1.2.2 Submissions

The date for submissions to the Board closed Thursday 29 November 2007, with late submissions accepted up to Thursday 6 December 2007.

1.3 Additional to consultation process

A Kapiti based group of private individuals formed WeCare. The purpose of the group was '*to oppose any option by C&C DHB to disband the public district nursing service in the Kapiti and Wellington region*' (www.wecare.org.nz). Earlier in the year We Care developed a petition and collected over 6,000 signatures by July 2007. As this preceded the development of a consultation document and formal consultation process, the petition has not been considered in the report.

During the consultation, WeCare developed and distributed forms that supported no change to the district nursing service. The feedback received from these forms is included in this report.

2. Summary and analysis of written and oral submissions

2.1 Overview of written and oral submissions

The total number of written submissions received was 79.

The consultation documentation included a booklet for written submissions. Written submissions not presented in the booklet provided were also accepted.

Respondents were asked to provide the type of organisation they worker for, if any. The following outlines an overview of the groups of respondents.

Respondents¹	Number	Percent
C&C DHB staff	16	21
Other organisation	33	38
Individual	30	41
Total	79	100

Respondents were asked to indicate the number of people who contributed to a submission, however not all provided this information. Based on the information provided, it is estimated that at least 145 people contributed to the 79 submissions.

One group made an oral submission to the Board.

The rest of this section outlines a summary of the responses and the key themes that emerged from the submissions.

2.2 Do you agree that district nursing services, allied health services and support workers should all work together in a coordinated way?

Eighty-six percent of the responses agreed the services should work together in a coordinated way and supported the proposal.

'This would prevent fragmentation of services, facilitate a team approach to care, and avoid duplication of services.'

'We are strongly of the opinion that district nursing services, allied health services and the all-important support workers should work together in an coordinated and integrated way.'

¹ See appendix A for a list of respondents.

A coordinated approach was considered important to improving communication both between providers and with the client.

'Yes, as our clients repeatedly tell us that having multiple visitors in their homes, each from a different organisation and completing different tasks, is confusing and annoying.'

Some responses considered that as district nursing and allied health services and support workers already work together in a coordinated way that this should continue. Several noted that where this does not happen, it is due to a lack of communication and under-developed processes.

Others considered that although coordination was already a requirement of services, this could be improved and strengthened to achieve the goal of fully integrated services.

One respondent noted that:

'Service and agencies working together is a current requirement irrespective of how they are structured and organised. The aim of change should be to make it as easy as possible for services/ occupational groups to do so in order to achieve better client outcomes.'

Fourteen percent of responses did not answer the question.

2.2.1 Improve processes, communication and coordination between providers

Many responses noted the need to improve the communication, coordination, and processes between services. This was required to ensure needs are met, to ensure clients do not *'fall between the gaps'*, to develop *'collaborative practices based on patients needs'*, and to make effective use of resources.

'Irrespective of whom the care providers are, the prompt screening and allocation of services is dependent on the efficiency of the communication interface.'

Systems that ensure that there is clear communication and pathways between services to enable shared planning and smooth transitions between services are required.

Multiple services

Some respondents noted that the needs of a client often required a number of health professionals and support workers to be involved in their care. The example outlined in the consultation document included district and specialist nurses, care managers, support workers and a dietician. An improvement in coordination will not necessarily reduce the need for such multi-disciplinary services.

'With such a big chain of people...we may feel things work in a coordinated way, [however] consumers may not agree.'

Other respondents noted that the range of services would continue to be provided by multiple organisations such as primary care, home support providers, non government organisations (such as Mary Potter Hospice and residential services) and the DHB. The risks of the limited approach to improving coordination would create and result in a different set of issues with ongoing potential for poor communication and coordination at the interfaces between the teams and services, and fragmentation.

Proposed solutions

A range of solutions and improvements in processes, communication and co-ordination were suggested. These included:

- further defining the role of the Care Coordination Centre,
- improving the triaging of urgent referrals by the Care Coordination Centre,
- referring the current referral processes² between providers and the Care Coordination Centre,
- developing information systems to include shared electronic clinical notes and assessment data across primary, community and Hospital services,
- joint multi-disciplinary teams,
- shared understanding, planning and monitoring of care across services,
- co-locating services or positions where possible,
- increasing use of flexible contracts focussed on meeting the needs of the service users,
- clarifying roles, responsibilities and accountabilities across the system,
- developing a key worker system.

Key workers

Many submitters considered there was a need to establish a key worker or similar³ role. The key worker would be a single point of contact for the client and all primary and community services.

One respondent provided the following description of the role:

'The role needs to be flexible to ensure it is responsive in coordinating and brokering services following secondary discharge, acute demand and rapid response situations, but also link with primary care.'

There were different views on how the key worker should be provided. Options ranged from:

- primary care,
- establishing a new case management agency,
- extending the role of the care managers, and
- mixed approach.

² *'This is to address problems such as ensuring consistent confirmation of the receipt of referrals, prescription clarification, health care providers who are unavailable, avoiding delays...'*

³ Other terms given for similar types of role were case manager and case coordinator. To avoid confusion the single term 'key worker' has been used in this report.

A mixed approach would mean that the service best placed to provide the key worker role may vary. However with appropriate support and information systems in place, the role should be consistently implemented.

If the role is not provided by the care managers employed by the Care Coordination Centre, this role would need to be differentiated from the key worker. One suggestion was that the care manager role should be reviewed as it may be appropriate to be more closely aligned with the package of care providers.

'Care managers could facilitate more seamless care through direct involvement in care planning by working with the [package of] care providers at the clinical interface.'

Leadership and a team approach

Others noted that a whole system and integrated approach was required to avoid unnecessary hospital admissions, improve discharge planning and provide timely community follow-up. This requires a well coordinated structure, good management and leadership for a team approach to client care.

'The model should create a team feeling so all disciplines feel part of the same team working towards the same goal. A model that makes us all feel that we are under the same umbrella.'

2.2.2 Extend the proposal to include primary health care

Some considered the proposal should be expanded to include primary health care including practice nurses. This was considered important to improving the integration of home and community services with primary health care, and to meeting acute and long term age-related and chronic health needs in a *'seamless and integrated way that meets the potential of the Primary Health Strategy'*.

One group of respondents noted that:

'The context of primary health and secondary care had changed significantly since 2004 [when the home and community care model was developed] and we feel it was erroneous to operate from the problems and solutions identified at that time.'

Other developments include the establishment of mobile nursing roles and CarePlus funding for use by people in primary care with two or more chronic illnesses.

Some respondents considered these developments had changed the health and community services environment. Some thought that *'primary health care should [now] provide the lead for health delivery to individuals in their homes.'* They considered the proposals should be reviewed and the role of primary health care services in a fully integrated home and community care service framework should be reconsidered. Options proposed included increasing the delivery of primary health care services provided in the home. One respondent extended this to providing support to carers and home support workers.

One respondent extended the proposal to other community services noted that:

'All options are oriented to meeting demand (reactive/ crisis) need rather than being proactive. The weakness in all the models is that integration with primary health services and any other providers appear to have minimal attention.'

2.2.3 Relationship and coordination with C&C DHB

Many respondents noted the need for community-based services and C&C DHB to maintain close working relationships. This is important to ensuring that information is shared between the agencies and planning is coordinated.

If there is a change of provider, some respondents noted the risk of district nurses becoming isolated from the Hospital and specialist nurses. This needs to be maintained to provide coordinated service delivery to a client.

Some considered a change in providers would impact on the quality of the services provided, and the ability of community nurses to meet the expectations required of them.

'Care will be compromised if specialist nurses work for C&C DHB and district nurses work for a private provider who may not have the high standards expected from their organisation...'

Other respondents commented on ways of continuing to develop the quality of services. These includes combined workforce development and ensuring community nursing and allied health staff can continue to access the Professional Development Unit provided by C&C DHB.

2.2.4 Kapiti

Many of the submissions noted issues specific to Kapiti. Often these considered that integrated care is already provided in that district, and that district nursing is a central component of the system.

'The community nursing service in Kapiti has been described by the community as the jewel in the crown for C&C DHB.'

At the Kapiti Health Centre primary, secondary outpatient, Maori and community care services are co-located and this is considered to have many benefits including that services are able to liaise and share knowledge of mutual clients. One suggestion was that the Centre could be developed to accommodate a wider range of home and community care services including allied health.

A view expressed by several respondents was that the C&C DHB should explore with the community how a fully integrated community and home services can be achieved without contracting any more providers. It should build on and strengthen the current providers and enable the community to meet the increasing age related needs of its

population. This was considered particularly important given the travel distance from Kapiti to a Hospital.

One of the reasons provided for not supporting a change in ownership and responsibility for providing district nursing and allied health services was:

'The Kapiti Coast is on the margins of the C&C DHB area with limited ability to influence the Board's decisions and this has compromised the level of service for our community. Introducing a partner or partners will further reduce the ability of Kapiti residents to influence the available service.'

2.3 Do you agree that we should continue to develop services into the home?

Eighty-one percent of these responses agreed that C&C DHB should continue to develop services into the home. This was considered important to meet the growing demand for these services and providing an appropriate response.

One respondent noted:

'The increasing pressures of an ageing population, health workforce shortages and a growing prevalence of chronic illness is being met by increasing expectation of greater and higher quality community-based care and outcomes.'

Demand for improved and integrated primary health care services will continue to grow and district nursing services will need to be support and expanded to meet this need.

The proposal also recognises *'that most research finds that people do better in their own home surrounded by their own people and belongings'*, a view endorsed by many respondents.

Nineteen percent of responses did not did not answer the question.

There were a range of suggestions for developing services in the home and these are summarised below.

2.3.1 Meet the needs of carers

The emphasis on providing services in the home should recognise and support the roles of family/ whanau and carers. This should include consideration of their needs. One respondent provided the following example:

'I have visited clients with terminal conditions who wanted to be at home and were supported by their families. But the support workers were not trained on how to use a hoist or manual handling techniques. Well trained professionals and suitable resources are required to make these services work for carers.'

One respondent proposed that in some situations family/ whanau or carers should be paid to provide care on a temporary or ongoing basis.

2.3.2 Increase resources

Some respondents considered that developing services into the home required a corresponding increase in resources. Most often this was considered necessary to meet the needs of a growing population and associated demand. Others linked this to the establishment of the new regional hospital. A reduction in number of beds available will increase the emphasis on earlier discharge dates and reduce lengths of hospital stays, and some considered a flow on effect would be an increase the acute disability needs in the community.

'We are concerned that as we continue to increase the amount of provision of services in the home, there will not be an equivalent increase in resources to meet these demands.'

Sufficient levels of resource are required to ensure services are able to provide an appropriate and timely response to demand.

Staff also need to have the right skills.

'Care managers and staff need to be trained to not only deal with the elderly but also with the chronically ill.'

Some questioned whether with the current workforce shortages it was feasible to continue to provide a 24 hour district nursing service.

2.3.3 Coordinated hospital admissions and discharges

There is a need to increase the planning and coordination of hospital admissions and discharges. Respondents provided examples of poor or delayed follow-up post-discharge from hospital. Examples covered a range of services including district nursing, the Care Coordination Centre and packages of care providers.

Some respondents consider that currently health professionals make assumptions about a person's home situation and that, post discharge, family and friends will be available to provide support and this may not always be the case.

A disability service provider noted that:

'Our experience suggests that if a person is identified as being in residential care then early discharge is activated, without any regard to the capability and competency of disability services to meet the need of acutely unwell people.'

Ideas for development include assessing a person's home situation prior to a planned admission to Hospital to ensure supports are in place upon discharge, and improving the timeliness of assessments. One example of where this did not occurred involved a

person being discharged home on Friday but a support assessment not occurring until the following Monday.

Some responses advocated for a key worker or liaison-type roles between hospital and community service. The goal would be to provide a prompt response and problem solving to ensure discharges planning and services were coordinated.

2.4 Do you think the integrated care team approach would address the issues that we still face?

Fifty-six percent of the responses agree that the integrated care team approach would address most issues. Respondents considered it would improve communication and coordination between services and improve the likelihood of an appropriate and timely response.

Sixteen percent of responses were unsure the integrated team approach would fully address the issues.

Eight percent of respondents did not agree that the integrated care team approach would address most issues. These responses often considered that an integrated team approach was already in place, and that change would disrupt this.

Some of these respondents had used and were satisfied with the services.

'Integrated care is what used to be called cooperation and communication and this worked perfectly well when my husband and I needed immediate help...'

Twenty percent of responses did not answer the question.

2.4.1 Issues not fully addressed

The most common reason for not agreeing or being unsure of the proposed integrated team approach, was that it did not fully address the issues.

Gap commonly noted included the role and relationship with primary health care and communication between providers as previously discussed in this report.

Other common areas to be addressed included the responsiveness of all home and community services including district nursing, allied health and particularly home support workers, and the capacity of those services to respond to demand.

One group of respondents considered the proposals do not address...

'...the increasing need for registered staff to meet the demand for delegation and supervision/ direction of the community support workers required by all community providers.'

Other areas considered not fully addressed by the proposals included co-ordination between:

- C&C DHB rehabilitation service and community providers. This is important to the continued development of a restorative package of care approach.
- District nurses, specialist nurses, support workers and the allied health team. Co-location between these roles was considered important to team cohesion.

2.5 Do you agree with the developments that we are proposing?

Forty three percent of the responses agreed with the proposed developments. Some respondents qualified their support for the proposals. Comments were similar to those previously discussed including the need to achieve integration across a broader range of services including primary health care, community-based services, Hospital and rehabilitation services.

Nineteen percent of the responses disagreed with the proposal. Commonly these respondents considered the current district nursing service is working well and that change will disrupt the service.

These responses proposed that C&C DHB has the foundations for an integrated team approach and should continue to provide and develop these services. A common reason for this view was that these services are appropriately provided by public sector organisations. Another view was that the DHB should not confine itself to the delivery of Hospital services. This could result in broadening the gap between Hospital and community services, and stifle innovation within the DHB.

Some thought that a community-based provider will decline referrals for people that have complex needs. Other views included that '*there are too many private health services making a profit at the DHB's expense*'.

Others considered that district nurses should be part of a team as specialist nurses and have the same employer, which would be C&C DHB.

Sixteen percent of the responses were unsure of the developments or did not respond to the question. Twenty percent of the responses did not answer the question.

2.6 What is your preferred option?

Question five asked the respondents for their preferred option to developing community nursing and allied health service. The following table outlines the options and the responses received from the submission booklets.

Option	Description	%
1	Expand and develop Community Health Service by the Hospital forming a partnership to deliver fully Integrated Care Services (acute and chronic).	45
2	Introduce a provider to deliver fully Integrated Care Services (acute and chronic).	8
3	Current packages of care providers to share provision of all Community Health Services and deliver fully Integrated Care Services (acute and chronic).	5
4	Deliver all home based service through a single (per district or TLA) provider that supports fully Integrated Care Services (acute and chronic).	8
5	Continue existing model which does not support fully Integrated Care Services.	25
Total		91%

Nine percent of the responses did not indicate a preference for option one to five.

Below is a summary of the types of comments made on each option.

2.6.1 Option 1: Expand and develop community health service by the hospital forming a partnership

Many respondents who supported this option noted their support was conditional on knowing which organisation would partner with C&C DHB, and the details of how the partnership would be enacted.

The option had a sub question. This asked whether a partnership to expand and develop Community Health Service should be not-for-profit. Eighty-five percent of the responses agreed that the partnership should be formed on a not-for-profit basis. This was considered essential to providing accessible and equitable client-centred services.

Other comments on the option included that it would:

- Enable the development of community nursing and retain the relationship with specialist nursing and the Hospital. These relationships are vital to providing fully integrated community services.
- Allow the engagement of a partner with expertise and willingness to invest in the service.
- Enable the current district nursing and allied health team to continue and provide the same level of 24 hour service.

- Provides some surety to the current team – *'particularly if they continue to be employed on the same terms and conditions.'*

One suggestion was that the partnership could be piloted in one area and the outcomes evaluated before proceeding with full implementation. Other respondents thought one of the strengths of this option would enable the service model to evolve and develop over time, while others saw this as a risk with C&C DHB would eventually withdraw from the service.

Other community organisations and C&C DHB staff (including those that provide specialist nursing services) stated an expectation that they would be involved in discussions on the partnership, as it could significantly impact on roles, responsibilities and interfaces. They would want to be assured that key service requirements continue to be met.

Although some respondents preferred the option they questioned if it was feasible. Some thought it unlikely that C&C DHB would be able to identify a suitable partner. Others suggested there could be more than one partner and that Primary Health Organisations should be considered as an option.

2.6.2 Option 2: Introduce a provider to deliver fully integrated care services

This option was considered to be very disruptive to current services and generally not supported.

One respondent proposed a modified version of this option. This would see a fourth entity established to provide case management for people with acute and chronic needs; were being discharged from hospital, and eventually those with palliative care needs. The fourth entity would incorporate district nursing and allied health services and work closely with the current packages of care providers.

2.6.3 Option 3: Current packages of care providers to share provision of all community health services

Comments that supported this option included that it would reduce the number of workers and organisations involved with a person. This would improve communication and response to need.

Those who did not support the option, considered the current capacity and service delivery issues associated with packages of care precluded the viability of this option. It would also over-stretch the community nursing and allied health resource and the ability to provide 24 hour services. This could create inequities between providers and areas.

The option was not supported by two packages of care providers. One of the providers considered as it would not provide the scale required to efficiently manage this service. The option was likely to be expensive and potentially pose a risk to client safety. The second provider said it would disrupt initiatives and progress currently underway.

Other respondents considered that this option could be extended to include a wider range of primary and community-based providers working under a common service framework with a contracted lead provider.

2.6.4 Option 4: Deliver all home based service through a single provider (per TLA) that supports fully Integrated Care Services

This option was supported on the basis that it would enable services to develop and respond to the needs of an area. One respondent summarised that the option recognises that *'one size does not fit all'*.

Others noted that this option could create different communication issues. Hospital services would need to liaise with multiple providers. The option would create different boundary and interface issues and potentially increase fragmentation.

The option was also rejected for reasons similar to option 3 – that it would also over-stretch the community nursing and allied health resource, and could create inequities between providers and areas.

2.6.5 Option 5: Continue existing model

Respondents who preferred this option, commonly considered that the district nursing service is currently effectively provided by C&C DHB and that this should continue. Any changes could threaten or disrupt the current workforce and the delivery of an essential service. This could create uncertainty for service users and undermine confidence in the service.

Many respondents considered that the option should be extended to include C&C DHB continuing to work towards an integrated care service. This option is discussed in the next section.

Comments that did not support this option were that it did not allow community nursing and allied health to be developed into fully integrated services.

2.6.6 Comments on the options

Some respondents commented that the consultation document did not provide sufficient information on the options to enable a considered or assured choice.

One respondent who preferred option 1 noted:

'The consultation document does not provide any evidence that such a partnership has been shown to be the most effective means of achieving integrated care services. In the absence of such evidence option 1 may be only a conceptual improvement.'

This view was shared by other submitters. One noted that the Board had not provided any evidence that contracting out community nursing and allied health services would be more effective than a publicly owned organisation.

Many respondents were concerned that option 5 was presented negatively in the consultation document and meetings.

'The presentation of option 5 is clearly negative in that it presents only one possible benefit and a raft of risks and disadvantages.'

Others said that most of the options had potential but that further explorative discussions with community providers, primary health care and communities was required.

2.7 Other options

Respondents were asked if there were other options they would like the Board to consider. Three alternative options for developing community nursing and allied health services were proposed. All of the options propose that C&C DHB should be responsible for the delivery of community nursing and allied health services.

2.7.1 C&C DHB develop community nursing and allied health services

The most common suggestion was to extend option 5 to include C&C DHB continuing to work towards an integrated care service by building on and developing the current district nursing and allied health services.

Options for developing the services included:

- increasing the number of home support workers working as part of the team,
- developing acute and chronic care specialities,
- improving technology and information systems,
- working more closely with primary health care, and
- increasing the capacity of the service by increasing the number of positions.

2.7.2 C&C DHB develop community health service

This option is similar to the one above, but takes a broader view of how community health services could be developed. The submission was detailed and a summary of the key components to this option is outlined below. Some other components have previously been discussed in this report e.g. the need to invest in and develop information systems between providers.

1. District nurses and specialist nurses would be closely aligned and co-located to provide an integrated care team approach that spans Hospital and community services.
2. Co-locate complex care managers (currently located within the Care Coordination Centre) with the community health service.
3. Explore the development of a nurse practitioner role to enhance community care to people with complex needs.

4. Increase the focus of palliative care services (with the aim of avoiding situations where a person's care is compromised by inadequate training to support workers employed by package of care providers).
5. Develop of discharge planning pathways between the Hospital and community health service and provide additional resources e.g. discharge planners available seven days a week, and training.
6. Close collaboration with primary health care services in treating and case managing people with chronic diseases, and to develop a model of care.

2.7.3 C&C DHB establish a new publicly owned body

This body would report to and be the responsibility of the Board. The proposed new body would be structurally separated from the existing administrative arrangements for hospital-based services. The proposed functions of the new body included:

- direct delivery of community nursing and allied health services,
- responsible for long-term and ongoing development of the services,
- providing some oversight of packages of care services,
- subject to regular independent reviews,
- responsible for developing, integrating and implementing a new multi-disciplinary team approach to community nursing and allied health services over the next three to four years.

A long term goal would be to have a sufficiently robust and flexible structure to allow it to assume responsibility for the delivery of carer and restorative packages of care if necessary i.e. if the existing contracted arrangement do not provide suitable services.

2.8 Other comments

Respondents made a range of other comments. Common themes are summarised below.

2.8.1 Services should provided on a not-for-profit basis and continue to be free

Irrespective of which option the Board decides to develop further, many respondents stressed the need to ensure the community nursing and allied health services should continue to be free to the client. Their concern is that at some stage in the future, a community-based service would introduce charges, particularly if the organisation intends to make a profit from the service. This was often considered to be a poor use of public funds raised through taxes and that it could reduce the quality, availability and effectiveness of the services and accountability for this. This contributed very strong preferences for community nursing and allied services to be delivered from a not-for-profit basis.

2.8.2 Partnership

There was a good level of support for a partnership approach for providing community nursing and allied health services provided the partnership was established on a not-for-profit basis. However some respondents were concerned that over time the arrangement would change, and that the Board would withdraw from the partnership. Others had a different view and saw that this could be a natural evolution of the service model as alignments with other community-based services and primary health services were made.

2.8.3 Cost cutting

Several respondents considered that the proposals for developing home and community care related to the goal of reducing costs by reducing the level of pay to the district nursing and allied health staff, and increasing the reliance on carers and home support workers.

2.8.4 Allied health services

Although part of the consultation, few comments were made on the allied health services. The submissions that did address allied health were detailed and indicated that further discussion on the best way of providing and delivering these services was warranted. Comments included:

- that a community-based model would most effectively meet the needs of people with chronic illnesses and disabilities,
- the need to increase resources both within the hospital and community,
- the need to ensure good alignment with a range of services.

2.8.5 Maori, Pacific and low income groups

The consultation document noted that the needs of Maori and Pacific were a priority for the Board. Other groups requiring specific consideration include refugees, migrants and households on low incomes. These groups often have high health needs yet the consultation document did not explain how the options would better meet their needs and this requires further exploration.

2.8.6 Evaluation

The consultation document did not provide information of the outcomes of the changes that have already occurred including the establishment of the Care Coordination Centre. As this information will have a bearing on the further development of home and community services, some respondents would have liked this to have been included.

The future evaluation of services should include:

- how the care is delivered,

- the views and experiences of the service users and their carers, including improvements in their wellbeing,
- staff recruitment, retention and job satisfaction.

2.8.7 Ongoing discussions

A group of respondents noted that once the Board had decided the structural approach to the development of community nursing and allied health services...

'...there still remains much work to be done on the range of measures, quality assurance mechanisms, funding controls, service delivery guidelines etc...to ensure an improved/ acceptable standard of service delivery. It is our view that this latter part of the process should be informed by vigorous, open community consultations.'

3 Summary and analysis of meetings

Notes of each meeting were recorded and this section outlines a summary of the key themes that emerged from the meetings.

3.1 Partnership approach

The Board proposed an option where the Hospital would establish a partnership with a community-based organisation to provide community nursing on a not-for-profit basis. The option was often considered to have potential by attendees. The Board was unable to provide details on the partner (as selection of a partner would have pre-empted the outcome of the consultation), the legal basis of the partnership and how it would work in practice. This appeared to impact negatively on the level of support for the option.

Others thought that the Board should consider a wider range of community-based partners and suggestions included Primary Health Organisations and Pacific Health Services.

3.2 Risks of changing providers of district nursing

A common theme was the possible risks associated with changing the ownership and responsibility for providing district nursing from the hospital to community-based providers. The risks were considered to be significantly higher where the community-based provider intends to make a profit from the service.

The range of risks considered to be associated with community-based providers included:

- inappropriately drawing a profit from a tax payer funded service,

- potential of a monopoly provider of district nursing leading to poor quality services at an inflated price,
- lack of investment in the workforce leading to reduced service quality,
- different levels of pay (community-based providers were considered to pay less than the Hospital),
- loss of connection with the Hospital would make it difficult for district nurses to carry out their role,
- difficulties of effectively monitoring and addressing quality issues,
- loss of accountability for the service - the Board of C&C DHB are publicly elected and accountable, and the public would have no say in the governance of a private organisation.

A common concern was that if district nursing was contracted to community-based providers, and this was unsuccessful, it would be difficult to re-instate the service within C&C DHB.

There was some support for the ability to community-based organisations to provide community nursing and the Nurse Maude service in Christchurch was noted as a successful example. The benefits of this type of service delivery model included the ability of community nurses to provide support and training to home support workers.

3.3 Rationale for change

Some people commented that the Board had not provided sufficient information and a rationale for change. Suggestions of the type of information that could have been usefully included in the consultation document included a cost and benefit analysis of the options.

3.4 Value the existing district nursing services

Many people said that they valued and trusted the existing community nursing service and the role they have in supporting people in their homes. They were concerned that changes would disrupt a workforce and service delivery. This appeared to contribute to led to many attendees concluding that there was no benefit in changing the current provider.

3.5 Community nursing workforce

A common theme was the shortage of nurses. Any changes to the employer of community nurses were considered a threat to maintaining the current workforce. Comments included that community nurses currently employed by C&C DHB could be unwilling to work for a community provider, and that a community provider could be unable to attract the number of nurses required. This could impact on the availability of services and place pressure on primary health care providers to meet the gap.

It was also noted that increasingly nurses were unwilling to work on a 24 hour roster and there was a lack of male nurses able to work with men. Irrespective of how integrated community nursing services are developed, the challenges of attracting, developing and maintaining a skilled workforce to meet the requirements of the service will need to be addressed.

3.6 C&C DHB should develop the service

These comments recognised the need to develop district nursing to provide integrated home and community services. It was proposed that C&C DHB should continue to provide district nursing and undertake the development of the service in line with the integrated vision.

3.7 Communication and planning

Communication and shared planning between services was noted to be a current issue that required addressing. The most common example of where this failed to occur related to the quality of discharge planning from hospital and the impact this may have on the person and their family/ whanau or carers.

'We get people being discharged from hospital but without proper planning. The hospital makes assumptions about what supports are available in the community.'

This was considered to be a hospital-based issue but that a wider systems response was required to address this. One option was to develop a liaison role that supported planning and coordination between the hospital and community services. Other views were that the district nurses have a role in rectifying issues that have arisen from a discharge planning.

Another option to improve communication between services was to physically co-locate community services together. This would ensure the relationships and communication between providers were established and maintained.

Although the number of assessments a person undergoes to access and receive services has reduced with the establishment of the Care Coordination Centre, these should be further reduced. One example given was that the Care Coordination Centre and the package of care provider both completed assessments, often within a short timeframe.

3.8 Other comments

3.8.1 Care Coordination Centre and Packages of Care

The development of the Care Coordination Centre and packages of care that has occurred in recent years received positive comments.

Packages of care are implemented by home support workers and they are a valued part of the workforce. However the quality of the service provided by home support workers is not yet consistent and suggested areas for further development include:

- increasing the continuity of home support workers engaged with a person,
- developing the level of skill and a career pathway for home support workers, and
- increasing the level of clinical support provided to home support workers.

A further area for development is extending the focus of home and community care services to include spiritual, social, income and housing needs, and the needs of family and carers in assessments and packages of care.

The DHB representatives noted that the suggestions were aligned with the goals in place for further developing the service.

3.8.2 Shortage of general practitioners in Kapiti

At the Kapiti meeting, the shortage of general practitioners and the impact on this has on the health of the community was discussed. The flow-on effects include the inability of community members to access government-funded primary care schemes like Care Plus.

4 Additional to consultation process

In addition to the consultation process, WeCare developed and distributed forms that supported no change to the district nursing service. There were different versions of the form and these varied in the level of detail and information provided.

Version one

The more detailed versions of the form commented on options one and five.

'What's wrong with option 1?

The C&C DHB strongly promotes option 1 – forming a 'partnership' with an outside provider to operate our district nursing service. C&C DHB wants the community to back Option 1 without even knowing who the partner is and how the option will work.

Why choose option 5? Only option 5 guarantees keeping our district nursing services directly through public ownership in the DHB. It must be properly resourced and expanded to meet our growing needs.'

The majority (65 percent) of the submissions received were made on these forms.

Version two

This was one of two versions of a form printed in a local Kapiti⁴ newspaper. The form included the following statement:

'What fix something that isn't broke? Why form a partnership with an outside provided to operate out district nursing service?

Keep our district nursing services under direct ownership of the DHB.

Option 5 will keep us alive.

Expand the resource to meet our growing need?'

The form referenced option 5 only. Six percent of submissions received were made on this version of the form.

Version three

This was the briefest form and it was printed in a local Kapiti newspaper. The form included the following:

'I support to option 5. No change to our district nursing service. Keep under the DHB – not contracted out/ services to another provider. Expand/ resource to meet our growing needs.'

Twenty three percent of responses were made on these forms.

⁴ A form appeared in the Kapiti Observer 19 November. The report writer has not ascertained if the forms appeared in any other papers or dates.

Number of forms

Submitters provided their address on the forms. The following table shows the number of forms received and the area the respondents were from.

Area	Number	Percentage
Wellington/ Porirua	106	7
Kapiti	1405	88
Other	75	5
Total	1586	100

Appendix 1: Submitters

Written submissions were received from:

Annie Kieser, C&CDHB
Dr Mythily Ramanathan, Wellington People's Centre, Medical Services
Barbara Barendregt
Helen Gannon
Angus McDougall
Sipaia Kupa, C&C DHB
Richard Medicott, Island Bay Medical Centre
Leila Claypoole, Maraeroa Health Clinic
Margaret Guthrie
Beryl Mary Reynnds
Helen Reynnds
Claudia Hosking
Gaynor Nairn
Doug Inch
Mrs Ivy P Hancox
Sharon Elson, C&C DHB
Sue Wolyncewicz, C&C DHB
Lance Wiggins
Louise Wiggins
Catherine Gregory
Kapiti Therapies Team, C&C DHB
Sheree East, Nurse Maude
Sheila Hayhurst
Janice Lowe
Molly Seah, C&C DHB
Steve Wittaker, C&C DHB
Annette Helliwell, Stroke Club
Ellie Garden
Dan Romanis, Royal District Nursing Services
Di Andrews
D Shaw
Kate Syer
John Sutherland
M Syer
Andrew Thompson Davies
Ruth Moxon, C&C DHB
Wendy Rhodes, IDEA Services Ltd
Peter Sander, Kapiti Coast Grey Power Association
Susan Shingleton, Kapiti Community Health Group Trust
Margaret Sanders, C&C DHB
Eileen McKinlay, Wellington Primary Health Care Nurses Reference Group
Warwick Taylor, Wellington Residents Coalition
Debbie Bastings, Wellington MS Society

Peter Macaulan
C J McKay
Allison Chappell
Beverley Chappell
Donna Voice
Kerri Arcus
Dr Andrew Simpson, Wellington Blood and Cancer Centre
Mercedes Utges Blesa, C&C DHB
Ria Earp, Mary Potter Hospice
Sue McCullough, PSA
Clive Cameron, Waikanae Health Centre
Sandy Lyster, C&C DHB
J J Herbert
Dr Anne Else
Bernice E Kelly
Mark Woodard, Presbyterian Support Central
Brenda Anderson, C&C DHB
Michael Howard, WIPA, Capital PHO, Tu Mai
William Scollay, Paraparaumu Raumati Community Board
Peter Hausmann, Healthcare of New Zealand Ltd
John Britton, Wellington Free Ambulance
John Wane, Capital Nursing
John Watkeys, Kapiti PHO
R Russell
Inga O'Brien, Cancer Society
W Adamson
Janis Warburton, C&C DHB
Matthew Callahan, C&C DHB
Gordon Strachan
K Lusty, Kapiti District Trust
Vicky Noble, SECPHO
Samantha Hutcheson, Kapiti District Council
NZ Nurses Organisation, on behalf of members working within the Community Health Services at C&C DHB

Oral Submission:

Wellington Residents Coalition