Nelson Marlborough Health
TE WAIORA

MEMO

To:	Board Members
From:	Bridget Jolly, Models of Care Programme Director
Date:	22 August 2018
Subject:	**UPDATE: Models of Care Programme**

Status

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

The purpose of this memo is to provide an update to Board Members on Models of Care (MOC) Programme progress.

Programme Progress

Patient Journey Mapping and/or initial workshops have been undertaken for all workstreams except Planned Care (8 September). These have been successful in identifying a range of initiatives as well as building support for change from across the NMH system.

The focus in the next month will be on planning and progressing selected initiatives in a co-ordinated manner and communicating these across the NMH system. The Clinical Working Group (CWG) will play a key role in considering, prioritising and communicating initiatives.

Workstream progress of note:

- **End of Life Care:** Initiatives identified through patient journey sessions have been validated against the palliative care review (see appendix for initiative overview). The palliative care contract is being negotiated, with changes to include hospice in-reach to both Wairau and Nelson Hospitals. Advanced Care Plan (ACP) facilitators have been appointed (start early September) and training in ACP will take place in October. Work is underway to localise the ACP HealthPathway from Christchurch. Once the pathway is finalised ACPs will be visible on Health Connect South.

- **Primary Led Care and the Health Care Home (HCH):**
  - HCH information forums took place on 31 July (Nelson) and 1 August (Marlborough) and were well attended: Nelson (51 practice attendees) and Marlborough (21 practice attendees). The Expression of Interest (EOI) for practices to become tranche one HCH practices was released on the 31 July (closing date 24th August 2018).
  - The HCH Steering Group has agreed to include five practices across Nelson and Marlborough in tranche one, commencing 1 October 2018 and staggered by quarter 2;1;2. A selection panel will meet to shortlist practices on 30 August. The final selection for tranche one HCH participants will be announced 14 September.
  - The HCH Steering Group considered how to allocate the approved $400k budget for HCH year one. They agreed on an equity and deprivation approach to target Maori, Pacific and vulnerable populations.
  - A paper has been prepared for the August ToSHA meeting recommending continued incentivised funding for 2019/20 and out years.
  - A meeting has been planned for 30 August to consider what additional initiatives the MOC programme should be progressing through the Primary Led Care workstream in parallel to the HCH initiative, noting also there will be significant primary and community focused actions arising from all other work-streams.

- **Access for Vulnerable Populations:** Consumer hui have been held at Te Āwhina Marae (18 July) and Crossroads Marlborough (27 July). A meeting has been planned for 7 September with Service Providers, Nelson Marlborough health professionals and Te Waka Hauora team. The purpose is to understand the range of initiatives underway across the providers and agree how to progress and prioritise initiatives including how to expand existing initiatives e.g. into other vulnerable communities such as migrant and refugee communities.

- **Long Term Conditions:** Patient Journey Mapping sessions have taken place on 15 August (Marlborough) and 20 August (Nelson).

- **Unplanned Care:** Patient Journey Mapping sessions have taken place on 24 July (Nelson) and 7 August (Marlborough).

- **Planned Care:** An 'unconference' is planned for the 8th September. This is a participant driven meeting. Responsibility rests with the participants to generate the agenda, deliver the content, and record the outcomes and actions.

- **Virtual Health:** A formal request for Care Foundation funding has been submitted and will be discussed at the 27 August Care Foundation meeting. This funding will be used to recruit a project manager to work across district and conduct a series of virtual health pilots across different virtual health opportunities (for example, patient to GP, GP to specialist).

- **Mental Health and Addictions:** The MH&A programme has identified a programme of work in order to make improvements across six system drivers. Recent activity has included piloting an integrated employment support model (IPS - Individual Placement Support) in partnership with the NGO provider of services and the Wairau Adult team, transitioning to an all ages after hours roster and having 22 primary nurses trained with Mental health Credentialing programme. More information on the system drivers and key activities are included in Appendix Two.

Indicative Business Case (IBC)

Treasury and the Ministry of Health visited NMDHB to discuss IBC scope, timeframes, and expectations. This confirmed that the IBC needs to consider overall system change, and the importance of the MOC work to inform this. The MOC team is working closely with the IBC team to ensure that key MOC assumptions are available to the right level of detail and in line with the IBC timeframes. The MOC and IBC team will need to work closely with key stakeholders to develop and confirm these system wide assumptions.

Resources

CE approval has been received to recruit a Communications Officer and Improvement Analyst to join the MOC programme team. These additional resources will help progress communication and data analysis activities and allow the core MOC programme team to focus on supporting MOC projects and initiatives.

Lessons Learned from the NZNO Strike

The NZNO strike was a catalyst for altering some models of care for the duration of the strike, for example the extension of services being provided within Aged Residential Care Facilities. The MOC programme held a 'lessons learned' session which identified opportunities for changes to models of care and identified what resources and process

change would be required to support this. Next steps are to discuss these further with the CWG at the next meeting on 28 August.

Data Analysis
Progress has been made on sharing and analysis of PHO and DHB data. An initial combined data set has been developed, and indications are that this will be very useful for understanding patient flow across the system, with the ability to interrogate the data through a number of filters.

Bridget Jolly
Programme Director

RECOMMENDATIONS:

THAT THE MODELS OF CARE UPDATE BE RECEIVED.

Appendix One: End of Life Care Initiatives

The following initiatives were identified during the End of Life Care Patient Journey Mapping Sessions. Note that the EOLC working group is developing more detail around these and considering prioritisation and timing.

Initiative	Objective
Advance Care Planning (ACP)	• Assist people to identify their personal wishes for End of Life Care • Increase visibility of plans; shared with all health providers as appropriate
Conversations Campaign	• Normalise death & dying • Encourage people to plan ahead
Patient Care Coordination	• Easy access to End of Life Care services, support & equipment through a single coordinator / case manager as appropriate
Complex Older Adult Team	• Improve care coordination across care settings and professions for older persons with multiple morbidities and high risk factors
Palliative Care In-Reach: Hospital	• Improve education and clinical support for hospital based staff responsible for patients at the end of their lives
Hospice Care Out-Reach to ARC	• Improve education and clinical support for aged residential care staff responsible for complex patients at the end of their lives
Options for Treatment & Resuscitation form (OtTer)	• Assist people to understand in more clinical detail the realistic End of Life treatment options to achieve the wishes in their Advanced Care Plan • Have frank and honest conversations with patients before emergency care is needed
Patient “Passport”	• Single patient information pack for End of Life Care (e.g. ACP, OtTER, nursing care plan, life tube) • Shared Care Plan

Appendix Two: Mental Health and Addictions Programme Update

6 system drivers	Improvement work update
 Equity and Equally well	• A Cardio-metabolic monitoring and intervention guidelines have been developed for staff to facilitate this process • A team building cultural development day was held for the Blenheim based teams, Adult, Older persons, CAMHS and AOD, in partnership with Te Waka Hauora
 People and whanau participation	• Family Whanau advisor has been appointed to support Nelson Tasman and Blenheim teams • The following core skills for the MH&A staff, as endorsed by the consumer advisor, are now available and have been incorporated into performance appraisals; Trauma informed care, Person centred care & Recovery focus
 connected systems	• 55% - 58% uptake of flu vaccinations for eligible mental health clients in Blenheim • A document to outline process for intake, allocation and flow through the service is being drafted, to ensure all processes are well documented and understood by the services
 one team	• One Wellbeing plan has been developed for use across all services. This is looking to be being adopted by the South Island Alliance • Closer linkages with Health of Older persons team to plan community needs across the spectrum of dementia need
 build trust and recovery focus	• An integrated employment support model (IPS - Individual Placement Support) is being piloted in partnership with the NGO provider of services and the Wairau Adult team
 high performing	• 22 primary nurses trained with Mental Health Credentialing programme. Another programme planned for later this year, taking enrolments now • A robust transition plan has been developed to support teams as we transition to an all ages after hours roster • Project teams have been established for the following HQSC priority areas: Seclusion, transitions of care and suicide prevention.