

TO Hospital Advisory Committee
FROM Lyn Horgan
Operations Director
Hospital Services



MEMORANDUM

DATE 28 June 2010

SUBJECT District Nursing Service Review-
Proposed Service Reconfiguration

1. PURPOSE

MDHB no longer achieves budget and this is largely due to rising cost structures within the hospital division, MidCentral Health (MCH). The year end position 2009/10 is forecast to be a deficit of \$9.8 million.

A number of financial service reviews are already under way within MCH. In addition, five areas where there is potential over-servicing and/or duplication are being reviewed, including District Nursing's night service. There was an estimated identified savings of \$375k for the service review of District Nursing.

2. SUMMARY

Consultation with staff has occurred, together with community and stakeholder engagement.

Staff have put forward a number of other means of reducing costs, including the establishment of District Nursing clinics and the cessation of wound care supplies to people no longer requiring District Nursing care.

Discussions have been held with Arohanui Hospice proposing to maintain the current District Nursing Night Service.

This partnership sees the Hospice contributing to the cost of continued provision of the night service. This has been agreed in principle with the Acting Chief Executive/Director of Clinical Services and the Director of Palliative Care.

The formal proposal will be presented to the Arohanui Hospice Board meeting on the 20 July 2010.

With Arohanui Hospice's proposal and the financial savings proposed by staff the service can make financial improvements of no less than \$400,000 and can maintain the night service.

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This proposal is supported by the service, the clinical and management leadership and Funding Division.

This report sets out the findings of the review process.

4. RECOMMENDATION

It is recommended:

- *That on the basis of the partnership arrangement with Arohanui Hospice (agreed in principle) the District Nursing night service continue;*
- *That the District Nursing Service's hours of cover be formally amended to show that statutory holidays are as per weekend cover;*
- *That as from 1 September 2010 the provision of wound care supplies be for District Nursing Service patients only, and that existing clients be supported in transitioning to new arrangements by the end of the financial year;*
- *That it be noted the District Nursing Service will be discharging wound care patients once they are stable and independent with managing their chronic needs;*
- *That District Nursing outpatient clinics be established in Palmerston North, Dannevirke, Pahiatua and Otaki by 1 October 2010, with a subsequent reduction in nursing staff levels of 1.50 FTE and amalgamation of District Nursing runs in Palmerston North;*
- *That it be noted payment for attendance (optional) at staff meetings for off duty staff have ceased;*
- *That it be noted that as part of the implementation of this service reconfiguration, District Nursing staff rosters and roles will be reconfigured and that this will be linked to the "productive community" pilot and be at least cost neutral;*
- *That the reconfiguration of District Nursing services provide financial benefits of no less than \$400,000; and*
- *That a post event audit review of the District Nursing service reconfiguration be conducted in April 2011.*



District Nursing Service Review

Proposed Service Reconfiguration

June 2010

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1. Executive Summary

MidCentral District Health Board (MDHB) has entered into a period of financial constraint and must reduce costs in line with revenue and/or increase revenue.

Five areas have been identified where there is potential over-servicing and/or duplication, one of which is District Nursing's night service.

District Nursing's night service is unique in New Zealand and is highly regarded. It is estimated that cessation of the night service would reduce costs in District Nursing by \$245,000.

A proportion of the District Nursing Service's work is palliative care. Arohanui Hospice is also a key provider of palliative care nursing and the two organisations work closely together. The Arohanui Hospice is required to provide emergency palliative care nursing services on a 24 hour basis. It currently does this through the District Nursing Service.

Discussions have been held with Arohanui Hospice proposing to maintain the current District Nursing Night Service.

This partnership sees the Hospice contributing to the cost of continued provision of the night service. This has been agreed in principle with the Acting Chief Executive/Director of Clinical Services and the Director of Palliative Care.

The formal proposal will be presented to the Arohanui Hospice Board meeting on the 20 July 2010.

Consultation with staff has occurred, together with community and stakeholder engagement.

Staff have put forward a number of other means of reducing costs, including the establishment of District Nursing clinics and the cessation of wound care supplies to people no longer requiring District Nursing care.

With Arohanui Hospice's proposal and the financial savings proposed by staff the service can make financial improvements of no less than \$400,000 and can maintain the night service.

This proposal is supported by the service, the clinical and management leadership and Funding Division.

This report sets out the findings of the review process.

2. Recommendation

It is recommended;

- *That on the basis of the partnership arrangement with Arohanui Hospice (agreed in principle) the District Nursing night service continue;*
- *That the District Nursing Service's hours of cover be formally amended to show that statutory holidays are as per weekend cover;*
- *That as from 1 September 2010 the provision of wound care supplies be for District Nursing Service patients only, and that existing clients be supported in transitioning to new arrangements by the end of the financial year;*
- *That it be noted the District Nursing Service will be discharging wound care patients once they are stable and independent with managing their chronic needs;*
- *That District Nursing outpatient clinics be established in Palmerston North, Dannevirke, Pahiatua and Otaki by 1 October 2010, with a subsequent reduction in nursing staff levels of 1.50 FTE and amalgamation of District Nursing runs in Palmerston North;*
- *That it be noted payment for attendance (optional) at staff meetings for off duty staff have ceased;*
- *That it be noted that as part of the implementation of this service reconfiguration, District Nursing staff rosters and roles will be reconfigured and that this will be linked to the "productive community" pilot and be at least cost neutral;*
- *That the reconfiguration of District Nursing services provide financial benefits of no less than \$400,000; and*
- *That a post event audit review of the District Nursing service reconfiguration be conducted in April 2011.*

3. Purpose

MDHB no longer achieves budget and this is largely due to rising cost structures within the hospital division, MidCentral Health (MCH). The year end position 2009/10 is forecast to be a deficit of \$9.8 million.

As a result, a Financial Recovery Programme, working towards a break-even budget in 2011/12, was required to be prepared by the MDHB for the Minister of Health (January 2010) and this is now in place. This plan includes continuation of cost saving initiatives implemented by 30 January 2010 and an ongoing requirement to achieve efficiencies.

Productivity within the hospital continues with higher levels of activity across most services. The costs associated with this activity have exceeded our income. It is imperative that we live within budget.

A number of financial service reviews are already under way within MCH. In addition, five areas where there is potential over-servicing and/or duplication are being reviewed, including District Nursing's night service. There was an estimated identified savings of \$375k for the service review of District Nursing.

4. Service Description

District Nursing services are an integral part of local health services, using a combination of intensive, advanced home based care, care co-ordination and case management to promote faster recovery from illness and smooth the transition between services or from medical dependence to functional independence for patients with complex care needs. District Nurses support patients with complex health care needs to achieve maximum health, quality of life and independent living by preventing and/or minimising the extent and impact of any acute or acute on chronic (acute exacerbations) health care need they experience.

The MCH District Nursing Service has long been recognised as being at the forefront of community service delivery in New Zealand (NZ), winning awards for innovations such as Hospital in the Home (HITH), Post Emergency Department Assessment and Liaison (PEDAL) and General Practice Assessment and Liaison (GPAL).

Currently MCH offers a 24 hour a day, seven day a week service, including but not limited to;

- General District Nursing
 - Wound and skin integrity care – acute/chronic
 - Continence enhancement and management

- Post Chemotherapy management and monitoring
- Medication administration and oversight
- Gastrostomy management
- Hospital in The Home (HITH) – predominantly IV Therapy
 - Intravenous/Subcutaneous/Intramuscular medication therapy (antibiotic treatment for infective disorders, nutritional support, hydration, anticoagulants)
- Direct GP referral service
- Provide palliative care in the community in partnership with Arohanui Hospice
- Referral service to support discharge planning from the hospital

4.1. Interventions

District Nursing interventions include but are not limited to the following;

4.1.1. Assessment

- Assessing that the patient is not deteriorating, that they are demonstrating adequate signs of recovery, are not at risk of falling in their home and providing equipment to reduce that risk, e.g. walking frames, hand grips, over toilet frames, shower stools.

4.1.2. Administration of Medications

- Intravenous (IV) antibiotics to treat a wide range of infections at home rather than in hospital.
- Intravenous IV fluids to treat excessive vomiting in pregnancy at home rather than in hospital.
- Intramuscular injections – usually to treat people experiencing vomiting and nausea after chemotherapy.
- Subcutaneous injections – insulin or anticoagulant treatment of blood clots – usually while teaching people to administer themselves.
- Subcutaneous fluid infusions to treat dehydration in older adults at home rather than in hospital.
- Enemas either for the acute management of constipation or as a regular bowel management regimen.
- Eye drops for elderly patients after eye surgery.
- Syringe driver therapy – a combination of medications in subcutaneous infusion pump to provide continuous medication administration to minimise symptoms commonly associated with end stage cancer and other terminal diseases.

4.1.3. *Wound Care*

- Providing complex wound care dressings and management including 'vacuum assisted wound closure' therapy.

4.1.4. *Continence Management*

- Changing urinary drainage catheters (both at regular planned intervals and when acutely blocked or leaking) and educating patients about how to manage living with a catheter – including how to prevent urinary tract infections.
- Changing ostomy bags – both at planned times when first teaching patients how to manage these including how to prevent breakdown of skin surrounding stoma, dietary advice to prevent stoma blockage, and assisting patients when acute issues arise such as when a stoma bag leaks, comes unstuck, or bursts.
- Implementing a bowel management programme via enemas, fibre bulking agents and diet to ensure patients re-establish a regular bowel pattern – also involves educating patients to prevent constipation.
- Implementing a pelvic floor exercise and bladder retraining programme to enable patients to be urinary continent without need for continence products.

4.1.5. *Acute Personal Care and Rehabilitation*

- Providing showering and hygiene nursing cares for patients recently discharged from hospital or who are in our admission avoidance programmes (GPAL and PEDAL) who do not yet have adequate strength to manage safely on their own.
- Providing nursing assistance, education and monitoring to patients recovering from illness to ensure they recover by taking their medications appropriately, eat and drink adequately, mobilise sufficiently, following their treatment plan etc.

4.1.6. *Palliative Cares*

- Symptom management such as pain, nausea, vomiting, bleeding, skin care and pressure area care due to bed/chair bound state, incontinence, and/or deteriorating health state, catheter and bowel cares, hygiene care, family support, carer relief.

4.1.7. *Patients with a long term health condition*

- Teaching people who receive all their nutrition via a Percutaneous Endoscopic Gastrostomy (PEG) feeding tube directly into their stomach

- how to manage to do this independently, e.g. teaching them how to work the pump and put up the feeding bags each night and how to look after the tube and stoma (hole in their stomach) so that there are no complications.
- Providing after hours support for people who are on home oxygen in case they have problems with their equipment and need some assistance/advice to manage.
 - Assisting those caring for a person at home who requires suctioning at regular intervals every day to prevent oral fluid secretions from being aspirated (entering their lungs) and causing them to develop pneumonia. This involves educating the family about how to do the suctioning safely, how to work the equipment and providing support/advice if problems occur
 - Assisting people whose functional or cognitive disability means they have a fragile and unpredictable health status, and without support from the District Nurses would not be able to remain out of residential care, e.g. responding to acute muscular skeletal pain that develops due to being bed bound and immobile
 - Assisting people with chronic pain to achieve reduced levels of pain and to improve their self pain management through nursing education, support, advice, and collaboration with Nurse Practitioner and General Practitioners (GPs).
 - The District Nursing Service also provides Direct Observed Therapy for some TB (Tuberculosis) patients in the weekend as the Public Health Service does not have nurses working in the weekend.

4.1.8. *Hospital in the Home*

Examples of conditions treated at home by the District Nursing Service under HITH include;

- Orthopaedic infections – infected hip joint, osteomyelitis (infection in the bone) septic arthritis, infected rotator cuff, infected scapula, infected spinal disc, infected metalware
- Endocarditis (infected heart valves)
- Heart failure
- Hyperemesis (excessive/unsafe vomiting in pregnancy – requiring IV antiemetics and intravenous fluid therapy)
- Cellulitis and other soft tissue infections – infected coronary artery bypass graft, infected lymphoma, infected wound, breast abscess, infected femoral graft
- Septicaemia
- Respiratory infections – infective exacerbations of cystic fibrosis, COPD, pneumonia

5. Service Profile

5.1. Entry Criteria

Work is currently being undertaken at a national level to determine and define the entry criteria to the District Nursing Service. Currently the following applies;

Referrals that indicate the patient's health care needs cannot reasonably be managed by general practice or other primary health care team alone, e.g.;

- Patient has a complex health condition (either short term or long term) and the level of nursing skill required to manage it can only be provided by a District Nurse, i.e. complex wound care, OR, there is not alternative service available to provide the required level of care.
- Patient currently unable to safely travel.
- Patient housebound.
- Patient requiring frequent nursing interventions, e.g. 1-3 nursing visits a day.
- Patient requiring nursing care for a prolonged period of time, e.g. for more than four days.
- Patient may require unscheduled and rapid response nursing care during day, weekend, or after hours, i.e. redivac drain (wound).

The above referrals would still only be accepted for District Nursing if they showed the patient had a health care need that, if not addressed, placed them at medium to high risk of;

- Being in significant pain/suffering/distress/experiencing irreversible health/functional decline.
- Imminently being admitted to hospital.
- Being unable to discharge from hospital.
- Being unable to self manage causing a compromised health state that isn't life threatening but, if left, will lead to more extensive problems.
- The patient's inability to self manage is placing a level of pressure on family/carer that is causing the family/carer's health to deteriorate.

5.2. Volumes

5.2.1. Overall District Nursing Service

Volumes are purchased by the MDHB Funding Division for the provision of Community/District Nursing services throughout the MDHB region. The following is forecasted year end volumes against budget.

Table 1: District Nursing Volumes – 2009/2010

			2009 / 2010				
			Budgeted Vols	Forecast Yr End	Vol Var	\$ Var	less 2%
DOM101	District Nursing	Contacts	52,560	59,562	-7,002	-622,968	
DOM107	Personal Svcs	Hours	955	959	-4	-97	
M80005	Palliative	Patients	444	512	-68	-81,044	
			53,959	61,033	-7,074	-704,108	-690,026

The District Nursing Service is a demand driven service, and is forecasting year end to be over delivering against contract by more than 7,000 volumes or \$690k.

In addition to the above volumes the District Nursing Service also provides;

- ACC volumes forecast year end (contacts) = 15,051
- Hospital in the Home forecast year end (contacts) = 1,920

It is noted, however, that in April and May patient contacts have been at their lowest level for the past 13 months. In April the District Nursing Service began to promote changes to service delivery including increasing the rate of patient/family members carrying out some aspects of their own treatment at a level higher than the service has traditionally done before. While it is true that referral rates were also lower during the month of April and May, possibly due to a mild start to the winter season, there are early signs that the District Nursing Service can continue to reduce patient contacts without reducing quality of care through the above changes.

5.2.2. Night Service Volumes

Throughput for the night service is on average slightly over six patients per night. The following is year-to-date data to 31 May 2010, extrapolated out to the 2009/10 financial year end.

Table 2: District Nursing Night Service Volumes (contacts) and FTE 2009/10

Night Shift	Yr End Forecast	Per Shift
General District Nursing	573	1.6
Palliative Nursing Care	329	0.9
Wound Care	319	0.9
Continence Management	470	1.3
IV Therapy / HITH	242	0.7
Hygiene / Ostomy	27	0.1
	1,959	5.4

A snapshot of activity undertaken by the night service was manually collated for March to determine what portion of activity was considered acute rather than routine. There were 65 scheduled visits for the month, e.g. patients who had planned visits during the night. The actual number of visits, however was 142 – the variance of 77 being patients who required a night visit due to either an acute care need, who were seen during the day and assessed as requiring an

additional night visit, or new patients referred to the service that day being triaged as requiring a visit that night.

Table 3: District Nursing Night Snapshot of Activity (contacts) – March 2010

	<u>Night Shift</u>	<u>Average Per Night</u>
Scheduled number of visits	65	2.60
Acute patients	77	3.08
Actual number of visits	142	5.68

5.2.3. *Productive Community Programme*

The District Nursing service will be using the NHS Productive Community Programme the Ministry of Health (MoH) is piloting in this DHB to further embed the proposed District Nursing changes and to develop and implement other productivity measures to achieve more savings for the service.

The MoH sought registrations of interest to be a test site for the Productive Community Programme. The programme provides an evidence based approach to improve the way teams work across the range of services and pathways of community care.

The programme supports staff who deliver frontline community services such as primary health care nurses, therapists and health visitors. It focuses on those areas of improvement where teams can make the biggest difference, in the shortest time, for the largest number of patients.

The programme aims to;

- Increase patient facing contact time
- Reduce inefficient work practices
- Improve the quality and safety of care
- Revitalise the workforce, and
- Put staff at the forefront of redesigning their services

Health Care Development successfully submitted a proposal to deliver this within the MDHB. Initial training was attended early March and from this the proposed sites of Manawatu based District Nurses and the Manawatu PHO chronic care nursing team were identified as suitable. Initial meetings have been held with MCH – Sue Wood, Jan Dewar, Colleen Bary and Denise White, with verbal approval given for the pilot.

5.2.4. *Age Profile*

The average age of a patient receiving services from District Nursing is 65.

Table 4: District Nursing Service Age Profile – 2009/10

Minimum Age	3
Average Age	65
Maximum Age	105

The following breakdown is based on active patients currently being seen by District Nursing, with 60% of patients from the 65 and over age group.

Table 5: District Nursing Service Age Grouping – 2009/10

Age Group	No of Pts
0-24	48
25-49	126
50-64	137
65+	459

5.2.5. Geographic Profile

The District Nursing Service provides care to any person living within the MDHB region, working out of seven bases (Feilding, Pahiatua, Dannevirke, Foxton, Otaki, Levin, Palmerston North) and co-ordinated centrally from the Palmerston North base. Every patient has access to the same type, level and quality of District Nursing care no matter where they live in the MDHB region. Some HITH patients have lived as far as two to 2.5 hours' car travel time away from Palmerston North Hospital.

Weekend activity is predominantly within the Palmerston North City at 93% of all contacts. Horowhenua has 1.43%, Manawatu 5.07% and the Tararua has less than 0.50%.

Night activity has similarly proportioned percentages with Palmerston North City at 94%, Horowhenua at 1.10%, Manawatu 4.73% and Tararua 0.06%.

5.2.6. Benchmarking

MCH District Nursing Service is the only service in New Zealand that currently delivers scheduled and planned nursing cares on duty 24 hours, seven days a week.

Service delivery approaches vary significantly across NZ. Some factors that influence this variation in service delivery are;

- Whether the District Nursing Service is more rural in nature.
- What services their local hospice provide.
- Proximity to 24/7 Accident & Medical and/or Emergency Department (ED) services.

- Whether the service has a strong emphasis on hospital admission avoidance.

Approximately 50% of District Nursing Services contacted provide, on average, 8 a.m. – 10 p.m. shifts seven days a week, with no on-call after hours.

It should be noted that the MoH has recently commissioned a benchmarking profile of District Nursing Services across NZ to identify opportunities for future utilisation. MDHB and Capital & Coast DHB are co-jointly participating in this programme, providing District Nursing resource to research the profile, a detailed description of every District Nursing Service in NZ and will assist future DHB planning, reviews and/or benchmarking. It is anticipated that this work will be completed by January 2011.

6. Current Staffing Arrangements

6.1. Night Service

Currently the night service has a budget of 3.36 FTE. This is made up of one Registered Nurse (RN) and one Care Assistant (CA) on each night. The CA accompanies the RN at night for safety reasons and assists with patient care where appropriate (e.g. patient handling).

The RN/CA night team covers the entire MDHB area, e.g. they could see a patient at Dannevirke and then travel through to Otaki in the same night. When the night team are not providing direct patient care, administrative tasks are completed at the Palmerston North base, e.g. discharge summaries for both day and night services.

6.2. Statutory Days Roster Reduction

A full complement of staff is currently rostered for statutory days, e.g. Monday to Friday roster of 22.11 FTE RNs and 6.74 Enrolled Nurses (ENs)

The current weekend service is provided by 11.81 RNs and 1.4 ENs.

6.3. Change to Nursing FTE

A range of models of care focusing on avoidable hospital admissions, early discharge, and shared care arrangements with patients' wider health care teams have been developed and implemented by the District Nursing Service and have achieved both quality care and productivity gains for the organisation. Sufficient clinical nursing leadership expertise and resources within the service was required to develop and implement these. Many are just at the stage of being embedded (i.e. GPAL) and require evaluation and

continuous improvement. To achieve further productivity gains while still maintaining care quality, changes to how the District Nursing Service delivers care to patients are proposed. Sufficient clinical nursing leadership capacity and capability will again be required for these changes to be appropriately implemented and sustained throughout the service.

It is also anticipated that implementation of the business case for 'better, sooner, more convenient Primary Health Care' will bring changes to District Nursing Service delivery. Consequently, the team will need sufficient resources to lead the strategic direction of the service, and develop and maintain the liaison and functional links between the District Nursing Service and both sides of the continuum of care (primary and secondary care referring groups/key stakeholders), while still providing effective and efficient nursing management and clinical oversight of day to day District Nursing 'business as usual'. Without adequate senior nursing resources to support this, there is a risk the service's resources will be fully occupied with day-to-day service delivery with key members not contributing to the redevelopment of services to ensure emerging processes and services align to deliver clinically effective and efficient pathways of care.

There has been an increase in Senior Nursing FTE from an actual of 3.90 in 2007/08 to the current level of 4.45 FTE. It has been identified that higher duties allowances which receive an FTE allocation (0.16) have distorted the actual FTE, as has a payroll coding anomaly whereby the allocation against Senior Nursing/Registered Nursing has been incorrect (variance of 0.22 against Senior Nursing).

Overall nursing levels (inclusive of Registered Nursing, Enrolled Nursing and the Referral Nurse) are over budget by 0.73 year-to-date.

Table 6: District Nursing FTE Levels – 2009/10

	2009/2010		
	Budget	Actual	Variance
Senior Nursing	3.71	4.45	-0.74
Nursing	43.37	43.36	0.01
	47.08	47.81	-0.73

Please note that the above actual FTE has been adjusted to reflect the correct FTE.

7. Current Financial Situation

7.1. Current

The current position of the District Nursing Service, inclusive of Price and Volume Schedule (PAVS) and ACC revenue and associated costs, is forecasting a deficit of \$193k. This is \$78k more than the deficit budgeted.

Table 7: District Nursing Current Financial Situation – 2009/10

	Actual	Budget	Variance
Current state as at 31st May 2010:	(\$177)	(\$124)	(\$53)
Forecasted bottom line at 30 June 2010:	(\$193)	(\$115)	(\$78)
Surplus/(Deficit)			

8. Options for Consultation

The following options for financial savings within the District Nursing Service were proposed and have been consulted on. The formal options from the Board Framework were consulted on, in addition to other options that were identified and developed by the District Nursing Service during the process.

8.1. Formal Options

8.1.1. Night Service

District Nursing Services would no longer be provided between the hours of 11 p.m. and 7 a.m. However, services would be provided seven days a week between the hours of 7 a.m. and 11 p.m.

8.1.2. Statutory Day Roster

Previous practice within District Nursing was for the roster on a statutory day to be the same as a normal working day (Monday to Friday), e.g. 28.10 FTE covering from 7 a.m. to 11 p.m. As part of the reconfiguration process, a reduced level of rostered staffing has been implemented to cover the 11 statutory days throughout the year. This reduced roster is the same as the weekend cover, e.g. 11.80 FTE.

This was a formal option for consultation, and during the service review process the District Nursing Service agreed that this initiative could be implemented for immediate savings.

8.1.3. Nursing

The original proposal to cease the night service included a reduction in senior nursing staff positions (0.88 FTE) within the service. During the consultation process with staff, the District Nursing Service considered the full nursing complement be reviewed and that this be aligned to proposed new ways of delivering care, such as the establishment of outpatient clinics and

amalgamation of District Nursing runs. Through these service changes (discussed in sections 6.3) the nursing staff establishment for district nursing would reduce by 1.5 FTE.

8.2. Other Options Identified During Review Process

The following potential savings have been identified by the service.

Table 8: District Nursing Service Potential Savings

Potential Savings - 2010/2011 year	\$,000	FTE
Additional outpatient clinics	63	0.5
Combining current DN 'runs'	84	1
Cease payment for meetings	8	0
	\$155	1.5
Additional saving - 2011/2012 year		
Cease provision of Wound Care Supplies *	40	0
	\$195	1.5
Combined Savings		
	\$195	1.5

* Given there will need to be a “phase-in” of this initiative, significant financial benefits will not be realised until 2012.

8.2.1. Outpatient Clinics

The month of March 2010 was the busiest month overall in the 12 month period April 2009/March 2010, with a total of 497 new referrals and 5,062 hours of care delivered – compared to the average of the same period of 443 referrals with 4,743 hours of care delivered per month. It was recognised that this situation could not continue without change.

In light of the review process and the requirement for change, the District Nursing Service undertook a snapshot survey of all patients who were accessing the service in the month of March. In addition, the ACC Community Nursing contract was changed as of 1 April 2010 requiring patients who are not housebound to have their ACC wound care at a clinic. ACC is a significant funder of the District Nursing Service, and to retain this revenue changes in service delivery need to be made to ensure compliance to contract.

Each key worker nurse reviewed the patients within their run with respect to ability to self manage part of their care, practicality of attending clinic for care, how frequently they were being visited and whether supplies were being left, for independent self care.

The data gained from this survey identified;

- In Palmerston North region approximately 25% of District Nursing patients are currently suitable to be seen in a District Nursing clinic. (This is over

and above the capacity of the current “Walking Wounded” clinic run daily from Kowhai House, Palmerston North)

- Tararua region has 76 patients, of which 21 were identified as suitable to come to clinic (40% of Pahiatua’s case load and 20% of Dannevirke’s caseload).
- Otaki has 40 patients of which 18 (45% of total case load) have been identified as suitable to come to clinic.

Feilding and Levin bases were also surveyed, and the data showed that clinic based care is already well established (daily half day clinics in both Feilding and Levin) and the minimal potential increase in the patient count was not likely to be of significant financial impact. Foxton base is unsuitable for running a clinic due to the poor state of repair of the building.

Feedback from a patient survey following the implementation of the first “Walking Wounded” clinic in 2005 highlighted that many have a preference to attend a clinic, as this means they can be seen at a scheduled time and no longer need to “wait around at home” for the District Nurse to arrive. Specifically;

- “Depends on how well I am. When I was “wobbly” a nurse coming in was wonderful. Once I was stronger, having somewhere to go out to was beneficial to my recovery.”
- “Fits in better with my day- to-day plans – over and done first thing in the morning.”
- “Wins hands down! At the clinic you have a set appointment time and get seen straight away. If waiting at home, you could be there all day waiting! The clinic gives patients their independence back.”

It is proposed that a second District Nurse led clinic, Monday to Friday, be implemented on the Palmerston North Hospital campus.

The clinic will be staffed as a result of minor changes to the current geographical ‘run’. Each run would remain manageable in caseload with potentially 25% of patients attending the new clinic.

Further savings would be made by one car and one telephone no longer being required. Reduced driving time would enable the attrition of 0.30 RN FTE (currently vacant), and petrol costs would be reduced by approximately 11 hours a week.

Tararua covers one of the largest geographical areas in New Zealand, which creates challenges to delivery of care. The snapshot survey in March showed 27% of Tararua region’s caseload could attend clinic. These patients’ total weekly care currently requires approximately 16 hours a week (3.5 hours a day over five days). Eight hours travel time is associated with these patients.

It is proposed to implement a District Nurse clinic twice a week in Dannevirke and three times a week in Pahiatua to achieve the following savings;

- Reduced time in driving equates to 0.2 registered nurse FTE (currently vacant).
- Some reduction in petrol costs.

No changes in staffing would be required to implement clinics in both Dannevirke and Pahiatua. Clinic space is available at both areas at no additional cost to MCH. Some negotiation with other users will be required as part of the implementation process to ensure best use of the shared resources.

Currently the Otaki base has no available clinic space, as the District Nurses operate from a single office within a combined GP/PHO complex. Identified suitable patients from the survey showed total weekly care requiring approximately nine hours a week (1.8 hours a day over five days). Eight hours of travel time is associated with these patients. If clinic space was made available to the Otaki DNs – travel and petrol savings could be made.

8.2.2. Combining Current District Nursing 'Runs'

In addition to 6.4.1 above, as part of this reconfiguration process, six current Palmerston North runs have been configured into five runs. This occurred to re-balance workload on the resignation of a staff member.

This has resulted in 1.00 RN resource, one car and one telephone no longer being required. The RN position is currently vacant and will not be recruited to. This position will be removed from the 2010/11 budget.

8.2.3. Cease Payment for Attending Monthly Business Meetings

Historically nurses attending the monthly business team meetings, and who were not rostered to work that day, were paid to attend. Attendance at these meetings is optional. However, this initiative was introduced to support broad attendance at a meeting where business/issues and reports are discussed concerning all members of the team. This practice is not carried out elsewhere within MCH.

Communication channels to ensure all staff are advised of team meeting content and discussion, and that all staff have opportunity to contribute to team development and processes currently exist.

As part of the reconfiguration process, staff have been advised that they will no longer be paid to attend these monthly business meetings on their rostered days off. Core education is held in forums other than the Business Team Meeting, and Service Governance rests with the Quality Meeting, whose members all attend in work time.

It should be noted that payment to attend required education days would continue as usual.

8.2.4. *Reconfiguration of Roster/Roles*

As part of the roll-out of the service reconfiguration and “the productive community” pilot, staff rosters and roles will be realigned to support changes in service delivery and patient care requirements.

The aims will be;

- Maintain flexible staffing across the region.
- Manage annual and education leave requirements.
- Ensure staffing levels base by base and shift by shift, match workload requirements, taking into account our proposed changes in patient care delivery, and the expected fluctuations of a demand driven service.

Administration staffing requirements and roles will also be reviewed within this process and changes to contracted hours as necessary. This work will be cost neutral.

8.2.5. *Provision of Wound Care Supplies to Self Caring District Nursing Patients*

Currently the District Nursing Service provides supplies for 30 patients with long term chronic wounds. However, as these wounds are stable and the patient or family completely self manage, District Nursing expertise is not provided. The current Ministry of Health Specialist Community Nursing Service Specifications states;

“The service will supply or facilitate access to identified/prescribed consumables and/or supplies and/or equipment as given in Appendices 2-4 at the back of this document, or as determined by the care plan delivered under this contract. This will include on-going long-term supplies, such as wound dressings, where the patient remains under the care of the community nursing service”

These patients have a long term health condition, and are currently managed by their General Practitioner (GP) as and when required, e.g. they can see their practice nurse for a once a month nursing review of their stable wound if they wish.

Providing all wound care supplies free of charge to this small group of patients incur costs to the service of \$40k. The timeframes that these patients have been on the District Nursing Service books receiving supplies only (i.e. no nursing input) range from one year to 12 years.

In the future, it is proposed that patients, once stable and completely independent with managing their chronic wounds, be discharged from the District Nursing Service and purchase their own wound care supplies.

For the current patients mentioned above, a transition process will need to be developed with the patient to prepare them for discharge and purchasing their own supplies. This will include providing information about funding alternatives and supporting documentation (i.e. letter from District Nursing Service to WINZ on behalf of patient). This individualised change process may take some time.

This process may take time to implement and savings may not be evident in the 2010/11 year.

Note: This does not apply to ACC patients who receive their supplies directly via ACC systems.

9. Feedback from Staff Consultation and Community Feedback

The consultation process included staff (in accordance with the Management of Change requirements in Collective Agreements), and feedback received from the community was also considered prior to making the final recommendations.

9.1. Submission Summary

Twenty-one submissions were received in response to the consultation document;

- District Nursing Service (45 signatories to a core submission, with some adding additional comments)
- Clinical Nurse Specialist, District Nursing Service
- Arohanui Hospice – Nursing Leadership Group
- Arohanui Hospice – Director of Clinical Services/Acting Chief Executive
- Hospital Palliative Care Team
- Clinical Nurse Specialist, Child Health Services
- Clinical Effectiveness Facilitator, PSCE/Business Leader, Public & Dental Health
- Change Manager, Supportlinks
- Dr Greig Russell, Medical Director, City Doctors
- Primary Health Care Clinical Governance Council
- Chair, Palliative Care Partnership Management Group, Compass Health

Submissions directed to the Chief Executive Officer, Chairman, or via Communications;

- Chief Executive Officer, Ryder-Cheshire Foundation (Manawatu)
- Chairman, Arohanui Service Trust
- Director of Clinical Services, Arohanui Hospice

- Chair, Palliative Care Partnership Management Group, Compass Health
- John Crowley, Trustee, Arohanui Hospice Service Trust
- Registered Nurses, Feilding Medical Centre
- Four members of the community who have been or are recipients of services from District Nursing (as either patients or family)

The major focus of the submissions was on the proposal to remove the night service provided by District Nurses (2300 – 0700 hours). No support was expressed for this proposal, although some alternative ways of maintaining a night service from District Nurses were proposed.

Most submissions focused entirely on the proposal to remove the night service; there was mostly support from the District Nurses themselves for the other proposals for cost savings.

The Arohanui Hospice (a number of submissions) and the Palliative Care Partnership Management Group (Compass Health and Arohanui Hospice) strongly support the retention of the night District Nursing Service, which is a key component of the successful Palliative Care Partnership. Other submissions, both from within MidCentral Health and those from patients/families who have been, or are, recipients of the District Nursing Service also strongly supported the retention of the night service.

The proposal to cease the provision of the night service has been highlighted as being contrary to the MCH Business Case March 2010, “Transforming Primary Health Care Services” which states, inter alia: *“The aim of the future is to both strengthen connections between the primary care team, intermediary care (district nursing) and case management services, and to optimise the role of intermediary care in management of after-hours and urgent response”*. The Business Case cites aspirational targets for the next three years as being;

- *Reduce presentations to the Emergency Department by 30%.*
- *Reduce avoidable hospital admissions to Medical Wards and Assessment, Treatment and Rehabilitation for over 65 year olds by 20%.*

It has also been noted that the proposal is inconsistent with the Palliative Care Strategy which sets the expectation that *“palliative care services should be provided for most dying people and their families/whanau in their own home, where this is their wish”* and that each person who is dying has access to *“domiciliary nursing services and equipment to provide symptom control, nursing management 24 hours a day seven days a week in the community to provide all patients with access to essential palliative care services in a co-ordinated and responsive manner”*.

The 24/7 District Nursing Service has been identified as playing a significant role in;

- Increasing support for the terminally ill at home.
- Increasing support for patients at home with complex needs, e.g. IV therapy or major wound care.
- Providing support for patients being discharged from Emergency Department (ED).
- Providing support for patients not requiring admission to hospital.
- Supporting early discharge from hospital.

It has been suggested that rather than “cost saving”, if the night District Nursing Service were to be removed, it would involve considerable “cost shifting”, and increases in costs elsewhere, e.g.;

- Increased ED admissions.
- Increased inpatient admissions and/or increased length of stay.
- Increased admission to aged residential care facilities.
- Increased demand for inpatient hospice care (only 10 beds available).
- Costs to patients (e.g. ambulance charges).

“Non-financial” costs to patients/families have been identified, e.g.;

- Not feeling secure enough to be discharged home without the knowledge that 24/7 support is available from the District Nursing Service.
- Distress at having to call an ambulance and go to ED; be admitted to hospital; having to move to residential care because they cannot safely remain at home without 24/7 support.
- Becoming more seriously unwell through reluctance to present to ED, and waiting for the daytime District Nurse to come.
- Not having the option to die at home because of the lack of palliative care support at night (adults and children).
- Potential inequity of access to services across the MDHB region.

If the night District Nursing Service ceases, there will be an estimated 109 hours of work per month (combination of nursing and administration input) required to be absorbed into current daytime resources.

9.2. Alternative Proposals

Suggested as interim measures pending implementation of the Business Case;

- Retain one Registered Nurse and one Health Care Assistant within District Nursing Service roster to provide scheduled and on-call care between the hours of 11 p.m. and 7 a.m. Request that Arohanui Hospice contribute to District Nursing Service RN salary.
- Retain one Registered Nurse within District Nursing Service rostered to provide on-call home visit support as required. Arohanui Hospice contribute to District Nursing Service RN salary. MCH provides a Health Care Assistant from the Health Care Assistant staff working in hospital

overnight when required to accompany the District Nursing RN on a call out visit.

- Retain one RN nurse within District Nursing who is rostered to work in the ED or with the “hospital after hours team” and who would provide on-call home visits as required during the night shift. Arohanui Hospice and ED to contribute to the RN’s salary costs. MidCentral Health would provide, as required, a Health Care Assistant from staff working in the hospital overnight to accompany the RN doing District Nursing call-out visits.

Another submission;

- Provision of service on a full on-call basis.

A detailed summary of the submissions is attached as Appendix 1.

10. Recommended Service Reconfiguration

As an outcome of the consultation process, the following service reconfiguration is recommended;

10.1. Night Service

The Arohanui Hospice and Palliative Care Partnership Management Group strongly support the retention of the night District Nursing Service citing that it is a key component of the successful Palliative Care Partnership. The Palliative Care Service Specifications, which form part of the contract that MDHB has with Arohanui Hospice, state that ‘*Domiciliary care will be available 24 hours for emergency situations*’. This is currently provided through the District Nursing Service.

10.1.1. Maintain District Nursing Night Service with support from Arohanui Hospice

Maintaining the night service would see the current 3.36 FTE being retained to provide the night service between the hours of 11 p.m. and 7 a.m., seven nights per week.

Discussions have been held with Arohanui Hospice proposing to maintain the current District Nursing Night Service.

This partnership sees the Hospice contributing to the cost of continued provision of the night service. This has been agreed in principle with the Acting Chief Executive/Director of Clinical Services and the Director of Palliative Care.

The formal proposal will be presented to the Arohanui Hospice Board meeting on the 20 July 2010.

10.2. Statutory Day Roster

A reduced level of rostered staffing has been implemented to cover the 11 statutory days throughout the year. This reduced roster is the same as the weekend cover, e.g. 11.80 FTE. This results in an annual FTE saving of 0.69 FTE or \$108k.

10.3. Other Options Identified During Review Process

10.3.1. Outpatient Clinics

The provision of additional outpatient clinics in Palmerston North, Tararua and Horowhenua will result in a saving of 0.50 FTE or \$63k. These FTEs are currently vacant.

10.3.2. Combining Current District Nursing Runs

The reconfiguration of six current runs into five equates to a saving of 1.00 FTE or \$84k.

10.3.3. Cease Payment for Attending Monthly Business Meetings

As part of the reconfiguration process, staff have been advised that they will no longer be paid to attend monthly business meetings on their rostered days off. This will result in a saving of \$8k.

10.3.4. Reconfiguration of Roster/Roles

As part of the roll-out of the service reconfiguration and “the productive community” pilot staff rosters and roles will be realigned to support changes in service delivery and patient care requirements. This work will be at least cost neutral.

10.3.5. Provision of Wound Care Supplies to Self Caring District Nursing Patients

Providing all wound care supplies free of charge to this small group of patients incur costs to the service of \$40k. This process may take time to implement and savings may not be evident in the 2010/11 year.

10.4. Support for Proposals

There is general support for the proposals of;

- Maintaining night service with Arohanui Hospice contribution
- Statutory day roster
- Other options identified by the service

General support is given by;

- MCH Clinical Board
- MCH Senior Management Team

11. Financial Impact

11.1. FTE Reductions

The recommended service reconfiguration would result in a reduction of 2.19 FTE. This is made up as follows;

Table 9: Recommended FTE Reductions

	FTE
Penal Days Reduced	0.69
Changes to Nursing FTE	1.50
Total Reduction	2.19

11.2. Proposed Financial Improvements

Overall proposed financial improvements of no less than \$400,000, have been identified in this reconfiguration. These include service efficiencies of 300,000.

Table 10: Proposed Financial Improvements

Change to Roster - Stat days	108,000
Service identified savings - first year	155,000
Service identified savings - following years	40,000
	303,000

The reduction of rostered staff to that of weekend cover for statutory days will result in a saving of \$108k.

Other options for savings identified by the District Nursing Service, e.g. additional outpatient clinics, combined District Nursing 'runs' and ceasing payments for meetings shows a reduction of \$155k.

Further saving of \$40k would be made in ceasing the provision of wound care supplies, but as this saving would not be realised until 2011/12.

11.3. Revenue

The reconfiguration will not result in any loss in revenue. Currently there is a high level of service over-delivery equating to approximately \$690k of unfunded activity. Therefore, there is capacity to decrease this unfunded activity if appropriate without impacting revenue.



Lyn Horgan
Operations Director
Hospital Services

12. Appendix 1: District Nursing Service Reconfiguration Reference Group

The following Reference Group members have been involved in the District Nursing Service Reconfiguration process.

<i>Team Member</i>	<i>Role</i>
Maggie Oulaghan	Project Manager
Lyn Horgan	Operations Director
Jurriaan de Groot	Clinical Director, Rehabilitation and Therapy
Sue Wood	Director of Nursing
Colleen Bary	Service Manager, ATR, Therapy & District Nursing
Julie Vickery	Charge Nurse, District Nursing Service
Denise White	Clinical Nurse Specialist, Community Services
Carrie Naylor-Williams	Service Manager, Emergency Department
Donna Ryan	NZNO Representative
Viv Laursen	HR Representative

CONFIDENTIAL - This document contains information that is confidential to the District Nursing Service. It is not to be distributed outside the District Nursing Service without the prior written consent of the District Nursing Service Manager.

13. Appendix 2: Submission Summary

MIDCENTRAL HEALTH DISTRICT NURSING SERVICE REVIEW SUMMARY OF SUBMISSIONS

1.0 EXECUTIVE SUMMARY

Twenty-one submissions were received, with the District Nursing Service (DNS) having 45 signatories **to a core submission.**

The consultation process included staff (in accordance with the Management of Change requirements in Collective Agreements), and feedback received from the community was also considered prior to making the final recommendations.

The major focus of the submissions was on the proposal to remove the night service provided by District Nurses (DN) (2300-0700 hr). No support was expressed for this proposal, although some alternative ways of maintaining a night service from DNs were proposed.

Most submissions focused entirely on the proposal to remove the night service; there was mostly support from the DNS themselves for the other proposals for cost savings.

The Arohanui Hospice (a number of submissions) and the Palliative Care Partnership Management Group (CompassHealth and Arohanui Hospice) strongly support the retention of the night DNS, which is a key component of the successful Palliative Care Partnership. Other submissions, both from within MidCentral Health and those from patients/ families who have been, or are, recipients of the District Nursing Service also strongly supported the retention of the night DNS.

The proposal to cease the provision of the night DNS has been highlighted as being contrary to the MidCentral Business Case March 2010 "Transforming Primary Health Care Services" which states, inter alia: *"The aim of the future is to both strengthen connections between the primary care team, intermediary care (district nursing) and case management services, and to optimise the role of intermediary care in management of after-hours and urgent response"*. The Business Case cites aspirational targets for the next three years as being:

- Reduce presentations to the Emergency Department by 30%
- Reduce avoidable hospital admissions to Medical Wards and Assessment, Treatment and Rehabilitation for over 65 year olds by 20%

It has also been noted that the proposal is inconsistent with the Palliative Care Strategy which sets the expectation that *"palliative care services should be provided for most dying people and their families / whanau in their own home, where this is their wish"* and that each person who is dying has access to *"domiciliary nursing services and equipment to provide symptom control, nursing management 24 hours a day seven days a week in the community to provide all patients with access to essential palliative care services in a co-ordinated and responsive manner"*.

The 24/ 7 DNS has been identified as playing a significant role in:

- Increasing support for the terminally ill at home
- Increasing support for patients at home with complex needs, eg IV therapy or major wound care
- Providing support for patients being discharged from Emergency Department (ED)
- Providing support for patients not requiring admission to hospital
- Supporting early discharge from hospital

It has been suggested that rather than “cost saving”, if the Night DNS were to be removed, it would involve considerable “cost shifting”, and increases in costs elsewhere, eg

- Increased ED admissions
- Increased inpatient admissions and/ or increased length of stay
- Increased admission to aged residential care facilities
- Increased demand for inpatient hospice care (only 10 beds available)
- Costs to patients (eg ambulance charges)

“Non-financial” costs to patients/ families have been identified, eg

- Not feeling secure enough to be discharged home without the knowledge that 24/ 7 support is available from the DNS
- Distress at having to call an ambulance and go to ED; be admitted to hospital; having to move to residential care because they cannot safely remain at home without 24/ 7 support
- Becoming more seriously unwell through reluctance to present to ED, and waiting for the daytime DN to come
- Not having the option to die at home because of the lack of palliative care support at night (adults and children)
- Potential inequity of access to services across the MDHB region

If the night DNS ceases, there will be an estimated 109 hours of work per month (combination of nursing and administration input) required to be absorbed into current daytime resources.

Alternative proposals:

Suggested by DNS staff as interim measures pending implementation of the Business Case:

- Retain 1 Registered Nurse (RN) and Health Care Assistant (HCA) within DNS rostered to provide scheduled and on-call care between the hours of 11 pm and 0700 am. Request that Hospice contribute to DNS RN salary.
- Retain 1 RN within DNS rostered to provide on-call home visit support as required. Hospice contribute to DNS RN salary. MCH provide HCA from HCA staff working in hospital overnight when required to accompany DN RN on call out visit.
- Retain 1 DN RN rostered to work in ED or with the ‘hospital after hours team’ and provide on-call home visits as required. Hospice and ED contribute to RN salary. MCH provide HCA from HCA staff working in hospital overnight when required to accompany DN RN on call out visit.

Another submission:

- Provision of service on a full on-call basis.

2.0 SUBMISSIONS

Submissions received in response to the Proposal for Consultation:

- District Nursing Service (45 signatories to a core submission, with some adding additional comments)
- Clinical Nurse Specialist, District Nursing Service
- Arohanui Hospice – Nursing Leadership Group
- Arohanui Hospice – Director of Clinical Services/ Acting Chief Executive
- Hospital Palliative Care Team
- Clinical Nurse Specialist, Child Health Services
- Clinical Effectiveness Facilitator, PSCE/ Business Leader, Public & Dental Health
- Change Manager, Supportlinks
- Dr Greig Russell, Medical Director, City Doctors
- Primary Health Care Clinical Governance Council
- Chair, Palliative Care Partnership Management Group, CompassHealth

Submissions directed to the Chief Executive Officer, Chairman, or via Communications:

- Chief Executive Officer, Ryder-Cheshire Foundation (Manawatu)
- Chairman, Arohanui Service Trust
- Director of Clinical Services, Arohanui Hospice
- Chair, Palliative Care Partnership Management Group, CompassHealth
- John Crowley, Trustee, Arohanui Hospice Service Trust
- Registered Nurses, Feilding Medical Centre
- Four members of the community who have been or are recipients of services from District Nursing (as either patients or family)

3.0 THEMES

The major focus of the submissions was on the proposal to remove the night service provided by DNs (2300-0700 hr). No support was expressed for this proposal, although some alternative ways of maintaining a night service from District Nursing were proposed.

Most submissions focused entirely on the night service proposal; there was mostly support from the DNS themselves for the other proposals for cost savings.

The Arohanui Hospice and Palliative Care Partnership Management Group strongly support the retention of the after hours DNS, which is a key component of the successful Palliative Care Partnership.

The District Nursing Service feedback was comprehensive, and their views were largely confirmed by submissions from both internal and external stakeholders.

Feedback from the District Nursing Service, including comments of support from other submissions, included:

The Service has met and achieved the objectives for establishing the 24hour/ 7 day District Nursing cover in 1995:

- Increasing support for the terminally ill
- Increasing support for patients with complex needs, eg IV therapy or major wound care
- Providing support for patients being discharged from ED
- Providing support for patients not requiring admission to hospital
- Supporting early discharge from hospital

Proposal is inconsistent with MidCentral Business Case March 2010 “Transforming Primary Health Care Services”, which states:

- The targets that will be aspired to in the next three years are to
 - Reduce presentations to the Emergency Department by 30%

- Reduce avoidable hospital admissions to Medical Wards and Assessment, Treatment and Rehabilitation for over 65 year olds by 20% (p.7)
- Enhancing intermediary care will mean an increase in district nursing capacity (p.20) and could reduce ED presentations by 30% (p.25) and admission to medical wards and AT & R by 20%
- The Clinical Regional Services Plan envisages that more health care will be provided at home and in the community including care for long-term conditions and rehabilitation from hospital (p.33)
- Intermediary care services offer specialist nursing expertise to support patients and their family/whanau at home who may otherwise require hospitalisation. District nursing provides secondary care outreach teams that assist with providing specialist care in the community setting. This includes
 - District nursing (general)
 - GPAL
 - HITH
 - PEDAL

The aim of the future is to both strengthen connections between the primary care team, intermediary care (district nursing) and case management services, and to optimise the role of intermediary care in management of after-hours and urgent response. In addition PEDAL will have extended hours - eg to 10pm weekdays and to operate on weekends (p.85)

The financial cost analysis undertaken for the Business Case has clearly identified that *"The cost of an extra 2.5 FTE for district nursing is significantly less than expected savings from avoided secondary care. Potential saving in resources of up to \$2.2m per year for a cost of \$275,000."* (p.109)

As well as the initiatives above that specifically outline opportunities for the DNS to contribute to transformation change in this region, the business case also outlines plans to implement extended paramedics in this region in order to reduce hospital admissions, and that nursing resources may be required within this team, particularly overnight.

Once this planning gets underway, there may or may not be a need for the district nursing night service any more, or the district nursing night team may be utilised to work in an integrated manner with the extended paramedics team.

Removing the district nursing night service until appropriate home based replacements are in place will cause this region's population to experience an unacceptable gap in equity and access of services. In addition, the clear goal of the business case is to reduce ED presentations, so making the choice to remove the night service where it is clear that this will lead to increased ED presentations does not contribute to the organisation achieving that goal.

In addition, the proposal to the cut the night service will really only lead to cost shifting rather than true savings for the organisation. For instance, shifting the management of patients expected and unexpected care needs during the night to ED and/or ambulance services, Hospice, or to Residential facilities for those with complex disabilities who may not be able to remain in their own home without DN night support.

Suggest that MidCentral Health supports the implementation of the business case by keeping the district nursing night service as it currently is until all planning around the advanced paramedics aspects of the business case implementation is completed and fully implemented.

One submission noted that there should be negotiation with the Community care teams regarding the impact of this decision will have.

Potential Impacts of withdrawing the Night Service (as identified through submissions)

Currently

From Feb 2009-Feb 2010, night staff made approximately 2,670 visits to over 500 patients – for both planned and unplanned essential nursing cares. While not all would correspond to an ED presentation, note that an average ED attendance costs \$282 (PPU figures).

Vulnerable patients and potential impacts – if no night service support

- Some patients will not feel secure enough to remain at home or to go home, or to accept HITH transfer.
- Patients may become more seriously unwell by delaying care until DN services resume in the morning as they may not wish or be able to attend ED – and will put extra pressure on morning staff.
- Some patients may not have transport or may rely on carers to assist them to get out of bed so will have to rely on an ambulance to take them to ED. There are time constraints getting to PN by ambulance from Horowhenua and Tararua and a cost to patients (both ambulance charges, and potential distress)
- Some people, particularly those with complex disability needs (eg those with multiple sclerosis, cerebral palsy, spina bifida, spinal injury) can only live in the community because there is a 24 hour service. *(DN night staff support a small number of patients, to remain out of residential care – eg a 50 year old person with high intensity and complex needs remaining at home, requiring assistance with episodes of acute muscular skeletal pain at night – compared with \$63,145 residential care costs.)*
- In the last 12 months 463 visits were made in relation to continence. At least 50% would be due to a leaking or blocked catheter. For any patient a blocked urinary catheter poses a significant risk; for patients with tetraplegia it is a possible life-threatening situation, due to dysreflexia, and urgent management is required.
- The Tararua and Horowhenua areas are likely to be without DN cover for 11 hours as the evening staff will not be able to leave PN after 9pm, carry out nursing care and be back in PN by 11.00pm to finish on time. This has the potential for increases in overtime costs with patients ringing in prior to 11.00 pm requiring attention eg blocked catheter, wound drainage systems with loss of patency, Vacuum Assisted Closure (VAC) machines malfunctioning or large wound exudate which would cause skin breakdown if not attended to. Equity of access to care will thus be reduced and/or staff may have to choose between working late and providing care, or leaving a patient in distress to wait for other services.
- Patients who have had chemotherapy within the last 48 hours and as a result of that have developed intractable nausea and vomiting may be visited by DNs and given Intramuscular Metoclopramide – avoiding the need for them to come to ED.
- Patients with a stoma/VAC/Medinorm or other drainage/collection system who have an unexpected event overnight and require assistance.
- Patients with Neutropenia (HITH) are managed in the community while they are well – while not seen routinely by night staff, they know they are available.
- Visits by night staff also enable people's work routines to continue uninterrupted (eg direct observed TB therapy, wound dressings changes, bowel management to maintain a safe bowel pattern for people with spinal injuries).

IV Therapy (222 visits/ 12 months) – including HITH patients

Scheduling of IV administration during 2300-0700 hrs increases the overall service capacity to manage home IV therapy patients – current day shift FTE capacity would not stretch to deliver all that is required. Patients referred by ED for home IV therapy to prevent hospital admission often have their treatment commenced between 2300-0700 hrs. If there was no night DN service, this would therefore mean a delay in patient discharge from secondary services, admission to secondary services or use/ remain in ED (which may impact in ED target wait times).

Cost comparison: Most home IV therapy visits cost \$150.00 each per day. Average medical and surgical ward bed day costs are, respectively \$380 and \$460 (and higher in specialty areas such as Ward 28 - \$610). Savings, therefore, for 222 visits over 12 months are \$42,180 (based on 111 medical ward bed days for 12 hourly IV administration).

MCH DNS manages patients with a higher degree of complexity under HITH than any other district nursing service in NZ – allowing patients to go home on 12 hourly home IV therapy. Over the last 12 months the DN Service has managed an average of 26 home IV patients a month – length of stay ranging from several days to 6+ weeks, achieving significant inpatient stay savings.

Consultant teams are confident to use the HITH system because they know the DN Service is available 24/7. If this resource was lost, a number of patients each week would have to remain longer in hospital.

Palliative care patients

Currently:

- Memorandum of Understanding with Arohanui Hospital to provide home based palliative care and end of life care symptom management and support throughout the district, 24/7.
- Community Specialist Nursing DOM 101 includes the delivery of palliative care in the home.

The removal of District Nurses from palliative care at night will have a major effect on what has been a major success story for MDHB – the high level of palliative care provided – due to the remarkable working partnership between Arohanui Hospice and MidCentral Health.

Most of the 270 palliative visits by night staff in the last 12 months relate to acute palliative care needs – and frequently prevent ED presentation or Arohanui Hospice medical staff to be called out for symptom management. Based on 200 ED presentations, the night service has saved MCH approx \$56,400.

Emergency care at night has become a vacuum. It is partially filled by St John, but they have no training in palliative care.

The acute needs addressed by the DNs is of a generalist nature and most often includes unblocking of catheters, administration of prescribed medications, settling of patients at night, management of incontinence, repositioning of patients, or general assistance and assessment in the case of falls, etc. In addition, many palliative patients require double nursing, and can only remain at home because of the DNS night support.

Child Health Services provide both hospital and home based palliative care services for children in the region, and the service is reliant on afterhours and weekend District Nursing support. The cost of Child Health providing this after hours service has been costed at \$67,000 per annum, and unlikely to be able to be provided, given the financial situation. If there is no after hours DNS, Child Health would not be able to offer a home based service for children who are dying.

Need to consider the influence of the availability of an overnight nursing service on the patient/ family choice to die at home; and this also assists inpatient capacity for Arohanui Hospice and PNH. This service provision is also consistent with the expectations outlined in the NZ Palliative Care Strategy.

Hospital admission avoidance programme – GPAL/ PEDAL

Over the last 13 months the DNS has provided admission avoidance/early discharge assistance for:

- 130 PEDAL patients referred from ED

- 21 MAPU patients referred by the PEDAL nurse to avoid admission (since opening in November 2009)
- 20 GPAL patients referred by GPs to avoid admission

GPAL/ PEDAL patients are supported by night staff represent approximate bed day inpatient stay savings of \$259,920 (based on 4 inpatient medical bed stay costs of \$380 per day for 171 patients). Without access to after hours DN Service assessment, it is likely that many patients currently sent home by the PEDAL team would be admitted instead.

Nine positive testimonials from GP Practices re GPAL included in the DN submission – with overall support for the service's ability to prevent hospital admission.

A comment on GPAL from one submission – a feeling among DNs that while it is a good concept it has not taken off well and there are very few GPs who use it. Seems the amount of documentation they have to do is too much to set it up. Don't consider it a successful programme – but PEDAL is very proactive and worthwhile.

4.0 QUALITY OF SERVICE

The most recent DNS patient satisfaction survey (140 respondents):

- 80% indicated their level of satisfaction with how their health care needs overall were treated was 5/5
- 9% - 4/5
- (Remainder – didn't answer or rated N/A)

One of the strengths of the night DNS (as opposed to any other night service) is that they have access to patient notes and information and an overview of the whole service promoting continuity of care. They can also link with the DN key worker, the GP and the hospice to inform them of the patient's condition and make a plan to review and manage their care.

International research robustly supports that home based care is safer, cheaper, prone to less risks, incidents and adverse events, than inpatient care, particularly for older adults.

Another submission (external) noted that in many ways the District Nurses with their presence in homes and their high skills and experience are the best part of the health service. If anyone's work is frontline it is theirs.

5.0 OTHER IMPACTS OF REMOVING THE NIGHT SHIFT

The DNS have submitted that there are a number of tasks undertaken by the night shift staff when they are not visiting patients. There is no capacity within the administration team to take on extra work in the daytime (they already work approx 3-4 hours overtime each week), and nursing staff are already stretched to complete their daytime work within their shift hours (often missing meal breaks). There are insufficient computers for individual nurses to type their own discharge summaries.

The tasks include:

Collating discharge files	13.3 hours per month
Making up new patient folders	20.0 hours per month
Filing	3.3 hours per month
Boxing files to return to medical records	2.0 hours per month
Updating Clinical /MDHB manuals for all bases	2.0 hours per month
Quality surveys	3.3 hours per month
Discharge letters	66.0 hours per month

Total **109.0 hours per month**

Where possible most of the administration tasks are carried out by the Care Assistant. If they had to be transferred costs are:

- Administration typing costs = \$16.53/hour
- RN costs = \$31.84/hour

One submission indicated that there could be service improvements in terms of how the administration tasks are undertaken.

6.0 OTHER COMMENTS/ PROPOSALS IN CONSULTATION DOCUMENT

There was limited feedback in respect of detail in respect of volumes, delivery to contract and service provision vs service specification.

Statutory day roster (6.1)

Supported provided the DNS can ensure sensible rostering at extended public holiday times (eg Christmas and Easter).

Outpatient Clinic in Palmerston North (6.4.1)

Supported – less travel cost and time. Challenge will be access to sufficient space in all areas. Organisational support to establish these and other clinics will be crucial.

Ceasing payment for attending monthly business meetings (for staff not on duty at the time of the meeting) (6.4.3)

Supported by the DNs – except for one who comments that monthly meetings are generally accepted best practice, based on the HDSS standards. Perhaps monthly meetings could include Quality and Risk – thus combining two separate meetings held currently.

Reconfiguration of Roster/ Roles (6.4.4)

Supported, provided that review is DN team lead and informed.

Suggest have CN level staff work a 4 on 4 off roster, and a 9-hour day – with one CN on duty only (not a double up or more some days). They are often at work outside their paid hours. Also a Team Leader approach would work in the DN bases where the DN can have increased responsibility for staff in their office area and sharing and support of workload.

Provision of wound care supplies (6.4.5)

Supported – patients in this group do not require specialist level nursing care and could be self managing with oversight from their General Practice Team. Patients could be advised to purchase their products through bulk stores to decrease their costs.

Tararua Clinics (6.4.6)

Supported. Challenge will be access to sufficient space in all areas.

One submission suggested there could be logistical issues for the Tararua DN undertaking a combination of home visits and clinics; and potential hardship imposed on the more “able” patient expected to travel to the clinic.

Otaki Clinics (6.4.7)

Supported. Challenge will be access to sufficient space in all areas.

7.0 ALTERNATIVE PROPOSALS

Alternative proposals (8.1-8.3 below) were submitted by the DNS as interim measures pending implementation of the Business Case. These savings were estimated to achieve between \$200-\$225,000 (submission contained detailed calculations).

7.1 Proposal 1:

Retain 1 RN and HCA within DNS rostered to provide scheduled and on-call care between the hours of 11 pm and 0700 am. Request that Hospice contribute to DNS RN salary. This would enable the following to continue:

- Deliver IV therapy overnight to enable the number of home IV therapy patients DNS currently can take, avoiding the need for MCH to keep these patients in hospital.
- Provide on-call over night support as required to PEDAL discharges from ED and GPAL referrals from GPTs, City Doctors and Radius after hours GP services (as per initiatives in MDHB Business case to increase hospital admission avoidance through use of 24 / 7 DNS). This would provide ED, PEDAL and GPTs with the confidence to trial home based recovery rather than seek admission for them.
- Prevent ED attendances by providing on-call support to particular patient groups, eg patients with a blocked catheter or a leaking stoma, problems with their home oxygen.
- Enable people living at home with complex disabilities to remain out of residential care. At present DNS is supporting three people with complex disability support needs to remain at home.
- Provide essential on-call palliative care to ensure this region meets its obligations under the NZ Palliative Care Strategy. This strategy requires patients to have access to essential palliative care services within their homes as and when required (ie available in their home 24/7). For the past year the night service has provided on average five palliative care visits a week.
- Ensure DNS discharge summaries are typed up and signed by an RN in a timely manner for the approximately 400 patients it discharges each month. Currently the night staff type and sign them and send copies to GPs, the patient, and other health professions as indicated. This mandatory task takes approximately 10 minutes per discharge.
- Maintain DNS quality monitoring programme without placing additional pressure on daytime administration staff. Twice a year a sample of patients is surveyed to ascertain their level of satisfaction with the quality of services they receive. Once a year all referring services are surveyed to ascertain their level of satisfaction with the quality of our services. The night staff print and mail all these surveys, enter all returned surveys into the quality data base and provide a report on any trends to the DNS service improvement committee for addressing as required.

In addition, the DNS Night staff pick up on-call support as required for other patient groups currently being providing by other MCH departments, eg Renal home dialysis patients, Diabetes pump patients. This would save each of those departments their on-call rates costs.

7.2 Proposal 2:

Retain 1 RN within DNS rostered to provide on-call home visit support as required. Hospice contribute to DNS RN salary. MCH provide HCA from HCA staff working in hospital overnight when required to accompany DN RN on call out visit. This proposal would enable the following:

- On call support as necessary to PEDAL/ GPAL patients for hospital admission avoidance to continue
- Other departments would no longer need to fund on-call services to their patient groups
- Hospice would not need to pick up provision on on-call over night essential palliative care
- Continue to prevent ED attendances by providing on-call support to particular patient groups.
- Continue to enable people living at home with complex disabilities to remain out of residential care.

7.3 Proposal 3:

Retain 1 DN RN rostered to work in ED or with the 'hospital after hours team' and provide on-call home visits as required. Hospice and ED contribute to RN salary. MCH provide HCA from HCA staff working in hospital overnight when required to accompany DN RN on call out visit. This proposal would enable the following:

- On call support to PEDAL and GPAL patients enabling hospital admission avoidance to continue
- Other departments would no longer need to fund on-call services to their patient groups
- Hospice would not need to pick up provision on on-call over night essential palliative care
- Continue to prevent ED attendances by providing on-call support to particular patient groups.
- Continue to enable people living at home with complex disabilities to remain out of residential care.
- Extra pair of RN hands in ED

7.4 Proposal 4:

Another submission supported an on call night nursing service, and not total removal as there has been no impact analysis done in the proposal on the financial consequences of removing the night service.