
MEMO

To: Board Members
From: Bridget Jolly, Models of Care Programme Director
Date: 17 October 2018
Subject: **UPDATE: Models of Care Programme**

Status

This report contains:

- For decision
- Update
- Regular report
- For information

Progress Overview

As discussed in the previous Board update, the Models of Care (MOC) Programme has summarised some emerging themes and initiatives (attached at the Appendix for reference). This output has been shared with a wider stakeholder group during September.

Feedback on the initial change initiatives was generally positive, but some feedback identified concerns that the initiatives are not transformative enough, and may not be identifying the major opportunities for change within the hospital settings.

In conjunction with the MOC programme, work is underway to progress the Indicative Business Case (IBC). This work includes clarifying and resolving key strategic issues that will be of significance for considering Nelson Hospital capacity and configuration and for options analysis in the IBC (the IBC Board update provides more detail). Advancing these issues will also provide important direction and detail to inform the MOC work.

Combined with the IBC work underway, the MOC Programme believes that, at this point in time, an appropriate breadth of initiatives and issues are being considered. We will continue to test and challenge thinking to ensure that transformative change remains the focus for the MOC programme.

Progressing Initiatives

The programme is conscious that the identified initiatives need to continue to show progress and become tangible change activity in order to maintain stakeholder support for change. Activity of note in progressing initiatives includes:

- Virtual Health – Care Foundation funding has been approved, this will support piloting virtual health initiatives across the district. The next steps include bringing together a range of people from across Nelson Marlborough Health to agree potential pilot activities and to recruit a project manager to work with clinicians to progress the work.
- End of Life Care – in conjunction with Grey Power, focus groups have been held in Stoke (25 September), Takaka (27 September) and Nelson (8 October) to support conversations about death, dying and end of life care. The Advanced Care Plan service is in contract. Negotiations are underway with the two Hospices and District Nursing to advance the Palliative Care review recommendations.
- Planned Care – an identified MOC change is shifting follow up appointments for melanoma and breast cancer from specialist to the patient's GP. This is well aligned with the desired MOC requirements including services being delivered closer to home, developing a skilled workforce, empowering consumers and a more connected system. There are a number of system changes required to enable this change including GP access to diagnostics and ease of information sharing between specialists and GPs. Work is underway to understand potential funding implications and bring this to scale by using a similar model in other departments.

- Towards Equity – note that the name of this workstream has been changed from Vulnerable Populations. A series of Service Provider hui are underway, bringing together providers from across the system to understand what initiatives are in place, how to work together better across the NMH system, and identify opportunities for joint system initiatives.

Resources

Project management resources within the programme team are becoming stretched as more initiatives require support to undertake appropriate levels of analysis and planning. Decisions may need to be made in the New Year about using additional NMH resources to enable change.

The MOC Programme has undertaken a recruitment process for a data analyst and communications advisor. A preferred candidate for each role has been identified and, subject to approvals, should start within the next six weeks.

Health Care Home (HCH) Update

The final selection meeting occurred for Tranche One HCH General Practices on 28 September. Five practices were selected equating to a combined 37,625 enrolled patients which is 26% of the district's enrolled population for Year One of the HCH programme. The practices are:

- Stoke Medical Centre
- Francis Street Health
- Scott Street Health Centre (soon to be Civic – Family Health)
- Greenwood Health
- The Doctors Motueka.

In parallel to this process, it emerged that the HCH Expression of Interest (EOI) was not clear in relation to the HCH resource and funding that practices would receive beyond Year One. ELT also expressed concern about the level of investment required beyond Year One before fully understanding what other resources would be needed to align and what the expected outcomes would be.

As a result, PHO and DHB leadership agreed to notify the practices that there was a change to the EOI, to be explicit that practices would be offered an HCH agreement for Year One and further work would be undertaken to consider on-going resourcing and investment for HCH Year Two and beyond. As part of this notification, the DHB and PHO signalled a desire to partner in a co-design process to inform this work and to consider what other system changes are required to enable HCH. These co-design sessions will commence on 31 October 2018.

Bridget Jolly
Programme Director


Appendix One: MOC – Emerging Themes

Models of Care: a multi-year health system transformation programme

Emerging themes from MOC conversations across Nelson Marlborough's health system


- Embed wider health professionals in to general practices e.g allied health, social work, psychologists
- Strong support for Health Care Home model
- Opportunities for Primary services to deliver acute care 24/7
- Specialist services held outside of secondary care setting
- Desire to maximise multiple virtual health opportunities
- Access to more diagnostics in primary care

Primary and community health care is critical




- Increasing complexity of health needs requires an integrated health system
- Patients and extended care teams able to view and contribute to shared care plans
- Wrap around care and rapid response opportunities closer to home but integrated multi-disciplinary teams required
- Ease of two-way access between primary care and specialist advice aid to integration
- Patient centred IT system, with shared Information

A system view and integration are fundamental




- Traditional locations of delivering services need to be reconsidered, particularly to support equity
- Need to take health services 'to the people' e.g. in the home, workplaces, schools
- Use primary and community care workforce better to support delivery of services, including pharmacy
- Build capacity and capability in Age-related Residential Care to support more complex patients

Changed settings of care



- Targeted service delivery to high risk and high and complex needs
- Mental health needs to be integrated across the system
- Acknowledgement of frail and elderly and their complex needs
- Equity needs to be considered across all change
- Decisions on how and when people access care are influenced by cost

One size does not fit all (especially for Vulnerable Populations)



Initiatives that have been identified so far include:

Health Care Home	Shifting follow up appointments to General Practice
Sharing PHO and secondary care data	Virtual health consults
Hospice in-reach to Wairau and Nelson Hospitals	Conversations campaign: normalising conversations about death and dying
Improving GP access to specialist advice	Complex older adult team
Shifting clinics into primary care settings	Advanced care planning
Shared care plans accessible to all	Improved access to diagnostics

