Disability Support Advisory Committee

Meeting

Wednesday 5 June 2013
1:00pm

Training Room
CCS Disability Action
14 Erson Avenue
Royal Oak
Auckland

Hei Oranga Tika Mo Te Iti Me Te Rahi
Healthy Communities, Quality Healthcare
INTRODUCTIONS
ATTENDANCE AND APOLOGIES
CONFLICTS OF INTEREST
Conflicts of Interest Quick Reference Guide

Under the NZ Public Health and Disability Act Board members must disclose all interests, and the full nature of the interest, as soon as practicable after the relevant facts come to his or her knowledge.

An “interest” can include, but is not limited to:

- Being a party to, or deriving a financial benefit from, a transaction.
- Having a financial interest in another party to a transaction.
- Being a director, member, official, partner or trustee of another party to a transaction or a person who will or may derive a financial benefit from it.
- Being the parent, child, spouse or partner of another person or party who will or may derive a financial benefit from the transaction.
- Being otherwise directly or indirectly interested in the transaction.

If the interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence the Board member in carrying out duties under the Act then he or she may not be “interested in the transaction”. The Board should generally make this decision, not the individual concerned.

Gifts and offers of hospitality or sponsorship could be perceived as influencing your activities as a Board member and are unlikely to be appropriate in any circumstances.

- When a disclosure is made the Board member concerned must not take part in any deliberation or decision of the Board relating to the transaction, or be included in any quorum or decision, or sign any documents related to the transaction.
- The disclosure must be recorded in the minutes of the next meeting and entered into the interests register.
- The member can take part in deliberations (but not any decision) of the Board in relation to the transaction if the majority of other members of the Board permit the member to do so.
- If this occurs, the minutes of the meeting must record the permission given and the majority's reasons for doing so, along with what the member said during any deliberation of the Board relating to the transaction concerned.

IMPORTANT

If in doubt – declare.
Ensure the full nature of the interest is disclosed, not just the existence of the interest.

## ADHB WDHB DSAC INTERESTS REGISTER

<table>
<thead>
<tr>
<th>NAME OF MEMBER</th>
<th>ORGANISATION</th>
<th>ROLE</th>
<th>FINANCIAL INTEREST</th>
<th>NATURE OF INTEREST</th>
<th>DATE OF LATEST DISCLOSURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sandra CONEY (Chair)</td>
<td>Councillor Auckland Council</td>
<td>Chair Parks Committee</td>
<td>Fees</td>
<td>Fees</td>
<td>2 May 2011</td>
</tr>
<tr>
<td>Jo AGNEW (Deputy Chair)</td>
<td>Professional Teaching Fellow, School of Nursing, Auckland University Casual Staff Nurse ADHB</td>
<td>Salary</td>
<td>Salary</td>
<td>Salary</td>
<td>7 September 2011</td>
</tr>
</tbody>
</table>
| Max ABBOTT          | Auckland University of Technology  
Raeburn House  
Health Workforce New Zealand  
AUT Millennium Ownership Trust  
Social Services Online Trust  
The Rotary National Science and Technology Trust | Pro Vice-Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences  
Patron  
Board Member  
Board Member  
Chair  
Board Member     |                                   |                                 | 28 September 2011 |
<p>| Pat BOOTH           | Fairfax Suburban Papers in Auckland                                           | Consulting Editor                        |                    |                    | 24 June 2009              |</p>
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<thead>
<tr>
<th>NAME OF MEMBER</th>
<th>ORGANISATION</th>
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<th>FINANCIAL INTEREST</th>
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<th>DATE OF LATEST DISCLOSURE</th>
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<tbody>
<tr>
<td>Susan BUCKLAND</td>
<td>Writer, editor Medical Council of NZ Occupational Therapy Board Northern Region Ethics Committee</td>
<td>Self-employed Professional Conduct Committee member Professional Conduct Committee member Member</td>
<td>Fees Fee</td>
<td></td>
<td>12 September 2012</td>
</tr>
<tr>
<td>Lester LEVY</td>
<td>University of Auckland Business School New Zealand Leadership Institute Health Benefits Limited Tonkin &amp; Taylor Waitemata District Health Board Auckland Transport</td>
<td>Professor (Adjunct) of Leadership Co-Director Deputy Chair Independent Chairman Chairman Chairman</td>
<td></td>
<td>1 November 2012</td>
<td></td>
</tr>
<tr>
<td>Robyn NORTHEY</td>
<td>Self employed Contractor Hope Foundation A+ Charitable Trust</td>
<td>Project management, service review, planning etc. Board member Trustee</td>
<td></td>
<td>20 June 2012</td>
<td></td>
</tr>
<tr>
<td>Michelle CAVANAGH</td>
<td>Te Taurahere O Ngati Porou Ki Tamaki WDHB – HWFNZ Hauora Maori Coordinator Northland DHB Kai Ora Hauora Northern Regional Coordinator</td>
<td>Involvement Part time employee Contractor</td>
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<td>7 March 2012</td>
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<td>NAME OF MEMBER</td>
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<tr>
<td>Maria HULL-BROWN</td>
<td>Employee Mental Health Foundation</td>
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<td></td>
<td>Board member HOPE Foundation for Research on Ageing</td>
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<td></td>
<td>Council Member Age Concern Auckland.</td>
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<tr>
<td>Dairne KIRTON</td>
<td>CCS Disability Action National Board</td>
<td>Northern Regional Representative</td>
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<td>23 November 2011</td>
</tr>
<tr>
<td>Jan MOSS</td>
<td>Complex Carer Group</td>
<td>Co-ordinator</td>
<td></td>
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<td>30 September 2011</td>
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<td></td>
<td>WDHB SSOAS Stakeholders Group</td>
<td>Member</td>
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<td></td>
<td>Operational Trust YES Centre</td>
<td>Board Member</td>
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<td></td>
<td>MOH Disability Workforce Reference Group</td>
<td>Member</td>
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<tr>
<td>Susan SHERRARD</td>
<td>CCS Disability Action</td>
<td>Contract</td>
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<td>7 March 2012</td>
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<td></td>
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<td>Auckland Council Strategic Advisory Group</td>
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<tr>
<td>Russell VICKERY</td>
<td>Ripple Trust</td>
<td>Trustee</td>
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<td>14 November 2012</td>
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<td></td>
<td>Auckland CCS Disability Action</td>
<td>Life member</td>
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<td>TalkLink Trust</td>
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<td>Auckland Disability Law</td>
<td>Member Steering Committee</td>
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<td></td>
<td>Waitakere Community Law</td>
<td>Committee member</td>
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<td></td>
<td>Disability Consultant</td>
<td>Self Employed</td>
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<td>Wilson Home Trust</td>
<td>CCS Disability Action Nominee</td>
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<td>Management Committee</td>
<td>Care Managers Research,</td>
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<tr>
<td></td>
<td>Disability Consultant</td>
<td>Auckland University Nursing School</td>
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CONFIRMATION OF MINUTES

- WEDNESDAY 13 MARCH 2013
# Auckland District Health Board and Waitemata District Health Board
## Disability Support Advisory Committee
### Minutes

Minutes of the Auckland District Health Board and Waitemata District Health Board, Disability Support Advisory Committee meeting held on Wednesday, 13 March 2013 in the Training Room, CCS Disability Action, 14 Erson Avenue, Royal Oak, Auckland commencing at 1:00pm

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## ATTENDANCE AND APOLOGIES

The Chair declared the meeting open at 1:04pm.

**Committee Members**

<table>
<thead>
<tr>
<th>Auckland (WDHB)</th>
<th>Waitemata (ADHB)</th>
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<tbody>
<tr>
<td>Sandra Coney</td>
<td>Jo Agnew</td>
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<tr>
<td>Pat Booth</td>
<td>Susan Buckland</td>
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<tr>
<td>Dr Lester Levy</td>
<td>Robyn Northey</td>
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<tr>
<td>Marie Hull-Brown</td>
<td>Dairne Kirton</td>
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<td>Susan Sherrard</td>
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**Management in Attendance**

### ADHB

- Dr Denis Jury – Chief Planning & Funding Officer
- Sue Waters – Chief Health Professionals Officer
- Kate Sladden – Planning & Funding Manager
- Hilary Carilie – Planning & Funding Manager

### WDHB

- Dr Debbie Holdsworth – Chief Planning & Funding Officer
- Tim Wood – Group Manager Funder NGOs
- Samantha Dalwood – Disability Strategy Coordinator
- Sue Skipper – Operations Manager Older Adults and Home Health
- Kartina Lenzie-Smith – Programme Manager

**Secretary**

Ian Bell – Board Administrator (ADHB)

**Apologies**

Apologies had been received from Max Abbot (WDHB), Jan Moss, Russell Vickery and Ailsa Claire (ADHB).

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## CONFLICTS OF INTEREST

There were no declarations of conflicts of interest for any item on the agenda.
### CONFIRMATION OF MINUTES 14 NOVEMBER 2012

**Moved Sandra Coney; seconded Jo Agnew**

That the minutes of the ADHB and WDHB Disability Support Advisory Committee meeting held on 14 November 2012 be confirmed as a true and correct record.

Carried

### ACTION POINTS 14 NOVEMBER 2012

**Funding Boundaries**

A letter under Sandra Coney’s name is to be drafted to ACC concerning funding boundary issues that impact on clients and patients.

**Auckland Council Disability Group**

Contact with the Auckland Council Disability Group is to be followed up.

Lester Levy advised that at an Auckland Transport meeting a person had addressed the Board on access and that person had been later invited to be added as a member to an advisory group. The new electric trains would have three compartments with the middle unit having excellent access. There was more emphasis on disability access at Auckland Transport. The recent incident of a disabled person being stuck and injured at a rail crossing was under Kiwi Rails jurisdiction but a collective approach between agencies was being taken. While all risks could not be eliminated there would be greater rail and pedestrian separation. Auckland Transport has their own advisory group looking at practical issues but was looking at cooperating with the Auckland Council Disability Group.

**Funding Streams**

There were a number of funding streams for reducing barriers and a paper would be brought to the next meeting.

**Disability Review of Projects**

Both DHBs have policies that all Facilities works have disability representation. While the Boards had that requirement there was a need to know that it was effective, rather than a box ticking exercise, and was not just to meet regulations but to exceed those requirements. The WDHB Surgical Centre has had disability advice over the patient’s entire journey. ADHB did work with Samantha Dalwood but were taking a mainstreaming approach as part of all business cases, both new or refurbishment, addressing access from the point of view of patients and visitors.

**Health of Older People Consumer Representative Group**

The request for information on remuneration and reimbursement and the Terms of Reference of the Regional HOP Consumer Representative Group was carried forward.

**Caring Counts Report**

Some estimate of what the cost would be to implement the Caring Counts report recommendations would be brought to the next meeting.

### Chairman’s Report

The Chair reported that she, Marie Hull-Brown and Jo Agnew had attended the Caring Counts conference with Jo Agnew attending a subsequent meeting where she was the only DHB representative. Issues included pay rates, travel time and travel costs, and the need for care workers to be supported in attaining qualifications. Up-skilling workers was seen as a way of increasing their remuneration.

A report is to go to both DHB Boards on the financial implications for boards.

Lester Levy advised that both Boards had changed the care of older people in the community. The aim of staff to treat patients well required staff to be treated well. This would include changes
Sandra Coney advised that there had been a presentation to the Auckland Council on a living wage which was shown to have positive outcomes in such things as staff satisfaction and staff retention.

### 7.1 Quarterly Report on the Implementation of the NZ Disability Strategy

The invitation to the Planning for the Implementation of the NZ Disability Strategy 2013/2016 on Tuesday 2 April was noted with Jo Agnew and Sandra Coney to attend. Good progress was being made. There was ongoing work on accessibility information on websites and a request for pamphlets that can be read with scanners.

There was disabled parking at North Shore Hospital but this required access by a ramp or sloping road and the parking spaces would need to be moved to get flat access. The back entrance through MRI was an option, but not ideal, and this continued to be an ongoing issue with one suggestion being valet parking for disabled. It was agreed that the Committee be invited to view the site at 1pm on Wednesday 20 March 2013 prior to the joint CPHAC meeting.

### 7.2 Quarterly Report on Activities

While there was some progress on dementia at the strategic level there were still issues of who went where and some blocks with a need to devolve more resources to the coalface and to have a Strategic Plan related to the population demographics. Funding and planning needed to be done in a timely manner as aging was a major driver of dementia services demand. While it was a Ministerial and Board priority there needed to be a regional approach as people moved in the region and there was a requirement to provide for special needs. The region consisted of the four northern DHBs.

Moved Sandra Coney; seconded Lester Levy

*That the Disability Support Advisory Committee recommends to the ADHB and WDHB Boards that a regional plan be developed for Aged Related Residential Care services.*

Carried

This recommendation must have a contextual background.

### 8.1 National Dementia Cooperative

There was national, regional and then each DHB groups with a need to get all aligned. In the Northern Region, while approaches are different, they were learning from each other. The National Cooperative struggled to fund the coordinator and was still fragile. Richard Worrell was on the Cooperative’s steering committee which consisted of people in all parts of the spectrum, carers, patients and families with the cooperative being to influence, exchange knowledge, encourage local networking and have input to the national dementia framework.

It was noted that the collection of papers on dementia care was encouraging and the status of this area is growing.

Moved Robyn Northey; seconded Susan Buckland

*That the DSAC Committee approves the continued support by both Waitemata DHB and Auckland DHB in the following areas:*

- Support for the 2013 Dementia Knowledge Exchange forum / conference
- Showcasing dementia research and innovation in Waitemata and Auckland through the Awhina Health Campus
- Inclusion of the National Dementia Cooperative in relevant strategic forums in the region
- Efficient communication and wider dissemination of useful resources through a new Dementia Section in The Long Term Conditions Bulletin published by Health Navigator NZ
- Using the National Dementia Cooperative as a vehicle for spreading best practice across the range of providers
8.2 Regional Dementia Workgroup

Richard Worrell and Gavin Pilkington were in attendance.

Following the directive to develop dementia pathways the National Cooperative and Regional Workgroups were established. At the regional level opportunities to operationalise care, from diagnosis to end of life, linking with and being consistent with the national framework with a focus on delivery of service and standards. While there was agreement on the service guidelines there were different approaches by the DHBs. A change in the culture of care was trying to be achieved through a Living Well with Dementia Plan in parallel with the Health Passport. The Living Well with Dementia Plan needed to be integrated with the Shared Care Plan as most sufferers don’t only have dementia but other morbidities as well.

 Moved Sandra Coney; seconded Jo Agnew

That the DSAC Committee:
1. Endorses the Northern Region Dementia Services Guide;
2. Notes the development of the Living Well with Dementia Plan tool;
3. Notes the development of the National Dementia Framework and the input of the Northern Region; and
4. Endorses the future work plan.

Carried

8.3 ADHB Dementia Care Pathway

“This is Me” was used on the wards and it differs from the Health Passport but was part of care planning with staff. There was a review on how it is use from when diagnosed through the continuum progression so people knew about the person. This paralleled with the Health Passport which was a national programme. The pilot in ADHB was supported and would be compared with the WDHB approach and should be integrated into care planning including electronic access. This would also follow the patients when they moved into residential care.

 Moved Sandra Coney; seconded Robyn Northey

That the Committee:
1. Endorses the trial of the “This is Me” and “Living Well Plan”.
2. Notes the “This is Me” tool
3. Notes the Living Well Plan

Carried

8.4 WDHB Dementia Care Pathway

One of the differences at Waitemata was the focus at primary care level with gerontologist nurse specialists and PHOs expected to be involved by having Dementia Care Plans electronically available to GPs.

 Moved Sandra Coney; seconded Robyn Northey

That the Committee:
1. Notes the development of a draft primary care cognitive impairment pathway.
2. Endorses the pilot and evaluation of the primary care cognitive impairment pathway.
3. Notes that the pilot and the evaluation will be reported to the Committee.

Carried
8.5 Waitemata PHO Dementia Care Pathway

The PHO was developing an electronic tool for GPs. The gerontology nurse specialist was testing this with Maori and Pacific and high needs patients as it was originally developed for a Pakeha population. This raised the question of testing it with Asians who had a growing older population. The challenge for DHBs was adding extra demands on GPs so there was a need to give them support and efficient tools that are affordable for them. Widespread implementation would be a challenge.

Moved Marie Hull-Brown; seconded Susan Buckland

*That the Committee notes the content of this paper and notes and endorses the development of an electronic tool to enable earlier recognition of dementia.*

Carried

InterRAI

Katrina Lenzie-Smith gave a presentation on InterRAI in the Auckland and Waitemata DHBs. In the early 2000s it was recognised that there was a need for standardisation of the assessment process across NZ, that there be standardised collection’ reporting and preparing of data, tools for screening and assessment should be complimentary part of an integrated system and assessors must receive specialists training. InterRAI was one of four clinical assessment instruments considered by the Ministry. The term InterRAI covered; Inter being international and RAI; Resident Assessment Instrument which used algorithms for clinical decision support and comprehensive care planning. It is used in more than 30 countries and provides a suite of tools based on a best practice to promote evidenced based care.

Following the 2010 Aged Related Residential Care (ARRC) review all DHBs endorsed a business case to implement InterRAI assessments. Initially the tool was voluntary but will be mandatory by July 2015 with an Annual Plan requirement of 100% of ARRC facilities using or training their nurses to use by 30 June 2014. Progress to date was that all Home Based Support Services assessed people 65 years and over but there is a slow update of ARRC training. There was a higher uptake within ADHB facilities than WDHB.

Challenges were the National managed implementation had DHBs funding the costs, ARRC uptake had been slow, there is software instability, poor support post training, training time is long and assessments take an average of 4 hours per person. The training is a real challenge for smaller facilities as were the hours required for assessment. There is concern in the MoH and a lot of engagement with them. $15m was being spent on implementation but the ongoing cost to maintain was unknown.

It was agreed that there was a need to elevate the issues to the Boards.

Moved Sandra Coney; seconded Robyn Northey

*That the DSAC Committee recommends that there be an urgent report on InterRAI to the respective DHB Boards in their confidential section.*

Carried

GENERAL BUSINESS

The topic for the next meeting would be the Northern Region Health Plan.
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<tr>
<td>The meeting closed at 3:20pm</td>
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<tr>
<td>The next scheduled meeting is:</td>
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<tr>
<td>1:00pm, Wednesday, 5 June 2013</td>
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<tr>
<td>Training Room, CCS Disability Action</td>
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<tr>
<td>14 Erson Avenue</td>
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ACTION POINTS

- WEDNESDAY 13 MARCH 2013
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<th>Item</th>
<th>Detail</th>
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<tr>
<td>Carried forward</td>
<td>Waitemata to review the assigned disability parking positions to see that they are in the right locations and size.</td>
<td>Tim Wood</td>
<td>Completed</td>
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<td>Carried forward</td>
<td>The Secretary was to follow up with Colleen Brown on organising a meeting with the Auckland Council Disability Group.</td>
<td>Sandra Coney</td>
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<td>Carried forward</td>
<td>The Committee asked for information on remuneration and reimbursement and the Terms of Reference of the Regional HOP Consumer Representatives Group.</td>
<td>Katrina Lenzie-Smith Tony O’Connor</td>
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<td>Carried forward</td>
<td>Some estimate of what the costs would be to implement the Caring Counts report recommendations (after their report is available)</td>
<td>Denis Jury Tim Wood</td>
<td>To go to full Board of each DHB</td>
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<tr>
<td>Carried forward</td>
<td>Management to bring forward options to reduce funding barriers and while the problem is defined it was better to approach the MoH with solutions and options for a way forward. A pilot for 0-1 years was suggested as a way forward.</td>
<td>Denis Jury</td>
<td>November</td>
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<td>5</td>
<td>A letter under Sandra Coney's name is to be drafted to ACC concerning funding boundary issues that impact on clients and patients. (Item 9.1 14 November 2012)</td>
<td>Tim Wood</td>
<td>To be advised</td>
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CHAIRMAN’S REPORT

6.1 Health Passport
6.1 Health Passport
1. **Health Passport - Advice Received Executive Officer**  
   **Age Concern North Shore Inc**

   Janferie Bryce-Chapman, 5 June 2013

   On behalf of the Waitemata District Health Board Specialist Services for Older Adults (SSOA) Stakeholder network who discussed the Health Passport at their March meeting along with the “Living Well with Dementia Plan” (ADHB). We supported a decision by the SSOA Governance Group to reject the “Living Well with Dementia Plan” resource and felt that the Health Passport could include the needed information and patients need only one resource to carry with them. We also agreed that the Health Passport should be a smaller size e.g., actual passport size for ease of fitting in handbags and men’s pockets.

   For the Information of the Disability Support Advisory Committee
7.1 Waitemata DHB Home Based Support Services

7.1.1 Proposal for Change
7.1.1 Feedback Survey Question

7.2 Northern Regional Health Plan (NRHP) Health of Older People Workstream Update
7.1 Waitemata DHB Home Based Support Services Proposal for Change
The Proposed Changes

The proposal includes moving to what is called a ‘Case-mix’ model where funding is based on the mix of clients seen by the providers. The DHBs mentioned above have adopted a Case-mix approach to fund HBSS. A number of other DHBs are also in the process of transitioning to a Case-mix model.
‘Case-mix’ is a widely used model that is used extensively in New Zealand and overseas primarily to fund inpatient hospital stays. In a HBSS ‘Case-mix’ model clients are classified into groups based on the mix of functional needs. Providers are paid a set amount depending on the level of care required by the clients they provide services to. This model will allow flexibility for providers to customise care based on needs. It also supports a restorative and goal based approach to care whereby clients are involved in their care and are empowered to achieve optimal functioning and independence.

Another proposed change is better integration between HBSS, primary care and WDHB Needs Assessment and Service Coordination (NASC). Currently clients receive services in the community from a range of providers however services are not as well integrated as they should be. The DHB wishes to address service fragmentation by establishing formal linkages between various providers so that clients experience coordinated care across the health system.

With an aging population and rising incidence of chronic illnesses, not only will future need for HBSS likely go up, but clients are also likely to have more complex needs as well. To manage this, the DHB is proposing prioritisation of services to those with higher needs to ensure the sustainability of HBSS in the district. The DHB also wishes to consult on Individualised Funding where clients manage their own funding and are accountable for arranging their own service.

The Consultation Process

A project team has been set up within the DHB Planning & Funding Team to manage the consultation process. Waitemata DHB has engaged with its MOU partners and has taken their lead on how to best consult with Maori providers and communities.

The consultation will commence on May 27, 2013 when the consultation documents will be publicly available on Waitemata DHB’s web site. The ‘Waitemata DHB Home Based Support Services Proposal for Change’ and the feedback form are attached to this paper. Stakeholders are encouraged to complete the feedback form online by using survey monkey. Alternatively the feedback form can be printed off the website, completed by hand and posted to the address provided.

The DHB is not holding public meetings however organisations / groups are welcome to request a face-to-face meeting with the DHB by contacting Imelda Quilty-King, Community Engagement Coordinator, Waitemata DHB.

We will be consulting with a range of stakeholders including clients, current HBSS providers, General Practices, NGOs and other DHBs.

The consultation period will end on 24 June, 2013. The DHB will collate all feedback and a summary of feedback along with a recommendation as to how HBSS should be provided will be presented to the Board for approval.

If the outcome of the consultation is a change in the model of care, the DHB will then liaise with the National Health Board regarding the service change process. The DHB will also seek input from Auckland DHB under the Agreement for Bilateral Collaboration between the two DHBs. Finally, the DHB will take into consideration all relevant information prior to making a final decision on the proposed model of care.

A decision paper describing the outcome of the consultation will then be presented to the Board for approval.
7.1.1 Proposal for Change
Waitemata District Health Board
Home Based Support Services

Proposal for Change

May 2013
# Table of Contents

GLOSSARY .................................................................................................................. 3

1. INTRODUCTION ....................................................................................................... 4

2. BACKGROUND ......................................................................................................... 5

3. WAITEMATA DHB POPULATION .............................................................................. 6

3.1. WAITEMATA DHB CATCHMENT ......................................................................... 6

3.2. UTILISATION OF HOME BASED SUPPORT SERVICES ...................................... 7

4. CURRENT HOME BASED SUPPORT SERVICES ...................................................... 7

5. AIMS OF THE PROPOSED CHANGES .................................................................... 8

6. THE PROPOSED CHANGES .................................................................................... 9

6.1. PROPOSAL 1 - CHANGE TO RESTORATIVE MODEL OF CARE .......................... 9

6.2. PROPOSAL 2 - CHANGE TO A CASE-MIX METHOD OF FUNDING FOR ALLOCATING HOME AND COMMUNITY SUPPORT SERVICES .................................................. 10

6.3. PROPOSAL 3 – BETTER INTEGRATION OF HOME AND COMMUNITY SUPPORT SERVICES WITH PRIMARY CARE, SECONDARY CARE AND LOCAL COMMUNITIES .............................................. 12

6.4. PROPOSAL 4 - PRIORITISING SERVICES TO CLIENTS WITH HIGHER NEEDS ........ 13

6.5. PROPOSAL 5 - DEVELOPING A QUALITY FRAMEWORK FOR HOME AND COMMUNITY SUPPORT SERVICES ................................................................. 14

6.6. PROPOSAL 6 - OPTION OF INDIVIDUALISED FUNDING .................................. 15

7. HOW TO PROVIDE FEEDBACK .............................................................................. 16

8. PROPOSED TIMEFRAMES .................................................................................... 17

APPENDIX 1 – PROPOSED CARE REFERRAL AND ASSESSMENT PROCESS ............... 18

REFERENCES ............................................................................................................. 19
Glossary

**Care Manager**: Registered Health professional working for a HCSS provider. Generally a care manager refers to a health care professional, typically a nurse or social worker, who arranges, monitors, or coordinates long-term care services (also referred to as a care coordinator or case manager). A care manager may also assess a patient’s needs and develop a plan of care, subject to approval by the patient’s physician.

**HBSS**: Home Based Support Service (current service name)

**HCSS**: Home and Community Support Service (proposed new service name)

**InterRai**: Is an electronic assessment tool which includes the Minimum Data Set Home Care (“HC”) and Contact Assessment (“CA”) tools for the assessment of the needs of older people in hospital, the community or in residential care who may need to receive long-term publicly funded support.

**LTS-CHC**: Long Term Support – Chronic Health Conditions (previously called Interim Funding)

**NASC**: Needs Assessment and Service Coordination - helps older adults and their caregivers access support services in the community to enable older adults to stay at home as safely and independently as possible as their needs change or following an admission to hospital.

NASC also assists younger adults who require support services following illness or hospitalisation, have a chronic health condition or as part of a palliative care package
1. Introduction

Home Based Support Services (HBSS) are an important service for a rapidly growing part of Waitemata District Health Board’s (DHB) population. They allow people to maintain independence and remain in their home and reduce the overall cost to the health system by preventing or delaying residential care placement. Waitemata DHB currently spends $26 million per annum on HBSS and this is very likely to increase.

Waitemata DHB’s HBSS is funded using a system inherited when the Ministry of Health devolved funding in 2003. In general, HBSS and Needs Assessment and Coordination (NASC) function reasonably well but there are a number of issues that have led many DHBs to already change their model of care. Other DHBs are also considering similar changes.

Waitemata DHB is committed to providing the best care for everyone. To enhance the quality of HBSS and to ensure that services are client centered, and provided in a coordinated way, Waitemata DHB is planning on making some changes to these services.

We have reviewed published literature, information on other DHB’s models and sought the advice of Waitemata and other New Zealand experts. This has led us to suggesting some proposed changes, which we would now like to consult on.

The overall aim of the changes is to support older people and some younger people with chronic health conditions to live safely and independently in their home in the community.

In summary the proposed changes we are consulting on are:

- Adopting a restorative and goal-based approach to care
- Move to Case-mix model from fee-for-service (FFS) model
- Greater integration between HBSS, NASC and general practice teams
- Prioritising service to ensure clients with high needs are catered for appropriately
- Increased emphasis on quality improvement
- Adoption of Individualised Funding model

The purpose of this document is to consult with the Waitemata community on the changes we are considering. The DHB is seeking feedback to ensure that any proposed changes will enhance service provision, help inform any subsequent implementation plans and minimise unintended consequences.

The DHB is not holding public meetings however your organisation / group is welcome to request a face-to-face meeting with us by contacting Imelda Quilty-King,
2. Background

By 2051 the percentage of New Zealanders over 65 will double and those 75 years and older will increase three-fold. Currently around 36% of all people aged 75 and over have a moderate disability (requiring some assistance or special equipment but not daily assistance) and 18% have a severe disability (requiring daily assistance). Of people aged 85 years and older around half live at home with assistance and 28% live in residential care.

As well as the social advantage for older people of living at home the cost is substantially lower. We have been very successful in assisting older people to remain at home. The proportion of the population over the age of 85 years living in aged residential care has declined from 40 percent in 1988 to 27 percent in 2008. At the same time the level of dependency of people living in rest homes has substantially increased suggesting that more people with a health and support need are remaining at home. Support services provided in the person’s home have made a significant contribution to achieving this.

District Health Boards contract for support services to be provided to the elderly in their own homes based on their level of need. These services are collectively known as “home based support services” (HBSS) and include a range of housework and personal care services. In 2012/13 Waitemata DHB will spend nearly $26 million dollars on HBSS. These HBSS are also provided to a small number of people under 65 years old with chronic health conditions that have a high need for support to remain living at home. The DHB’s proposed changes include the HBSS services provided to these clients as well.

HBSS have been provided by Waitemata DHB since devolution of disability support service funding to DHBs on 1 October 2003 for people aged 65 and over and people aged 50-64 who are close in age and interest to those of an older age. The model of care that Waitemata DHB uses is largely the same as when it inherited the services from the Ministry of Health. However the aims of the services are changing. The Health of Older People Strategy (2002) states that Long-term support providers will build in opportunities for appropriate health promotion, disability prevention and rehabilitation. Restorative care, where possible, for people receiving HBSS is a Ministry of Health requirement of DHBs. A number of DHBs have adopted or are examining different models of providing HBSS with an aim of increasing restorative care. Waitemata DHB therefore feels it is timely to examine our current model of care and alternatives.
The Office of the Auditor General undertook a review of Home Based Support Services for older people in 2011 and made a number of recommendations on how all DHBs should improve their approach to managing the quality of these services, including strengthening management contracts and using performance data to drive continuous quality improvement. The expectations of the Minister of Health for 2013/14 further reinforces these identified requirements for service change by asking for: greater support to older people for safe, independent living at home; improved support for people with long-term conditions; greater service integration, particularly with primary care; and smarter use of the workforce.

The national Home and Community Sector Standards were reviewed and new standards referred to as; NZS 8158:2012 were released in 2012. It is mandatory for publicly funded providers to have certification to these standards as of 1 September 2013. The new standards reflect the philosophical shift to provide services in a way that maximises independence and supports achievement of client goals. One of the key changes in the approach is from the historical task based ‘do for’ model of care i.e. the Support Worker undertakes a prescribed list of tasks for the client, towards an approach aimed at enabling clients to do as much for themselves as possible, to meet their own goals. This document will refer to the proposed new services as Home and Community Support Services (HCSS) to reflect the wider scope of the service.

Waitemata DHB is also moving to a collaborative approach with Auckland DHB, whereby the teams responsible for the planning and funding of NGO contracted services (including HCSS) are merging. Wherever possible the approaches to service delivery for the two DHBs will align. Auckland DHB transitioned to a model similar to what we are proposing in 2009.

The scope of the proposed service change is constrained by the current budget of HBSS. Waitemata DHB has no ability to make additional investment in HBSS unless equivalent savings can be made in residential care or other health care as a result of the changes.

3. Waitemata DHB Population

3.1. Waitemata DHB Catchment

Waitemata DHB serves the largest DHB population in the country - more than 560,000 people. It is also the second fastest growing of New Zealand's 20 DHBs. It serves residents of North Shore, Waitakere and Rodney districts (coloured area in the map below).
The DHB provides secondary hospital and community services from North Shore Hospital, Waitakere Hospital and over 30 community sites throughout the district.

3.2. Utilisation of Home Based Support Services

Waitemata DHB has the second largest over-65 population in the country (behind Canterbury). Currently the DHB funds HBSS services for approximately 5,300 clients, with a total of approximately 80,000 hours of care provided each month.

Of the current HBSS clients;
- 29% are male and 71% are female
- 93% are Pakeha/European, 3% are Asian, 2% are Maori and 2% are Pacific people
- 30% are under 80 years old, 52% are between 80 – 89 years old and 18% are 90 years old and above.

4. Current Home Based Support Services

All assessments and reviews of care are done by NASC. Self-referrals or referrals from hospital services, GPs or other health providers are received through a single triage system in the DHB. How soon an older person is assessed is based on the risk of poor health or safety of the client and any carers. Needs assessments are
undertaken by the NASC service either on the ward or in the community. NASC are now using \textsuperscript{1}InterRai for all assessments.

HBSS is one of a range of supports that NASC can put in place. Other support may include residential care placement, dementia day care and respite care. NASC may also refer to other clinical services for assessment and treatment. If HBSS are required NASC will work with the client/family and develop an allocation of hours per week for household management and/or personal care.

Waitemata DHB currently funds HBSS on a fee-for-service basis; purchasing household management, personal care and some advanced personal care. Support is provided by eight HBSS providers, including two Maori and one Pacific provider.

HBSS providers also do an assessment of the client and their home setting (and goal setting in some cases) to allow them to develop a service plan for the client. This assessment will usually be undertaken by a health professional i.e. nurse or allied health. To some degree this duplicates the assessments undertaken by NASC. Currently there is little sharing of information or integrated care between HBSS providers, NASC and other services in the health system.

HBSS providers are currently funded to provide care and support, rather than assist with a client’s rehabilitation. The current model tends to encourage support workers to do a set of tasks as quickly as possible, within the allocated time. There is also no incentive for support workers to encourage independence.

A client is re-referred to NASC when there is a change in their needs, usually because there has been deterioration in their health or ability to care for themselves. NASC will review or re-assess their needs and then allocate them a new package of support hours or perhaps authorise entry into residential care.

5. Aims of the Proposed Changes

A number of possible aims for a change in the model of care are put forward. These are:

- A greater focus on restorative care. This means working to improve a person’s independence where this is possible, and maintaining current abilities as much as possible for all others. Evidence suggests that this can lead to improved function and quality of life and reduced downstream requirements for services.
- Greater focus on promoting health, managing long term conditions and supporting self management. This might involve care managers working more closely with primary care.

\textsuperscript{1}InterRai is an electronic assessment tool which includes the Minimum Data Set Home Care (“HC”) and Contact Assessment (“CA”) tools for the assessment of the needs of older people in hospital, the community or in residential care who may need to receive long-term publicly funded support.
• Improving integration with secondary care, community services, community resources, and particularly, with general practice.
• Improving quality and in particular information about quality. It is acknowledged that currently measurement of quality is very poor.
• Addressing workforce issues. Currently support workers are often minimally trained, on casual contracts, and always poorly paid. Whilst funding limits addressing these issues fully some improvements should be achievable.
• Ensuring we meet clients needs in terms of accessibility, flexibility, client involvement and control, and cultural appropriateness.
• Defining the target population for the HBSS service and in particular considering whether the lowest needs clients remain a priority for services.
• Working with Auckland DHB to align the two DHBs’ HBSS models of care.
• Improving service delivery efficiency
• Controlling cost.

6. The Proposed Changes

6.1. Proposal 1 - Change to restorative model of care

A major aim of changing models of HCSS delivery, both in NZ and internationally, has been to move to a restorative model of care. Frequently HCSS services are begun after hospitalisation or some other event that has led to functional decline. There is an opportunity to use HCSS, often in collaboration with other services, to assist clients to regain their function and independence. Clients have functional limitations which may be reversible, stable or progressive. Home based support workers may be able to assist clients with recovery or preventing deterioration of function. However, traditionally home based support is often seen as ‘doing things for people’ rather than assisting them to regain the ability to do it for themselves. This can lead to embedding disability rather than helping a person to maximise their recovery. Restorative approaches emphasise promotion of healthy lifestyles and daily routines, social support, exercise, and autonomy and control.

However, it is acknowledged that many people receiving HCSS have long-term and mainly stable loss of function. In these cases a restorative approach is less useful, although the principle of continuing to maximise independence and prevent deterioration is still applicable. International research has found that the restorative approach does not necessarily lead to a reduction in hospitalisation but the programmes were felt to be cost-effective and lead to higher quality of life, and client and carer satisfaction.

New Zealand research has found that a restorative approach to HCSS led to improved health related quality of life and an increase in the proportion of people requiring less or no ongoing support. A goal setting research trial in Auckland found that goal setting with HBSS clients led to an improvement of health related quality of
There was also a corresponding change in the type of services provided by the HCSS provider.

Effective services for restoration of function requires assessment, goal setting, and reassessment processes, extra training and supervision of support workers, sufficient time to undertake the roles, correct incentives, and integration with existing care plan developed by specialist / allied health DHB staff.

Waitemata DHB proposes to change to a restorative model of care, with care management for clients with complex needs. The services will be delivered to support achievement of client goals. The services will be able to be delivered in a flexible manner (rather than a set number of hours per week) so they can be responsive to changes in client need and circumstances. A greater range of services will also be able to be provided, including facilitating attendance at community activities, supporting carers and promoting self management of chronic conditions.

Goal based care plans will be developed by the client and their family/whanau and the care manager, employed by the HCSS provider. Examples of client goals could be to attend a family wedding, or go to the toilet unaided in the night, or prepare lunch unassisted. The care plans would then be broken down into smaller goals to work on each week with the Support Worker. Every three months (or more frequently if required) the care plan would be reviewed and new goals set. NASC and care managers would be trained in the use of goal setting tools with clients.

6.2. Proposal 2 - Change to a case-mix method of funding for allocating Home and Community Support Services

Waitemata DHB proposes to move from the current Fee-for-service (FFS) funding model to a Case-mix funding model for the provision of the DHB-funded HCSS for its population.

Currently HBSS is funded in Waitemata on a FFS basis where clients’ needs are assessed and they are allocated a certain number of hours of service per week. HBSS providers are paid on invoice for care delivered to the client up to these limits.

A few DHBs around the country have moved from a FFS model to a ‘Case-mix’ model for HCSS such as Auckland DHB, Capital & Coast DHB and Canterbury DHB. A Case-mix system is widely used in hospitals to fund inpatient stays, where patients are classified into a number of groups based on their clinical profile and the treatments they are likely to need. Providers are paid a set amount depending on the type and number of patients they treat.

A HCSS ‘Case-mix’ system is very similar in concept to the ‘Case-mix’ system used in hospitals. However, whilst the hospital system is based upon groups with similar clinical profiles the HCSS ‘Case-mix’ system groups together clients who have similar needs and identifies what resources they require. The category which a client’s
needs most appropriately fit into is identified from the InterRai assessment. HCSS providers are funded an agreed amount based on an estimation of the number of clients they have in each category over the funding period.

The amount paid to providers is based on an average, which means there are likely to be swings and round-abouts for providers while providing services. At times the level of care needed by a client may exceed the funding whereas at other times care may cost less than the funding. The important thing is that this method of funding gives providers the flexibility to provide care based on the needs and goals of the client, and to customise care as the client’s needs change.

One of the clear advantages of case-mix models, where funding is not tied to delivery of a list of tasks or amount of services, is that they allow for greater flexibility of service delivery. Providers have greater opportunities to design care programmes that meet client support needs and fluctuations in health.

**Why is Case-mix Funding Model being proposed?**

A Case-mix model could be interpreted by some as just another method to fund the same service. However, it is more than just funding. It is about bringing in a fundamental shift in the way home-based services are provided to enable them to be more responsive to a client’s needs and goals, and work with them to achieve the best possible outcome.

In the current FFS model payment is based on the quantity of service (hours provided per week), rather than a longer-term package of care developed to best suit clients’ needs and goals. The current system does not incentivise the provider to deliver coordinated and integrated care with a goal of greater client independence. Instead, it may encourage providers to focus on delivering the allocated hours of care rather than what will achieve the best outcome for the client in the long-term.

With the case-mix model instead of having to stick to a capped weekly allocation of hours, providers have the full flexibility to scale services up and down as client’s needs and goals change. This also gives providers an opportunity to involve clients in planning their care with a longer term view rather than week by week. Relationships between providers and clients becomes more trusting and effective.

A Case-mix model removes the ‘quantity’ aspect of care and instead emphasises quality as providers are paid a set amount based on the functional needs of clients they provide services to. This ensures that clients are offered services appropriate for their level of assessed need. Thus every client within the Waitemata district receives comparable package of care for the same level of need irrespective of their location and provider.

Providers have the opportunity to provide care that is integrated and coordinated within the community which can minimise duplication of resources. It is a real
opportunity for providers to be innovative, look for ways to do things differently and enhance the quality of service clients receive.

The Case-mix model also allows the DHB to better monitor the quality and costs of services being provided to clients. The performances of various providers can be compared to ensure that clients receive the level of service appropriate for their need and that there is sufficient accountability.

6.3. Proposal 3 – Better Integration of Home and Community Support Services with Primary Care, Secondary Care and Local Communities

Many clients receiving HBSS have complex needs and receive services from a range of health providers. It is generally acknowledged that integration between HBSSs and primary care, community nursing, allied health services, and secondary services is usually inadequate. The model that Waitemata DHB is proposing will try to address this issue in a number of ways.

A single point of entry (SPOE) to older people services will ensure initial co-ordination between services. Older People that are referred to the SPOE will be screened and identified as having non-complex or complex care needs.

Non-complex clients generally have a physical disability and only need support with managing their home, shopping, and/or meal preparation. Complex clients generally have a physical disability and/or medical conditions that means they also need assistance looking after their personal cares. Some examples of the sort of assistance they might need are; showering and dressing; managing their medication; toileting or prompting to complete tasks. They may also have a brittle social support.

Non-complex clients will be referred to a HCSS provider who will undertake an InterRai contact assessment. Getting HCSS providers to complete the InterRai assessment will reduce duplication of assessments. Currently all clients have an InterRai assessment by NASC and then HBSS providers do their own assessments with the client. The HCSS will work in conjunction with primary care to get relevant information about the client’s health and support needs and develop a holistic care plan. After completing the care plan, the care managers of the HCSS would supervise the support worker, undertake client reviews and liaise with other services including primary care. This approach will also minimise the involvement of different agencies in the clients care and reduce potential client confusion as they will have less people to deal with.

Complex clients will be referred to the NASC service for assessment. Clients with complex needs are likely to have regular contact with different health services such as; specialist hospital services, pharmacy, allied health, primary care and other non-governmental support services. Relationships, connections and good systems of communication between the NASC, HCSS provider and other services that the client is using is crucial for successful care coordination and delivery. As NASC will no
longer be doing assessments of non-complex clients they will have more time to spend on coordinating care for complex clients. Assessments of older people that are inpatients in hospital will continue to be provided by NASC in a timely way, prior to discharge home. Please refer to Appendix 1 for a flow chart of a client’s journey in the proposed model.

The proposed model will create better linkages with primary care by aligning NASC staff and HCSS providers with geographical areas. Clients will be encouraged where possible to use the HCSS providers allocated to their area. This is to facilitate the development of closer working relationships between all involved in the client’s care.

Working in a locality based way means that HCSS providers gain a greater knowledge of all the various community services that are available in that area.

This approach will also be more efficient for Support Workers. As their clients will be in a smaller geographical area and less time will be spent travelling between clients.

A further opportunity in the proposed model of care is to enable information that is relevant to a client’s care to be able to be shared electronically between health services and HCSS providers. Providers will need to have in place appropriate online security measures for safe transfer of personal information to protect privacy and confidentiality of clients. This will facilitate a more integrated approach to care planning and delivery, and enable a greater responsiveness to changes in health status. It will also create efficiencies as some assessments will not need to be duplicated.

6.4. Proposal 4 - Prioritising services to clients with higher needs

Waitemata DHB is proposing to prioritise services to clients that have complex health and disability support needs. This would mean that clients that are at low risk of poor health and safety at home would be unlikely to receive services. This group of clients are generally healthy and are still active outside of their homes. They currently receive about one hour per fortnight assistance with some household management tasks.

If the proposal to reduce services to low needs clients goes ahead the DHB will do a thorough re-assessment of each client before making any changes to their services. Clients who are currently receiving these services will be reassessed by NASC. NASC will liaise with each client’s GP to get their input into the re-assessment. Following the re-assessment some clients that are generally well and able to look after most of their daily living needs and shopping needs themselves or with the support of family/community, will no longer receive DHB funded HBSS services.

The re-assessment process will probably identify some clients whose health and ability to look after themselves has deteriorated since their last assessment, and
need more support than is currently provided. These clients will be allocated a new package of care and continue to receive DHB funded services.

Why is this change being proposed?

The main purpose of this proposed change is to ensure clients with higher needs have access to services appropriate for their level of need within available resources.

6.5. Proposal 5 - Developing a quality framework for Home and Community Support Services

As part of the proposed changes the DHB would like to improve the quality of HCSS and the ability to monitor the quality of the services provided.

The Auditor General’s review of HBSS noted that information about quality of services is patchy and incomplete. He also found that the Ministry and DHBs cannot be confident that HBSS are effective and efficient, or that they can provide assurance that cultural differences can be taken into account. The review also found HBSS workforce issues; low wages, casual employment conditions with poor guarantee of work hours and income, high staff turnover (up to 40% per annum), and poor training provision.

There are currently a number of sources of information on quality of service delivery including reporting on contracts, compliance with standards, audits, and client complaints systems. However, these provide only limited information for assuring quality.

Measurement of quality can look at the quality of the inputs (e.g. proportion of support workers with training), quantity of inputs (e.g. number of hours delivered), processes (e.g. reviews up to date), intermediate outcomes (e.g. proportion requiring reduced support), or final outcomes (e.g. hospitalisation). Under the proposed new model of care, HCSS providers will use InterRai assessments. This will provide the opportunity for better information for quality and for comparing results between organisations and DHBs.

Some DHBs have also changed the way they work with HCSS providers as part of changing to a new model of care. They form co-operative groups or ‘alliances’ with the providers and address issues of quality together. This can lead to the development of mutually beneficial solutions and improve the sharing of information between HCSS providers and the DHB. Providers may also assist each other through this shared problem-solving and learning approach.

The Auditor-General also noted that as older people’s care becomes more complex, the skill level of support workers needs to increase. Providers told the Auditor-General that they cannot increase skill levels due to current funding arrangements.
DHBs that have moved to case-mix systems aim to improve the quality of the workforce. Restorative care models require a workforce that has some higher levels of training and socialisation in the model. In addition the flexibility of case-mix funding is felt to provide an opportunity for HBSS providers to invest in their workforce and to use them more efficiently. It is reported that support workers are more likely to be given permanent contracts and provided training, and staff-turnover may be lower.

In other areas of NZ that have already moved to a restorative model of care, they have found that support worker satisfaction improves, staff turnover is lower and attendance at training sessions improves. Also, the new Standards for HCSS requires 75% of workers will need to have completed level 2 training.

Under the proposed case-mix system there is a greater opportunity to measure the quality of services provided. Outcomes that could be measured include; the proportion of clients that subsequently require no further support or reduced levels of support; and proportion of clients that are admitted to hospital for unplanned admissions. Broad outcome and quality reporting systems would need to be developed with the providers that are selected to provide the new model of care.

6.6. Proposal 6 - Option of Individualised Funding

Some disabled people, particularly those with chronic health conditions would like to have greater control and flexibility over what support services they receive and when. Often these people have unique circumstances that are not well catered for by a DHB contracted HBSS provider.

Disability Support Services, funded by the MOH have developed a model of care called Individualised Funding where the client purchases the supports and services they need.

The client is assessed and allocated services in the same way as other clients by NASC. However, instead of receiving services from a HBSS provider, they receive money from the MOH/DHB to purchase the services they need themselves.

Individualised Funding gives people more choice, control and flexibility over how, when and who provides their supports. Clients that receive Individualised Funding accept responsibility for managing their funding and being accountable for the employment of their support workers. If the DHB went ahead with this option we would contract with an organisation that can support Individualised Funding clients. This organisation would assist the client with administering the funding, such as; budgeting, recruiting support workers, employment agreements, managing payments and other legal requirements.

Individualised Funding is not for everyone and the number of people that use this option are likely to be small. However, it can be a useful option for people that
would like to have greater control over their care and find that their particular needs are not well catered for by HBSS providers.

The allocated package of care and funding is the same whether a client chooses a HCSS provider or Individualised Funding. Therefore, Individualised Funding is neither more expensive nor cheaper than the cost of HCSS.

7. How to Provide Feedback

The purpose of this document is to consult with the Waitemata district community on whether the changes proposed are supported as the best way forward.

Waitemata District Health Board is seeking feedback to: ensure that the proposed changes enhance service provision; help inform any subsequent implementation plans; and minimise unintended consequences.

To provide feedback please visit our website www.waitematadhb.govt.nz and complete the feedback form online using survey monkey, or print out of the feedback form and post the completed form to:

Imelda Quilty-King,
Community Engagement Coordinator
Waitemata DHB
Private Bag 93-503
North Shore 0740

A hard copy of the form can also be requested by contacting Imelda Quilty-King, Community Engagement Coordinator, Waitemata DHB, on mobile: 0212236099 or by email: hbssconsultation@waitematadhb.govt.nz

The deadline for submissions is 5pm, Monday, June 24, 2013

Waitemata DHB recognises that proposals such as this can cause anxiety or stress for people. The DHB will ensure a fair and transparent process is undertaken and people are treated with respect.

Please contact: Imelda Quilty-King, Community Engagement Coordinator, Waitemata DHB (email: hbssconsultation@waitematadhb.govt.nz or mobile: 0212236099) if you have any queries on this proposal.
8. Proposed Timeframes

The timeframes for the consultation process are below:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Timeframe</th>
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</thead>
<tbody>
<tr>
<td>Public Announcement of Consultation</td>
<td>May 27, 2013</td>
</tr>
<tr>
<td>Consultation phase</td>
<td>May 27, 2013 to June 24, 2013</td>
</tr>
<tr>
<td>Written Feedback Closes</td>
<td>June 24, 2013</td>
</tr>
<tr>
<td>Summary of feedback presented to WDHB Board</td>
<td>July 24, 2013</td>
</tr>
<tr>
<td>Summary of feedback presented to key stakeholders</td>
<td>August 2, 2013</td>
</tr>
<tr>
<td>Summary of feedback available on website</td>
<td>August 9, 2013</td>
</tr>
<tr>
<td>Final recommendations presented to the Board</td>
<td>September 2013</td>
</tr>
</tbody>
</table>
Appendix 1 – Proposed Care Referral and Assessment Process

Multiple Referral Sources

- Primary Care
- Hospital Staff
- District Nurses
- Self referrals

Home and Older Adult Triage System

Referral Screening and Triage

Clients with ‘Non-Complex’ needs
- Assessment undertaken by Care Manager employed by HCSS Provider
- Client driven goal based care plan to support health, wellbeing and independence
- HCSS Care Manager

Clients with ‘Complex’ needs
- Assessment undertaken by NASC employed by WDHB Home and Older Adult Services
- Client driven goal based care plan to support health, wellbeing and independence
- NASC Needs Assessor

- InteRai Assessment Tool
- Plan of Care

Key Contact
References


7.1.2 Feedback Survey Question
Welcome to Waitemata DHB Home Based Support Services (HBSS) consultation.

Waitemata DHB is extending an opportunity to the community to provide feedback on the proposed Model of Care for Home Based Support Services.

The proposed changes are contained in the document called Waitemata DHB Home Based Support Services Proposal for Change available on the website www.waitematadhb.govt.nz

Please complete the following survey:

1. The DHB's aims of the proposed changes to HBSS are listed in section 5 in the Proposal for Change. Do you support these?
   
   [ ] Yes  [ ] No  [ ] Unsure

   Any comments?

2. Waitemata DHB proposes moving to a restorative and goal-based approach to HBSS as described in section 6.1 in the Proposal for Change. Do you support this?
   
   [ ] Yes  [ ] No  [ ] Unsure

   Any comments?

3. Waitemata DHB proposes moving to a Case-mix model of funding for HBSS as described in section 6.2 in the Proposal for Change. Do you support this?
   
   [ ] Yes  [ ] No  [ ] Unsure

   Any comments?
4. Waitemata DHB proposes that HBSS will have better integration with general practices, hospital services, WDHB community services and local communities as described in section 6.3 in the Proposal for Change. Do you support this?

☐ Yes  ☐ No  ☐ Unsure

Any comments?

5. Waitemata DHB proposes to prioritise services for clients who have higher needs and are at greater risk of poor health and safety described in section 6.4 in the Proposal for Change? Do you support this?

☐ Yes  ☐ No  ☐ Unsure

Any comments?

6. Waitemata DHB proposes to develop a quality approach to HBSS and focus on improving the quality of services clients receive as described in section 6.5 in the Proposal for Change. Do you support this?

☐ Yes  ☐ No  ☐ Unsure

Any comments?

7. Waitemata DHB proposes that clients requiring HBSS are given the option of Individualised Funding as described in section 6.6 in the Proposal for Change. Do you support this?

☐ Yes  ☐ No  ☐ Unsure

Any comments?
8. Do you have any other suggestions that you think could be important to consider in the redesign of HBSS?

9. Are you responding to this survey as a:

☐ HBSS Provider or staff member
☐ Waitemata DHB staff member
☐ Other health service provider or staff
☐ Are you currently receiving home-based services
☐ Are you a family member
☐ Other

Please post this survey to:

Imelda Quilty-King
Community Engagement Coordinator
Waitemata DHB
Private Bag 93-503
North Shore 0740

You can also scan the completed survey and email it to hbssconsultation@waitematadhb.govt.nz

Feedback needs to be received by the DHB by **5 PM on 24 June 2013**

Thank you for providing us with your feedback

If you would like to receive a copy of the Outcome of this consultation please enter your NAME, POSTAL ADDRESS or EMAIL.

Waitemata DHB will use your details for the purposes of this consultation only and will not share them with any other party unless required to do so by law.

Name: ________________________________
Postal address: ________________________________
City/Town: ________________________________
Postal Code: ________________________________
Email Address: ________________________________
7.2 Northern Regional Health Plan (NRHP) Health of Older People Workstream Update
Date 5 June 2013
To Combined Disability Support Advisory Committee (DSAC) for ADHB and WDHB
From Tim Wood, Group Manager – Planning & Funding, WDHB
Denis Jury, Chief Planning and Funding Officer, ADHB
Author Dr Alan Davis, Clinical Lead & Chris Pegg, Programme Manager - Health of Older People / Stroke, Northern Regional Alliance Limited (formerly NDSA)
Subject Northern Region Health Plan (NRHP) Health of Older People Workstream Update

Purpose
The purpose of this paper is to provide an update to the combined DSAC on the progress of the Northern Region Health of Older People (HOP) Programme and proposed plan for 2013/14.

Progress To Date
Year to date, the 2012/13 Implementation Plan for HOP is on target for Quarters 1-3.

The Ministry of Health assessment of the Quarter 3 Progress Report resulted in “achieved”, together with the following comments:

- **HOP**: Thank you for your report. We note that two of your DHBs are preparing to pilot their dementia pathway. We are pleased to note that engagement on the falls and pressure injuries work continues to increase. We would appreciate learning how your progress towards or target of a 20% reduction is going, in the next quarter. Will you also have data on the proportion of ARRC facilities that will have implemented a falls reduction programme? We are pleased to note the successful roll-out of the Transfer of Clinical Information project.

**Key Deliverables achieved for the first nine months of 2012/13**

1. Progress with Dementia has accelerated this year:
   - A Dementia Services Guidelines document has been drafted for the Northern Region and is currently before a consumer group prior to being finalised and published.
   - Two DHBs are preparing to pilot their Dementia Pathways while the other two DHBs are at slightly earlier stages of developing their models of care
   - The Northern Region Dementia Forum (in conjunction with the MOH) in April was well attended with cross-sector participation.

2. Engagement by the ARRC sector on falls and pressure injuries reductions, continues to increase with approximately 60% voluntarily participating in training and workshops.
   - Monthly reporting of falls and pressure injury data is now being submitted by ARRC.
   - The workshops and training sessions run by First, Do No Harm continue to be well attended.

3. The roll-out of the Transfer of Clinical Information (aka “Yellow Envelope”) was successfully rolled out on the 18 March. The standardised process was achieved through a lot of goodwill, negotiation and teamwork over the four DHBs and ARRC providers. It should be noted that this initiative was achieved 3 months earlier than scheduled.

4. The number of Advanced Care Planning conversations with people 65+ continues to track well ahead of the annual target.

5. Dr Alan Davis took up the role of Clinical Lead in October (previously there had been a vacancy of six
6. Consumer participation has been carried over to July. There has been a shift in philosophy, away from a standalone consumer group, to now having direct representation on the HOP Clinical Network Group. Simultaneously, discussion is about to occur with the Maori Health Gain Team for Waitemata and Auckland, around Kaumatua representation.

Focus for 2013/14

The HOP regional plan has been slightly revised and consolidated to focus on the following five key areas:

1. Cognitive Impairment
   - Continue to develop and roll-out Dementia Care Pathways
   - Agree consistent driving assessment process
   - Organise annual Dementia Forum
2. Quality & Safety
   - Further progress falls & pressure injury reduction strategies and increase ARRC participation.
   - Ensure there are consistent Delirium assessments within acute hospital
3. Medication Management
   - Review Atlas of Variation results for older people
   - Evaluate after hours medication processes in ARRC
4. Acute/Potentially Avoidable Hospitalisation
   - Measure effectiveness of Transfer of Clinical Information between DHB/ARRC
   - Appraise management of specialized beds eg Pyshco Geriatric Beds
   - Encourage Influenza Vaccination uptake for ARRC staff
   - Inform regional rehabilitation project
5. InterRAI
   - Establish regional governance group
   - Support ARRC / DHBs to increase uptake of interRAI

Appended overleaf, is the Driver Diagram which depicts the plan for next year.

Patient Outcome Measures to be reported on a regional basis are:

- All DHBs will implement a dementia pathway
- 20% reduction in falls causing major harm in those ARRC facilities that have implemented a programme.
- 75% of ARRC facilities will have implemented a falls reduction programme
- 20% reduction in pressure injuries in those ARRC facilities that have implemented a programme
- Reduction in patients >75 years readmitted to hospital within 28 days
- 32% of ARRC providers will be participating in the roll-out of interRAI
- 40% of clients receiving long term Home Based Support Services have an interRAI clinical assessment within the previous 12 months

Please note: the first draft of the HOP submitted to the MOH in March has been assessed as “supported”. This means the Northern Region provided the strategic and implementation focus required, and there is alignment between the regional plan and DHB Annual Plans. The final version is being submitted to the MOH for Ministerial on 24 May.

Appendices

Health of Older People Driver Diagram April 2013
IMPROVEMENT ACTIVITIES

8.1 Quarterly Report on the Implementation of the NZ Disability Strategy
   8.1.1 Disability Strategy Workshop
   8.1.2 Current Status at 1 June 2013

8.2 Quarterly Report on Activities
8.1 Quarterly Report on the Implementation of the NZ Disability Strategy
Date 5 June 2013

To Auckland and Waitemata DHB - DiSAC Committee

From Debbie Holdsworth, Chief Planning & Funding Officer, WDHB
Denis Jury, Chief Planning & Funding Officer, ADHB

Author Samantha Dalwood, Disability Strategy Coordinator, WDHB

Functional Group Auckland and Waitemata DHB Funding and Planning Managers

Subject DISAC Update Report on the implementation of the NZ Disability Strategy in Auckland & Waitemata DHBs

Purpose

The purpose of this report is to provide an update to DiSAC on the progress and activities occurring across both DHB’s to implement the NZ Disability Strategy. Material is provided across both Boards where appropriate, and for specific Boards as outlined.

Recommendation:

That the report be received by DiSAC.

NZ Disability Strategy Implementation Plan 2010-2013

The joint WDHB/ADHB Implementation Plan status report is attached in Appendix I.

2013-2016 DHB Disability Strategy Implementation Plan

52 people attended this event on 2 April. As well as staff from the two DHBs, there were also people from Auckland Council, Deaf Aotearoa, Foundation for the Blind, CCS Disability Action, Human Rights Commission, Health & Disability Commission, IDEA Services and People First.

There has been some great feedback from the morning. For example, from the Health & Disability Commission;

‘I must say that I was really impressed with the way the session was handled - with such a large group of people, it is easy to get off track or to have one group monopolise/take over the discussions - so it was fantastic planning on your part. Due to the people who attended, the focus, the energy and the inspiration from all the people in the room really led to great discussions, and this will no doubt be a key point in the future of the DHB.’

Attendees also really liked the graphic facilitation of the meeting, particularly the group of Deaf people. I have attached some of the workshop charts. The drawings are a really accessible and interesting way of presenting information.

The overarching visions from the workshop are:

- Everyone Matters
- Equity
- Inclusion
- Valued
The five work streams that came from the workshop are:

- Communication and Information
- Buildings and Access
- Staff Attitude and Responsiveness to disabled people
- Engaging with disabled people and getting their input
- Employment of disabled staff

A draft Implementation Plan is being developed and this will go out to the people attending the workshop for feedback. The plan will incorporate the recommendations from the 2011 report done for ADHB, the Disability section of the 2012-12 ADHB Annual Plan and the current Disability Strategy Implementation Plan. The draft will also be circulated internally for comment.

### Accessible Car Parking

Members of the Committee met at North Shore Hospital on Wednesday 20 March 2013 to look at the accessible parking. The group agreed there are some changes that can be made quite easily and will improve the accessible journey for disabled people from the car park to the hospital entrances. Facilities have been informed of the Committee Member’s recommendations and the changes will be made in the next couple of months.

### Accessible Communication

The Disability Strategy Coordinator is currently writing guidelines for Accessible Communication to go across both DHBs. These will include making written information, such as leaflets and brochures more accessible, but also information on the websites.

Feedback from the planning workshop was that information is not always available in different formats. Feedback from the Association of Blind Citizens was that forms and other information could be available on the website so that it could be read before the person arrived at hospital.

An excellent example of accessible communication has been the WDHB Bowel Screening project. Elizabeth Brown, the Community Coordinator for the project, liaised with Deaf Aotearoa and the Association of Blind Citizens, as well as many other community groups, to make sure that the information is available in many formats and is as accessible as possible.

Work is starting with Communications Departments at both DHBs to improve their websites and make information more accessible to everyone.

### Counties Manukau DHB DiSAC

The Disability Strategy Coordinator was invited to Counties Manukau DHB April DiSAC to talk about the work that we are doing across Auckland and Waitemata DHBs.

They are particularly interested in the Disability Awareness e-learning, the Implementation Plan for 2013-16 and the implementation of the Health Passport. A member of their DiSAC committee attended the Planning Workshop and was very interested in the work that is being planned.

### Appendix I: Joint WDHB/ADHB Disability Strategy Implementation Plan progress report.

### Appendix II: Implementation Planning Workshop Charts
8.1.1 Disability Strategy Workshop
WELCOME

DISABILITY STRATEGY WORKSHOP

Waitemata District Health Board

Auckland DHB
PLANNING QUESTIONS

1. Where are we NOW?

2. What's going on AROUND us that we need to take into account?

3. What will it LOOK LIKE when we get it right?

4. How will we GET THERE?
Our Vision...

People are empowered
\[\text{control over condition & care}\]

People feel valued in their work & there are no barriers to personal improvement

People feel lucky to live in NZ!

2013

Accessible communication
- it is clearly understood what this means

There is clear wayfinding

People know a visit to hospital is barrier free

2016

There is a culture of accessibility & inclusion

Everyone matters
- included
- supported
- understood

Plain language information is shared with the patient

Staff are aware of the needs of people with intellectual disabilities & their families

There is informed consent

They understand

There is a process for people to ask follow up questions & to receive answers in preferred format
8.1.2 Current Status at 1 June 2013
Waitemata DHB & Auckland DHB
Implementation of the New Zealand Disability Strategy 2010-13
Current Status at 1 June 2013
## Disability Awareness: Educating staff and challenging stereotypes & assumptions

### Current Status at 1 June 2013

<table>
<thead>
<tr>
<th>What we will do… actions</th>
<th>Who will work on this… Partners / Collaborators</th>
<th>When will actions take place… in what order</th>
<th>What is the current status?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide a range of disability awareness training, targeting specific services.</td>
<td>Head of Departments GMs and key leaders DiSAC Committee Learning &amp; Development</td>
<td>Ongoing</td>
<td></td>
</tr>
</tbody>
</table>

- **COMPLETED** Collaborative work with Northland DHB to develop a Disability Awareness e-learning module. The training went live on 19 Sept 2011.
- August 2012 – ADHB to start using the training as part of staff orientation.
- November 2012 – The fifth training scenario - working with people with high/complex needs- has been completed and added to the Disability Awareness e-learning training.

<table>
<thead>
<tr>
<th>What we will do… actions</th>
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<th>When will actions take place… in what order</th>
<th>What is the current status?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Write article for Healthlines on Disability Coordinator role.</td>
<td>Communications</td>
<td>Q1 2010/2011</td>
<td><strong>COMPLETED</strong> June 2013 – article in ESC newsletter about benefits of engaging Disability Advisor role in DHB projects.</td>
</tr>
</tbody>
</table>

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</thead>
<tbody>
<tr>
<td>Target team meetings to introduce Disability Coordinator role.</td>
<td>Head of Departments GMs and key leaders</td>
<td>Ongoing</td>
<td>Taking the Health Passport to Team Meetings.</td>
</tr>
</tbody>
</table>

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</thead>
<tbody>
<tr>
<td>Develop clearer policies and procedures for working with patients with disabilities.</td>
<td>Quality Community Organisations</td>
<td>Q1-Q4 2010-2012</td>
<td>November 2012 – draft report will be brought to DiSAC once completed.</td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td>Develop ‘Disability Champions’ across WDHB and ADHB.</td>
<td>GMs Operations Managers Charge Nurse Managers</td>
<td>Q1-Q4 2010-2012</td>
<td></td>
</tr>
<tr>
<td><strong>What</strong> we will do... actions</td>
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</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------</td>
<td>---------------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Review current Mobility/accessible car parking.</td>
<td>Traffic Services Facilities Dept Communications Dept</td>
<td>By Q4 2010/2011 Ongoing</td>
<td>May 2013 – Mobility parking spaces moved closer to main entrances at Waitakere and North Shore Hospitals to improve patient journey.</td>
</tr>
<tr>
<td>Increase knowledge of Mobility/accessible parking by security staff.</td>
<td>Traffic Services</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Create maps of accessible car parking. Include maps in appointment letters and have them available on website.</td>
<td>Traffic Services Communications Dept Outpatient Departments</td>
<td>Ongoing</td>
<td>COMPLETED Nov 2011 – new site maps have been completed. New information to be included with Outpatient appointment letters.</td>
</tr>
<tr>
<td>Walk through ‘patient journey’ to look at accessibility issues.</td>
<td>Community Groups - IHC, Age Concern, Foundation for the Blind, Facilities Department</td>
<td>From Q1 – Q4 2010-2012</td>
<td>ADHB accessibility report has raised issues that go across both DHBs. November 2012 – External signage and way finding audit has been completed. Recommendations being presented next month. November 2012 – Introduction of coloured dots on the floor of ED/ADU to improve way finding.</td>
</tr>
<tr>
<td>Complete barrier free audits of all leased buildings.</td>
<td>Barrier Free Advisor Facilities Department</td>
<td>From Q1 – Q4 2010-2012</td>
<td>Oct 2011 – Disability Strategy Coordinator has completed the 2-day Barrier Free training.</td>
</tr>
<tr>
<td>Develop accessibility audit policy and process for all new facilities.</td>
<td>GM Facilities Facilities Team</td>
<td>By Q4 2010-2012</td>
<td>March 2013 – The WDHB Standardisation Guidelines for all new buildings include Barrier Free recommendations.</td>
</tr>
<tr>
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</tr>
<tr>
<td>Ensure public waiting areas, wards and treatment areas meet the needs of a range of impairments, including autistic spectrum disorders.</td>
<td>Facilities Team Outpatients Team</td>
<td>Ongoing</td>
<td>Nov 2011 – it is now standard that the Disability Strategy Coordinator and the Consumer Engagement Coordinator are included in facilities planning.</td>
</tr>
<tr>
<td>The Disability Reference Group will work to raise and improve access issues.</td>
<td>Disability Reference Group</td>
<td>Ongoing</td>
<td>March 2012 – Community Engagement Coordinators from both DHBs are working together to develop a community engagement joint strategy. The Disability Strategy Coordinator is linked into this work.</td>
</tr>
</tbody>
</table>
### Communication and Access to Information

**Empowering people through knowledge and understanding**

**Current progress at 1 June 2013**

<table>
<thead>
<tr>
<th>What we will do... actions</th>
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<th>When will actions take place... in what order</th>
<th>What is the current status?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure WDHB/ADHB website is accessible – both internet and intranet.</td>
<td>Communications Team</td>
<td>Ongoing</td>
<td>June 2013 – work to start with Communications Managers to look at both websites and web content and improve accessibility and information.</td>
</tr>
<tr>
<td>Ensure patient information is in plain language with clear layout and good visuals.</td>
<td>Communications Team Waitakere Health links &amp; Health Link North Literacy Reference Group</td>
<td>Ongoing</td>
<td>May 2013 – Health Links North and their Health Literacy group have been reviewing patient information for the new Elective Surgery Centre. Also reviewing the patient DVD.</td>
</tr>
<tr>
<td>Increase formats of key documents, e.g. District Strategic Plan.</td>
<td>Communications Team</td>
<td>Ongoing</td>
<td>March 2013 – developing guidelines for Communications Team on how to make communications more accessible and inclusive to all.</td>
</tr>
<tr>
<td><strong>What</strong> we will do... actions</td>
<td><strong>Who</strong> will work on this... Partners / Collaborators</td>
<td><strong>When</strong> will actions take place... in what order</td>
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</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Set up Disability Reference Group.</td>
<td>-Waitakere &amp; Rodney Health links &amp; North Shore Community Health Voice. -Community Engagement Team. -General Managers. -Quality Team. -Community Groups working with traditionally ‘silent’ groups, eg. People with intellectual disabilities, people with Alzheimer’s disease.</td>
<td>Ongoing</td>
<td>May 2013 – Ongoing work to make sure that people with disabilities are being included in all areas of planning and development across both DHBs.</td>
</tr>
<tr>
<td>Ensure people with disabilities are identified as stakeholders in planning projects.</td>
<td>General Managers DISAC and Board members (to request reports)</td>
<td>Ongoing</td>
<td>See above.</td>
</tr>
<tr>
<td>Improve the complaints process and make it more transparent.</td>
<td>Quality Team</td>
<td></td>
<td>COMPLETED There is a dedicated person in the Quality Team to respond to complaints. The whole complaints process is being reviewed and the aim is to make a clearer, more transparent process accessible to all.</td>
</tr>
<tr>
<td>Develop group of self-advocates with intellectual disabilities.</td>
<td>IHC –Self Advocacy Team &amp; Health Advisor. Spectrum Care People First.</td>
<td>Ongoing</td>
<td>May 2013 – working with the IHC National Self Advocacy Coordinator to get feedback from people with learning/intellectual disabilities of their experiences in healthcare.</td>
</tr>
</tbody>
</table>
## Employment Opportunities

Providing employment opportunities for people with impairments and carers

### Current Progress at 1 June 2013

<table>
<thead>
<tr>
<th>What we will do... actions</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Review all recruitment and employment policies and make recommendations as required.</td>
<td>HR Group Manager Recruitment Manager Workforce Planning</td>
<td>Q1-Q4 2010-2011</td>
<td>COMPLETED - Reviewed and rewritten the 2006 “HR Guide for Recruitment and Retention of People with Impairments” with HR. Involved in review of HR policies.</td>
</tr>
<tr>
<td>Review support given to Hiring Managers during the recruitment process.</td>
<td>HR Group Manager Recruitment Manager Occupational Health General Managers</td>
<td>Q1-Q4 2010-2011</td>
<td>COMPLETED - Working with HR to review the ‘Impairments at Work’ Policy.</td>
</tr>
<tr>
<td>Encourage the use of ‘Mainstream’ and other supported employment agencies.</td>
<td>HR Group Manager Recruitment Manager Workforce Planning Hiring Managers</td>
<td>Ongoing</td>
<td>August 2012 – ADHB have employed two staff members through the Mainstream programme.</td>
</tr>
<tr>
<td>Review the process for the recruitment of staff with disabilities.</td>
<td>Occupational Health HR Group Manager Recruitment Manager Hiring Managers</td>
<td>Q1-Q4 2010-2011</td>
<td>COMPLETED - Have reviewed the process. Met with Occupational Health to discuss their role. There is work to be done to support Hiring Managers, but centralised budgets are very positive.</td>
</tr>
<tr>
<td>Collect data on the number of staff with disabilities (at the time of employment and/or when a disability is acquired).</td>
<td>HR Group Manager Workforce Planning GM, Decision Support Systems</td>
<td>Ongoing</td>
<td>May 2012 – Working with the Workforce Development Manager to look at how data can be recorded and updated to reflect the number of staff who identify as having a disability are employed by WDHB.</td>
</tr>
</tbody>
</table>
8.2 Quarterly Report on Activities
Date | 5 June 2013
--- | ---
To | Auckland and Waitemata DHB - DiSAC Committee
From | Tim Wood, Funding and Planning Manager, Denis Jury, Chief Planning and Funding Officer
Author | Katrina Lenzie-Smith, Health of Older People, Programme Manager, Waitemata DHB 
Kate Sladden, Health of Older People, Programme Manager, Auckland DHB
Functional Group | Auckland and Waitemata DHB Funding and Planning Managers
Subject | DISAC Quarterly Report on activities in Auckland & Waitemata DHBs

**Purpose**
The purpose of this report is to provide an update to DISAC on the progress and activities occurring across both DHBs. Material is provided across both Boards where appropriate, and for specific Boards as outlined.

**Recommendation:**
That this report is received by DISAC.

**Background**
Health of Older People (HoP) services are directed by the Minister of Health, the 2012/13 Northern Region Health Plan, (NRHP), Waitemata DHB and Auckland DHB Annual Plans, and the Māori Health Plan. We are currently working on the 2013/14 Annual Plans to ensure that we address the key challenges of the over 65 age group. This includes planning for growth in demand for dementia and acute services; strengthening coordination and delivery of whole of system care by enhancing cooperation with primary, community and ARRC sectors, and providing informed choice for older people in their care to minimise dependence.

**The Northern Region Health Plan (NRHP)**
Key performance measures are intended to demonstrate that services better meet the needs of older people while managing growth, this is presented in a separate paper to DISAC.

**Māori Health Plan**
A Kaumātua Hauora Strategy is currently being developed.
Home and Community Sector Services (HCSS)

Auckland DHB
Good progress has been made on developing a Balanced Scorecard for HCSS with measures in the following domains: client perspective; financial perspective; learning and growth perspective; business process (internal) perspective. The Balanced Scorecard will be implemented in July 2013.

There has been discussion with the HCSS community providers on working with the DHB around early discharge of patients and reducing the acute bed pressure at Auckland City Hospital. The providers have developed a proposal of services they could offer.

Waitemata DHB
Following the review of home based support services the HBSS Steering Group recommended some proposed changes to the model of care. The proposed changes are now being consulted on with stakeholder and the community, these are presented in a separate paper to DISAC.

Specialist Services for Health of Older People at Auckland DHB
A project manager has been employed for the Dementia Care Pathway, the Governance Group is established and the subject matter expert working group has had its first meeting. A decision has been made to use a co-design approach for the development of the pathway and the process for this is currently being scoped working alongside experts in co-design.

Specialist Services for Older Adults at Waitemata DHB
Progress with the integration under the five work streams continues with the following providing an update since the last report.

Some of the 5 subprojects have now progressed into business-as-usual.

a) Delirium
The subproject is aiming to complete the developments from its four work-streams and to integrate those into business-as-usual status early in 2013/2014:
   a. Assessing Risk and Making a diagnosis
   b. Minimising Confusion (Cognitive interventions)
   c. Modifiable Risk Factors (Physiological interventions)
   d. Medication management

b) Facilities
The remedial work in Ward 12 will be completed in 2013. The Senior Management Team resolved that as a result of withdrawal of national capital funding and the limited capital funding within the DHB the plans for some ‘new buildings’ for older adult services will not proceed at this time. The decanting planning work undertaken to date will be closed off, and used to inform longer term planning.

Work on the models of care for rehabilitation and the refurbishment of Ward 12, will continue. These will be managed as part of business-as-usual.

c) Clinical Educator
The training programme is well underway and is now classed as business-as-usual.

d) Single Point of Entry
The streamlined referral process and triage process at North Shore Hospital and Waitakere Hospital sites have been in place since early March 2013 and are proving effective. This subproject is on track to move into business-as-usual from 1 July 2013.

e) Dementia
The Dementia Subproject will retain project status for 2013/2014 as it is at the critical stage of finalising the Waitemata DHB Cognitive Impairment Clinical Pathway. It will be piloted with 12 GPs (6 per PHO) and 60 patients from 1 October 2013 – 30 June 2014. The pilot will be evaluated to inform rollout across
The DHB’s 300 GPs during the following 2 years.

- The SSOA Clinical Reference Group has confirmed the primary care ‘sections’ of the pathway. The focus is now turning to confirmation of the pathway ‘sections’ involving secondary care: Gerontology Nurse Specialists (GNS), Geriatricians, Mental Health Services Older Adults; and the Tertiary Memory Service.
- Auckland University, Freemasons Dept of Geriatric Medicine are currently developing the evaluation plan for the ‘pathway pilot’.
- Recruitment of the 12 pilot GPs and their teams will be undertaken soon by the 2 PHOs and a pre-pilot training programme will follow utilising primary and secondary care clinicians.

ARRC at Waitemata DHB

Over the last quarter, the 58 ARRC facilities have had the opportunity to meet in two forums (the quality forum for managers and owners) and the Residential Aged Care Integration Programme (RACIP) work group. The purpose of these meetings is to network, inform and develop clinical guidelines. These meeting also interface with the NRHP and Waitemata DHB Annual Plan.

One example is the falls and pressure injuries targets with the First Do No Harm (FDNH) team. Local ARRC facilities agreed in principle through the forums to send data on falls and pressure injuries in return for information on how they compare in anonymised data across the region. FDNH are offering training days on models of improvement. The GNSs are available to support facilities to implement planned changes to reduce falls and pressure injuries. Data collection will be through the RACIP programme however there is no facility collating data at this stage.

Current projects of RACIP Work Group include:
1. A pamphlet for families of people with advanced dementia living in ARRC is now available on www.wdhb-agedcare.co.nz website
2. A booklet for families of people with advanced dementia living in ARRC is being developed. The aim of this booklet is to inform families about the final stages of dementia, Advanced Care Planning, appropriate and inappropriate interventions. The booklet has been sent to experts in the field for clinical review.

Vaccinator Training Courses

Eighteen Registered Nurses (RN) participated in a flexible Learning Vaccinator training course for RNs working in ARRC facilities coordinated between Waitemata DHB and the Immunisation Advisory Centre. This is the first ‘adult only’ vaccinator course that has been offered to ARRC providers in the Waitemata district.

On the 22nd April RNs from ARRC facilities were welcomed to Waitemata DHB for the course run by the Immunisation Education Facilitator. The practical assessments were completed with the cooperation of the Aria ARRC provider group who made two venues available for the nurses to vaccinate residents. Initial feedback on the course has been very positive, as such, this will be utilised in 2013/14 planning.

The aim of the training is to maximise the number of residents and staff that can have ready access to influenza vaccination prior to the flu season each year. Whilst the efficacy of the vaccine is less for older adults it has been shown to reduce the severity of the illness, reduce hospitalisations and death related to influenza. The World Health Organisation recommends that all healthcare workers working with older adults in residential aged care are vaccinated. The vaccination has greater efficacy amongst younger people and staff are less likely to bring the influenza virus into the workplace if they have been vaccinated.

ARRC at Auckland DHB

There have been two forums for ARRC providers over the last quarter:
- A study day was attended by 122 ARRC health care assistants. Topics covered were: infection control; pressure area causes; fracture neck of femurs; and documentation.
- A forum was attended by 41 ARRC managers. Topics on the programme included the Yellow
Envelope, interRAI, data reporting for falls and pressure injuries, IV Access in ARRC pilot, dementia care pathway and discussion around opportunities for additional services in ARRC.

The ADHB Quality Care for Older People website was launched for ARRC facilities to record their data on falls and pressure injuries as well as for sharing ideas, resources and providing practical support. This website is an updated version of the SOAR website that was previously used but has been simplified and revised so that is set in the New Zealand context rather than being based on the Australian audit system.

**Vaccinator Training Courses**

Eleven Registered Nurses from ARRC have undertaken the flexible Learning Vaccinator training delivered by the Immunisation Advisory Centre (as in WDHB); this was a combined course with Counties Manukau DHB. The RNs have completed the training and are waiting to undertake their practical assessment. Feedback will be sought from ARRC providers on this approach and will be utilised in planning for 2013/14.

**Warm up Waitemata DHB**

This programme offers free insulation to low incomes families across the district. Since Warm Up-Waitemata commenced in February 2012, the programme has received referrals from 906 households, comprising 249 children (under the age of 2 years), 562 children (under the age of 14 years) and 672 adults over the age of 65 years. As of 6 May 2013, a total of 515 low income homes have been insulated. The ethnicity of the households have been described as: (8%) Pacific, (10%) Asian, (15%) Māori and, 67% European.

Referrals distributed across Waitemata DHB were as follows:
- 45% from West Auckland
- 24% from the Rodney District
- 31% from the North Shore

The future of this programme is uncertain for financial year 2013/14.

**Long-term Supports for Chronic Health Conditions (LTS CHC)**

Devolution of LTS CHC from the Ministry to regions was completed in Q1 2011. The Northern Region has put in place arrangements regionally to oversee and report on LTS CHC.

Key achievements in the Quarter 3 2012/13 include:
- An LTS CHC client model of care has been drafted. This will set standards for clients to have agreed clinical outcomes, corresponding service coordination and planned clinical follow-up and review. The following support services will be developed under the model of care;
  - Rehabilitation
  - Mental health
  - Dementia
  - Children
  - Age generational appropriate service options
- Ongoing work to establish regionally consistent assessments, standard tools and regionally practiced principals and policies includes:
  - Bimonthly LTS CHC Regional Review Panel meeting to review and monitor clients over $80k. 8 clients over $80k pa were reviewed and monitored by Panel in Q3.
  - Monthly meeting with Taikura Trust to discuss clients with unclear eligibility and joint funding opportunities.
  - Peer review with Midland region is being conducted to compare assessment outcomes and service utilisation.
- A review has been initiated for a potential regional review of InterRAI reports to profile client base and utilisation.

- Ongoing enhancement of provider contracts includes;
  - The new Individually Funded (IF) contract that was raised by CMDHB to provide greater flexibility for the very complex high end clients has been engaged by its first client whose needs were raised in a Ministerial as not being adequately met under other current contracts. Other clients whose needs would also be better met under an IF contract are also reviewing the contract for their use.
  - An updated terms and conditions section for residential care contracts has been prepared and can be rolled out with the contract roll-over process.

- Service development work continues to progress with a focus on understanding specific client detail to better identify service gaps.

- Work has been initiated to also better understand what services are currently or could be available in the community to develop a procurement strategy for service gaps identified now and for out years.

- The MoH is considering a proposal submitted by the region to dis-establish the LTS CHC national reviewer role on 30 June 2013, but in its place have a National Resolutions Panel established by 1 July 2013.
9

CONFIRMATION

9.1 Action Points for next DSAC Meeting

9.2 DSAC Feedback to Board
AUCKLAND and WAITEMATA DISTRICT HEALTH BOARD
DISABILITY SUPPORT ADVISORY COMMITTEE

MEETING DETAILS

<table>
<thead>
<tr>
<th>Item</th>
<th>Page No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introductions</td>
<td>001</td>
</tr>
<tr>
<td>2. Attendance and Apologies</td>
<td>003</td>
</tr>
<tr>
<td>3. Conflicts of Interest</td>
<td>005</td>
</tr>
<tr>
<td>4. Confirmation of Minutes 13 March 2013</td>
<td>013</td>
</tr>
<tr>
<td>5. Action Points 13 March 2013</td>
<td>021</td>
</tr>
<tr>
<td>6. Chairpersons’ Report</td>
<td>025</td>
</tr>
<tr>
<td>6.1 Health Passport</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>1:15pm</td>
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<tr>
<td>7.1</td>
<td>Waitemata DHB Home Based Support Services Proposal for Change</td>
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<tr>
<td>7.1.1</td>
<td>Proposal for Change</td>
</tr>
<tr>
<td>7.1.2</td>
<td>Feedback Survey Question</td>
</tr>
<tr>
<td>7.2</td>
<td>Northern Regional Health Plan (NRHP) Health of Older People Workstream Update</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8</th>
<th>2:00pm</th>
<th>Improvement Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1</td>
<td>Quarterly Report on the Implementation of the NZ Disability Strategy</td>
<td></td>
</tr>
<tr>
<td>8.1.1</td>
<td>Disability Strategy Workshop</td>
<td></td>
</tr>
<tr>
<td>8.1.2</td>
<td>Current Status at 1 June 2013</td>
<td></td>
</tr>
<tr>
<td>8.2</td>
<td>Quarterly Report on Activities</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9</th>
<th>Confirmation</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1</td>
<td>Action Points for next DSAC Meeting</td>
</tr>
<tr>
<td>9.2</td>
<td>DSAC Feedback to Board</td>
</tr>
</tbody>
</table>

**NEXT MEETING**

**Time and Date:** 1:00pm – 4:00pm, Wednesday, 28 August 2013  
**Venue:** Training Room, CCS Disability Action, 14 Erson Avenue, Royal Oak, Auckland

_Hei Oranga Tika Mo Te Iti Me Te Rahi_  
_Healthy Communities, Quality Healthcare_