

WISE WORKPLAN March – September 2007: PROGRESS REPORT – NOVEMBER 2007

Box = end result

Underline = meetings

Bold =documents

WISE + number = WISE plan objective referred to

Project & Tasks	Deliverables & by when	Progress
1. Set up Community Coordinating Service (see also Homecare review and InterRAI below)		
1. Ongoing project team – extend to DIS. other NASCs & PHO 2. Recruit new Project Coordinator 3. Do Implementation Plan & get EMT approval 4. Support new project coordinator	1. <u>Coordinate</u> meetings Feb – July 2. Implem Plan approved by EMT 1 June 3. Comm Coord Service starts 1 March 2008	Project coordinator appointed Draft implementation plan going to EMT on 27 Nov.
2. Develop & implement a clear model of care & plan for funding long-term support services		
1. Receive responses to the Request for Expressions of Interest (REOI), outlining direction & seeking interest 2. Discuss REOI with providers individually & jointly (including AT&R and other internal DHB), and clarify internally what we want, how it fits with other WCDHB plans eg 2020 3. Send out RFP and/or start negotiations for services in a staged process: <ul style="list-style-type: none"> • Long-term residential (alongside ARC process) with restorative focus (ie greater clinical & rehab specialist input) • Short-term non-acute/respite/rehab (see 4 below) • Homecare with restorative focus (see 5 below) 	1. <u>Meetings</u> with DHB & non-DHB providers completed (includes secondary care, ATR, residential & homecare) and a clear funding plan finalised with bed numbers & expenditure levels – by end April 2. RFP out and/or <u>negotiations</u> started by 1 June for <ul style="list-style-type: none"> • Additional longstay beds, with greater clinical & rehabilitation input • Short-stay non-acute beds for long-term rehab, carer support and respite care, and palliative care • Restorative homecare service 3. Services in place by 1 July 2008	Draft funding plan going to EMT 27 Nov. showing budgets and timeframe for the interrelated changes to older persons services from Dec 07 to Dec 08: Tender s for respite care, daycare, dementia daycare and supportive housing projects – Dec 07 Letter of advice to resid providers seeking additional longstay hospital beds – Dec 07

3. Reefton older persons services		
1. Include model of care for older persons services into overall Reefton plan	Any ongoing work as needed eg Rural Innovation Fund proposal	Consultation held & project manager being funded via MoH's Rural Innovation Fund
4. Stronger community role for specialist health of older peoples services (including non-acute rehab beds)		
<p>1. Work with AT&R to develop plan for a stronger role in advising, training and supporting primary and community services, including home-based carers, residential care facilities and primary nursing/medical services</p> <p>2. Discuss location and resourcing of short-stay non-acute beds for longer term rehab, get agreement to this from all stakeholders, organise funding and contracting arrangements and commission the beds</p> <p>3. Improved stroke service organised by AT&R</p>	<p>1. Plan developed for a stronger community role for AT&R (part of Secondary care planning) – by 1 Sept 2007</p> <p>2. Additional resources available for advising, training and supporting primary and community based services, particularly allied health</p> <p>3. Plan developed for new non-acute rehab beds by end April 2007 and agreed with stakeholders</p> <p>4. New beds established by 1 January 2008</p> <p>5. Improvements to stroke service in place by 1 January 2008</p>	<p>Working with Director of Nursing to begin a pathway of care approach for older people, to involve the whole older persons' sector in a process of discussing how to reconfigure services to get better collaboration, better use of specialist skills, and better training and support for residential care, homecare, primary and community providers.</p> <p>Recommendations for changes to AT&R service likely to fall out of this process eg staff training, additional community-based specialist staff, stroke pathway protocols and service etc.</p> <p>Likely pathways: frailty/multiple conditions, stroke, delirium/dementia</p> <p>Process to involve workers from AT&R, hospital wards, primary health, community services, residential facilities and homecare agencies etc.</p>

5. Reconfigure home-care services on restorative model

1. Discuss ways of implementing restorative model with potential providers as part of REOI discussions, including DHB & non-DHB
2. Ensure adequate community allied health resources are available – develop plan for this (alongside plan for stronger community role for AT&R)
3. Ensure adequate appropriate training initiatives are in place – meet trainers, work with HR
4. Develop a work plan for implementation of a restorative model (incl carer training, allied health & other resourcing, funding/contracting method, link to CCS etc) & get EMT approval
5. Consultation on proposed changes
6. Possibly pilot a restorative approach at Buller Health as part of a staged West Coast rollout
7. Finalise contracts & providers

1. Meetings with potential DHB and non-DHB providers during March/April, including
2. Discuss development of community allied health services with DHB provider, & do **EMT paper** to get approval for increased resources
3. **Meetings on training held mid 2007 and training initiatives in place** by 1 March 2008
4. **Homecare work plan** completed for EMT approval by 30 June (priority given to getting CCS up & running, but this can be done alongside)
5. **Consultation document** available by 1 July. Consultation period July-August
6. Start pilot restorative approach at? Buller Health by 1 March 2008
7. Rollout of restorative approach in all contracts by 1 July 2008

Ruth Kibble of Careerforce coming to West Coast to talk with DHB, other funders and homecare & residential providers about carer training and also about intersectoral initiatives to get more people into carer workforce – late Nov.

Discussion held with Auckland Uniservices about feasibility of using their SMART multi-disciplinary training programme of a restorative approach to older peoples care

6. Implement InterRAI standard assessment tool in Community Coordinating Service		
<ul style="list-style-type: none"> 1. Include InterRAI planning & costing in CCS implementation plan, following national guidelines 2. Possibly pilot InterRAI at ?Buller Health, also as an evaluation of how current assessment practice compares to InterRAI benchmark (explore such high rest home entry, gaps in current homecare etc) 3. Participate in national roll-out of InterRAI if it happens 	<ul style="list-style-type: none"> 1. InterRAI costing & planning included in CCS implementation plan by 1 June 2. <u>Possible pilot</u> started 1 Sept 2007 and completed 30 June 2008. 3. InterRAI proposal approved by EMT by 31 December 07 & <u>rolled out</u> from 1 Oct 2008 	<p>Still waiting for MoH to decide whether/how much to fund a national rollout of InterRAI.</p> <p>WCDHB will do own costing exercise and consider building into older person budget for 0809</p>
7. Encourage supportive housing developments		
<ul style="list-style-type: none"> 1. Include in REOI discussions 2. Contact councils, Abbeyfields groups, residential providers & other potential funders & providers to set up joint projects 	<ul style="list-style-type: none"> 1. Raise in REOI <u>discussions</u> in March/April 2. <u>Discuss</u> with all potential funders/providers in Grey, Buller and Westland by 30 June, and have <u>joint agreements in place</u> in all areas by March 08 	<p>No further work done on this yet, been waiting for new councils</p>
8. Implement health promotion part of WISE plan, including falls prevention & Disability Action Plan		
<ul style="list-style-type: none"> 1. Alan Lloyd (SISSAL) & new HEHA worker to get this going 2. Monitor implementation of Disability Action Plan 	<ul style="list-style-type: none"> 1. <u>New worker</u> by 1 April & <u>expanded programmes in place</u> by 1 July 2. Ongoing <u>meetings</u> with DIS 	<p>The 2 halftime HEHA workers have been actively developing plans and ideas and canvassing older people for their experience and requirements for physical activity opportunities</p> <p>Need to do more work on monitoring and progressing the Disability Action Plan</p>

9. WISE plan – make sure it is implemented & monitored

1. WISE groups supported in quarterly monitoring & advisory role 2. Keep WCDHB website updated	1. WISE groups in Greymouth & Westport meeting quarterly 2. Ongoing updating of website	Quarterly meetings held in September
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