Nelson Marlborough Health
TE WAIORA

MEMO

To:	Board Members
From:	Bridget Jolly, Models of Care Programme Director
Date:	21 November 2018
Subject:	**UPDATE: Models of Care Programme**

Status

This report contains:
☐ **For decision**
✓ **Update**
☐ **Regular report**
☐ **For information**

Programme Overview
The MOC programme is developing insight into:

- What the MOC change is seeking to achieve (the design requirements)
- What initiatives will achieve the design requirements
- How these initiatives will work together, across the system, to achieve the change being sought.

This is being captured into a MOC document, which will be used to summarise emerging thinking and provide direction to key stakeholders. It will also provide information on the key MOC assumptions, and enable these to be communicated and challenged. Appendix one captures the initial points of view, including: linking design requirements to the current set of initiatives, and a system-wide view of initiatives. This document will continue to develop and will be provided to the Board at the next update.

Progress Overview
The MOC programme is starting to monitor individual initiative progress, as well as workstream progress. This recognizes the importance of continuing to drive workstream activity which focuses on particular areas (for example Long Term Conditions), as well as driving specific initiatives (for example virtual health pilots, Healthcare Home). See Appendix two for the initiative tracking overview.

Of note is the following progress:

- The End of Life Care 'conversations campaign' is continuing. This has included a series of community meetings and a survey which seeks to understand how comfortable consumers feel when talking about death and dying, what is important to them, and any plans they may have in place. A series of 'spring fling' events are being held with consumers in Blenheim (5 December) and Nelson (14 December). These afternoon tea events are designed to raise awareness and provide support to complete an Advanced Care Plan. Public Trust is attending to answer questions about Enduring Power of Attorney and wills
- Work is being undertaken to develop a draft Model of Care for supporting Complex Older Adults, with the aim to take the draft model out for wider engagement and challenge once drafted
- Assumptions on the potential impact of MOC changes on acute demand in the hospital are being developed for the Indicative Business Case. The team is working with the DHB Intelligence and Reporting team to develop this assumption set, which will be tested with the Clinical Working Group and the Business Case Engagement Group
- The primary care nursing Mental Health credentialing programme is continuing this month in Nelson Tasman. Unfortunately there are not currently enough people enrolled in Marlborough to run a separate programme there

- The Individual Placement and Support (IPS) Supported Employment trial in Blenheim is progressing well, with two employment specialist staff now co-located with the Marlborough adult community team and working in an integrated model with the MH clinical teams. This is being progressed through the Mental Health and Addictions Programme (see Appendix three for more detail).

Alignment with IBC Activity

The recent Indicative Business Case (IBC) activity has been beneficial for progressing MOC, particularly the recent workshops on the Strategic Configuration Issues and the Departmental Survey. These have provided insight into future MOC and identified potential MOC initiatives which will be considered through the MOC Programme of work. The initiatives identified have provided a beneficial balance to the existing initiatives, and have created insight and opportunities across the system. These include:

- The importance of a workforce strategy to identify and develop the NMH future workforce, and to reset expectations about how to best use the skills and experience of the workforce
- The criticality of an IT system that enables shared care planning, with access to health professionals across the system (including those outside NMH such as St John's)
- Improvement of communication and access between secondary and primary care health professionals is desired across the system. Benefits anticipated include reduction in referral rates and the shift of some activities into primary care, given that advice can be sought and received easily between clinicians if required
- There are opportunities to undertake activities in different settings, and by different health professionals. This is not limited to moving activities to primary care settings (for example the conversation may be between undertaking procedures through outpatients vs the day stay unit). These discussions will be important for planning the future scale and scope of the outpatients department and the role of the community hubs.

Health Care Home (HCH) Update

- The five practices for the Tranche One HCH General Practices are in the Establishment Phase, during which background is provided for practice staff, knowledge and skills are developed in the HCH practice change team and a practice implementation plan is developed
- Further work is being undertaken to consider on-going resourcing and investment for HCH Year Two and beyond. The DHB and PHOs have initiated a co-design process to inform this work and to consider what other system changes are required to enable HCH. There has been positive feedback from attendees to the co-design sessions about the willingness of participants across the NMH system to work together to help enable the success of the HCH project. The co-design sessions highlighted opportunities to support HCH, which will be discussed with ToSHA and ELT at upcoming meetings, prioritised, and an action plan will be developed and communicated.

Resources

In order for the MOC changes to be successful, they need to have a high degree of clinical involvement. As the initiatives start to progress, the degree of clinical time required to support planning and implementation is becoming more apparent. Conversations are underway to identify the most effective way to enable clinicians to contribute to the MOC programme of work.

The MOC/IBC communications advisor (0.5FTE) starts on 26 November. Her time will be used across both the IBC and MOC programmes. The preferred candidate for the data analyst role did not accept the position, and the position has been re-advertised.

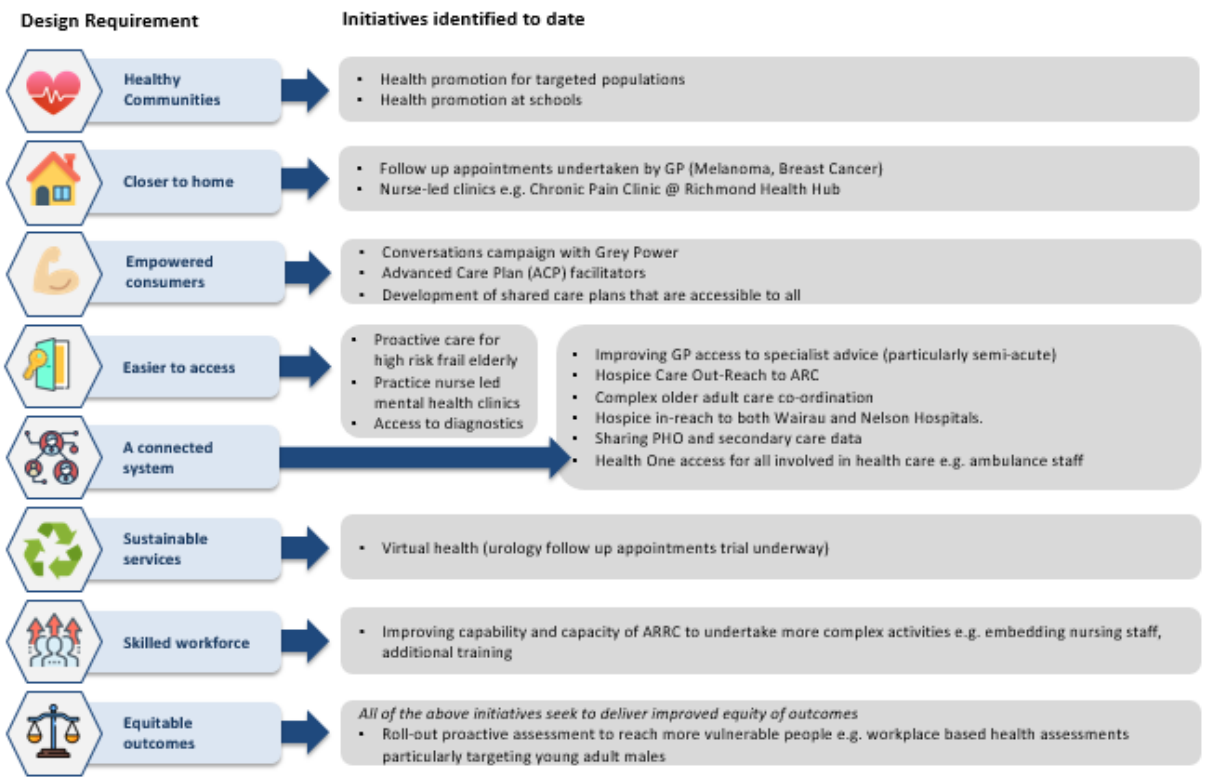
Bridget Jolly
Programme Director

Appendix One: Emerging MOC thinking

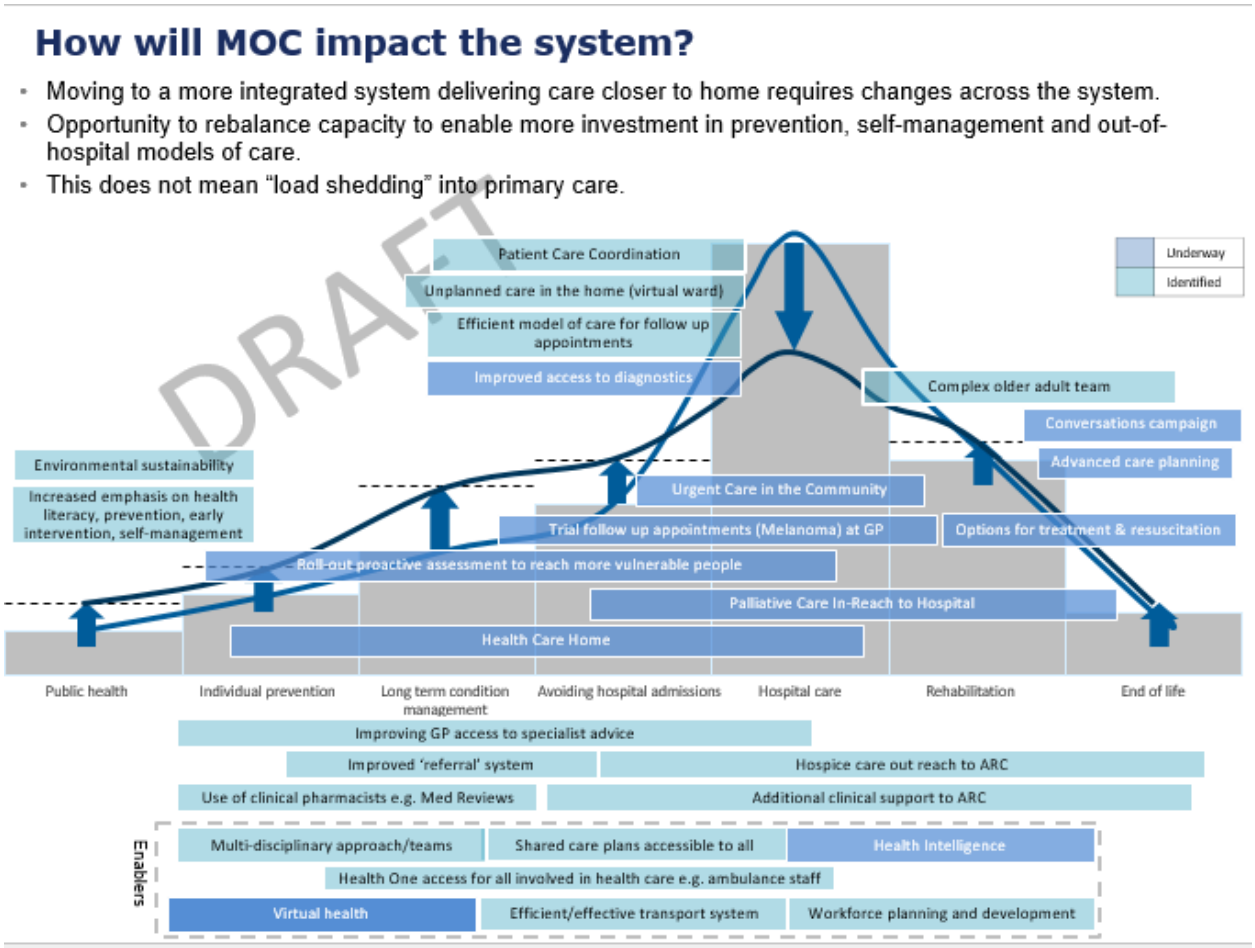
1. The MOC Programme has developed a set of Design Requirements, which have been previously discussed with the Board. These are based on NMH's key strategic documents, and set out what the MOC design needs to deliver. They provide a basis for assessing and prioritising MOC initiatives against.

MOC Design Requirements	
Healthy communities	We will contribute to healthy environments, social health and connected communities that will reduce unnecessary or preventable demand on health services
Closer to home	Health services will be provided closer to where people live, learn, work and play. Primary care remains people's main health care home.
Empowered Consumers	People will be empowered to manage their own health, getting the services and support they need. They are our partners in the design and delivery of health and health services
Easy to access	People will be able to easily access and navigate the support and services they need with care closer to home
A connected system	Health services are integrated and are better connected with each other and with wider public services. Health information is easily available to consumers and their care team
Sustainable	Health services will meet community health needs now and in the future. Systems and processes are clinically and financially sustainable, and support environmental sustainability.
Skilled workforce	Services are designed to allow everyone to use and continue to develop their skills, knowledge and experience to maximum effect/impact, in a way that improves the work life of clinicians and staff.
Equitable outcomes	Policies, practices and environments will support health and wellbeing, improve Maori health, and reduce disparities particularly for our vulnerable communities

2. Linking the initial set of initiatives to the design requirements allows the MOC programme to consider the breadth of depth of initiatives.



3. The MOC programme is starting to build an assumption set about the potential impact of MOC changes across the system. The first step is building an understanding of what parts of the system the initiatives could impact. The diagram below is starting to apply that mapping, and will continue to be developed with input from the CWG.



Appendix Two: Initiative Tracking

Models of Care Programme

Initiative Tracking as at 16 November 2018

Initiative	Stage	Status	Commentary/progress since last report
Conversations Campaign	U	On Track	Confirmed dates ACP 'Spring Fling' events with consumers – Blenheim at The Wine Station on 5 December; Nelson at Fairfield House on 14 December. Partnering with Public Trust.
Improved access to specialist advice	P	Some Delays	Clinical Governance support to share cell phone numbers between pharmacists and GP. Work underway to find secure mechanism.
Improved access to diagnostics	P	On Track	Initial meeting to understand specifics. Survey being designed to understand GP perspective/requirements
Complex Older Adult Team	P	Some Delays	Workshop confirmed issues; need for more concrete actions. MOC to be worked up by subset of wider group.
Frailty Pathways	S	Some Delays	Workshop confirmed issues; need for more concrete actions. MOC to be worked up by subset of wider group.
Trial follow up appointments (Melanoma) at GP	P	Some Delays	Data analysis to identify wider implications of shifting follow ups to primary care e.g. funding
Virtual Health Pilots	U	On Track	Urology pilot underway. Other pilot sites being identified.
Palliative Care Review Recommendations	U	On Track	Negotiations are underway with the two Hospices and District Nursing to advance the Palliative Care review recommendations.
Unplanned Care in the community	P	On Track	Proposal drafted; Data needed; Then submit to CWG for review.
Health Intelligence (sharing data across system)	I	Delays	Data sharing agreement in place, data collection underway, Tableau report in draft form. Delays in sharing of data due to miscommunication, now resolved.

Stage	
S	Starting phase – identified, work undertaken to collect data, understand problem, identify key resources
P	Planning underway, next steps being developed
I	Implementation
U	Pilot / activity underway
E	Evaluation

Initiatives identified but not underway	
Patient Care Co-ordination	Better use of clinical pharmacist (e.g. ARC, shift of work to pharmacy setting)
Change to MOC so that patients are not referred/transferred in and out of systems	Interdisciplinary teams
Cross-district transport system	Shared care plans
Additional clinical support to ARC	FSA in different care settings
Workforce planning and development	Shifting care into different setting e.g. into procedure rooms
Clarify future role of Community Hubs	Hospice Care Out-Reach to ARC

Appendix Two:
Mental Health and Addiction, October report:

MH&A is well represented in both the IBC and MOC processes. It is becoming clear across our system that mental health and addictions is expected to be integrated with all services right across the system.

Our focus this month has been progressing the initiatives listed below, building on last month:

6 system drivers	Improvement work update:
Equity	• Working with the reporting and IT teams to develop data extraction parameters to allow Te Waka Hauora to efficiently identify the ethnicity of people admitted in a daily report, for physical and mental health services, to ensure support can be offered to our vulnerable population groups.
Equally well	• Dedicated nursing resource committed to implement a system to achieve robust Cardio-metabolic monitoring across the system - a monitoring form has been developed and being trialled across the service • Trialing a programme called '100 Primary Care Places' in Marlborough to support people to transition back to primary care successfully.
People & whanau participation	• Consumer advisor continues to lead the project to increase the uptake of real time feedback across the service. • Whanau Advisors supporting the refresh of the "Just ASK" notice board to ensure up to date and useful for whanau.
connected systems	• Focus on utilisation of Trendcare in Inpatients in alignment with other inpatient services – with focus on safe staffing levels
one team	• Planning an education session for pharmacy staff • CAMHS clinical coordinator attends monthly MDT meetings in a GP as a trial to discuss complex cases and ease channels of communication
build trust with a recovery focus	• Trauma Informed care education is recognised as a core workforce education required across the service and delivery has begun across all teams.
high performing	• Primary care nursing credentialing programme is continuing this month in Nelson Tasman. Unfortunately not enough people enrolled in Marlborough to run a separate programme there. • IPS Supported Employment trial in Blenheim is progressing well, with two employment specialist staff now co-located with the Marlborough adult community team and working in an integrated model with the clinical teams