

**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
<b>1. Set up Community Coordinating Service (see also Homecare review and InterRAI below)</b>		
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. <b>Implem Plan</b> approved by EMT 1 June 3. <b>Comm Coord Service</b> starts 1 March 2008	<b>Project coordinator appointed            Draft implementation plan going to EMT on 27 Nov.</b>
<b>2. Develop &amp; implement a clear model of care &amp; plan for funding long-term support services</b>		
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"> <li>• Long-term residential (alongside ARC process) with restorative focus (ie greater clinical &amp; rehab specialist input)</li> <li>• Short-term non-acute/respite/rehab (see 4 below)</li> <li>• Homecare with restorative focus (see 5 below)</li> </ul>	1. <u>Meetings</u> with DHB & non-DHB providers completed (includes secondary care, ATR, residential & homecare) and a <b>clear funding plan</b> finalised with bed numbers & expenditure levels – by end April 2. <b>RFP</b> out and/or <u>negotiations</u> started by 1 June for <ul style="list-style-type: none"> <li>• Additional longstay beds, with greater clinical &amp; rehabilitation input</li> <li>• Short-stay non-acute beds for long-term rehab, carer support and respite care, and palliative care</li> <li>• Restorative homecare service</li> </ul> 3. <b>Services in place by 1 July 2008</b>	<b>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:</b>  <b>Tender s for respite care, daycare, dementia daycare and supportive housing projects – Dec 07</b>  <b>Letter of advice to resid providers seeking additional longstay hospital beds – Dec 07</b>

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	<b>Consultation held &amp; project manager being funded via MoH's Rural Innovation Fund</b>
<b>4. Stronger community role for specialist health of older peoples services (including non-acute rehab beds)</b>		
<p>1. Work with AT&amp;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&amp;R</p>	<p>1. <b>Plan</b> developed for a stronger community role for AT&amp;R (part of Secondary care planning) – by 1 Sept 2007</p> <p>2. <b>Additional resources</b> available for advising, training and supporting primary and community based services, particularly allied health</p> <p>3. <b>Plan</b> developed for new non-acute rehab beds by end April 2007 and agreed with stakeholders</p> <p>4. <b>New beds</b> established by 1 January 2008</p> <p>5. <b>Improvements</b> to stroke service in place by 1 January 2008</p>	<p><b>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.</b></p> <p><b>Recommendations for changes to AT&amp;R service likely to fall out of this process eg staff training, additional community-based specialist staff, stroke pathway protocols and service etc.</b></p> <p><b>Likely pathways: frailty/multiple conditions, stroke, delirium/dementia</b></p> <p><b>Process to involve workers from AT&amp;R, hospital wards, primary health, community services, residential facilities and homecare agencies etc.</b></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**

<b>6. Implement InterRAI standard assessment tool in Community Coordinating Service</b>		
<ul style="list-style-type: none"> <li>1. Include InterRAI planning &amp; costing in CCS implementation plan, following national guidelines</li> <li>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)</li> <li>3. Participate in national roll-out of InterRAI if it happens</li> </ul>	<ul style="list-style-type: none"> <li>1. <b>InterRAI costing &amp; planning</b> included in CCS implementation plan by 1 June</li> <li>2. <u>Possible pilot</u> started 1 Sept 2007 and completed 30 June 2008.</li> <li>3. <b>InterRAI proposal</b> approved by EMT by 31 December 07 &amp; <u>rolled out</u> from 1 Oct 2008</li> </ul>	<p><b>Still waiting for MoH to decide whether/how much to fund a national rollout of InterRAI.</b></p> <p><b>WCDHB will do own costing exercise and consider building into older person budget for 0809</b></p>
<b>7. Encourage supportive housing developments</b>		
<ul style="list-style-type: none"> <li>1. Include in REOI discussions</li> <li>2. Contact councils, Abbeyfields groups, residential providers &amp; other potential funders &amp; providers to set up joint projects</li> </ul>	<ul style="list-style-type: none"> <li>1. Raise in REOI <u>discussions</u> in March/April</li> <li>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</li> </ul>	<p><b>No further work done on this yet, been waiting for new councils</b></p>
<b>8. Implement health promotion part of WISE plan, including falls prevention &amp; Disability Action Plan</b>		
<ul style="list-style-type: none"> <li>1. Alan Lloyd (SISSAL) &amp; new HEHA worker to get this going</li> <li>2. Monitor implementation of Disability Action Plan</li> </ul>	<ul style="list-style-type: none"> <li>1. <u>New worker</u> by 1 April &amp; <u>expanded programmes in place</u> by 1 July</li> <li>2. Ongoing <u>meetings</u> with DIS</li> </ul>	<p><b>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</b></p> <p><b>Need to do more work on monitoring and progressing the Disability Action Plan</b></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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