



3DHB COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

Meeting Held:

1 September 2017

Boardroom

Pilmuir House

Hutt Valley District Health Board

Lower Hutt

COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEES

Agenda



1 September 2017 9:00am to Midday
Board Room, Rose Garden, Hutt Valley District Health Board

	ITEM	ACTION	PRESENTER	MIN	TIME	PG
1 PROCEDURAL BUSINESS				15	9:00am	1
1.1	Karakia					-
1.2	Apologies	RECORD	F Wilde			-
1.3	Continuous Disclosure - Conflicts of Interest	ACCEPT	F Wilde			2
1.4	Confirmation of Minutes 3 July 2017	APPROVE	F Wilde			6
1.5	Matters Arising	NOTE	F Wilde			-
1.6	Action List	NOTE	F Wilde			12
1.7	Combined Terms of Reference	NOTE	F Wilde			14
DISCUSSION						
2.1	Palliative Care Strategy: <ul style="list-style-type: none"> Progress against the 3DHB Palliative Care Strategy. 	ENDORSE	H Carbonatto	60	9.15	16
2.2	Advanced Care Planning <ul style="list-style-type: none"> Advanced Care Planning Update Presentation 		C Epps H Rigby			24
MORNING TEA					10.15	
2.3	Aged Care Services Update <ul style="list-style-type: none"> Discussion on aged care services Discussion on Quality Assurance 	ENDORSE	H Carbonatto	60	10.30	27
DISCUSSION						
3.1	Sub regional Disability Update <ul style="list-style-type: none"> Paper 	DISCUSS	P Boyles	15	11.15	37
OTHER						
4.1	Resolution to Exclude the Public <ul style="list-style-type: none"> Paper 	APPROVE	F Wilde	30	11.30	42
ADJOURN						
APPENDICES						
2.3.1	Appendix 1 – Quality Assurance and Obligations – Health of Older People Services					43



COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEES

Conflicts & Declarations of Interest Register

UPDATED AS AT AUGUST 2017

Name	Interest
<p>Dame Fran Wilde <i>Chairperson</i></p>	<ul style="list-style-type: none"> • Deputy Chair, Capital & Coast District Health Board (includes HAC) • Chair, Remuneration Authority • Deputy Chair NZ Transport Agency • Chair Wellington Lifelines Group • Director Museum of NZ Te Papa Tongarewa • Member Whitireia-Weltec Council • Director Business Mentors NZ Ltd • Director Frequency Projects Ltd • Chief Crown Negotiator Ngati Mutunga and Moriori Treaty of Waitangi Claims • Chair Wellington Culinary Events Trust • Chair National Military Heritage Trust
<p>Mr Andrew Blair <i>Member</i></p>	<ul style="list-style-type: none"> • Chair, Southern Partnership Group (appointed jointly by Ministers of Finance and Health to provide governance for the redevelopment of Dunedin Hospital) • Member of the Board of Trustees of the Gillies McIndoe Research Institute • Member, Hutt Valley District Health Board Finance, Risk and Audit Committee • Chair, Hutt Valley District Health Board (from 5 December 2016) • Former Member of the Hawkes Bay District Health Board (2013-2016) • Former Chair, Cancer Control (2014-2015) • Former CEO Acuity Health Group Limited • Director, Safer Sleep Ltd • Director, Safer Sleep LLC Ltd • Advisor to the Board, Forte Health Limited, Christchurch • Owner and Director of Andrew Blair Consulting Limited, a Company which from time to time provides governance and advisory services to various businesses and organisations, include those in the health sector • Chair, Capital & Coast District Health Board (from 5 December 2016) (includes HAC) • Chair, Hutt Valley District Health Board Hospital Advisory Committee • Member, 3DHB combined Community and Public Health and Disability Support Advisory Committees
<p>Ms Eileen Brown</p>	<ul style="list-style-type: none"> • Member of Capital & Coast District Health Board

Name	Interest
<i>Member</i>	<ul style="list-style-type: none"> • Board member (until Feb. 2017), Newtown Union Health Service Board • Employee of New Zealand Council of Trade Unions • Senior Policy Analyst at the Council of Trade Unions (CTU). CTU affiliated members include NZNO, PSA, E tū, ASMS, MERAS and First Union. • God daughter/family friend employed as a solicitor at specialist health law firm, Claro.
Ms Sue Kedgley <i>Member</i>	<ul style="list-style-type: none"> • Member, Capital & Coast District Health Board (includes HAC) • Member, Greater Wellington Regional Council • Member, Consumer New Zealand Board • Shareholder in Green Cross Health • Step son works in middle management of Fletcher Steel • Deputy Chair, Consumer New Zealand • Environment spokesperson and Chair of Environment committee, Wellington Regional Council
Mr Alan Shirley <i>Member</i>	<ul style="list-style-type: none"> • Member, Wairarapa District Health Board (includes HAC) • Member, Wairarapa, Hutt Valley and CCDHB CPHAC DSAC Committee • General surgeon at Wairarapa Hospital • Wairarapa Community Health Board Member • Wairarapa Community Health Trust Trustee (15 September 2016)
Jane Hopkirk <i>Member</i>	<ul style="list-style-type: none"> • Member, Wairarapa District Health Board • Member, Wairarapa, Hutt Valley and CCDHB CPHAC DSAC Committee • Member, Wairarapa Te Iwi Kainga Committee • Kaiarahi, Takiri Mai Te Ata, Kokiri Hauora • Member, Occupational Therapy Board of New Zealand (23 February 2016)
Kim Smith <i>Member</i>	<ul style="list-style-type: none"> • Employee of Te Puni Kokiri • Trustee for Te Hauora Runanga o Wairarapa • Brother is Chair for Te Hauora Runanga o Wairarapa • Chair, Te Oranga o Te Iwi Kainga • Sister, Member of Parliament
Lisa Bridson <i>Member</i>	<ul style="list-style-type: none"> • Member, Hutt Valley District Health Board (Includes HAC) • Member, 3DHB Combined CPHAC DSAC Committee • Hutt City Councillor • Chair, Kete Foodshare
Yvette Grace <i>Member</i>	<ul style="list-style-type: none"> • Member, Hutt Valley District Health Board (includes HAC) • Deputy Chair, 3DHB combined Community and Public Health and Disability Support Advisory Committees • Chair, Te Oranga O Te Iwi Kainga Māori Relationship Board to Wairarapa DHB • Trustee, Rangitane Tu Mai Ra Treaty Settlement Trust • Manager, Compass Health Wairarapa • Member, 3DHB Youth SLA (Service Level Alliance) • Member, Te Whiti Ki Te Uru Central Regions Māori Relationship Board

Name	Interest
	<ul style="list-style-type: none"> • Husband, Family Violence Intervention Coordinator and Child Protection Officer Wairarapa DHB • Husband, Community Council, Compass Health • Husband, Community member of Tihei Wairarapa Alliance Leadership Team • Sister in law, Nurse at Hutt Hospital • Sister in Law, Private Physiotherapist in Upper Hutt • Niece, Nurse at Hutt Hospital
<p>Prue Lamason <i>Member</i></p>	<ul style="list-style-type: none"> • Member, Hutt Valley District Health Board (Includes HAC) • Member, 3DHB combined Community and Public Health and Disability Support Advisory Committees • Deputy Chair, Hutt Mana Charitable Trust • Deputy Chair, Britannia House – residence for the Elderly • Councillor, Greater Wellington Regional Council • Deputy Chair, Greater Wellington Regional Council Holdings Company • Trustee, She Trust • Daughter is a Lead Maternity Carer in the Hutt
<p>John Terris <i>Member</i></p>	<ul style="list-style-type: none"> • Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Hospital Advisory Committee • Member, 3DHB combined Community and Public Health and Disability Support Advisory Committees
<p>Mr Derek Milne <i>Member</i></p>	<ul style="list-style-type: none"> • Member, Wairarapa District Health Board • Member, WrDHB CPHAC/DSAC (30 March 2016) • Brother-in-law is on the Board of Health Care Ltd • Daughter, GP in Manurewa, Auckland
<p>Fa'amatuainu Tino Pereira <i>Member</i></p>	<ul style="list-style-type: none"> • Managing Director Niu Vision Group Ltd (NVG) • Chair 3DHB Sub-Regional Pacific Strategic Health Group (SPSHG) • Chair Pacific Business Trust • Chair Pacific Advisory Group (PAG) MSD • Chair Central Pacific Group (CPC) • Chair, Pasifika Healthy Home Trust • Establishment Chair Council of Pacific Collectives • Chair, Pacific Panel for Vulnerable Children • Member, 3DHB CPHAC/DSAC
<p>Dr Tristram Ingham <i>Member</i></p>	<ul style="list-style-type: none"> • Senior Research Fellow, University of Otago Wellington • Member, Capital & Coast DHB Māori Partnership Board • Clinical Scientific Advisor & Chair Scientific Advisory Board – Asthma Foundation of NZ • Trustee, Wellhealth Trust PHO • Councillor at Large – National Council of the Muscular Dystrophy Association • Trustee, Neuromuscular Research Foundation Trust • Member, Wellington City Council Accessibility Advisory Group • Member, 3DHB Sub-Regional Disability Advisory Group

Name	Interest
	<ul style="list-style-type: none"> • Professional Member – Royal Society of New Zealand • Member, Institute of Directors • Member, Health Research Council College of Experts • Member, European Respiratory Society • Member, Te Ohu Rata o Aotearoa (Māori Medical Practitioners Association) • Director, Miramar Enterprises Limited (Property Investment Company) • Daughter, Employee of Hutt Valley based Māori provider (Tu Kotahi Māori Asthma Trust) • Wife, Research Fellow, University of Otago Wellington
<p>Sue Driver <i>Member</i></p>	<ul style="list-style-type: none"> • Member of Capital & Coast District Health Board (Including HAC) • Member, 3DHB combined Community and Public Health and Disability Support Advisory Committees • Community representative, Australian and NZ College of Anaesthetists • Board Member of Kaibosh • Daughter, Policy Advisor, College of Physicians • Former Chair, Robinson Seismic (base isolators, Wgtn Hospital) • Advisor to various NGOs
<p>'Ana Coffey <i>Member</i></p>	<ul style="list-style-type: none"> • Member of Capital & Coast District Health Board (Including HAC) • Member, 3DHB combined Community and Public Health and Disability Support Advisory Committees • Councillor, Porirua City Council • Director, Dunstan Lake District Limited • Trustee, Whitireia Foundation

3DCPHAC/DSAC Meeting (MRG)

DATE:	3 July 2017	TIME:	9.30am-1.00pm
VENUE:	Boardroom, Grace Neill Building, Wellington Hospital		
PRESENT:	Dame Fran Wilde (Chair), Bob Francis, Derek Milne, Alan Shirley, John Terris, Jane Hopkirk, Sue Driver, Lisa Bridson, Prue Lamason, Eileen Brown		
IN ATTENDANCE:	Debbie Chin(10.10am), Rachel Haggerty, Adri Isbister, Nigel Broom, Ashley Bloomfield, Helene Carbonatto, Jenny Langton, Fiona Watson (minutes)		
PUBLIC	A member of the general public		
PRESENTERS	<p>Primary Care: Dr Jeff Lowe, Chair ICC for Capital & Coast District Health Board Adri Isbister, Chief Executive on behalf of Justine Thorpe , Wairarapa DHB Helene Carbonatto, Group Manager Planning & Funding, Hutt Valley DHB Bridget Allen, Chief Executive, Te Awakairangi Health Network</p> <p>Regional Cardiology Plan: Dr Nick Fisher, Cardiologist Jeanine Corkel, cardiology programme lead TAS</p>		

	Agenda Item	Discussion	Action Required And by Whom
1	PROCEDURAL BUSINESS		
1.1	KARAKIA	Karakia was led by Jane Hopkirk Committee Chair, Dame Fran Wilde welcomed members, DHB staff and visitors	
1.2	APOLOGIES	Received from Andrew Blair, Sue Kedgley; Yvette Grace	
1.3	INTEREST REGISTER	NOTED need to action updated list of interests Lisa Brisdon advised new conflict of interest	Lisa Brisdon to email secretary
1.4	Confirmation of previous minutes	The previous minutes were accepted as a true and correct record Eileen Brown/Jane Hopkirk	
1.5	Matters arising	No matters arising	
1.6	Action points	NOTED headlines/titles for action points are not accurate reflections of the agreed actions 2.3 Equity Monitoring Indicators 2.5 Regional Public Health Update Report: That DHBs and providers work together on housing issues and concerns	
1.7	Final CPHAC/DSAC Terms of Reference	Check to ensure that the Terms of Reference encompass everything set out in legislation.	

		CONFIRMED Rachel Haggerty: that the Terms of Reference reflect the legislation and should be read as consistent with legislative obligations	Completed. No change required.
2	DECISION		
2.1	<p>Primary Care</p> <p>Dr Jeff Lowe, Adri Isbister, Helene Carbonatto, Bridget Allen</p>	<p><u>Issues raised regarding the sustainability of primary care and VLCA. Need to look at funding mechanisms for primary care and inequities associated with current VLCA model.</u> General concern expressed regarding the equity issues in primary care which need to be addressed. SUGGESTED: that the three Chief Executives keep each Board updated on the work underway reviewing primary care.</p> <p>Importance of ensuring a patient voice/experience is present in primary care discussions.</p> <p>Make better use of care pathways and ensure a whole of system approach is taken rather than primary/secondary care focus.</p> <p>There is a need for vendors of IT tools to all use standards that support inter-operability.</p> <p>More proactive patient story-telling necessary.</p> <p>DISCUSSION: around the key role of nurses in delivering many of the new services offered in primary care</p> <p>RECOMMENDATION: that the Committee add an additional recommendation as an outcome of the discussion:</p> <ul style="list-style-type: none"> • The three sub-regional CEs keep each Board updated on progress with national to review primary care <p>RECOMMENDATION: To ENDORSE the proposal</p>	Presentation attached

<p>2.2</p>	<p>Regional Specialist Services: Dr Nick Fisher</p>	<p>Presentation on Heart Health Services</p> <p>NOTED: that there were big challenges implementing initiatives across the region or sub-region regarding cardiac care.</p> <p>NOTED: recommendations to CEs and had been endorsed.</p> <p>NOTED: the presentation set out the need to improve delivery of cardiac services across the region. Inefficiencies within hospital system leading to poorer health outcomes for heart attack patients depending on where they live. Need for collaboration between the regions.</p> <p>DISCUSSION: regarding the cardiac network recommendations around referral and access to secondary care. All hospitals in the country have signed up.</p> <p>NOTED: regarding barriers to shifting the model of care there is debate around referral and transfer as this is a Ministry of Health led national conversation; how Central TAS works across the six regional centres; and IDF mechanisms</p> <p>Clinical guidelines are being picked up; Regional Service Plan is being implemented establishing timelines and the STEMI pathway; first step is implementing the PCI lab at MidCentral (2 years away) then Hawkes Bay in 2-4 years</p> <p>The Committee was advised that at the sub-region echocardiography needs to consider how to make it a 3 DHB service.</p> <p>Implementing the Cardiac system of care will provide a model for a collaborative approach for other services</p> <p>RECOMMENDATION: To ENDORSE the proposal.</p> <p>Request the 3 Chief Executives advise on a sub-regional approach for implementing the cardiac model and timeframe</p>	
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2.3	Services for Young People with Alcohol and Other Drugs and Co-Existing Mental Health Problems	<p>NOTED: the sub-region doesn't have a youth primary mental health service and the paper proposes a new model for delivering youth primary mental health care.</p> <p>Concern was raised about children who may have mental health and addiction issues (e.g., addictions due to secondary exposure) that fall outside the scope of the proposed service; what is the impact then for their access to care (e.g., if they fall outside the proposed age-range).</p> <p>NOTED: the focus for now was on primary and community care for youth, not specialist services. It could be school-based or other youth based service. It is a small investment and it is important we focus on where the greatest gaps are right now, which is for youth.</p> <p>ENDORSE: The Committee ENDORSED the recommendations of the paper.</p>	
3 DISCUSSION			
1	Sub-regional disability update	<p>NOTED that the sub regional Disability strategy has been launched noting the positive public reception. The key issue is now implementing it and gaining traction with each of the actions.</p> <p>The Disability passport is underway.</p>	
4.0 ANY OTHER BUSINESS			
4.1	Role of CPHAC/DSAC	<p>DISCUSSION: the need to ensure that CPHAC/DSAC adds the most value for the three DHBs noting the DHBs are:</p> <ol style="list-style-type: none"> 1. Part of a national Health System 2. A larger regional care focused group 3. A sub-region with less hard focus on 3DHB than previously 	

		<p>Should more focus be placed on those areas where we are clearly linked.</p> <p>Concern was raised about reassignment of areas and it was NOTED that there was some strategic value in a sub-regional discussion about issues.</p> <p>SUGGESTION: that a paper be developed to reflect changes and new focus areas</p>	
<p>NEXT MEETING – 1 September 2017, 9.00am Board Room, Rose Garden, Hutt Valley District Health Board</p>			

DRAFT

SCHEDULE OF ACTION POINTS - PUBLIC CPHAC-DSAC COMMITTEES

AP No:	Topic:	Action:	Responsible:	How Dealt With:	Delivery Date:
Ex CPHAC-DSAC Public Meeting 3 July 2017					
2.2	Regional Services	Request the 3 Chief Executives advise on a sub-regional approach for implementing the cardiac model and timeframe.	Director, SIP	The approach to implementing the cardiac model is a regional approach. The Plan is being developed with the support of TAS and is one of the four priorities for the central region.	There will be a further update to CPHAC DSAC in November.
4.1	Role of CPHAC/DSAC	It was NOTED that there was some strategic value in a sub-regional discussion about issues. Suggestion that a paper be developed to reflect changes and new focus areas.	Director, SIP	A paper is included in the September agenda for discussion.	September 2017

ITEMS CLOSED SINCE LAST MEETING – 24 MARCH 2017

AP No:	Topic:	Action:	Responsible:	How Dealt With:	Delivery Date:
Ex CPHAC-DSAC Public Meeting 6 June 2017					
1.7	Final CPHAC/DSAC Terms of Reference	Amend and correct grammatical errors. Reflect 3DHB representation and clarify if there is a process for proxies in the absence of members particularly from sub regional group and Maori Partnership Board	Secretariat	Completed. No change required for ToR.	Closed
2.1	Mental Health and Wellbeing	Equity and co-design needs to be explicitly stated in recommendations:	Director, SIP	Regular updates provided to CPHAC/DSAC meetings. Whole System Investment Plan early 2018.	First meeting 2018.
3.2	Quality Assurance – Health of Older	No staff to patient ratios; acute shortage of nursing staff; adequacy of our monitoring systems. Quality	Director, SIP	Discussion at September 2017, CPHAC/DSAC.	September, 2017

AP No:	Topic:	Action:	Responsible:	How Dealt With:	Delivery Date:
	People	improvement re medical care. To reduce elderly presentations to ED.			
3.3	Bowel Screening	Bowel screening rolling out at Hutt Valley and Wairarapa DHB.	CE, HVDHB	Update on bowel screening to CPHAC/DSAC. These services are implementing in short timeframes. The update for CPHAC DSAC has been delayed till September 2017 .	September, 2017
1.3	Interest Register	Lisa Brisdon advised new conflict of interest.	Lisa Brisdon; Secretary	Emailed to Secretary who included it in Interest Register	Closed
Ex CPHAC-DSAC Public Meeting 20 May 2016					
2.3	Equity Monitoring Indicators	Requested management to bring back to the Committee in the next Equity Report an outline of the specific actions in the Annual Plan and the Maori Health Plan and advice to the Committee so it could advise the Boards on an equity action plan over a longer time period.	Director, SIP	Replaced by development of Equity Approach presented at March 2017 meeting. Recommendations to come back to November 2017 meeting	November, 2017
2.5	Regional Public Health Update Report	Report back on DHBs role in working with the homeless as they often have high health needs and find access to services difficult.	HVDHB	On work programme for November 2017.	November, 2017



Terms of Reference

Capital & Coast, Hutt Valley and Wairarapa District Health Board Community and Public Health Advisory Committee and a Disability Support Advisory Committee

June 2017

<p>Compliance</p>	<p>In accordance with section 35 of the New Zealand Public Health and Disability Act 2000, the Boards shall establish a Community and Public Health Advisory Committee and Disability Advisory Committee (hereinafter called “The Committee”) whose members and chairperson shall be as determined by the Boards from time to time.</p> <p>The Committee shall comply with the New Zealand Public Health and Disability Act 2000. The terms of reference of the Committee shall be to do the following in a manner not inconsistent with the New Zealand Health Strategy.</p> <p>The Committee shall comply with the Boards’ Standing Orders for Statutory Committees.</p> <p>These Terms of Reference:</p> <ul style="list-style-type: none"> • are supplementary to the provisions of the Act and Schedule 4 to the Act; • supersede the previous Terms of Reference dated 30 April 2013; • are effective from March 2017.
<p>Functions of the Committee</p>	<p>The functions of this Committee are to give the advice to the full Board of each DHB on:</p> <ul style="list-style-type: none"> • the needs, and the factors that may affect the health and disability status, of the residents of the DHB; • the disability support needs of the resident population of the DHB; • priorities for use of health and disability support funding. <p>The aim of the Committee’s advice is to ensure that each DHB maximizes the overall health gain for the population and promotes the inclusion and participation in society, and maximize the independence of the people with disabilities within the DHB’s resident population through:</p> <ul style="list-style-type: none"> • the range of disability support services the DHB has provided or funded or could provide or fund for those people; • the service interventions the DHB has provided or funded or could provide or fund for the population; • the policies the DHB has adopted or could adopt for those people. <p>The Committee’s advice will be consistent with the New Zealand Health Strategy.</p> <p>The Committee shall present its findings and recommendations to the Boards for their consideration.</p>
<p>Objectives and Accountability</p>	<p>The Committee shall:</p> <ul style="list-style-type: none"> • monitor the health status and health and disability support needs of each DHB resident population providing advice to each Board; • provide advice to each Board on the implications of health and disability need and status for planning and funding of nation-wide and sector-wide health and disability goals; • provide advice to each Board on policies, strategies and commissioning (planning and funding) to support improved health and disability outcomes in each district;

	<ul style="list-style-type: none"> • provide advice to each Board on priorities for health improvement and independence as part of the strategic and annual planning process to improve health gain and independence within each district; • provide advice to each Board on strategies to achieve equity in modifiable health and disability status amongst the population of each DHB including but not limited to Māori, Pacific, people living in high deprivation, people with mental health and addiction conditions and people with disabilities; • monitor and advise each Board on the impact of health and disability support services being provided for the resident population of each DHB including the effectiveness of disability support services being provided for the DHB resident population; • provide advice to each Board on the delivery of health services accessed by people with disabilities including how it can effectively meet its responsibilities towards the government’s vision and strategies for people with disabilities; • identify issues and opportunities in relation to the provision of health services that the Committee considers may warrant further investigation and advise the Board accordingly; • identify when ‘expert’ assistance will be required in order for the Committee to fulfill its obligations, and achieve its annual work plan by co-opting experience when required; • report regularly to each Board on the Committee’s findings (generally the minutes of each meeting will be placed on the agenda of the next Board meeting); • collaborate as required with Committees of other district health boards in the interests of providing optimum, economical and efficient services; • perform any other functions as directed by the respective DHB Boards.
Authorities and Access	<p>The following authorities are delegated to the Committee:</p> <ul style="list-style-type: none"> • to require the Chief Executive Officers and/or delegated staff to attend its meetings, provide advice, provide information and prepare reports upon request; • to interface with any other Committee(s) that may be formed from time to time.
Meetings	<p>The Committee shall hold no less than five meetings per annum, but may determine to meet more often if considered necessary by the Committee or upon that instruction of the Boards.</p>
Quorum	<p>A quorum is a majority of Committee members, and must include at least one member from each Board and at least one co-opted member from the Sub-regional Disability Advisory Group, Sub-regional Pacific Advisory Group or Māori Partnership Boards.</p>
Membership	<p>Membership of the Committee shall be as directed by the Boards. The Committee has the ability to co-opt expert advisors as required.</p>
Procedure	<p>Schedule 4 of the New Zealand Public Health and Disability Act will apply to the business and procedure of the Committee.</p>



**CPHAC-DSAC
DISCUSSION PAPER**

Date: 1 September 2017

Author	Joanne Edwards, Wairarapa DHB Jan Marment, CCDHB Jazz Heer, Hutt Valley DHB
Endorsed by	Helene Carbonatto, HVDHB Rachel Haggerty, CCDHB Nigel Broom, Wairarapa DHB
Subject	Progress against the 3DHB Palliative Care Strategy

RECOMMENDATION

It is recommended that the CPHAC-DSAC Committee:

- 1. ENDORSE** the progress by each of the 3 DHBs against the sub-regional Palliative Care Strategy which was developed with the oversight of the Lower North Island Palliative Care Managed Clinical Network and approved by the combined CPHAC-DSAC at their November 2016 meeting.

1 PURPOSE

The purpose of this paper is to inform the committee about progress against the 3 DHB Palliative Care Strategy which was completed under the oversight and governance of the Lower North Island Palliative Care Managed Clinical Network and approved by the Committee at their November 2016 meeting.

2 BACKGROUND

In March 2014 a contract for \$500,000 over three years was signed between the Ministry of Health (for Health Workforce New Zealand) and Capital and Coast DHB (for the Lower North Island Palliative Care Managed Clinical Network). The project outcomes were to improve access to palliative care for people to receive care closer to home, and to enable services to work in a seamless, integrated and cost-effective way. The objective of the managed clinical network (the network) was to develop a funding framework which supports an efficient and effective service model for palliative care, an innovative and sustainable workforce, and effective clinical leadership and governance.

Strategy development

The project team engaged with clinicians and service providers representing the wider health and social sector, including aged residential care facilities and NGO providers. A series of carer/consumer forums were also hosted across the sub-region. These forums provided excellent feedback about our palliative care system, what works well, what needs improving and formed the basis of the strategy.

Following an extensive process of engagement, the Strategy identified 6 goals to improve care. These are:

Goals

- 1.** Patients and their whānau have early discussions as end of life approaches to ensure they make early informed choices about the what, where and how of care and support they receive (Self management)

2. Patients and their whānau receive coordinated assessment, care planning and review throughout their illness (Planning)
3. Patients and their whānau experience equitable and seamless care through coordinated service provision (Integration)
4. Patients and their whānau experience high quality services in different settings (Quality)
5. Care in the last days of life is comprehensive, with good symptom control, is in the most appropriate setting in the company of whānau and/or friends (Last days of life)
6. Whānau experience high quality care after death (After death support)

Essentially the document outlines future palliative care services within the Wellington, Hutt Valley and Wairarapa DHBs. It ensures that a palliative approach is offered to patients and their whānau from the time when it is first identified that end of life is approaching. It calls for timelier conversations with earlier planning involving multiple disciplines. Primary care is identified as requiring taking a stronger lead role throughout the palliative care journey, with the support of specialist palliative care providing episodic input as and when required. More responsive nursing and allied health services need to be made available to a wider range of palliative care patients to better support primary care's growing role. The earlier identification and recognition by health professionals about curative treatment moving to palliative care will enable patients and their whānau to make informed life choices.

Local Implementation Update

Wairarapa DHB

Since approval of the "Living Well, Dying Well" strategy, the local Palliative Care Network has worked towards its implementation. The terms of reference of the Network are currently being reviewed to align more closely with Tihei Wairarapa (the Alliance Leadership Team).

The strategy locates palliative care firmly in the realm of primary care practice. In this setting, the Gold Standard Framework is being used to guide multidisciplinary proactive care planning, intervention and support. This approach commenced in Carterton Medical Integrated Family Healthcare Centre and is currently being rolled out across other Wairarapa GP practices.

The Palliative Community Nursing Service is part of the Community Health Service. This service has a clinical nurse specialist as the expert in palliative nursing, working alongside a senior nurse trained in palliative care and a special interest team of 3 district nurses. All palliative care nursing is based from Masterton for the whole Wairarapa district. Specialist clinical support is provided by Te Omanga Hospice. Specialist psychosocial support is available through the WrDHB and counseling is also provided by Wairarapa Hospice. A Palliative care nurse educator provides a wide range of education across all providers of palliative care including age residential care (ARC) facility staff, district nursing, ambulance etc.

The service was evaluated in April/May 2017 and it highlighted a number of potential development areas such as:

- Further development of relationships between clinical and psychosocial components of the palliative services.
- Development/adoption of appropriate IT platform for community palliative nurses working across primary and secondary facilities.
- Potential to have single point of entry and triage through Palliative interRai assessment
- Change management and coordination in transition process to Palliative interRai assessment and the new DHB patient management system.
- Potential to move towards integration of standardized model of care planning across all sites in Wairarapa.

The new funding for innovation in palliative care has led to a number of developments which have focused on strengthening support for age residential care to provide effective palliative care and enhancing support provided for families.

Hutt Valley DHB

Since approval of the strategy, a project team has been established under Hutt Inc (the Alliance Leadership Team) that reports regular progress on how the DHB is implementing the various components of the Strategy. Work across the Hutt Valley began with a 'stocktake' of the many initiatives already underway, which then helped to determine priorities and a work programme to achieve the strategy vision.

The plan over this year includes work across seven Vanguard Pilot Sites (four General Practices and three Residential Care Facilities) to test and pilot new models of care and best practice along the palliative care patient journey. The sites, each with a nominated clinical champion, have been selected to represent a mix of practice/facility size, geographical location, and blend of training/expertise. Learning will be rolled out and embedded through further service development. This work is being led by a collaborative partnership across the palliative care system (Hospital/Hospice/General Practice/NGOs/Residential Care), reporting to our Alliance Leadership team Hutt INC.

We have combined this work programme with the Advance Care Planning work in the Hutt Valley as both require a skilled workforce with confidence and competence to have sometimes challenging conversations that elicit people's values, preferences and their understanding of their condition and illness trajectory.

Work is now complete on the packages of care for primary care to support the development of palliative care plans and provide services to patients in the last days of life. Training has also been developed to support this process via Te Omanga Hospice, as well as the appointment of designated liaison staff (team includes 2 nurses and counsellor/social worker) to offer advice and consultation for GPs/Practice Nurses. Work across the vanguard pilot sites will serve to embed this practice towards palliative care becoming 'everyone's business'.

The Hospice has a very well established relationship with residential care facilities across the Hutt Valley providing guidance, support and services in rest homes to support palliative care needs of aged care clients. New funding in place this year, the hospice has also been able to provide funding to 'back-fill' residential care nurses to be on placement at Hospice for up to a week to increase their knowledge and skills in delivering palliative care.

CCDHB

The Palliative Care strategy (Living Well Dying Well) implementation project is sponsored by SIP and will report to the ICC Alliance Leadership Team.

Project planning is underway with a stocktake of current palliative care projects which will be combined with an analysis of current palliative care services. Such a review will highlight gaps, priorities and opportunities.

The first phase of the project, utilising key stakeholders, is developing the "strategy" palliative care model. The model will be implemented as 'proof of concept' in a designated locality. The locality selected will be associated with Health Care Homes and a higher need population. A collaborative partnership of palliative care providers will test the new model of palliative care within this local community. The palliative care providers will include: aged care facilities, hospital palliative specialists, hospice specialists, general practice, NGOs, Community Nursing Services and Home and Community Support Services.

Once the developed model has been evaluated and any required modifications made, further expansion and implementation will occur across the DHB.

As with HVDHB, this work programme is being combined with the Advance Care Planning work. The following table highlights progress against implementation against each of the agreed goals.

	Wairarapa DHB	HVDHB	CCDHB
<p>Patients and their whānau have early discussions as end of life approaches to ensure they make early informed choices about the what, where and how of care and support they receive (Self-management)</p>	<p>Initial discussion between GP and patient/family.</p> <p>Referral through FOCUS (NASC) to Kahukura (DHB service) – and discussion about appropriate and available to options to support the person and their family.</p> <p>A two day course for Advanced Care Planning (ACP) was held in Masterton in March and attended by health professionals from primary care, age residential care, NASC and Wairarapa DHB. Evaluation indicated a marked increase in confidence of the attendees in ACP discussions. Local forums will be held with GPs later this year.</p> <p>The DHB has established a trial brokerage service to establish an Enduring Power of Attorney (EPOA) for 15 selected patients who meet socio-economic criteria. This service is for low cost lawyer services funded through the Wairarapa Community Health Trust.</p> <p>Support Group meetings provided by Hospice Wairarapa: Caregivers, family & friends of terminally ill people have the opportunity to be supported within a peer group setting and increase their knowledge about:</p> <ul style="list-style-type: none"> • Understanding the medical journey • Looking after yourself • Practical care 	<p>Palliative Care Planning established</p> <p>Early identification and discussion by way of a palliative care plan in primary care has been established. This initiative is free to patients, assigns a lead palliative carer, identifies patient/whānau needs and ensures access to care 24hrs/7 days week.</p> <p>Work across the vanguard pilot sites will identify opportunities for service developments to support this goal.</p> <p>Strategy implementation work is being combined with the advance care planning (ACP) work programme, so includes promotion and access to ACP training and resources. Staff from across the hospital, general practice and residential care facilities have undertaken this training and there are a number of Clinical Champions across our health system.</p> <p>Further training will be offered in the next month.</p>	<p>Palliative Care planning is in development.</p> <p>Anticipatory Care Planning in Primary Care is now operational with a contract developed and finalised between PHO and hospice.</p> <p>There is a focus to ensure uptake via practice relationship team, promotion of the service by PHOs.</p>

	<ul style="list-style-type: none"> • Communications and relationships • Legal matters • Financial matters • Grief and bereavement • Care after death 		
<p>Patients and their whānau receive coordinated assessment, care planning and review throughout their illness (Planning)</p>	<p>Assessment and service co-ordination is provided by FOCUS Single Point of Entry with specialist input for assessment and care planning from Kahukura, DHB palliative care nurses. Specialist input also supports ARC providers in their assessment and care planning for palliative residents.</p> <p>InterRAI Palliative Care is to be introduced nationally within 2017/18. Training for assessors is due to commence. Assessment and service co-ordination is provided by FOCUS Single Point of Entry with specialist input for assessment and care planning from Kahukura, DHB palliative care nurses.</p>	<p>Te Omanga Hospice now has a designated team of primary care liaison staff (nurses, social worker/counsellor and OT) who are available to provide support to primary care to support assessment and management of palliative patients by their general practice.</p> <p>Work across the vanguard sites will enable this team to support these patients to access resources and services like equipment or education and support for carers caring for palliative family/friends.</p> <p>The introduction of the InterRAI palliative care tool nationally is a key development to alleviate unnecessary assessment/questioning from palliative care patients. Training for our needs assessment and service coordination team for the InterRAI palliative care tool will commence shortly. There is an opportunity to consolidate the various assessment and planning tools to reduce duplication. This will be explored further through the work at the vanguard pilot sites.</p>	<p>Age Residential Care (ARC) and Primary Care partnership nurses – 1.8 FTE Registered Nurse and 0.5 FTE Social Worker have been appointed to support planned and coordinated care.</p> <p>Training sessions are underway with both Primary Care and ARC with the next session planned for November.</p> <p>The RN's who are trained then join the increasing core of Link Nurses and have regular meetings with the Hospice Aged Residential Care RN.</p> <p>Anticipatory Care Planning - training for GP's underway.</p> <p>Tablets and Phones roll out for hospice implemented.</p> <p>InterRAI Palliative Care is to be introduced within 2017/18. Training for NASC assessors is due to commence.</p> <p>Enhanced Pasifica Support. New staff appointed and orientation undertaken. Developing a Pasifica plan, Pasifica Advisory Group has been set up.</p>

<p>Patients and their whānau experience equitable and seamless care through coordinated service provision (Integration)</p>	<p>Since November 2016, Carterton Integrated Medical Centre initiated and piloted a model of care using the Gold Standard Framework to provide a structured approach in their management of palliative patients. In May 2017 Masterton Medical Centre, also began Gold Standard Framework meetings. The inter-disciplinary meetings involve the practice G.Ps, practice nurses, community pharmacist and DHB Allied staff working holistically to identify and address patient needs using the "7Cs of the framework; coordination, communication, continual learning, care of the dying, continuity, carer support and control of symptoms.</p>	<p>Specialist support from Te Omanga Hospice (TeO) for primary palliative care providers (i.e. GPs, Hospital and Residential Care Facilities) has been advanced and work across the seven vanguard sites will further enhance and embed this.</p> <p>This has enabled one particular practice to establish an inter disciplinary team (GPs, practice nurse, HV Service Care Coordination staff, OT, Hospice nurse and Hospice counsellor/social worker) to regularly review their palliative patients to identify any health and psycho-social needs with solutions to address these.</p> <p>Building links between vanguard pilot sites but also enhancing their interface with other services like the hospital, HV Service Care Coordination and other home and community providers will improve collaboration/coordination, sharing of information and ensure equitable access to services for palliative patients and their families/Whānau .</p>	<p>Collaborative Pasifica palliative case study underway with Massey University.</p> <p>Enhanced Maori Manaaki This is progressing with Auckland Tikanga development. Outsourced contractor is in place.</p>
<p>Patients and their whānau experience high quality services in different settings (Quality)</p>	<p>Age residential care (ARC) providers are separately contracted for palliative respite care – with requirement for palliative care training of their RNs. The DHB provides partnership nurses who have specialised palliative care knowledge and skills to provide support to ARC providers who are</p>	<p>Existing and new initiatives to build competence, capability and capacity across the vanguard sites in the first instance, and then wider will be promoted and staff will be supported to engage.</p>	

	<p>providing care for palliative patients. The intended outcome is that all ARC RNs involved in providing palliative and end of life care will have the nursing knowledge and skills to do so.</p> <p>ARC providers are also supported in their development of 'Link Nurses' to ensure palliative care best practice is extended across the workforce. The Link Nurses act as facility champions.</p>	<p>TeO Hospice Link Nurse training is in place where nurses spend a week with Hospice Team and receive funding to backfill.</p> <p>ACP Training is another opportunity for staff to develop skills to have these, sometimes difficult, conversations.</p> <p>TeO Hospice also offers a 'training/support' programme for family carers.</p>	
Care in the last days of life is comprehensive, with good symptom control, is in the most appropriate setting in the company of whānau and/or friends (Last days of life)	<p>Kahukura specialist palliative care nurses provide advice and support for symptom control, with support from Te Omanga Hospice Specialist Palliative care service (medical and nursing).</p> <p>The ARC Link Nurses will be leading the implementation of Te Ara Whakapiri in ARC.</p> <p>Hospice Wairarapa fund a day/night respite support service to prevent or reduce carer fatigue among people who are caring for someone on the end of life pathway to remain at home.</p>	<p>Introducing and embedding Te Ara Whakapiri (Last Days of Life) Guidelines and Toolkit.</p> <p>A pilot project has begun to introduce this at Hutt Hospital and the surgical ward has been selected as a potential pilot site. Work with the Vanguard Residential Care facilities to introduce this will commence shortly, and then to general practice before further roll out.</p> <p>There is now Hospice support and funding for general practice to continue to support patients in the last days of life who wish to die at home and whom do not need specialist support from the hospice.</p>	<p>The Te Ara Whakapiri (Last Days of Life) Guidelines and Toolkit is being introduced across both Mary Potter Hospice and appropriate DHB staff.</p> <p>Following which it will be introduced across ARC, for example via the Link Nurse training.</p>
Whānau experience high quality care after death (After death support)	<p>Kahukura provide debriefing with whānau, as appropriate. Debriefing is also provided for ARC staff that develop strong relationships with their residents and can need support to cope with some deaths.</p>	<p>A Hospice counsellor/social worker has been appointed to provide this service to patients who do not receive hospice services and are managed by their GP.</p> <p>Through early engagement at general</p>	<p>Psycho-social support.</p> <p>A counsellor has appointed for bereavement/psychosocial support. Literature and other provider review of bereavement programs has been completed and plans underway to</p>

	<p>Hospice Wairarapa provide psycho-social support which includes bereavement and one year follow-up.</p>	<p>practice of palliative care planning, the needs of family/carers are considered and will also help identify what might be needed after death. This work will be further explored at each of the vanguard pilot sites.</p>	<p>establish a new bereavement model for MPH that will support families beyond those who have been admitted to MPH service. Joint bereavement program about to launch in collaboration with the Cancer society for under loss of a spouse in the under 45 group. Several “debriefings” and loss/grief teaching sessions in ARC.</p>
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**CPHAC-DSAC
DISCUSSION PAPER**
1 September 2017

Authors	Catherine Epps, CCDHB Helen Rigby, 3DHB
Endorsed by	Nigel Broom, Wairarapa DHB Helene Carbonatto, HVDHB Rachel Haggerty, CCDHB
Subject	Progress with Advance Care Planning in the sub-region

RECOMMENDATION

It is recommended that the CPHAC-DSAC Committee

- a. **NOTE** that Advanced Care Planning (ACP) gives people an opportunity to document how they would like to be treated and cared for at the end of their lives, particularly if they are unable to speak for themselves.
- b. **ENDORSE** the progress of the Advance Care Planning Project and the future direction proposed.

1 PURPOSE

The purpose of this paper is to update CPHAC DSAC on progress with the 3DHB Advance Care Planning (ACP) project.

2 BACKGROUND

Advance care planning (ACP) has emerged internationally in recognition that dying has become highly medicalised over recent decades resulting in people being provided with sometime futile or non-beneficial treatment at the end of their lives that might prolong life while there is little quality of life remaining. ACP gives people an opportunity to think about and document what makes life meaningful to them and how they would like to be treated and cared for at the end of their lives, particularly if they are unable to speak for themselves.

Aims of the 3DHB ACP project (since August 2015) have been to increase awareness and engagement of both public and health professionals in ACP and embed ACP in usual practice across the health sector. This recognises that ACP is an evolving process that should start early in the community when people are well and continue across their life/health journey. Health professionals in all parts of the sector need to be prepared to discuss ACP.

Clinical governance of ACP is provided by a Sub-Regional ACP Steering Group. At a regional level, the 3DHBs are part of a Central Region ACP Reference Group with a guiding Central Region ACP Framework. The National ACP Cooperative and Health Quality and Safety Council lead and support national initiatives and provide ACP training.

Locally the 3DHBs have supported ACP initiatives through the employment of an ACP project manager. Additionally all 20 DHBs funded the national ACP programme and training with funding agreed in the

2016/17 year. On-going national funding from the DHBs for a 5 year national ACP strategy has been requested and is under discussion.

3 PROGRESS

3.1 What are we trying to achieve?

Consumers across different cultures and backgrounds that have:

- early and on-going discussion about end of life and dying in families, communities and health settings
- end of life experiences that match their values and preferences
- appointed & informed proxy decision makers for health care (ideally legally appointed enduring power of attorney (EPA)).

A health professional work-force that:

- is ready to assist people in shared decision making about their treatment and end of life preferences
- utilises ACPs and EPAs when people are unable to speak for themselves
- avoids provision of futile and non-beneficial treatment.

A system that:

- has accessible information about people's advance care plans or advance directives

3.2 How are we doing?

Some achievement highlights include:

Consumer Awareness

- 2017 50+ presentations to date with 1100 attending – two thirds of these members of the public
- In 2016 over 1200 consumers heard about ACP through public presentations or promotional stands (e.g. at Older Person's Expos)
- Anecdotally – some consumers are now raising ACP with their GPs and with each other

Health Professional Engagement

- over 100 clinicians have attended national ACP face to face training in 2016 - 2017
- over 150 clinicians are in the 3DHB area are in the ACP 'Champions' Group

Systems/Embed in Services

Four general practices were pilot practices to embed ACP into their systems. All increased their coded ACP activity:

- Masterton Medical: 4 in 2015; 30 in 2016
- Muritai Health: 0 in 2015; 50 in 2016
- Paraparaumu Medical: 14 in 2015; 194 in 2016
- Whitby Doctors: 19 in 2015; 50 in 2016

4 NEXT STEPS

Continue with an over-arching 3DHB ACP strategy and tailor local work to:

- align with roll out of Living Well, Dying Well

- align with other initiatives such as Choosing Wisely and Health Care Homes
- explore general practice team models for integrating ACP
- engage Maori with ACP
- engage Pacific with ACP
- integrate ACP process in pilot aged residential care facilities
- develop efficient electronic storage and sharing systems

5 FURTHER READING

<http://www.smh.com.au/national/the-day-i-meet-you-in-the-emergency-department-will-probably-be-one-of-the-worst-of-your-life-20151105-gkrbm7.html> A short powerful piece from a Melbourne doctor advocating for advance care planning.

BMJ Detering, K. et al (2010) The impact of advance care planning on end of life care in elderly patients: randomised controlled trial

Atul Gawande (2014) Being Mortal: Medicine and What Matters in the End – <http://atulgawande.com/book/being-mortal/>



**CPHAC-DSAC
DISCUSSION PAPER**

1 September 2017

Author	Joanne Edwards, Wairarapa DHB Jan Marment, CCDHB Kate Calvert, HVDHB
Endorsed by	Helene Carbonatto, General Manager, HVDHB Rachel Haggerty, CCDHB Nigel Broom, Wairarapa DHB
Subject	Health of Older People Services across the sub-region

RECOMMENDATION	
It is recommended that the CPHAC-DSAC Committee	
1. ENDORSE the approach taken by the 3 DHBs with respect to the management of aged care providers in the community and residential care to support them to achieve quality outcomes.	
Appendix A: Quality Assurance and Obligations – Health of Older People Services	

1 PURPOSE

The purpose of this paper is to inform CPHAC-DSAC about Aged Care services across the sub-region, how we audit these, key issues within the sector and how these have been addressed over time¹.

2 SUMMARY

The aged care sector is continually changing and because it is largely driven by market forces, is subject to socio-economic influences outside the control of the DHBs. Over the past 10 years, there has been a considerable emphasis on improving quality of care for frail older people, whether they are living at home, in the community or in residential care. However, there is always room for improvement and incidents involving care of this vulnerable group of our population are always taken seriously by the DHBs and Ministry of Health (MoH). If such a situation does occur, there are robust processes in place for investigating and resolving it to achieve quality improvement.

Requirements for compliance with Health and Disability Standards have increased and there is a tight MoH auditing programme in place for residential care providers. The greater number and severity of adverse findings from an audit, the shorter the auditing cycle. DHB complaints processes and issues of concern also contribute to this decision by the Ministry.

3 BACKGROUND

The aged care sector has changed significantly over the last 10 years. As the proportion of older people in our population has increased, so has the nature of the aged care sector and market. With those changes, the growth in the market has led to a number of reviews and strategies to improve quality in particular within the aged care sector. Of note, the following have had sentinel impacts on the journey to improve quality of care for those older people who are most frail and vulnerable:

¹ **Older people:** people aged 65 and over or aged 50 to 64 with age related needs.

- 2001: New Zealand Positive Ageing Strategy, cross government strategy
- 2002: The Ministry of Health introduced an audit process of certification of ARC facilities, as set out in the Health and Disability Services Standards
- 2002: Health of Older People Strategy – Health Sector Action to 2010 to Support Positive Ageing
- 2009: Office of the Auditor General Review of the certification process of ARC facilities
- 2010: Aged Residential Care Service Review (Grant Thornton report)
- 2011: Office of the Auditor General audit “Home Based Support Services for Older People”
- 2012: Home and Community Support Sector Standard (NZS 8158:2012) Mandatory requirement for auditing providers against the standards
- 2012: Follow-up review by the Office of the Auditor General which identified that the Ministry of Health had appropriately addressed the recommendations outlined in the 2009 report and suggested further improvements.
- 2014: Office of the Auditor General, “Home-based support services for older people: Progress in responding to the Auditor-General’s recommendations”
- 2014: Settlement agreement between the Crown, DHBs, providers and unions to resolve significant issues facing the Community Health Sector. This included payment of time and mileage to home support workers and employment for guaranteed hours. It was implemented in 2015 and 2016-17 and was intended to stabilise this vulnerable workforce.
- 2015-16: Evaluation for the Ministry of Health of whether changes made to the auditing processes have translated into improved outcomes for people living in ARC facilities
- 2016: Office of the Auditor General, follow-up audit “Home based Support Services for Older people”
- 2016: New Zealand Health Strategy
- 2016: Healthy Ageing Strategy which replaced the 2002 Health of Older People Strategy
- 2017: Care and Support Workers Pay Equity Settlement Agreement to acknowledge the value of this workforce and endorse their training.

Each of these has improved the care of our vulnerable older citizens. A retrospective look at descriptive reports such as “A Report into Aged Care” (2010) highlights considerable improvement over recent years. Appendix 1 references this report’s recommendations to illustrate improvements made to date.

4 AGED CARE SECTOR

4.1 The Community

Most people prefer to stay at home as they age. Strategies enabling this have been successful - with DHBs reporting the entry to residential care trend is less than the demographic increase.

Staying at Home

More than 60% of all those receiving funded support are being supported to live at home. Various developments have enabled this including:

- Improved training framework for support workers, allowing them to support greater complexity of care in the home
- Supporting carers through increased use of respite and day care
- Supporting GPs through: health pathways, healthcare communities, healthcare home in a number of pilot sites in CCDHB
- Funding small NGOs to provide face to face support to those in greatest need
- Home and Community Support services that encourage restoration and independence through the use of allied health and a well trained support worker workforce
- Specialists providing more support in the community and to GP practices
- Programmes supporting people to recover and rehabilitate in their home
- Proactive and mature Needs Assessment and Service Coordination agencies

- Residential village populations have grown. These living arrangements are able to support people longer in their villa by addressing the problems of loneliness and insecurity. Both of these are significant factors in tipping the balance for people choosing to remain at home.

Non-Government Organisations (NGOs)

Services provided by the smaller NGOs are invaluable to improving the quality of life for those elderly who require support to live at home. They are acknowledged within the Healthy Ageing Strategy (2016) as instrumental in enabling people to stay independent, connected and respected. Some are funded directly by the DHBs, and others are national organisations funded via the Ministry of Health.

Most of the NGOs meet regularly with the Needs Assessment and Service Coordination agency and the DHBs. These groups are well established and enable networking and information sharing.

A sample of the NGOs active for the elderly in the community includes:

Supported independent Living (SIL)

This assists those who are very vulnerable living at home because of isolation, lack of natural supports and social issues. The range of support is wide and includes managing hoarding, budgeting, isolation, and addictions. The service providers accept referrals from the Needs Assessment and Service Coordination (NASC) agency and provide reports to the DHBs.

Alzheimers Wellington

Field workers visit people with dementia and their carers at home. This ensures that they are well aware of what support is available, both funded and unfunded. The NGO provides group and individual education sessions for both those with dementia and their carers. They also provide social interaction through a day activity programme. They are fully engaged in educating health professionals on the dementia pathway and advocating for its use and full implementation. They accept self-referrals and provide reports to the DHB Health of the Older Person Portfolio Manager. They are receiving more referrals from GPs as a result of the Dementia pathway implementation.

Mission for Seniors (do not receive funding from the DHB)

This organisation supports people who have little resource to call on – those who are in poverty and isolated. They provide food, transport, social events and a field worker who visits. They have a strong hands on approach.

Accredited Visiting Service

This is a national service provided by Age Concern with funding provided by DHBs. In the Hutt Valley there has been a change in manager and the number of people being visited at home by volunteers has increased. This is a well-respected service that matches volunteers to older people who are isolated and/or lonely.

Kokiri Marae

Support to Koro and Kuia through the whānau ora programme.

Parkinson's, Arthritis and Stroke

Whilst not specific to the elderly, these NGOs offer field worker support to those with the illness and their carers. They provide education, navigation of services and individualised support. This is funded through regional and national contracts.

Age Concern Wairarapa

Health promotion, information and education for older people is provided through Age Concern Wairarapa. This service works with the Wairarapa DHB to promote priority health related messages (e.g. falls prevention, enduring power of attorney, and information to support carers). The service enables information and education of older people with regard to optimising independence and safety in the community.

Wesley Community Action

Wesley Community Action has recently been successful in receiving the contract for elder abuse and neglect services across Hutt and CCDHB from Ministry of Social development. They also provide support and advocacy services for older persons – both in the community and in people’s homes.

Carer Support

Support for carers was identified by the DHBs as a priority for 2016/17. Using interRAI data, the project focused on identifying carers who are struggling and ensure they are receiving the support required. This on-going project has already resulted in: additional contracts awarded to local providers such as a dedicated respite bed in Wellington. A review of allocation guidelines and a more user friendly process for accessing day care will be undertaken.

Other Government agencies and local councils are also implementing strategies – for example Dementia Friendly Communities.

Integration

An integrated approach to proactive multidisciplinary planning has also been gaining traction in Wairarapa through Tihei Wairarapa.

Hutt Valley DHB has also embarked on a programme of work to improve the integration of older person’s services between specialist services, community health services and primary care. An older persons clinical network is about to be established under the Alliance Leadership Team (Hutt INC) which will provide oversight to a number of integration programmes of work (including dementia care and specialist teams in the community), and the development of Health Care Home across the Hutt Valley in the next year will also see an improved focus on the needs of the frail elderly.

CCDHB’s Health Care Home programme supports the frail older person through a team-based health care delivery model, led by primary health clinicians, providing comprehensive and continuous health and social care with the goal of supporting individuals to obtain the best possible health outcomes. The Healthcare Home initiative is focused on Community Service Integration including for older people.

4.2 Home and Community Support Service (HCSS)

People who need help to stay in their home can be visited by support workers and assisted with activities of daily living. The DHBs spent \$21,469 million across the sub-region in 2015/16 to support older persons remain in the home via HCSS agreements. The Home and Community Support Service sector for people over 65 years of age has undergone a significant change with the establishment of a single provider, bulk funded restorative service (via Access) in both HVDHB and CCDHB in 2016. This service has quality targets to meet and incentives to enable people to do as much of their daily living activities as they can.

While the new service is becoming established the DHBs are monitoring weekly:

- responsiveness of the service
- training support workers undertake
- quality improvement initiatives
- complaints

The IT improvements and support worker training focus are making a difference to the quality and timeliness of services people are receiving in their home.

HCSS have evolved from a non-essential service to an essential service for many people. The ability of the HCSS to provide timely and quality service is fundamental to people being able to stay at home. This trust by the client requires consistent service delivery, which given the numbers of people receiving support at home, can be difficult to consistently achieve. The recent pay equity settlement will have an impact with more support workers staying in the job. This is a fundamental requirement for a quality service.

4.3 Aged Residential Care

The DHBs spent over \$100M in aged care services across the sub-region in 2015/16, with Wairarapa spending \$11,962 million, CCDHB spending \$59,526 million, and HVDHB spending \$34,991 million in 2015/16. Aged care services cover rest home level care, hospital level care and dementia level care. Clients can be charged for additional costs over and above this care, with aged care facilities charging anything from \$0 to \$60 per day.

There are 61 aged care facilities across the sub-region, with Wairarapa contracting with 13 facilities, Hutt contracting 15 facilities and CCDHB contracting with 33 facilities.

Any aged care facility can enter into the market under the Social Security Act and receive DHB Funding if they meet HealthCERT requirements. DHBs are required to enter into an Agreement with an aged care facility that has passed certification requirements. This means that the 'market' for rest homes, the type of rest homes and who they cater for is not governed by DHB who would normally commission services based on needs but via the Social Security Act. Rather the sector is subject to market forces and continual expansion- contraction as providers compete for occupancy. Designing aged care services for a population is therefore difficult to do as a DHB, and is a policy issue that has been a national issue for some time.

Providers of residential care for older people fall into 3 categories:

- Religious and Charitable Trusts
- Private limited companies
- Public limited companies

Over the past few years, there has been an expansion of public limited companies providing aged care services in terms of both the size and diversity of settings and also the number of sites owned by a few companies. There continues to be a noticeable increase in residential villages which are linked more with housing than support services, but also often have a facility on site. The system is based on commercial interests for shareholders. People living in the villages usually have an occupational right agreement (ORA) with the owner and are not covered by the ARC agreement or its provisions for quality assurance.

Religious and charitable trusts often have a different value system and are often well connected to and supported by their community. They are however under increasing financial pressure, often associated with lower occupancy caused by residential care expansion and the lack of historical investment in their facilities.

Private providers are facing the same challenges as the Religious and Charitable sector, but because they are often very small facilities, their financial sustainability is even more vulnerable.

The DHBs closely monitor occupancy levels and their potential impacts on residents (e.g. staffing levels, falls, hospital admissions), and work with providers to include quality indicators in their facility processes.

A commercial focus does not necessarily imply that quality of care has less attention. The ultimate commercial incentive of full beds and few audits is only possible through achievement against the Health and Disability Safety Standards. If quality is poor and standards are not met, certification period will be shorter. This in turn results in a shorter auditing cycle (e.g. annually) which is more expensive for the ARC provider. Not only that, their reputation as a quality provider is called into question and the outcome in such a competitive market is likely to be lower occupancy.

There are contractual and legislative controls regarding the cost of care in a residential facility. Quality of care is expected to be the same regardless of the person's financial status. Contractually, residents must have the choice of whether they wish to pay additional charges relating to their accommodation.

Quality Assurance

The paper presented to CPHAC-DSAC in November 2016 (Refer Appendix 1) outlined the quality requirements for residential care:

- All Residential Care providers must be certified by the Ministry of Health before the DHB can contract with them.
- All DHB service contracts include requirements for meeting quality and legislative obligations.

- DHBs monitor the compliance and quality of residential services in partnership with the MoH. The Ministry through HealthCERT are responsible for the administration of the Health and Disability Services (Safety) Act 2001.

The paper also described related mechanisms the Ministry and DHBs use to ensure quality assurance in residential care such as:

- Audit frequency and how findings are addressed
- Provider monitoring

Alongside the national comprehensive audit programme of aged care facilities, there is a lot of work that goes into supporting aged care facilities more locally.

Wairarapa DHB approach to Quality Improvement

Wairarapa DHB assists all providers to take a quality improvement approach to the services they provide through their audit and complaints processes. In addition, DHB examples include:

- Provides specialist input for education of staff, assisting with care planning of complex residents, providing specialist clinical advice and education/mentoring of staff. Specialty areas covered include Health of Older People, Psychogeriatrics, Rehabilitation, Palliative Care, Wound Management, Respiratory, Cardiac, Diabetes, Continence, and Pain. These inputs are from nurses, specialist nurses, allied health and DHB medical staff. There were 1235 such visits to ARC facilities in 2016/17.
- Education sessions provided free of charge for ARC and HCSS staff (all levels) (126 sessions in 2016/17)
- Regular meetings are held with ARC and HCSS providers to provide a forum for information, updating and service review
- All contracted providers have access to DHB learning resources (e.g. Ko Awatea e-learning web site)
- The DHB provides partnership nurses who have specialised palliative care knowledge and skills to provide support to ARC providers who are providing care for palliative patients. The outcome is All ARC RNs involved in providing palliative and end of life care will have the nursing knowledge and skills to do so.
- Consumer feedback is given through a variety of methods such as whanau debriefing and regular consumer stakeholders forums.

Hutt DHB approach to quality improvement

HVDHB assists all providers to take a quality improvement approach to the services they provide through their audit and complaints processes. All complaints (either from consumers, Ministry of Health or the facilities themselves through Section 31) are followed up immediately, tracked, recorded, and resolved (usually with an agreed set of actions depending on the complaint) within agreed timeframes (usually within 10 working days).

There are also a number of local initiatives underway in the Hutt Valley that further support aged care facilities:

- There are two nurse practitioners from the Older Persons and Rehabilitation Service (OPRS) dedicated to providing clinical support and development to aged care facilities. They meet with facilities monthly, provide training on key clinical care issues, and work through issues of quality improvement as they arise within the services.
- The DHB brings aged care nurses and manager's together bi-monthly to discuss general clinical issues of interest, and ensure there is strong connection between the providers.
- A designated team of nurses from Te Omanga Hospice is available to support facilities to meet the palliative care needs of their residents.
- The Hospice provides additional resourcing i.e. support worker for patients at the end of life and living in residential care.
- Hospice delivers a Link Nurse training programme for residential care nurses which involves a 5 day placement in a hospital/palliative care setting where these nurses work alongside palliative care staff to develop skills and build confidence in delivering basic palliative care. The facilities receive funding to backfill staff. Following the training, monthly networking occurs between the facilities/hospital/hospice to enhance and support to embed this link role at the facility.

- Staff at facilities are also encouraged to attend Advanced Care Planning training which serves to build expertise in having difficult conversations and documenting this.
- Consumer feedback is given through a variety of methods such as whanau debriefing and regular consumer stakeholders forums

With respect to HCSS services, the DHB bring together Access (the provider of HCSS services) and the older person's consumer representatives from across the Hutt and CCDHB district on a quarterly basis to work through issues of quality and complaints. This is an opportunity to hear first-hand what the issues are, what is working well, and hold the provider to account for improvements via regular reporting.

CCDHB approach to quality improvement

Quality Improvement is a continuous process both within Aged Care Facilities and in the teams of specialists that support them. This has contributed to every aged care facility in CCDHB having 3 or 4 year certification. Quality Improvement is a requirement of all providers with DHB funded services and the following services are available:

- PDRP programme for registered nurses with monitored and increasing numbers registered on the PDRP
- Specialist input providing residential staff with education and assistance with planning the care of complex residents. This includes the community specialist and generalist nurses, Nurse Practitioner and Nurse Practitioner in training having regular visits to Aged Care facilities. Mary Potter Hospice link nurses - to provide support for those residents in aged care who require palliative care
- Advanced Care Planning discussions and proactive support across facilities
- Regular meetings with ARC and HCSS providers to monitor quality markers for the sector. This includes quarterly support and education meetings with Aged Care clinical managers and the Director of Nursing – Primary and Community.
- Attendance of HOP representation at CCDHB Primary Secondary Clinical Governance meeting with support to develop a report to understand quality care markers for the sector. Initial report in development.

5 IMPROVING OUTCOMES

In 2015-16 the Ministry of Health contracted Auckland University of Technology to evaluate whether changes made to the auditing processes have translated into improved outcomes for people living in ARC facilities ("Improving Outcomes in Age Residential Care")². The evaluation utilised a variety of data sources. Audit data evidence showed an increased number of ARC facilities were awarded a 4-year certification period in 2015, compared to 2009, along with lower numbers of partially attained criterion scores. Analysis of existing audit and other data provided, demonstrated that facilities are required to have quality processes in place, and that these processes are an integral part of service provision on a daily basis. They concluded that the weight of evidence across all data sources supports the audit process changes as beneficial to quality of care and improved outcomes for residents.

The evaluation also included interviews with stakeholders. The report concluded that "There is strong evidence to suggest that these changes are, in general, now well embedded within ARC facilities and provide a robust platform to positively influencing outcomes for people living in ARC. ...This feedback supported the continuing move away from process driven to consumer outcome focused auditing."

6 PAY EQUITY

The introduction of guaranteed hours in the HCSS sector, as well as pay equity in both the HCSS sector and aged care facilities will have an important positive step for the sector both in terms of recruitment and retention of key support workers. It will also improve the quality of services as employers attract more qualified and well paid staff to work in the sector. On the flip side, it remains unclear what the medium term financial impact of

² July 2017 - Improving Outcomes in Age Residential Care; Report prepared for the Ministry of Health, Associate Professor Stephen Neville, Associate professor Valerie Wright-St Clair, Dr David Healee, Dr Judith Davey

pay equity will be on the aged care sector in particular as the funding for pay equity has been passed through the facilities on an average rate. Those facilities who have a lower paid workforce to begin with will no doubt be beneficiaries of the funding, whereas those facilities with more experienced staff who had been employed for longer will be penalised.

The full impact of pay equity alongside aged care facilities that were already vulnerable due to vacancies is unknown, though there have already been a number of closures nationally (and more to come no doubt) where the double impact of pay equity and vacancy rate will force some facilities to close their doors. For fee paying clients, facilities have already increased their fees by up to \$200 a week to cover the effect of pay equity, and the extra daily charge rates for publically funded clients will also no doubt increase.

These issues have all been raised with the Ministry of Health who were party to the settlement with the sector and Unions. We have voiced our concerns and also discussed the need for policy work to address the management of the market over time.

APPENDIX 1 A Report into Aged Care³ - Key Recommendations and Sector Improvements

	Recommendation	Progress
1	Establish an independent Aged Care Commission and Commissioner	A separate Aged Care Commission has not been established. The Health & Disability Commissioner (HDC) is an independent agency set up to promote and protect the rights of consumers who use health or disability services. It does this through a local network of advocates, mediation or investigation. This includes making sure complaints about health or disability services providers are taken care of fairly and efficiently.
2.	Establish a technical working party (made up of experts from industry – including providers, the unions and consumers – and aged care specialists	The NZ Health of Older People Steering Group has representatives from ministry of Health, TAS, and each DHB region at General Manager and Portfolio Manager levels. It has a work programme which links with regular forums with ARC provider representatives and Home and Community Support providers. Subject specialists are co-opted as appropriate. Technical working parties with a wide range of stakeholders are also established for specific projects (e.g. current models of care project). “Co-design” is a concept being increasingly adopted to ensure the consumer voice is heard.
3	Government funded training provided to all age care staff – in residential and home based support services	All training for staff undertaking interRAI assessments in residential care has been funded centrally. Regional funded opportunities have included dementia training, and advance care planning. Locally, DHBs provide a considerable range of education opportunities for aged care providers (residential and home based), especially through their clinical specialists (e.g. palliative care, and wound management).
4	Minimum staffing levels for nurses and care givers to be mandated in regulations	The Grant Thornton report (Sept 2010) identified a recommended range of staffing ratios for the different levels of care. Based on literature findings, current practice and recommendations from an expert advisory panel the Ministry issued a staffing indicator to be used as guidelines to meet the standard for safe staffing. Although this guideline is not mandatory it is generally accepted and used by ARC providers and DHBs as a reference point.
5	A star rating system for age care facilities to be developed and made publicly available on the Aged Care commissioner’s website	A star rating has not been implemented. However, the Ministry of Health website has easy access to the latest audit summary for each certified facility. Comparisons of length of certification period, number of corrective actions and any accolades for continuous improvement are provided for public viewing.
6	Audits – accredited auditors, unannounced audits, focused on monitoring quality and care practices	Auditing agencies are accredited and the Ministry (HealthCERT) work with them to ensure a consistent approach. Not all audits are unannounced, but Surveillance audits are (half way through the certification period). Auditing methodology now focuses more on outcomes and tracer methodology is used to gain a more complete picture of

³ 2010 October, A Report into Aged care; What Does the Future Hold for Older New Zealanders? New Zealand Labour, and Green Party in conjunction with Grey Power

		the resident's care.
7	All residential aged care facilities and home based support providers to operate under greater transparency and accountability	There are increased reporting with regard to incidents and complaints (e.g. complaints categorisation, pressure injuries, reassessment time frames). InterRAI is also now providing ARC providers, DHBs and the Ministry with a comprehensive view of the status of their residents (e.g. falls risk, continence). A number of projects have focused on acute bed days for older people and readmission rates as high level system measures and these measures can also be linked through NHIs with services provided.
8	Pay parity for aged care staff (including residential and home based support) with staff working in public hospitals and the community	On 1st July this year the Pay Equity settlement was implemented for care and support workers in the aged care sector (residential and home based support). In addition, for some clients with complex needs, DHBs work with providers to ensure client specific training and monitoring. This can occur in hospital or the community.
9	A national contract for home care workers and aged residential care workers	This has not occurred.
10	Greater consistency for home support services	Quality Standards have been implemented for Home Based Support (2012) and providers are now audited on those standards. Work is currently underway to develop a national model.
11	National face-to-face standardised model for home based assessments	The interRAI was fully implemented as the national tool for home based assessments from 2009 to 2012. Now all older people who receive long term support have an interRAI assessment to inform their care planning. In addition the interRAI assessment system has also now been implemented for all residents in aged care and is due to be rolled out for palliative care.
12	More integrated networks for home support services	Agencies other than ARC providers who also provide support for older people are now able to read the client's interRAI assessment. In addition, technology is enabling increased integration across the health spectrum (e.g. shared care record). This aspect of development is yet to become fully established.
13	More specialist gerontology training offered across the sector to address the desperate shortage of specialist services	The number of nurse practitioners has increased nationally and across the 3 DHBs, with some specialising in health of older people.
14	Consistent packages for dementia patients	The importance of respite care and supporting carers in other ways, especially those caring for someone with dementia has been a project focus for the 3 DHBs over the past few years. The NASCs have been requested to actively follow-up usage of respite care allocation and work with the family carers around options which best suit them (e.g. respite in the home).



**CPHAC-DSAC
INFORMATION PAPER**

Date: 18 November 2016

Author	J Marment and J Edwards
From	A Gray, Acting Group Manager, Health of Older People and Mental Health Sandra Williams, Acting Director, SIDU
Endorsed by	Debbie Chin, CE Capital & Coast DHB Ashley Bloomfield, CE Hutt Valley DHB Adri Isbister, CE Wairarapa DHB
Subject	Quality Assurance and Obligations – Health of Older People Services

RECOMMENDATION

It is recommended that the CPHAC-DSAC Committee

- a. **Note** the update;
- b. **Note:**
 - i. All Residential Care providers must be certified by the Ministry of health before the DHB can contract with them.
 - ii. All DHB service contracts include requirements for meeting quality and legislative obligations.
 - iii. DHBs monitor the compliance and quality of residential services in partnership with the MoH. The Ministry through HealthCERT are responsible for the administration of the Health and Disability Services (Safety) Act 2001.
 - iv. According to advice received by Buddle Findlay, DHBs’ obligations under the Health and Safety at Work Act (2016) are considered to be addressed through the DHB’s “normal contract management and performance of their other statutory obligations.”
 - v. Buddle Findlay have also noted that essentially the same obligations which apply to ARC services also apply to HCSS and all other providers contracted by the DHB.

1 PURPOSE

The purpose of this paper is to inform CPHAC-DSAC about quality assurance mechanisms which are in place for Health of Older People with regard to meeting the Health and Disability Safety Standards and relevant legislation requirements for the Health and Safety at Work Act (2016).

2 SUMMARY

- All Residential Care providers must be certified by the Ministry of health before the DHB can contract with them.
- All DHB service contracts include requirements for meeting quality and legislative obligations.
- DHBs monitor the compliance and quality of residential services in partnership with the MoH. The Ministry through HealthCERT are responsible for the administration of the Health and Disability Services (Safety) Act 2001.
- According to advice received by Buddle Findlay, DHBs’ obligations under the Health and Safety at Work Act (2016) are considered to be addressed through the DHB’s “normal contract management and performance of their other statutory obligations.”
- Buddle Findlay have also noted that essentially the same obligations which apply to ARC services also apply to HCSS and all other providers contracted by the DHB.

3. CERTIFICATION, AUDITING & MONITORING PROCESS IN AGED RESIDENTIAL CARE

3.1 Certification

- All facilities are audited by a Designated Auditing Authority (DAA) for certification.
- Certification can be between one and four years.
- Facilities have a surveillance audit half way between their certification periods. This is an unannounced audit. Therefore if a facility has a three year certification they are audited every 18 months.

The audit is based on the Health and Disability Sector Standards and the Aged Residential Services agreement. The standards include: Consumer rights, Organisational Management, Continuum of Service delivery, Safe and Appropriate Environment, Restraint Minimisation and Infection Protection and Control

Without certification a facility would not be able to hold a contract with the DHB.

3.2 Other Types of Audits

3.2.a Provisional

Prospective providers undergo a provisional audit to establish the level of preparedness to provide a health and disability service and conformity prior to a facility being purchased or developed.

3.2.b Partial provisional

This is undertaken to establish the level of preparedness of a certified provider to provide a new health and disability service.

Both provisional and partial provisional audits are for a maximum of one year.

All of the above audits are publically available on the MoH website. File path is:

<https://www.health.govt.nz/your-health/certified-providers/aged-care>

3.2.c Claims Audit

Claims audits are undertaken randomly unless specifically requested by the DHB to assess a provider financial compliance.

There has been one request in the past 12 months for a specific financial audit of an aged care facility following an anonymous call to the DHB.

3.3 Certification periods

As at October 2016 Capital and Coast have 100% of the ARC facilities with three or more years accreditation. The data for the other sub regional DHBs is included for comparison.

The maximum 4 year certification period requires the facility to have none or very few low risk corrective actions and to have been commended for quality and care initiatives. CCDHB has a very high % of facilities with the highest certification period of 4 years.

ARC certification periods in the subregion

Certification Periods Aged Residential Care				
22/07/2016	Months certified			Total
	48	36	24	
HVDHB	3	12	0	15 (excl 1 new facility)
	20%	80%	0	100%
CCDHB	14	20	0	34
	41%	59%	0	100%
Wairarapa	1	8	2	11 (excl 2 new providers)
	9%	73%	18%	100%

3.4 Monitoring Corrective Actions Arising from an Audit

DHBs work with the facilities once an audit has been undertaken agreeing a plan to address all corrective actions and monitor compliance with the plan. This approach works well.

It enables the DHBs to:

- identify those facilities that could gain the most benefit from additional quality improvement inputs such as Nurse Practitioner (or other) led education sessions. Other learning and development opportunities have been developed in each DHB to support ARC facilities. CCDHB employs a PDRP and District Nurses input to support up-skilling within ARC teams. The Older People Nurse Practitioners and the Director of Nursing Community have significant input into ARC facilities.
- Monitor the progress against the corrective actions and share examples of good practice.
- Maintain and strengthen relationship between the facility and the DHB.

4. HEALTH & SAFETY LEGISLATION – AGED CARE SERVICES

4.1 All NGO providers, including NASC

A letter from Buddle Findlay on 10th January this year, clarified responsibilities of DHBs with regard to the changes in the Health & Safety legislation. In clauses 7 and 8 of the advice letter (which was also endorsed in August), Buddle Findlay states:

“Clearly what is reasonable and practicable will depend of a number of factors, and the steps that are practicable for the DHB to take when it is the provider of services will not, of course, be the same as the steps that it is practicable for it to undertake as the funder. While the DHBs cannot contract out of their duties (clause 29) they can and should:

- undertake due diligence when selecting providers*
- clearly define the DHB’s and providers’ respective responsibilities;*
- monitor the provider so as to ensure that the provider is doing what is agreed; and*
- address any safety issues that arise.*

These are of course all steps that the DHBs take in the course of their normal contract management, and in the performance of the DHBs’ other statutory responsibilities. In short, we don’t think the responsibilities that the DHBs have potentially under health and safety legislation changes the DHBs’ substantive obligations”

Through the Ministry of Health Sector Services, DHBs use a standard contract format which includes a section on General Safety Obligations:

C29.1 You will protect consumers, visitors and staff from exposure to avoidable/preventable risk and harm. This section includes contract requirements under:

- Risk management
- Equipment maintenance
- Infection control/environmental and hygiene management
- Security
- Management of internal emergencies and external disasters
- Incident and accident management
- Prevention of abuse and/or neglect

In addition to this contractual requirement, SIDU sent a letter to all contracted providers earlier in the year, reminding them of their obligations (attached as appendix 1 and 2).

Accompanying this letter was a questionnaire for further discussion with providers as opportunity arose and these discussions are ongoing.

In addition auditing of contracted providers includes consideration of the questions contained in the questionnaire. The DHB will follow up with any corrective actions arising from these audits.

4.2 Aged Residential Care (ARC)

As outlined in Section 2 above, the aged care facilities are audited via the Ministry of Health process which includes audit against the Health and Disability Standards and the contractual obligations under the national Aged Related Residential Care (ARRC) agreement. Although the proposed changes to health and safety legislation were considered in context of the 2016 national agreement review for aged residential care, on advice from Buddle Findlay, no related change to the contract was seen as required. There are some providers who have not yet responded and they will be followed up at providers meetings scheduled over the next few months. BY March 2017 staff will have identified any providers who they remain concerned about. Issue based audits will be available if further action is required.

Standards address workplace safety in sections relating to Quality and Risk Management and human resource management where the standard states:

“Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.”

The DHB contract requires aged care facilities to document and implement policies in relation to:

- occupational health and safety
- infection control
- safe food handling
- safe management and administration of medications
- safe storage and use of chemicals/poisons
- prevention, detection and removal of abuse or neglect of subsidised residents, visitors and/or staff

Facilities are also required to document and implement policies, processes and procedures for:

- identifying key risks to health and safety, evaluating and prioritising these risks
- dealing with the risks
- minimising the impact of internal emergencies and external or environmental disasters
- accident and hazard management that safe guard residents, visitors and staff from avoidable incidents, accidents and hazards.

The facilities must also comply with WorkSafe legislation. This requires them to view the facility as a workplace and all people within that facility therefore are subject to WorkSafe’s regulations.

With regard to the national agreement for ARC a memo was sent from DHB Shared Services to DHBs in February and endorsed in August with regard to the DHBs’ obligations under the Health and Safety at Work Act (April 2016). It was based on the legal advice from Buddle Findlay. The key message was that the current provisions for ARC are seen as appropriate:

In summary, a change to the aged residential care agreement in respect to the proposed changes to health and safety legislation is not seen as required.

The ARC contract already includes a number of provisions relating (or relevant) to health and safety.

In addition, the ARC contract gives DHBs the power to intervene if it has concerns about services being provided, including the power to specify “compliance requirements” following an audit. These are likely to be sufficient for DHBs to have fulfilled their PCBU obligations.




WorkSafe NZ has held education sessions during the provider meeting held with the DHB and Aged Residential Care Managers. These have been well attended.

4.3 Home and Community Support services (HCSS)

DHBs again sought Buddle Findlay advice in August 2016 in a response to a request from Health Care NZ for an amendment to the agreements under which it provides home and community support service.

Buddle Findlay noted that to meet their obligations, DHBs need to ensure that they undertake due diligence in selecting providers, clearly define the DHBs' and providers' respective responsibilities, monitor providers to ensure that they are doing what is agreed (and to ensure so far as is reasonably practicable that health and safety matters are being appropriately resourced, identified, managed and addressed), and address any health and safety concerns with the providers if and when they arise.

Buddle Findlay also noted that essentially the same obligations which apply to ARC services (as described above) also apply to HCSS. *“ The above are all matters that the DHBs should be attending to as part of their normal contract management and performance of their other statutory obligations.”*

  		CPHAC/DSAC DISCUSSION PAPER
		Date: 1 September
Author	Dr Pauline Boyles	
From	Rachel Haggerty: Executive Director of Strategy Innovation and Performance CCDHB	
Endorsed By	Adri Isbister CEO Wairarapa DHB Ashley Bloomfield CEO Hutt Valley DHB Debbie Chin CEO Capital and Coast DHB	
Subject	Launch of and update on the Sub Regional Disability Strategy	
<p>RECOMMENDATION</p> <p>It is recommended that the Boards</p> <ol style="list-style-type: none"> NOTE the development of a performance monitoring framework against the Disability Strategy. NOTE the progress and funding update on the health passport review NOTE identified steps to address systemic difficulties for older disabled people in transition to aged care NOTE the establishment of a joint Interim Clinical Governance (Needs Assessment Services) Hutt and Capital and Coast DHBs NOTE the stepped approach to building disability competence within the health workforce. 		

1 PURPOSE

This paper provides an update to CPHAC DSAC on the implementation of the Subregional Disability Strategy and the priority actions. It also outlines the equity issues for older people and the importance of Needs Assessment and Coordination (NASC) approaches, and building competency in our workforces.

2 SUB REGIONAL DISABILITY STRATEGY

In June 9th 2017 a new disability strategy for the sub region was launched following board endorsement. Feedback on the plan from around the country has been very positive and other DHBs including Hawkes Bay DHB are actively using the strategy to guide their own planning.

Communications to Minister Wagner, sub regional and national partners are planned in advance of international Disabled Person's week in December. In order to meet the needs of all interested and impacted parties the plan has to be available in word, easy read and New Zealand Sign Language. This process will take three months.¹

¹ <https://www.ccdhb.org.nz/news-publications/publications-and-consultation-documents/sub-regional-disability-strategy-2017-2022.pdf> All reports to boards are based on specific identified outcome areas against which DHB performance is measured

The current priorities are; the performance management framework, the Health Passport and the Health & Disability Commission (HDC) National Conference 2017.

2.1 Performance Monitoring Framework

When the Sub Regional Disability Strategy was presented to CPHAC DSAC in April, very specific feedback was given from members on the need for a clear and tight monitoring framework to assess success indicators against each outcome area

The development of a framework based on annual and longer term goals is now underway. Priorities for 17/18 within the new framework will be presented at the December CPHAC DSAC and board meetings of the year.

2.2 Health Passport Review (Collaboration with HDC and the Ministry of Health)

A number of initiatives to improve data sharing area are underway. To this end, the Wairarapa, Hutt Valley and Capital and Coast DHB have been working with the Health and Disability Commissioner to consult on a revised version of the health passport

The following extract highlighting the work of the sub regional DHBs is from a press release on the Minister's report on New Zealand performance on health and wellbeing²:

"The Health Passport is used all over New Zealand and can be used in any hospital. In Wellington, Hutt Valley and Wairarapa hospital staff have been focusing on how the Health Passport has been working since it was introduced in 2013.

Capital & Coast, Hutt Valley and Wairarapa District Health Boards are working with the Health and Disability Commissioner to revise and improve the Health Passport with input from clinicians and consumers. The revision is based on what people who have used it have said. This includes hospital staff who read what people have written.

*These three District Health Boards are working together on many agreed actions to make sure disabled people have the best possible standards of health care"*³

The sub regional District Health Boards are recognized as the leading DHBs in implementing system change to improve the health and wellbeing of disabled people.

New Partnership arrangement DHBs Ministry of Health and HDC

Following a meeting with the Director General of Health, Chai Chuah, in April 2017 an opportunity to work with Price Waterhouse Cooper (PWC) was offered on a "sprint" approach to design of an application or other alternative versions of the health passport.

A further meeting with the Director of PWC attended by key partners led by DSS Finance Manager and Bob Francis led to identification of the advantages of such a project to all parties concerned.

A proposal from PWC funded by DSS is being considered by HDC and the Sub Regional DHBs on a two stage co design process. Funding is guaranteed for the first two parts and further funding for completion will require a new business case to Chai Chuah that will address outcomes of the NZ Health Strategy. It is noted that Disability Support Services (DSS) do not hold sole responsibility for a cross health national tool The goal of achieving a prototype for sub regional testing by early 2018 remains. It is expected that the evaluation will inform a national roll out 2018/19 alongside other national stakeholders within the health and disability sector.

² Ministry of Health and Office of Disability Issues Report 2017

³ <https://www.odi.govt.nz/nz-disability-strategy/strategy-action-stories/outcome3-in-action-health-passports/>

The Health and Disability Commissioner and the Director of Disability Strategy agreed on a joint contribution for this government report

2.3 HDC National Conference November 2017

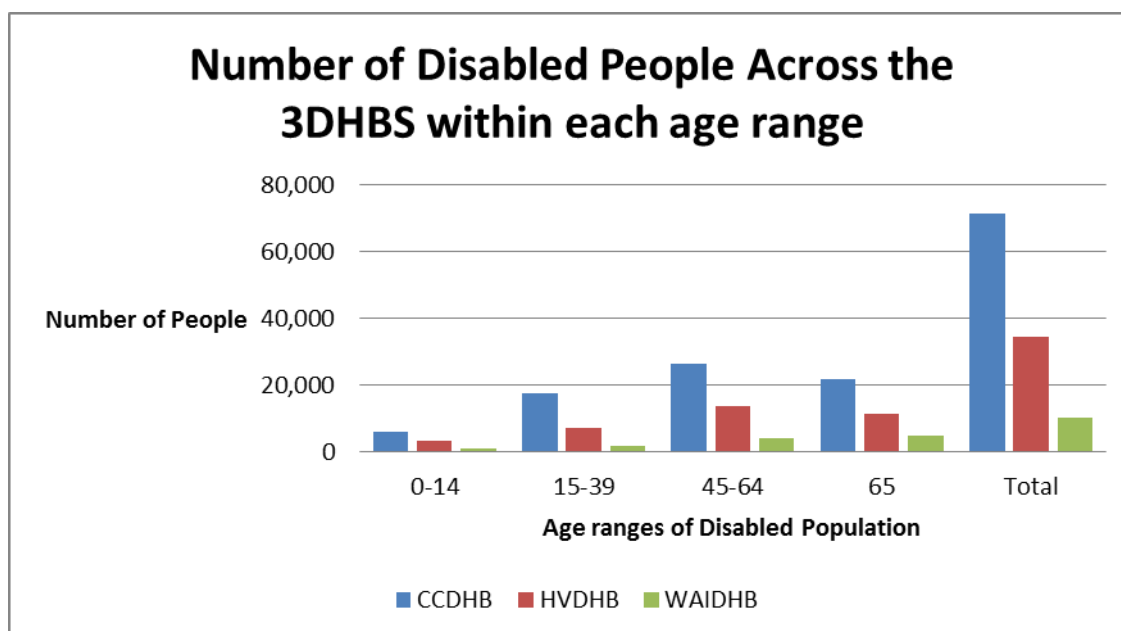
The Director of Disability Strategy and Performance has been invited to co present with the Deputy Commissioner (HDC) on tools and strategies to improve communication and access for disabled people to health and disability service providers. This will include a strengths based exploration of the feedback provided by disabled people over previous years on the health passport and general service provision.

3 EQUITY ISSUES FOR OLDER PEOPLE WITH DISABILITIES

3.1 Age demographic of disability

The Statistics NZ census data 2013 identified that 59% of people over 65 identified at least one or more impairment category. The graph below shows the sub regional breakdown of the older disability population. Consideration within health system planning for the growing older disability population in the future aims to move beyond the configuration and delivery of Aged Care services as currently defined. Strategies to improve the ability of people to become health literate and self empowered within health to plan for old age and illness and to access care close to home are central principles of a new direction, Figure one below outlines the incidence of disability within each age range within the Wellington Sub Regional DHBs

Figure One:



This graph shows the number of disabled in each DHB in the Wellington Sub Region and breaks that's down into age ranges. Looking at this graph, HVDHB has approximately 35,000 disabled people, WAIDHB, 10,000 and CCDHB 72,000. The 45-64 age brackets have the largest disabled population across all three DHBs.

3.2 Adapting health and disability funded services for an older population

The growth in the disability population between 2001 and 2013 is significant in the 45 to 64 year and over 65 age groups.⁴ People with life long disabilities are living longer while others are acquiring disability related to significant often multiple long term conditions. The latter group is particularly dependent on DHB funded health services and are among the most difficult to support and place appropriately.

⁴ Between 2001 and 2013 disability population increased from 16% to 24% NZ Stats census data

During consultation on the disability strategy between 2013 and 2016, local communities and intersectoral partners identified the following areas for priority action with regard to older people with disabilities:

- People with lifelong disabilities and the issues in transfer to aged care
- Older people with Autism Spectrum Disorder, learning disabilities, mental health and addiction issues and appropriate aged care service expertise
- The service gaps and lack of holistic needs assessment for people with chronic health issues under 65. People over 50 are often identified within older persons funding stream as "like in age and interest".
- The requirement for disability responsiveness training for home and community support services
- The negative impact of funding silos and fragmented services

The sub regional disability strategy programme of work seeks to support the planning and funding Health of Older persons' teams with initiatives that aim to address the barriers people using services experience with transition, in older age. The strategic actions below represent priority areas of action that enable services to better integrate, communicate and collaborate particularly where people are in circumstances that lead to multiple referrals across the range of funding streams available.

Strategic Action	Inclusion and support
Focus area 2	The sub-regional DHBs will improve and promote the full inclusion of disabled people and will ensure the best service for disabled people and their families is available on an equitable basis. e sub-regional DHBs will improve and promote the full inclusion of disabled basis
2.4	Ensure health professionals are flexible and responsive to person specific needs
2.4.1	Encourage co-design process to model of care and service models that takes a holistic approach to service development and delivery
2.4.2	Promote the updated guidelines/algorithm for staff to ensure the service and placement needs of people who do not meet required criteria for services or funding are addressed in a timely way
2.4.3	Initiate a clinical governance group with clinicians and NASCs to ensure people with the most diverse needs are prioritised and placed in the most appropriate setting
2.8	Promote a whole of life approach to Needs Assessment and Service Coordination (NASC)
2.8.1	Establish a whole of life approach to NASC which encompasses knowledge from across the DHB, Ministry of Health, primary care and providers towards an integrated NASC
2.8.2	Provide guidance to reduce fragmentation and streamline funding streams and services (as above 2 - 4.3)

3.3 Clinical Governance and Needs Assessment

To illustrate an example of the 2.4.3 and 2.8.1, this section addresses the issues identified in transition at different ages and/or across funding streams. Wairarapa DHB has a single point of entry for both older people and younger people eligible for Ministry of Health funding. This creates a “whole of life approach” to needs assessment in spite of separate funding streams and considerably reduced fragmentation and confusion for people using services. The easier pathway experienced in Wairarapa is evident in feedback from the population.

Such an approach is much more difficult at Capital and Coast and Hutt Valley DHBs. In February an “Interim Clinical Governance Needs Assessment and Service Coordination” (ICG NASC) was established at CCDHB followed by joint clinical governance with Hutt Valley in June 2017.

This group remains in early stages but provides an opportunity for clinicians and funders to meet together and discuss referrals from hospital and community. Such referrals are usually to address the needs of people for whom no single funding stream can respond easily. Participants include service leaders from all four NASCS involved in each area⁵ This has the immediate impact of declines between services without clear rationale for example where the physical mental health or disability support needs are the primary reason for referral. Clinical advice is critical along with the understanding clinicians gain about funder responsibilities and concerns.

The group operates within person centred principles with an explicit Triple Aim approach. The panel is chaired by one of the Chief Medical Officers with the Director of Disability Strategy and Performance to ensure appropriate clinical and professional leadership.

The group while it is challenging for participants is well attended and provides a forum for discussion on a number of subjects. This includes how to work towards a greater focus on shared responsibility for positive patient outcomes while being mindful of stewardship over vote health funding. The group in short works towards culture change and a more positive whole of life focus

CCDHB is also working on a significant programme of work on a whole of life approach to needs assessment and service coordination over the next eighteen months. Themes and data analysis from the ICG approach will be collated and inform future commissioning approaches.

3.4 Disability Literacy for health and Home and Community Support Staff

Basic disability literacy has been identified by communities across all age groups as a priority need for the health home and community support services. The gap is often relating to appropriate communication, respect for the expertise of people and their families as well as lack of consideration for the impact of a range of significant impairments.

The development of a comprehensive education framework is an active⁶ priority within the sub regional disability strategy. An e-learning tool has now been shared across the sub regional DHBs and has been mandatory within Hutt and Capital and Coast DHBs for a year. Wairarapa ELT in August agreed that the tool should become mandatory for all staff as a first step to building competence. This is a small but significant step towards a safer responsive health workforce.

Technology that allows similar access to community and NGO sectors is now being explored. This includes the e learning and other tools such as the disability alert and summary needs assessment (DSN) to the community and home care sector.

⁵ Includes Mental Health, Care coordination (predominantly but not exclusively over 65) NIDCA (Needs assessment for people under the intellectual disability care act) and two Ministry NASCS Capital Support (CCDHB internal MOH contract) and Life Unlimited (Hutt Valley private MOH NASC)

⁶ A plan to develop content at pre-registration level for clinicians and suitable for the NGO sector within their staff orientation is being designed alongside appropriate experts.

  		CPHAC/DSAC DISCUSSION PAPER
		Date: 1 September 2017
Author	Fran Wilde, Chair, CPHAC DSAC Committee	
Subject	RESOLUTION TO EXCLUDE THE PUBLIC	
RECOMMENDATION It is recommended that the Board:		
a) Agree that as provided by Clause 32(a), of Schedule 3 of the New Zealand Public Health and Disability Act 2000, the public are excluded from the meeting for the following reasons:		

SUBJECT	REASON	REFERENCE
Structure of CPHAC/DSAC Across the Sub-Region	Subject to Board consideration of the Boards of CCDHB, WrDHB and HVDHB	

* Official Information Act 1982.