

National Framework for Home and Community Support Services (HCSS)

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Section one: National Framework for Home and Community Support Services

Introduction

The New Zealand Healthy Ageing Strategy (2016)¹ (the Strategy) and the Director-General's Reference Group (DGRG) report on in-between travel² (2015) have called for new ways of working in home and community support services (HCSS) to respond to the multiple and growing demands on HCSS. The DGRG report identified the following as key issues facing HCSS in New Zealand:

- increasing demand in terms of both the number of people needing care and the complexity of that care
- inconsistent, fragmented service delivery with no national approach
- a lack of focus on the person at the centre, including funding arrangements that create inefficiencies in the system and negatively impact on the older person
- a lack of regularisation of the HCSS workforce, resulting in high turnover
- increasing skill and competency levels required for support workers, including in relation to health and safety
- inconsistent quality improvement processes
- wide variation in contract agreements and insufficient funding to increase supply to a level that will meet the growing demand.

The Strategy identifies a vision to enable older people to live well, age well and have a respectful end of life in age-friendly communities. This vision will be achieved by ensuring our policies, funding, planning and service delivery:

- prioritise healthy ageing and resilience throughout people's older years
- enable high-quality acute and restorative care, for effective rehabilitation, recovery and restoration after acute events

¹ Associate Minister of Health. 2016. *Healthy Ageing Strategy*. Wellington: Ministry of Health.

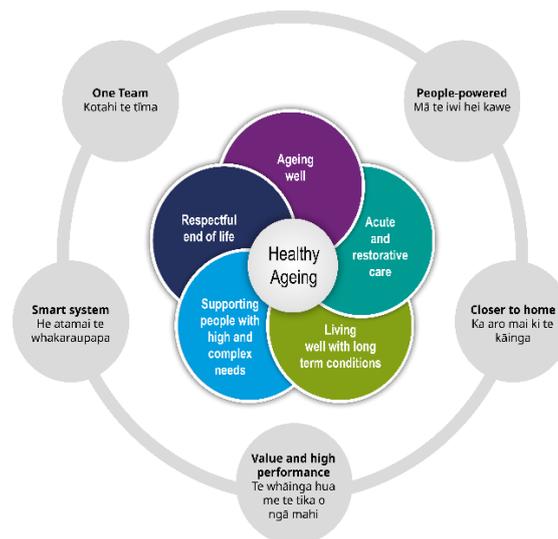
² DGRG. 2015. *Towards Better Home and Community Support Services for all New Zealanders: Advice to the Director-General of Health from the Director-General's Reference Group for In-Between Travel*. Wellington: Director-General's Reference Group for In-Between Travel.

- ensure older people can live well with long-term conditions
- better support older people with high and complex needs
- provide respectful end-of-life care that caters to personal, cultural and spiritual needs.

The Strategy provides the framework to guide development and continued improvement in services and supports for older New Zealanders (see Figure 1). It outlines actions to change the system in ways that will achieve improved and more equitable outcomes for older New Zealanders through greater integration and smarter use of the workforce and technology.

One of the Strategy’s identified priority actions is to ‘identify and implement models of care that are person-centred, needs-based and equitable, and deliver high-value, high-quality and better outcomes through HCSS across New Zealand’.

Figure 1: Strategic framework for healthy ageing



In New Zealand, over 75,000 older people receive government-funded HCSS provided in their homes. In 2017/18 district health boards (DHBs) funded HCSS at a cost of over \$478 million. Typical HCSS include help with personal care and household management as well as clinical coordination and support for older people to remain active and independent. Such services can be a critical way of supporting the continued health and wellbeing of older people, enabling them to stay in their own homes and to be more connected to their community. As the Controller and Auditor-General’s report into HCSS for older people notes, ‘Assurance about the quality and adequacy of those services is important for the older people receiving them and for those of us who care about people receiving the services’.³

Most people aged between 65 and 74 years live at home without any formal assistance. However, the proportion of people needing assistance increases with age. Older people

³ Controller and Auditor-General. 2011. Home-based Support Services for Older People: Performance audit report. Wellington: Office of the Auditor-General.

receiving HCSS are generally aged over 75 years. Around half the population aged 85 years and over live at home with HCSS, while another 28 percent live in residential care. Other older people have informal support from family, whānau and friends, or pay for support services privately.

Older people, including those with considerable disability, generally prefer to live at home rather than in residential care. By staying at home, an older person can maintain their social networks and continue to be part of their community.

As well as having these social advantages for older people, providing support to people who cannot receive the care they need from their friends, whānau and family has clear financial advantages for the health system. Providing an older person with effective HCSS can delay their admission to aged residential care or avoid it altogether.

As with all health services, HCSS need to be effective and fiscally sustainable over time.

Overview of the National Framework for Home and Community Support Services

While all DHBs commission services and supports to meet local population needs, they vary significantly in what HCSS they fund and how. DHBs and the Ministry of Health (the Ministry) have identified that introducing a National Framework is the means to guide the sector to change in the ways desired and to improve the overall quality of services experienced by older people and their families and whānau. Therefore, the scope of the work was defined as to:

Develop a national framework for sustainable future models of care for publicly funded home and community support services (HCSS) that support older people to live well, get well, and stay well closer to home.

This National Framework for Home and Community Support Services (National Framework) will guide DHBs for future commissioning, developing, delivering and evaluating home and community support services to improve national consistency. It includes:

- a vision and principles to guide service design
- core (essential) components of services that could be expected anywhere in the country
- an outcomes framework describing the outcomes sought from HCSS at individual, population and system levels.

The National Framework covers DHB-funded services for:

- people aged 65 years and over who have an assessed need in response to an interRAI assessment and meet criteria for funding

- people considered to be alike in age and interest – for example, Pacific peoples and Māori aged over 55 years, and others aged over 60 years, with age-related disabilities
- older people receiving HCSS who require increased support following an acute health episode who have required hospitalisation
- HCSS that may continue concurrently with short-term Accident Compensation Corporation (ACC) services.

Two other initiatives are linked with developing the National Framework, which will help to achieve consistent service commissioning and delivery and consistent resource allocation.

First, a National Service Specification for HCSS. This service specification will become the nationally mandated specification describing in detail the services and service approaches required of DHBs and providers. This National Service Specification will be implemented by July 2022, in line with DHB service commissioning timetables. This approach aims to achieve the best balance between national consistency and flexibility for DHBs in meeting the needs of their populations.

Second, a nationally consistent case-mix methodology will be developed for all DHBs to use as a way of improving targeting resources according to need. Some DHBs are already applying case-mix methods to resource allocation or use. However, they are using different versions of the methodology, resulting in some inconsistency in resource allocation and lack of transparency across DHBs. This indicates the need for a single, nationally consistent case-mix method that will also be implemented across all DHBs by July 2022.

Why we need a National Framework

National and international developments in HCSS models focus on:

- improving national consistency by better integrating services
- improving the capability of the workforce to support more complex needs as the population ages and becomes more ethnically diverse
- using new models of care – especially integrated and restorative approaches – to increase participation and self-determination of older people and their whānau, families and carers
- supporting older people to self-manage in their own homes
- using new and emerging technologies to improve efficiencies in coordination of care, monitoring and communications
- responding to new opportunities and new demands facing the HCSS workforce and providers
- making transformational change to ensure a robust future market for HCSS providers.

Below we look at each of these developments in more detail.

Addressing inconsistency of services across the country

Over the last 10 years, DHBs have been changing the way they provide HCSS to give a greater emphasis on flexibility and integration. Many DHBs are now using a case-mix model, with strong restorative or enabling models of care. Innovative models and frameworks such as the Calderdale Framework have also begun to influence models of HCSS in New Zealand. However, these innovations are not consistent nationally, as DHBs differ in their case-mix approaches, restorative approaches and requirements of HCSS providers. They also do not follow a nationally consistent approach in assessing the:

- quality of the services
- impact of those services on the outcomes of older people
- satisfaction of older people and their families and whānau with those services.

Responding to the more complex needs of an ageing and more diverse population

New Zealand's population is ageing: the number of older people will increase substantially over the next decade. This older population, and our communities, will also become more ethnically diverse. The Māori population aged 65 years and older is projected to increase by 79 percent from 2016 to 2026. The older Pacific population is expected to increase by 63 percent and the older Asian population by 125 percent in this same period.

As the older population grows, particularly among Māori, the need for care will increase substantially. The New Zealand cohort Life and Living in Advanced Age Study (LiLACS) estimates that the number of people needing care more than once a day may increase by more than 200 percent for Māori and by approximately 75 percent for non-Māori from 2016 to 2026.

Because people are also living longer, more people have care and support needs arising from a mix of physical and mental health conditions, including frailty and dementia in old age. Enhancing the ability of older people to age well and supporting them to live well with long-term conditions – no matter how complex those conditions are – is critical to enabling older people to continue to participate socially and feel valued.

Changing models of care

The health system has adapted over the last 10 years in significant ways. With changing models of care, services have:

- delivered more care in the community, with stronger relationships across services
- developed real or virtual interdisciplinary teams working together around the care of patients
- involved people in taking a more active role in assessment and care planning.

In recent years, the New Zealand health system has focused strongly on ensuring that people can remain independent for as long as possible, living within their own communities. Measures to achieve this outcome include increasing use of re-ablement models (supporting people to regain their independence after illness or injury), early supported discharge, hospital avoidance, integration and shifting care closer to home.

HCSS also have a key role to play in greater integration with primary and community teams to support older people, particularly people with complex health and wellbeing needs.

This new approach requires responsive, agile and collaborative services delivered by a well-trained and stable workforce to meet the changing and growing needs of older people. HCSS need to be flexible, responsive and of high quality to support these changing models of care.

Self-management

A sustainable health system needs to:

- support people to take a lead in managing their own health
- enable more integrated care for people who have complex needs
- expand the range of care provided in communities.

HCSS, alongside many other providers of health services, have an important role in supporting this move to greater self-management.

Technology

Digital technology has created the platform to support these changes. It has the capacity to place people, their families and whānau at the centre of the care by:

- supporting people to manage more of their health needs at home through self-monitoring and access to professional advice using remote diagnostics
- undertaking shared care planning that also supports the ability of older people, health care professionals, support workers and social service providers to share accurate and reliable information with each other.

Technology developments in the broader health system will influence the speed at which the HCSS sector can take up supporting technology. Where technology is available to help older people, then the sector should take advantage of these opportunities.

A changing workforce

The health system cannot implement system change, nor operate effectively, without a responsive and well-trained health workforce. The in-between travel and pay equity settlements support opportunities for new models of care. The improvements in carer conditions are expected to reduce staff turnover and increase skills in the care and support workforce.

Improving models of care will create new opportunities for, as well as new demands on, the HCSS workforce and providers. Examples are the opportunities and demands to:

- invest in and use technology to work more productively and engage more proactively with older people, so that the right thing to do is the easiest thing to do. Technology, along with good support to use it, can rapidly change workforce behaviour, including by encouraging staff to participate in interdisciplinary teams, share information and use the technological tools consistently
- create interdisciplinary team models that foster new ways of working and enable the workforce to adapt and take innovative approaches to services within communities
- support the workforce to achieve a work–life balance so that they can stay healthy, and invest in the education and training they will need to work differently
- ensure the workforce reflects the population it is serving and increasingly focus on the strategies already in place to attract more Māori and Pacific peoples to health roles
- enable health professionals and kaiāwhina to work to the full extent of their scope, including by expanding opportunities for care and support workers to contribute more to care planning and monitoring.

The HCSS market

Nationally, approximately 75 providers of HCSS are contracting to DHBs, ACC and disability support services. The variety of providers includes large, medium-sized and small private providers, iwi-based providers and charitable providers; some of these providers have contracts with several DHBs.

The provider market has consolidated in recent years and continues to do so in order to remain viable as the health and disability system has sought better-value services that are more responsive to the more complex needs of the older population. Some DHBs have also implemented re-ablement models, supporting more flexibility in how services are provided to better respond to changing needs.

Pay equity, guaranteed hours and in-between travel settlements have had impacts on providers. One result has been to further consolidate the market, as HCSS providers seek to strengthen the core business systems required to implement these requirements.

In some cases, the in-between travel and pay equity settlements have made the provision of HCSS more complex. This National Framework for future development of HCSS provides guidance on some of the changes needed to realise the benefits of the settlements, such as increased investment in the workforce.

As noted in the DGRG's report, a 'burning platform for change' supports models of care and growing demand:

there is a view that the HCSS sector is at risk of becoming unsustainable within the next decade (Deloitte 2015), and there is a lack of confidence that HCSS are effective,

efficient or capable of meeting the expected future increase in demand (Office of the Auditor-General 2014).⁴

From our engagement across the sector, we identified the following factors as central to delivering high-quality HCSS and underpinning a robust future market for HCSS:

- being financially sustainable
- being innovative and flexible
- meeting the needs of individuals and populations in the ways they want
- recognising and providing for different levels of complexity and acuity
- measuring effectiveness
- showing evidence of continuous improvement strategies
- giving providers as much funding certainty as possible
- having the mechanisms to integrate with other services
- supporting workforce stability and sustainability.

The National Framework aims to bring these areas for improvement into the national context and provide further guidance on how to undertake more transformative changes.

How we developed the National Framework

In developing this National Framework, we drew on information from the latest literature, and recent local and international experiences of changes in these services. We also engaged with key stakeholders in the HCSS sector, which included engaging with older people and their families and whānau.

In June 2017, clinicians, providers, unions, funders and other stakeholders took part in a national workshop. This workshop helped to build relationships across the sector, build a common understanding of the concerns in the sector and shape the future direction of HCSS work.

Regional workshops were held in early to mid-2018, along with two further workshops to ensure that Māori and Pacific voices were heard. Contributions to this National Framework also came from discussions with clinical and community representative bodies. We tested the vision and principles of a proposed national framework and asked for stakeholders' thoughts about core components of good HCSS. Input from the workshops was rich and varied.

Section four summarises the key themes from the consultation.

⁴ DGRG. 2015. *Towards Better Home and Community Support Services for all New Zealanders: Advice to the Director-General of Health from the Director-General's Reference Group for In-Between Travel*. Wellington: Director-General's Reference Group for In-Between Travel, p 8.

How we will implement the National Framework

Supporting the National Framework, a National Service Specification sets out the strategic direction and objectives, along with the care, quality and monitoring requirements that all DHBs are expected to meet by 2022 (see Table 1). The National Framework will be embedded into DHBs' Nationwide Service Framework, specifically the Operating Policy Framework and Service Coverage Schedule.

Table 1: Systems to implement the national framework

System	Detail
National requirements	Outlined in Service Coverage Schedule.
Contractual	Each DHB develops own contract/s.
Service specifications	National Services Framework Library holds the Tier One Community Health, Transitional and Support Services service specification and the Tier Two National Service Specification for Home and Community Support Services.
Regulatory	No legislative regulatory framework or requirements.
Standards	Home and Community Support Sector Standard NZS8158:2012. DHBs have agreed to include a requirement for audit against these in HCSS contracts. Audit reports are available to funders through HealthCERT.
Access to services	A needs assessment using an interRAI assessment.
Eligibility	<p>Must have needs for HCSS identified through an interRAI needs assessment:</p> <ul style="list-style-type: none"> • Personal care – services have no charge to the client. • Household management – services that have no charge to Community Services Card (CSC) holders. People who do not have a CSC may be required to contribute. <p>May include support, clinical and coordination services on a DHB-by-DHB basis.</p>

When we will implement the National Framework

When we introduce the National Framework will depend on when DHBs' and providers' contracts come up for renewal. Some districts will be able to begin implementing changes more quickly as contracts with their HCSS providers come up for renewal; others will have to wait longer for contracting rounds to come up.

For DHBs that are already delivering the core components, shifting to this framework will be relatively easy. For others, moving from a fee-for-service model to a case-mix model may be more costly and will require slower implementation. The National Framework sets the direction, but how it is implemented will be up to DHBs, as guided through the

National Service Specification. The pace of implementation will vary depending on what DHBs need to address locally and what needs and supports the wider system addresses. Other components of this framework rely on broader needs to be addressed across DHBs, such as the need to establish shared care platforms across the country.

Section two: Vision and key principles of the National Framework

Vision for home and community support services

High-quality services that flexibly meet the needs of individuals, are person-, family- and whānau-focused and culturally appropriate, are sustainable over time, and are delivered by a competent, skilled, well-trained workforce.

HCSS should focus on understanding the individual needs of each older person and their family and whānau, and on goals centred on the person, with the aim of maximising and maintaining the older person's independence for as long as possible. The older person must be an active participant in planning their care, setting their own goals and identifying a range of possible services that could support them. HCSS must be flexible, allowing the support worker to respond to the client's individual needs as these needs change.

The enabling approach underlying the National Framework aims to ensure that a comprehensive and flexible range of services is available for older people. Appropriately skilled organisations and support workers will support and deliver those services. The future approach to HCSS is expected to be proactive to focus on regaining or maintaining function, preventing or slowing down a decline in mental and physical function in older people and supporting their family, whānau and caregivers. If an older person enters a life stage where palliative care is necessary, the service delivery will adjust to meet palliative support needs.

Integrated HCSS are core to improving outcomes for older people. HCSS should be part of the wider primary and community care team, participating in interdisciplinary teams, particularly where older people have complex health and social needs, and involving their families and whānau. HCSS will ideally inform care plans for the older person through shared care platforms.

HCSS sit in complex environments and it is important that HCSS are well linked to the communities they work in. DHBs are increasingly arranging their services with a greater focus on integrating service with the broader community.

Key principles of the National Framework

1. Person-directed

The older person is actively involved in assessment and care planning to identify their strengths, values and life goals, and the support needed to overcome any barriers to achieving those goals. This will be achieved through consistent, comprehensive and timely assessment and individualised care planning.

2. Connected

The older person and their family and whānau have a seamless pathway through connected services, with HCSS working as part of a multidisciplinary team involving primary and community support. Care plans, where possible, are available on shared care platforms, and older people can see and engage with their own health information.

3. High quality and safe

The older person and their family and whānau have confidence in the services they receive, are guided through their care plans, and experience few cancellations and disruptions to their schedule. Services maintain continuous quality improvement and assurance. A well-trained, culturally competent workforce delivers the services, with the workforce skill mix matched to the complexity of the older person's assessed needs.

4. Flexible

HCSS respond to the changing needs of the older person and their family and whānau in a timely way. They put additional supports in place promptly to support the older person to avoid the need to go to hospital and allow for early supported discharge of people receiving HCSS.

5. Equitable

Older people and their families and whānau have equity of access to services. Services and supports are accessible, culturally appropriate, flexible, integrated and family-centred. They are responsive to diverse needs such as those of the lesbian, gay, transsexual, queer and intersex (LGBTQI) community.

6. Responsive to Māori

Māori health aspirations are understood and realised, and services explicitly act to improve Māori health outcomes and address inequities. Older Māori and their whānau, hapū and iwi are supported to improve their own health and wellbeing.

7. Cost effective and sustainable

Services are financially sustainable. Resources, including the workforce, are used in the most cost-effective way within the parameters of the other principles.

The vision and key principles outlined above are built on the foundation of He Korowai Oranga – the Māori Health Strategy.

He Korowai Oranga has an overall aim for Pae Ora to achieve wellbeing. Pae Ora includes three interconnected elements: Whānau Ora (healthy families), Mauri Ora (healthy individuals) and Wai Ora (healthy environments).

He Korowai Oranga recognises the special relationship between the Crown and Māori through the Treaty of Waitangi – te Tiriti o Waitangi. In particular, it recognises that services and supports are aligned with te Tiriti o Waitangi to enable participation at all levels; partnership in delivering support; and protection and improvement of Māori wellbeing. These outcomes can be achieved through understanding each other's aspirations and:

- recognising the health needs and aspirations of Māori, as individuals and as part of a whānau, hapū or iwi, to improve Māori health outcomes
- enabling whānau, hapū, iwi and Māori to exercise control over their own health and wellbeing (rangatiratanga and mana motuhake).

These key elements were developed following feedback and workshops with stakeholders from across the older people sector. We will seek to measure each of these elements.

Section three: Core components of national Home and Community Support Services

This section outlines the core components of what older people and their families and whānau can expect from HCSS nationally.

The core components of HCSS will incorporate an enabling model of care in which older people are supported to maintain independence, to care for themselves, to be connected with family and whānau and to participate in their communities for as long as possible. The enabling approach requires registered health professionals – including nursing, allied health and social workers – to coordinate HCSS in consultation with the older person.

HCSS focus on understanding the individual needs of older people, within the context of their family and whānau, and setting goals that are aimed at maximising and maintaining their independence for as long as possible. The older person is an active participant in planning their care, setting their own goals and identifying a range of possible services that could support them. Services are flexible, within the scope of support packages, allowing the support worker and carers to respond to the person's individual needs and to review them as needs change.

HCSS are not intended to replace natural support systems. There is an expectation that support is planned and provided within the context of natural supports, including family and whānau and other available community supports, such as volunteer services, and that these are integrated in a flexible and responsive way.

Part of ensuring that a range of responsive services is available for older people involves using an enabling HCSS model. The service approach is expected to be proactive in order to maintain function and, where possible, prevent a decline in function and coping mechanisms in both older people and their family, whānau and caregivers. If older people enter a life stage where palliative care is necessary, the service delivery will adjust to reflect the palliative support needs of the individual. The intent of this model is to ensure the service provided is delivered by appropriately skilled organisations and support workers.

HCSS may include:

- non-complex assessment and reassessment
- service (support) planning
- coordination of support workers to deliver the support plan.

The core components of how HCSS should be provided will be nationally monitored so that we can consistently measure our progress towards realising these. As discussed in Section one, a National Service Specification for HCSS will set out details of services to be commissioned from HCSS providers and will be implemented by July 2022 as DHBs enter new contracting rounds.

Nine core components

1. Nationally consistent assessments

The interRAI suite of tools provide comprehensive and consistent assessment of older people receiving support in the community. Older people are assessed by trained health professionals using the appropriate assessment tool.

Assessment involves stratification to work out a person's level of acuity and allocate appropriate resources, using tools such as case-mix methods and interRAI data. HCSS clients' acuity is matched to the ability and capability of the case worker. The health professionals use a nationally consistent case-mix method to allocate resources according to client need.

2. Support planning

Support plans are developed considering the goals and aspirations of the older person. Goals focus on achieving maximum independence and normalised socialisation. Support plans document how to reach goals and how to measure their achievement. Equipment is supplied in a timely manner.

3. Enabling focus

Support plans will focus on enabling the older person, aiming to enhance their functionality wherever possible. Older people are encouraged to participate in Functional Activities of Daily Living (ADL) and exercise through everyday activities. This outcome is achieved by giving support workers the training and supervision they need to encourage the older person to participate in household activities and exercise programmes.

4. Integrated

Care is delivered in a coordinated and connected way with a team-based approach. Teams include the person, family and whānau, informal networks, home and community support teams, primary health care, allied health, district nursing, non-governmental organisations, the wider health interdisciplinary team and the broader intersectoral team (such as Work and Income, and housing).

5. Competent and supported workforce

Support workers receive Career Force Level 2 training as a minimum. The workforce is further trained for the capability required to provide services that consistently meet the needs and mix of people receiving HCSS. This training will enable the support worker to identify an older person's functional decline if and when it happens and communicate this to relevant health professionals.

Employers support training opportunities for their workforce, to ensure the HCSS team has competent, qualified clinical staff enabled to work to the full extent of their scope. They will support robust care planning, provide clinical oversight and optimise the functional ability of the older person. The workforce is responsive to the needs of Māori, Pacific peoples and minority groups, including LGBTQI.

Employers meet all employment and training commitments to care and support workers established by the in-between travel and pay equity settlement agreements.

6. Clinical oversight

Registered health professionals are part of the team and are able to provide assessments and oversight to the HCSS team. Roles and duties may include: delegating and supervising non-regulated staff; conducting comprehensive assessments, writing and reviewing support plans, and managing care support; analysing goal activity; and helping to integrate services across primary, secondary and community care.

7. Optimum use of natural supports

HCSS provide one component of support, alongside a range of natural supports for an older person and their family and whānau. The public health system works within a capped envelope, and HCSS make one contribution to a package of care for an older person. Family, whānau, friends and communities, where possible, are a part of the care plan, alongside HCSS. Optimising the role of natural supports may also involve training and supporting family and whānau to fulfil this role.

8. Culturally competent

Staff with training in cultural competence provide support. Support is respectful and enhances dignity and mana. Programmes are targeted to particular groups, such as Māori, Pacific peoples and migrants. Family and whānau are trained to provide care where needed and appropriate. Where an older person would prefer carers from their own cultural background, this will be supported as much as possible.

9. Performance focused

HCSS collect data in a comprehensive and consistent way and use it to measure and improve services. Access to national shared data is available, where possible, to inform quality improvements and benchmarking – for example, through shared access to interRAI records. Ethnicity data is collected where possible and used to improve outcomes for Māori, Pacific and Asian populations.

Section four:

Consultation with older people and the home and community support sector

In developing this National Framework, we undertook consultation with the aim of gaining the views and input of older people, their families and whānau and the wider HCSS sector on the future provision of HCSS.

In June 2017, PricewaterhouseCoopers (PwC), on behalf of the Ministry, held a workshop for clinicians, providers, unions, funders and other stakeholders. The workshop helped to build relationships across the sector, build a common understanding of the concerns in the sector and shape the work of future HCSS.

As part of a 'ground up' approach in March and April 2018, the Ministry and DHBs held a series of workshops around the country in five different locations (Auckland, Hamilton, Wellington, Christchurch and Palmerston North).

Two further workshops were held in May 2018 to ensure that Māori and Pacific voices were adequately heard. First, a hui in Hamilton at the Rauawaawa Kaumātua Charitable Trust had more than 20 participants, including representatives of several local iwi, kaumātua, DHB representatives and providers. Second, a Pacific fono at Counties Manukau DHB drew approximately 30 representatives from local Pacific providers, older people, practice nurses and DHB representatives who work with Pacific peoples.

The development of the National Framework also drew on feedback and information gathered from extensive consultation around the country for the Healthy Ageing Strategy.

Format of the 2018 workshops

The workshops outlined the background and approach to the work on future HCSS and provided a set of draft principles for discussion. The aim was to test whether the principles were what the participants wanted future HCSS to follow, as well as to establish what they thought were core components of HCSS.

To this end, the workshop asked participants four key questions.

1. How do I get into the system? (identification and referral)
2. How do my needs get assessed and plans made? (stratification, assessment and planning)
3. What are my options for getting support? (service delivery)
4. What if my needs change? (review, exit and changing levels of need)

To answer these questions and to encourage discussion, each workshop prompted participants to identify:

- core components of future, high-quality HCSS and how these link to the principles
- the systems and processes that need to change to achieve high-quality HCSS
- their priorities for change
- what innovation is needed
- their most radical ideas for change in the sector.

Input from the workshops was rich and varied. The many ideas from these were recorded, summarised and sent back to participants.

Results of consultation

During the development of the Healthy Ageing Strategy, older people identified opportunities to improve home support. These included the opportunity to:

- increase choice and control for older people (eg, around choice of carers)
- include family and whānau in assessment, planning and delivery
- expand the range of supports offered and improve flexibility around changing needs
- improve coordination or integration of services (eg, to reduce the number of assessments needed)
- simplify the process of raising concerns or complaints about care.

Sector representatives (including providers, non-governmental organisations, and iwi and fono providers) identified the above issues in the workshops as well. They also gave feedback about the need for older people and their families and whānau to:

- have their support needs identified in a timely and flexible way
- have support within, and connect to, their communities
- access a range of appropriate resources and information so they can make informed choices
- be supported and empowered to manage their own health care (self-management)
- participate in assessment and planning processes and settings that are culturally appropriate
- have plans that are developed flexibly and that provide choice and control

- have support from integrated services that have strong alliances across different sectors
- know who to speak to if their needs change, know how to speak to them, and feel supported to give feedback about how to improve their care
- have smooth processes for temporarily or permanently leaving services.

DHBs see that future improvements to HCSS should be financially and clinically sustainable in a system that is integrated (horizontally and vertically), with the aim of improving efficiency and ultimately achieving better outcomes for older people. DHBs also gave examples of what they have already achieved through existing models, service changes and improvements in HCSS. They expect providers to embrace new ways of working and take up new technologies.

DHBs recognised that growing numbers of older people have more complex needs and higher acuity. They also asked for:

- health services accessed by older people to be more integrated, such as between hospital, pharmacy and primary care services
- updated service delivery approaches
- clear communication to older people about support available – including time limits on that support as appropriate
- consistency in the number and frequency of assessments and reassessments, along with consistency in the eligibility for, allocation of, and type of services available across DHBs
- flexibility and a restorative approach (where appropriate)
- working across funding streams within DHBs, for example, between short-term and long-term HCSS, and between funders, ACC and disability support services).

HCSS providers would like to see consistency in contracting and pricing approaches, continuity of contractual arrangements and commercial relationships to give greater business sustainability.

Providers would also like future approaches to HCSS to balance older people's desire for flexibility with providers' obligations in terms of guaranteed hours and sufficient funding to invest in staff and service development.

Care workers and unions want to be a valued part of the health care support team. They would like to have access to appropriate training and skills development, a clear career path, appropriate and supportive supervision and safe rosters.

Hearing Māori and Pacific voices through targeted workshops

Some key points Māori participants raised were the need to:

- acknowledge the unique relationship that Māori have with the Crown through the Treaty of Waitangi
- link HCSS with Whānau Ora and the wider community
- increase support for whānau to care for their own
- use navigators to support people to access available services.

Some of the key points Pacific participants raised were the need to:

- support families adequately in a family-centred way
- use a variety of communication methods to inform older Pacific peoples about what services are available
- assess the needs of older Pacific peoples in flexible ways, including through self-assessments and by training other health professionals (eg, fono nurses and practice nurses) to carry out interRAI assessments
- provide timely assessments so older Pacific peoples are not waiting weeks for an assessment
- make translators available and use them when needed.

Appendix A: Continuous improvement – outcome measures and accountability

Note: These outcome measures and indicators are operative drafts to be refined and tested through the 2019/20 financial year. We include them here to demonstrate their current status and broad direction.

At a high level, HCSS aim to improve the quality of life, for all categories of people (equity aim) using resources in a manner that is value for money – that is, to achieve the ‘triple aims’. Figure 2 sets out the way the Health Quality & Safety Commission (2011) describes the triple aims.

Figure 2: The triple aims



To improve quality of life for older people needing help at home, services:

- restore and maintain function
- support activities of daily living
- meet the needs and preferences of the older person in a timely way
- maintain independence and respect

- provide safety – that is, avoid injury to the older person, their caregiver and staff
- coordinate with other services
- continue to involve older people’s families and whānau.

Measuring how well services meet these high-level outcomes is challenging, particularly because the cost involved could otherwise go to those services. DHBs can use measures to indicate the progress of the health of their older population compared with previous periods and also to monitor the quality of services funded via HCSS.

The following are key measures that a national standards framework should include. Appendix B sets out more specific measures.

Home support

interRAI prevalence indicators

To measure specific outcomes for HCSS, interRAI assessments are an excellent source of data. At present, DHBs differ widely in their proportion of older people receiving HCSS with interRAI *home care* or *contact* assessments and the frequency of their reassessments. For this reason, these indicators are useful for measuring trends over time within a DHB, but comparisons between DHBs should only be used with considerable caution.

Timeliness

Timeliness of assessments and service is an important aspect of meeting an older person’s need and is easy to measure. Time between referral and assessment, and between assessment and a person receiving the first HCSS, is critical, as is understanding the level of missed and late carers.

Other factors

A number of measures are not indicators of outcomes but provide helpful information to interpret outcome indicators over time or between DHBs. Important measures in this area are the frequency of reassessments, percentage of contact assessments compared with home care assessments and the percentage of hospital assessments. Complaints received, number of emergency department visits, qualification levels of workers, and missed visits may also give some indication of outcomes.

Appendix B: List of outcome measures and indicators to monitor HCSS

Note: These outcome measures and indicators not confirmed are to be developed and refined throughout the 2020/21 financial year.

Indicator	Outcome indicator specification	By	Source
Aged residential care (ARC) bed days	ARC bed days per population by DHB of domicile with estimated maximum contribution of older people in rest home category added, age standardised	DHB	CCPS
Weight loss	Older people with unintended weight loss	DHB, ethnicity	interRAI
Falls	Number of older people who record a fall on follow-up assessment	DHB, ethnicity	interRAI
Social isolation with distress	Older people who are alone for long periods or always and also report feeling lonely, or older people who are distressed by declining social activity	DHB, ethnicity	interRAI
Disruptive/intense daily pain	Older people having daily pain and intense pain, or pain disrupts activities	DHB, ethnicity	interRAI
Inadequate pain control	Older people who have pain and are receiving inadequate pain control	DHB, ethnicity	interRAI
Any injuries	Older people with fractures or unexplained injuries	DHB, ethnicity	interRAI
No flu vaccination	Older people who have not received influenza vaccination within the last two years	DHB, ethnicity	interRAI
Hospitalisation	Older people who have been hospitalised, have visited a hospital emergency department, or have received emergent care since last assessment	DHB, ethnicity	interRAI
Caregiver distress	To be confirmed	DHB, ethnicity	interRAI

Indicator	Outcome indicator specification	By	Source
Timeliness	Percentage of notifications that do not have an interRAI assessment by the date indicated by its urgency	DHB	interRAI
Entry to residential care	Percentage of new entrants into ARC at each MAPLe and CHES score from last home care assessment before entering ARC		interRAI
Frequency of reassessments	Average days between assessments of all home care assessments where the older person has had a previous home care or contact assessment	DHB	interRAI
Percentage of contact assessments	The percentage of assessments for people living at home that were contact assessments	DHB	interRAI
Assessments undertaken in hospital	The percentage of home care assessments undertaken in hospital	DHB	interRAI
Complaints received	Number of complaints about home support services received by providers or DHB as a percentage of home support older people	DHB	DHB data
Emergency department visits	Emergency department visits as a percentage of the number of older people receiving home support	DHB	DHB
Qualifications of workers	To be confirmed	DHB	Provider
Missed or late visits	To be confirmed	DHB	Provider
High-cost home support	The percentage of long-term home support for older people that costs the DHB more than the average DHB cost of the relevant aged residential care category	DHB	Provider
Complaint management	Proactive management of complaints, including providing an update to those involved in making the complaint on its resolution Trends in adverse/sentinel events monitored and remedial improvement actions undertaken	DHB	Provider
Assessment	Total registered nurse contact assessments Total assessments due Percentage completed of those due Average wait time by risk level Target: Low: 5 week days Med: 2 week days High: 1 day (Monday to Friday)	DHB	Provider

Indicator	Outcome indicator specification	By	Source
Review	Total reviews complete Total reviews due Percentage completed of those due	DHB	Provider
Support service commencement, service responsiveness	Number of new supports started Date of referral Date of first contact Date of service start Average wait time from referral to start by risk level Target: Low: 10 week days Med: 7 week days High: 1 day (Monday to Friday)	DHB	Provider

Note: CCPS = Clients Claims Processing System; SLM = System Level Measures