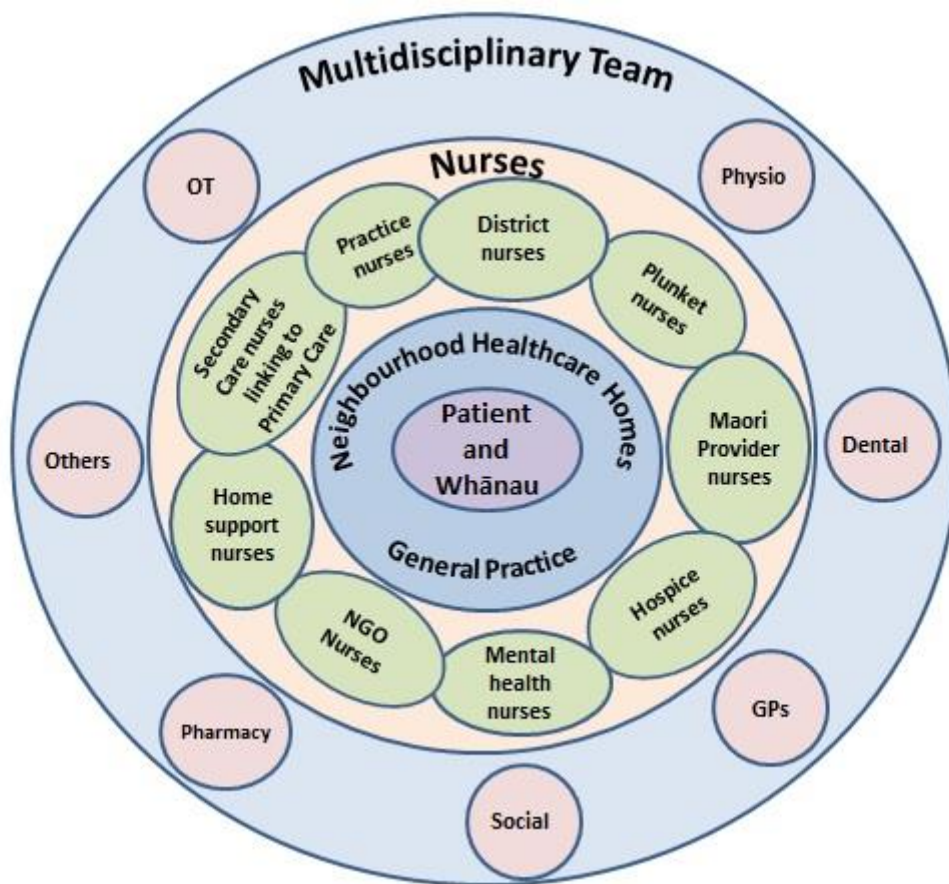


# Whangarei Primary and Community Nursing Model of Care and Implementation Plan



July 2016

Final Approved version

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## Executive Summary

The time has come for a major change in the way primary and community nursing services are organised so that they are patient and whanau centred and meet the inequity challenges that currently exist. Over an eighteen-month period, with wide consultation, consumers and nurses and other stakeholders have designed this new primary and community nursing model of care for Whangarei. It is a step in the broader integration agenda, which is part of the Neighbourhood Healthcare Home (NHH) change project.

The NHH model promotes general practices as coordinating hubs for patients. It supports changes to ways of working that will make general practice an easier place for people to access, and aims to free up capacity so that the team can work more effectively, particularly with high needs patients. It also is focussed on developing linkages between the general practice and other providers in the vicinity and with secondary services.

Key elements of change to improve the system have been agreed and planned.

- **Nurses will work in named teams**, working closely with NHH general practices, in a virtual network or on site. The long-term vision is for all nurses to be part of a NHH network. Systematic maintenance and refining of the network system will support collaborative care and improve flow of information. The new network will also include linkages between primary and secondary nursing services and the wider inter-professional team.
- **There is a NHH Nurse Navigator** who will support implementation of all aspects of the new model, with a special focus on quality improvement at the interface between primary and secondary care, and preventing readmissions.
- **A continuous quality improvement approach.** The NHH Nurse Navigator will utilise “Plan-Do-Study-Act” (PDSA) cycles to test and refine the model, support the changes, reduce costs and remove barriers to access.
- **An equity focus** will support strengthened linkages with Māori nursing services, and will create workforce development opportunities for cultural competency.
- **Shared Care Planning and coordination.** All high need patients will have a shared care plan developed in collaboration with the patient about ‘what matters to them’. A Shared Care Coordinator will be named, who (with the support of the NHH Nurse Navigator) can instigate case management meetings when required.
- **Electronic referrals** will benefit the patient by avoiding delays and enabling early care.
- **A workforce development programme** will engage nurses from across the sector to build teamwork and to support the change process across primary and community nursing services. Developing a primary healthcare nursing competency framework is fundamental to this programme.
- **General practice will be the patient’s healthcare home** which means that wherever possible patient care is located in, or explicitly linked to, general practice.
- **Strengthening and developing collaborative relationships with the** broader inter -professional team.

The implementation of these changes will be over seen by the Associate Director of Nursing (ADON) Manaia PHO, and will commence as soon as possible in the new financial year. The model will be jointly funded by Manaia PHO and Northland DHB.

These changes are needed to improve consumer and patient experience, especially for Māori, to make the best use of the resources we have, and to improve worker satisfaction.

## **1. Neighbourhood Healthcare Homes (NHH)**

The Whangarei primary and community nursing model of care is an integral part of the Neighbourhood Healthcare Home (NHH) model that is being implemented in Northland.

The NHH is an innovation in primary healthcare care service delivery, designed to advance and achieve the triple aim of improved patient experience; improved population health and; reduced cost of care. It provides enhanced primary care services of value to patients, their families, and the care teams who work with them. The evolving model promises improved access to high-quality patient-centred primary care, through trusted relationships with patients, families, and caregivers. The model incorporates team-based care with clinicians and staff working at the top of their skill set. It provides cost-effective care, coordination, and population health management which connects patients to their NHH and to their community.

In Northland, the following components of care within the NHH model have been identified. General practices will be implementing changes in the following areas:

- Equity management
- Call management
- Doctor phone triage
- Telephone consultations
- Patient portals
- Consumer and community engagement
- Integration with social and community sector
- Engagement with the new model of nursing care
- New model of Care Plus for long term condition management
- Clinical and administrative pre work prior to consultations
- Extended hours
- Patient and whanau centric appointments
- Expanded use of roles and new roles
- Applying lean principles
- Quality and safety

In the 2016/17 year 6 practices will be supported to make change to the new model. They are

- Bush Road Medical Centre
- West End Medical Centre
- Widdowson Sprague Medical
- Paramount Medical Centre
- Te Whare Ora O Te Hiku O Te Ika
- Kerikeri Medical Centre

In the next two years, further practices will be supported to take up the model.

## **2. Primary and Community Nursing, Whangarei**

The primary and community nursing component of NHH involves linking up, coordinating, and where possible, co-locating the range of nursing services around a network of NHH practices. Building collective capability and expertise in the care of people with long term conditions is an important component of both the nursing model and the Neighbourhood Healthcare Home. The proposed nursing model of care is an integrated, patient focussed model designed to engage the patient in partnership with their healthcare provider which, in many cases, is their nursing team.

During 2015, a comprehensive consultation process took place with nurses, midwives, nurse managers, NZNO representation and consumers. During the consultation process several challenges within the current system were identified, highlighting the need for change.

**Consumers told us the key issues for them are:**

- **Consistency:** they want health professionals working together so that their care is consistent
- **Coordination:** they want to be able to access care from several services, with everyone involved to understand what is happening with their care
- **Communication:** they want clear communication that is consistent, accurate and given in a way that they can understand
- **Accessibility:** they want services close to home, and to be able to access these services at a time suitable to them. They do not want to wait for extended periods of time for their care to be delivered
- **Care-plans:** they want to have a patient / whanau centred care-plan, which is developed with, and used by, their health team
- **Holistic care:** They want to be treated as a whole person
- **Financial:** They want the new model of nursing not to increase the cost of care
- **Skilled work-force:** They want their nurses to be highly skilled, and to do what needs to be done, when it needs to be done

**From the consultation the following principles were identified:**

- Integrated nursing care in the Whangarei community will promote meaningful connections
- Nursing care in the community will be affordable and accessible to our people to ensure equity
- Proactive and preventative care with a population health approach will underpin our nursing model of care in the community
- There will be a strong nursing workforce functioning at the top of their professional scope

The principles informed key change concepts, or building blocks, which have been socialised and modified as a result of feedback from the sector.

**The final change building blocks are:**

- An equity focus
- Triaging and managing transfers of care for patients with identified high need/ high clinical risk, in partnership with the range of nursing services
- Shared Care Coordinator for patients with identified high need/ high clinical risk
- Shared care-planning
- Workforce development
- Named teams of nurses

### 3. The new model of care

#### 3.1 Key elements of change to improve the system have been agreed and planned.

- **Nurses will work in named teams**, working closely with NHH general practices, in a virtual network or on site. The long-term vision is for all nurses to be part of a NHH network. Systematic maintenance and refining of the network system will support collaborative care and improve flow of information. The new network will also include linkages between primary and secondary nursing services and the wider inter-professional team.
- **There is a NHH Nurse Navigator** who will support implementation of all aspects of the new model, with a special focus on quality improvement at the interface between primary and secondary care, and preventing readmissions.
- **A continuous quality improvement approach**, the NHH Nurse Navigator will utilise “Plan-Do-Study-Act” (PDSA) cycles to test and refine the model, support the changes, reduce costs and remove barriers to access.
- **An equity focus** will support strengthened linkages with Māori nursing services, and will create workforce development opportunities for cultural competency.
- **Shared Care Planning and coordination**, all high need patients will have a shared care plan developed in collaboration with the patient about ‘what matters to them’. A Shared Care Coordinator will be named, who (with the support of the NHH Nurse Navigator) can instigate case management meetings when required.
- **Electronic messaging and referrals** will benefit the patient by avoiding delays and enabling early care.
- **A workforce development programme** will engage nurses from across the sector to build teamwork and to support the change process across primary and community nursing services. Developing a primary healthcare nursing competency framework is fundamental to this programme.
- **General practice will be the patients’ healthcare home** which means that wherever possible patient care is located in, or explicitly linked to, general practice.
- **Strengthening and developing collaborative relationships with the** broader inter-professional team.

#### 3.2 What is the change?

| Old Model  | New Model   |
|--|---|
| Individually focussed  | Patient / whānau focussed   |
| Inequitable access to care and inequitable health outcomes for Māori | Focus on equity and engagement with Maori provider services   |
| Service centred  | Patient / whānau centred  |
| Nurses working separately to general practice separately             | Development of networks between all primary and community nursing services and NHH practices, which may be virtual or physical. |

|  |  |
|--|--|
| <p>Primary secondary interface weak which leads to poor continuity of care<br/>Referrals not always made in a timely manner at time of assessment, or when care needs change, and not always to the correct provider</p>   | <p>Strengthened primary care contribution to the secondary system especially for high needs patients at transfer of care from hospital back to primary care.<br/>The NHH Nurse Navigation role oversees triage and referrals at points of transfer for patients with high need / high clinical risk.<br/>Current secondary discharge/ referrals system will be enhanced with primary care nursing input at point of referral.<br/>A quality improvement approach to change through linkage between primary and secondary services.</p> |
| <p>Lack of primary / secondary interface mechanism to address system failure<br/>Various pathways on hospital discharge dependent on:</p> <ul style="list-style-type: none"> <li>• judgement about ability to pay</li> <li>• perceived skill level of nurses,</li> <li>• compliance with department wishes</li> <li>• knowledge of, and relationships with, a range of services</li> </ul> | <p>Primary /secondary partnership approach to quality improvement<br/>The NHH Nurse Navigator will have the capacity and ability to take a quality improvement approach to issues that arise between primary and secondary care on discharge, especially for high need/high risk patients The role will act as a ‘trouble-shooter’ to find sustainable solutions for discharge issues between primary and secondary care, working within a quality framework.</p>  |
| <p>Variable quality relationships between the wider primary and community nursing services and general practice teams</p>  | <p>A named team of nurses, with a shared vision, will be linked up with a NHH. Shared learning will build relationships and team work.<br/>Development will be supported by the NHH Nurse Navigator and the ADON Primary Care, who will broker sustainable solutions to support patient centric care.</p>  |
| <p>People with long term needs do not routinely have a comprehensive coordinated care plan which is developed and agreed with the patient. Care plans are not routinely shared with those involved with care</p>   | <p>An electronic care planning tool will be available for the team and the patient to plan care together.<br/>An identified Shared Care Coordinator will oversee the plan of care.</p>   |
| <p>Variable level of competency of primary and community nurses</p>  | <p>Standardised competency framework and process to enable all nurses working in primary care to have the same level of generic skills. All nurses to be supported to work at the top of their skill set.<br/>Shared education on leadership competencies, multi-disciplinary team work, cultural competency for members of the NHH team.</p>  |

### **3.3 What difference will it make to the patient?**

The patient's experience of care will be improved because:

- More services will be in one place which will make it easier for the patient and mean less travel and cost
- They will be helped to access other services that they need
- The services will be working together and therefore more coordinated, especially regarding transfers of care. This will mean that it is simpler for the patient, and there are fewer delays in care.
- They will understand what the plan is for their care which they have been involved in developing, and who is involved with their care.
- They will know who to go to if they have a problem, and if it is a complex problem it will be resolved through a case management approach
- If there are any problems with provision of dressings, between District nursing and Primary care there will be a way to get a patient centred resolution supported by the NHH Nurse Navigator.
- the quality of nursing services will be improved through a competency approach to nursing care care, and workforce development opportunities such as cultural competency, shared care planning, managing expanded roles etc

### **3.4 What difference will it make to the workers?**

- There will a reduction in wasted nurse time because of the connecting up of services through the named team of nurses around a NHH practice, and through the shared care planning tool. .
- Enhanced team development through shared workforce development opportunities and quality initiatives within the named team of nurses
- Increased collegiality being part of a broader team which will also extend to the multidisciplinary team which will strengthen relationships and enhance communication and coordination
- There will be primary care expertise and knowledge, closely linked with secondary services through the NHH Nurse Coordinator, and so day to day issues between primary care and secondary care can be resolved.

### **3.5 What difference will it make to the system?**

- Reduction in wasted health money through lack of coordination
- Reduction in readmissions rates because of the coordination of care
- Improved health outcomes for risk stratified high need population (in collaboration with the Advanced care plus programme)





**NORTHLAND HEALTH SERVICES PLAN**  
*Whāngai Ora - Mahi Kia Kotahi*



**Phases of care**

**Initial contact:**

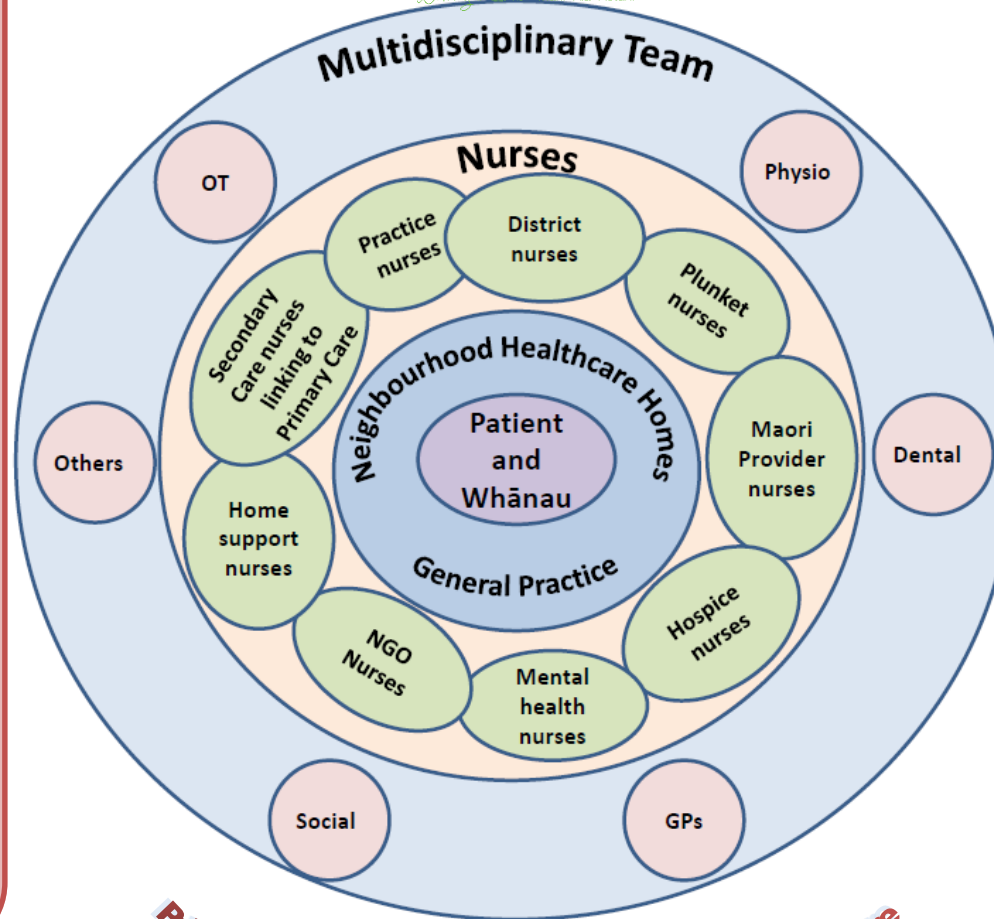
- Whakawhanaungatanga: Introductions and role clarification
- Nursing assessment

**Short term:**

- Coordinated discharge care and referrals— use of electronic referrals and secure messaging. Quality improvement processes.

**Long term:**

- Prioritising high needs patients identified in NHH
- Includes social needs
- Proactive transition management
- Advanced Care Plus
- Shared Care Plan
- Electronic referral



**Primary and Community Nursing Model of Care**

**NHH Coordination**

- Networks of nurses linked with NHH practices
- Partnership model between primary and secondary care
- NHH risk stratified high need population are priority
- Coordination for transfer of care
- Shared care plans
- Shared Care Coordinator identified
- Communication and Information hub

**Equity**  
 Changes will not disadvantage patients  
 Māori providers more linked in to the NHH

**NHH coordination**  
 Coordinated triage and referral system for patients with high need/risk at transfer of care.

**Shared Care planning— Shared Care Coordinator**  
 High needs patients will have a shared care plan, with named team members and a Shared Care Coordinator

**Nursing workforce model**  
 Workforce model with a competency framework

**Identified team**  
 Named team of nurses in a network around NHH practices  
 Nurses communicate names and roles to patients

#### **4. Nursing roles and delivering the new model of care**

The new model of care is agnostic regarding employers. There is no intention to change employment of any primary and community nurses. There is a focus on coordination in this model which is necessary to support patients in navigating the complexities of the fragmented health system. Patients expressed this need clearly in consultation.

**4.1.1 Existing role - The Associate Director of Nursing (ADON): Manaia Health PHO**, will oversee and drive the change process for the project to:

- Identify and name the extended team of nurses working within the NHH
- Work with the NHH Nurse Navigator to develop and establish the new role
- Develop a communication plan agreed on by the NHH team of nurses to enable open discussion and problem solving throughout the change process
- Further develop the core set of competencies for the primary healthcare nursing team and commence implementation through an annual planned study programme
- Build team-work and relationships with the general practice and nursing teams through shared learning
- Facilitate linkages and relationships between hospital –based nursing services and primary care
- Support the integration of specialist nursing services into the NHH Nursing Team
- Lead and implement the change process using PDSA cycles to maintain traction and support the process

**4.1.2 A new role – Neighbourhood Healthcare Home Nurse Navigator role** will be established to work with, and report to, the ADON role. The key functions of this care coordination role is to:

- support patients with high needs / high clinical risk as they transition from the hospital back to their NHH team ensuring care is in place to prevent their re-admission and ensuring the transfer of care is seamless for the patient
- Liaise with secondary care teams who have linkages with primary care acting as the patient's navigator as required
- resolve any issues that occur for high needs/high clinical risk patients between services
- develop, promote and strengthen the relationships, systems and processes required to support high quality systemic integration in line with NHH development
- ensure that high risk /high need patients have a Shared Care Coordinator and a shared care plan.
- support practical implementation of electronic shared care planning, referral systems and health messaging
- support quality improvement initiatives for a successful transfer pathway
- be a specific point of contact between secondary and primary care services
- work with, and problem solve alongside the ADON for successful implementation of the new model of care.

#### **4.1.3 Existing role - Shared Care Coordinator**

The high need patient's Shared Care Coordinator will be identified by them at the time of commencing on Care Plus. This is an existing health professional identified by the patient as being their 'go to person' once they arrive home. This could be, for example, an Iwi Provider Nurse already involved with their care, or their Care Plus practice nurse. The Shared Care Coordinator will take an over view of the range of services working with the patient and keep checking with the patient that everything is running smoothly. They will continue using and developing the electronic shared care plan with the patient. If the patient requires a

higher level of intervention, patients can be referred to specialist nursing services through their Shared Care Coordinator. If required, the Shared Care Coordinator will arrange a multidisciplinary case management meeting at the patient's NHH, to ensure the patient receives the most appropriate care, from the right person. They may enlist assistance from the NHH Nurse Navigator to set this up and get the right people at the meeting. This role involves both care coordination and case management.

#### **4.1.4 Existing role - The Care Plus Nurse: Long term care and management**

Long term care and management of patients with identified high need/ high clinical risk will be delivered through the NHH's Care Plus programme. Care planned with the patient will be both proactive and interactive. Nurses will telephone patients in advance of visits to prepare the patient for their consultation and arrange any pre-tests. They will also contact patients post discharge and connect with the patient when key interventions are required. The patient will have access to their electronic shared care-plan into which the multi-disciplinary team can write. The patient's identification of 'what matters to me' and their social needs will be included in their care-plan.

#### **4.1.5 Existing role: Practice Nurse Leader**

Each NHH practice, during the establishment phase will identify a Practice Nurse Leader to be part of the internal change team. Funding for release time will be available for this role during this phase.

#### **4.1.6 Existing Roles: District Nurses**

District nurses will not change employment but will link with, and be assigned to, the named teams of nurses around NHH practices, which will be developed by the NHH Nurse Navigator and the ADON Manaia. Where possible, District nurses will be co-located in a general practice. This will be negotiated on a case by case basis, however as a principle it is expected that the mutual benefit be realised of such a scenario. If co-location is not possible, other mechanisms to support the physical presence of district nurses within general practice will be developed, such as regular meetings or huddles between district nurses and the general practice team. The NHH Nurse Navigator will have a close working relationship with the Manager of District Nursing services and together they will develop solutions that are patient centric, when issues arise between general practice and district nursing.

#### **4.1.7 Existing roles: Nurses within Māori providers**

As equity is a priority for both this project and the NHH overall, processes to ensure inclusion of Māori provider nurses into the named team of nurses around a practice will be carefully designed with full consultation with the relevant providers. Cultural competency will be prioritised as a development focus.

#### **4.1.8 Existing roles: Nurses within from other NGOs.**

Integration and coordination between general practices and all nurses in primary and community based roles is intended through having the 'named team of nurses' around general practice. Coordination issues and quality issues between general practice and any providers will be worked on by the NHH Nurse coordinator, with a solutions focus.

### **5. Process of implementation**

The new nursing model of care for Whangarei will initially be initiated in practices which are part of the Neighbourhood Healthcare Home development. Following successful implementation the model will be expanded to the broader Whangarei community, and then potentially, with further consultation, Northland wide.

A newly formed NHH implementation governance group will closely monitor progress against the key performance indicators. A PDSA process will be utilised to achieve desired outcomes. A comprehensive communication plan will keep stakeholders informed of progress.

## 5.1 Increasing equity

The intention of this project is to reduce inequities. Careful implementation is required, with robust monitoring to ensure there are no unintended consequences. Consumers clearly stated they did not want there to be any increased financial burden to them through change. Therefore, there will be no major change to services provided by district nursing that are currently free. Over time, non-complex care will be transitioned to primary care. Mechanisms for funding support to those who cannot afford to access primary care in this way will be explored when the new primary care funding model is known.

It is the intention to support and enable general practice to work more closely with Maori providers, which will increase acceptability of services to patients and whanau.

Equity management is part of the broader NHH components of care to ensure NHH development practices commit to a range of specific actions to improve inequity.

Kaupapa Māori models which enhance understanding will be used to strengthen relationships. Maori providers already work under these models and further training for the non-Māori work force will be included in the implementation of the new model of care. Some examples of these models are the Takarangi framework, Te Kapunga Putohe, and Te Hononga.

## 5.2 NHH coordination for triage and referral of patients with high needs/ high clinical risk

### 5.2.1 Transfer of care from Hospital

This process will be supported by the new role to add primary care expertise into the transfer process – a Neighbourhood Healthcare Home (NHH) Navigator. This role will work in a partnership model with hospital services, general practices, and other providers to improve discharge processes, and to facilitate a 'joined up' system of discharge which includes a quality improvement dimension. Specifically the NHH Nurse Navigator will be part of the CNS team meetings in order to develop linkages and relationships.

Current secondary nursing services who have a role to play in coordinating care for high need 'high clinical risk patients transferring to primary care include:

- District Nursing
- Health of older People (HOP) Community gerontology Specialist nursing team
  - Community Gerontology nurse (Dargaville)
  - Post discharge care coordination Nurse
  - Clinical nurse specialist
  - Clinical nurse specialist fracture liaison service
- Medical Outreach Nursing services
- CNS :Stroke nurse
- CNS :Diabetes
- Cardiac Rehabilitation services
- Paediatric outreach services
- Community Assessment Rehabilitation Service (CARs)
- Needs Assessment Service Coordination (NASC) assessors
- A full list of NDHB Clinical Nurse specialist roles are included in appendix 1. These roles will be important linkages for the NHH Nurse Navigator.

While there are a number of coordination roles involved, through consultation with these services it has become clear that the primary care linkage is weak, and needs strengthening for patient continuity of care.

Each quarter the NHH practices will supply to the NDHB a list of patients with high need / high clinical risk as established through the advanced care plus risk stratification process. When these identified patients are admitted to NDHB an electronic alert will be sent to the NHH Nurse Navigator. Working with the patient and primary / community nursing services the NHH Nurse Navigator will ensure the right care is in place to prevent their readmission and ensure the transfer of care is seamless for the patient and that follow-up is arranged with the most appropriate service following discharge from hospital.

### **5.2.2 Transfer of care between primary and community nursing services**

The team of nurses linked to the NHH practices will be an established network with clearly defined roles. Electronic as well as team communication within the network will allow referrals to be managed directly between nursing services, with the NHH Nurse Navigator available to streamline and improve processes as required.

For example when there is an issue related to most appropriate setting for care, such as a patient who would prefer to have their dressing completed by Primary care, but the type of dressing is not available in primary care, this kind of negotiation will be handled between the NHH Nurse Navigator and the leadership of the services to resolve them in patient centred way.

### **5.2.3 Technological enablers of coordination**

Electronic referral systems and shared care planning are in the early stages of development. This proposed new functionality complements triage and referral processes, focussing on coordinating care transfers for the high need/high risk population identified through the NHH risk stratification process. Patients who are identified with high need / high clinical risk will be part of the new Care Plus programme in their general practices. They will have a shared care plan. The purpose of this new function is to ensure the right services are 'wrapped around the patient' to ensure a smooth, connected pathway.

### **5.3 Shared care planning and Shared Care Coordinator**

All high needs patients identified within the NHH as part of the enhanced Care Plus programme will have an identified Shared Care Coordinator and a shared care plan. The mechanism for the shared care plan is through an electronic tool, Care Connect (CCMS). CCMS has the capacity to show who is involved with a patient's care and identifies the Shared Care Coordinator. The care-plan outlines the patient's goals, and what is currently in progress to achieve these goals. The goals are agreed with the patient and are structured around the key question, 'What matter's to me?' Achieving the capability to have this tool implemented is a joint project with several NDHB departments and primary care providers who are committed to its use.

The Shared Care Coordinator of care will be identified during the care planning process in partnership with the patient. Initiation of the Shared Care Coordinator and the care plan will occur mostly in primary care, although in some instances, particularly for patients with complex needs, care plans will be initiated in secondary care prior to discharge.

## **6. Competency based primary and community nursing workforce development / training**

There are existing frameworks outlining expected primary healthcare nursing competencies. Work has been done in Northland bringing the various strands together in a proposed Northland set. It is the intention to drive an awareness and training around achieving generalist primary nursing competencies which include cultural competencies. Existing avenues for nursing development will be used, such as Continuing Nursing Education sessions, as well as new opportunities for NHH shared forums.

Key areas of training to support the model of care changes will be identified. Potential training could include:

- Care planning

- Improving health literacy
- Cultural competency,
- Motivational interviewing,
- Having difficult conversations,
- Recognising and acting on change talk.
- Improving therapeutic relationship between nurses and consumers
- Equalising power imbalances
- Exploring information about the range of services available
- Using technology to support patient education and information e.g. Health Navigator
- Utilising patient stories and patient journeys

## **7. Identified named teams of nurses working together within a network of NHH practices**

As part of NHH development a dynamic directory of nurses linking with the Neighbourhood Healthcare Home network will be developed and maintained. This named team of nurses will work closely with NHH practices. They may be a virtual team or could potentially be co-located. To ensure connectivity for all sites, Nurses will be encouraged and invited to establish mechanisms for communication, referral, and for review of how things are working. A communication feedback mechanism for both team members and patients will be established to address issues as they arise.

Leadership will articulate and reiterate expectations about the patient needing clear information about 'who is who' in their team. This will be audited as part of the evaluation of the proposed model of care. Supporting a culture of respectful relationship with consumers includes basic courtesy of the team introducing themselves, and explaining their role within the NHH. Utilising other enablers such as clear name badges, easily understood role names / designations, and organisation boards with photos of members of the health team will demonstrate in a visual way the 'who's who' of the health team.

## **8. Key performance indicators**

### *Quantitative*

- % reduction in readmission rates for risk stratified population
- % reduction in High intensity users 3 + non admitted Ed attendances
- % reduction in High Intensity users 2 + hospitalisations
- % increase in linked activity between General Practice and external community nursing services
- % increase in reported improved coordination by General Practice nurses
- % increase in number of patients with high need/clinical risk have a completed and up to date shared care plan
- % increase in referrals of Maori to specialist services
- % Maori patients with high need/clinical risk with a shared care plan
- 95% of patients coordinated express satisfaction that their care is connected
- % increase in numbers of nurses participating in a PDR Programme
- % increase in nurses reporting active usage of competencies

### *Qualitative*

- Stakeholders report they are informed about the change process
- The General Practice team knows who to access across the range of nursing service.
- High need patients express satisfaction with the process of transition of care
- Maori patients report smooth transitions of care
- Patients with a care plan report that they have been involved in the development of the plan
- The General Practice team can name their key contacts across nursing services

- Patients with a plan report they feel that the plan accurately reflects what matters to me
- Nurses report usefulness of primary care competencies
- Communications mechanisms are established across nursing services

**9. What is the level of high need/risk in the NHH practices?**

Northland DHB and Manaia Health PHO and Te Tai Tokerau PHO have collaborated on a piece of work developing GP information reports, which we have in detail for each practice in Northland. These cover a range of indicators of relevance in estimating the work that needs to be done in implementing the new model of care.

For example across the four NHH practices in Whangarei we know that in 2014:

| Total enrolled population | Care plus <sup>1</sup> population (5%) | Enrolled population diagnosed with Diabetes | No with CVD | Enrolled service users (ESU) with diabetes who had an unplanned hospitalisation | ESU with diabetes – non admitted ED | ESU with CVD who had an unplanned hospitalisation | ESU with CVD –non admitted ED | Total attendances ED | HIU ED 3+ non admitted | HIU Hospitalisations 2+ unplanned |
|---------------------------|--|---|-------------|---|-------------------------------------|---|-------------------------------|----------------------|------------------------|-----------------------------------|
| 24,531                    | 1226                                   | 1350  | 2208        | 247   | 247                                 | 570   | 444                           | 6917                 | 291                    | 1704                              |

GP information report data 2014

- Each practice will be working with the new care plus programme to risk stratify their high need patients. This detailed work is underway, and will be utilised for the coordination part of the model.

**10. Conclusion**

Through an extensive consultation process, this new model of nursing care has been designed for the Whangarei area in the first instance. It will commence implementation within the first Neighbourhood Healthcare Homes practices, with the overall intention of the new model of care being extended across Whangarei. Beyond Whangarei, the process requires further consultation with stakeholders.

The model has been designed on the basis of people’s voices, both consumers and workers describing the challenges within the system. The silo’ed nature of services which negatively impact on patient’s experience of care is a key theme running through the consultation, and developing better connectedness is central to the changes planned. Conversations about this need are not new, and the complexity of making real change which involves many services can be daunting, however this is an opportunity to do better for the health of the people, especially those with high and complex needs.

There is a real willingness, energy and commitment to making the changes required successfully and sustainably, and from July 2016, the real practical implementation work will commence.

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<sup>1</sup> Current CarePlus enrolment from the Whangarei practices is 2009, but the programme is being revised with a view to 5% of a practice population being supported through the new Care Plus programme. It is currently over subscribed.

Appendix 1.

| <b>Clinical Nurse Specialist roles</b>                   |
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| Data extracted 1 June 2016                               |
| bus_title  |
| CLINICAL NURSE SPECIALIST                                |
| CLINICAL NURSE SPECIALIST - CARDIOLOGY                   |
| CLINICAL NURSE SPECIALIST - WOUND CARE                   |
| CLINICAL NURSE SPECIALIST / REGISTERED NURSE PDRP EXPERT |
| CLINICAL NURSE SPECIALIST / RN PDRP PROFICIENT           |
| CLINICAL NURSE SPECIALIST BREAST CARE                    |
| CLINICAL NURSE SPECIALIST CHILD PROTECTION               |
| CLINICAL NURSE SPECIALIST COLO-RECTAL                    |
| CLINICAL NURSE SPECIALIST CONTINENCE                     |
| CLINICAL NURSE SPECIALIST DIABETES                       |
| CLINICAL NURSE SPECIALIST DIABETES PDRP EXPERT           |
| CLINICAL NURSE SPECIALIST DIABETES- PRESCRIBER           |
| CLINICAL NURSE SPECIALIST ECZEMA                         |
| CLINICAL NURSE SPECIALIST ED/ RN                         |
| CLINICAL NURSE SPECIALIST ENT                            |
| CLINICAL NURSE SPECIALIST GERONTOLOGY                    |
| CLINICAL NURSE SPECIALIST HEPATITIS                      |
| CLINICAL NURSE SPECIALIST HOME HAEMODIAYSIS              |
| CLINICAL NURSE SPECIALIST INFECTION CONTROL              |
| CLINICAL NURSE SPECIALIST INFECTION PREVENTION & CONTROL |
| CLINICAL NURSE SPECIALIST KAITAIA OPD                    |
| CLINICAL NURSE SPECIALIST MEDICAL OUTREACH               |
| CLINICAL NURSE SPECIALIST OPHTHALMOLOGY                  |
| CLINICAL NURSE SPECIALIST OSTOMY                         |
| CLINICAL NURSE SPECIALIST PAEDIATRIC DIABETES            |
| CLINICAL NURSE SPECIALIST PAIN MANAGEMENT                |
| CLINICAL NURSE SPECIALIST PRE ASSESSMENT CLINIC          |
| CLINICAL NURSE SPECIALIST PREDIALYSIS                    |
| CLINICAL NURSE SPECIALIST SURGICAL OPD                   |
| CLINICAL NURSE SPECIALIST TAPUHI                         |
| CLINICAL NURSE SPECIALIST TRANSPLANT                     |
| CLINICAL NURSE SPECIALIST WARD15                         |
| CLINICAL NURSE SPECIALIST-FRACTURE LIASON SERVICE        |
| CLINICAL NURSE SPECIALIST/ CLINICAL NURSE EDUCATOR       |
| CLINICAL NURSE SPECIALIST/ NURSE COORDINATOR             |
| CLINICAL NURSE SPECIALIST/ REGISTERED NURSE              |
| CLINICAL NURSE SPECIALIST/CLINICAL NURSE EDUCATOR        |
| CLINICAL NURSE SPECIALIST/REGISTERED NURSE PDRP EXPERT   |
| TEAM LEADER / CLINICAL NURSE SPECIALIST                  |