HUTT VALLEY DISTRICT HEALTH BOARD

Community Public Health Advisory Committee

16 NOVEMBER 2018

Ground Floor Board Room, Pilmuir House, Lower Hutt Hospital, High Street, Lower Hutt 9.00am.

	ITEM	ACTION	PRESENTER	MIN	TIME	PG
1 PROCEDURAL BUSINESS						
1.1	Karakia			2 min	9.00am	
1.2	Apologies *(Andrew Blair)*	**Record**	P Lamason	3 min	9.02am	
1.3	Continuous Disclosure - Conflicts and Declarations of Interest Register	**Confirm** **Accept**	P Lamason P Lamason	2 min	9.05am	2
1.4	Confirmation of Draft Minutes 17 August 2018	**Approve**	P Lamason	5 min	9.07am	4
1.5	Matters Arising	**Note**	P Lamason	3 min	9.12am	7
2 PRESENTATIONS						
2.1	a) Health of Older Persons 2018 Update	**Discussion**	Kate Calvert Service Planning Integration Manager, Hutt Valley DHB	30 min	9.15am	8
2.2	b) Connecting Care in the Community	**Discussion**	Susan Bowden Manager, Care Coordination Hutt Valley DHB	30 min	9.45am	
2.3	c) Presentation from Wesley Community Action	**Discussion**	David Hanna Director, Wesley Community Action	30 min	10.15am	
3 OTHER						
3.1	General Business	**Note**	P Lamason	15 min	10.45am	
DATE OF NEXT MEETING TBC – BOARDROOM, GROUND FLOOR, PILMUIR HOUSE, HUTT HOSPITAL						

APPENDICES		
2.1	**Health of Older Persons 2018 Update**	
2.1.1	Health of Older Persons Report	8
2.1.2	Hop Dashboard 2018/07/31	16

Conflicts & Declarations of Interest Register

Hutt Valley District Health Board
Community & Public Health Advisory Committee

UPDATED AS AT 01 NOVEMBER 2018

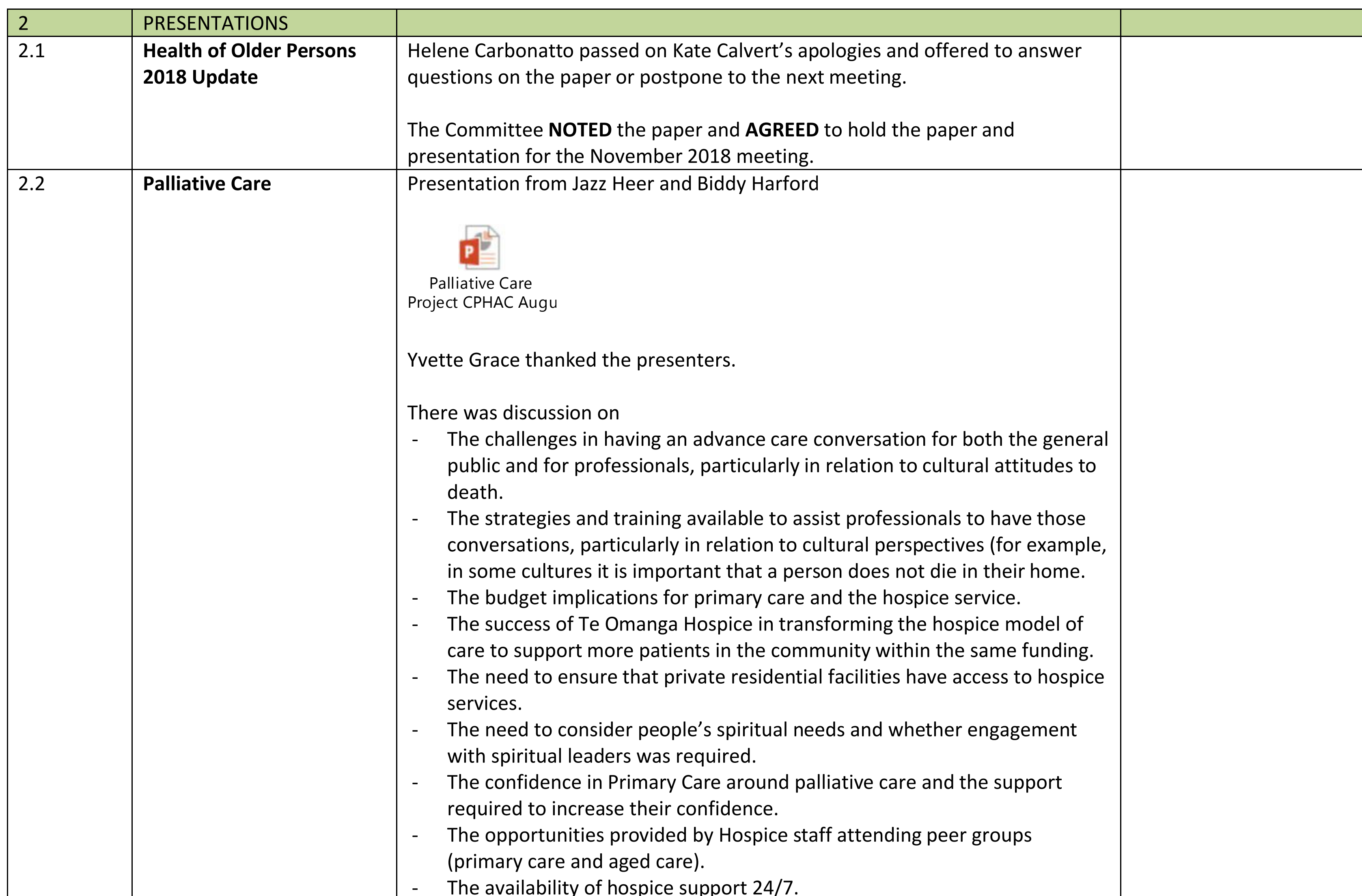
Name	Interest
Yvette Grace *Chairperson*	• Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Hospital Advisory Committee • Deputy Chair, 3DHB combined Disability Support Advisory Committee • General Manager, Rangitane Tu Mai Ra Treaty Settlement Trust • Husband, Family Violence Intervention Coordinator Wairarapa DHB • Sister in law, Nurse at Hutt Hospital • Sister in Law, Private Physiotherapist in Upper Hutt
Prue Lamason *Member*	• Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Hospital Advisory Committee • Member, 3DHB combined Disability Support Advisory Committee • Deputy Chair, Hutt Mana Charitable Trust • 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
John Terris *Member*	• Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Hospital Advisory Committee • Member, 3DHB combined Disability Support Advisory Committee • National President of Media Matters in NZ – a viewer advocacy group work in the area of TV and the internet, and incorporating Children's Media Watch • Patron – Hutt Multicultural Council Inc
Lisa Bridson *Member*	• Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Hospital Advisory Committee • Member, 3DHB combined Disability Support Advisory Committee • Member, Hutt Valley District Health Board Community and Public Health Advisory Committee • Hutt City Councillor • Chair, Kete Foodshare
Mr Andrew Blair *Member*	• Chair, Capital & Coast DHB • Chair, Hutt Valley District Health Board • Chair, Hutt Valley District Health Board Hospital Advisory Committee • Member, Hutt Valley District Health Board Finance, Risk and Audit Committee • Member, 3DHB combined Disability Support Advisory Committee • Member, Hutt Valley District Health Board Community and Public Health Advisory Committee • Owner and Director of Andrew Blair Consulting • Advisor to the Board, Forte Health Ltd Christchurch • Former member of the Hawke's Bay DHB (2013-2016) • Former Chair, Cancer Control (2014-2015)

Name	Interest
	• Former CEO, Acurity Health Group Limited • Advisor to Southern Cross Hospitals in relation to the opportunity to participate in the establishment, ownership and operation of a private surgical hospital facility in the Queenstown Lakes region • Chair, Queenstown Lakes Community Housing Trust
Tim Ngan kee *Member*	• Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Finance, Risk and Audit Committee • Member, Hutt Valley District Health Board Hospital Advisory Committee • General Practitioner, Churton Park Medical Care • Partner, Churton Park Medical Care
Ken Laban *Member*	• Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Finance, Risk and Audit Committee • Member, Hutt Valley District Health Board Hospital Advisory Committee • Trustee, Hutt Mana Charitable Trust • Member, Ulalei Wellington • Chairman, Hutt Valley Sports Awards • Member, Greater Wellington Regional Council • Commentator, Sky Television • Broadcaster, Numerous Radio Stations • Member, Christmas in the Hutt Committee • Trustee, Te Awakairangi Trust • Member, Computers in Homes

CPHAC Meeting Minutes

DATE:	17 August 2018	Time:	9.00am – 11.40am
VENUE:	Board Room, Pilmuir House, Hutt Hospital, Lower Hutt		
PRESENT:	Yvette Grace (Chair), Prue Lamason, Tim Ngan Kee, John Terris, Lisa Bridson, Taefa Heker Robertson, Teresa Olsen		
APOLOGIES:	Ken Laban, Dale Oliff		
IN ATTENDANCE	Brian Nevin (Minutes), Helene Carbonatto, Kerry Dougal (until 10.00AM)		
PUBLIC	No members of public present		
PRESENTERS	**Palliative Care** Jazz Heer, Strategy, Planning and Outcomes, HVDHB Biddy Harford, Chief Executive, Te Omanga Hospice		

	Agenda Item	Discussion	Action Required and by Whom
1	PROCEDURAL BUSINESS		
1.1	**KARAKIA**	Yvette Grace led the Karakia and welcomed attendees to the Hutt Valley DHB CPHAC Meeting. Yvette welcomed new member: Taefa Heker Robertson and Teresea Olsen	
1.2	**APOLOGIES**	**Received** from Ken Laban and Dale Oliff	
1.3	**INTEREST REGISTER**	New members will need to complete the Conflict of Interest Register. Board Members would note any further conflicts.	Heker will email through to Christine with his interest register update
1.4	**CONFIRMATION OF PREVIOUS MINUTES**	Minutes were accepted as true and correct. Moved **Prue Lamason,** seconded by **Tim Ngan Kee**	
	MATTERS ARISING	All action points completed	



2	PRESENTATIONS		
2.1	**Health of Older Persons 2018 Update**	Helene Carbonatto passed on Kate Calvert's apologies and offered to answer questions on the paper or postpone to the next meeting. The Committee **NOTED** the paper and **AGREED** to hold the paper and presentation for the November 2018 meeting.	
2.2	**Palliative Care**	Presentation from Jazz Heer and Biddy Harford Palliative Care Project CPHAC Augu Yvette Grace thanked the presenters. There was discussion on - The challenges in having an advance care conversation for both the general public and for professionals, particularly in relation to cultural attitudes to death. - The strategies and training available to assist professionals to have those conversations, particularly in relation to cultural perspectives (for example, in some cultures it is important that a person does not die in their home. - The budget implications for primary care and the hospice service. - The success of Te Omanga Hospice in transforming the hospice model of care to support more patients in the community within the same funding. - The need to ensure that private residential facilities have access to hospice services. - The need to consider people's spiritual needs and whether engagement with spiritual leaders was required. - The confidence in Primary Care around palliative care and the support required to increase their confidence. - The opportunities provided by Hospice staff attending peer groups (primary care and aged care). - The availability of hospice support 24/7.	

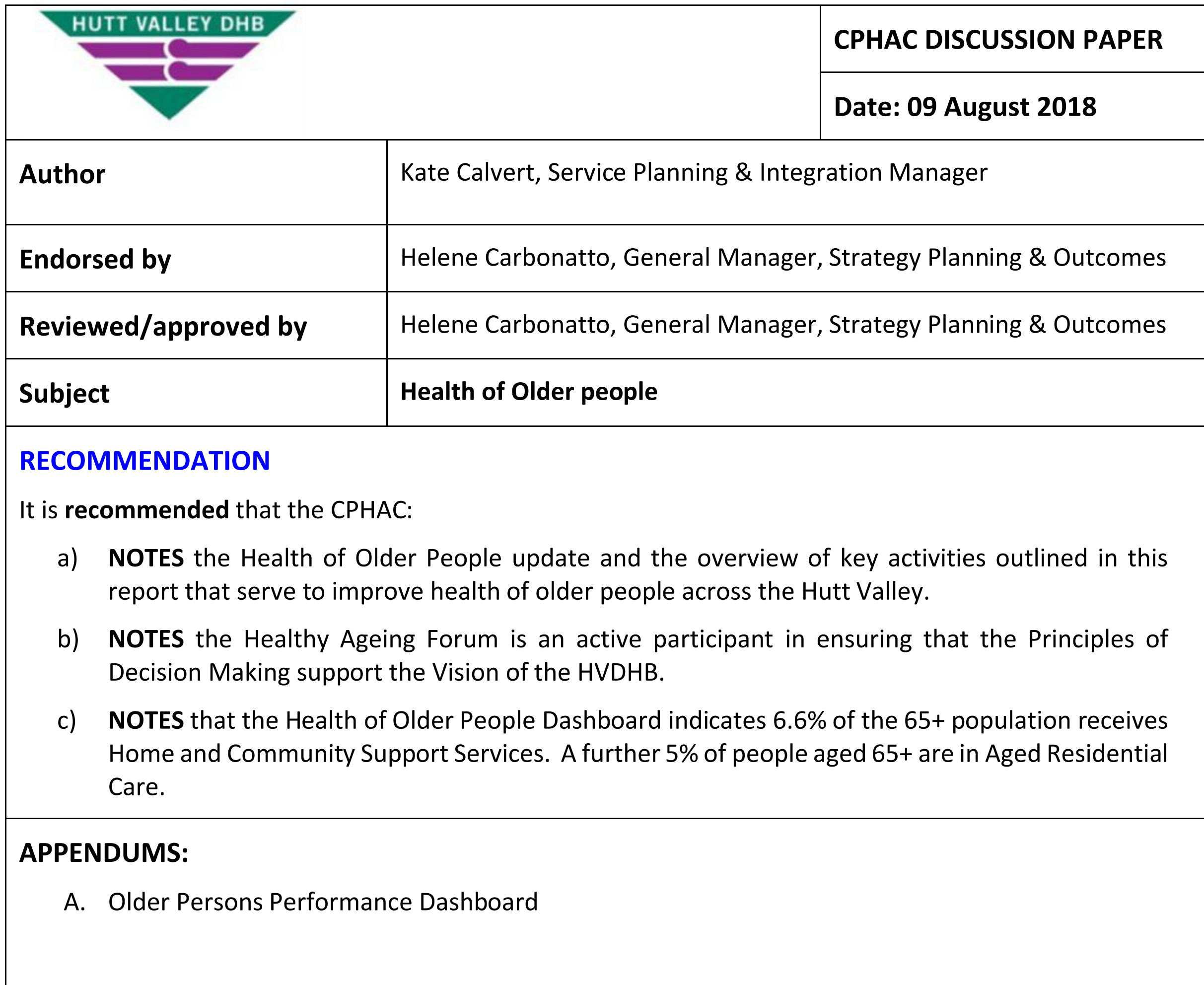
		- The need to balance the philosophy behind Advance Care Planning and the process / form filling. - That the Strategy is applicable across the 3 DHBs and that there is a nationally led piece of work to consider Māori and Pacific community perspectives. - The continued development and implementation of the model in the 7 vanguard sites. Jazz Heer offered to bring an update in 2019 The Committee **NOTED** the presentation and the Living Well, Dying Well Strategy	
3	DISCUSSION		
3.1	**CPHAC Membership (Public Health Expert)**	The Committee **AGREED** to invite a representative from Regional Public Health to the February 2019 meeting	Helene Carbonatto to invite an RPH representative.
3.2	**Work Programme**	The Committee **NOTED** the updated work programme	
4	FOR INFORMATION		
4.1	**Funding of Dental Treatments for Low Income Adults**	Helene Carbonatto introduced the paper and drew attention to the prohibitive costs of Funding of Dental Treatments for Low Income Adults and that this does not sit in the current DHB priorities. There was discussion on the broader dental issues affecting the population, especially the children's services and that this was evident in the Ambulatory Sensitive Hospitalisation (ASH) rates. There was a general discussion on the likely best way to address oral health need was by taking a broader approach to addressing the needs of whanau with complex health and social needs. Helene noted the Kohanga pilot underway with the dental service to support improved oral health in young children. The Committee **NOTED** the paper.	
5	OTHER		
5.1	**General Business**	No general business.	

CPHAC **PUBLIC**

MATTERS ARISING FROM PREVIOUS MEETINGS

Original Meeting Date	Ref	Topic	Action	Resp	How Dealt with	Delivery date	Completed Date
18 May 2018		**Interest Register**	Advise of Interest Register update	John Terris	Email Kristine McGregor so she can update the formal Interest Register	August 2018	
17 August 2018		**Interest Register**	Advise of Interest Register update	Taefa Heker Robertson	Email Christine Rabone so she can update the formal Interest Register	November 2018	
17 August 2018		**Health of Older Persons 2018 Update**	Agenda Item to be carried over for presentation and discussion at the November 2018 CPHAC Meeting	Christine Rabone	Arrange for Kate Calvert to present at next CPHAC Meeting	November 2018	
17 August 2018		**Palliative Care**	Palliative Care update to be presented in 2019	Christine Rabone	Include in 2019 Work Programme	TBC - 2019	
17 August 2018		**CPHAC Membership**	Regional Public Health Representative to attend February 2019 CPHAC Meeting	Helene Carbonatto	Identify and invite RPH representative to February 2019 CPHAC Meeting	February 2019	

PUBLIC



HUTT VALLEY DHB	CPHAC DISCUSSION PAPER Date: 09 August 2018
Author	Kate Calvert, Service Planning & Integration Manager
Endorsed by	Helene Carbonatto, General Manager, Strategy Planning & Outcomes
Reviewed/approved by	Helene Carbonatto, General Manager, Strategy Planning & Outcomes
Subject	**Health of Older people**

RECOMMENDATION

It is **recommended** that the CPHAC:

a) **NOTES** the Health of Older People update and the overview of key activities outlined in this report that serve to improve health of older people across the Hutt Valley.

b) **NOTES** the Healthy Ageing Forum is an active participant in ensuring that the Principles of Decision Making support the Vision of the HVDHB.

c) **NOTES** that the Health of Older People Dashboard indicates 6.6% of the 65+ population receives Home and Community Support Services. A further 5% of people aged 65+ are in Aged Residential Care.

APPENDUMS:

A. Older Persons Performance Dashboard

1. PURPOSE

The purpose of this paper is to provide the CPHAC with an overview of the programmes that support healthy ageing in the Hutt Valley region. The paper also includes a Health of Older Persons Performance Dashboard which provides a snap shot of performance in this area.

2. BACKGROUND

Our planning confirms a significant growth rate in our older population with at least 1 in 4 people being aged over 65 by 2040 (refer Figure 1).

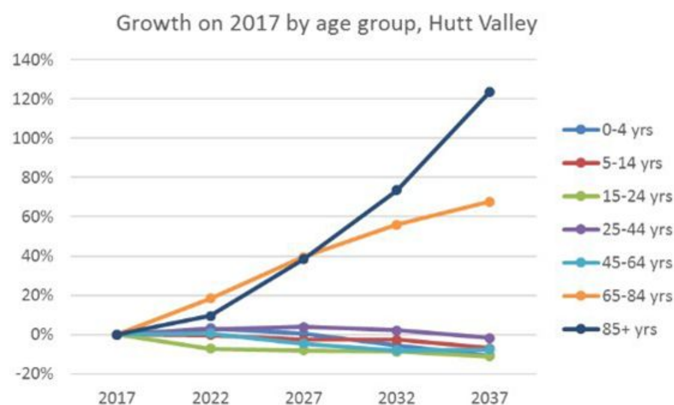


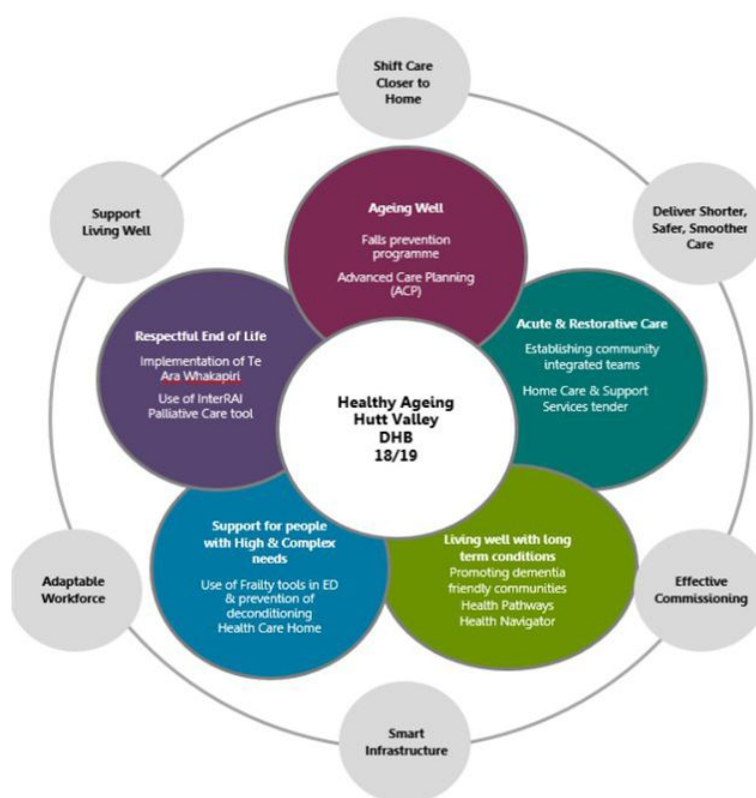
Figure 1 Growth on 2017 by age group, Hutt Valley DHB

There will be resulting demand for community, primary care, hospital, and residential care services as the clinical needs of this ageing population become more complex. It is essential for the HVDHB to focus their efforts on supporting healthy ageing to enable 'older people to live well, age well, and have a respectful end of life in age-friendly communities'[1].

3. STRATEGIC ALIGNMENT

The New Zealand Healthy Ageing Strategy was released in 2016 and provides a useful framework with five key outcome areas we can focus our actions on. Implementing the Healthy Ageing Strategy in the Hutt region is underway, with Figure 1 localizing each of the five key areas under that Strategy with alignment to *Our Vision for Change* that works to transform our health system and shift from high cost, reactive and bed-based care to a focus on wellness and healthcare that is preventative, proactive and closer to home.

Figure 1: Hutt Valley DHB Healthy Ageing Strategy – Work Programmes



Under the five elements of the Healthy Ageing Strategy, we are advancing the following:

3.1 Ageing Well

A range of services are in place to enable older people to continue to live in their own homes in their communities. These include:

- Implementation of the Pay Equity Legislation which has led to a framework for Support Workers to progress in their Support Worker carer. Level 4 trained Support Workers can provide care to complex clients in the home environment under the supervision of a Registered Nurse.
- Supporting carers through increased use of respite and day care.

[1] Healthy Ageing Strategy, 2016.

- Supporting GPs through: health pathways, healthcare communities, and the newly established healthcare home model.
- 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.
- A national Falls Prevention Programme, Living Stronger for Longer, that provides in-home (one to one) as well as community based Strength & Balance classes.
- Proactive and mature Needs Assessment and Service Coordination agencies.
- Residential village populations have grown. These living arrangements are able to support people to live 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.

Falls Prevention and Management

The Hutt Valley is part of the 3 DHB Falls Management Model. Components of the model include proactive identification of falls risk (including medication review and the home environment assessment), notification of fractures due to falls and access to Strength and Balance classes that may be community based or provided one to one. A part-time Physiotherapist and full-time Allied Health Assistant have been recruited to provide the In-Home Strength and Balance Service for Hutt Valley clients. These roles are part of the Community Allied Health Team. The community based Strength and Balance Service is provided by accredited community providers and coordinated by Sport Wellington. Ensuring the classes are reaching vulnerable population groups is the focus for 2018/19.

Dementia

A strong focus has been placed on supporting Dementia Wellington in providing timely and accessible information and support to people living with dementia in the community. A steering group, including a supporter of a person living with dementia, a community advocate, Dementia Wellington, Wesley Community Action and a DHB Pacific Health Facilitator, has looked at socialisation opportunities in the Hutt Valley. Evidence informs us that people living with dementia want to continue to do the things that they have always done. An aspect of the work plan is to inform and guide a range of organisations and business to become dementia friendly. Included in the conversation are the two Hutt City Councils. These conversations are in their early stages. A 2 DHB meeting that focuses on the needs of Māori and Pacific people living with dementia is also contributing to the conversations. Information, dementia friendly café opportunities, dementia friendly golf days, a volunteer buddy course and cognitive stimulation therapy are all outputs of the group.

Dementia Day Care Programmes Review

A review of Dementia Day Care Service is underway. The Hutt Valley has 6 Aged Residential Providers who are able to support people living with dementia in day care programmes funded by the DHB. One ARC provider is able to provide care in a secure setting. There is one non-residential provider who also provides day care. There are challenges with the current model if we align current services with the guidance outlined in the NZ Dementia Framework. Through a series of community based workshops, with People Living With Dementia (PLWD), their whanau and with service providers; we identified important advantages and key challenges with the current service model. The costs of some activities will be a barrier (e.g. transport costs) and knowing who the key person to communicate with is, regarding the PLWD is difficult. The facility worker is not available or unable to come to the phone. Care planning is minimal at day care programs so there is no sense of any changes in the illness over time. There is a need for families to be engaged. Day care does not support the needs of full-time working family members who are the informal carers of many living with dementia. There is no coordination between activities nor the value to ensure they are meaningful, physical and provide socialisation.

The current support for PLWD is uncoordinated. There are pockets of good practice that, if rolled out, can provide a sustainable model of care as the ageing population increases. Day care does not support families who are providing care for their family member living with dementia while they need to work. Supporting the carers needs strengthening with advice about using respite regularly and not saving it up for a crisis. Flexibility in allocation of funding to individuals will support carers to continue to be able to look after their family member at home for longer. Carers need to be reassured about the quality of care and impact on their family member. Home care support based costs are less than the costs of residential care. Therefore, enabling clients to remain at home for as long as it is possible is the best use of resources.

3.2 Acute and Restorative Care

Community Health Services Integration

Community health Services Integration (and in particular reconfiguring our district nursing and allied health services to better respond to the needs of patients referred from the primary care team, as well as supporting improved hospital avoidance and early supported discharge) will support the reduction in acute hospital bed days and lead to better health outcomes for older patients. The early identification of risk of falls in primary care as well as a planned common use of a frailty tool will support preventative intervention sooner and closer to home in the older person age group. A consultant liaison model supports primary care access to geriatrician advice over the phone and is available out of hours. A further program of work to include a multi-disciplinary review of clients in Aged Residential Care is under consideration.

Medicine Service Improvement Plan

The early recognition of frailty in the ageing population by primary care or ED can prevent admission to hospital. The Medicine Service Improvement Project has a number of work streams. The Red2Green work stream is looking at improving how in-patients are discharged. The key is that a discharge date is set at the time of admission. The deconditioning of the older person on admission to hospital is fast, and delays in discharge increase the risk. So through the use of electronic whiteboards, identifying what is delaying a discharge will be identified. This includes the work of the Needs Assessment and Service Coordination Team who provide assessments for entry into care or for home care support services. Frailty is also being considered at ‘the front door’ of ED to identify this group of patients sooner. Key is the role of primary care to reduce ED admission by also implementing a frailty identification plan.

Home and Community Support Services

In preparation for our Home and Community Support Services Tender, we are engaging with both community and consumer stakeholders to better understand their views of the components of good service that would allow older person to remain independent in their own homes for as long as possible.

3.3. Living Well with Long Term Conditions

Health Pathways

Clinical Pathways providing electronic best practice for primary care are continuing to be developed and localised across the sub region. Over 360 pathways[2] are now live, 12 pathway reviews have been completed, and multiple pathways are under development. Over the recent quarter, the Health Pathways Team have localised the following pathways:

[2] *Over 50 pathways have gone live throughout 2017/18 and we have met our Q4 target of 360 pathways.*

- Dyspepsia and Heartburn / GORD, Goitre in Adults, Thyroid Nodule, Ultrasound Thyroid, Thyroid Advice, Endocrinology Requests, Chronic Throat Irritation, Oral Ulceration, Oral Lesions, Dental and Oral Surgery, assessment for Adults, and Video Learning

Following a review of the Cognitive Impairment and Dementia Pathway, the most viewed pathway of HVDHB, there has been an increase in referrals to Dementia Wellington. Help and advice is being sought sooner, enabling access to a range of opportunities to supporting people living with dementia.

Health Navigator

The Health Navigator patient information website is in place across our sub region. This is a web based resource that supports the population to keep well, through providing a source of accurate health information, self-management guides and person centric support tools.

Melon Health

Following a review of self-management work, the project team investigated innovative digital self-management support options for patients with diabetes and long term conditions to address the gaps and opportunities identified (especially service gaps and equity issues for Māori and Pacific).

BetaMe was identified through this process and is an online, web based programme that includes peer support, education, health coaching as well as other medication reminders, health and symptom tracking. HVDHB has contracted with Melon Health who has developed this 16 week disease management programme for people with obesity, CVD, pre-diabetes and Type 2 diabetes.

Melon Health is working closely with TeAHN and Ropata Medial Centre to offer this digital health programme to the Hutt Valley population (with a focus on Māori and Pacific) for the next 12 months. This will be evaluated after 6 months to inform decisions about future investment in digital health programmes to support self-management.

3.4 Support for People with High and Complex Needs

Health Care Home

Part of the work underway in Health Care Home is ensuring the implementation of the 'year of care' for those identified as at risk. Using a risk stratification indicator with the populations of the Health Care Home Practices, the group with the most complex needs with be provided with proactive care planning. This work is aligning with our Palliative Care Project, which is now also linking in Older persons expertise at Inter-disciplinary meetings when reviewing dying patients who also have age related issues like frailty, dementia and loss of function.

Clinical Support for residential care staff

There is an ongoing programme of training and support delivered to residential care staff (nurses and caregivers) to strengthen knowledge and expertise to enable the management of residents with high and complex needs. This includes Nurse Practitioners from the Older Persons team with expertise in physical and mental health undertaking case reviews and education sessions monthly at residential facilities. Reviews often identify gaps in knowledge as well as quality improvement opportunities. They are now delivering this programme in 13 facilities. Nursing education and support is also available from Te Omanga Hospice to enable staff to care and support those residents at the end of life. These nurses are also available for any clinical advice and support that might be needed.

Additional support and guidance from specialist doctors is also available from the gerontology team and Te Omanga Hospice via phone for any facility doctors or nurse managers to support the clinical management of residents presenting with complex needs.

3.5 Respectful end of life

Work is well underway to implement our Palliative Care Strategy, and in particular broadening the scope of reconfiguration of how Hospice supports primary care, residential care, and the hospital; to better support those with palliative needs earlier in their journey. This is the subject of a separate paper to the CPHAC in this same agenda.

4. THE HEALTHY AGEING FORUM

The Alliance Leadership Team (ALT also known as Hutt INC) governs the integration work programme and is committed to improving the care and health for older people in the Hutt Valley. In 2017, the ALT endorsed the establishment of a forum that was primarily focused on the needs of our older population to support healthy ageing. This would complement other networks and better align projects within the integration work programme. Given the number of change programmes already underway, it is essential that we focus our efforts on enhancing and embedding the current work programme, alongside communicating, sharing learnings and strengthening input and linkages across agencies/services within our health system.

The Hutt Valley Healthy Ageing Forum aims to bring together clinicians, managers and community members from across health and social services. The purpose is to share information, collaborate and seek input to successfully implement work currently underway in the older person's health area. This Forum will be held twice annually and enables the Healthy Ageing Strategy implementation in the Hutt Valley.

The first forum was held on June 19th 2018 and was attended by approximately thirty people. The attendees included local GPs, PHOs, Home Care & Support Service providers, Aged Residential Care Managers, City Council representation, NGO's and Hutt Hospital based clinicians. The presentations include the 3 DHB Falls Prevention Model and its local implementation as well as an example of how hospital based clinicians are incorporating Advanced Care Planning as part of their regular work. The example focused on cardiac patients for whom their diagnosis can lead to a sudden deterioration in health.

The event provided stimulating questions. The awareness for a whole population approach to ensure the prevention of disease and deconditioning as the population travels through the life span is required to keep people well and in their communities. The need to understand what older people want to enable them to stay engaged was asked. A further issue was the need to continue to strengthen how hospital and community services link to support older people to stay safely in their homes. The next Forum will be held in November.

5. OLDER PERSONS SERVICES PERFORMANCE DASHBOARD

In order to better understand our investment and outcomes to support older people, a performance dashboard has been developed and is attached as appendix one.

It tells the story of the Hutt Valley older population, its current utilisation of acute services and visits to primary care. The dashboard illustrates that despite living with long term conditions, home based support services are enabling a large group to continue to live at home. Day programmes and respite care support informal carers to continue 'to care'. Five per cent of the over 65 age group are currently in Aged Residential Care, though the number of people in aged care has reduced as more people stay supported in their own homes for longer.

The first section of the chart provides further information on the rate of growth of the older age group and the ethnic breakdown.

- Health of Older People in Hutt Valley, the population aged over 65
- A breakdown of the over 55+ age group by ethnicity.
- Two charts indicating the numbers and growth in the over 65 age group between 2018 -2030

Key points to note are:

- ED utilisation by older persons remains static, with about 55% of ED visits by people aged 75 years and over.
- Acute beds days for older people has reduced over the last few years, showing the value of supports we have in the community for this group to allow them to return home faster and the concerted efforts by the system to move people through the system quicker
- At 85 years there are more people in ARC than who are receiving home care and support services. The number of new people entering ARC is slowly reducing.
- 5% of the total Hutt population of those aged over 65 years are in Aged Residential Care.
- The number of subsidised beds has decreased as there is no current high demand despite increased numbers of people over 75 entering ARC.
- In the Home and Community Support section of the Dashboard, there is an increase in the number of clients staying at home with supports – with nearly 50% of clients receiving an hour of supports a week, with a further 28% receiving between 2-4 hours per week.
- Day care, carer support and respite care is increasing to support more individuals.
- As more individuals choose to stay in their own homes for longer, it is expected that this group of carer supporting activities will increase.
- There is an increase in the number of visits to the GP and Practice Nurse in the 65+ years age group, visits still remain higher for Māori clients

6. OPERATIONAL FOCUS

6.1 Aged Residential Services

Part of our management of the older person's portfolio is the significant oversight of our aged care facilities. We currently have 15 facilities in our district, with a further two facilities looking to establish themselves in the next two years. We spend $37,297,000 per annum on aged care services, including $253,500 for respite services and $361,000 on day care services.

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.

Aged residential care services are provided at different levels of care:

- Rest Home - people can do some daily tasks themselves but cannot manage safely at home. (e.g. need help during the night)
- Continuing Care – as above and requires a higher level of resource (e.g. immobile and requires specialist equipment and registered nurse oversight, and clinical input)
- Dementia – requires a secure environment (e.g. person wanders and becomes lost)
- Specialised Hospital Services (Psychogeriatric) – requires a high level of staffing resources for people with a very high level of dementia or challenging behaviour within a secure environment.

Entry into long term residential care is based on peoples' long term support needs. For a person to receive DHB subsidised care, they must meet income and asset limits as assessed by Work and Income. People may be assessed as eligible to be admitted into aged residential care but choose to remain at home.

The average age of admission to residential care has increased from 82 to 84 years since 2011. This reflects good availability of home-based support services that allow people to remain in their own homes longer. Most of the time services work very well for the people being cared for but sometimes people don't get the care they need, in terms of both timing and intensity.

Aged care facilities are monitored in numerous ways including the following:

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 is not be able to hold a contract with the DHB.

Provisional Audits

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. Partial provisional audits are 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.

Claims Audit

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

Certification Periods

As at August 2018, HVDHB has 100% of the ARC facilities with three or more year's accreditation. The maximum 4 year certification period requires the facility to have no or very few low risk corrective actions and to have been commended for quality and care initiatives. We have 3 facilities with the highest certification period of 4 years (March 2018).

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 for their 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.

6.2 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.
NGOs are funded by the Hutt Valley DHB to support older people in the community.

- **Wesley Community Action Supported Independent Living (SIL) Contract**
  This assists those who are very vulnerable living at home due to 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 DHB.

- **Dementia Wellington (previously known as Alzheimer's Wellington)**
  Dementia Wellington has a schedule of advice sessions to raise awareness of the issues of living with dementia. For people living with dementia and their supporters they provide a two day courses aimed at newly diagnosed people living with dementia. Dementia Educators (Registered Nurses or Social Workers) visit people with dementia and their supporters at home. This ensures that they are well aware of what support is available. They also provide social interaction through community based, dementia friendly activities. Cognitive Stimulation Therapy can be provided when funding allows and includes music therapy.

  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's Health of the Older Person Portfolio Manager. The DHB contributes approximately 25% of the costs of the service with grants, private donations, and fundraising which contribute to service delivery

- **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 Kaumatua Support Services**
  The role of the Kaumatua service is to assist in improving the welling of Māori Kaumatua enhancing their health status. Information and contacts are provided to gain confidence to access health services that contribute to a healthier lifestyle. Examples of support include improving access to health services through access to transport, supporting visits to hearing services, GP and specialist appointments as well as group opportunities to support physical activities such as swimming.

- **Parkinson's, Arthritis and Stroke Support Services**
  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.

6.3 Carer Support

The role of informal carers in enabling older people to stay at home in their communities is critical. However, through InterRAI assessments the pressure on carers has been measured. Carers who are not supported or unaware of services that can be provided may choose to transfer their care to that of an aged residential care facility, earlier than was necessary. Providing respite day services or volunteer buddy services, carer support groups can support this group of informal workers. The DHB funds 3 dedicated

respite beds that can be booked in advance through the Needs Assessment and Care Coordination Service. Carers need support to use respite regularly to prevent a negative impact on their own wellbeing needs.

6.4 Home & Community Support (HCSS)

The Home and Community Support Service sector for people over 65 years of age is a bulk funded, single provider (Access) , restorative services approach that has been in place in both HVDHB and CCDHB since 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. Weekly and quarterly monitoring and Key Performance Indicator attainment have enabled reassurance to both DHBs that a satisfactory service has been provided.

In July 2018, the Boards of Hutt Valley and Capital Coast Health DHBs posted their intention to issue a tender for home and community support services for people over 65 years of age on the Government Electronic Tender Site (GETS). A Request for Tender will occur early September 2018, with services in place from 1 April 2019. This is a planned, mutual and amicable decision with Access Community Health Services to go back to the market.

The DHBs are generally pleased with the quality of service provided by Access Community Health, which has worked hard to meet the needs of our clients and grow a professional and skilled workforce and service. While circumstances such as the impact of pay equity have played a role in this mutual decision, all parties concluded that offering some choice of provider better suits the needs of clients who want to live independently in their homes for as long as possible. For the time being, nothing will change and clients will continue to receive services from Access Community Health until 1 April 2019. Stakeholder meetings are being held in August 2018.

6.5 NASC Services

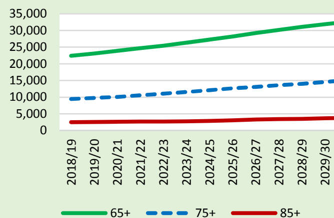
The Needs Assessment & Care Coordination Service is mandated to work with people in need of care, and their families, to identify support needs and determine eligibility for ministry funded support services. As well as supporting those with chronic health conditions and age related health issues, there are separate NASC services supporting people with disabilities and diagnosed mental health conditions who also require additional support.

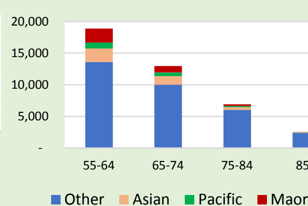
The Hutt Valley NASC (also known as Care Coordination) is provided by Nurse Maude. The service has strong relationships with primary care, the hospital teams and community organisations in the Hutt Valley.

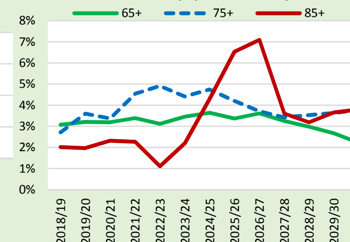
Health of Older People

15% of HVDHB are age 65+		22,420
Upper Hutt	32%	7,097
Lower Hutt	68%	15,323

Maori aged 55+	3,520	13%	of Maori people
Pacific aged 55+	1,780	15%	of Pacific people
Asian aged 55+	3,980	22%	of Asian people

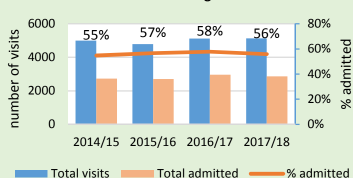


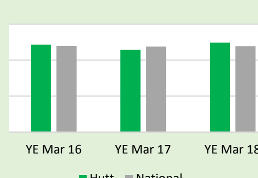


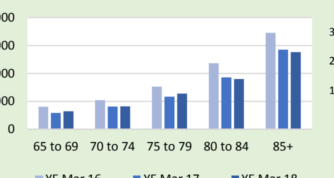


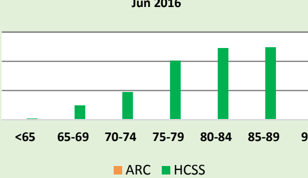
Acute Service Utilisation

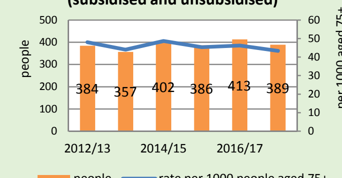
Older people living well will need less of these services









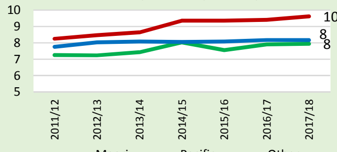


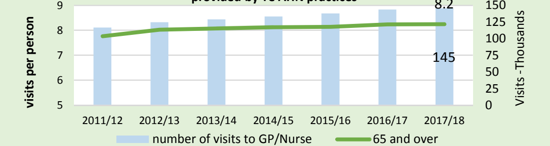
Primary Care

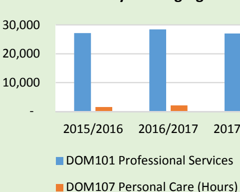
Enrolled with a Hutt GP (TeAHN & Ropata) Jul 18

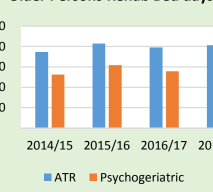
People aged 65+	21,140
Maori aged 55+	3,209
Pacific aged 55+	1,843

May include non Hutt Residents



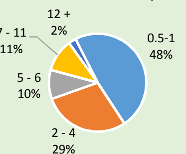


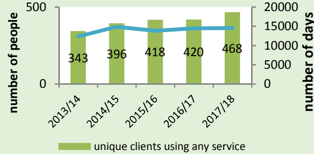


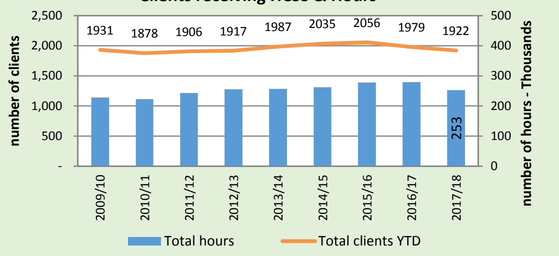


Home & Community Support

2017/18 - $000	Actual	Budget	Variance
Home Based SS (incl travel)	$ 16,005	$ 15,643	-$362
Carer Support	$ 163	$ 164	$2
Day Programmes	$ 437	$ 361	-$76
Respite Care	$ 1,072	$ 895	-$177







Age Residential Care

2017/18 - $000	Actual	Budget	Variance
Continuing Care & Psychogeri	$ 17,715	$ 19,250	$1,535
Rest Home & Dementia	$ 11,360	$ 12,310	$950
IDF Outflow	$ 4,599	$ 4,317	-$282

People aged 65+ in ARC (June 2018)	5%
Ave no. years receiving DHB ARC subsidy (Jun16)	2.2

number of ARC facilities in HVDHB	15
Rest Home beds	333
Dementia beds	153
Psychogeriatric beds	46
Continuing Care beds	95
RH/Continuing Care swing beds	532
Total beds	**1159**