



Waitemata
District Health Board

Best Care for Everyone

Disability Support Advisory Committee

Meeting

Wednesday 28 August 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*

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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.

This sheet provides summary information only - refer to clause 36, schedule 3 of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004 for further information (available at www.legislation.govt.nz) and “Managing Conflicts of Interest – Guidance for Public Entities” (www.oag.govt.nz).

ADHB WDHB DSAC INTERESTS REGISTER

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Sandra CONEY (Chair)	Councillor Auckland Council	Chair Parks Committee	Fees		2 May 2011
Jo AGNEW (Deputy Chair)	Professional Teaching Fellow, School of Nursing, Auckland University Casual Staff Nurse ADHB		Salary Salary		7 September 2011
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
Pat BOOTH	Fairfax Suburban Papers in Auckland	Consulting Editor			24 June 2009

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Susan BUCKLAND	Writer, editor Medical Council of NZ Occupational Therapy Board Northern Region Ethics Committee	Self-employed Professional Conduct Committee member Professional Conduct Committee member Member	Fees Fee Fee Fee		12 September 2012
Lester LEVY	University of Auckland Business School New Zealand Leadership Institute Health Benefits Limited Tonkin & Taylor Waitemata District Health Board Auckland Transport	Professor (Adjunct) of Leadership Co-Director Deputy Chair Independent Chairman Chairman Chairman			1 November 2012
Robyn NORTHEY	Self employed Contractor Hope Foundation A+ Charitable Trust	Project management, service review, planning etc. Board member Trustee			20 June 2012
Michelle CAVANAGH	Te Taurahere O Ngati Porou Ki Tamaki WDHB – HWFNZ Hauora Maori Coordinator Northland DHB Kai Ora Hauora Northern Regional Coordinator	Involvement Part time employee Contractor			7 March 2012

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Maria HULL-BROWN	Employee Mental Health Foundation Board member HOPE Foundation for Research on Ageing Council Member Age Concern Auckland.				1 November 2012
Dairne KIRTON	CCS Disability Action National Board	Northern Regional Representative			23 November 2011
Jan MOSS	Complex Carer Group WDHB SSOAS Stakeholders Group Operational Trust YES Centre MOH Disability Workforce Reference Group	Co-ordinator Member Board Member Member			30 September 2011
Susan SHERRARD	CCS Disability Action Ripple Trust Auckland Council Strategic Advisory Group	Contract Trustee			7 March 2012
Russell VICKERY	Ripple Trust Auckland CCS Disability Action TalkLink Trust Auckland Disability Law Waitakere Community Law Disability Consultant Wilson Home Trust Management Committee Disability Consultant	Trustee Life member Trustee Member Steering Committee Committee member Self Employed CCS Disability Action Nominee Care Managers Research, Auckland University Nursing School			14 November 2012

CONFIRMATION OF MINUTES
- WEDNESDAY 5 JUNE 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, 5 June 2013 in the Training Room, CCS Disability Action, 14 Erson Avenue, Royal Oak, Auckland commencing at 1:00pm

2 ATTENDANCE AND APOLOGIES

The Chair declared the meeting open at 1:00pm.

Committee Members

Sandra Coney (WDHB) (Chair)
Jo Agnew (ADHB)
Susan Buckland (ADHB)
Robyn Northey (ADHB)
Dairne Kirton
Russell Vickery

Max Abbott (WDHB)
Pat Booth (WDHB)
Jan Moss
Marie Hull-Brown
Susan Sherrard

Management in Attendance

ADHB

Dr Denis Jury – Chief Planning & Funding Officer
Carolyn Simmons Carlsson – Professional Leader Allied Health for Sue Waters – Chief Health Professionals Officer

WDHB

Leanne Catchpole – Programme Manager Health of Older People
Tim Wood – Group Manager Funder NGOs
Samantha Dalwood – Disability Strategy Coordinator
Kartina Lenzie-Smith – Programme Manager

Apologies

Apologies had been received from Lester Levy (ADHB & WDHB), Sue Waters and Ailsa Claire (ADHB).

Moved Sandra Coney/Seconded Jo Agnew

That the apologies be received.

Carried

3 CONFLICTS OF INTEREST

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

4	CONFIRMATION OF MINUTES 13 MARCH 2013
	<p>Moved Sandra Coney/Seconded Marie Hull-Brown</p> <p>That the minutes of the ADHB and WDH B Disability Support Advisory Committee meeting held on 13 March 2013 be confirmed as a true and correct record.</p> <p><u>Carried</u></p>
5	ACTION POINTS 13 MARCH 2013
	<ul style="list-style-type: none"> • Disability parking positions - Tim Wood completed the review of the assigned parking positions • Meeting with the Auckland Council Disability Group - Sandra Coney will defer setting this meeting until after the upcoming elections • Information on remuneration and reimbursement and the Terms of Reference of the Regional HOP Consumer Representatives Group – Denis Jury to ensure this information is circulated at the next meeting. • Funding boundary issues that impact on clients and patients - Tim Wood will draft letter under Sandra Coney's name by Friday, 7 June 2013.
6	Chairman's Report
6.1	<ul style="list-style-type: none"> • Health Passport - The information was taken as read. • Disability Sector Workshop Sandra Coney reported that it was well attended and people appeared very engaged. • Disabled Access to North Shore Hospital The crossover was not built for cost reasons. However, there is a solution and a very cost effective one. There are a number of mobility car parks to the left of the entrance and it is intended to do a like-for-like swap in another area. This will take away the need to get up the hill to the entrance. Entrance three can also be used which provides protection from the elements. These are good outcomes which can be implemented quickly. • Auckland Council Unitary Plan Sandra Coney attended a workshop at the Fickling Centre in Three Kings. She reported that there were a lot of planning issues that affected the health sector and it would be prudent to keep an eye on what occurred with this plan.
7.1	Waitemata DHB Home Based Support Services Proposal for Change
	<p>Leanne Catchpole, Team Leader Health of Older People and Healthy Lifestyles spoke to her report.</p> <p>Process for submitting Auckland and Waitemata District Health Boards are working very closely together. The process is working well, however a new model needs to be defined.</p> <p>The consultation process started on 27 May with public consultation documents being available on WDH B's website. Submitters can do an online submission or print off a hard copy to fill in and post.</p> <p>The consultation process will end on 24 June. The DHB will collate all feedback and a summary of that feedback along with a recommendation as to how HBSS should be provided, will be presented to the Board for approval.</p> <p>ADHB may take some of this feedback and modify their model.</p>

Jo Agnew asked that it be minuted that this is not an initiative to save money but is designed to upgrade service.

Proposal for Change

The Chairperson asked Leanne Catchpole to go through the six points of change with the committee. In brief they are:

1. Restorative model of care

There is to be a greater focus on moving to home based support. It includes more interaction with other carers and agencies with the aim of maximising an individual's independence.

2. Change to case mix method of funding for allocating home and support services.

Looking at moving from current fee-for-service funding model to a case-mix model. This type of model emphasises "quality" as providers are paid a set amount based on the functional needs of their clients. The client should be getting a service that is appropriate for their level of need.

3. Better integration of Home and Community Support Services with Primary Care, Secondary Care and Local Communities.

Will provide a better level of care for both complex and non-complex clients because they will be screened at the single point of entry. The approach is more efficient for support worker as clients will be in smaller geographical areas. Less travel time is required and a greater knowledge of the services within their geographical area will be gained. Information will be able to be shared electronically between services and providers enabling an integrated approach to care planning and delivery.

4. Prioritising services to clients with higher needs.

Those clients at low risk would be unlikely to receive services. A thorough reassessment of each client will be undertaken before making any changes to the services they receive. NASC will liaise with the clients GP to get input for the reassessment. This change is required to ensure that higher needs clients have access to services appropriate for their level of need within the available budget.

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

The framework has come about as a result of the Auditor General's review of HBSS. He found that the Ministry and DHB's could not be confident that HBSS are effective and efficient, or that they can provide assurance that cultural differences are taken into account. There are also workforce issues of low wages, high turnover and poor training provision.

Under this new system there is a greater opportunity to measure the quality of services provided.

6. Option of Individualised Funding

The client is assessed by NASC but receives money from MoH/DHB to purchase the services and support they need. This type of funding gives people more choice, control and flexibility over, how, when and who provides the support.

Key comment from the committee was that:

- Careful consideration needed to be given to the individual's feelings as well as their medical conditions when deciding if services were to be changed or withdrawn.
- Concern was expressed around processes that should be in place for letting the older persons family know when services were withdrawn. Older people do not always understand their obligations or what was due to them.
- If an older person is judged capable of looking after themselves, how do you discharge that person effectively? It was advised that there is dialogue with the family and the GP before

	<p>any service is withdrawn.</p> <ul style="list-style-type: none"> • Some older people liked to be able to “do” for themselves and would prefer to be able to vacuum and dust but might require assistance in getting out and about. It would be preferable that they had this choice. • Sandra Coney asked how the model impacted on up-skilling of support workers. <p>Tim Wood advised that stability of workforce is gained due to flexible hours and therefore perception of conditions improved allowing time for up-skilling.</p> <ul style="list-style-type: none"> • Currently there is very little sharing of information so there is little information on quality of care or benchmarking. <p>Discussion moved to how people were to make submissions.</p> <ul style="list-style-type: none"> • Concern was expressed over putting forward a submission in an easy to read format and/or a braille version. It was advised that what was available was a simple two page submission form. • The committee were adamant that this must reach as many people as possible. It needed to be distributed in libraries, to support agencies, societies and disabled networks <p>Officers advised that all the providers were to be given a copy of the advert to use in whatever forum they deemed necessary and that local newspapers and newsletters were being targeted.</p> <p>Moved Sandra Coney/Seconded Marie Hull-Brown</p> <p>That the report of Leanne Catchpole, Team Leader Health of Older People and Healthy Lifestyles dated 5 June 2013 be received.</p> <p><u>Carried</u></p>
<p>7.2</p>	<p>Northern Regional Health Plan (NRHP) Health of Older People Workstream Update</p>
	<p>Tim Wood and Denis Jury advised that year to date the implementation plan is on track. Key deliverables in the first 9 months included:</p> <ul style="list-style-type: none"> • Progress with dementia – a guidelines document had been drafted and a pilot was being prepared • Increased participation and engagement in falls and pressure injuries training • Roll out of the “yellow envelope” strategy had been very effective • Number of advanced care planning conversations with people 65+ is ahead of its annual target <p>Alan Davis, Geriatrician from Northland District Health Board was in attendance and spoke to the report. He advised that:</p> <ul style="list-style-type: none"> • It was a learning exercise, as services to older people are highly complex • Service configurations are defined by service needs and not the clients needs • Looking particularly at areas of high need • Collaborative approach embraced • Spend is \$350m per year <p>Committee members commented as follows:</p> <ul style="list-style-type: none"> • Yellow Envelope a great success • The Committee Chairperson, Sandra Coney asked about a new E-care tool where the client can ask questions electronically. Alan Davies advised that not everyone has computers and therefore this solution is not for everyone.

	<p>Moved Sandra Coney/Seconded Pat Booth</p> <p>That the report by Dr Alan Davis, clinical lead, Northern Regional Alliance Ltd, dated 5 June 2013 be received</p> <p><u>Carried</u></p> <p>[<i>Secretarial Note</i>: It was recommended by Jo Agnew that the “yellow envelopes” be presented to both Boards with a brief description of how the system works.]</p>
8.1	Quarterly Report on the Implementation of the NZ Disability Strategy
8.1.1.	<u>Disability Strategy Workshop</u>
	<p>Samatha Dalwood, Disability Strategy Coordinator spoke to her report.</p> <p>She advised that:</p> <ul style="list-style-type: none"> • The first draft on workshops and visual notes and been started and sent out for feedback. • Key visions from the workshop are that; everyone matters, equity, inclusion and being valued • The five streams that resulted are: <ul style="list-style-type: none"> - Communication and information - Buildings and access - Staff attitude and responsiveness to disabled people - Engaging with disabled people - Employing disabled staff. <p>Moved Robyn Northey/Seconded Jan Moss</p> <p>That this Committee invite the Ministry of Health to brief the committee and discuss concerns of people under 65 in the Auckland region about receiving respite and residential care.</p> <p><u>Carried</u></p>
8.2	Quarterly Report on Activities
	<p>The report was taken as read:</p> <p>Leanne Catchpole outlined some key areas that the Committee should be aware of.</p> <ul style="list-style-type: none"> • Two projects in dementia care will still retain project status in 2013/2014 with pilots being rolled out <p>Vaccination training for residential care providers - 22 nurses in Waitemata area done training and the success has meant that they are already planning for next year</p> <ul style="list-style-type: none"> • Warm Up Waitemata - programme offering free insulation to low income families is uncertain for the next financial year. Leanne responded to questions from the committee advising that 2/3rds of the funding comes from ECCA and a 1/3rd from third party funding. Counties-Manukau has arranged for Ortex to pick this up but Counties-Manukau will not fund the management component. • Ward 12 – remedial work will be finished in 2013 however, some of the plans for new buildings for older adult services has had to be shelved for the time being due to the withdrawal of national funding • Young babies with disabilities not receiving support – this will be the subject of a report later in the year

	<p>Moved Sandra Coney/Seconded Pat Booth</p> <p>That the report of Katrina Lenzie-Smith, Health of Older People, Programme Manager dated 5 June 2013 be received</p> <p><u>Carried</u></p>
9.0	<p>CONFIRMATION</p> <p>Action Points for Next DSAC Meeting</p> <ol style="list-style-type: none"> 1. Invite the Ministry of Health to brief the committee and discuss concerns of people under 65 in the Auckland region about receiving respite and residential care. 2. A brief presentation be made to both ADHB and WDHB Boards on the “Yellow Envelope” system and process and how it works
	NEXT MEETING
	<p>There being no further business the meeting closed at 2:23pm</p> <p>The next scheduled meeting is : 1:00pm, Wednesday, 28 August 2013 Training Room, CCS Disability Action 14 Erson Avenue Royal Oak Auckland</p>
	<p>CONFIRMED</p> <p>CHAIR: DATE:</p>

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ACTION POINTS

- WEDNESDAY 5 JUNE 2013

**Disability Support Advisory Committee
Action Points from the Meeting held on Wednesday 5 June 2011**

Item	Detail	Designated	Action
Carried forward	The Secretary was to follow up with Colleen Brown on organising a meeting with the Auckland Council Disability Group.	Sandra Coney	Deferred until after the election
Carried forward	The Committee asked for information on remuneration and reimbursement and the Terms of Reference of the Regional HOP Consumer Representatives Group.	Katrina Lenzie-Smith Tony O'Connor	Item on this agenda
Carried forward	Some estimate of what the costs would be to implement the Caring Counts report recommendations (after their report is available)	Denis Jury Tim Wood	To go to full Board of each DHB
Carried forward	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.	Denis Jury	November
Carried forward	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)	Tim Wood	To be advised
Item 8.1.1 5 June 2013	That this Committee invite the Ministry of Health to brief the committee and discuss concerns of people under 65 in the Auckland region about receiving respite and residential care.	Katrina Lenzie-Smith	Item on this agenda
Item 7.2 5 June 2013	A brief presentation be made to both ADHB and WDHB Boards on the "Yellow Envelope" system and process and how it works.		Due for report to DSAC after post launch review

CHAIRPERSON'S REPORT

PRESENTATION

-

- **PEOPLE UNDER 65 IN THE AUCKLAND REGION
RECEIVING RESPITE AND RESIDENTIAL CARE**

PAPERS

- 8.1 DISAC Update Report on the Implementation of the NZ Disability Strategy in Auckland & Waitemata DHBs**
- 8.2 Engagement & Consultation Financial Recognition (Public Participation Reimbursement)**

8.1 DISAC Update Report on the Implementation of the NZ Disability Strategy in Auckland & Waitemata DHBs

Auckland & Waitemata DHBs
 Auckland/Waitemata District Health Board
 DiSAC Meeting

Date	1 August 2013
To	Auckland and Waitemata DHB - DiSAC Committee
From	Dr Debbie Holdsworth, Director of Funding, WDHB & ADHB Sue Waters, ADHB Executive Director Allied Health, Scientific & Technical
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 DHBs 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 2013-2016

The new joint Waitemata DHB/ADHB Implementation Plan 2013-2016 and progress report is attached in Appendix I and Appendix II.

2013-2016 Disability Strategy Implementation Plan

This plan is now complete. It has been out for review internally to both DHBs and also externally to members of the disability sector and disability community.

The five work streams in the plan are:

1. Communication and Information
2. Buildings and Access
3. Staff Attitude and Responsiveness to disabled people
4. Engaging with disabled people and getting their input
5. Employment of disabled staff.

The plan incorporates the recommendations from the 2011 report done for ADHB, the Disability section of the 2012-13 ADHB Annual Plan and the current joint Disability Strategy Implementation Plan. It is a great example of a collaborative piece of work between the DHBs and disabled people and reflects what disabled people want to see happen over the next three years.

It is on Waitemata DHB and ADHB staff intranet sites, which has generated some interest, particularly in the pictures used.

There has been a positive response from many of the staff who will be involved in the implementation of the plan. In particular Communications and Facilities have had discussions with the Disability Coordinator around improvements that can be made quickly and for little cost.

Accessible Car Parking

The changes to the accessible parking at North Shore Hospital have been completed. There has been positive feedback about the location of the parking spaces and the ease of access to the main hospital building.

Waitemata Health Excellence Awards

The new Elective Surgery Centre (ESC) was a unique opportunity to work with Facilities and ESC to provide clear and consistent signage and way finding. A project group met regularly with ESC and Facilities and then took the proposed signage out to consumer groups for feedback. Members of the groups included Maori Health, the disability sector and Health Link North. We also sourced clinical input from staff.

With collaboration, good will and the inclusion of consumers in the process we ended up with consistent, accessible signage throughout the building. We had clear guidelines around which signs should be translated into Maori and have promoted the use of international symbols where possible. Having a consumer voice built into the process does not cost more money or take any more time, but adds so much value. The ESC signage is 'by the people, for the people' and embraces the WDHB values of Connected and Everyone Matters.

The Disability Coordinator has entered this piece of work for the Waitemata Health Excellence Awards as an example of inclusion. It is titled **Finding a Way: A collaborative project to provide simple, accessible signage in ESC.**

Disability Champions

One of the goals of the Disability Strategy Implementation Plan is the development of Disability Champions across ADHB and WDHB. In WDHB we are developing a similar model to the Violence Intervention Programme leaders, known as the VIP Team. A Job Description for the role is being developed and interested people will be asked to apply and be interviewed. There is no money attached to the role, but the process supports the value that is placed on the role. Disability Champions are expected to have a good knowledge of a wide range of disabilities, an understanding of the Social Model of disability and a commitment to empowering disabled people in a health setting. There will be ongoing training attached to the role and forums for the Champions to meet. The Disability Champions will be able to bring their experiences in the provider arm of the DHB to the Funding & Planning arm and support the reduction of inequalities through their work.

Contact Centre Consultation

The possible joining together of the two DHBs contact centres is a great opportunity to improve the telephone service. The automated system is difficult for some people to navigate. This is also an opportunity to look at offering Deaf people the ability to communicate with the DHB using text through a webtext facility. The Disability Coordinator also provided feedback requesting for Contact Centre staff to have training in using the NZ Relay service.

Appendix I: Joint WDHB/ADHB Disability Strategy Implementation Plan 2013-2016

Appendix II: Joint WDHB/ADHB Disability Strategy Implementation Plan progress report

Waitemata DHB and Auckland DHB Implementation of the New Zealand Disability Strategy 2013-2016



**Communication and
Access to information**
Empowering people
through knowledge and
understanding



Waitemata DHB & Auckland
DHB are fully inclusive



Physical Access
Overcoming a
disabling society



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



**Community and
consumer engagement**
Working within a family and
patient centred framework



Disability Responsiveness
Educating staff and
challenging stereotypes
and assumptions



Communication and Access to Information

Empowering people through knowledge and understanding

Accessible Communication guidelines developed.
Review of Web content and presentation.
Increase formats of key documents, e.g. Strategic Plans.
Review the automated telephone system with regard to access for people with disabilities.
Review the possibility of improved text communication to patients.
Continue the implementation of the Health Passport across both DHBs.
Work with the Deaf community to improve access to interpreters.
Encourage the use of interpreters for non-English speaking families.



Community and Consumer Engagement

Working within a family and patient centred framework

Ensure a diverse range of disabled people are identified as stakeholders in all projects and service development.
Engage regularly with the disability sector to develop their capacity to influence decision making and increase DHB responsiveness.
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.
Continue working with Health Links to increase health literacy through fully accessible patient information.



Employment Opportunities

Equal employment opportunities for people with impairments and carers

Encourage the use of supported employment agencies.
Review all recruitment and employment policies and make recommendations to improve inclusion and employment opportunities for disabled people, as required.
Collect data on the number of staff with disabilities (at the time of employment and/or when a disability is acquired).
Work with Hiring Managers to increase disability awareness.
Working with HR to look at how the DHBs support staff with Carer responsibilities.



Disability Responsiveness

Educating staff and challenging stereotypes & assumptions

Work with Dieticians to improve the nutritional outcomes for disabled patients.
Develop 'Disability Champion' roles across the DHBs.
Promote the Disability Awareness e-learning module to all staff across the DHBs.
Provide a range of disability awareness training, targeting specific services.
Develop tools to increase staff skills for working with people with communication difficulties.
Ensure public waiting areas, wards and treatment areas meet the needs of a range of impairments, including people with autistic spectrum disorders.



Physical Access

Overcoming a disabling society

Encourage the use of symbols and pictograms in signage and way finding.
ADHB Disability Champions will complete the 2-day Barrier Free Training.
An accredited Barrier Free Advisor will be involved in all new Facilities work.
Adoption of Universal Design principles in all Facilities work.
Building standards document developed in ADHB.
A review of accessible toilets in ADHB buildings to be completed.
Work with Auckland Transport to improve accessible transport between hospital sites.
Investigate the reported shortage of wheelchairs available - both numbers and sizes.



Waitemata DHB and Auckland DHB Implementation of the New Zealand Disability Strategy 2013-2016

Current Status at 1 August 2013



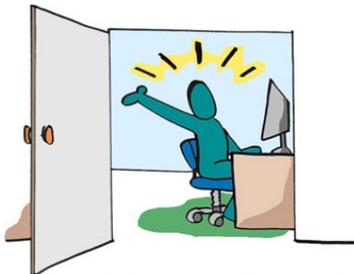
Communication and
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Employment Opportunities
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Community and
Consumer engagement
Working within a family and
patient centred framework



Disability Responsiveness
Educating staff and
challenging stereotypes
and assumptions



Communication and Information Empowering people through knowledge and understanding
Current Status at 1 August 2013

<u>What</u> we will do... actions	<u>Where</u> we are now...current status
Accessible Communication guidelines developed.	July 2013 - Communications Teams have received the Office for Disability Accessible Communications Guidelines for information.
Review of Web content and presentation.	August 2013 - Work starting with Communications Managers to look at both websites and web content and improve accessibility and information.
Increase formats of key documents, e.g. Strategic Plans.	
Review the automated telephone system with regard to access for people with disabilities.	July 2013 – Gave feedback around better support for disabled, particularly Deaf, people accessing information via the telephone into the Contact Centre consultation.
Review the possibility of improved text communication to patients.	July 2013 – Gave feedback around better support for disabled, particularly Deaf, people accessing information via the telephone into the Contact Centre consultation.
Continue the implementation of the Health Passport across both DHBs.	Ongoing
Work with the Deaf community to improve access to interpreters.	
Encourage the use of interpreters for non-English speaking families.	Working with Asian Health to look at the use of interpreters for disabled people and their families.



Community and Engagement Working within a family and patient centred framework
Current Status at 1 August 2013

<u>What</u> we will do... actions	<u>Where</u> we are now...current status
Ensure a diverse range of disabled people are identified as stake-holders in all projects and service development.	
Engage regularly with the disability sector to develop their capacity to influence decision making and increase DHB responsiveness.	July 2013 - CCS Disability Action have run a workshop for disabled people to talk about their experiences of the health system and recommendations for improvement. CCS will meet with the DHBs and PHOs to discuss the key points and to have an opportunity to respond to the issues raised.
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.	
Continue working with Health Links to increase health literacy through fully accessible patient information.	Ongoing work.



Employment Opportunities Equal employment opportunities for people with impairments and carers
Current Status at 1 August 2013

<u>What</u> we will do... actions	<u>Where</u> we are now...current status
Encourage the use of supported employment agencies.	
Review all recruitment and employment policies and make recommendations to improve inclusion and employment opportunities for disabled people, as required.	
Collect data on the number of staff with disabilities (at the time of employment and/or when a disability is acquired).	In the staff management system staff can now tick a box to say that they identify as having an impairment and can add information about this impairment. This means that we are starting to collect data on the number of staff with impairments.
Work with Hiring Managers to increase disability awareness.	August 2013 - reviewing the current Recruitment & Retention of Staff with Disabilities / Impairments guidelines.
Working with HR to look at how the DHBs support staff with Carer responsibilities.	Working HR and Carers NZ to develop initiatives to become a CareAware workplace. CareAware is a national initiative from Australia to support organizations to become carer friendly workplaces.



Disability Responsiveness Educating staff and challenging stereotypes & assumptions
Current Status at 1 August 2013

<u>What</u> we will do... actions	<u>Where</u> we are now...current status
Work with Dieticians to improve the nutritional outcomes for disabled patients.	Disability Coordinator is presenting a paper at the Dieticians Conference in September 2013 called 'For want of a straw: Nutrition and Hydration for People with Disabilities in a Health Setting'. Dieticians have completed an audit on patient feeding across the two DHBs. This had a focus on patients who may need support to access food or drinks. We are waiting for the results of this audit to be collated to update the data.
Develop 'Disability Champion' roles across the DHBs.	Starting to create a job description of the Disability Champion role.
Promote the Disability Awareness e-learning module to all staff across the DHBs.	Ongoing.
Provide a range of disability awareness training, targeting specific services.	Karen Noble, Nurse/Health Adviser from IDEA Services is presenting on 21 August as part of the Awhina Speaker Series – 'Intellectual Disability & Health – Working together for the best outcomes'.
Develop tools to increase staff skills for working with people with communication difficulties.	
Ensure public waiting areas, wards and treatment areas meet the needs of a range of impairments, including people with autistic spectrum disorders.	



Physical Access Overcoming a disabling society
Current Status at 1 August 2013

<u>What</u> we will do... actions	<u>Where</u> we are now...current status
Encourage the use of symbols and pictograms in signage and way finding.	Elective Surgery Centre is a great example of clear, user-friendly signage.
ADHB Disability Champions will complete the 2-day Barrier Free Training.	
An accredited Barrier Free Advisor will be involved in all new Facilities work.	July 2013 – had discussion with Allan Johns, ADHB Facilities Manager.
Adoption of Universal Design principles in all Facilities work.	July 2013 – had discussion with Allan Johns, ADHB Facilities Manager.
Building standards document developed in ADHB.	July 2013 – had discussion with Allan Johns, ADHB Facilities Manager.
A review of accessible toilets in ADHB buildings to be completed.	July 2013 – had discussion with Allan Johns, ADHB Facilities Manager.
Work with Auckland Transport to improve accessible transport between hospital sites.	
Investigate the reported shortage of wheelchairs available - both numbers and sizes.	

8.2 Engagement & Consultation Financial Recognition (Public Participation Reimbursement)

Engagement and Consultation Financial Recognition (Public Participation Reimbursement)

Contents

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1. Overview

Purpose

Auckland and Waitemata DHBs recognise the contribution of people external to the DHB who are invited to contribute their expertise and advice. It is important to have a consistent approach to the financial recognition of this contribution. This policy lays down rules on how to ensure this.

Scope

This policy is applicable to all Auckland and Waitemata DHBs' Board members and employees (full time, part time, casual and temporary) and contractors who are involved in any matter that requires engagement or consultation.

DHB Board members, employees and contractors will implement this policy when:

- Consulting patients and other community stakeholders
- Engaging the wider public and/or key stakeholders about important decisions.

This policy does not apply to employment matters.

This policy also applies to all of ADHB and WDHB and extends to their involvement on regional projects.

2. Definitions

Term	Community
Community	Community can be defined by place, identity and shared interest. For the purposes of this policy, a community member is anyone who may be interested and/or affected by a health-related activity, proposal or decision to be made.
Consultation	Consultation is identified as part of developing and implementing health and disability services and programmes in section 22 of the <u>New Zealand Public Health and Disability Act 2000</u> and the <u>Local Government Act 2002</u> . The process includes soliciting public feedback on a proposal and decision-makers being able to demonstrate that they have taken that feedback into account when finalising a proposal. The objectives of District Health Boards under section 22 include: ... (f) to reduce, with a view to eliminating, health outcome disparities between

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Term	Community
	<p>various population groups within New Zealand by developing and implementing, in <u>consultation</u> with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders:</p> <p>(g) to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services:</p> <p>(h) to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services:</p> <p>...</p> <p>For Auckland and Waitemata DHBs, the term consultation also has a particular meaning with the context of the Treaty of Waitangi and the <u>Memorandum of Understanding with Ngati Whatua</u>. Waitemata DHB also has a particular obligation to consult under its Memorandum of Understanding with Te Whanau o Waipareira.</p>
Engagement	Engagement is not a legislated process. It can take many forms and serve many purposes that allow patients and other community stakeholders to inform and/or participate in decisions that affect their health and the development of services that they receive. Informing the community does not, in itself, constitute engagement. Engagement requires dialogue and building relationships.
Stakeholder	A stakeholder is a person or collective that has something of value at stake that may be affected by a proposal or decision to be made. Who a proposal's stakeholders are will depend on the subject-matter of the proposal and should therefore be identified accordingly.

3. Policy

3.1 Policy Statement

Auckland and Waitemata DHBs recognise the contribution of people external to the DHB who are invited to contribute their expertise and advice. It is important to have a consistent approach to engagement and participation of the community and key stakeholders. This policy lays down rules on how to ensure this.

This policy covers people from the community, consumer and other stakeholder sectors who are not otherwise receiving remuneration for their time and participation in DHB activities. It includes invitations to people to participate and contribute in one-off initiatives as well as people who contribute their expertise to longer term projects.

This policy applies equally to both the DHB provider arm and the Planning and Funding Team. Management consultants engaged by the DHBs must also follow these guidelines.

The underlying principles for this policy include:

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- The active engagement of DHBs with people in the community adds value by improving decision making, building knowledge and enabling fair and informed judgments.
- The DHB will invite people from the community to participate in one-off or ongoing events, focus groups, advisory and reference groups and in special project work.
- The DHB will ensure that the time and effort of people in contributing to the development of DHB initiatives will be appropriately resourced in all respects.
- All expenditure decisions in recognition of public participation in DHB activities will be made with integrity and transparency.
- In any one group or advisory situation, all people participating will be considered equal, irrespective of their profession, qualifications, experience or background.

Respect/Manaaki

Manaaki is defined as “to support, take care of, give hospitality to, protect, look out for”.

Recognition of people invited to participate in DHB activities requires that they are positively valued and shown respect. This requires sensitivity to people’s cultural and social diversity and an awareness of issues for people with disabilities. This means that people assisting the DHB should be provided with sufficient resources to enable and support effective contribution. This includes the provision of sufficient information for projects, support with transport or other needs as required, giving refreshments, sending out minutes or a record of community input and formally acknowledging people for their participation in writing. Ensuring that the venue and the information are fully accessible.

Auckland and Waitemata DHBs recognise community input by demonstrating to participants that their input is seriously considered and is reflected in health planning and funding decisions.

Koha/gifts

Koha/Gift is defined as an ‘unconditional gift’, and may be presented as a token of appreciation for contributions made to DHB activities. Gifts should not be given regularly to the same person as they may then constitute taxable income. Gifts may be given in the form of petrol vouchers or other tokens of appreciation.

People already on a salary or a contract which covers their participation should not receive a gift.

The value of a gift for a person involved in any one project should not exceed \$50.00.

Out of Pocket Expenses

People who participate in DHB activities may be reimbursed the reasonable expenses associated with their participation. The amount reimbursed must be capable of justification by reference to the travel expenses the participant is likely to have incurred.

The table below provides a guide to the kind of reimbursements associated with different types of work. The recognition is aligned to the degree of engagement along a continuum. This recognises that some of the engagement work does not carry responsibility or accountability while other activities do. People who are invited to work alongside the DHB on special projects, generally longer term, with specific accountabilities need to be recognised at a higher rate than people who provide their views on a one-off basis.

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In all cases, the amount and type of expenses must be approved by the project or initiative's budget holder in advance with the upper limit established. For group work that may last for several meetings or is ongoing, there must be a contract in place between the consumer or community representative and the budget-holder (or their delegate). See the procedural guidelines referenced in the 'Associated Documents' section for the base contract and a description of the contracting process.

People already on a salary or a contract which covers their participation should not receive any out of pocket expenses for participating in a project.

The DHB will not compensate people for taking time off work or for loss of income or costs of a locum etc as a result of providing input to DHB projects.

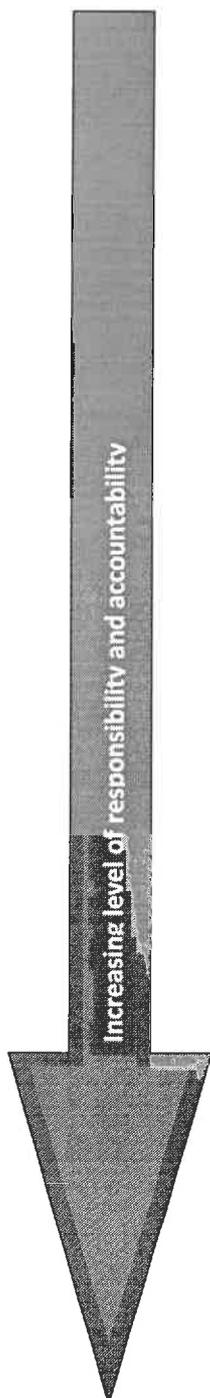
Eligible people should itemise their out of pocket expenses by invoice and should also acknowledge receipt of the payment. Reimbursements should be open and transparent.

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Recognition along the Continuum of Engagement



	Type of Activity	Extent of Financial Recognition	Paid by
1	<p>To Inform the DHB Participation in a public consultation e.g. attending a public meeting, hui, fono or discussion group</p>	<ul style="list-style-type: none"> • None • Assistance if requested to arrange transport or taxi voucher for people who would otherwise not be able to attend in accordance with the Travel Expenses Table below • Assistance if requested with interpreters, or other supports that are essential for participation • Koha where appropriate to recognise an individual's contribution to DHB activities 	<ul style="list-style-type: none"> • No payment • Taxi vouchers posted out prior to the meeting • Interpreters arranged internally
2	<p>Invited to Advise the DHB Participation in a one off focus group or reference group or other one-off groups</p> <p>Invitation to help with one off cultural support or other specialist expertise</p>	<ul style="list-style-type: none"> • Reimbursement of reasonable out-of-pocket expenses up to \$125.00 per meeting • Assistance if requested with taxis/transport for people who would otherwise not be able to attend in accordance with the Travel Expenses Table below 	<ul style="list-style-type: none"> • Reimbursement in form of petrol or book voucher etc • Taxi vouchers
3	<p>Invited to Consult, Partner or Collaborate Participation in an ongoing reference or advisory or working group or special project</p>	<p>Participation with the expectation of regular input for a specific timeframe or period Reimbursement of actual out of pocket expenses and payment of an honorarium for time to a maximum of \$100.00 per hour with a maximum payment for both expenses and honorarium of \$250 per meeting.</p> <p>Expenses may include travel, childcare, special aids for participation and out of meeting work</p>	<ul style="list-style-type: none"> • An Honorarium is paid in recognition of time made as tax deducted payment. Paid retrospectively on invoice. • Expenses reimbursed are tax exempt.

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The basis for reimbursement of travel expenses is set out in the table in Note 2 below. The amounts to be reimbursed represent the reasonable costs of travelling by car (IRD mileage rate of \$0.74 per kilometre has been used as the basis for the calculation) within the distances specified.

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Note 1: Recognition and remuneration will only apply to external parties who have been invited to attend the meeting or workshop or participate in the DHB group or project.

Note 2: Out of pocket expenses for those in Category 2 “Invited to Advise the DHB” are based on the costs of a return trip from their home/work to the DHB and are as follows:

Return Trip distance	Expenses reimbursement
0-40km	\$30
41-60km	\$50
61-90km	\$70
91-120km	\$90
120km+	\$125

DHB Board advisory committee rates are set at \$2500 for 10 meetings, i.e. \$250 per meeting inclusive of preparation time. Remuneration for external parties’ attendance at any DHB meetings / workshops should not exceed this amount.

Note 3: Exemptions for payments above this level of remuneration can be approved at the discretion of the General Manager or persons with delegated authority

Note 4: This policy does not preclude paying a lesser hourly rate for attendance.

- In appointing external people to participate in reference, advisory, working groups or special projects, it should be clearly stated from the outset whether the person has been invited to contribute as a representative of their organisation or established community network, or as an individual.
- When identified as representing their organisation or established community network, payment for the person’s time will be dependant on whether the external party is employed by an organisation funded by the DHB where the funding includes an intention for the two parties to work together on key activities. In this case neither the person nor their organisation shall be additionally remunerated for these activities.
- When identified as contributing as an individual and the person is employed by an organisation funded by the DHB, where the funding includes an intention for the two parties to work together on key activities, payment will be considered on a case-by-case basis.

Note 5: Compliance with internal DHB processes for paying suppliers is required. This includes setting up suppliers with accounts payable prior to invoices being presented. This is the DHB’s responsibility not the invitee’s.

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4. References

Associated Documents

The table below identifies associated documents.

Type	Title/Description
ADHB & WDHB Policy and Guidelines	<u>Public Consultation & Engagement Finance</u> <u>Contractors & Consultants - Engagement</u> <u>Appointing Consumer Representatives for Improvement Initiatives - Guidelines (to be written)</u>
Cabinet Office Circulars and Papers	<u>Cabinet Office Circular CO (09)5 Fees framework for members appointed to bodies in which the Crown has an interest</u> Cabinet paper CAB (00)19/14 Governance of DHBs: Electoral Process and Related Issues
Inland Revenue Advice	<u>Inland Revenue Department 2009 legislative advice – “Tax treatment of reimbursements and honoraria paid to volunteers”</u> Fact Sheet IR278 “Payments and gifts in the Māori community”
Legislation	New Zealand Public Health and Disability Act 2000 Local Government Act 2002
Ministry of Health	Operational Policy Framework Service Change Rules, Principles and Processes for District Health Boards Consultation Guidelines for the Ministry of Health and District Health Boards relating to the provision of health and disability services (2011)

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IMPROVEMENT ACTIVITIES

9.1 Health of Older People Quarterly Report on Activities in Auckland & Waitemata DHBs

9.1 Health of Older People Quarterly Report on Activities in Auckland & Waitemata DHBs

Date	28 August 2013
To	Auckland and Waitemata DHB - DISAC Committee
From	Debbie Holdsworth, Director Funding, Auckland and Waitemata DHBs
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	Health of Older People quarterly report on activities in Auckland & Waitemata DHBs
<p><u>Purpose</u> 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.</p>	
<p><u>Recommendation:</u> That this report is received by DISAC.</p>	
<p><u>Background</u></p> <p>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. The 2013/14 Annual Plans have been approved by the Ministry of Health and are now being implemented 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 Age Related Residential Care (ARRC) sectors, and providing informed choice for older people in their care to minimise dependence.</p>	

The Northern Region Health Plan (NRHP)

The focus for quarter four 2012-13 for the HOP Clinical Network has been on; finalising the HOP Northern Region Health Plan (NRHP) for 2013-15, establishing reporting requirements for four new regional KPIs, completing the Dementia Services Guide, and furthering falls and pressure injury initiatives.

Following submission of a robust first draft of the HOP NRHP and attendance at the CEO/CMO Challenge Session, it was pleasing to note that the MOH had assessed our draft plan as “supported”. A ‘Driver’ Diagram has been developed with the HOP Clinical Network and as a useful way to illustrate our goals, the outcomes and the actions to achieve these. Due to a number of DHB imperatives, several projects scheduled for 2013/14 have already commenced e.g. a review of psycho-geriatric beds in ARRC, establishment of regional interRAI group/s and rehabilitation/community planning.

A regional Maori DHB advisor representing HOP will be joining the HOP Clinical Network Group in August, whose task is also to develop a Kaumatua strategy for the Auckland and Waitemata DHBs.

Yellow Envelope

The purpose of the yellow envelope is to provide a standardised process throughout the Northern Region DHBs by the means of a single yellow envelope, for the transfer of essential resident documentation between the ARRC facility and public hospital. The yellow envelope is designed to go with every resident who is transferred to hospital for evaluation and treatment from an ARRC facility, and completed on every resident or inpatient transferred to an ARRC facility from hospital. It provides essential information in one, easily recognisable place, to ensure the safe handover of the resident to hospital staff, with all the necessary forms inside that staff need to evaluate and manage the ARRC resident.

Consistent use of this yellow envelope will help an ARRC facility, and the hospital ward/clinical area to:

- Provide essential information in one, easily recognisable place that will lead to the most appropriate follow-up of the resident.
- Ensure the safe handover of the resident between hospital and ARRC facility staff.

A post launch review is planned to evaluate whether the implementation of the ‘yellow envelope’ has been a success across the Northern Region, when completed, this will be reported back to DISAC.

Dementia

The Dementia Services Guide (DSG) has been completed which included consultation at a consumer/carer forum comprising of people with dementia and their carers. The consumer/carer group felt the vignettes in the DSG accurately reflected their experience of dementia care as it is provided at this present time and were a useful way of illustrating the challenges of dementia. The DSG is currently being edited and will be published shortly.

All four DHBs have prepared an implementation plan for Dementia Models of Care / Clinical Pathways with one pilot currently underway. There is regional representation on all of the DHB steering and/or advisory groups.

Further to a capacity problem with Psycho-Geriatric (PG) Beds in ARRC, a project scope has been developed to undertake a regional review. This has been endorsed by the HOP Clinical Network and will be overseen by the regional Dementia work group.

First, Do No Harm (FDNH)

Collaboration continues to strengthen with falls and pressure injuries reduction strategies with the ARRC sector.

- Data submission from ARRC on the number of falls and pressure injuries has commenced. More focus and encouragement is required to increase the number of ARRC providers participating and resource at several DHBs to collate the data.
- The recent Health Round Table (HRT) focused on Falls. All four DHBs in the Northern Region are members of the HRT and it was useful to participate in discussion and comparisons of data

across New Zealand.

Acute Presentations from Aged Related Residential Care (ARRC)

Information on the reduction of people acutely presenting and/or admitted in the region was reported for the first time. There was a slight reduction of 1% fewer people presenting acutely to Emergency Department from ARRC (target = 15%). Conversely, there was an increase of 2,023 bed days for those patients admitted acutely from ARRC (target = 2,000 bed day reduction). One factor which may be contributing to the results is the higher acuity of residents as there is a shift in the number of rest home beds being converted to hospital level care across the region in the last 12 months. Other factors are; this report only captures subsidised residents (which are thought to have on average, a higher acuity) and one DHB has significantly higher bed days particularly in the second quarter. Understanding the reasons will be a focus of Health of Older People Clinical Network in the coming Financial Year.

InterRAI

Positive progress is starting to be made across the Northern Region. A regional group has been formed with systems clinicians, healthAlliance and planning/funding managers and the ability to progress and resolve issues with the national project team is improving. All the DHBs have agreed to share their data and report regionally. However, the major impediment to reporting on the two interRAI KPIs, is that one of the DHBs was outside of the regional data warehouse. The DHB in question asked to be included and healthAlliance is facilitating the transfer of data but could not do this in time for the reporting cut-off for quarter four 2012-13. Also, contributing to the delay has been a lack of business reporting specifications generated nationally so this is being determined at a regional and DHB level.

The Pharmaceuticals work stream was stopped due to the recommendation from the Northern Region Clinical Leaders Group who strongly felt the scope of work proposed in the HOP RSP was overly ambitious, coupled with the addition of the Regional Stroke work stream.

For quarter one 2013/14 activities are focussed on the following:

- Commence implementation of HOP RSP for 2013/14
- Appoint consumer representative to HOP Clinical Network Group
- Publish and distribute the Dementia Service Guide
- Commence Psycho geriatric Bed Review
- Evaluate and handover "Yellow Envelope"
- Establish regional interRAI Governance Group
- Confirm data collection and analysis for interRAI and new KPI reporting.

Māori Health Plan

A Hauora Kaumātua Strategy is required for Auckland and Waitemata DHBs to address three key population issues:

1. Equity of access for older Māori to services and programmes
2. Equality of health outcomes, and
3. Ensuring Māori attain and enjoy their rights and privileges of quality of health and wellbeing as do their Treaty partners.

The Hauora Kaumātua Strategy continues to be discussed and debated in a variety of fora which include a range of kaumātua groups, gerontology specialists, whānau and community groups. The project plan for the strategy is due to the Māori Health Gain Manager in August 2013, after which wider formal consultation with dedicated advisory groups will follow.

Home and Community Sector Services (HCSS)

Auckland DHB

At the beginning of the year ADHB and the HCSS providers embarked on the process of developing a Balanced Scorecard (BSC) for HCSS to monitor performance of the service. The process was facilitated by the University of Auckland and comprised of four workshops where measures were identified and a definition for each measure was agreed. Version one of the BSC has now been completed and comprises those measures that were identified as essential for purpose and where data was already being collected. The intention is that the Scorecard will be built on over time. Below are the four domains for the BSC with examples of areas that are measured in each domain. The Service Development Group has agreed to produce a BSC using 2012/13 year data to use as baseline. Providers' quarterly reporting will be amended to reflect the BSC measures.

Balanced Scorecard domains;

- Client Perspective: satisfaction with service; quality of life; complaints and risk rating; clients discharged to independence; clients moving to a lower category
- Business process perspective: skilled staff (level 2,3,4 support workers); missed visits; clients per assessor; culturally appropriate service provision; assessments as a proportion of clients; clients discharged to natural supports; clients moving between categories; clients being readmitted within 30 days; adverse events
- Financial perspective: variance against budget; growth in clients numbers; admissions to aged residential care; admissions to acute care and other medical services; cost per product type; complex versus non complex client split; gain/loss from change in category mix; gain/loss from change in client numbers.
- Learning and growth perspective: client profiles using interRAI; innovations; measure of carer stress.

Complex Clients

Work continues on a process to categorise complex clients receiving HCSS so that tiered rates of payment can be used rather than a flat rate for all complex clients.

Complaints Pilot

ADHB has volunteered to be one of three DHBs participating in the MOH's Complaint Categorisation Pilot. This Pilot is being undertaken in response to the Auditor General's Report: Home-Based Support Services for Older People (2011) that included a recommendation for strengthening consumer complaints processes.

Waitemata DHB

The Waitemata DHB consultation on proposed changes to the HBSS model of care closed on 24 June 2013. The feedback has been analysed and a summary, including recommendations was presented to the Audit and Finance Committee on 9 August. The feedback summary is attached as appendix one. Work is now being undertaken on the procurement and communication plans.

Specialist Services for Health of Older People at Auckland DHB

Work is underway to expedite weekend discharges from Older People's Health wards; this was raised as an issue in the Patient Voice Survey.

Rehabilitation plans have been made visible to patients and family members and an information pamphlet for patients and families prior to admission is also being developed.

Dementia Care Pathway

A co-design approach is being used for the development of the Dementia Care Pathway. This was a decision of the Governance Group and Expert Working Group and it has meant extending the time frame for completion of the Pathway to the end of 2013. The co-design approach focuses on understanding and improving patient and carers experiences of services as well as the services themselves. Two process mapping workshops have been conducted with health stakeholders and carers. The information from these mapping workshops is currently being analysed. A stocktake report of all existing dementia related services has also been completed.

Specialist Services for Older Adults at Waitemata DHB

The Specialised Services of Older Adults (SSOA) Project officially closed on 30 June 2013 as 4 of its 5 subprojects have progressed from project status to business-as-usual status.

Facilities Subproject:

- Subproject closed. Now business-as-usual activity.

Workforce Development Subproject:

- Subproject closed. Now business-as-usual activity.

Single Point of Entry Subproject:

- Subproject closed. Now business-as-usual activity.

Delirium Subproject:

- Some of the 4 work streams had not completed development of their 'resources' by 30 June, but these will be completed soon.
- Discussion is continuing amongst Waitemata DHB senior clinicians re the routine cognitive screening process to be adopted in the hospital wards. The experience of conducting and the findings from the Delirium Point of Prevalence testing is informing the decision.
- This subproject is progressing toward business-as-usual status too.

Dementia Subproject:

- From 1 July 2013 Dementia is a project within the new Waitemata DHB Health of Older People workplan.
- The Waitemata DHB Dementia Project is aligned with national and regional dementia developments.
- The Waitemata DHB Dementia Project is tracking to plan.
 - The Waitemata DHB Clinical Reference Group is progressing toward confirmation of the Waitemata DHB Cognitive Impairment Clinical Pathway.
 - A contract has been agreed with the two PHOs (ProCare & Waitemata PHO) re the requirements for the 12 GPs and their Practice Teams (6 per PHO) who will pilot the Waitemata DHB Cognitive Impairment Clinical Pathway from November 2012 to July 2014.

ARRC at Auckland DHB

A number of small stand alone rest homes are struggling to remain viable with occupancy rates declining. One facility closed in July 2013 due to a sustained period with a low number of residents. A concern is the quality of care that can be provided as a facility becomes less viable and this is being monitored by the DHB Quality Facilitator.

An ARRC study day was attended by 83 enrolled and registered nurses. Topics covered were: pre-morbid anxiety, recognizing decline in older adults, diabetes management in the context of residential care and care of the COPD patients and their journey.

A trial for an Early Warning System for ARRC residents is in the planning stage. This is a method for facilities to identify the signs early that something more serious may be going on and to take action sooner to provide the appropriate care and reduce hospital admissions. Ten facilities are participating in the trial.

The interRAI training facilitator attended the ARRC Steering Group meeting and is available to attend ARRC cluster group meetings in the ensuing months. Over the last month there has been an increase in the number of facilities engaged with interRAI from 19 to 25. Auckland and Waitemata DHB continue to have monthly interRAI provider forums to discuss any issues and feedback to the national interRAI project team.

ARRC at Waitemata DHB

The 60 ARRC facilities within Waitemata DHB work with the Community Gerontology Nursing Service (GNS) in a collaborative model called the Residential Aged Care Integration Programme (RACIP). The service has six gerontology nurse specialists (3.3 FTE) and two wound care nurse specialists (1 FTE) led by the gerontology nurse practitioner (0.5 FTE): (The other half of the GNS and NP role is with community dwelling older adults). The team provide comprehensive geriatric assessment of individual residents with recommendations and consult with geriatricians when required (there is no formal community geriatrician). They also provide clinical education for staff. There is also one GNS focussed on Maori elders with complex health issues across WDHB including ARRC facilities.

Waitemata DHB facilitates two regular forums for our 60 ARRC facilities (the quality forum for managers and owners) and the RACIP work group (managers and clinicians from aged care facilities, GNS, Funding and Planning Quality Nurse Leader and experts in the field: Alzheimer's society, Hospice). The purpose of these forums is for networking, informing, developing clinical guidelines. An outcome from the RACIP forum has been the recent launch of a pamphlet entitled "Dementia decision-making journey: Where to from here?" This provides information for family members of people with advanced dementia living in residential care. It introduces the idea of dementia as a terminal illness and that advance care plans are important. The RACIP forum is now working a more detailed booklet for family members of people with advanced dementia living in residential care. It will support families to understand and be prepared for end stage dementia, advance care plans, appropriate and inappropriate interventions.

Quarterly off site education: In May a session was held on falls prevention, it was attended by 128 people.

Onsite education: Topics are offered bimonthly. Facilities can choose to have an alternative or an extra topic according to need. Head to Toe Assessment for Caregivers (April/May): 44 facilities. Depression (June/July): 40 facilities. Other topics including male catheterisation (May – July): 27 facilities.

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

Devolution of LTS CHC from the Ministry to the regions occurred exactly two years ago in quarter one 2011. The Northern Region has a regional approach for managing and reporting on LTS CHC services.

Key achievements for quarter four 2012/13 include:

- Models of care are being developed for each of the following LTS CHC service groups. These will set standards for clients to have agreed support outcomes, corresponding service coordination and planned clinical follow-up and review.
 - Children
 - Mental health support services
 - Dementia and other significant cognitive impairments
 - Age generational appropriate service options
 - Rehabilitation.
- Ongoing work to establish regionally consistent assessments, standard tools and regionally practiced principals and policies including:
 - Bimonthly LTS CHC Regional Review Panel meetings to review and monitor clients with an annual service package of \$80,000 or more. Twelve clients were reviewed and monitored by the Panel in quarter four.
 - Monthly meetings with Taikura Trust to discuss clients with unclear eligibility and joint funding opportunities.
 - Ongoing peer review with Midland region to compare assessment outcomes and service utilisation.
 - Work with HOP to obtain a regional InterRAI data download that can be utilized to develop LTS CHC reports to profile the client base and utilisation.
- Ongoing enhancement of provider contracts and contract variations for 2013/14.
- A procurement strategy for LTS CHC is being developed that;
 - Identifies LTS CHC service gaps based on the LTS CHC model of care developed for the service groups cited above.
 - Will conduct a stock take of contracts available to other related agencies such as DSS that could also be appropriately utilised by LTS CHC clients.
- The National GMs of Planning & Funding accepted a proposal submitted by the region for the MOH to dis-establish the LTS CHC national reviewer role on 30 June 2013 and in its place establish a National Resolutions Panel. A resolution panel will provide better clarity between LTS CHC and DSS eligibility, review funding stream eligibility for disputed complex high cost clients and conduct robust decision making that will establish national precedents. This will support a more transparent client base (and projected cost) for LTS CHC.
- Regional analysis has indicated over the last 12 months that LTS CHC has achieved more effective and efficient utilisation by way of;
 - Lower number of clients utilising high HBSS hours and subsequently a greater number of clients utilising low HBSS hours.
 - A fair number of rest home clients have transferred to HBSS and subsequently a drop in client numbers at the lower priced end of residential care.

Funding

- The Northern Region's deficit has been projected on an accrual basis between \$1.37m and \$2.04m for 2012/13 based on the MOH's historical funding model. The risk share model has calculated apportionment based on each DHB's population based funding formula (PBFF) share. The deficit is expected to be higher in 2013/14 as the MOH funding envelope transitions to a Population Based Funding Formula.
- Despite the significant increase in eligible clients the deficit has been maintained due to the decrease in utilisation of services by the region. Given the scale and having no control over the eligible number of high end clients means the region will only be able to make marginal change to the deficit without significant changes in the level and mix of services provided.



Waitemata DHB Home Based Support Services Consultation Feedback Summary Report

Acknowledgement

Waitemata DHB would like to thank all respondents who took the time to provide valuable feedback. The DHB would also like to thank everyone who has assisted the project team with the consultation process.

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Glossary

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.

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

1.1. Purpose

The purpose of this document is to present to the general public and the wider stakeholders a summary of the feedback received from the Home Based Support Services consultation undertaken by Waitemata District Health Board (DHB) in May-June 2013.

1.2. Background and Context

Home Based Support Services (HBSS) are an important service for a rapidly growing part of Waitemata DHB's 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 providing a total of approximately 80,000 hours of care each month for 5,300 clients and, this is very likely to increase with the changing demographics. 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 for HBSS. Other DHBs are also considering similar changes.

Waitemata DHB is committed to providing the best care for everyone. 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 that would enhance the overall quality of HBSS and would ensure that services are client-centred and provided in a coordinated way so that older people and some younger people with chronic health conditions are adequately supported to continue to live safely and independently in their homes.

1.3. What did the DHB consult on?

Waitemata DHB undertook public consultation between May 27, 2013 and June 24, 2013 on the following proposed changes:

- A restorative and goal-directed approach to HBSS in Waitemata
- A casemix model of funding for HBSS
- Better integration of HBSS with other services provided in the community
- Prioritising services to high needs clients
- Adopt a quality approach to HBSS
- Option of Individualised Funding (IF)

1.4. Why did the DHB undertake consultation?

The DHB's aims of the consultation were:

- To ensure that the proposed changes would meet the needs of the Waitemata community
- To obtain feedback from stakeholders and consumers and their families and Whanau on the proposed changes
- To better understand the range of perspectives of different stakeholders and consumers

- To enable involved individuals and organisations to constructively engage in any change process.

2. The Consultation Process

For Waitemata DHB, the term 'consultation' has a particular meaning within the context of the Treaty of Waitangi and its Memorandum of Understanding (MOU) with Ngati Whatua and Te Whanau O Waipareira Trust. Prior to commencing consultation, Waitemata DHB engaged with the MOU partners and the Maori Health Gain Manager Waitemata DHB Planning and Funding to discuss engagement with Maori and sought their services and networks to consult with Maori stakeholders and wider Maori communities.

The DHB's HBSS Consultation Plan also had input from the Pacific Health Funding and Planning Manager Waitemata DHB/Auckland DHB and the Advisor, Asian Health, Waitemata DHB. The Community Engagement Coordinator, Waitemata DHB worked with Healthlink North and Waitakere Healthlink to ensure relevant stakeholders were well informed and that appropriate engagement with the local community was undertaken.

2.1. Consultation Methods

The DHB employed the following methods to consult with stakeholders and the general public.

2.1.1. Briefing Meetings

Prior to commencing consultation two briefing meetings were held to inform and advise the key service provider stakeholders i.e. those who were most likely to be affected by the proposed changes, which included the current HBSS providers contracted by Waitemata DHB and the DHB's Needs Assessment Support Coordination (NASC) team. At the briefing meetings the Team Leader, Health of Older People, Planning & Funding, Waitemata DHB presented an overview of the proposed changes and copies of the consultation document were given out. These meetings were well attended with over 20 representatives from seven HBSS providers and almost 40 NASC staff attending.

2.1.2. Consultation Documents

Consultation commenced on May 27, 2013 when the following documents were emailed to stakeholders and were also loaded on to the DHB public website:

- Introductory message
- The Proposal for Change
- A Summary of the Proposal for Change
- A link to survey monkey
- Feedback Form
- Frequently Asked Questions

In the introductory message stakeholders were advised that hard copies of the consultation documents could be obtained from the DHB and that the DHB would welcome any request for face to face engagement. The contact details (mobile phone number and email) of the relevant DHB personnel were also provided. Stakeholders and consumers were invited to complete the feedback form (hard copy/online) and return to the DHB by 5pm Monday June 24, 2013.

Stakeholders were also requested to forward the consultation documents on as appropriate to their networks.

2.1.3. Press Advertisement

Advertisements were published in the three local papers (North Shore Times, Western Leader, and Rodney Times) twice during the consultation period (week starting 27th May and 10th June) to inform the general public of the consultation. The advert directed the readers to Waitemata DHB's public website for accessing the consultation documents. It also provided the contact details (mobile phone number and email) of DHB personnel if anybody wished to request hard copies of the consultation documents or schedule a face-to-face meeting or had any query.

The advert was also published in various consumer advocacy related newsletters e.g. Healthlink North, Waitakere Healthlink, North Shore Community and Social Services (NSCSS), Community Waitakere (formerly known as West Auckland District Council of Social Services –WADCOSS), and the Primary Care Newsletter.

2.1.4. Engagement during the Consultation Period

During the consultation period the DHB engaged with stakeholders and the general public primarily by three avenues: telephone, email, and face to face meeting. The Planning and Funding Team, Waitemata DHB received approximately 180 phone calls during the consultation period. Most callers were older people who were anxious and apprehensive that services they were getting could stop or be reduced. The DHB personnel were able to clarify the proposed changes and their likely impact on consumers. Just over 100 callers were happy with the information given over the phone and did not wish to be sent the consultation documents. The rest of the callers requested the Proposal for Change (detailed or summary or both) and the Feedback Form be mailed to them. Hard copies were sent to 62 callers and 9 copies were sent out by email. A few queries were received by email requesting for clarifications such as the likely impact on palliative care clients, smaller HBSS providers and current services being received by clients. These queries were responded to and no further feedback was received.

During the consultation period the DHB received five requests for face to face meetings. One meeting was held with a current HBSS provider and two meetings were held with two HBSS providers who are not currently contracted by Waitemata DHB. The DHB also met with a community organisation and a Maori organisation. A request for a face to face meeting was received from a HBSS provider after the consultation period was over which the DHB had to decline. The Funding and Planning Team also presented the Proposal for Change at the Disability Advisory Committee meeting on 5 June 2013. The Committee discussed the proposed changes and sought clarification on the consultation plan.

2.1.5. Expert Advisory Group

An expert advisory group has been set up by the DHB to assist with the redesign of the HBSS model of care if the proposed changes go ahead as an outcome of the consultation process. The main purpose of the advisory group is to provide independent, unbiased, professional advice and opinion that would support the DHB's aim of making overall improvement to home based services in a sustainable way. The group has senior clinical and academic representation from the DHB Provider Arm, Primary Care, University of Auckland and the DHB's Maori Health Gain Team. Currently there is no consumer representation on the group however the DHB's

Community Engagement Coordinator is 'place-holding' till such time direct consumer input is required.

2.2. Collation and Analysis of Consultation Feedback

Respondents were requested to provide feedback by completing an online survey by using survey monkey or by sending hard copy surveys in the mail. A number of older people requested printed copies of the proposal close to the consultation closing date. To allow for the slowness of the postal service, feedback received by mail in the days following the close of consultation was accepted.

The online survey monkey tool was used to collate the findings of the survey. Out of 77 completed feedback surveys 54 were completed online and the remaining 23 were received in hard copies or by email and, were manually entered onto survey monkey.

Prior to analysing the survey feedback was categorised under two broad headings: quantitative and qualitative. Quantitative information referred to the numerical data related to the consultation. Qualitative information referred to the feedback received from respondents in the form of comments posted on survey monkey or received via written/email correspondence.

Quantitative analysis was performed using the 'analyse' tool on survey monkey which produced the various percentages as presented below under 'Quantitative Consultation Findings'. Qualitative analysis was performed by examining comments (from 77 respondents) on survey monkey and written feedback (from 9 respondents) for recurring key themes and patterns¹. Some information did not have recurring themes but was deemed relevant and thought to have made useful point and therefore was included in the analysis.

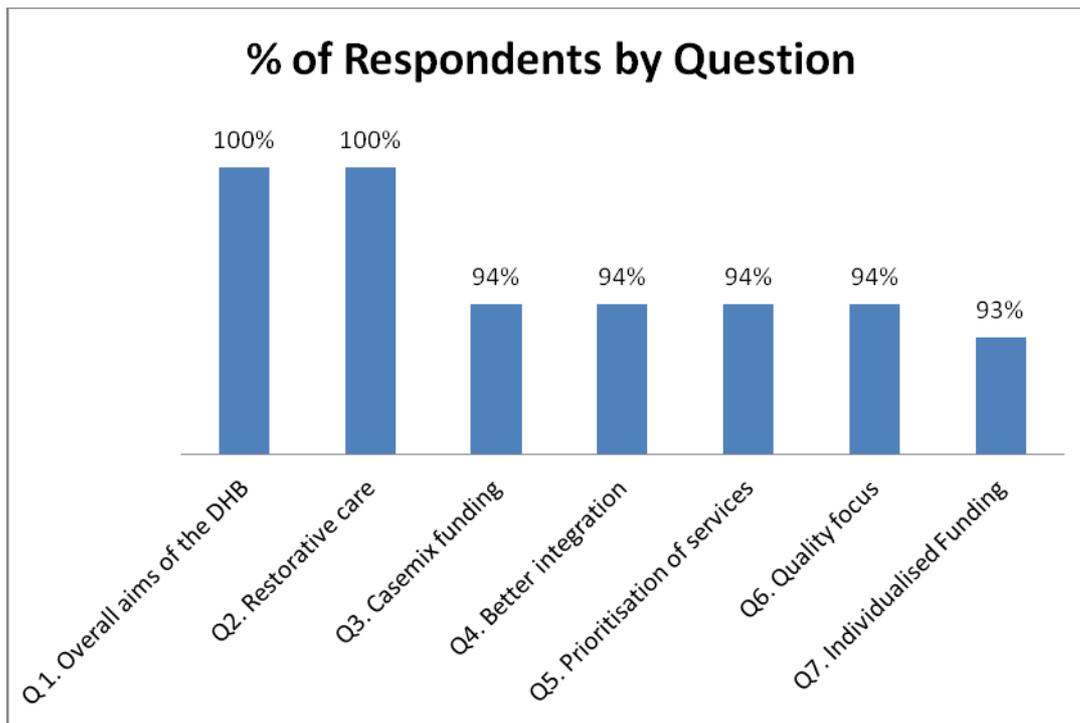
3. Consultation Findings

3.1. Quantitative

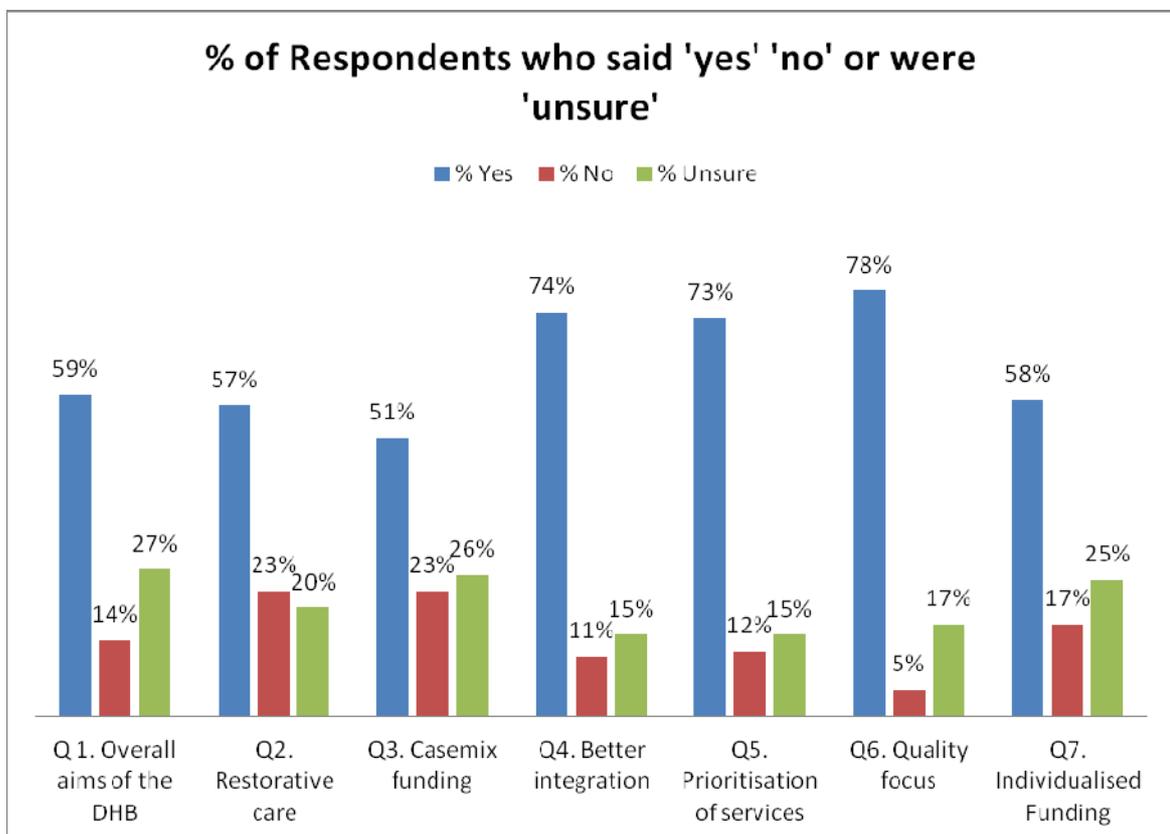
The DHB received 77 completed surveys in total. The Bar Chart below shows the % of respondents who responded to each of the questions. Approximately 93% of respondents answered all seven survey questions.

¹ A 'theme or pattern' is considered 'key' when it is reflected in at least 5-10% of the responses.

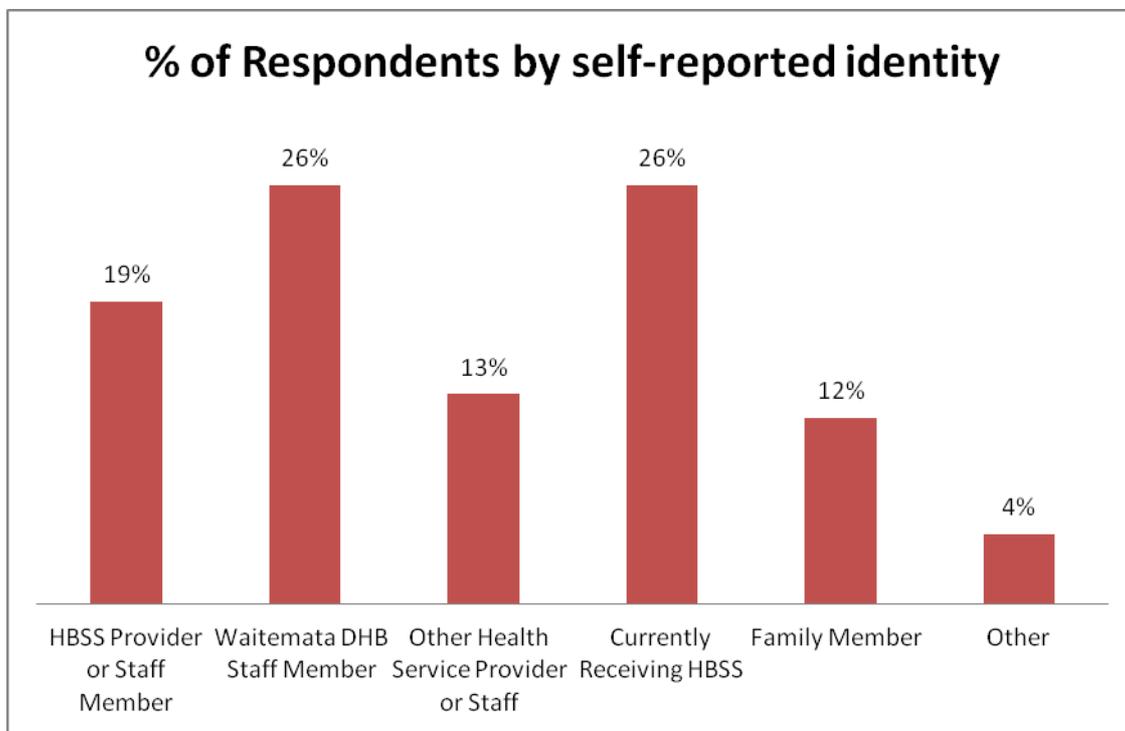
³Aims:



The Bar Chart below shows the % of respondents who responded 'yes', 'no' or 'unsure'. It is important to note that overall at least a quarter of the respondents were 'unsure' about question 1, 3 and 7. This finding correlates with comments from a number of respondents seeking further clarification on the details of casemix funding and expressing concerns around the suitability of IF for older people. Uncertainty around these questions would have contributed to respondents feeling unsure of the overall aims of the DHB.



The Bar Chart below shows the % respondents by self-reported identity. Over a quarter of the respondents identified themselves as currently receiving HBSS. Waitemata DHB staff members represented 26% of respondents. Just under 20% of respondents identified themselves as HBSS providers whereas other health service providers or staff represented 13% of respondents. It is important to note that 12% of respondents were family members of older people.



3.2. Qualitative

Presented below are key feedback themes related to each question/proposed change.

Question 1: ²Overall Aims of the DHB

Overall, 59% of respondents supported the overall aims of the DHB as outlined in the consultation document while 14% did not support the overall aims of the DHB and 27% were unsure.

Some of the comments from those who supported the DHB’s aims were: “very supportive of the restorative model of care”; “I would like to feedback my endorsement of the consultative document”; “I think the existing services do need some changes.....”; “it’s important that client’s needs are met appropriately”; “when reviewing WDHB catchment demographics and aging population, ... business as usual is no longer an option”; “if it works it will be and should be for

²

- A greater focus on restorative care, on promoting health, managing long term conditions and supporting self management.
- Improving integration with secondary care, community services, community resources, and particularly, with general practice.
- Improving quality and service delivery efficiency
- Ensuring we meet clients needs in terms of accessibility, flexibility, client involvement and control, and cultural appropriateness.
- Addressing workforce issues. Currently support workers are often minimally trained, on casual contracts, and always poorly paid.
- Defining the target population for the HBSS service and in particular considering whether the lowest needs clients remain a priority for services
- Controlling cost
- Working with Auckland DHB to align the two DHBs’ HBSS models of care

the benefit of the patients”. Some respondents supported the proposed aims provided current services were maintained while some felt that the proposed changes could “present an opportune time to increase training and wages in this essential employment sector”. The proposed restorative model of care was seen as a model that puts patients’ needs first and enables them to “improve or maintain functioning rather than tasks being done for them”. It was highlighted that only 2% Maori and 2% Pacific clients currently accessed services.

It was felt by certain respondents from the Waitemata DHB Older Adults and Home Health Services that the proposed redesign of HBSS could reduce NASC workload and assist with current staff shortage and long wait time for assessment for household management –“our service cannot keep up to the demands ... due to the increasing ageing population and also the complexity of the medical and social situation seems to be increasing”.

A whanau ora provider gave feedback that Maori should receive support through a whanau ora approach rather than DHB contracted HBSS services, so that they can receive a comprehensive package of support that addresses the needs of the whole whanau.

HBSS providers who in other DHBs have adopted similar models indicated that the proposed changes will “give providers an opportunity to redesign their service and embrace restorative care” which focuses on developing a single support plan based on client-centred goals and takes into consideration “client’s strengths and abilities, self management of chronic conditions and essential links with other services”. One provider commented: “working to improve a person’s independence and maintaining current abilities and function” can potentially reduce “downstream requirements of services”. Another provider commented that the proposed changes would “add value to service delivery and improve the quality of life of clients and their families and Whanau”. Overall the main benefits of this model were outlined as: improved efficiency, more opportunities for workforce development, provision of better quality care, and increased client and staff satisfaction. That said certain providers felt that compared to the current system the proposed model would assign more responsibility to providers. This means providers will need to “lift their game and ensure they have appropriate and well trained workforce available”. It was also highlighted that small providers “will not be able to manage this” and overall “application of restorative model of care” will be a challenging undertaking. Some felt that the proposed funding model would need to be cognisant that the sector would only be stable if providers were funded sufficiently to remain financially viable.

Respondents who did not agree with the proposed aims viewed this exercise as a way to cut or manage costs by limiting access. Some comments were: “fear it is really a cost cutting exercise”; “... saving money by forcing changes on people who cannot fight back”; “just a bit wary of this leading to loss of funding where it is needed”; “.....changes are designed to restrict access and capitate homecare within a restricted budget”; “I don’t believe that it (the proposal) reflects the current needs of our elderly population & will require a huge admin component to implement”. Some clients felt that providers were large organisations and the DHB needed their support to implement the proposed changes to ensure “elderly are really cared for properly”.

A number of respondents felt that the proposal lacked details around how the proposed model would work in reality as reflected in some of the comments: “the devil is in the details”; “fine words but these are management speak that is not in my view supported by actual examples of how this will be done”; “insufficient details is provided in the document on the means and

funding required for the changes proposed”. Feedback showed that some respondents felt there was insufficient information in the proposal regarding the “impact of the proposed changes on clients and service providers” or “the funding impact of the changes proposed”. Concerns were raised that “some clients could be disadvantaged by the goal-directed care” while “clients with perceived low needs may be overlooked” as the proposal appears to call for a “shift focus to administration rather than focusing on client needs”.

Some respondents highlighted potential conflict of interest if HBSS providers themselves undertook assessment of and assigned services to non complex clients. It was felt that providers could potentially abuse the system by over-servicing or under-servicing clients irrespective of need. Some comments were: “it’s hard to be objective when you have a personal financial gain involved”; “I do have concerns that agencies will have a vested interest in maintaining low/medium need clients within their system”. It was strongly recommended that independent audits are undertaken to ensure clients are receiving services appropriate for their need. Some also felt that the proposed changes are unlikely to address the working conditions and wage issues of support workers within the sector. A consumer advocacy group felt that this was an opportunity to introduce HBSS in the retirement village settings and recognise retirement villages as HBSS providers. The villages could then use their own staff to provide services which will be more efficient system without time spent on travel as is the case currently.

In summary, over half the respondents supported the proposed overall aims of the DHB to improve the quality of home based services. However respondents pointed out that a robust change management process will be required to implement such a major ‘culture shift’ along with an ongoing monitoring system to ensure quality of care. Experiences of HBSS providers who have been involved with the development and implementation of similar models in other DHBs were positive: “It has been shown that a restorative, goal based approach improves outcomes and client satisfaction. It offers an opportunity to develop a well trained workforce who is empowered and supported by their employer”. One provider pointed out: “Our experience is that even where the service recipient enters palliative services, the restorative programme continues to add value through its emphasis on enhanced decision making for the client”.

3.2.1. Question 2: Restorative and Goal-directed Care

Overall 57% respondents supported the DHB’s proposal for a restorative and goal-directed approach to HBSS whilst 23% did not support and 20% were unsure.

Some of the comments from those who supported the proposal were: “I applaud the move toward the restorative model” because it facilitates “.....prevention of decline and promotion of health as a way of maintaining patients safely in their own surroundings for as long as is practicable and possible”; “I fully support this approach”; “flexible delivery is important and is not being supplied by the current model”; “proposed changes could encourage clients in regaining independence”; “clients are involved in the development and review of their goals”; “we agree that maximising independence is an important goal for all and greater involvement in decision making is valuable in that process”.

HBSS providers with experience in restorative and goal-directed care were in support of the proposed change and listed a range of benefits of this approach, for example: 1) increased flexibility of service delivery as opposed to a prescriptive fee for service approach, 2) promoting independence, 3) encouraging recovery, 4) regaining and maintaining function and mobility, 5)

focusing on active recovery to prevent unnecessary loss of independence. In their experience support workers reported improved job satisfaction due to better opportunity for training and also seeing clients improve under their care. One provider said: “restorative model ensures the client has maximum opportunity to remain safely and independently in the home of their choosing”. They went on to say that “the model focuses on meeting support needs in a holistic manner” that takes into account the social needs of clients and utilises “formal as well as informal resources” to meet those needs. That said providers also indicated that they made significant investment (e.g. workforce development) to successfully develop and implement restorative model of care. Restorative approach was described as “HBSS providers effectively partnering with clients, their family and Whanau and funders” to ensure “resources are targeted to clients with highest support needs”. It was noted that the model worked better within an integrated multidisciplinary environment and was shown to “make a huge difference in the life of an older person” by linking them with support networks and services available in the local community. However it was strongly recommended that a quality improvement and outcomes monitoring system be built into the proposed model.

Providers also commented that a “case management approach encourages collaboration, advocacy, communication and resource management”. In a restorative approach the “emphasis is on client decision making” which in turn facilitates “self-management”; it is about “helping older people to manage their life in spite of their chronic conditions rather than just trying to manage the conditions”. Such approach “takes into account all the factors that affect an older person’s health and wellbeing” and makes clients feel “empoweredbetter for their self esteem and mental health”. An allied health practitioner suggested that restorative approach offers an opportunity to enhance the ability of older people to maintain strength by “support workers becoming ‘activity coaches’ to help elderly overcome the barriers older people face when trying to access more traditional forms of exercise” ... “the support worker is a facilitator of the activity, setting up the environment, providing motivation, prompting and supervision to complete the exercise programme [available on a DVD]”. One provider suggested that the eligibility of HBSS be expanded to include those requiring “short term support due to incapacity or hospitalisation, those with palliative care needs that are not covered by other services and those with inadequate natural supports”. In their experience these clients could “benefit from a package of supports that has a restorative focus”.

Feedback suggested that the term ‘restorative’ care was interpreted by many respondents as ‘full recovery of function’. Respondents felt quite strongly that restoration is not a viable option as most older people have non reversible chronic conditions and perhaps permanent loss of function and cognitive impairment: “it is likely that older people’s health and functional condition will continue to decline than improve”; “those living alone or with dementia could struggle”; “how do you improve the impaired sight and hearing of a 94 year old lady living at home?”; “restorative is not in the capability of most elderly people (over 80)”. Instead the focus is on safety and providing support to maintain a certain standard of living to help older people remain at home: “we support them to stay at home and make them as comfortable as possible there is little or no chance of restorative goal based care”; “their whole aim is to....remain in their home with support, manage their ³ADLs and keep their home reasonably clean”. Some respondents even thought that a restorative approach can even be regarded as an “insult” to

³ ADLs means Activities of Daily Living

older people and their family considering their permanent disability. Some wondered whether older people would even be interested in goal setting and clients with complex needs, dementia etc could struggle to understand this approach and fail to meaningfully engage in a goal setting process with support workers. On the whole these comments indicated that the term 'restorative' mislead respondents into thinking the model proposes to rehabilitate people to their previous level of functioning. A suggestion was made around possibly using the term 'aims' instead of goals. That said some respondents felt that "short term goal setting can be useful along with monitoring and reassessment to ensure services meet needs"; "older people have short term goals which work well to achieve short term improvements".

Goal setting for older people was perceived by some respondents to be unrealistic as their only goal is "to remain in their own home". Some were of the view that a goal-directed approach might be more appropriate for clients younger than 65 who are "not so frail and less medically complex" or clients with temporary disability e.g. "recovering from surgery or illness". A primary care provider expressed concerns around support workers carrying out unrealistic goal setting and suggested that an alternative could be using gerontology nurse specialists instead. It was felt that the proposal failed to explain the role of the family and Whanau in the new model.

Concerns were raised that a restorative approach would be resource intense and could take longer as support workers "would need to work alongside the older person instead of doing it for them" which is more time-consuming considering somewhat limited abilities of many older people. Such a significant change will require a considerable lead in time. Some respondents were sceptical whether the purpose of a restorative approach was to cut costs or to achieve improved outcomes for clients: "I am unsure that the agenda looks to benefit the older population or is more interested in saving money"; "this is a smoke screen, all home care is goal based as it stands ... the only reason for making changes is to restrict access". Some felt that even though "a reablement model" can be beneficial to clients some providers might not be able to make sufficient investment to make it work. It was also pointed out that "restoration and reablement" would require additional allied health resources which would all add to additional cost. A question was raised "in the absence of additional funding how would this be managed"?

In summary over half the respondents supported the DHB's proposal for a restorative and goal-directed approach to HBSS. However feedback suggested that to a number of respondents the term 'restorative' meant 'recovery of full function' or 'total reablement' (which is not what the DHB meant). As a result those respondents felt this approach would be more appropriate for clients who have temporary loss of function instead of older people with permanent disability. However HBSS providers with experience in restorative approach had a very different view as reflected in their feedback around the potential benefits for older people of this approach. Some respondents were unsure whether the DHB's current providers would have sufficient resources to implement this model while some thought this was a cost cutting exercise in the guise of a 'restorative approach'. If the model is to go ahead the DHB will need to work with the community and stakeholders to clarify that it is about older people having 'aims' and being provided with goal-directed care to optimise functioning.

3.2.2. Question 3: Casemix Funding Model

Just over half (51%) the respondents supported the DHB's proposal to move to a casemix funding model from the traditional 'fee for service' model while just under 20% didn't support the proposal and over a quarter of the respondents were unsure .

Respondents in favour of the casemix model commented that compared to the traditional model casemix provides "greater flexibility to tailor support to meet the client's needs and support them to achieve their goals" and allows "to customise care based on needs and I do support the approach". Casemix funding model was perceived as "sensible to fund this way, it ensures quality not quantity.... the patients in most need get the most support". It was also felt that "it is timely for WDHB to move forward to the case-mix model to provide home based support in the best interest of patients with an emphasis on quality of care and patient safety". Some respondents agreed with the casemix concept in principle but felt further consultation was required prior to developing the detailed model. Some felt "checks need to be in place to ensure clients are receiving the service they require"; "I am in favour of this casemix model if it was properly organised and monitored". It was envisaged that the proposed model would "increase efficiency with service provision" however the transition from the current to the new model needs to be managed appropriately. It was also pointed out that from Auckland DHB's experience "the model takes some years to effectively settle into and providers would need support to make the transition". One provider suggested that the DHB should look at aligning casemix distribution with geographical distribution of providers. A consumer advocacy group felt this model can be extended to include retirement villages where the services can be provided by their own staff who are trained and currently deliver similar services. A Maori provider indicated that "Flexi funding provides the best option for Maori".

Providers with experience in casemix funding listed a number of benefits of the model: 1) facilitates improved understanding between needs assessment services, HBSS providers and the funders about targeting services to those with the highest need, 2) understanding the risks associated with different casemix groups, 3) shares the risks between providers and funders, 4) creates the right environment for providers to be innovative, 5) provides an efficient framework for providing flexible service, 6) providers having more responsibility for planning, delivery and reporting of services that translates to "higher quality and better trained staff", 7) as funding is upfront providers have the ability to plan and structure their workforce better.

One provider said: "moving to a model that looks at outputs has allowed our organisation to investigate more innovative ways of delivering serviceswe have found that the casemix model has removed the quantity aspect of care and has emphasised quality as providers are paid a set amount based on the functional needs of clients we provide services to". Feedback suggests that the model enabled providers to not only plan "workforce training" but also plan "targeted training for specific groups of clients" and offer "greater scope for work security" to support workers. Overall these providers saw the casemix funding model as "an opportunity that enables flexibility to provide the right level of support at the right time by the right person". It was also perceived as: "... a fairer and more manageable model" that not only "results in better outcomes for people using services but decreases provider administration time and costs" in the long run. However some providers felt that the new model would allow the DHB to transfer some of the financial risks to the providers as funding would be capped for each casemix group and paid upfront and, providers would be responsible for managing their budget. Providers also indicated

that there are hidden costs associated with complex clients and that should be taken into account while establishing the funding model.

A number of respondents felt that the proposal did not provide a detailed explanation of the casemix model and how it differed from the current model. Some of the comments were: “I do not understand this”; “I am unsure about casemix”; “reading the information it seems it is supposed to be superior model but I am unsure”; “there is insufficient information here to make a definitive decision”; “it appears to be bulk funding”. Some also thought that the proposal failed to provide details around how the DHB was going to manage the increase in costs from what seems to be a “huge increase in monitoring to ensure clients receive appropriate care”. One respondent said: “this seems to be a form of outsourcing that may encourage providers to reduce support to fit the funds” implying that the model could become a disincentive for providing the right care ultimately leading to a “budget based as opposed to client needs based” model. Some were also sceptical about the purpose of the model as reflected in their comment: “it seems like a fairer system” but it is perhaps a “cost cutting idea all around”. The proposal was thought to have implied that as client’s need changes so does the level of care. Any cost overrun incurred from exceeding original allocation (of hours) is therefore offset by periods of lower level of care. Respondents did not agree with this concept and felt that in reality older people are more likely to require higher level of care as they age.

Strong feedback was received with regards to the proposal lacking details around what safeguards should be in place to prevent potential abuse e.g. “cream skimming” i.e. “potential adverse selection of clients”. Some of the comments were: “what are the checks and audit procedures that will ensure thatclient’s needs are met..... and that the providers’ financial gains does not take precedence over the needs of the clients”. Concerns were raised around the possibility of providers abusing the system by manipulating assessment outcomes in a way that allows under-servicing or over-servicing of clients. Questions put forward were: “Who will monitor”? How is the provision of care to the client monitored and reported”?

Some were sceptical whether the providers had the expertise to cope with the flexibility this model provided. One respondent referred to a time prior to the establishment of NASC when HBSS providers managed their own budgets without success and, recommended that clear guidelines are developed right from the outset. It was also felt that the casemix model may favour the big providers and the DHB was urged to provide appropriate assistance to the current providers who have no experience with casemix model. Considering there will not be any increase in total HBSS funding, some were unsure how casemix funding would address the issue that it takes longer encouraging clients to do tasks by themselves rather than just doing it for them. It is therefore likely that “support workers would still be tempted to complete the tasks as quickly as possible if there is no real incentive to do otherwise”.

A primary care provider felt that by grouping patients with diverse clinical profile according to functional needs could potentially put them at risk and compromise equitable access which could have implications for the clients’ general practice teams. They felt a hospital casemix system “made sense” because unlike HBSS, patients are grouped by clinical profile and have access to specialist staff as appropriate. Some respondents were of the view that “each client has individual needs” therefore were unsure how in the new model clients are lumped together in groups and still receive client specific care. It was strongly recommended that if the DHB went

ahead with casemix model these risks need to be managed beforehand. It was suggested that consulting with DHBs (for example Auckland DHB) who are using this model could be useful.

In summary, over half the respondents supported the casemix proposal. However a number of respondents were unsure of what casemix funding was and would have liked more detailed explanation. Providers with previous experience in casemix funding were supportive of the proposal and highlighted a number of potential benefits of the model. Some respondents questioned the ability of the current providers to manage their budgets in the new model and felt “checks and balances” need to be in place to prevent potential abuse. The DHB was urged to support providers who have no experience in casemix model.

3.2.3. Question 4: Integration of Services

Seventy four percent of respondents supported the DHB’s proposal to establish better integration of HBSS with general practices, hospital services, Waitemata DHB’s Community Services and local communities. Eleven percent of respondents did not support this proposal while 15% of respondents were unsure.

Some of the comments from those in favour of better integration were: “this area has been inadequately integrated”; “in our experience this is essential for quality care”; “there is currently a level of disconnect between the providers of HBSS and the patient’s GP with the provision of appropriate technology it would be the role of the provider’s care managers to update the GP”; “collaboration between community therapist and agency caregivers would lead to the best outcome for patients”; “greater integration across the sector will lead to better outcomes for older people especially those with dementia”; “any sort of integration between organisations would be a wonderful thing to see happen”. One respondent said “... having closer connections to the community HBSS would have a positive approach more streamlined integrated quality care would be beneficial for all” and will help minimise “duplication” of resources.

HBSS providers with experience in casemix model indicated that “integrating services will provide a continuum of care, where services are coordinated and responsive so consumers receive the right care at the right place at the right time”. Integration was described by some providers as “an essential component of the model” while some felt that integrating services could be a way of addressing capacity issue in the sector. Providers who worked within a partnership model commented that “working in an alliance framework facilitates partnerships based on trust and understanding of each other’s roles and skill set”. One provider felt that integration ensures that “clients not falling through the gaps and being more fully informed and in control of their situation”. Another provider felt that the focus should be on building capacity in primary care and community based services which would improve: 1) “integration between services”, 2) create “efficiency” and 3) reduce “the risk of disconnect between multiple services that may be involved in supporting person’s care”. It was clear from the feedback that providers believed that “good (and timely) linkages improve quality of care” and minimise duplication. Most providers indicated that a ‘single point of entry’ (SPOE) for HBSS referrals would be critical for successful integration of HBSS with other services: “SPOE is vital”; “integration of services has been successful with the SPOE being key to this”. SPOE also benefit clients by identifying patients at risk so that appropriate plan of action can be instituted.

The overall feedback was that within a connected environment most clients report some improvement even if it is only through a sense of control over their service provision. One HBSS provider said: “having a shared information portal has proved valuable” as it enables other providers involved in the care of a particular client to access relevant information online in an efficient way. This allows providers to have the information they need to make decisions without undue delays: “...all people involved with the client have access not only to the assessment but also the goal ladder including information relating to goal attainment”. A consumer advocacy group felt “it will be an advantage to have the patient’s information available to all who genuinely need it”. One stakeholder pointed out the role ⁴interRAI can potentially play in assisting with better integration: “used properly interRAI produces information that can be shared across the sector.....that will enable efficiency and effectiveness of care as well as support as it will identify those who require further restorative strategies and treatment”.

One respondent expressed serious concerns over what they perceived as “huge gaps” in the discharge planning “pathway” from “hospital to community care area to ultimately home”. It was felt that the situation was “very worrying” considering “the capacity of the elderly person to understand and self advocate” and at times “the vested interests” of their “family and independent advocate”.

Some were of the opinion that integration could work if the roles and responsibilities of each provider are well defined and agreed to – “as long as services maintain their own boundaries and respect boundaries of others”. Some agreed in principle but felt sufficient information was not provided in the consultation document on how integration was actually going to take place – “there is no explanation as how this integration will occur and what form it will take”; “I feel it will not be an easy task to achieve this integration”; “if this to take place a lot of coordination would be necessary”. A primary care provider supported the proposal but felt appropriate systems should be in place while triaging clients into complex and non complex groups to ensure clients did not get “lost between cracks”. Another primary care provider felt that integration with primary care can be challenging as general practices are largely “small scale private enterprises with different drivers to that of the DHB”.

Some said “best of Britishcommunication is worst in healthcare can’t see it working”; “this new system costing more to administer for no gain”. Some asked the question that within an integrative context “where will responsibility/accountability rest”? Some were extremely anxious about their information being shared across multiple providers – “as a client I absolutely do not support sharing of information should only take place with specific consent”.

In summary, three quarters of respondents supported the DHB’s proposal to better integrate HBSS with other services clients may be receiving. Providers who had experience with similar models felt that working within an alliance framework could help coordinate and integrate multiple services. This would ensure that clients do not fall through cracks and improve efficiency by minimising duplication of effort.

⁴ interRAI stands for (International Resident Assessment Instrument) and is an international collaborative to improve the quality of life of vulnerable persons through a seamless comprehensive assessment system.

3.2.4. Question 5: Prioritisation of Services

Overall almost 73% of respondents supported the DHB's proposal to prioritise services for clients who have higher health needs and could be at greater risk of poor health and safety at home. Approximately 12% of respondents did not support the proposal while 15% of respondents were unsure.

Some of the comments from those who were in favour of prioritisation were: "prioritising in a way that targets funds in the direction where the best health & social outcomes can be achieved is critical"; "this allows for the most vulnerable clients to gain access quicker"; "clients with high needs need top quality care"; "higher needs = high risk of harm = need for increased support"; "... resource expend would be much more productive being focused on the more complex patient". Some respondents felt that in the past there could have been some degree of over servicing as certain clients received relatively high care packages - "I have found that in some cases home management service is unnecessary". Comments were also made around the potential effects of over servicing that puts clients "at risk of becoming dependent" and "limits their functional ability and opportunity to remain at home". It was felt that over servicing goes "no way to empowering clients to take control of their own households and needs while they are able to do so". Respondents also felt that at times "there is a level of expectation from people that they need certain services that they could potentially find ways to do themselves".

Comments from HBSS providers showed significant support in favour of a referrals management system where clients are categorised into 'complex' and 'non complex' based on needs and the providers are responsible for assessing and managing the latter group of clients. Providers saw this as an opportunity for developing organisational capability whilst the complex clients get prompt attention from specialist services (NASC). However providers also felt that a clearly defined pathway to access specialist support if needed is critical for success of this system. Similar views were expressed by other stakeholders who felt that the current NASC waitlists for low need clients was "unsustainable and fraught with risk"; by prioritising NASC services for complex clients and allowing HBSS providers to assess and provide services to non complex clients, both groups will "get more timely assessment and services they need". Comment from a Maori organisation indicated that the Whanau Ora approach provides a pathway of care that will meet the needs of Maori.

One provider suggested that within the context of casemix model the DHB could consider prioritising services by indentifying clients who would fall in category 1 and therefore won't require weekly or fortnightly service. However to manage this group of clients safely at home they could be visited by a social worker every 3/6 months to identify any signs of deterioration. The social worker can also help link these clients to relevant services in the community which will help delay "the movement of this group of clients to groups requiring regular services".

The prioritisation approach was seen by some respondents as a "black and white approach" and "a very short sighted view of the needs for supporting people with lower needs". It was felt that this proposal might have arisen from "out of date perception that there are still people receiving household management so that they can play bowls or save money by not paying for housekeeping....." however in reality "there are very few clients with home help that do not need it". Some respondents felt that on the whole the DHB's prioritisation proposal was a 'money saving' and "cost cutting" exercise.

A significant number of clients as well as consumer advocacy groups have raised strong concerns around the potential impact of removing household assistance to low need clients. It was feared that without household help some low needs clients could become high need clients (for example if they have a fall/sustain injury while cleaning the bath) and would require a far higher level of services down the track. Comments were made: “some low needs older people won’t be able to manage without some help with housework”; “... household/shopping help can make all the difference to an elderly person”; “without household assistance they won’t be able to enjoy their expected lifestyle in their own residential unit with the stress of being unable to cope with their own cleaning ... the alternative would be rest home ... a much costlier solution”.

Feedback also included comments around the “gains that have been made to date through assisting low need clients”. Early intervention with these clients has helped reduce risks of “falls, injuries and stress” and “has enabled family/Whanau to keep their loved ones at home for longer” which would have had significantly favourable impact on the “downstream requirements of health services”. Respondents acknowledged that “in fiscally constrained environment limited resources need to be directed to those with the most need” however “removing services for low need clients may result in deterioration of function and ultimately increasing need” and leave “..... many dissatisfied people that lose services”.

The DHB was urged to look at the “whole picture” in terms of the social impact of removing household services to low need clients. It was suggested that a prioritisation approach will “require incorporation of informal support into care delivery which will promote service sustainability”. Consumer advocacy groups also felt that too much emphasis was being placed on removing household management services for low needs when this is a rapidly growing section of the older population. A community organisation that promotes community participation felt that the DHB’s proposal to “target HBSS services to those with a high health need removes any allowance for a proactive, preventive approach to maintaining independence and residing within their own home environment”. They also felt that with increasing demand on HBSS, “there is likely to be a shift to Aged Residential Care facilities” however the proposed changes did not indicate “any certainty for facility owners and therefore no incentive to invest in future demand so if this fails, where will patients present ... Hospital.”

There was support for reassessment of low need clients who are currently receiving household management service however concerns were raised around the resource required to reassess these clients – “the cost of reassessing every low need client would be high”; “who is going to do the reassessments”? Some felt that the current system adequately prioritises clients – “NASC is already doing this with success”; “The existing needs assessors do this job already”. It was thought that the main issue was the lack of resource in NASC for “timely reassessment” and “follow up” of existing clients. Many respondents also referred to the current waitlist for NASC assessment for household management and sought clarification around how these clients would be managed if the DHB went ahead with the prioritisation approach: “what would happen to the huge number of clients currently waiting”? It has been suggested that the DHB engages with general practice teams while reassessing existing clients to ensure clients did not get “lost between the cracks”.

In summary, there was support for prioritising services to clients with complex needs however the DHB was urged to take into consideration the downstream impact of removing household

management services to low need clients. It was acknowledged that targeting services to those with the most need made sense but doing so at the expense of those with low needs was described as “... robbing Peter to pay Paul”.

3.2.5. Question 6: Quality Focus

Overall almost 79% of the respondents supported the DHB’s focus on improving quality of services, while 5% did not support the proposal and 16% were unsure.

Those who supported the DHB’s focus on quality commented: “this is really needed urgently things are not always as they appear”; “ensuring quality is key to success for clients, providers and funders”; “the quality framework should be the basis upon which the delivery and funding mechanisms are developed”; “a focus on improving quality of services is certainly a very good thing”; “people deserve to receive quality services”. A recipient of HBSS for 8 years said: “there appears to be no consistent method of monitoring and checking on the services delivered”. One stakeholder highlighted the role of InterRAI in improving the quality of HBSS “when used as a clinical decision support tool” by assisting “support workers to make decisions based on evidence rather than opinion”. It was stressed that “InterRAI based scores are not about numbers – they are about making the best decisions for the person (client)”.

Most respondents felt that quality of service is directly influenced by the calibre of support workers, therefore it is critical that support workers receive appropriate training and are empowered and supported by their employers to deliver the best possible care to clients: “Staff who provide services deserve to be well trained, supported and adequately resourced to carry out what is often challenging, intense and highly personal work”. According to a HBSS provider duly trained staff “understands how a restorative model of care works and has the ability to mentor and empower clients to maximise independence and support them to achieve their goals”. It was stated that provider’s “ability to access, train and adequately pay higher quality support staff” is pivotal to achieving quality and “consistency of care” across the district. Providers need to be committed to “workforce development” for example some have invested in dedicated “workforce training and recruitment team to plan and deliver staff training and retention initiatives”. Overall it was felt that a quality approach focusing on outcomes is a far better way of utilising their resources instead of spending time dealing with “complaints, staff turnover, performance issues”.

Comments from HBSS providers who have experience with similar models revealed that a robust quality framework needs to be built in as an integral part of the model. In other words quality is not separate from the model rather it is embedded right through the entire system; providers need to build “quality processes at the core of their business”. One provider said: “a strong quality focus is the cornerstone of our business and we strongly agree with quality systems and outcomes”. Certain benefits of adopting a quality improvement approach were outlined: 1) a high percentage (up to 80% in some cases) of support workers with level 2 or level 3 training, 2) opportunity for ongoing training and education, 3) increased job satisfaction, 4) work life balance, 5) more workers with permanent employment agreements, 5) reduction in staff turnover, 6) increased number of discharges for those who do not require services any longer, 7) greater flexibility, 8) development of innovative ways of delivering services focusing on outputs and outcomes.

Providers also commented that the DHB needs to adopt “a holistic” approach to quality and clearly defined outcomes should be established right from the outset. It was noted that the “quality framework needs to be flexible to allow for the diverse needs of clients as well as different nature and scale of organisations”. Experience of providers who worked within an ‘alliance’ framework showed that working in a transparent and collaborative way greatly contributed to quality improvement. It was felt that for an alliance to work effectively there needs to be a common understanding of the requirements and appropriate “checks and balances in place”. The overall feedback was that “benchmarking and sharing ideas can work even in a competitive environment”.

Consumer advocacy groups felt that ‘quality’ for clients meant having: 1) the option to access the provider of choice not a provider “delegated by the DHB” and 2) the opportunity for a face to face assessment rather than a telephone interview because it is not uncommon for older people not to complain especially on the phone even when things are not right. Some respondents felt that the model of care does not need to be changed to bring in a quality focus. Some felt that the DHB’s Older Adult and Home Health Services has already developed a robust quality framework which can be adopted for HBSS without reinventing the wheel. It was also pointed out that “continuous involvement” of general practice teams in developing the HBSS quality framework is critical.

Some respondents felt that the DHB’s proposal did not contain sufficient details around how a quality framework would be established and how quality would be measured and monitored – “it is not clear in the document how quality improvement will be achieved”; “I support this, but wonder how quality will be measured”. A suggestion was made that the DHB used the logic model to establish an outcomes measurement framework and set up suitable performance indicators. It was also suggested that customer feedback should be an integral part of the quality improvement system because “what is requested for service and what is actually done may vary considerably”. It was felt that measuring quality particularly functional independence can be challenging. The DHB was urged to work collaboratively with the HBSS providers to establish a framework that works for all concerned.

One respondent referred to the Auditor General’s report on HBSS review which outlined the possible areas for improvement. It was felt that the proposed ‘restorative’ approach would require a lot of case management resource. Moving to a casemix funding would not automatically allow providers access to additional resources. Questions were therefore raised around how without an increase in total funding providers would be able to invest in workforce development and other quality improvement initiatives. Some felt that the establishment of an elaborate quality improvement system will “add another layer of administration and the associated costs”.

Respondents questioned how the DHB would ensure that the providers invest in capacity and capability building and how issues like low wages, high turnover, lack of training opportunities, and lack of guaranteed hours could be addressed by this proposal. It was felt that a wage structure that incentivises experience and training should be established to ensure retention of skilled staff. Some respondents felt this was “big words to cover up restriction of services” and were “sceptical what it will actually look like in reality”.

In summary, there was significant support for the DHB's proposal for a quality focus to HBSS. Providers who had adopted similar approaches in other DHBs indicated positive experience with improvement in service and staff satisfaction. A number of respondents felt that quality of care is closely linked to workforce development and retention of skilled staff. Some however felt that measuring quality is a challenging task and that the DHB's proposal failed to present relevant details around how quality would be measured and monitored. For example, how the DHB would ensure that providers invest in workforce and quality improvement activities. It was also highlighted that how without an increase in funding providers are expected to implement a robust quality improvement framework.

3.2.6. Question 7: Option of Individualised Funding

Overall 58% of respondents supported the concept of individualised funding (IF) while 17% did not support the proposal and 25% were unsure.

Those who supported the IF option did so because it offers older people and younger people with a chronic illness an alternative option for accessing home based support services as opposed to the existing system. Some of the comments were: "This is best news. Please let it be available as soon as possible"; "Giving people another option of choice is always a good idea"; "As the aged care sector grows the demand for individualised funding in this sector could grow".

Some felt IF is most likely to work better for those who have strong support networks and require flexibility e.g. younger adults with chronic conditions who are more independent and may work shifts or older people who are relatively well both physically and mentally. Some comments were: "younger and more independent clients may wish to manage their own services"; "For those with cognition ... it would seem to allow packages to be structured around their goals better and adapt quicker to their needs"; "... some younger people with Multiple Sclerosis use IF they have greater control and flexibility there are older people who use this model too it would be good to have it available".

It was highlighted that most older people have multiple chronic conditions and are on multiple medications and may even suffer from possible cognitive impairment; therefore they are unlikely to be willing to organise and manage their own care by as shown in the UK: "Direct payment system in the UK found that older people are often reluctant to take such responsibility and understand this model". It was felt that such responsibility or burden should not be placed on older people.

It was clear from the feedback that IF has been seen by some clients and their families/guardians as an opportunity to organise and manage their care in a way that most appropriately suits their needs. However it was also pointed out that IF could be easily open to abuse by family, guardians and others involved which could put older people at risk of receiving substandard care compromising their health and safety. Some comments were: "... take the money and use it for non-service uses"; "... this system could be exploited". The example of ACC was cited where a similar system has been implemented however it was stressed that "it would require a gatekeeper to prevent abuse".

Most respondents who were in favour of IF also felt strongly that a robust monitoring system needs to be in place to ensure quality of care and skill levels of support workers and, to prevent any potential abuse: "... increased need to have quality assurance that the tax dollar is achieving

the quality of life outcome for the person receiving the service”; “needs to be checks in places against abuse”; “... well monitored ... this is a good option.” However it was also pointed out that having “checks and balances” in place to prevent potential abuse in turn may make this a very “costly system to operate as more support and people will be needed.”

It was also suggested that the DHB needs to develop clear guidelines and access criteria and ensure there is a robust process in place to manage IF. Some comments were: “clear parameters need to be in place so that clients/families are truly making an informed choice”; “care will need to be taken in determining the category of people who should have this service available to them.” Feedback also suggested that the DHB engages the services of an accredited agency to appropriately administer and manage IF “ have an organisation to help implement and assist the client to organise their own care”. Some felt that for IF to work certain practical issues needed to be clarified for example, how clients find a replacement when their regular worker is away or how a family member can be paid if they had to step in as a carer or what happens if a client runs out of funds. A comment was made that sufficient funding should be allocated to clients on IF to ensure they are able to “fully satisfy their needs”.

HBSS providers who have successfully implemented IF and are currently hosts for IF in the disability sector, mental health and addiction services (including respite) have commented that it has been a positive experience. Some comments were: “Clients enjoy the flexibility and ownership that IF brings”; “... fits in with their lifestyle and makes them feel empowered to make their own choices”; “..... IF helps them regain control over their lives”. Feedback however acknowledged that even though IF has been successful in the disability sector and “most definitely provides clients with choice and control” but “not without its challenges” because some clients in the disability sector have found self-managing their support too challenging and “not worth the effort”.

It was pointed out that for a host provider there is “initial set up cost” and upfront investment to establish the system. It is important that a host provider is able to offer clients a range of options around how they would like their IF to be managed – it could be just managing the funds through to providing support workers. Providers have acknowledged that “there could be pitfalls” but those can be managed through “good systems.” Educating clients on how IF works was also considered critical because clients need to understand that “both the provider and the client have a set of responsibilities” to ensure quality of care and achievement of agreed goals and outcomes.

In summary there was significant support for the DHB’s proposal to make IF available as an alternative funding option for people receiving HBSS. However specific risks associated with this initiative were also highlighted by most respondents. Providers who have successfully implemented IF around the country suggested that IF can be administered successfully if appropriate risk mitigation strategies are in place. It was strongly recommended that the DHB engaged the services of an accredited agency to administer and manage IF and had a robust monitoring system in place to safeguard the health and safety of clients choosing this option as well as prevent any potential abuse. Client education was also regarded critical for a well functioning IF system. It was recognised that the number of people who would choose to use IF is likely to be small however for these people it is likely to provide significant benefits through greater flexibility and control over the care they receive.

3.3. Miscellaneous Feedback

Some of the feedback received did not relate to any particular survey question however raised valid points and therefore have been summarised in the 'miscellaneous' section.

A community organisation that promotes community participation in health service planning felt that "the proposed changes needed to be considered from a systems approach, not an individual service"; therefore it was felt that the proposal needed "to take account of potential impacts on other services including Age Related Residential Care". It was also highlighted that the proposal failed to refer to "any evidence base to justify a change", considering "there is substantial literature indicating that such a model is not fit for purpose and has significant flow-on effects" including data from other DHBs that adopted similar models. A community specialist palliative care provider queried "how palliative care clients would be impacted through the proposed changes" to HBSS. A comment was made that the DHB needs "to ensure that service is available across the whole district including rural areas" and it was strongly felt that the way the DHB could make it happen in an economically was to by engaging local providers. One respondent commented that the proposed changes do not address "one aspect of mental health care ... enabling house bound clients to socialise" considering social isolation is a major issue for older people.

Feedback from an ethic health support service suggested that while planning the HBSS redesign the DHB needs to ensure the following:

- Culturally appropriate and services and flexible models of care are delivered to culturally and linguistically diverse (CALD) Older People
- HBSS Providers are culturally capable and understand the impact of the migrant or refugee journey on the health/ mental health of the CALD Older Person and ensure there are processes in place to access accredited interpreters
- HBSS providers recruit and provide language matching bi-lingual care-givers who understand CALD family responses to care and end of life care for Older People, and work in partnership with the CALD older adult clients and their family
- HBSS providers inform people from CALD backgrounds and their carers of their rights and responsibilities, using the client's preferred language and modality
- HBSS providers promote awareness of the new HBSS services /models/ options by disseminating information in appropriate languages and via appropriate modes of communication

A point was made around the possible usefulness of restorative care for hospital inpatients who spend long periods of time in the wards without much physical activity and end up losing functional competencies – "most older people who are admitted to DHB wards spend days in bed with little intervention to address the risks of functional decompensation ..." It was felt that "there is poor discharge planning and people are often sent home with little in the way of equipment, therapy programmes..... support services often arrive days after the person is home". Whilst this feedback is outside of the scope of this consultation it is relevant to the continuum of care and will be passed onto the provider-arm.

One respondent felt that NASC assessments that take place in hospital prior to discharge often fail to consider the true home environment and therefore subsequent assessments are often required. It would be more efficient to do a thorough assessment once. It was suggested that

“often it takes a professional to step in” and identify what is actually going on with an older person’s life before appropriate support are put in place; this requires a ‘case manager’ or ‘client coordinator’ assigned to each client as part of the support plan who can “hopefully support and advocate for the client in all fields required” . One respondent felt that that the DHB needs to consider alternatives to electronic means of communication/interaction because some older people may not have access to the “internet”.

Some providers who have worked with the proposed model have provided useful information on implementation, quality improvement and ongoing monitoring. This information was deliberately excluded from this report however the DHB may choose to refer to this feedback during the redesign of HBSS.

4. Conclusion

It is Waitemata DHB’s objective to improve the overall quality of HBSS within the district. The DHB therefore has proposed a major overhaul to the current HBSS model and undertaken public consultation on the proposed changes.

Consultation feedback showed that at least half the respondents supported all the proposed changes while almost 60% supported at least three out of the seven proposed changes. However feedback has also highlighted that a goal-directed approach to HBSS along with the introduction of a casemix model of funding would be a major ‘culture change’ for the district and significant work needs to be undertaken to facilitate this change process. Effective engagement and communication with stakeholders and consumers will be essential to successfully introduce and embed change. In addition a robust quality framework will be needed for ongoing outcome monitoring to ensure that clients are receiving care appropriate for their needs.

10

CONFIRMATION

10.1 Action Points for next DSAC Meeting

10.2 DSAC Feedback to Board



**AUCKLAND and WAITEMATA DISTRICT HEALTH BOARD
DISABILITY SUPPORT ADVISORY COMMITTEE**

MEETING DETAILS		
Time and Date	1:00 pm – 3:30 pm, Wednesday, 28 August 2013	
Venue	Training Room, CCS Disability Action, 14 Erson Avenue, Royal Oak, Auckland	
Members ADHB & WDHB	Sandra Coney (Chair), Dairne Kirton, Jan Moss, Jo Agnew, Dr Marie Hull-Brown, Max Abbot, Pat Booth, Robyn Northey, Susan Buckland, Susan Sherrard, Russell Vickery.	
Apologies	Max Abbot, Ailsa Claire	
In Attendance	Dr Dale Bramley, Leanne Catchpole, Michele Cavanagh, Dr Debbie Holdsworth, Ronnelle Baker, Linda Harun, Katrina Lenzie-Smith, Tim Woods, Sue Waters, Marlene Skelton	
	Item	Page No
1	Introductions	001
2	Attendance and Apologies	003
3	Conflicts of Interest	005
4	Confirmation of Minutes 5 June 2013	013
5	Action Points 5 June 2013	021
6	Chairpersons' Report (verbal)	025
7	Presentation – Bryan Agnew and Estelle Muller - MoH <ul style="list-style-type: none"> • People under 65 in the Auckland Region receiving respite and residential care 	027

8	Papers 8.1 DISAC Update Report on the Implementation of the NZ Disability Strategy in Auckland & Waitemata DHBs 8.2 Engagement & Consultation Financial Recognition (Public Participation Reimbursement)	029 031 045
9	Improvement Activities 9.1 Health of Older People Quarterly Report on Activities in Auckland and Waitemata DHBs	055 057
10	Confirmation 10.1 Action Points for next DSAC Meeting 10.2 DSAC Feedback to Board	093
NEXT MEETING		
Time and Date: 1:00pm – 3:30pm, Wednesday, 20 November 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*