An Integrated Model of Care for Community Nursing in the Bay of Plenty

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1. Introduction

Our Vision is that by 2018 community nursing services in the Bay of Plenty will be well co-ordinated and continue to be provided by multi-skilled nurses, supporting community teams who provide patient-centred, timely care in the most appropriate setting. Nurses will work together with GPs and hospital teams and wherever possible, patient care will be based within general practice.

A Community Co-ordination Centre will be the single point of entry for all referrals and information. Qualified, experienced nurses will triage referrals to the most appropriate care provider and the Centre will be a source of information for patients and Whanau. Standardised assessment and eligibility criteria will underpin treatment decisions and determine the appropriate service and setting for care, whether in a clinic, community setting or at home. The workforce will be supported to deliver the model of care. Service delivery will contribute to the transfer of knowledge and skills to people, family/Whanau to enable them to self-manage. An integrated model of care will be made possible through the ability for nurses to electronically access, input and share care plans and core clinical patient information regardless of setting.

The proposed community nursing service model supports;

- A Whanau Ora approach
- patients with proactive care management;
- general practices with long term care management;
- workforce to flexibly work across boundaries;
- acute care with responsive community based nursing;
- health and social services with integrated complex care;
- Co-ordinated care and access to common information for patients, families, communities, health and social agencies.

The main features of the proposed model of care are set out in Section 4.

Why?

It has long been recognised that there are opportunities to reduce duplication, enhance services in the community and provide services closer to home. The responsibility for the management and delivery of District Nursing has been a widely debated discussion point at local, regional and national levels for a number of years. Largely, caution has been displayed by DHBs nationally, in part due to the fact that PHOs have been developing their capability and capacity to manage a wider range of health services.

The BOPDHB has signalled its intent to work with the PHOs to further explore and maximise service improvements in community and district nursing services to better manage growth in acute demand and manage future capacity demands from an increase in long term conditions and ageing. In September 2014 the Bay of Plenty Alliance Leadership Team resolved to establish a project team, the Community Nursing Service Level Alliance Team (CNSLAT) to explore and develop recommendations for a more integrated patient-centred model of care.

The work is aligned with and underpinned by the BOP Integrated Healthcare Strategy 2020[1] (the IHS). The IHS is a longer-term strategy to foster the whole Bay of Plenty health system to work together to integrate services and co-ordinate care better around the needs of people, their family and whanau. The Strategy has adopted by the Bay of Plenty District Health Board and the Primary Health Care Organisations (PHOs) in the district as the overarching approach integration, quality and service improvement. The IHS and associated action plan encompasses 7 interlinked themes aimed at enabling systematic and consistent improvement and along with the supporting alliancing and primary care policy environment has set the tone and foundations for the approach and model of care development.

Approach

The following approach was used to develop the Model of Care:

Clinical leadership - A clinically-led project group, the Community Nursing Service Level Alliance Team (CNSLAT), appointed by BOPALT, led the development of the model of care. Members of the CNSLAT are set out in Appendix 6. The CNSLAT held 10 face to face meetings. During each meeting we considered the data and information we had gathered from our enquiries, stakeholder feedback, and lessons learned from our site visits. With this information, collectively we developed our vision for the future and model of care.

Co-design –To understand our local context, the challenges specific to the Bay of Plenty and help us design the future, we sought input and advice from a range of stakeholders and patients, providers, advocacy groups, professional clusters and unions. Feedback was collected through: two open forums in Tauranga and Whakatane; group-specific workshops; an online survey; and patient brochures.

A Community Nursing Integration Project page was established on the BOPDHB website. The page contained information about the project, regular updates from CNSLAT meetings, and the on-line survey for people to give us their feedback and ideas.

We asked patients and stakeholders to describe what integrated community nursing services means to them, the barriers and opportunities to be explored, where we are doing well, and what were their priorities for change. A summary of feedback is attached as Appendix 3.

Information gathering – A stock-take of current community nursing services was undertaken and is attached in Appendix 1.

A literature search by the University of Otago and a review of the most relevant Community and District Nursing Models from around New Zealand and elsewhere was undertaken

Three of the most relevant models to our work were selected for site visits – Canterbury, Waikato and Hawkes Bay - and members of the project team visited these places to learn first-hand from those that have experiences and results to share from changes made. We are grateful to all

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[1] BOP Integrated Healthcare Strategy 2020 http://www.bopdhb.govt.nz/media/57858/bop-intergrated-healthcare-strategy-2020-final-published-version.pdf

people we visited for their generosity and time. Written reports of the site visits are attached in Appendix 5.

Demographic profiles, projections and a health needs analysis for the Bay of were not specifically undertaken for this project as these can be found in the following strategies and accountability documents (copies of which can be found on the BOPDHB website http://www.bopdhb.govt.nz/your-dhb/a-z-publications/#sthash.nDCsp1j7.dpbs) including:

- BOPDHB Annual Plan 2014/15
- Maori Health Plan 2014/15
- Health of Older People Strategy 2012-2017
- Child and Youth Health and Wellbeing Strategy 2014-2019
- Palliative Care Services Plan (BOP) 2011-2016

Alignment with policy and strategic priorities – We have drawn on current central government policy environment, our DHB priorities and accountability documents to seek the relevant alignment to the context of the project, including the 'Better Sooner More Convenient' framework, the Integrated Performance and Incentive Framework, Minister's Letter of Expectations, and the BOPDHB Annual Plan 2014/15 and the BOP Integrated Healthcare Strategy 2020.

2. Definition

For the purposes of this project, the Bay of Plenty Alliance Leadership Team (BOPALT) defined DHB and PHO funded community nursing services as being in scope.

ACC nursing services and privately funded nursing services are out of scope.

The CNSLAT recognised there are obvious and beneficial synergies for better integration with a number of services. In an effort to manage the size and scale of the project, the SLAT recommends that further development work be undertaken to consider how the following services can be integrated as part of a phased approach:

- DHB funded community allied health services;
- DHB-funded home based support services.
- Community Mental Health nursing
- Public Health nursing.

General Practice

The proposed model of care supports general practice as the patients' medical home. Therefore we anticipate an impact on General Practice and how they will support the model of care. The likely impacts are set out in Section 6.

Kaupapa Maori

The model of care is intended to be underpinned by the values and principles of Whanau Ora and Whanaungatanga. Further developments and implementation will benefit from the guidance, expertise and advice of nurses working in Kaupapa Maori services.

3. Findings

Overview

Community nursing services in the Bay of Plenty include services provided by the BOPDHB: District nursing, the Community Response team, and the Opotiki Primary Nursing services; and a range of nursing services provided by the 3 PHOs covering school based nursing services, long term condition management, rheumatic fever, health target related activity, cancer care, Well-child Tamariki Ora, GP Outreach services for people who have high needs, and advanced Kaupapa Maori Nursing Services. A stock-take was undertaken as part of this work and is attached in Appendix 1.

Patient feedback

Patients and families told us that services are highly valued. People told us the nurses are kind and caring, experienced and responsive, and services are convenient and efficient and nurses do a great job for their communities. People find the support and advice essential and it helps them to maintain independence. Issues identified included difficulties with finding information about what services are available and knowing who does what; having different nurses visiting each time or staff changes making it necessary to repeat needs leading to inconsistency with care and follow up at times; people would like to have more communication about when nurses will be visiting.

Stakeholder feedback

Stakeholders and providers told us that community nurses are an excellent resource for communities providing essential care in the home to patients with complex needs enabling them to stay at home and prevent admissions or readmissions to hospital; often care is delivered over and above contracts; the skill set of community nurses is highly valued, particularly in wound care, continence and stomal care, and long term condition management; community nurses are reaching patients that do not engage traditionally with general practice; Kaupapa Maori services are valued and understand the needs of their communities; it is important for hospital services to be able to discharge patients safely and timely to reduce length of stay and demand pressures.

Issues and barriers identified included difficulties with knowing what services are available and for whom, and who else is providing care at the same time; transfers of care to the community following a hospital stay could be better and there is a lack of co-ordination for people with complex needs; the system is complex and difficult to navigate with multiple entry points and referral processes; Often there are inconsistencies with information and difficulties getting the right information to provide care; access to services is inequitable; stakeholders thought that more care could be provided in general practice or in clinic settings but that cost is seen major barrier; time, volume and administration constraints prevent nurses from providing holistic patient-centred care or being able to address social determinants.

The project identified the variety and complexity of ways that community nursing services are delivered throughout the Bay of Plenty. However, due to different ways that services are contracted and funded with varied reporting requirements (e.g. price/volume, FTE, by programme or service) and little outcome data, it was difficult, within the scope and timeframe of the project, to make any meaningful comparisons as to clinical effectiveness and productivity between the various services. It is recommended that further work be carried out to develop consistent ways of collecting data and reporting on patient outcomes as part of any implementation plan and measurement framework.

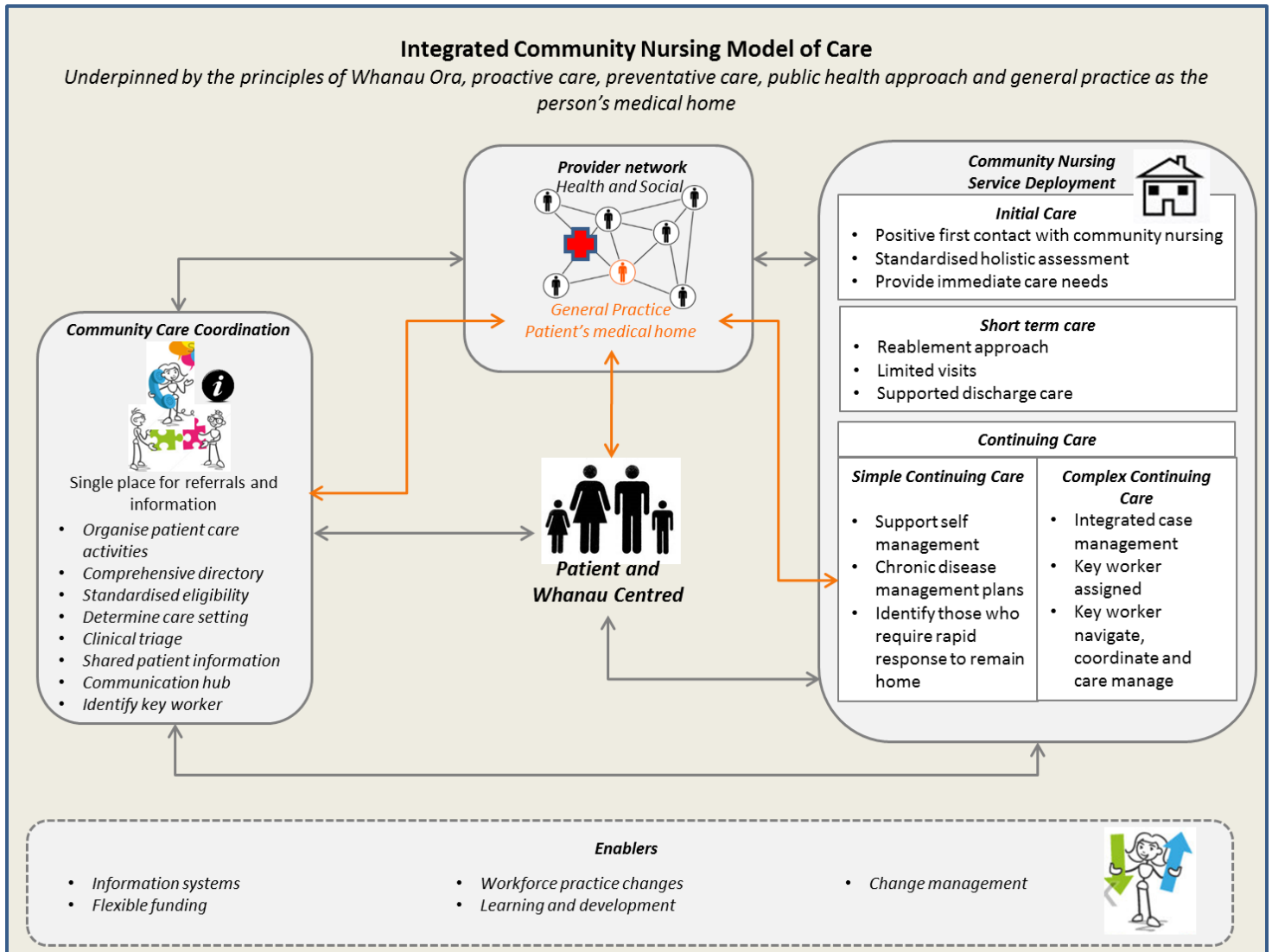The current referral process for the largest services was investigated and is attached as Appendix 2.

Summaries of stakeholder and patient feedback are attached in Appendix 4 and 5.

The following themes emerged as being the basis for developing our vision and the Integrated Model of Care for Community Nursing:

- Patient and family centred care/Whanau Ora
- Sharing information
- Co-ordinating Care
- Workforce
- Funding

4. Model of Care

Integrated Community Nursing Model of Care

Underpinned by the principles of Whanau Ora, proactive care, preventative care, public health approach and general practice as the person's medical home

Provider network
Health and Social

General Practice
Patient's medical home

Patient and Whanau Centred

Community Care Coordination

Single place for referrals and information
- *Organise patient care activities*
- *Comprehensive directory*
- *Standardised eligibility*
- *Determine care setting*
- *Clinical triage*
- *Shared patient information*
- *Communication hub*
- *Identify key worker*

Community Nursing Service Deployment

Initial Care
- Positive first contact with community nursing
- Standardised holistic assessment
- Provide immediate care needs

Short term care
- Reablement approach
- Limited visits
- Supported discharge care

Continuing Care

Simple Continuing Care	Complex Continuing Care
- Support self management - Chronic disease management plans - Identify those who require rapid response to remain home	- Integrated case management - Key worker assigned - Key worker navigate, coordinate and care manage

Enablers
- *Information systems*
- *Flexible funding*
- *Workforce practice changes*
- *Learning and development*
- *Change management*

4.1 Aims

The aims of the model of care are:

1. Development of a more integrated, patient-centred model of care underpinned by a Whanau Ora approach;
2. Better co-ordinated care for people in their homes;
3. Strengthening general practice as the patient's medical home; and
4. Making best use of nursing workforce and resources to release time to care, maximise impact and reduce administration.

4.2 Principles

The following principles underpin the model of care:

Partnership – The plan is aimed at further developing the Bay of Plenty Alliance Leadership Team and promoting a more collaborative, whole-of-system approach to health service delivery. The principle of partnership is further extended to promote the concept of co-design and co-delivery - that all those who experience health services, including people, their families and Whānau will have a say and a role in how services are designed and delivered.

Eliminating inequalities – We will seek to eliminate disparities in health between groups that results in an unequal distribution of good health. Further, that those actions aimed at eliminating inequalities 'do so in a way that benefits all members of society but with preferential benefits to those who experience more suffering. This is known as proportionate universalism'[2].

The New Zealand Triple Aim[3] - The Triple Aim is a framework for achieving quality improvement in the New Zealand health system that pursues three dimensions: Improved quality, safety and experience of care; improved health and equity for all populations; and best value for public health system resources.

Whānau Ora – We adopt the principles and values of Whānau Ora, an inclusive and culturally anchored approach that promotes that improvements in an individual's wellbeing can be brought about by focusing on the family collective and vice versa. All services should contribute to the transfer of knowledge and skills to enable people to self-manage.

Whānaungatanga – We will foster interconnectedness through relationships and shared experiences and working together which provides people with a sense of identity and belonging.

Values –There is a mutual respect for and acceptance of each Alliance partner's values.

4.3 Features

The main features of Model of Care are:

1. General Practice is the patient's medical home. This means that wherever possible, patient care is based in general practice.

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[2] New Zealand Medical Association's Position Statement 'Health Equity'.

[3] Health Quality and Safety Commission

2. There is a single place/process for BOP-wide Community Care Co-ordination. Features of Community Care Co-ordination are described in Section 4.4.

3. Access to service will be based on a standardised eligibility criteria:

    a. Eligibility should consider clinical, access and financial eligibility.

    b. Service model should consider how we will engage with those who are not engaged or not enrolled with general practice

[Note: CNSLAT recommends that further work be done on eligibility criteria which will provide a means of determining which patients are required to pay a co-payment, irrespective of what service is delivered and where. E.g. consider the use of community services card, high need, quintile 5.]

4. Triage will be undertaken by appropriately, qualified and experienced nurses.

    a. Service Information is required about what services are available to inform best fit for patient for care delivery. This will require a comprehensive service directory to be available, and patients informed of choice where available.

5. Core clinical patient information is shared, added to and accessed electronically by all clinicians involved in a patients care.

6. Service deployment will be underpinned by the principles of proactive care and has three broad aspects being:

    a. first contact care;

    b. short term care; and

    c. continuing care.

    This is described in more detail in the Section 4.5.

7. The best use of available community nursing workforce to support the model of care, to release time to care, maximise impact and reduce administration. Recommended workforce practice requirements are set out in Section 4.6.

8. Connected systems that will follow a patient rather than a patient following multiple health programmes.

9. Services are responsive to demand e.g. seasonal variations, holiday periods, elective surgery demands, and available 7 days a week.

10. Back office functions take care of the inevitable bureaucracy and reporting requirements so nurses' time can be dedicated to patient care.

11. Funding is bundled and provided in packages of care.

4.4 Community Care Coordination

What is community care coordination?

Care Coordination is a function that deliberately organises patient care activities, communicates and shares relevant information amongst all of the people involved with a person's care to achieve safer, effective and timely care. The main goal of care coordination is to best meet the patient's needs. This means the patients' needs and preferences are known and it is well communicated at the right time to the right people.

What are the functions of community care coordination?

Community Care Coordination has dual role providing both service coordination and care coordination. The functions of Community Care Coordination include the following:

- Provide a clinical service
- Receive referrals
- Validate referrals
- Seek out additional information where needed to inform onward referrals and initiating care
- Provide clinical triage – urgency, prioritisation, predicting needs and organise care accordingly (e.g. Flu injection) and refer to GPs and others as appropriate.
- Determine and allocate to a named health professional for care coordination including rapid response service where it is appropriate
- Facilitate transition of care where required
- Assessing patient needs and goals
- Creating proactive care plans in partnership with patients
- Service coordination function to assist the community nurses. This will include exploring and exploiting available resources to have best first response for client – determine who best place to provide the service.
- Monitoring and follow ups and responding to change in needs
- Supporting patients self-management plans
- Be the communication and information hub for patients and healthcare workers and providers in relation to all things community nursing
- Scheduling, workload prediction function for community nursing service
- Uses and maintains Information Communication Technologies that enables visible workforce, matching resources to needs, practice alignments etc.
- Provide regular reporting for decision making, performance, quality and risk monitoring
- Feedback to referrers
- Working with planners in aligning resources with patients and population needs

Who will access the Community Care Coordination?

When a person in the community requires nursing care for *whatever reason*, and is referred *by whomever*, the referrals will be sent to a central point. This should take account of existing direct access processes.

Criteria for entry to Community Nursing Services

The criteria for accessing community nursing services should be based on the model of care, support the New Zealand Triple Aim and BOP Integrated Healthcare Strategy. These criteria are to be developed.

The enabling functions:

There are a number of enabling functions that need to be considered in developing community care coordination. These include:

- Technology that supports the following functions:
  - Referral processing
  - Screen and triage functionalities
  - Scheduling
  - Workload overview and capacity planning
  - Visible mobile workforce management
  - Service coordination
  - Can link with assessment modules
  - Communication – linked with telephony
  - Reporting – Ministry of Health mandatory reporting and other reporting and performance monitoring requirements.
- Training and education
  - Information, communication and technology
  - Support professional standards and knowledge and skills frameworks
  - Policies, procedures, pathways and protocols
- Change management
  - Leadership, ownership and champions
  - Proactive care philosophy
  - Team philosophy – new team which is broader and based on patient need and not limited by employment or contract.
- Funding
  - Adequate
  - Follows the care where required
  - equitable and transparent
  - Outcome based
  - Flexible

4.5 Service deployment models

Service delivery will cover the following three broad aspects which are underpinned by the principles of Whanau Ora, proactive and preventative care, a public health approach and enabling general practices to be the patient's medical home.

Service will support the chronic care model, seek to manage acute demand and post discharge care.

1. Initial or first contact care

First contact care is when a community nurse has the first interaction with a patient following a referral for any reason or when a community nurse sees the patient when a patient's needs have significantly changed. Our aim is to identify the patients' health and social needs and deliver whatever care required to commence a positive engagement with the community nursing services.

a. Care will cover a number of things including health, wellbeing and social aspects
b. Includes standardised holistic assessments e.g. InterRAI suite of tools;
c. Will be Whanau-centred

d. Is timely and generally takes longer for the nurse to complete this visit/ inter action
e. May include post discharge care
f. Will meet the needs identified in, and based on, the assessment
g. Gather enough information to commence care planning

2. **Short-term care**

Short term care is generally provided to patients who require care for a short time frame or following a hospital admission e.g. 4 visits or less. Our aim is to enable the patients to get to their normal living environment as soon as possible and regain independence.
a. Under pinned by a restorative or reablement focus
b. Maybe episodic but take a holistic view
c. Facilitate an early supported discharge (START or CREST type service)
d. Anticipated completion of treatment within 4 visits.

3. **Continuing Care**

a) Simple continuing care
   For all patients who require long term continuing care services will provide the following through a general practice where it is considered the patient's medical home;
   i. Specific chronic disease management plans
   ii. Develop and support self-management plans
   iii. Patient and whanau education and awareness
   iv. Proactive and targeted rapid response service for those who need a short term intervention to prevent them from a hospital admission
   v. Promotes and supports health literacy
   vi. Has a Whanau Ora approach.

b) Complex care
   In this group of patients, we will identify those who are at most clinical risk of admission (e.g. to hospital or ARC) and receive care from multiple services (e.g. may include use of current InterRAI data) and, in addition to the above, for these patients services will provide the following:
   i. Integrated case management
   ii. Key worker who will be the first point of contact
   iii. Key worker will assist with navigation and care management
   iv. Key worker will liaise with service coordinators to navigate the provider eco system.

4.6 Workforce practice requirements to support the Model of Care

The Ministry of Health, the New Zealand Nurses Organisation, College of Nurses Aotearoa, Te Ao Maramatanga (NZ College of Mental Health Nurses) and Te Kaunihera O Nga Neehi Māori o Aotearoa (National Council of Māori Nurses) formed the National Nursing Consortium to provide for a national endorsement process of professional standards and knowledge and skills frameworks. These frameworks describe the knowledge and skills required by nurses to practice in specialty areas such as diabetes and addiction nursing and can be found on the Ministry of

Health website here: http://www.health.govt.nz/our-work/nursing/nurses-new-zealand/knowledge-and-skills-frameworks-nurses

These are aimed at addressing nursing skills and knowledge development needs and align with the proposed model of care.

The scope of practice of a registered nurse enables them to work as a generalist community nurse in accordance with the proposed model of care. The scope is described by the Nursing Council as:

Registered nurses use nursing knowledge and judgement to:

- assess health needs

- provide care

- advise and support people to manage their health.

They practise independently and in collaboration with other health professionals, perform general nursing functions, and delegate to and direct enrolled nurses, healthcare assistants and others. They provide comprehensive assessments to develop, implement, and evaluate an integrated plan of health care, and provide interventions that require substantial scientific and professional knowledge, skills and clinical decision making. They do this in a range of settings in partnership with individuals, families, whanau and communities.

Registered nurses may practise in a variety of clinical contexts depending on their educational preparation and practice experience.

They may also use this expertise to manage, teach, evaluate and research nursing practice.

Registered nurses are accountable for ensuring that all the health services they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards.

Some registered nurses will have conditions on their scope of practice, if their qualifications or experience limit them to a specific area of practice. The Nursing Council's Competencies for Registered Nurses describe the skills and activities of registered nurses. For further information see http://www.nursingcouncil.org.nz/Nurses/Scopes-of-practice/Registered-nurse

However, the model will require a range of workforce practice changes that support working in a more integrated, holistic, patient-centred way. These include:

- Expanding roles and increasing skill and capability in primary care.
- Working in multi-disciplinary, community teams.
- Provide patient and family centred care/Whanau Ora
- Contributing to improving health literacy of patients and providers and transferring knowledge in a way that enables them to self-manage.
- An ability to contribute to continuous quality improvement.
- Contribute to positive change management for patients, family/Whanau
- Contribute to organisational change.
- Information technology literate.
- Facilitation and communication skills.
- Being supported to work more flexibly across boundaries.

These changes to practice will require a collaborative approach, strong commitment and support of the DHB, PHOs and providers to achieve.

4.7 Other influences

Co-location

Co-location has been the subject of extensive debate. There are advantages and disadvantages to a co-located model. For example there are distinct advantages in co-location to retain and improve specialist knowledge. But there is a need to improve accessibility to, and establish and maintain relationships with, general practice. During site visits by SLAT members, co-location of staff e.g. district nurses co-located within a general practice, were common features of service improvement initiatives. Our observations included that co-location of staff was beneficial for facilitating change to traditional practice and service models, but findings from evaluations showed that co-location of itself did not increase collaboration between services or improve patient outcomes. Co-location was helpful to increasing awareness of each other's roles initially but it was the other opportunities for regular liaison, education and joint service planning, developing relationships and increased collaboration that were the keys to new ways of working and improving patient's health.

Locality planning

Occuring simultaneously with this project, the DHB, Eastern Bay PHA and Sapere Research Limited have been undertaking an exercise looking at how services in Opotiki can be transformed to achieve a clinically and financially sustainable service delivery model, whilst maintaining and improving health outcomes for the population.   The work has involved 3 components: undertaking a stocktake on what the current provision looks like and if there are any issues with the current provision; a forecast based on known demographic changes and how demand might change in the future; and finally a vision articulated for what future health services may look in light of how sustainable the current service configuration is in terms of the future demand forecasts.

At the time of writing this document, the first two components of the work had been completed. The third component being the development of the recommendations for proposed model of care and future service configuration was work in progress with an expected delivery date in July 2015.

It is important to reference this work as it will have a bearing and influence on the options for implementation of the model of care for Opotiki. However, although the projects have been undertaken simultaneously, and for valid reasons have used a different methodology, the findings, themes and proposed future state are consistent with both BOP Integrated Healthcare Strategy 2020 and the proposed integrated model of care for community nursing articulated in this document.

We therefore expect that the model of care for community nursing will not be at odds with the recommendations, once finalised, for future service configuration for the Opotiki area.

Capacity and Capability Planning

Work is underway on a project that assesses the capacity and capability of the health system in the Bay of Plenty district over the next 15 – 20 years. It was considered that a more proactive approach to planning for health services was necessary. This project will look at existing and planned health related services and identify where gaps exist. The project outcomes include positions on (i) the range and types of health services required to meet the needs of the community into the future; and (ii) the capacity and capabilities required of health services providers in the district. The project has just commenced and is expected to finish by the end of this year.

5. Information Systems to support the Model of Care

The information system requirements to support the Model of care should include the following features:

Full services directory

Outcome measures

Common E-Referral

Telephony

Clinical risk stratification tools

Scheduling

Common holistic assessment

Integrated Community Nursing Services

Mobile workforce support

Shared care Plan

Patient Portal

Clinical Pathways/ Decision Support Tools

Access to primary care PMS

Access to Eclair

- Full directory of services available for Community Care Co-ordination Centre
- Consistent outcome measures and reporting systems across nursing services with the ability to view and compare results.
- Standardised E-referral.
- Standardised holistic assessment able to be carried out in a patient's home
- Shared care record
- Clinical pathways and supporting education are developed for access to specialist nursing services
- Community healthcare professionals have access to Eclair
- Hospital-based healthcare professionals have access to agreed set of primary care patient data
- Patients have portals to view general practice data
- Population risk stratification tools available
- Case-mix and decision support tools in use.
- An information system that supports management of a mobile workforce.

6. Impacts

The anticipated impacts of the model of care are:

1. Patients are enabled to self-manage;
2. More care is provided in general practice, in particular supporting self-management and simple continuing care;
3. Changed capacity in community nursing services through more appropriate referrals to focus increasingly on complex and acute care;
4. Better integrated health plans for high needs patients;
5. Reducing duplication through better co-ordination;
6. Care in the home provided to those who need it by fewer people;
7. Reducing length of hospital stay.

7. Measures

Suggested measures include (aligns with the Integrated Healthcare Strategy framework):

Theme: Patient and family centred care/Whanau Ora

- Improved Patient Experience
- Improved Health Target performance/IPIF Measures
- Decrease in projected growth in emergency department presentations
- Improvements in Maori Health Plan indicators
- Increased proportion of population living well in their own homes

Theme: Shared information:

- Evidence of Electronic Shared care record developed
- Evidence of Comprehensive Service Directory developed
- Evidence of access to patient information in clinical data repositories by clinicians.

Theme: Care Co-ordination

- Reduced re-admission rates
- Evidence of Eligibility criteria developed.
- Referrals seen within time frames.
- Care coordination centre measures [to be advised]
- Clinical pathways developed
- Reduced duplication of assessments

Theme: Workforce
- Evidence of upskilling in areas identified as development opportunities in Section 4.6.

- Evidence of collaborative approach to training.

Theme: Funding

- Flexible funding, packages of care developed

8. Recommendations

Recommendations for BOPALT:

1.   Endorse the model of care;

2.   Request that Planning and Funding develop options for implementation.

The following issues have not been resolved and it is recommended that these be addressed in any resulting implementation plan.

- Information system requirements to support the model of care
- Investment required for service innovation, capital and human
- Best configuration of existing funding to support the model of care
- Change Management process

3.   Consider how the workforce practice requirements can be supported and collaborative, whole of system approach to training can be fostered.

4.   Discusses and provides feedback on the preferred communication approach with stakeholders and patients following the outcome of the BOPALTs decisions.

9. Appendices

1. Current Services
2. Referral processes
3. Summary of stakeholders/groups engaged in the design
4. Summary of stakeholder feedback
5. Literature review and site visit reports
6. Acknowledgements

Appendix 1: Current Services

Stocktake of Community Nursing Services in BOP (current to May 2015)

Summary Community
Nursing Services BOP.

The approximate total budget for all community services within scope is $15 million per annum in 2014/15.

General Practice

There are a total of 39 general practices in the Bay of Plenty servicing an enrolled population of approximately 206,600 people (Ref: MOH website, 2015Q2 PHO Demographics).

PHO	Total Enrolled	Total practices	GP Full Time Equivalent
WBOPPHO	149,874	26	119.43
EBPHA	45,757	11	26.70
NMO Ltd	11,003	2	7.6
Total	**206,634**	**39**	**153.73**

General Practices are largely independent business and total staff and FTE nursing numbers are not known. It is recommended that practices be surveyed for this information as part of any implementation plan.

Appendix 2: Referral processes

Currently, each service has its own process for receiving, entering and triaging referrals. There are multiple entry points to the system. A summary of the main referral process for the largest services, including the BOPDHB Needs Assessment and Service Co-ordination Service, SupportNet, is attached below.

Referral Pathways.pdf

Appendix 3: Summary of Stakeholders engaged

Ideas and feedback was received from stakeholders via the following:

- Open Forums held in Tauranga and Whakatane
- Patient Feedback Brochure
- On-line Survey Monkey

Attendees at the open forums included clinicians and managers from district and community nursing services, allied health, Regional Community Services, hospital General Medicine and Health in Ageing, hospice, general practice, pharmacy, PHOs and Planning and Funding.

Group Specific meetings were held with:

- Volunteer Patient Advisory Group
- Health Liaison Committee
- District Nurses
- Provider Arm Cluster Leaders
- Bi-Partite Forum
- Western Bay of Plenty Primary Health Organisation Clinical Committee
- Eastern Bay of Plenty PHA
- Child and Youth Health Services
- Regional Maori Health Services
- Pacific Island Community Trust
- Clinical Nurse Specialists (hospital based)
- Nurse Practitioners Forum

Attendees sharing their ideas at the Open Forum in Whakatane in February 2015

Appendix 4: Summary of stakeholder and patient feedback

Summary of feedback from the open forums in Tauranga and Whakatane in February 2015.

CNSLAT - Open
Forums Feedback and

Summary of feedback from the on-line survey:

Summary of survey
feedback.pdf

Appendix 5: Literature review and Site Visit Reports

Paper prepared for CNSLAT on relevant community and district nursing service models

Paper - Community
and district nursing se

University of Otago Literature Review   Site Visit Report – Canterbury

Community or district
nursing models Univer

Site Visit Report
Nurse Maude.pdf

Site Visit Report – Waikato   Site visit report Hastings

Site Visit Report -
Waikato.pdf

Site visit report -
Hastings.pdf

Visit with Hastings Health Centre and Hawkes Bay Health

Appendix 6: Acknowledgements

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