Disability Support Advisory Committee Meeting

Wednesday 12 March 2014
1.30pm

Training Room
CCS Disability Action
14 Erson Avenue
Royal Oak

Hei Oranga Tika Mo Te Iti Me Te Rahi

Healthy Communities, Quality Healthcare
Agenda
Disability Support Advisory Committee
Wednesday 12 March 2014

Venue: Training Room, CCS Disability Action, 14 Erson Avenue, Royal Oak
Time: 1.30pm

ADHB and WDHB Members
Sandra Coney (Chair)
Jan Moss
Max Abbot
Jo Agnew
Judith Bassett
Pat Booth
Michele Cavanagh
Dr Marie Hull-Brown
Dairne Kirton
Dr Lester Levy
Robyn Northey
Russell Vickery

ADHB and WDHB Staff
Dr Dale Bramley Chief Executive Officer Waitemata District Health Board
Ailsa Claire Chief Executive Auckland District Health Board
Leanne Catchpole Programme Manager Funding Team
Samantha Dalwood Disability Strategy Coordinator Waitemata District Health Board
Dr Debbie Holdsworth Director Funding – Auckland and Waitemata District Health Boards
Katrina Lenzie-Smith Programme Manager, Health of Older People
Marty Rogers Maori Health Gain Manager
Kate Sladden Funding and Development Manager, Health of Older People
Tim Wood Funding and Development Manager, Primary Care
Marlene Skelton Corporate Business Manager
Sue Waters Chief Health Professions Officer

Other staff members who attend for a particular item are named at the start of the minute for that item

Apologies
Dale Bramley

Register of Interests
Does any member have an interest they have not previously disclosed?
Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?

Agenda
Please note that agenda item times are estimates only

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2 CONFLICTS OF INTEREST
3 CONFIRMATION OF MINUTES 20 NOVEMBER 2013 001
4 ACTION POINTS 20 NOVEMBER 2013 009
1:45pm 5 CHAIRPERSON’S REPORT 013
6 IMPROVEMENT ACTIVITIES 015
1:55pm 6.1 Health of Older People Quarterly Report on Activities in Auckland and Waitemata 017
2:10pm  6.2  Update Report on the Implementation of the NZ Disability Strategy in Auckland and Waitemata DHBs  025

7  PAPERS  033
2:25pm  7.1  Funding Barriers for Support Services for Children  035
2:40pm  7.2  Funded Family Care  039
3:00pm  7.3  Current Policy for ACC Funding for Falls Programme  047

3:15pm  8  CONFIRM  051
8.1  Action Points for next DSAC Meeting
8.2  DSAC feedback to CPAC
8.3  DSAC feedback to Board

9  GENERAL BUSINESS  053

Next Meeting  Wednesday 4 June 2014 at 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*
**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.

<table>
<thead>
<tr>
<th>Name of Member</th>
<th>Organisation</th>
<th>Latest Disclosure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sandra CONEY (Chair)</td>
<td>Chair – Waitakere Ranges Local Board, Auckland Council</td>
<td>12 Dec 2013</td>
</tr>
<tr>
<td>Jo AGNEW (Deputy Chair)</td>
<td>Professional Teaching Fellow - School of Nursing, Auckland University Casual Staff Nurse - ADHB</td>
<td>15 Jan 2014</td>
</tr>
<tr>
<td>Max ABBOTT</td>
<td>Pro Vice-Chancellor (North Shore) and Faculty of Health and Environmental Sciences, Auckland University of Technology Patron - Raeburn House Board Member - Health Workforce New Zealand Board Member - AUT Millennium Ownership Trust Chair - Social Services Online Trust Board Member - The Rotary National Science and Technology Trust</td>
<td>28 Sept 2011</td>
</tr>
<tr>
<td>Judith BASSETT</td>
<td>Nil</td>
<td>15 Jan 2014</td>
</tr>
<tr>
<td>Pat BOOTH</td>
<td>Consulting Editor - Fairfax Suburban Papers in Auckland</td>
<td>24 June 2009</td>
</tr>
<tr>
<td>Lester LEVY (Ex-officio)</td>
<td>Chairman - Waitemata District Health Board Chairman - Auckland Transport Independent Chairman - Tonkin &amp; Taylor Deputy Chairman – Health Benefits Ltd Chief Executive - New Zealand Leadership Institute Professor (Adjunct) of Leadership - University of Auckland Business School</td>
<td>6 Dec 2014</td>
</tr>
<tr>
<td>Robyn NORTHEY</td>
<td>Self-employed Contractor - Project management, service review, planning etc. Board Member - Hope Foundation Trustee - A+ Charitable Trust</td>
<td>20 June 2012</td>
</tr>
<tr>
<td>Michelle CAVANAGH</td>
<td>Involvement - Te Taurahere O Ngati Porou KI Tamaki Part time employee - HWFNZ Hauora Maori Coordinator, WDHB Contractor - Kai Ora Hauora Northern Regional Coordinator – Northland DHB</td>
<td>7 Mar 2012</td>
</tr>
<tr>
<td>Maria HULL-BROWN</td>
<td>Employee - Mental Health Foundation Board member - HOPE Foundation for Research on Ageing Council - Member Age Concern, Auckland.</td>
<td>1 Nov 2012</td>
</tr>
<tr>
<td>Dairne KIRTON</td>
<td>Northern Regional Representative - CCS Disability Action National Board</td>
<td>23 Nov 2011</td>
</tr>
<tr>
<td>Jan MOSS</td>
<td>Co-ordinator - Complex Carer Group Member - SSOAS Stakeholders Group, WDHB Board Member - Operational Trust YES Centre Member - MOH Disability Workforce Reference Group</td>
<td>30 Sept 2011</td>
</tr>
<tr>
<td>Russell VICKERY</td>
<td>Member - Ripple Trust Life Member - CCS Disability Action, Auckland Trustee - TalkLink Trust Member, Steering Committee, Auckland Disability Law Committee Member - Waitakere Community Law Self-employed - Disability Consultant CCS Disability Action Nominee - Wilson Home Trust Management Committee Disability Consultant - Care Managers Research, Auckland University Nursing School</td>
<td>14 Nov 2012</td>
</tr>
</tbody>
</table>
CONFIRMATION OF MINUTES

WEDNESDAY 20 NOVEMBER 2013
Minutes of the Disability Support Advisory Committee meeting held on Wednesday, 20 November 2013 in the Training Room, CCS Disability Action, 14 Erson Avenue, Royal Oak commencing at 1:00pm

ADHB and WDHB Members Present
Sandra Coney (Chair)
Dairne Kirton
Jan Moss
Dr Marie Hull-Brown
Pat Booth
Robyn Northey
Susan Buckland,
Russell Vickery

ADHB and WDHB Staff Present
Kate Sladden  Funding and Development Manager – Health of Older People
Linda Harun  General Manager, Child Women and Family services
Katrina Lenzie-Smith  Programme Manager – Health of Older People
Tim Woods  Funding and Development Manager, Primary Care
Sue Waters  Chief Professions Health officer
Marlene Skelton  Corporate Business Manager

1    INTRODUCTIONS

There were none to be made.

2    ATTENDAND AND APOLOGIES

Apologies were received from Max Abbott, Jo Agnew and Lester Levy and from staff, Ailsa Claire, Dr Dale Bramley and Dr Debbie Holdsworth.

3    CONFLICTS OF INTEREST

Sandra Coney advised that the Interests register needed to be updated to reflect that she no longer held the positions of Councillor- Auckland Council and Chair – Parks Committee, Auckland Council. She was now the Chair of the Waitakere Ranges Local Board.

There were no declarations of conflicts of interest for any other items on the agenda.

4    CONFIRMATION OF MINUTES 28 AUGUST 2013

The following amendments are to be made to the minutes:

- Insertion of Lester Levy (Board Chair) in the attendance record
- Page 7 change the Acronym STAR to SPA
- Page 8, item 8.1 change the term “Disabled Champions” to “Disability Champions
- There was discussion in regard to the “First Do No Harm” initiative and funding for
Tai Chi with clarification being requested around what the intention was behind the wording; “It was suggested that this could be revisited.” Tim Wood advised that ACC had withdrawn funding from the “Falls Programme” and was currently reviewing what the programme will contain. It was agreed that Tim Wood would ascertain from ACC what was occurring with funding for the “Falls Programme”

Resolution: Moved Sandra Coney/Seconded Robyn Northey

That the amended minutes of the Disability Support Advisory Committee meeting held on 28 August 2013 be confirmed as a true and correct record.

Carried

5 ACTION POINTS 28 AUGUST 2013

Clarification was sought from the Committee as to what was intended when it was asked that, “options be brought forward to reduce funding barriers and while the problem is defined it was better to approach the Ministry of Health with solutions and options for a way forward. A pilot for 0-1 years was suggested as a way forward.”

It was agreed that this related to babies that were medically fragile and whether the babies and families were receiving the support required.

Action

A report on funding mechanisms currently in place to support medically fragile babies and their families be made to the March 2014 meeting.

6 CHAIRMAN’S REPORT

The Chair expressed her appreciation to all committee members for their contributions over the last term of the Board.

She advised that it was with regret that she had received the resignation of Susan Sherrard from the committee.

On behalf of the committee members, Pat Booth thanked Sandra Coney for her able leadership during her term on the Board.

7 PRESENTATION – Health Passport & Residential Facility Taupaki Gables

Linda Venables, Regional Manager of Radius Care made a presentation to the committee demonstrating the successful introduction of the Health Passport within the residential facility, “Taupaki Gables”.

Linda advised that from 1 July 2013 the Health and Disability Commission had been working directly with relevant community organisations to facilitate the distribution of passports to consumers on a nationwide basis. Advocates from the nationwide Health and Disability Advocacy Service are assisting the Health and Disability Commission with the distribution of Health Passports to all rest homes and disability residential homes throughout the country.
Radius Taupaki Gables is a 60 bed rest home and private hospital aged care facility in west Auckland and was one of the first to trial the Health Passport before it went live in July. This has been seen as a quality improvement which has gained Taupaki Gables four years certification with three CIs (continuous improvements) and no partial attainments at the audit in June 2013.

The Health Passport is used in conjunction with the Yellow Transfer Envelope and provides extra “individual” information which may not be known by hospital staff, particularly where the resident is unable to speak for themselves.

The advantage of the Health Passport is that it can be completed before a resident ever has to attend hospital. It also allows family to record their family members little foibles, likes and dislikes and what they would have preferred before they were unable to communicate this for themselves. These details can then be incorporated into an individual nursing care plan.

The Health Passport comes in two sizes, the larger one being preferred as it fits with other documents in the Yellow Transfer Envelope.

Matters covered in discussion and in response to questions included:

Asking how the staff at the residential home ensured that everyone involved in the patients care gets to see the information in the Health Passport. Linda advised that care plans are revised regularly every three months or more as required. At this point the resident, family, nurses and carers are interviewed to review the information and ensure that it is relevant and able to be incorporated into an individual nursing care plan.

It was asked whether those holding a power-of-attorney are also closely involved in the care plan agreement. Linda advised that this is often the case but in some instances the resident does not want family or others involved.

The advantage of the Health Passport is that it can be transitioned through all stages of required care and the aim is to have it in place right throughout the health sector.

Resolution: Moved Sandra Coney/Seconded Marie Hull-Brown
That Linda Venables, Regional Manager of Radius Care be thanked for her presentation.
Carried

8 PAPERS

8.1 Review of Key Objectives and Areas of Focus for the Disability Support Advisory Committee (2011-2013).

Sandra Coney, Committee Chair, advised that this item was placed on the agenda to facilitate discussion in order to determine what progress members felt had been achieved in regard to previously agreed areas of focus.

Carers

Jan Moss raised the issue of carers and felt that more focus could have been applied in this area. She made the following points; that:

- Documentation by agencies was written as if all disabled people were cognitively
unimpaired

- The new legislation itself allows the disabled person to be treated as the employer and while this might be satisfactory for those that can communicate it made no provision for legal carers of people who were cognitively impaired.

- There are conflicts of interest between agencies empowered to fund family care which make it difficult for the individual dealing with such agencies and removes choices from the individual.

- Jan would like to see policy broad enough to encompass all situations that those who are cognitively impaired might face

**Action**

That a report come to the March meeting with a briefing on current policy and an action plan in regard to the issue of patient carers where the patient is cognitively impaired and required by law to act as an employer but is not competent to undertake this role.

**Disability – Equal Access**

There was frustration expressed at the slow rate of change in the area of equal access. A discussion was had in regard to how managers could be best supported to influence a positive outcome. It was felt dialogue on the issue must be maintained at all levels however, it needed to be remembered that change came about via way of the Ministry and at this level there were political agendas that had to be considered. It needed to be acknowledged too, that if you placed more emphasis on one area then others of equal importance were likely to fall by the wayside.

**Aged Residential Care – Monitoring**

Dr Marie Hull-Brown noted that more had been achieved in this area but not necessarily as a result of anything that this Committee had done but rather as a result of media scrutiny. However, the Committee could be proud of some of the initiatives it had supported.

**Summary**

Committee members felt that it had been useful to have identified areas of focus to work with and that it had assisted in allowing achievements to be made in key areas.

**Resolution:** Sandra Coney/Seconded Dairne Kirton

That the report be received by the Disability Support Advisory Group.

Carried

9 IMPROVEMENT ACTIVITIES

9.1 Health of Older People Quarterly Report on Activities in Auckland and Waitemata District Health Boards
The report was taken as read:

Matters covered:

**Northern Region Health Plan – interRAI data**

In answer to a question in regard to interRAI data the committee were advised that a northern region data warehouse has been set up that will allow for both individual District Health Board and regional reporting views. The early problems with data entry had been overcome by placing a focus on the training of nurses to understand how to carry out interRAI reporting and the value of what they could obtain if done correctly. There had been a huge shift in attitude as a result.

A lot of effort had been applied to reassuring those connected with management of aged care residential facilities that the earlier issues had been resolved. Visibility of reports will eventually increase the utilisation of this data.

**Home Based Support Service Providers**

Tim Wood advised that Waitemata District Health Board is moving to adopt the Auckland District Health Board model. There is a long tail of “low needs” patients at Waitemata District Health Board, around 900 people, waiting for and not receiving household management assistance.

Jan Moss expressed a concern over the definition of “low needs” and Tim advised that this is an assessment conducted with the individual about alternative ways for them to manage tasks. There is no intention of denying individuals support. This is about being smarter in the type of assistance that is being offered to keep the individual independent for as long as possible.

This is a process conducted with individuals that would occur throughout their health continuum and was aimed at maintaining levels of independence for as long as possible.

**Resolution:** Moved Marie Hull-Brown/Seconded Robyn Northey

**That the report be received by the Disability Support Advisory Group.**

**Carried**

9.2 **Update Report on the Implementation of the NZ Disability Strategy in Auckland and Waitemata DHBs**

In the absence of Debbie Holdsworth, Director of Funding, Waitemata and Auckland District Health Boards, the report was taken as read.

Matters covered in discussion were:

**Presentation at Dieticians Conference**

An audit had been conducted across both District Health Boards and it was found the results were remarkably similar. Of note was that it was an area that could be managed better.
overall. It was found that elderly with comorbidity issues were not able to effectively feed themselves and this was not helped by a turnover in staff that cared for them.

Sue Waters emphasised that everyone has a responsibility to ensure that a patient eats. While the physical responsibility for feeding can be delegated, nurses have a responsibility to ensure that a patient is well hydrated and nourished. Improvement initiatives have been identified and are to be implemented.

Resolution: Moved Sandra Coney/seconded Pat Booth

That the report be received by the Disability Support Advisory Group.

Carried

10 CONFIRM

10.1 Action Points for next DSAC Meeting

That a report come to the March meeting with a briefing on current policy and an action plan in regard to the issue of patient carers where the patient is cognitively impaired and required by law to act as an employer but is not competent to undertake this role.

Tim Wood to ascertain from ACC what was occurring with funding for the “Falls Programme”

10.2 DSAC feedback to CPAC

There was no feedback to forward.

11 GENERAL BUSINESS

There was no general business this month.

The meeting closed at 2.50pm.

Next Meeting

The next ordinary scheduled meeting will be held:

1:00pm, Wednesday, 12 March 2014
Training Room, CCS Disability Action, 14 Erson Avenue, Royal Oak, Auckland

Signed as a true and correct record of the Disability Support Advisory Committee meeting held on Wednesday, 20 November 2013.

__________________________________________ Chair __________________________ Date
Action Points from Previous DSAC meetings

As at Wednesday 20 November 2013

<table>
<thead>
<tr>
<th>Meeting and Item</th>
<th>Detail</th>
<th>Designated to</th>
<th>Action by</th>
</tr>
</thead>
<tbody>
<tr>
<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>
<td>Deferred until after the election March 2014</td>
</tr>
<tr>
<td>Carried forward</td>
<td>A report on funding mechanisms currently in place to support medically fragile babies and their families be made to the March 2014 meeting.</td>
<td>Leanne Catchpole</td>
<td>Item 7.1 in this agenda</td>
</tr>
<tr>
<td>Item 7 28 Aug 2013</td>
<td>That Estelle Muller of the Ministry of Health be invited to address the DSAC meeting in June 2014 to give a more detailed update on progress made in delivery of respite care.</td>
<td>Marlene Skelton</td>
<td>June 2014</td>
</tr>
<tr>
<td>Item 9.1 28 Aug 2013</td>
<td>There were changes to the WINZ Benefits System in July an update detailing how this is impacting on the ADHB/WDHB population is requested.</td>
<td>Katrina Lenzies-Smith</td>
<td>June 2014</td>
</tr>
<tr>
<td>Item 4 20 Nov 2013</td>
<td>Tim Wood to ascertain from ACC what was occurring with funding for the “Falls Programme”</td>
<td>Tim Wood</td>
<td>Item 7.3 on this agenda</td>
</tr>
<tr>
<td>Item 8.1 20 Nov 2103</td>
<td>That a report come to the March meeting with a briefing on current policy and an action plan in regard to the issue of patient carers where the patient is cognitively impaired and required by law to act as an employer but is not competent to undertake this role.</td>
<td>Linda Harun</td>
<td>Item 7.2 on this agenda</td>
</tr>
</tbody>
</table>
CHAIRPERSON’S REPORT
IMPROVEMENT ACTIVITIES

6.1 Health of Older People Quarterly Report on Activities in Auckland and Waitemata

6.2 Update Report on the Implementation of the NZ Disability Strategy in Auckland and Waitemata DHBs
6.1 Health of Older People Quarterly Report on Activities in Auckland and Waitemata
HEALTH OF OLDER PEOPLE QUARTERLY REPORT ON ACTIVITIES IN AUCKLAND & WAITEMATA DHBS

Recommendation:

That the report is received.

Prepared by: Katrina Lenzie-Smith (Programme Manager Health of Older People) and Kate Sladden (Funding and Development Manager Health of Older People)
Endorsed by: Dr Debbie Holdsworth (Director Funding)

Glossary

ARRC – Age Related Residential Care
DHB – District Health Board
HCSS – Home and Community Support Services
LTS-ChC – Long Term Support for Chronic Health Conditions
VfM – Value for Money

1. 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.

2. Background

Health of Older People (HOP) services are directed by the Minister of Health, the 2013/14 Northern Region Health Plan (NRHP), Waitemata and Auckland District Annual Plans and the Māori Health Plan. We are currently preparing the 2014/15 Annual Plan, this expects DHBs to continue working with community and primary care to deliver integrated services for older people to support their continued safe, independent living at home; with a focus on avoiding hospital admissions and care after a hospital discharge. We also need to continue working with the Ministry of Health to improve home care, stroke services and dementia care pathways.

3. The Northern Region Health Plan (NRHP)

Key areas of achievement for the Health of Older People Clinical Network since the last report, have been: recruitment of an Age Related Residential Care (ARRC) Director of Nursing representative (Oceania), progressing and strengthening dementia initiatives, interRAI engagement and reporting, identifying medication safety improvements and the regional Psycho-Geriatric (PG) Bed Review.
The Northern Region Psycho-Geriatric Bed Review has been a major priority. The interim report findings have been presented to key stakeholder groups (DHB and ARRC PG providers), and received positive and constructive feedback. The final report is on track for completion at the end of February.

Feedback from ARRC providers is that an electronic means of data submission and automatic reporting for falls and pressure injuries would be a key incentive for participation. The Health of Older People Network and DHB Planning and Funding Managers have endorsed the development of a business case to assess the Quality Care for Older People application for it’s suitability for ARRC - currently in use at Auckland DHB. Other benefits include loading training information and quality documents used by home care providers and extending the range of key performance indicators over time.

The Health of Older People Network hosted a regional Fracture Liaison Workshop on behalf of the Ministry of Health and DHBs.

Regional data is now available for interRAI reporting, however further analysis is required as there are DHB differences. The Health of Older People Network is in discussion with Bupa to move interRAI forward through a number of demonstration sites in the Northern Region. A recent report from the Ministry of Health indicates nearly 100% engagement from ARRC providers in the region which is pleasing.

Reporting for the new key performance indicator, “reduction in patients aged 75+ readmitted into public hospital within 28 days” is ahead of schedule. For the 12 months to 30 September 2013, the result was 13.0% (baseline 12.9%).

The Health of Older People Network is working with ‘First Do No Harm’ who will be the lead for the Medication Safety Project. Representatives are now being recruited for the four sub-projects.

4. Home Based Support Services (HBSS)

4.1 Auckland DHB
Auckland DHB HBSS uses a case mix model to cluster client need and for each cluster/category there is a set daily pay rate. There are six categories for non complex clients and these have been in place for a number of years, however for complex clients a flat (average) daily pay rate has been used. In December 2012 Auckland DHB agreed with providers to introduce tiered daily pay rates for complex clients. Eight complex categories were developed in conjunction with the University of Auckland; these were based on interRAI (comprehensive clinical assessment) scores. Modelling was undertaken to ensure that the introduction of the eight complex pay rates would be a cost neutral exercise. However, there were issues with interRAI clinical assessment data, which delayed the ability to classify complex clients. When classification was able to be undertaken there had been a shift in complexity of clients that had not been apparent in the modelling exercise. This means pay rates calculated through the modelling exercise are not sustainable and would exceed the 2013/14 HBSS budget. The shift in complexity is currently being investigated and meetings are being held with providers to review the cost model and modify to ensure the HBSS budget is met.
4.2 Waitemata DHB
Waitemata is still in the implementation planning phase to shift to a very similar model as Auckland DHB.

4.3 HBSS Budget 2013 Additional Funding
In Budget 2013, funding of $5 million per annum nationally was allocated for home support services to help older New Zealanders stay in their homes longer.

The Letter Agreement for this funding specifies it is to be used to Increase personal care services to high need and complex older clients who would otherwise be in aged residential care by:

- Increasing hours provided to the complex categories or numbers of high need and complex older clients above the level previously planned.

Waitemata DHB also has approval to use the additional funding for:

- Employing two additional NASC Intensive Service Coordinators to provide regular reviews and re-assessments of these clients
- Completing a one-off catch-up project to assess all older adults that are currently on the NASC waiting list.

Waitemata DHB has recently appointed two Intensive Service Coordinators. As they are existing staff members, replacements for their existing positions need to be recruited before they can transition to their new roles. This is likely to be in May 2014. Four additional NASC staff have been employed to complete a catch-up project of completing over-due re-assessments of current patients and assess patients on the waiting list.

Auckland DHB will be passing on the additional funding to HBSS provider through the complex case mix model.

5. Dementia Care Pathway

5.1 Auckland DHB
Analysis of the co-design workshops and interviews held with patients, carers and stakeholders, to develop a dementia pathway, identified four key components of work. These were approved by the Stakeholder Group and the Dementia Care Governance Group as work programmes and the following workstreams have been established:

- **Carer Workstream** – focusing on the day to day information and support needs that people with dementia and carers require and on proactively identifying the support needs of carers who are critical to enabling ongoing home based care.

- **Integration Workstream** - focusing on the integration and alignment of all of the various agencies and services involved and so reducing the burden on people with dementia and carers to navigate the system.

- **Support Suite Workstream** - focusing on the identification and development of community based services to ensure that they meet the needs of people with dementia and carers e.g. respite care, day programmes, home based support etc.

- **Foundation Workstream** - focusing on the base competency requirements of all staff involved with clear accountabilities for each so that care is provided efficiently and
effectively by those with the appropriate skills.

Each of the workstreams have met twice during November/December 2013 and January/February 2014 and have agreed:
- Multidisciplinary and multiagency membership
- A project charter
- A meeting schedule for 2014
- An action plan to address the areas identified in the project scope.

Initial recommendations from each workstream will be presented to the Governance Group at the beginning of April 2014.

5.2 Waitemata DHB
The Waitemata DHB Cognitive Impairment Clinical Pathway is tracking to plan. Two of the 12 GPs withdrew due to work pressure and ProCare PHO is currently sourcing replacements.

The first group of patients and their carer (i.e. Spouse / Partner / family / whanau) who have consented to participate in the Pilot are nearing completion of the diagnostic workup process. Those with a confirmed diagnosis of dementia will soon trial the ‘Living Well With Dementia Care Planning Intra-disciplinary Meeting’ co-ordinated by the GP and Alzheimers Auckland.

The secondary care clinicians and pilot GPs and their Practice Nurses have had two action research meetings (17.12.13 and 11.02.14) where they discuss the Cognitive Impairment Clinical Pathway the GPs are piloting. The discussion focuses on ‘what is working / what is not working / what needs to change’. A change made from the action research meetings to date is patients with a provisional diagnosis of dementia are, with their consent, connected with Alzheimers Auckland before the definite diagnosis is made. The findings to date being that the patient and carer benefit immensely from Alzheimers Auckland education and support during the stressful time of working toward a definite diagnosis.

The action research methodology should by the end of the nine month pilot have developed a pathway that is appropriate for rollout to the 300 GPs across Waitemata DHB. The evaluation by Auckland University Department of Geriatric Medicine should inform the DHB whether this is an appropriate and sustainable pathway to be rolled out.

6. Aged Related Residential Care

6.1 Auckland DHB
Health of Older People is now under the new directorate Adult Community and Long Term Conditions in the restructure of the Auckland DHB provider arm. The process to develop a system wide plan under this new Directorate is commencing.

The specialist team had 327 consultations with aged residential care over the last quarter. Key reasons for these consults included: care planning follow up; skin care guidance; pressure injury advice; complex discharge from Auckland Hospital check ups; assessments from rest home to private hospital level of care.

Waitemata and Auckland DHB’s Disability Advisory Committee
A study day for aged residential care registered and enrolled nurses was held; topics were: leadership; data based decisions; and Lean in healthcare – how to identify waste. There were 86 participants.

All Auckland DHB ARRC facilities are now engaged with interRAI training as follows:
- 17 are fully competent (required number of nurses trained)
- 9 are competent (at least one nurse trained)
- 23 have signed an engagement agreement (to commence training)
- 11 have booked their training.

6.2 Waitemata DHB
The RACIP work group meets bi-monthly, its members are: managers and clinicians from ARRC facilities, Gerontology Nurse Specialists (GNS), Funding and Planning Quality Nurse Leader and experts in the field: Hospice, Dementia Nurse Specialist. The purpose of this group is networking, informing practice and developing clinical guidelines.

Current projects:
1. Development of booklet for family members of people with advanced and end-stage dementia living in residential care. The resource will support families to understand end stage dementia, advance care plans, and appropriate and inappropriate interventions. The content is finalised and it will now go to WDHB Design Department before printing and launching. An electronic version will be freely down loadable from the RACIP website www.wdhb-agedcare.co.nz

2. Development of two resources for end stage lung disease and for end stage heart disease have commenced. They will be similar in principle to the booklet for family members of people with advanced and end-stage dementia living in residential care. The new resources will support staff in aged care to help families understand disease trajectory and what end stage disease looks like. They will encourage appropriate symptom management, advance care planning and avoidance of preventable admission.

Quarterly off site education (November 2013): Medication reviews for registered nurses; 110 RNs attended.

Onsite educations: Topics are offered bimonthly. Facilities can choose to have an alternative or an extra topic according to need: Pain (October/November 2013); 323 RNs and HCAs received this education.

Cluster groups: These have been formed in response to the targets set by ‘First Do No Harm’ to reduce Pressure Injuries and falls by 20%. Facilities are encouraged to group together to support each other with quality improvements and data collection. There are four cluster groups up and running with 20 facilities represented.

All Waitemata DHB ARRC facilities are engaged with interRAI training as follows:
- 16 are fully competent (required number of nurses trained)
- 5 are competent (at least one nurse trained)
- 20 have signed an engagement agreement (to commence training)
- 18 have booked their training.
7. **New Provider Regulation and Monitoring System**

HealthCERT manages the regulatory mechanisms within the Ministry of Health to ensure ARRC facilities provide safe environments that meet the requirements of certification and deliver the expected standard of care. The new information management system called the Provider Regulation and Monitoring System (PRMS) introduced in November 2013, has been successfully implemented throughout the region after some initial teething issues.

8. **Long-Term Supports for Chronic Health Conditions**

The financial model for LTS-CHC has been regionally agreed. The regional risk share pool will be disestablished and each DHB will manage its own risk and utilisation costs, starting 1 January 2014 for metro Auckland DHBs. The Region will follow the national inter district flow process for LTS-CHC clients.

The following regional governance arrangements have been recommended to continue:

- Family Options should continue to be the regional LTS CHC NASC for clients under the age of 16 years
- The LTS CHC Regional Review Panel should continue with a mandate to sanction recommendations for clients with a service package around and over $80,000 including clients with joint funded services.
- LTS CHC should continue to have a work plan that is reported on through the Northern Regional Health Plan.
6.2 Update Report on the Implementation of the NZ Disability Strategy in Auckland and Waitemata DHBs
Waitemata DHB and Auckland DHB
Implementation of the New Zealand Disability Strategy 2013-2016
Current Status at 10 February 2014

Communication and Access to information
Empowering people through knowledge and understanding

Physical Access Overcoming a disabling society

Waitemata DHB & Auckland DHB are fully inclusive

Disability Responsiveness Educating staff and challenging stereotypes and assumptions

Employment Opportunities Providing equal employment opportunities for people with impairments and carers

Community and Consumer-engagement Working within a family and patient-centred framework
<table>
<thead>
<tr>
<th>What we will do... actions</th>
<th>Where we are now... current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessible Communication guidelines developed.</td>
<td>July 2013 - Communications Teams have received the Office for Disability Accessible Communications Guidelines for information.</td>
</tr>
<tr>
<td>Review of Web content and presentation.</td>
<td>Oct 2013 – Met with WDHB Communication Manager to look at specific access issues to the website and overall look.</td>
</tr>
<tr>
<td>Increase formats of key documents, e.g. Strategic Plans.</td>
<td>Oct 2013 – Met with WDHB Communication Manager to discuss the importance of other formats being considered and included where possible.</td>
</tr>
<tr>
<td>Review the automated telephone system with regard to access for people with disabilities.</td>
<td>Oct 2013 – Contact Centre consultation generated a huge amount of feedback, including a number of submissions about the challenges of an AVR (automatic voice recognition) system. A separate work stream has been set up to review this.</td>
</tr>
<tr>
<td>Review the possibility of improved text communication to patients.</td>
<td>July 2013 – Gave feedback around better support for disabled, particularly Deaf, people accessing information via the telephone into the Contact Centre consultation.</td>
</tr>
<tr>
<td>Continue the implementation of the Health Passport across both DHBs.</td>
<td>Ongoing. Becoming well known across the disability and health sectors across NZ.</td>
</tr>
<tr>
<td>Work with the Deaf community to improve access to interpreters.</td>
<td><strong>February 2014</strong> – have been in discussions with Deaf Aotearoa regarding VRI (Video Remote Interpreting), which is currently being rolled out around NZ. VRI gives access to interpreters via an internet video connection.</td>
</tr>
<tr>
<td>Encourage the use of interpreters for non-English speaking families.</td>
<td>Working with Asian Health to look at the use of interpreters for disabled people and their families.</td>
</tr>
<tr>
<td><strong>What we will do... actions</strong></td>
<td><strong>Where we are now...current status</strong></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Ensure a diverse range of disabled people are identified as stake-holders in all projects and service development.</td>
<td><strong>February 2014</strong> – WDHB Corporate Quality Team are currently recruiting a Patient Experience Manager. This role is accountable for the development, implementation and leadership of DHB-wide service excellence, focusing on patient experience, patient engagement and patient and family centred care. Disabled people will be included in this work.</td>
</tr>
<tr>
<td>Engage regularly with the disability sector to develop their capacity to influence decision making and increase DHB responsiveness.</td>
<td>Ongoing.</td>
</tr>
<tr>
<td>Ensure the voice of people with learning/intellectual disabilities, particularly people with high/complex needs, is included in consumer reviews of service planning and development.</td>
<td>Ongoing.</td>
</tr>
<tr>
<td>Continue working with Health Links to increase health literacy through fully accessible patient information.</td>
<td>Ongoing.</td>
</tr>
</tbody>
</table>
### Employment Opportunities

**Equal employment opportunities for people with impairments and carers**

**Current Status at 10 February 2014**

<table>
<thead>
<tr>
<th><strong>What</strong> we will do... actions</th>
<th><strong>Where</strong> we are now... current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encourage the use of supported employment agencies.</td>
<td>Ongoing.</td>
</tr>
<tr>
<td>Review all recruitment and employment policies and make recommendations to improve inclusion and employment opportunities for disabled people, as required.</td>
<td>Ongoing.</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>Ongoing.</td>
</tr>
<tr>
<td>Work with Hiring Managers to increase disability awareness.</td>
<td>Ongoing.</td>
</tr>
<tr>
<td>Working with HR to look at how the DHBs support staff with Carer responsibilities.</td>
<td><strong>February 2014</strong> – WDHB HR Workforce Development Team and Carers NZ are working on the following three work streams – 1. Carer Aware staff training, 2. a staff survey on caring responsibilities, and 3. Carer information being available on the staff intranet site.</td>
</tr>
</tbody>
</table>
### Disability Responsiveness

**Educating staff and challenging stereotypes & assumptions**

**Current Status at 10 February 2014**

<table>
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<th>What we will do... actions</th>
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<tbody>
<tr>
<td>Work with Dieticians to improve the nutritional outcomes for disabled patients.</td>
<td><strong>February 2014</strong> - Disability Coordinator presenting the paper ‘For want of a straw: Nutrition and Hydration for People with Disabilities in a Health Setting’ at the Paediatric Disability Update: A Multi-disciplinary Approach to Nutritional Issues on 31 March at Awhina, Waitakere Hospital.</td>
</tr>
<tr>
<td>Develop ‘Disability Champion’ roles across the DHBs.</td>
<td><strong>February 2014</strong> – ongoing work to develop the Disability Champion model.</td>
</tr>
<tr>
<td>Promote the Disability Awareness e-learning module to all staff across the DHBs.</td>
<td>Ongoing.</td>
</tr>
<tr>
<td>Provide a range of disability awareness training, targeting specific services.</td>
<td>Ongoing.</td>
</tr>
<tr>
<td>Develop tools to increase staff skills for working with people with communication difficulties.</td>
<td>Ongoing.</td>
</tr>
<tr>
<td>Ensure public waiting areas, wards and treatment areas meet the needs of a range of impairments, including people with autistic spectrum disorders.</td>
<td><strong>February 2014</strong> – Working with Facilities on the possible redesign of Ward 8 at North Shore Hospital. Facilities are looking at a complete resign of the ward, rather than just refurbishment. Consumer input has been received by the CCS Disability Action Health &amp; Wellness Group, as well as Deaf Aotearoa, Barrier Free Trust and the Blind Foundation.</td>
</tr>
</tbody>
</table>
### Physical Access
Overcoming a disabling society
**Current Status at 10 February 2014**

<table>
<thead>
<tr>
<th><strong>What</strong> we will do... actions</th>
<th><strong>Where</strong> we are now...current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encourage the use of symbols and pictograms in signage and way finding.</td>
<td><strong>February 2014</strong> - Elective Surgery Centre signage and way finding, which won a Health Excellence Award for Excellence in Compassionate Patient Support, is now seen as the WDHB standard. This is being used for the new Community Renal service in Albany.</td>
</tr>
<tr>
<td>ADHB Disability Champions will complete the 2-day Barrier Free Training.</td>
<td><strong>Ongoing.</strong></td>
</tr>
<tr>
<td>An accredited Barrier Free Advisor will be involved in all new Facilities work.</td>
<td><strong>Ongoing.</strong></td>
</tr>
<tr>
<td>Adoption of Universal Design principles in all Facilities work.</td>
<td><strong>Ongoing.</strong></td>
</tr>
<tr>
<td>Building standards document developed in ADHB.</td>
<td><strong>Ongoing.</strong></td>
</tr>
<tr>
<td>A review of accessible toilets in ADHB buildings to be completed.</td>
<td><strong>Ongoing.</strong></td>
</tr>
<tr>
<td>Work with Auckland Transport to improve accessible transport between hospital sites.</td>
<td></td>
</tr>
<tr>
<td>Investigate the reported shortage of wheelchairs available - both numbers and sizes.</td>
<td><strong>Oct 2013</strong> – 40 wheelchairs have been delivered to Waitemata DHB. Hospital Operations are clarifying how many have gone to which areas of the hospitals.</td>
</tr>
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7

PAPERS

7.1 Funding Barriers for Support Services for Children

7.2 Funded Family Care

7.3 Current Policy for ACC Funding for Falls Programme
7.1 Funding Barriers for Support Services for Children
FUNDING BARRIERS FOR SUPPORT SERVICES FOR CHILDREN

Recommendation

That the report be received.

Prepared by: Leanne Catchpole, Programme Manager Health of Older People and Healthy Lifestyles
Endorsed by: Dr Debbie Holdsworth, Director Funding Waitemata and Auckland DHBs

Glossary

DHB – District Health Board
DSS – Disability Support Services
LTS-CHC – Long-term Support Services for Chronic Health Conditions
MoH – Ministry of Health
NASC – Needs Assessment and Service Coordination

1. Executive Summary

There has historically been an issue of barriers to access to support services for children with both disability and personal health support needs. The Family Options service and Taikura Trust have worked together to develop a collaborative model for assessing these children. An issue remains in that the allocated services still need to be coordinated and funded separately by the respective agencies. The Northern region District Health Boards (DHBs) are requesting that this issue is addressed by the new LTS-CHC and DSS national Resolutions Panel.

2. Introduction/Background

At the November 2012 DSAC meeting an issue of funding barriers for support services for young children was discussed when the child had both disability and personal health support needs. As a result of the discussion DSAC identified a follow-up action; “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.”

This report provides DSAC with a progress update on resolving this issue.

3. Progress/Achievements/Activity

The MoH has acknowledged dual funding opportunities where appropriate under the MoH Operational Policy Framework 2013/14 between DSS and LTS CHC.

The Family Options Team that assesses and coordinates support services for children on behalf of the Northern region DHBs has worked proactively with Taikura Trust, the Disability Support Services (DSS) Needs Assessment and Service Coordination (NASC) team.
Family Options work on the principle of putting the child and family at the forefront of the NASC process. They have worked closely with Taikura Trust to develop a collaborative model of joint assessments. They are now able to do a joint assessment when appropriate for children that have both personal health and disability support needs.

Family Options and Taikura Trust are also asking families for consent to share assessment information between the two agencies when referring a child from one agency to the other. This reduces the need for the repeating the assessment, which is usually two hours long.

The Service Coordination component is still completed by each agency separately, as there is no mechanism for jointly funding the service through the Ministry of Health (MoH) contracting and payments system.

A National Resolutions Panel has recently been formed with representation from DHBs, DSS and the MoH. The role of the panel is to resolve any LTS-CHC and DSS funding disputes for individual patients and address inter-agency issues.

The Northern region DHBs are presenting a paper at the next meeting that includes the following requests;
1) National Resolution Panel to establish a consistent methodology to assist with calculation of percentage for joint funding that is patient focused.
2) National Resolution Panel to advocate for coordinated joint assessments when multiple assessments are required for the same service.
3) National Resolution Panel to establish a process which will enable monitoring and payments to be made to a single provider by two funders on a single contract.

4. Conclusion

Since this issue was presented at the November 2012 DSAC meeting progress has been on developing a joint assessment process for children. Separate processes by the respective agencies are still required for coordinating and funding the support services. This issue is being raised with the National Resolution Panel for them to address.
7.2 Funded Family Care
FUNDED FAMILY CARE

Recommendation

That the report be received.

Prepared by: Samantha Dalwood, Disability Strategy Coordinator, Waitemata DHB
Approved/Endorsed by: Linda Harun, General Manager, Child, Women & Family Services

Glossary

DSS - Disability Support Services
FASS - Funding Advisory Support Services
FFC - Funded Family Care
HCSS - Home & Community Support Services
IF - Individualised Funding
MoH - Ministry of Health
NASC - Needs Assessment & Service Coordination

1. Executive Summary

This paper is a response to the request at the DSAC meeting on 20 November 2013 for a briefing on current Funded Family Care policy in regard to the issue of patient carers, where the patient is cognitively impaired. The patient is required by law to act as an employer, but what happens where people are not competent to undertake this role. The Ministry of Health responded that they have considered people who do not have the cognitive capacity to act as an employer and suggest that a court appointed welfare guardian advocates for the person. The Ministry have also commented that the number of people eligible for Funded Family Care will be small enough that each situation can be responded to individually.

2. Introduction/Background

Funded Family Care (FFC) is the name of the new Ministry of Health policy to pay family carers. This follows the announcement in the 2013 Budget that eligible carers of disabled people under 65 (but not spouses) could apply to be their paid carer for up to 40 hours a week at the minimum wage. Funded Family Care started on 1 October 2013. The regulations and eligibility criteria require the disabled person to understand their new role as employer as the money will be paid directly to them and they will employ their family member. There have been complaints from the disability sector that this is confusing and could mean some people with high needs will not be eligible for funding through FFC.
3. Risks/Issues

There is a risk that disabled people may not be getting the support and funding allocation that they are entitled to because of confusing eligibility criteria.

There is a risk that some disabled people will not be cognitively competent to fulfil the role of employer and this will impact on their eligibility for funding through FFC.

Information from MoH about FFC is not currently being presented to disabled people in a fully accessible way.

4. Progress/Achievements/Activity

4.1 Eligibility
The Ministry of Health Funded Family Care Operational Policy (2013) states that “A disabled person who is eligible for HCSS (Home and Community Support Service) may be eligible to receive support services through FFC by meeting all of the primary eligibility requirements and at least one of the secondary requirements”.

4.1.1 Primary Eligibility Criteria
- The disabled person is 18 years of age or over and has been assessed by a NASC (Needs Assessment & Service Coordination) organisation as eligible to be allocated Ministry of Health funded HCSS, and
- The disabled person explicitly confirms to the NASC facilitator their preference to employ an able and willing parent or resident family/whānau member(s) to provide them with all or part of the personal care and household management supports within their HCSS allocation, and
- The family/whānau carer(s)\(^1\) who a disabled person chooses to employ to provide them with specified personal care and household management supports is:
  - aged 18 or over, and
  - is not the disabled person’s spouse, civil union or de facto partner.

4.1.2 Secondary FFC criteria
The disabled person is assessed as not being able to remain at home if they could not employ a family carer because:
- the disabled person is assessed as having high or very high disability-related needs and they would not be able to remain supported in their chosen living environment(s) if they could not employ their parent(s) or resident family/whānau member(s) to provide them with some or all of their personal care and household management supports, and/or
- the disabled person is assessed as having high disability-related needs and meeting these needs prevents their chosen parent(s) or resident family/whānau carer(s) from working in alternative full-time employment.\(^2\)

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\(^1\) A ‘family member’ under sections 70B(1) and (2) of the New Zealand Public Health and Disability Act 2000 is one of the following persons:
- a parent, step-parent, or grandparent
- b child, step-child, or grandchild
- c sister, half-sister, step-sister, brother, half-brother, or step-brother
- d aunt or uncle
- e nephew or niece, or
- f first cousin.
4.2 Advocacy
The FFC Operational Policy says that if the NASC is concerned that a disabled person lacks the capacity to fully understand the terms of FFC, then the NASC can recommend that the disabled person obtains an advocate to assist with explaining the terms of the FFC arrangement. The advocate would also be expected to assist the disabled person with understanding the employment requirements under the FFC arrangement and support them with their decision to proceed with FFC or not.

The advocate can be any natural support the disabled person chooses other than the family/whānau member(s) who they may be considering as their employed family/whānau carer(s).

It is not mandatory for a disabled person to obtain an advocate. If the disabled person chooses not to obtain an advocate the NASC’s must still be satisfied that the disabled person has made an informed and willing choice about the FFC option. There is no obligation on the NASC to proceed with the FFC arrangement if they are not satisfied with this requirement.

4.3 Contradiction of Eligibility
One blog on the subject, Autism & Oughtisms, says the new policy is contradictory as it expects only the most highly disabled will even qualify to pay family members, but in order to get the funding they must do very many things that would be automatically outside of the capabilities of the severely disabled.

“For example, the disabled person must be able to understand all their obligations under the funding agreement and all key aspects of the agreement. If they cannot, the funding is not approved. Those obligations include all core areas of employment law since the way the scheme is set up is to make them the employer of their family member, as funding is deposited in their bank account which they are then responsible for using to do the following: pay the family member who is supporting them, pay ACC levies, pay tax, and pay the Kiwisaver scheme. The disabled person is explicitly put in the position of an official employer, and explicitly expected to be able to understand and meet all employer obligations, which are extensive and highly complicated in their own right.”

Another element that has been described as contradictory is that in order to meet the scheme requirements, the disabled individual must be able to “explicitly confirm” their preference for a family member to do the work.

“How can the scheme on the one hand acknowledge that individuals may have severe communication difficulties, but insist as a necessary requirement that the disabled individual must be able to explicitly confirm a desire for an employment relationship, and must be able to show an understanding of the employment relationship?” questions the blogger.

In response to these sorts of criticisms, the Government has put in place support systems to help disabled adults make sense of the new policy. Five parties are involved in the funding set-up and ongoing review process: the disabled adult, the carer, the Ministry, NASC (Needs Assessment and Service Coordination) and the “host”, who are an organisation called FASS (Funding Advisory Support Services).

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2 Undertaking other work does not prevent the chosen family/whānau carer from being employed under FFC so long as the hours they are employed under FFC does not involve them in more than 40 hours of total employment per week.
4.4 Individualised Funding

It is worth noting that FFC is not part of Individualised Funding (IF) and is managed in a different way.

IF is a way of paying for disability support services. IF enables disabled people to directly manage the hours they are allocated for Home and Community Support Services. This can range from simply choosing support workers and planning how best to use the hours of support, to employing support workers and managing all aspects of the service delivery. IF is administered through a contracted IF Host. E.g. Manawanui-In-Charge.

The FFC host provider is FASS (Funding Advisory Support Service). There are no plans for additional host providers. FASS is a totally separate business entity to the IF hosts.

New Zealand’s IF does not exclude any disability that is within the present scope of Disability Services. Physical, intellectual and sensory disabilities are all included. Mental health support is not included. For children, or for people with disabilities where there is cognitive impairment, there is the possibility of a parent, guardian or approved carer managing the assessed needs budget on their behalf. There will be provision in the IF programme for the services of independent, appointed advocates for the disabled person to be available.

‘Experience has shown that the management of an IF budget can successfully work through a family or trust on behalf of an individual. Consequently the understanding required by the disabled person does not need to be set so high in some circumstances.’

This is in contrast to FFC, where it is stated in the Operational Policy that the disabled person must explicitly confirm their preference to employ a parent or resident family member to the NASC facilitator.

4.5 Response from Disability Support Services, Ministry of Health

4.5.1 The Ministry of Health have responded to the issues raised. They have said that the key principle of FFC is that the disabled person is at the centre of the policy and at the centre of decision making about their support.

4.5.2 The Ministry have responded ‘If a disabled person does not have sufficient capacity to understand their choices then they should have an advocate to assist them with their decision. This advocate can be a parent, family member, welfare guardian or another natural support. The advocate cannot be the disabled person’s employed family carer as this would mean they are effectively choosing to employ themselves under FFC which would create a conflict of interest’.

4.5.3 The Operational Policy indicates that the role of an advocate is to ensure understanding for the disabled person, it does not make clear what happens for people who do not have the cognitive ability to understand the concept of FFC or make an informed choice. The Ministry responded that "If a disabled person lacks capacity, a court appointed welfare guardian has the authority on their behalf to provide consent to proceeding with FFC so long as the welfare guardian is not also the family carer the disabled person wants to employ. If this is the case this could involve a conflict of interest so it is advised that an advocate other than the chosen family carer must provide this consent.”

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4.5.4 The Ministry was asked to clarify the role of host providers for both IF and FFC. Their response is that NASCs have an overview of the eligibility criteria for IF and FFC. If a person is eligible for IF, they contact an IF host provider, of which there are several, for example, Manawanui In Charge. If a person is eligible for FFC, they will be referred to FASS, who are the only FFC host provider. They are a separate entity to the IF providers.

4.5.5 Some people will be eligible for both IF and FFC. This means that they can employ a parent or resident family member for all or part of their allocation under FFC, but they will not be able to employ a parent or resident family member for any part of their allocation that is under IF.

4.5.6 The Disability Strategy Coordinator asked the Ministry why information about FFC was not fully accessible to disabled people. The Ministry said that the communications will be improved, including easy read versions of the information.

4.5.7 The Ministry also commented on numbers of people able to access FFC and stated that there is no cap on numbers. Although the numbers are estimated at 1,600, there may be more or fewer people who eligible for it. The Ministry added that FFC is aimed at people with ‘high or very high’ needs.

4.5.8 Disability Support Services are committed to ensuring that there is sufficient funding for all disabled people to obtain the supports they need.

4.5.9 The Ministry concluded that the numbers eligible for FFC will be small enough that people can be responded to on an individual basis.

5. Conclusion

The Ministry response would indicate that they have considered people who do not have the cognitive capacity to act as an employer and suggest that a court appointed welfare guardian can advocate for the person. The Ministry are clear that the welfare guardian cannot be the same person who would be employed under any FFC allocation.

6. References


Carers NZ website www.carers.net.nz

Ministry of Health. 2013. Funded Family Care Operational Policy. Wellington: Ministry of Health


FASS (Funding Advisory & Support Services) website www.fass.org.nz
7.3 Current Policy for ACC Funding for Falls Programme
Injury Prevention Programmes
– Older Persons Falls

Targeting the right person with the right services at the right time

Reducing the risk of falls and the incidence of injuries resulting from falls in older adults is a priority area for ACC and a priority activity within ‘Preventing Injury from Falls: The National Strategy 2005 – 2015’.

Falls are the most common and expensive cause of injury for older people. Around 30-60% of people aged 65 plus fall each year and 10-20% of these events result in injury such as hip fracture, hospitalisation or death. Falls can result in fear of falling with subsequent avoidance of physical activity and decline in health, and they are an independent predictor of premature entry into residential care even if there is no injury.

Falls account for over 80% of all injury related admissions to hospital for people over 65 years. However, falls are also preventable if people at risk of falling are targeted with an appropriate intervention.

ACC’s Injury Prevention strategy is to target older people who are showing evidence of being at risk of falls and provide robust and effective services, including working with health providers to reduce falls and injury risk. The three evidenced early interventions that ACC are involved in are:

- Targeted Vitamin D supplementation to reduce risk and injury from falls for people with Vitamin D deficiency
- Improving service provision in areas such as referral pathways, or provision of initial home assessment by occupational therapists for people identified as being at risk of falls
- Providing multifactorial community falls groups based on exercise and education

Components of a successful Injury Prevention programme:

Collaborative approach
Planning and design of initiatives should be undertaken collaboratively with health providers (DHBs/PHOs) and community based agencies

Agreed referral pathways
An intervention should be part of a larger process including development of clear pathways for identification and referral from the wider health sector (including paramedics, GPs, practice nurses, emergency departments, and ACC case managers) into the intervention appropriate for the person’s needs.

Targeted
ACC falls prevention interventions should be targeted to those people who are displaying signs of potential falls risk.

Proven content
Components should be designed and delivered by credible and qualified providers (e.g. for multifactorial falls groups - sports trusts for exercise, pharmacists for medication, and occupational therapists for environmental factors). Exercise approaches must fit in with recognised strength and balance techniques.

Self-sustaining
ACC funding should be limited to a set period of time, enabling establishment of clear pathways and reputation of intervention, so that benefits to the health sector are proven. This should provide a case for the incorporation of the initiative into business as usual for health providers and community.

Evaluated
Any interventions should be able to be evaluated, with positive results as the desired outcome.

1 Robinson / Campbell (2013). Falling Costs: The Case for Investment
2 Lord SR (2001): Falls in Older People – Risk Factors and Strategies for Prevention
CONFIRM

8.1 Action Point for next DSAC Meeting
8.2 DSAC Feedback to CPHAC
8.3 DSAC Feedback to Board
GENERAL BUSINESS