Community Nursing Integration Implementation Project

Working Group Co-opt Members Brief

03 May 2016

Purpose

The Bay of Plenty Alliance Team or the Community Nursing Integration Project Working Group has identified you as having particular expertise that is relevant for the Community Nursing Integration Implementation Project. In particular, you have been identified to participate as a member of a specific work stream.

The purpose of this document is to provide background and context to the project and anticipated resource commitments from you as a co-opt member of a project work stream.

Background

In November 2014, the Bay of Plenty Alliance Team (BOPALT) established a Service Level Alliance Team (SLAT) to develop a more integrated, patient-centred model of care for Community Nursing in the Bay of Plenty.

A paper outlining a proposed model of care was presented to the BOPALT committee and approved in principle in July 2015 ('the Model of Care'); noting that the implementation phase would provide opportunity to refine the Model of Care where relevant. A copy of the proposed Model of Care can be found on the following web link.

http://www.bopdhb.govt.nz/media/58212/an-integrated-model-of-care-for-community-nursing.pdf

In September 2015, the BOPALT agreed to form a Community Nursing Integration Project Working Group (the Working Group) to provide advice and expertise to inform the development of an implementation plan for the Model of Care. The BOPALT approved the terms of reference for the Working Group.

The Working Group

The Working Group was established in October 2015 and meets monthly to progress the following implementation work to date.

- ✓ Agreed to 11 work stream activities that breaks-down the model of care into actionable components of work.
- ✓ Members have identified their participation against the 11 work streams and suggested co-opt options where particular areas of expertise are sought.
- ✓ Application of whānau ora in practice and as a result re describing the model of care from a whānau perspective.
- ✓ A draft (work in progress) implementation plan including definition of service components such as initial care, short term care, routine chronic care and complex chronic care has been developed which provided detailed information on work stream activities as they are developed.

Project Approach

The BOPALT agreed to apply project management structure and a staged approach to implementation planning for the following reasons:

1. Components of the Model of Care have inter-dependencies; a staged approach will ensure implementation activities to be prioritised accordingly.
2. The Model of Care requires significant detailed operational work; a staged approach will ensure effective use of limited resources over a period of time.

3. Implications of the Model of Care include service changes; a staged approach will allow flexibility to implement small tests of change based on the Institute for Healthcare Improvement Model for Improvement methodology.

Based on the components of the Model of Care; we can approach the implementation planning activities into manageable work stream activities. This will enable the Working Group to take lead in areas of their expertise, co-opt members as required and expedite the work.

Whānau ora practices and communications work streams are the responsibility of the Working Group and not specific work stream group. The rest of the nine work streams as listed below have commenced their work in a phased approach with complex care being the last to launch.

1. Baseline information;
2. Community care coordination;
3. Initial care service delivery design;
4. Short term care service delivery design;
5. Routine continuing care service delivery design;
6. Complex continuing care service delivery design;
7. Workforce practices;
8. Information and technology support;
9. Funding, performance and measurements;

Co-opt Membership Commitments

Individual work streams will meet a maximum of 6 times in 2016 with duration of 60 minutes and on odd occasion for 90 minutes. The meeting locations will be either in Tauranga or Whakatane with video or tele conferencing facilities. We anticipate your commitment to a work stream will be between 15 to 20 hours in total including attendances at six meetings, reading and producing work in between meetings. Members are expected to contribute to work stream activities outside the scheduled meetings by leading and/or providing expert advice.

Complex Care Work stream

Complex chronic care has been loosely defined as services for patients who have unstable long term conditions that do not require urgent admissions or intervention and are at risk of long term complications or socially isolated. It also includes palliative care. This workstream is expected to re define the services before designing the associated community nursing services that are an appropriate care package.

This work stream has met once and is scheduled to hold five more meetings as per table below.

Complex Continuing Service Delivery	Thursday Thursday Thursday Thursday Thursday Thursday	28th April 26th May 16th June 7th July 4th August 18th August	8:45am – 9:45am 8:45am – 9:45am 10:15am – 11:15am 8:45am – 9:45am 8:45am – 9:45am 8:45am – 9:45am	Anushiya Ponniah (Lead) Julie Cowley Yvonne Boyes Tracey Morgan Caroline Vanstone Cindy Harper Kathy Shelley Moloney Vanessa Roguski General Practitioners (tbc)

Further Information about the project activities to date can be found on the BOPDHB website by using the following web link.

http://www.bopdhb.govt.nz/your-dhb/community-nursing-integration-project/

If you require further information please contact Anushiya Ponniah (Project Lead) on 027 565 4265 or anushiya.ponniah@bopdhb.govt.nz ; or Sarah Nash (Project Coordinator) on sarah.nash@bopdhb.govt.nz