TOSHA
TOP OF THE SOUTH HEALTH ALLIANCE

Primary and Community Health Strategy

2017

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Foreword

Our Primary and Community Health Strategy outlines our direction for primary and community health care across the Top of the South Island over the next 5-10 years.

It draws on, and supports, our existing plans: the Nelson Marlborough Health Services Plan (2015), the updated New Zealand Health Strategy (2016), He Korowai Oranga (2014) and the Nelson Marlborough Maori Health and Wellness Strategic Framework (2015).

We believe our Top of the South Health Alliance (ToSHA) is best placed to provide the leadership of the transformative 'step change' needed to deliver the new models of care outlined in this strategy. ToSHA will build on what is working well, including strong community spirit and determination, and a skilled and dedicated network of community health and care service providers. Together we will reshape the way we support the people of Nelson, Tasman and Marlborough to live well, stay well and get well. The strategy outlines how we will deliver and coordinate care in a way that is equitable and clinically and financially sustainable.

We talked with general practice teams, specialist services, Māori health providers and whānau, consumers and many community organisations. You gave us many ideas to improve the way we deliver primary health and care services, which have formed the foundation of this strategy. Our thanks to the people of Nelson, Tasman and Marlborough for your energy, enthusiasm and commitment to building an exciting future for health and care in our region.

Naku noa.

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Introduction

The people of Nelson, Tasman and Marlborough are generally healthier than many others in New Zealand[1]. However, like many countries across the world, we are facing significant challenges which will place our health and care system under extreme pressure in the years to come.

Our challenges include:

- Our population is getting older. More people than ever are living longer and living with more complex health conditions.
- Māori and Pacific people and those living in deprived areas still die younger and experience more ill-health than others in our community.
- More of our population are at increased risk of poor health as a result of growing rates of obesity, the harm caused by tobacco use and excessive alcohol and drug use.
- Like the rest of our population, people working in health services are also ageing. A significant number of them will retire in the next decade.
- We are facing increasing financial pressure from the rising cost of new technologies and treatments which we all expect to be able to access.

"'Future-proofing' of the Nelson Marlborough health system will require different resource allocation patterns, and adoption of new ways of working that improve access, make better use of the existing workforce and improve service performance"
From Good to Great: The Nelson Marlborough Health Services Plan 2015.

If the people of Nelson, Tasman and Marlborough are to continue to enjoy good health we need to rethink our planning and delivery of health and care services.

We know that continuing to deliver health services the way we are is not sustainable. We need models of care that are flexible and responsive to our population's growing and changing health needs

It is expected that the demand for general practice visits will grow by 30% by 2033, and the greatest increase in demand will come from those aged 75 or over. The increasing complexity of their health, contributed to by more and longer-term health conditions, means they will need more contact with primary health care professionals. If this demand is not met in primary and community care, it will increase the demand for specialist services.

Forecasts estimate that an additional 130,000 primary care consultations are needed, and if nothing changes this would require an additional 70-80 general practitioners over the next 15 years. Pharmacy is a young and growing workforce and nursing is a large, generalist and flexible workforce, both of which are well placed to be part of the change required. However, with predictions that over 50% of the present nursing workforce will retire by 2035, the nursing workforce also requires active planning and development to ensure they are clinically and culturally competent, and able to work to the full scope of their practice.

There is a similar pattern for specialist services - our future projections of demand tell us if we do nothing we will need a 50% increase in hospital bed capacity across the district (68% in Nelson and 48% in Wairau). This is the same as building one additional hospital and is not an option – we will not have the funds or the workforce to build and staff an additional hospital.

[1] Nelson Marlborough Health Needs and Services Profile 2015

Keeping people well and in the community must be the core feature of our strengthened primary and community health system.

We need to more closely align and support health and community care services to wrap around people and provided enhanced care in community settings. This new model of community care will strengthen wellness through health promotion and building health literacy for people to self-manage their health as appropriate.

We know from looking at health activity data across primary and community care that we will need to tailor our approach with particular groups in our community. Nearly half (48%) of the people who have two or more unplanned hospital admissions have been diagnosed with diabetes or cardiovascular disease. Planned care will be expected to deliver a decrease in these unplanned admissions.

Our new approach to providing integrated, high quality, health services continues to have primary and community health at its heart and will build on the existing skilled and dedicated network of community health and care service providers to collaborate with people, their whānau and their communities to deliver good health.

Our intent is to continuously improve the quality of health care and health outcomes across the Top of the South region regardless of who you are or where you live. Our new model of care will allow us to plan and tailor services to meet local implementation needs while allowing us to keep a district-wide approach and overview.

This document is presented in two parts. Part A outlines the Statement of Strategic Intent including the strategic outcomes being sought over the next 5-10 years. Part B will be a Roadmap of the actions required to achieve the strategy.

Our work will be guided by the following principles:

				
People will be able to access and navigate the system with ease.	Services will reduce inequality and meet the needs of Māori.	Services will be clinically safe and of high quality.	Innovation and experimentation will underpin all we do.	Consumers will be involved in the design of services.

Part A: Statement of Strategic Intent

We will meet the future health and care needs of our communities by delivering a sustainable, responsive primary and community health sector that is fully integrated with the wider system.

We will create an integrated, consumer-focussed primary and community health system that delivers health services in the right setting, at the right time and by the right people. This will require us to build on current strengths and implement new models of health care delivery better suited to the times in which we live now and in the future. It will also require working with people, their whānau, specialist health care teams and community organisations to support the new delivery systems.

We will know we are succeeding when we have achieved these outcomes:

1. **Integration / Pāhekotanga**: Health, social care, voluntary organisations and consumer groups work alongside each other to provide better care. Providers work together in a virtual or physical space so care is experienced as seamless.
2. **Equity / Matatikatanga**: People's health care needs are met through the provision of quality health care that is safe and delivers equity of outcomes. Funding models enable people with high health needs or those who are disadvantaged to receive the same services and attain equity of health outcomes.
3. **Supported Self-management / Tokowhaiarotanga:** People are supported to manage their own health. They have better access to health information and tools for managing their own health and the health of their family and whānau.
4. **Accessibility / Putanga Hauora:** People are able to access health care when and where needed. Most health care will be delivered in the community. When needed, specialist care will be available with clear pathways to get this care.
5. **Technology / Hangarautanga Hauora**: Technology is used effectively to support a seamless system, assist people to understand and take ownership of their health, and enhance access to services.
6. **Evidence-led / Taunakitanga:** Decisions about health care and the planning of future services are made based on local health intelligence and evidence. Design will take place at a local level, and keep a district-wide view, to meet the health needs of our communities.

Strategic Outcome 1: Supported Self-Management / Tokowhaiarotanga

People are supported to manage their own health. They have better access to health information and tools for managing their own health and the health of their family and whānau.

People over 65 years told us they want to look after their own health and be supported to prevent ill health

Maintaining health and well-being is a foundation component of the new model of care. The model acknowledges that health is multi-determinant, and that healthy living requires broader, more nimble partnerships. Access to regular healthy nutrition, a clean environment, safe and healthy housing, equitable access to education and income, all contribute to building wellness and resilience.

Good health is a major social investment. Public health teams ensure people have access to clean drinking water, safe food options, appropriate sanitation and healthy housing. Prevention, promotion and surveillance are important ways to keep people well, and reduce the strain on health services. Public health teams protect and improve the health of families and communities through promotion of healthy lifestyles, and disease and injury prevention.

Public Health teams, and in particular health promotion teams, have a key role to play in providing clear health messages that are easy to understand, and in providing access to trustworthy, evidence based health advice.

Health literacy includes provision of consistent health information of a high quality made available through community education, internet-based sites and accessible applications. Consumers will have access to health information in plain language and in a variety of formats that supports self-management and allows them to navigate (alone or assisted) effectively to the necessary care.

All health providers must be skilled communicators who help consumers to understand the first time they read or hear health information. Health providers must walk alongside consumers to support them to manage their own health and the health of their whanau, until they can walk alone.

People will be supported to manage their own health, from reducing health risk and building health resilience, to self-managing chronic and/or complex health conditions. People will remain in their own homes as long as possible. When the time comes, they are able to have a good death.

We will continue to collaborate with local authorities, government departments, community organisations and businesses to ensure that environments are health-enhancing. A systematic approach to health promotion sees integrated planning and policies aligned and supported by agreed system-wide incentives and disincentives. For example, the replacement of sugar sweetened beverages and artificially sweetened beverages with water in hospital cafes and council-owned premises.

"In the future it is important people are provided with the information they need to fully understand issues to do with health and wellness, are able to access health services and manage their own health care". Source: 'New Zealand Health Strategy — Future direction'.

Understanding how health fits into people's lives and the information or resources they might need to help them stay healthy will enable the provision of evidence-based health advice that can be easily understood and accessed. The appropriate use of technology will be available to support this.

We recognise that not everyone has the capacity to take care of their own health, and the health of their whanau. Some families struggle to put food on the table, and to keep their families safe and warm. For families facing these challenges, access to clear information is insufficient, and they will need additional support to receive coordinated services from a range of community, non-government and government organisations.

Strategic Outcome 2: Accessibility / Putanga Hauora

People are able to access health care when and where needed. Most health care will be delivered in the community. When needed, specialist care will be available with clear pathways to get this care.

People have the smoothest and quickest path to the care they need via a "front door" that is easy to find and easy to open. For most people, the care they need will be provided at this point. For others with complex health needs, this front door will be their single access point to the multiple, coordinated services they need.

Access to quality primary and community health care continues to be supported by personal choice. People will choose their own extended general practice provider, in all its varied forms. For some this will be extended general practice services nearest to where they live or work, available at their Marae, or for others it will be extended general practice services available through a nursing practice.

> Good health begins at home and in communities, so it makes sense to support people's health through services located close to these places where possible. *Source: 'New Zealand Health Strategy — Future direction'.*

In days gone by, a typical general practice would have one family doctor, operating out of their home. In contrast, the modern extended general practice will consist of a multi-disciplinary team – multiple doctors, nurses, and other health and care professionals – who work together in one physical location, or remotely via technology.

> *Young people value their free annual check-up with a dentist, and would appreciate a similar annual appointment with another health professional.*

The provision of options helps address some of the barriers to care. For example, a Marae based extended general practice provider may address cultural barriers for some consumers. Actively planning the location of extended general practice teams will also support increased access that may have previously been limited due to distance and access to public transport.

For many, the first primary and community health care contact needs to be a friendly face with time to listen. This was raised by our young people as a critical component of service development for youth. For some primary care settings this could be the most experienced clinician, who can effectively triage and accurately onwards refer as necessary.

If required, the first primary and community health care contact will coordinate care with other providers. For those with complex health needs whose journeys through the health and care system are likely to involve an extended care team across multiple services and agencies, there will be Case Managers, Care Coordinators and/or Navigators available to support as and when needed. These Navigators will be well-versed in all elements of the integrated health and care system and ensure that care is experienced seamlessly. Good system design should, as much as possible, reduce the need for navigation and increase ease of access to care.

On the other hand, some contacts can be quickly and efficiently handled by one clinician and sometimes does not need to be face to face. We need to ensure an appropriate response. Service providers will further reduce barriers by communicating simply, in a culturally appropriate way, and clearly using plain language.

Strategic Outcome 3: Integration / Pāhekotanga

Health, social care, voluntary organisations and consumer groups work alongside each other to provide better care. Providers work together in a virtual or physical space so care is experienced as seamless.

People will experience their health and care as a seamless service. This means that not only will we take a holistic approach that recognises physical, mental and spiritual health as one, but we will also build our new model of care with consumers at the centre. Integration is essential to manage transitions across settings of care, information gathering and exchange, case management and be responsive to consumer needs.

The first contact with the health system for most of us is our general practice team. The new model of care will deliver a transformative shift that will see extended general practice as the home for extended teams of multi-disciplinary health providers who can better coordinate and deliver planned care, particularly for those living with chronic health conditions. The extended general practice team will foster wellness, deliver screening services, acute, planned and coordinated care and have access to specialist or hospital-level services when required.

New working relationships will see the extended general practice team, community health care and support organisations, community pharmacies, secondary care, and government agencies work with consumers to coordinate care. People living with multiple and/or chronic health conditions will have their care planned through their extended general practice team.

Māori and young people told us that the way they were treated by staff influenced their health care experience. Positive staff attitudes were key to people feeling engaged, valued and part of their care.

The extended general practice will also coordinate and / or deliver primary and community health care after an episode of specialist care supported by clear protocols and pathways. To achieve this, we will relocate some secondary care services into the community and ensure primary care providers will have ready access to advice and support from secondary specialists.

Health Hubs are a good example. We have developed Health Hubs in Blenheim and Richmond that bring together primary and community care, specialist services and community health organisations under the one roof to improve service coordination and delivery.

This extension of general practice will integrate needs assessment services, general practice teams, primary health and allied health professionals, public health professionals, and community and non-government agencies. Specialist clinicians will be able to deliver specialist care in these community based settings.

Future services could include diagnostic services and the provision of walk-in urgent care clinics. The model may include new services such as a 'rapid response team' that would enable health professionals to quickly assess people and provide wrap-around services to avoid unnecessary hospitalisation.

Where establishment of an extended general practice with co-location of services is not feasible because of size and scale, a networked approach will be implemented, supported by the sharing of back-office services such as administration, human resources, business and IT support.

The new model of care for extended general practice will require teams of culturally competent health professionals and support workers working collaboratively and using their full range of skills and knowledge. There is good evidence that collaboration and working in teams can reduce fragmentation and increase the capacity of the system. All workers will also understand the role that they and their teams play in delivering health care. On-going training and development will support enhanced roles for nurses, community pharmacists, allied health professionals and the kaiāwhina/support workforce.

The extended health care team will ultimately be made up of teams of wider-skilled generalists. There will be an increased use of nurse practitioners and clinical nurse specialists with prescribing rights, supported by enrolled nurses and primary care practice assistants delivering elements of care. This will leave nurses more capacity to respond to the needs of people with complex, longer-term conditions.

The same applies to pharmacists whose clinical skills could be widely used to support wellness through health promotion, involvement in care planning, as well as the provision of services related to wellbeing or to specific diseases. Other roles such as Navigators, Case Managers, Care Coordinators and Physician Assistants may also be included as part of the extended primary and community health team.

Primary and community health care will continue to support improved health outcomes for people in the community, including improved mental health outcomes. Individuals have a variety of resources available to them within the community, including whānau, friends, churches and community agencies such as school guidance counsellors, community counselling services, social services and community support agencies.

However, for some people, this support will not be sufficient and they will need to access primary mental health care services through their chosen extended general practice provider. These services may be provided by a primary health care nurse, community health worker, pharmacist, community counsellor, or general practitioner. Those who need specialist support will benefit from a close working relationship between their extended general practice and specialist mental health services.

Strategic Outcome 4: Equity / Matatikatanga

***Equity**: People's health care needs are met through the provision of quality health care that is safe and delivers equity of outcomes. Funding models enable people with high health needs or those who are disadvantaged to receive the same services and attain equity of health outcomes.*

We know from our Health Needs Assessment and Service Profile (2015) that there is inequity in the health outcomes in our community, particularly for Māori, people with disabilities and those on low incomes.

The Nelson Marlborough Maori Health & Wellness Strategic Frameworks outlines how services can be responsive to Maori, which includes being consumer centred as well as whanau focused, affordable, accessible, tailored to need, support Maori workforce development, and allow Maori to be Maori.

Targeting of funding to the most vulnerable and at risk in our community will assist in achieving equity of health outcomes. This means funding will follow patients and will provide additional assistance for those with high health needs.

One of the fundamental tenets for the funding of primary and community health care is that cost should not be a barrier for access to services. The new model of care should ensure free or near-free service for those with the greatest disadvantage or identified as having high health needs.

We will use different contracting arrangements, such as those based on the delivery of quantifiable improvements in health outcomes, to maximise the impact of our investment. We will incentivise delivery of demonstrable improvements in health outcomes for those at greatest disadvantage.

To ensure greater certainty for agencies and providers who are contracted to deliver health and care services, we will adopt a longer-term investment and funding approach.

Māori men put working to support their whanau ahead of taking care of their health, and need access to health services outside working hours.

We will partner with government agencies and community based organisations with a role to play in the wider determination of health. Where multiple agencies are supporting people with multiple, complex needs it makes sense to ensure that all available funding is maximised.

Strategic Outcome 5: Technology / Hangarautanga Hauora

Technology is being used effectively to support a seamless system, assist people to understand and take ownership of their health and enhance access to services.

Technology will increasingly play a pivotal role in supporting the way services are delivered in the future.

Single shared electronic heath records will allow health providers to share information and build a unified source of information. It will support providers and consumers to communicate in real time and lead to improved decision making. A shared record means that people will only have to tell their story once to the system.

Patient portal technology will be widely available. A patient portal is a secure online website that gives patients convenient 24-hour access to personal health information from anywhere with an internet connection. Patient portal technology will also provide easier access to services from their general practice health care provider – online appointment booking, self-assessments, and self-monitoring will be commonplace. Reliable health advice will support people to become more responsible for their own health.

Young people like getting text reminders from services. They told us that they want app-based interactions and information available on websites

Advances in mobile applications will also support the gathering and sharing of personal health information. For example, a person or their home carer may send regular health check information directly to a health professional to enable early/rapid intervention.

Tele-health solutions have the potential to transform how people experience health care, particularly those in rural and remote areas, by allowing them to access specialist advice without travelling outside their immediate community or region. Good quality, well-connected video-conferencing will also assist in connecting health professionals and people as well as reducing the cost of travel throughout the district. Tele-health solutions can also moderate demand for face to face appointments from patients that could be safely and more conveniently cared for ‘virtually’.

The increased use of electronic referrals will support faster clinical decision-making and improved communication between clinicians supporting care to be delivered in the community.

It is acknowledged that technology is not always the best or most appropriate method of communication. Some consumers will continue to prefer a phone call with the results of their blood test, rather than accessing their results online. Others may not have internet access at home, or the technology necessary to access online health services. Health will continue to be a people centred service, with options available to meet the needs of consumers.

Strategic Outcome 6: Evidence-Led / Taunakitanga

Decisions about health care and the planning of future services are made based on local health intelligence and evidence. Design will take place at a local level, and keep a district-wide view, to meet the health needs of our communities.

The Top of the South covers a large geographical area. To ensure district-wide integration we will grow community networks of health professionals, providers and consumers who can identify gaps in services and develop solutions. These networks will take a broad view of health and join with local authorities, government departments and community agencies to support and strengthen a 'health-enhancing' environment.

Modern technology enables the collection and analysis of data, from multiple disparate sources to an extent that has not been possible in primary health care in the past. We now have access to an evidence-base of health information that can be used to plan more structured care at an individual level, especially for people with complex needs.

"Our system needs to become a learning system, by seeking improvements and innovations, monitoring and evaluating what we are doing, and sharing and standardising better ways of doing things when appropriate. Key tools to help make this shift are data and technology". *Source: 'New Zealand Health Strategy — Future direction'.*

Maori told us that continuity of care and advice was important, and they were worried and confused by conflicting advice.

Health Pathways are a good source of evidence-based information supporting primary care health professionals to plan care through the primary, community and secondary health system. Health Pathways enable all members of a health care team – whether they work in a hospital or the community – to be on the same page when it comes to looking after a particular person.

We can use these data systems to assist service providers in the management of their services, reporting and clinical audit.

Across the system, it will give us a district-wide view and help identify emerging priorities and plan and deliver timely responses. This district-wide summary will allow clinicians to identify services and interventions that best deliver our ambition.

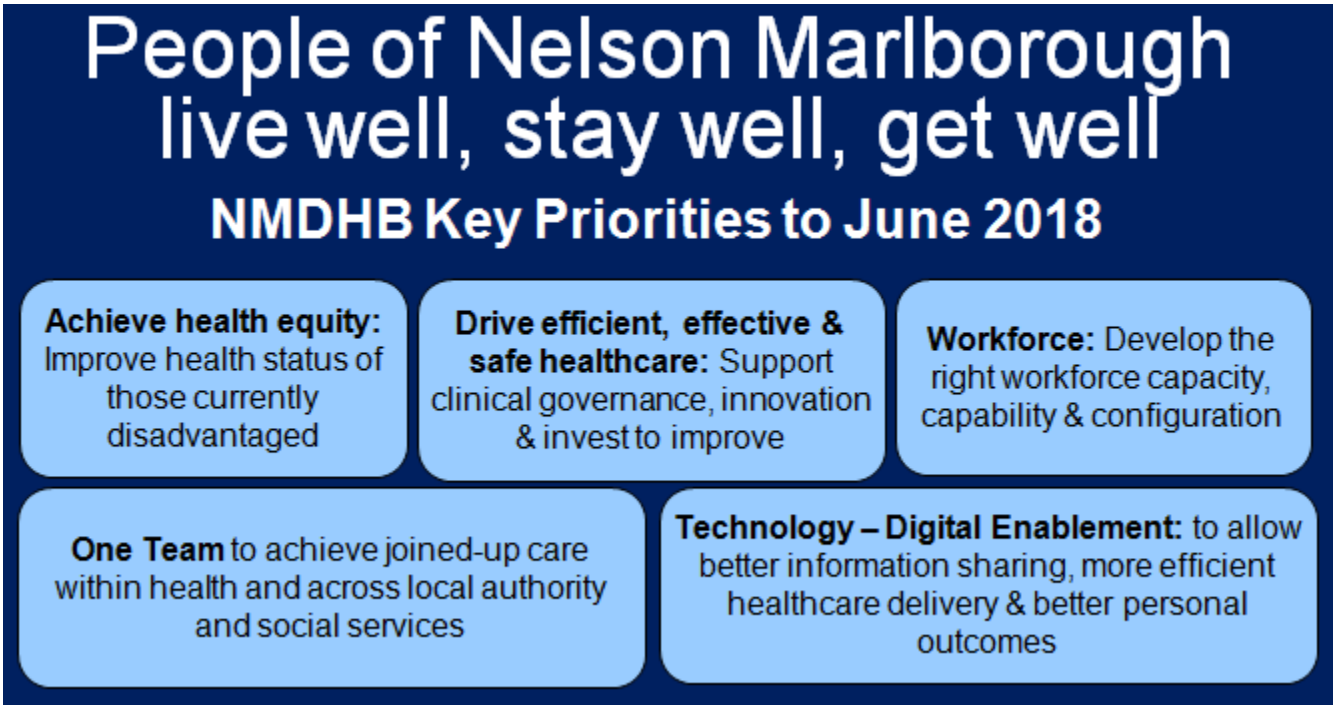
Part B: Road Map of Actions

The Strategy outlines a new vision for primary and community health care. It does not yet contain details of implementation, which will involve evaluation and prioritisation of the proposed changes to ensure health care in Nelson, Tasman and Marlborough continues to be of excellent quality and sustainable, now and in the future.

The Annual Planning and budget cycles of all key stakeholders have been aligned to prioritise actions and agree required funding investments.

To respond to the challenges outlined in the Strategy, and to make sure we continue to meet the health needs of our community, five priorities have been selected for the Nelson Marlborough health sytem:

1. Achieve health equity
2. Drive efficient, effective and safe healthcare
3. One Team
4. Workforce
5. Technology – digital enablement.



The five priorities are significant. Every year we will see an improvement in the priority areas, but the priorities will not be 'fixed' quickly. So the priorities are likely to remain the same for some time.

Action teams will be formed around key areas of work with oversight by the Top of the South Health Alliance (ToSHA). Engagement with consumers and communities will be an integral part of the process and a Consumer Council will be appointed to help prioritise and guide implementation.

Kau tau te whiriwhiri korero, mahia te mahi.

The talk has settled, get on with the work.