Community Nursing Integration Project

Stakeholder feedback from Open Forums in Tauranga and Whakatane

Summary

From the feedback received, we were able to identify some emerging themes which are summarised in Table 1 below. Note that this is an initial, high level analysis only. The full feedback from each forum can be found in Table 2.

Table 1

Problems and barriers	Emerging Opportunities and Solutions
Patient and family /Whanau needs: • Services need to be available 24/7 • Social determinants impacting on health • Cultural needs not being addressed • Inequity & Access • Complexity of needs • Complex system, difficult to navigate • Inconsistent information • Reaching vulnerable and disengaged population • Cost of services	***Patient and family/Whanau needs:*** • One point of contact • 'One stop shop' • Reduce complexity to support self-care • Improve health literacy • Cultural awareness • Whanau Ora approach
Co-ordinated Care • Duplication • Inconsistency • Fragmentation • Multiple providers, multiple referral systems • Poor 'transfer of care' to community following hospital admission	***Co-ordinated Care*** • One point of referral • Clear, consistent criteria • Multi-disciplinary input and approach • Identified care co-ordinator • Standardise processes • Better support for transfer of care to GP and community provider
Information Systems • Lack of information sharing • Difficulties accessing patient information to provide right care • System not joined up to share/transfer information easily	***Information Systems*** • Shared electronic patient records • Uniform operating system • Shared care record and plan • Mobile technology • Telehealth
Workforce • Future workforce shortages and ageing workforce • Increasing specialisation vs core skills • Lack of leadership • Lack of new grads	***Workforce*** • Specialists dedicated to community • Develop core skills • Generalist workforce supported by specialists • Workforce plan for future • Leadership and skills to support changes
Funding • Unmet need • Siloed funding • Cost barriers – public vs private/co-payment • Funding doesn't follow patient	***Funding*** • More high trust, integrated contracts • Outcomes focussed contracts • Targeted funding to those most in need

Table 2

Question	Tauranga Feedback	Whakatane Feedback
1. In your view, what is the problem to be solved?	• Early supportive discharge from Acute Ward – social – multi-disciplinary teams • Lack of funding for ageing population • PHO infrastructure currently does not support sustaining a large structure due to financial constraints • Lack of palliative care facilities/home for chronic conditions/non cancer • Education opportunities limited for both patient self-care and staff • Integrated communication between providers • BAU vs transitioning new model • Stop frequent flyers – loss of social community caring aspect • Getting appropriate services involved • Understanding the 'picture' as the patient perceives it • Communication flow between various services fragmented • Disconnected services – waste of money • Too many services confusing for patients • Possible non-alignment with national expectations / policy • Lack of shared documentation • Ineffective contracting – not aligned with community needs • Lack of leadership • Patch protection • Too fragmented – govt vs non govt • Funding – separate place, separate things • No all-encompassing model of care • Not one point of contact for referrals – triage to appreciate service • Not 24 hours • Better use of limited resources • Better use of skill set and defining core skill set • Best nurses to care for whanau, cultural considerations • Access and providing services to need • Improved communication between providers • Patient portals, communication & improving patient understanding • Getting/encouraging/supporting them to become a partner in health • Lack of knowledge of what other nursing services are available in the community - confusing for staff & patients - criteria? home visits? Cost to patient? • Access to information when out on home visits – tablets to check patient lab results, take photos of wounds etc to e-mail send to GPs & immediate access to other service systems • Funding – cost to patients for GP visits, availability to be seen • Improve access for patients • Stats – time consuming – is this effective use of clinical time? • More complex patients -hospital liaison – nurse role to advise hospital staff, assess complex patient prior to discharge • Financial barriers to nursing education • Increasing population	• Knowledge of available services • More people, less funding, better use of available resources • Ageing workforce • No new grads in community services, or coming into this area – as is specialised field/complexities • Multiple people/healthcare workers going into home to person with multiple co-morbidities – are they talking to each other? • Providers with short term contracts – no continuity • No obesity clinics • Multiple providers for similar services eg diabetes care leading to confusion re who to refer to, who is most appropriate provider, how do we decide/who should decide • Knowing the appropriate pathways/process for making referrals • Too many health providers providing the same service or similar • Challenges to access – confusion • Too much information – not consistent • Carers/clinicians don't see the full picture • Referral from Support Net to integrated case management – IT process • Lack of integration • Lack of consistent processes - standardisation • Not a single view of patients care - no shared care records • Increasing healthcare needs & associated costs • Patients don't know what services are available (many services) - fragmented & confusing • Money doesn't follow patient – funding silos • Provider contract boundaries inequitable • Competence – not always a patient choice of service • Not understanding clinicians professional boundaries • Knowing what's out there in present day • Fragmented • Unmet need – access into home/living situation • Transient population • Acute need • Co-ordination of service providers • Better communication for better patient outcomes • Better visibility – services • Increased understanding of available services • Ageing population & workforce • Service needs to reduce barriers – structural / policy / funding / competition / patient protection • Timeframe - shortage of hours for work completion • Increase referrals out to allied & others in communities • Lack of integrated services • Silos - specialities • Social determinants of health need addressing

<table>
<tr><th>Question</th><th>Tauranga Feedback</th><th>Whakatane Feedback</th></tr>
<tr><td rowspan="4">2. What are the opportunities? What are the barriers?</td><td colspan="2"><u>Opportunities</u></td></tr>
<tr><td>

Drive towards collaboration – takes longer
Upskilling – creation of new jobs – nurse practitioner/specialist
Educating the public around health literacy
Clinics to teach people en masse
Look at social determinates of health – housing education, poverty, employment
Networking & strengthening relationships
Increase skill mix
Do something special not just tinker at edges
Create same song sheet
Chance to integrate allied health – not just nurses (social services, justice, iwi)
Shared care pathways
More rational use of available funds / resources
People need difference levels of delivery of care – RN, support workers
Screening in WINZ
Whanau Ora example
Integrated family care
‘One Stop Shop’ – 0-100yrs, smears, dressings, immunisation, health checks, assessments – GP is general specialist
Collaborative relationship with nurses with specialist skill set to do all checks
Opportunistic time, flexibility to provide for whanau/family
Information sharing, resources
Access to high quality health care services in a safe & timely manner
Improve communication & streamline referrals
GP liaison nurse (district nursing based)
Duplication of Services – attending patients
Development/improvement of access to nursing education ie nurse development, nurse practitioner education
Improve knowledge of those making referrals from hospitals - services need to go in to explain their services/criteria

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Satellite clinics eg District Nurses, people coming to clinic not necessarily a hospital – Ohope, Taneatua etc
Better shared information between providers
Need to share/integrate accumulation of experiences/expertise
Single care view – shared care record & plan
Service co-ordination & better communication
Review contract specifications & application
Single directory of service
Webhealth to include community nursing within its directory
Referral that links practice, NGOs, secondary (hospital)
More high trust contracts (integrated approach) – outcome contracting (RBA)
Aligning DN to GP
Excellent DN service
DN service managing demand well
Self-management (self-referrals)
DHB infrastructure is there
Knowledge of staff
Whanau Ora models – client centred holistic approach
Collaboration through meetings to build trust & understand each other’s contracts & services
Shared resources & IT for all patients/clients
Poor discharge planning – needs better information (some improvements noted)
Central system for all services & contracts available for patients / whanau & other services

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<tr><td colspan="2"><u>Barriers</u></td></tr>
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GP fees – limited time, costly scripts, GP waiting times
Looking at patient centred care
Is nursing over specialised - more generalised nursing
Changing attitudes – all equal – working together
Desperate need for Social Workers in the community
Time constraints to deliver care
$$$ to service – the integration of primary & secondary services
Adequate absent cover
Job security and standards for staff
Competitive contractual environment
No shared vision for community nursing in Bay
No clear leadership structure in primary healthcare

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More people, less funding, better use of available resources
Ageing workforce
No new grads in community services, or coming into this area – as is specialised field/complexities
Multiple people/healthcare workers going into home to person with multiple co-morbidities – are they talking to each other?
Providers with short term contracts – no continuity
Don’t know what each service does, clarity on what each service is contracted to provide
Not all referrals done the same way ie some electronic, some faxed (paper)
Patch protection

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	• Conflict private GP practice vs public funded service • Poorly integrated IT systems – who will fund the integration? • Fragmented nursing work force development • Lack of information sharing • Lack of provision for services to go into the homes • Timeliness of reviews – allied health / specialist access • $$$!!! Cost of service, nurses, facilities, to patient for referal, transport (lack of) • Timely access • Fragmented care due to current skill set • Maximise workforce capacity • Patient not understanding about services available, info given (health literacy) • Resistance to change • IT systems – require universal system	• Opportunities to network with other providers caring for the same patient/client • Continuity of care - primary to secondary & vice versa • Community providers more 'power' if working together to 'fix' 1630 discharges that are not well planned & unresolved issues from hospital admission eg BNO for 5 days prior to discharge, meds not returned to patients, no discharge script • Lack of knowledge of organisations for both patients and HCPs • Cost/funding – significant barrier • Funding/cost, change, challenges • Education related to changes made & integration ie having to do different things • Who will be your new boss/leader • Funding silos • Contract boundaries of care • Clinicians not aware of all services available • Differing communication methods eg fax, e-referral • Workforce ageing • $$$ and time • Lack of consistent messages from HCPs • Funding models that encourage fragmentation • Patient enrolled in other areas • HUBS! • We have done this before • Communication systems • Those at coal face need to be decision makers • Duplications vs choices for patients eg cancer patients • Poor staffing – poor pay • Patient appointments need to be co-ordinated • Staff need to know communities •

Question	Tauranga Feedback	Whakatane Feedback
3. What is community nursing doing well now that we can build on?	• Co-ordinating services - connecting with other health suppliers • Building CRT to other disciplines • Stopping re-admissions to hospital • Better assessment of patient needs • Proactive with providing care to the 'vulnerable' • Improving referral services – a link missing (liaison nurse) • Providing advanced care in consultation with other networks • Popular with patients, good nursing care • Providing access to care – vulnerable, unable to get to GP / specialist • Recognise need for change • Improving linkages, communication, knowledge sharing – shift to ensure people understand • Fundamentals of trust, building relationships • Improving health literacy – give ownership to self-manage own health • Cultural appropriateness - community nurses are more aware & do it well – room for improvement? • Provision of safe & effective care • Promotion of self-care • Specialty wound care - build on this ensuring a holistic focus for patients • Equal access to care for all – develop clinics, more efficient time • DNs based together - provides opportunity to support each other if staff sick (able to assist/support with patient visits), working in an autonomous role, joint visits ie safety concerns	• D/N wound care – keep up to date & other providers up to speed • Enable patient to stay home if it is their wish as long as practicable to end of life – more care able to be provided in home • Great job at education (patients) • Building solid community based relationships • Stable workforce • Health promotion/education • Able to support early discharge and help to prevent re-admission • Providing holistic care • Providing patient centred care • Understanding our community in a culturally safe way - 'we live here' • Liaising with other healthcare providers • Good at providing (current evidence backed) • Practice health promotion • Giving service at short notice • More complex patients with limited resources • We 'care' for the patient • Deliver within existing constraints • Loyalty • Deliver 'over & above' • Professionalism • Connect with the patients, whanau/family (home visits) • PDRP expanding practice • Electronic documentation • Free community nurses = ASH rates down • Home visits when necessary • Transport from home to clinic is supported by community support workers • HUB • Holistic client centre – more power to the client • Improvements noted in smaller communities • Community partnerships • Budget - $$ value for networking opportunities • Community nurses high priority & make it work without extra DHB resources • DNS excellent resource in community • No acknowledgement received referral/feedback

Question	Tauranga Feedback	Whakatane Feedback
4. What is your vision for an ideal integrated community nursing service?	• Communication / networking • Good patient outcomes • Community hubs • Integrated IT systems • Govt owned – no private owners • Not profit driven • More educational opportunities to upskill eg no stoma therapy course in NZ • Identified H/C leader known to whanau/family • Barrier removal, strengthen relationships, transparency between services • Cost effective spending • Improve tech communications between primary & secondary care • Vision for ideal integrated community nursing service • Use of Telehealth • Single portal of entry – refer to one place and someone navigates & sorts it • One system, one budget • Clear nursing workforce development structure and scopes of practice • Community services aligned with primary healthcare across the spectrum, nurses talking to nurses • 'ONE STOP SHOP' – including dental • One referral link to one service • Shared patient notes - ease of communication • No overlap of services • More cost effective for patients	• One computer programme across all providers (PMS) • Better communication between all providers • Generic referral form • Care pathways available to all so all providers are aware of who is going into home & what each one is providing to patient/client • Timely information sharing • Appropriate funding – taking the competition out of the picture • Self-management • Improve communication especially integrated IT services • Services to be freely available to all including GP visits • Long term condition database integrated in GP services • Right service/time/expert – improve patient experience (triple aim) • Connected up care eg go in for immunisation, deliver b4 school check • Generalist workforce - connected with specialist • Upskilled workforce (robust educational pathways) • Workforce that believes in partnership (remove boundaries) • Co-ordinated care = patient journey easy eg diabetic patient>dietician, podiatry, retinal screening, self-management • Family health care centre of excellence – 'One Stop Shop' • Money to be on the ground helping patients to receive a service they are happy with • A well co-ordinated service with a good communication tool • No duplication • IT enabled • A service that is not fractured • Funding a patient journey • Te Kaha - do everything – Rural Health Nurse • DHB nurses sitting beside all nurses in community • Knowledge & skill on community plus nursing skills • Informed community - easy access • Integrated communication • Nurses who are valued • Nursing hub - packages of care, labs, HCA etc – doesn't need to be under on roof

Question	Tauranga Feedback	Whakatane Feedback
5. What would you like to see different in a year's time?	• Centralised referral system - one form • All the above: an integrated health care system implemented • Progress towards achieving vision above • Results of this workshop disseminated • One stop shop / service to clients in their home • Implementation within one year of a top quality, patient centred nursing service • Improve after hours access to medical services such as GPs to avoid unnecessary ED visits • Streamlined service that is accessible to patients • Improved communication between GPs - GP liaison nurse • Have tablets to improve access to patient info • Better awareness of other community nursing services • Improved use/more availability of clinics/Doppler clinics	• All of the above working!! • Something like ICM for community nurses – someone to assess what needs are required (co-ordinate which services may be needed in the home) • Not compartmentalising care • A centralised system for all services/referral providers – single process • Less over-lapping eg sexual health, diabetes • Specific director • Shared computerised patient management system • Better access especially IT ie integrated health records • We are more collaborative • Same computer systems • Hope all this not for nothing!! • See different in 12 months • Shared electronic health record between all providers • Flexible funding for outcomes • Central co-ordinated referral system • Patient is at the centre of all decisions • Training fund for new entry RNs • Some decisions made as to how the plan will be actioned • Virtual – Bay Nav • Nurse knowing who are involved in patient care • Nurses involving who they & whanau want in their care • Need to involve nurses who know their community - coal face • Better communication & management • Better linkage – medtech • Better integrated IT • Change contracts to enable collaboration/funding • Reliable funding – sustainable long term • Increase awareness /information services in community • Nurse led integrated meetings – trust/value one another's roles • Nurses + management = achievable better health services for EBOP people