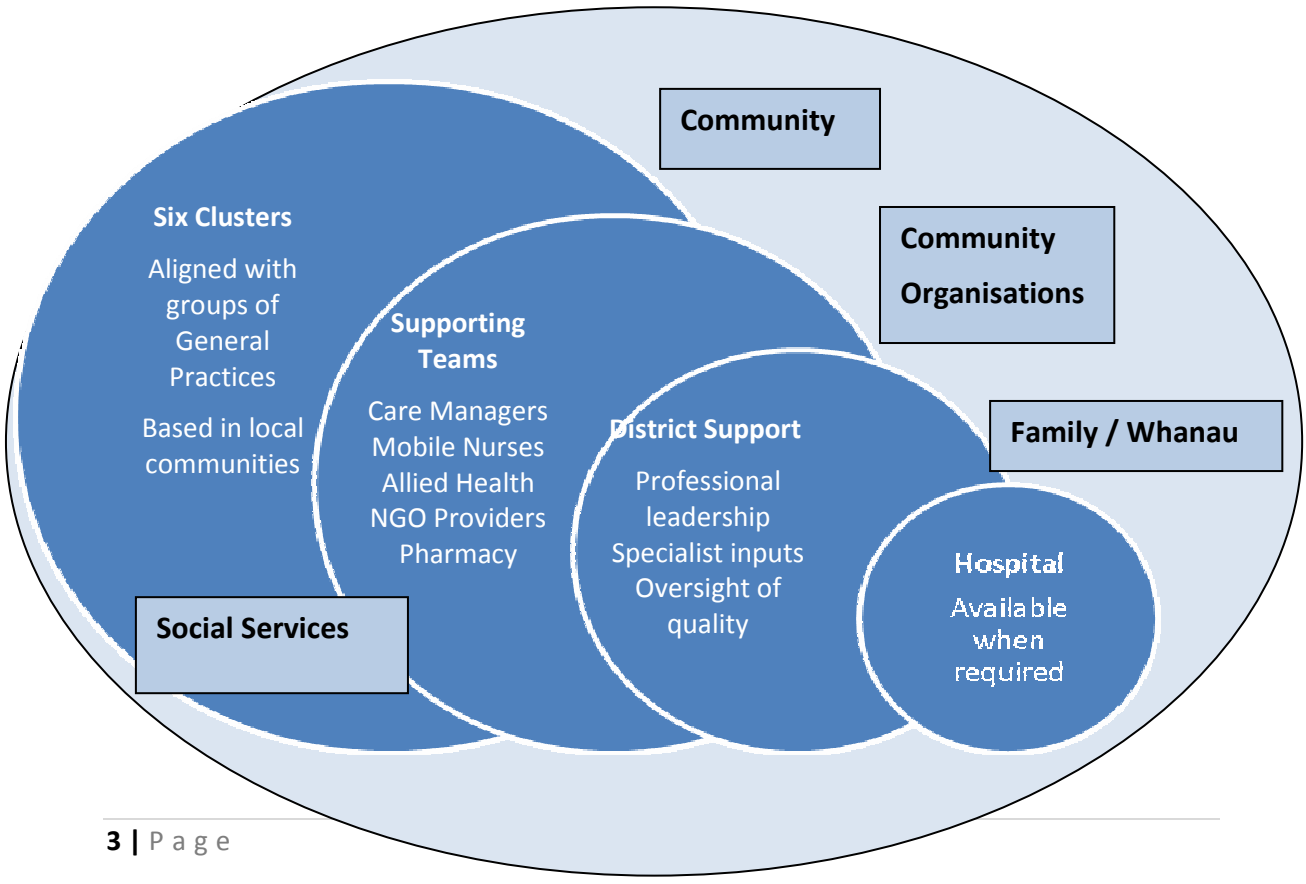
Executive summary

Project SPLICE has been initiated by Taranaki District Health Board to address the projected health needs of its older population and people who have a long term condition such as cardiovascular disease, diabetes and respiratory disease. Supporting the growth in demand for services associated with a growing older population and associated growth in the number of people with a long term condition is a national and international issue. Taranaki District Health Board is however faced with a significant complicating problem. Overall the population of Taranaki is projected to decrease by over 8% from 2001 to 2021 while at the same time the New Zealand population will grow by over 17%. While many other districts in New Zealand will gain additional health funding associated with demographic increases and be able to direct this towards service growth for long term conditions management and older people, Taranaki, will receive a reduced future funding track and must support growth by refocusing existing service activity.

The aim of this paper is to outline a structure that will, within currently available funding, on an evolutionary basis enable services to refocus around the needs of people with long term conditions and of older people as their health deteriorates. The recommended structure involves building on the strengths of general practice and existing community based service delivery to enable improved integration between services, reduced duplication and reduced risk of disconnect between multiple services that may be involved in supporting a person's care.

Simply put the recommended approach will mean people with complex needs will have an identified care manger who has an excellent relationship with their general practice and will work to ensure that all of the care they are receiving is connected. This person will work with a defined cluster of General Practices to allow relationships to develop and will be supported by a locally based team of nursing, allied health and non government organisations providing support services. Further support will be provided across the six proposed clusters through a District support and development unit that will include professional leadership, specialist input from nursing and doctors and provide oversight of care processes and professional development.



This is not a radical change. While significant, what is recommended builds on much of the infrastructure that is already in place in the Taranaki region. District Nursing services already operate in geographical clusters, Nurse educator services are already evolving to provide a mix of locally based service delivery and district wide delivery, General Practice is already looking at consolidating activity around Integrated Family Health Centres, and there are already examples of specialist services that are significantly community based. Innovative examples already exist where District Nursing is better integrated with General Practice and these are well regarded provided the isolation issues are addressed.

This project is being undertaken in parallel to the development of the Primary Care Midland Business Case for the Better, Sooner, more Convenient Initiative. The work is intended to be complementary and some developments will be dependent on progress made across both pieces of work. Due to development occurring in parallel some reconciliation in approach may be required.

Key changes that will be seen based on what is recommended in this report include the following:

- Further refinement of clusters to develop up to six clusters across the district including (i) Hawera and surrounding areas; (ii) Stratford and surrounding areas; (iii) Three New Plymouth clusters, one also covering western areas, and one supporting Inglewood; and (iv) Waitara and surrounding areas;
- Alignment of District Nursing, Community Allied Health, NGO and Pharmacy provision to these clusters;
- Develop primary and community nursing into practice/clinic based nursing and mobile nursing functions and extension to navigation activity for people under 75 with long term conditions;
- Development of NASC function into Care Management delivered in the clusters for people aged over 75 with complex needs and in the District support and development unit for people with non complex needs;
- Introduction of *inter*RAI to support comprehensive assessment for older people;
- Integration of triage and coordination for District Nursing, Short Term Home Based Support and non complex long term home based support[1];
- Establishment of a District Support and development unit including professional leadership, specialist nursing and medical input, alignment of limited FTE disciplines and establish quality oversight function; and
- Establishment of restorative home support services.

It is expected that these changes will improve the experience of older people and those with long term conditions when they are accessing the health system. More services will be based locally and, once someone has visited their general practice, it will be easier for them to find their way to other services they need. If people are not accessing general practice then they will be more likely to connect with the mobile nursing functions. People with complex needs will only need to tell their story once to their care manager and this person will work alongside their general practice to make

[1] Requirement for this function will be particularly dependant on the Midlands BSMC Business Case

sure they are getting the best response possible. People with less complex needs will be able to access prompt efficient advice and support via the phone or face to face when required.

General Practitioners and practice nurses will know who their local care manager is and they will be able to call them directly regarding any patient issues. As capacity builds they will also have access to navigators to assist people who have long term conditions. Support staff including district nursing, allied health and NGO staff will also be known to general practice. Overtime the role of district nurses will evolve into a mobile nursing function with clinic based activity supporting patients who are able to attend practice clinics. Specialist services will focus more on providing advice and oversight of care managers dealing with complex people. Discipline specific clinical leadership will be available district wide along with education and development opportunity for staff.

These changes are designed to address the current and future needs of older people and those with long term conditions in the Taranaki region. Taranaki DHB is already a high performer in related Health Targets involving management of people with diabetes and screening for cardiovascular disease. The recommended changes will provide the basis for supporting the increasing population of older people and prevalence of long term conditions within the resources that are currently available.