

TOWARDS BETTER HOME AND COMMUNITY SUPPORT SERVICES FOR ALL NEW ZEALANDERS

August 2015

*Advice to the Director-
General of Health from the
Director-General's Reference
Group for In-Between Travel*

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“The home and community support services sector is a crucial part of the health and disability sector, enabling people to be supported within their homes who may otherwise require residential or hospital care. While the sector has demonstrated a commitment to innovation, and the workforce places high value on providing a quality service to clients, the current environment is not enabling, there are barriers to service innovation and impediments to workforce development and support. This report provides advice and recommendations which aim to build a sustainable, comprehensive, professional future-focused sector.”

Director-General's Reference Group for In-Between Travel, July 2015

About this document

Area	Description
Summary	<p>This document was developed in response to the In-between Travel Settlement Agreement (“settlement agreement”). It aims to resolve issues facing the home and community support services (“HCSS”) sector and develop advice on transitioning to a regularised workforce.¹ The report was developed by a group appointed by the Director-General of Health; the Director-General’s Reference Group for In-Between Travel (DGRG). Two Working Groups² developed reports for the DGRG which included advice and recommendations on:</p> <ul style="list-style-type: none"> a. proposed future arrangements for the delivery and funding of HCSS b. transitioning to a regularised HCSS workforce. <p>This document begins with the DGRG’s advice and recommendations. The reports developed by the two working groups then form parts A and B of the document.</p>
Director-General’s Reference Group membership	<p>Cathy Cooney (Chair) Angela Foulkes (Deputy Chair) Jo Millar David Russell Robyn Scott</p>
Ministry of Health Representatives	<p>Ruth Anderson: Manager, Health Workforce New Zealand Kathy Brightwell: Group Manager, Populations Policy, Ministry of Health Karina Kwai: Manager, Health of Older People, National Health Board Tony O’Rourke: Employment Relations Specialist, National Health Board</p>

¹ A regularised workforce is one that provides the majority of workers with guaranteed hours and workloads, and where the workforce is paid a wage.

² Appendix 1: Acknowledgements outlines membership on the Working Groups

Director-General's Reference Group Analysis

Area	Key observations
Summary	<p>Background</p> <p>The review of home and community support services (“HCSS”) being conducted as part of the implementation of the In-between Travel Settlement Agreement (the settlement agreement) is the first comprehensive review of this type for the HCSS sector. In conducting this review, the Director-General's Reference Group (DGRG) has identified clear evidence of a burning platform for change. Service delivery is fragmented with provision via 20 district health boards (“DHBs”). The proliferation of funders, providers and approaches to care in the HCSS sector has created inefficiencies and significant variation in service provision, and is ultimately disadvantaging the person receiving HCSS. There is a lack of focus on the person, and a shift is required to emphasise the person's needs, prevention of illness, maintenance of wellbeing, reducing unnecessary hospital admissions and improving outcomes rather than the emphasis being on the funders and providers. Systems and structures are cumbersome, and duplication of effort is evident creating unnecessary stress for people receiving HCSS and inefficient use of limited funding.</p> <p>HCSS are delivered by a fragmented, semi-trained, itinerant workforce. Support workers have low wages (which are not linked to training or qualifications), poor working conditions, and high turnover. The DGRG acknowledges that people are being served by a core group of dedicated, and skilled workers. However, if the HCSS workforce issues are not addressed, the HCSS sector will be unable to retain an adequate workforce to meet the growing needs, in terms of both volume and complexity, of vulnerable consumers and the sector will become unsustainable.</p> <p>The HCSS faces a number of issues as identified by several recently released reports (Deloitte 2015; BERL 2015; Human Rights Commission 2012), which acknowledge the important future role for HCSS and outline the challenges facing the sector. One of these challenges is that the sector is struggling to develop nationally consistent service models in response to community demand. There has also been a growing number of legal challenges, mainly of an industrial workforce-related nature, which have emerged as a result of a lack of a cohesive and agreed strategy and aligned policy for the sustainable operation and development of services in the community and home environments. This means the sector is struggling to develop nationally consistent service models in response to community demand.</p> <p>Despite these issues, the HCSS workforce is becoming more qualified while still being paid at, or close to, the Minimum Wage, demonstrating a level of commitment by both the providers who are enabling access to training, and the individual support workers themselves. The DGRG has been impressed by the level of commitment by the sector to ‘do the right thing’ for people receiving services, and by the extent of good will being shown by the large and diverse support workforce. There is also considerable commitment by the sector to develop innovative models of service delivery. However, the ability to innovate has been impeded by current funding and contracting arrangements. For older people, ageing in place is the preference, but appropriate, person-centred support is needed to enable them to do so. Addressing the significant challenges in the sector will enable these vulnerable people to have the right support at the right time to live well and age well in place. This work has been completed outside of a larger economic analysis of the increasing demand for support to ‘age in place’ due to an ageing population.</p> <p>The overarching vision for government funded HCSS is for high-quality services that flexibly meet the needs of individuals, are person-focused, are sustainable over time, and are delivered by a competent, skilled, well-trained workforce. The recommendations proposed, if implemented, will achieve this vision.</p> <p>The DGRG has considered the evidence available and strongly requests that the recommendations proposed be accepted. The DGRG has identified that the HCSS are in a fragile state, which could place vulnerable people at risk of being unable to access quality services in the future. The sense of urgency is sufficient for the DGRG to consider that doing nothing is not an option. It is essential that the recommendations be considered as an integrated approach that</p>

Area	Key observations
Settlement Agreement for In-Between Travel	<p>forms a strategy for the future provision of HCSS. This means that implementing only one or some of the recommendations in isolation will not result in a sustainable sector.</p> <p>The Settlement Agreement is the impetus for developing advice and recommendations on the future provision of HCSS and the transition to a regularised HCSS workforce. The Settlement Agreement relates to Vote: Health funding.</p> <p>In September 2014 the Settlement Agreement was signed between all HCSS providers and workers, unions, all 20 DHBs and the Crown to resolve issues facing the community health sector. The Settlement Agreement has two parts.</p> <p>Part A: indicates that qualifying employees will be compensated at the Minimum Wage, at least for time spent travelling between client homes, from 1 July 2015, as well as travel mileage from 1 March 2016.</p> <p>Part B: requires that a DGRG be established to provide governance to two workstreams:</p> <p><u>workstream 1:</u> to conduct an investigation into the health funded HCSS and report back to the DGRG by 30 June 2015</p> <p><u>workstream 2:</u> to develop and oversee the transition of the workforce to a regularised workforce within 24 months of signing the Settlement Agreement to ensure the majority of workers have guaranteed hours and workloads and is paid a wage (as opposed to the current situation where workers are paid on a piecemeal basis).</p>
Process	<p>Advice about the HCSS sector and transitioning to a regularised workforce was provided to DGRG via two working groups: Working Group One (review of the HCSS sector) and Working Group Two (transitioning to a regularised workforce). Both working groups comprised representatives from settlement parties and included HCSS providers, unions and DHBs. Working Group One (review of HCSS) also included a consumer representative and a representative from an non-government organisation (NGO). The working groups' developed a comprehensive work programme which included engagement with members own networks, and reviewing best practice and evidence.</p>
Scope	<p>The DGRG's terms of reference tasked it to look into the HCSS sector and provide recommendations on how the following outcomes might be achieved and implemented (Ministry of Health 2014):</p> <ol style="list-style-type: none"> 1. There is a clear strategy for the development and delivery of services across funders on a national basis 2. The sector: is operating as efficiently and effectively as possible within a flexible framework, will provide value for money in the future where support is purchased by contract; and will be delivered within a fair and nationally consistent contracting framework that supports the principle of integrated joined up care 3. There is nationally consistent, sustainable, stable and equitable funding for HCSS with the sources of that funding aligned with the functions that service providers are required to perform 4. The transition to a sustainable regularised HCSS workforce is achieved successfully and is maintained with the majority of workers employed on guaranteed hours, receiving adequate paid training and receiving wages linked to qualifications, and with a case-mix/caseload mechanism in place to ensure the fair and safe allocation of clients at a safe staffing level.
ACC	<p>Population groups receiving HCSS include people aged 65 years and over (funded via DHBs), disabled people (funded by the Ministry of Health), and people recovering from injury (funded by the Accident Compensation Corporation - ACC).</p> <p>The Settlement Agreement relates to Vote:Health funding for HCSS which currently supports care for disabled people and for older people aged 65 years and over. ACC also funds home and support services for people recovering from injury or requiring ongoing home based care under ACC criteria; the same workforce and providers support and provide care for ACC clients.</p> <p>Although ACC is not subject to the requirements of the Settlement Agreement, ACC has been involved in both working groups to provide advice and support</p>

Area	Key observations
<div data-bbox="181 427 304 459">Summary</div> <div data-bbox="181 587 304 643">Increasing demand</div>	<p>and has indicated a commitment to an effective and sustainable HCSS sector. In principle, ACC supports the recommendations developed by the working groups. Once recommendations have been finalised by the DGRG and decisions made by the Director-General and the Minister, ACC has indicated it will consider what operational, contractual, and pricing changes may be required to support its providers to move towards a regularised workforce and to ensure consistency across the HCSS sector. This process would be subject to approval from ACC's Executive and Board as well as the Minister for ACC.</p>
	<p>Issues for the sector</p> <p>There is a range of issues and challenges that have been accumulating over time and now require urgent attention. These relate to: the increasing demand for HCSS in terms of both actual numbers and complexity of care; fragmented service provision; workforce-related issues due to high turnover of home and community support workers; the increasing skill and competency levels required of support workers, to cover areas such as quality and safety requirements; wide variation in current contract agreements; and insufficient funding to increase supply to a level that will meet the growing demand. These issues are all described in more detail below.</p>
	<p>The demand for HCSS is expected to increase significantly, particularly for the over 65 years age group, which is projected to grow from approximately 475,000 (12% of the population) to 1.2 million (25%) of the population by 2050.</p> <p>The over 80 years age group is the fastest growing of any age group, and is increasing by about 5% every year. Figure 1 shows the projected changes to the population aged 65 plus between 2011 and 2031. It shows both significant change in the age profile of the population and uneven spread of the older population around the country.</p> <p><u>Figure 1:</u> Proportion of the population aged 65 plus by territorial authority 2011 and 2031 (Source: Statistics New Zealand 2012)</p> <div data-bbox="488 826 1357 1393"> <p>2011 Proportion of Population Aged 65+ years</p> <ul style="list-style-type: none"> 9 – 14% 15 – 20% 21 – 25% 26 – 29% 30% + <p>2031 Proportion of Population Aged 65+ Years</p> <ul style="list-style-type: none"> 9 – 14% 15 – 20% 21 – 25% 26 – 29% 30% + </div>

Area	Key observations
Lack of consistency in service delivery with no national approach	<p>Data from the OECD indicates that on average per capita health expenditure for people aged 65 years and over is three to five times higher than for the 15 – 64 years age group, and that for people aged over 85 years per capita spending is almost eight times the all ages per capita average. This pattern is reflected in New Zealand with higher costs in later life from increased use of primary care services, more prescription medicines, and greater use of hospital emergency departments, inpatient and outpatient services, and HCSS.</p> <p>There is evidence of an increasing use of aged residential care facilities, with the costs to government escalating by \$46,284,078 between 2011 and 2013, as well as a growing rate of older people remaining in their own home resulting in increased costs in the HCSS sector.</p> <p>Chronic diseases are closely correlated with age, with a higher incidence of chronic diseases including heart disease, diabetes, and stroke with increased age. The rapid growth in the number of people living with one or more chronic diseases threatens the sustainability of the health system and New Zealanders' access to health services.</p>
	<p>Although there are high-level national service specifications, and some effective existing and evolving models of care, there is no nationally consistent approach for the delivery of HCSS. There is significant variation in objectives, practice and reporting standards resulting from the proliferation of contracts between the 20 DHBs, the Ministry of Health, ACC and multiple providers. National consistency would support greater equity of access for people receiving HCSS. For example, currently if a person receiving HCSS relocates to another DHB region, it is likely their access to HCSS will be different (and this is likely to be more pronounced if they move between a rural and an urban area). At the same time, DHBs and providers need flexibility to enable innovation and to address local supply and demand issues.</p> <p>In considering the available evidence and the experience across the HCSS sector, the DGRG has concluded that no one model of care for HCSS is appropriate for all population groups. Therefore, a pathway approach is recommended, based on person-centred care, with support provided in a holistic, integrated way, which will also address the current duplication and fragmentation.</p>
	<p>The DGRG has concerns about the lack of focus on the person receiving HCSS, particularly as many people receiving HCSS are vulnerable and have complex health needs. Evidence was presented on the significant degree of variation in service provision and funding in different parts of the country, which is leading to inequities for the individuals, for communities, and for the workforce.</p> <p>DHBs have successfully reduced rest-home-level bed growth through greater reliance on HCSS. The number of rest-home level beds is 22% (3000 beds) less than it would have been had per capita occupancy rates not been reduced. However, the ageing population means that, at 2012/13 occupancy rates, a further 7000 aged residential care beds will be required by 2021/22 unless the HCSS sector is supported and sufficiently resourced to expand and develop.</p> <p>Fragmented care plans and records for people receiving HCSS results in multiple assessments being completed by different workers, and duplication of processes and information sharing. The current fragmentation of the health ICT system presents an unnecessary impediment to the efficient delivery of health services to the people of New Zealand. The National Health IT Board has created a unified patient record and medical data sharing platform, but for a range of reasons, DHBs are able to 'opt out' of using this platform. Given our small population, not having the ability to share information through a national system is limiting performance and creating inefficiencies.</p>
Funding arrangements creating inefficiencies in the system	<p>In terms of funding, 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).</p> <p>DHBs have little or no additional funding to support the projected demographic changes and increases in consumer complexity that will place significantly greater demands on the HCSS sector.</p>

Area	Key observations
impacting negatively on client experience	<p>Economic forecast analysis and other recent publications by Treasury suggest that the funding expectation for Vote: Health growth will be limited to 2% per annum. Health expenditure has grown at an average rate of 5% per annum over the last 60 years and at an average of 8% per annum in the 2000s. Treasury suggests that this rate of growth is unsustainable in the context of an ageing population.</p> <p>The HCSS sector gets approximately three-quarters of its funding via Vote: Health (health and disability services) and receives about a quarter of its funding from ACC. Funding levels vary by service type, and the greatest variability lies between DHBs.</p> <p>The funding variability between DHBs for the same or similar services varies by over 25% with regard to the rate paid to providers. The total funding provided by DHBs for HCSS varies between 1.8% and 3.2% of the total budget of each DHB.</p> <p>Without urgent investment over the short-term, combined with a longer-term strategy to address the requirements of the sector, there is a significant risk that people will be unable to access high quality care. The DGRG noted that savings should occur over time as a result of implementing the proposed recommendations, although due to the significant increase in demand because of the ageing population much of the anticipated savings will be taken up by increasing volumes.</p> <p>Note that preliminary work has been completed in terms of the cost of regularisation, and this is discussed further in the workforce section of this report below. A separate initial Crown Budget bid will be necessary to ensure the sustainability of the sector, and further work is required to determine the level of funding required.</p>
Lack of regularisation of the HCSS workforce resulting in high turnover	<p>The HCSS workforce has an older age profile, is female dominated, ethnically diverse, has slightly more migrants (overseas born), and has lower qualification levels and lower incomes than the general working population. Low wages that do not recognise training or qualifications along with poor working conditions mean the workforce is prone to high turnover especially during times of low unemployment.</p> <p>Providers who have introduced some recognition of skill differentials in wage rates report that differentials are rapidly eroded by unfunded increases in statutory minima (such as the Minimum Wage, Kiwisaver contributions, and ACC rates).</p> <p>Generally the hours worked by support workers are based on the assigned client's needs and remunerated on a piecemeal basis, with no guaranteed hours of work or workloads. Rosters are developed but support workers and clients sometimes agree to vary rosters in order to accommodate unplanned events (such as client admission to hospital). Workloads are affected as the needs of clients fluctuate; for example, if they go on holiday, enter residential care or hospital, or no longer require the service.</p> <p>Turnover of the HCSS workforce is estimated to be at an average of 25-30% with 50% turnover in the first year of employment (PSA 2010). This means providers are constantly having to train new staff to a foundation induction level, thereby reducing their ability to train other staff to a higher level to manage more complex clients. At a system level, this training investment is lost to the sector.</p> <p>Despite these issues, the HCSS workforce is becoming more qualified while still being paid at, or close to, the Minimum Wage, demonstrating a level of commitment by both providers and individual support workers (Ministry of Health 2015) within a challenging environment which does not value or recognise the commitment of a workforce that is not perceived to have marketable skills.</p> <p>If regularisation of the workforce is not implemented, the evidence indicates that the HCSS sector will become unsustainable and that this will negatively affect ongoing service delivery and maintenance of service quality (Deloitte 2015). Regularisation of the HCSS workforce will enable:</p> <ul style="list-style-type: none"> increased quality and consistency of services delivered to clients increased worker capability to be responsive to client needs; greater certainty of employment and income for workers; support for worker training; recognition of training for workers; and a better articulated career pathway for support workers enhanced provider capacity to be able to recruit and retain their workforce, to be responsive to fluctuations in client needs, and to respond to

Area	Key observations
	<ul style="list-style-type: none"> changing models of care increased consistency and transparency in the basis for determining service delivery funding; increased accountability of providers for the use of allocated funding; and access to improved workforce and service delivery. <p>Preliminary work completed to inform this report suggests that an increase to baseline of between 11.54% (\$60.23 million) and 20.74% (\$108.26 million) would be required to ensure sustainable HCSS (see Figure 2). The cost modelling is workforce related in terms of appropriately positioning the workforce to meet demand. This includes the cost of regularisation, together with support for workforce training and recognition of qualifications. Note that the model in Figure 2 does not provide an indication of estimated costs in relation to HCSS provision and further work is required to assess and estimate these costs.</p>

Area

Key observations

Figure 2: Cost and price modelling scenarios in relation to workforce

Scenario	Basic Cost		Baseline with Travel funded			Add Additional SW Costs			Add Training		Add Differential- Current Mix						
		% Mix		% Mix	% Change on Base		% Mix	% Change on Base		% Mix	% Change on Base		% Mix	% Change on Base			
Entry Rate	\$ 15.00	100	\$ 15.00	100		\$ 15.00	100		\$ 15.00	100		\$ 14.75	40				
Level 2	\$ 15.00		\$ 15.00			\$ 15.00			\$ 15.00			\$ 15.50	35				
Level 3	\$ 15.00		\$ 15.00			\$ 15.00			\$ 15.00			\$ 16.25	25				
Additional SW Costs	No		No			Yes			Yes			Yes					
Travel	No		Yes			Yes			Yes			Yes					
Training	No		No	Increase		No	Increase		Yes	Increase		Yes	Increase				
Direct SW Wage	\$ 17.89		\$ 20.21	12.97	12.97	\$ 20.21	0.00	0.00	\$ 20.21	0.00	0.00	\$ 20.67	2.28	2.28			
Total Direct Costs	\$ 22.48		\$ 26.70	18.77	18.77	\$ 27.47	2.88	2.88	\$ 27.84	1.35	4.27	\$ 28.34	1.80	6.14			
Price with O/H and Margin	\$ 27.76		\$ 32.50	17.07	17.07	\$ 33.31	2.49	2.49	\$ 33.70	1.17	3.69	\$ 34.24	1.60	5.35			
Scenario Descriptions and Assumptions						Min Wage + \$1 and \$0.75 Inc			Min Wage + \$1 and \$1.20 Inc			Min Wage + \$2.50 and \$0.75 Inc			Min Wage + \$2.50 and \$1.20 Inc		
Baseline	DHBSS Pricing Model defaults or industry average used						% Mix	% Change on Base		% Mix	% Change on Base		% Mix	% Change on Base		% Mix	% Change on Base
	All SWs paid minimum wage					\$ 15.75	15		\$ 15.75	15		\$ 17.25	15		\$ 17.25	15	
	No travel included					\$ 16.50	30		\$ 16.95	30		\$ 18.00	30		\$ 18.45	30	
	No paid training time included					\$ 17.25	50		\$ 18.15	50		\$ 18.75	50		\$ 19.65	50	
	Paid Tea breaks but No additional support worker costs					\$ 18.00	5		\$ 19.35	5		\$ 19.50	5		\$ 20.85	5	
	Margin at 6%					Yes			Yes			Yes			Yes		
Add Travel	Paid travel added in addition to each client visit					Yes			Yes			Yes			Yes		
	Agreed in the IBT Settlement					Yes	Increase		Yes	Increase		Yes	Increase		Yes	Increase	
	Average Rates as per the agreement					\$ 22.40	8.37	10.84	\$ 23.18	12.14	14.70	\$ 24.19	17.03	19.69	\$ 24.97	20.80	23.55
	NB: Additional travel funding set aside for IBT					\$ 30.23	6.67	13.22	\$ 31.08	9.67	16.40	\$ 32.19	13.59	20.56	\$ 33.04	16.58	23.75
Add Additional SW Costs	Allowance for regular quality and client peer review meetings					\$ 36.25	5.87	11.54	\$ 37.16	8.53	14.34	\$ 38.34	11.97	17.97	\$ 39.24	14.60	20.74
	Allowance for downtime from guaranteed hours					Base for measuring new costs for regularising the SW workforce											
Add Training	Training costs calculated and amortised over 3.3 yrs					New costs flowing through the transition to a regularised workforce											
	Calculated using the weighted average SW hourly rate					Additional cost of moving to rates with entry level above minimum wage											
						Shows percentage increase in costs and price from Baseline with Travel funded											
Add Differential Current Mix	Qualification differential of \$0.75 per hour for Level 2 and 3 qualifications																
	Current Mix calculated from the data provided																
	Sets the entry level rate \$1 above the minimum wage and \$0.75 added for each qualification level																
Min Mage + \$1 and \$0.75 inc	Sets the entry level rate \$1 above the minimum wage and \$1.20 added for each qualification level					Purpose and Caveats: These scenarios have been built using the Costing/Pricing model jointly developed by the DHBs and providers. Industry average rates have been used in the main and actual values if applicable. The Model has been updated through discussion within Working Group 2. The updated model has not been audited, peer reviewed or otherwise validated as part of the working group process. The purpose of this work is to demonstrate the impact on costs and price through implementing the components within the settlement agreement, and using an average wage as a start point for the modelling. It is not intended to indicate a rate for funding services.											
Min Wage + \$1 and \$1.20 Inc	Sets the entry level rate \$2.50 above the minimum wage and \$0.75 added for each qualification level																
Min Wage + \$2.50 and \$0.75 inc	Sets the entry level rate \$2.50 above the minimum wage and \$1.20 added for each qualification level																
Min Wage + \$2.50 and \$1.20 Inc	Sets the entry level rate \$2.50 above the minimum wage and \$1.20 added for each qualification level																
Future framework	The scenarios modelling the future framework have 4 qualification levels and realistic distribution																

Lack of

HCSS aim to contribute to outcomes such as reducing the demand for residential care and acute care; delivering high quality home care services; and

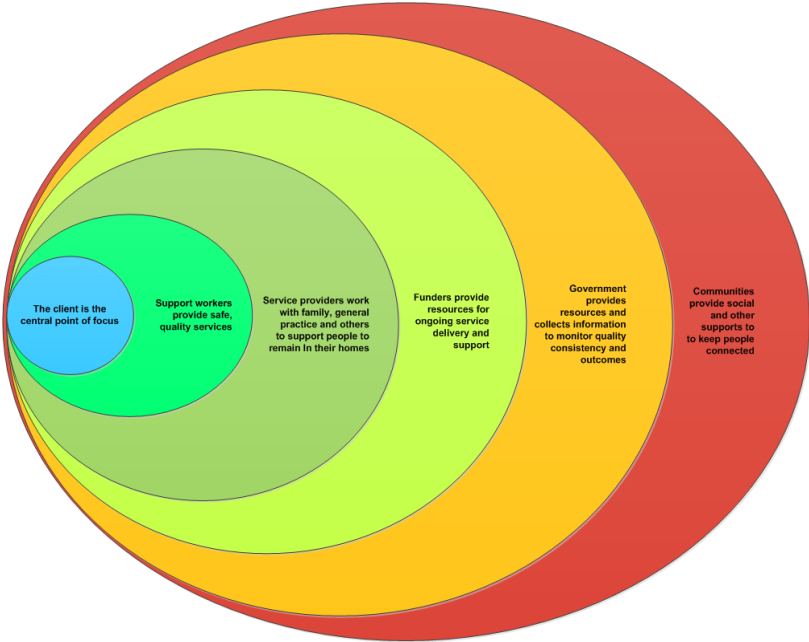
Area	Key observations
consistent continuous quality improvement processes	<p>receiving feedback that the person receiving services had a positive experience. These are all the results of having an effective, continuous quality improvement system in place.</p> <p>The Home and Community Support Sector Standards (the Standards) were developed to provide guidance and an audit review mechanism for ensuring that people who receive services in their home know what to expect and for providers to be held to account for their service provision.</p> <p>There is a concern among providers that their reducing financial margins - to what is reported by many as now being at an unsustainable level - negatively affects service coverage and service quality (Deloitte 2015). If national minimum standards were implemented, this would enable providers to identify where costs can and cannot be trimmed. As an example, the requirement that clients with a particular assessed level of complexity will require two support workers to assist with showers and/or bed transfers, would provide a guideline for the minimum staffing and funding levels required.</p> <p>A national service-level agreement is being recommended to improve consistency of access to services. Developing minimum service standards would be a useful component. Alliancing approaches also provide a forum for open discussions about the balancing that needs to occur in relation to price, service quality and risk sharing.</p> <p>There is also a need to ensure sector standards and evidence-based models are applied consistently, and information systems and indicators are developed to measure quality, effectiveness and client experience and satisfaction. Currently the national Home and Community Support Standards are not mandated, but they are included in contracts. We consider that there is a need for these Standards to be strengthened and enforced across the sector. Better information will enable funders to better understand the best balance between the price paid for services and the value of the services purchased.</p> <p>Guidance from the Health Quality and Safety Commission would be useful to guide this work as it develops.</p>

Recommendations

Area	Recommendations	Director-General's Reference Group commentary
Summary	<p>The DGRG has considered the future direction for health and disability services, strategic priorities for the Government, and relevant activities occurring within the sector in developing its recommendations. This has included consideration of the 'Ageing in place' and 'Better sooner more convenient care' strategies, with the goal of keeping people healthier in the community for longer and reducing unnecessary admissions to hospital (Ministry of Health 2011).</p> <p>Figure 3 shows the population groups that receive HCSS and that each group has its own history, expectations, philosophy and unique needs. These have been enshrined in government strategies (sometimes cross-agency), legislation and, in the case of disability, within a United Nations convention.</p> <p>As a result of these differences each population group has a different support model and direction in terms of a range of factors including: the choice and control of the support provided, the emphasis on rehabilitation and increasing functional ability, and the importance of social versus health outcomes. The service, assessment, allocation and funding models used would therefore be informed by evidence and best practice in each area and designed to ensure the outcomes listed above are achieved for each population group.</p> <p>Figure 3: Future home and community support service models</p> <p>The diagram illustrates the future home and community support service models. It is structured as follows:</p> <ul style="list-style-type: none"> Population groups / Model of support / Underpinning Legislation / Strategy: <ul style="list-style-type: none"> Health & Older Persons [including LTC and MH]: Restorative Model, Recovery Model. Strategies: Better Sooner More Convenient, Positive Ageing, Ageing in place. Disability: Client Directed Model. Legislation: UN Convention Rights of People with Disabilities, NZ Disability Strategy. Post Accident: Social Rehab Model, Maximise or Return to Independence. Legislation: ACC Legislation. Outcomes agreed across four groups: <ul style="list-style-type: none"> Clients: Person centred, Integrated approach, Sustainable contracting approach to reflect cost of service delivery and future demand. Government Funders: There is a permanent stable and valued workforce with a career pathway within the health and disability sector. Workforce [unions]: Workforce qualifications, competency and training are matched to the complexity of assessed client care needs. Providers: Ensuring continuous quality improvement. Proposed Future model: Client focus, for example CREST, START, Te Whiringa Ora; Needs assessment tool / case-mix allocation tool based on recognised methodology; Packages of care. Modelling based on requirements of Settlement outcomes: Levels of future demand, Complexity of future demand, Levels of funding, System or environmental constraints associated with ensuring a sustainable HCSS. Recommendations to Director General Reference Group: A vertical bar on the right side of the diagram. 	

Area	Recommendations	Director-General's Reference Group commentary
HCSS Service Delivery	<p>1. It is recommended that the DGRG's report and recommendations form the basis for the future strategic direction for the HCSS Sector over the next one to five years, and forms a workstream within the refresh of the Health of Older Person's Strategy, and the Disability Action Plan.</p>	<p>The fragmented approach to the delivery and funding of HCSS has failed to ensure equitable, efficient and accessible service provision. Sustainable HCSS will not be possible without a national approach, with staged implementation that is well linked to strategic direction and Government priorities. The development of a long-term HCSS strategic direction (five to ten years) should be considered within this one to five year period.</p>
	<p>2. It is recommended that the Ministry of Health work with other agencies, in existing forums, on the cross-agency integration of needs assessment functions and service coordination processes to improve effectiveness and efficiency for the client and the system.</p>	<p>People receiving HCSS complain about 'too many cars in the driveway', reflecting duplication of processes (assessment) and inefficient and unsatisfactory allocation of staff (eg, staff with only basic training may not be able to support injury care). Reducing duplication of services should increase efficiency and improve client experience. Improved consistency across DHBs (and other funders) should reduce variability of access to services.</p>
	<p>Figure 4: Proposed model of assessment, service allocation and service delivery for older people</p> <div><p>Proposed Model for Health of Older People</p><p>Individual clients' assessment, resource allocation and package of care agreement through case-mix</p><p>Client assessment and resource allocation</p><pre>graph TD Funders[Funders] -- "\$" --> ComplexClient[Complex Client CASE-MIX or FFS] HOP[Health of Older People Restorative and Maintenance Model; Supported to Recover] --> NASC[NASC: screening] NASC -- Complex --> interRAI1[interRAI assessment] NASC -- Non complex --> interRAI2[interRAI assessment] interRAI1 --> ComplexClient interRAI2 --> NonComplexClient[Non-complex Client CASE-MIX or FFS] ComplexClient --> AgreePlan[Client agrees care plan and package of care, within resource allocation, and with their preferred provider] NonComplexClient --> AgreePlan AgreePlan -- "Regularly repeat referral for re-assessment" --> interRAI1 AgreePlan -- "Regularly repeat referral for re-assessment" --> interRAI2 AgreePlan -- "Regularly repeat referral for re-assessment" --> AgreePlan</pre></div>	<p>Figure 4 provides a proposed approach to assessment, service allocation, and service delivery for the older people's population group. Note that there are other models for disabled people and for those receiving post-accident support, as outlined in Figure 3.</p>

Area	Recommendations	Director-General's Reference Group commentary
National agreement as foundation for HCSS and alliancing for local relationships	<p>3. It is recommended that a national agreement become the foundation for service provision for HCSS. The agreement will:</p> <ul style="list-style-type: none"> a. be person centred, as demonstrated and measured through client experience b. identify national service-level standards c. have a national pricing structure based on an agreed costing methodology d. have a national minimum base price that is reviewed and negotiated annually e. have an agreed national case-mix assessment methodology f. enable flexibility to reflect individual population need g. require regularisation of the HCSS workforce as per the approach proposed in recommendation 8 h. be reviewed annually. 	<p>This will support consistency and coherence in the provision of HCSS and will improve efficiency, and reduce the total cost of back office/procurement processes.</p> <p>Arrangements should be made to include training and quality recognition for workers and providers which have been undermined by irregular funding reviews and a dislocate between minimum wage movements and funding adjustments.</p> <p>Developing sequencing and structural arrangements for reviews that reflect budget and legislative timetables will require significant work, careful planning, and consideration of possible multi-year commitments.</p>
	<p>4. It is recommended that with a national agreement as the foundation, HCSS build on local alliancing arrangements as the mechanism to support responsiveness to local needs</p>	<p>Alliancing arrangements provide the mechanism by which regions can introduce innovation and flexibility in service provision, based on the foundation of a national agreement. This will balance the need for national consistency with regional/local flexibility.</p> <p>The DGRG acknowledges that alliancing relationships are evolving and recommend that the existing alliances continue to develop, rather than recommending the creation of an additional plethora of relationships which would impose additional costs and resourcing. We note that alliancing arrangements vary by region, and that some work may be needed to identify key components of an alliancing approach for the sector to build on and develop best practice elements.</p> <p>Examples of alliancing relationships already exist, which involve DHBs, HCSS providers, primary health organisations (PHOs), NGOs, and consumers. Further detailed work will be required to define what aspects can be subject to local innovation, and to what degree to safeguard the interests of the clients, the government, and other stakeholders with less power in decision-making forums.</p>

Area	Recommendations	Director-General's Reference Group commentary
	<p>5. It is recommended that HCSS have a person-centred approach that can be demonstrated and measured through client experience</p> <p><u>Figure 5:</u> Person centred service provision</p>  <p>6. It is recommended that DHBs and PHOs facilitate national implementation of the National Health Information Technology Board's patient record and medical data platform as soon as possible.</p>	<p>Working Group One articulated the need for a person-directed or client-directed approach to enable greater client involvement, choice and control over the supports they receive. The DGRG acknowledges that the direction of travel for disabled people is for client or person directed care, including the use of individualised funding. The DGRG is supportive of people being actively involved rather than passive recipients of care, but is cautious about the use of language and the implications that may arise from recommending a 'client directed' approach.</p> <p>Figure 5 shows the range of relationships within the HCSS with the person at the centre. Within this model, it is envisaged that:</p> <ul style="list-style-type: none"> • client needs, preferences and experiences are the start and end points for the delivery and funding of HCSS • the home and community support workforce is appropriately trained, fairly paid and supported to provide safe, high-quality services to meet client need, with respect and dignity • HCSS providers are resourced to meet the assessed needs of their clients in a way that recognises client choice and engagement, efficiently manages staff resources and builds a stable, confident workforce • funders will have sufficient resources to ensure a sustainable sector, using national tools and local alliancing approaches to meet the assessed needs of their client populations. <p>Technology provides significant opportunities, in terms of client outcomes as well as efficiency gains. A common health record and a coherent, coordinated technology platform would greatly improve the experience for the client by reducing the level of duplication and ultimately creating greater efficiency. The role of technology for HCSS should be further considered.</p>

Area	Recommendations	Director-General's Reference Group commentary
Funding	<p>7. It is recommended that funding for HCSS be appropriate, adequate and sustainable to deliver services to the sector based on agreed national average inputs per case-mix category. This includes:</p> <ul style="list-style-type: none"> a. funders determining their funding envelope for home and community support services based on identified packages of care and service volumes b. funders determining packages of care based on assessment outcomes c. the HCSS costing template (the 'price/cost model') developed by the DHB's through the Health of Older People Steering Group and the New Zealand Home Health Association³ being used to determine the price of delivery for aged care HCSS and forming the basis of the negotiation for the annual review of price included in the HCSS national agreement. 	<p>This approach will enable appropriately funded, safe, effective and cost-efficient HCSS via a funding model where both DHBs and providers assume risks over which they have control and can therefore influence the cost inputs.</p>
Regularisation of the Workforce	<p>8. It is recommended that HCSS providers move towards regularisation of the workforce. This is a requirement in the HCSS national agreement. This will include:</p> <ul style="list-style-type: none"> a. the provision of data to ensure funding is appropriately directed b. wage rates being consistent with those contained in an established remuneration scale that recognises qualifications and meets the needs of similar clients, and when undertaking similar tasks c. funding being included in a consistent price/cost model to enable paid training to level 3 for all support workers d. provisions covering employment status, guaranteed hours, and changes to employee hours of work being included in employment agreements e. the initial level of guaranteed hours being set at the 51% model, bearing in mind the associated caveat regarding funding availability f. the percentage of workers on guaranteed hours increasing over time to meet staged implementation milestones, in order to meet an aspirational goal of 80% of the workforce on guaranteed hours over a three-year period from the time of acceptance of the DGRG's recommendations. 	<p>A national agreement for HCSS provides the foundation for consistency, efficiency and sustainability, while regularisation and support of the HCSS workforce will be critical for enabling compliance with a national agreement.</p> <p>The aspirational goal of regularising 80% of the HCSS workforce is ground-breaking because no benchmark for other workforces has been identified. The DGRG acknowledges that for smaller providers, in particular, it may be challenging to achieve regularisation of 80% of their workforce. However, evidence has been provided to the DGRG from providers to demonstrate how they have achieved regularisation of their workforce.</p> <p>The DGRG notes that in moving to a regularised workforce, providers will incur a level of risk for non-utilisation support worker time. The level of risk has been estimated at approximately 3%.</p>
Training	<p>9. It is recommended that support workers be enabled to undertake training for a level 3 qualification within two years of commencing work, or within two years of the recommendations being implemented.</p>	<p>The DGRG has deliberated on the HCSS workforce and acknowledges that while it is expected that workers will be enabled to complete training as recommended, there will be a proportion of</p>

³ health.nz/Site/Health-of-Older-People-/HBSS-Template.aspx, accessed 12 June 2015

Area	Recommendations	Director-General's Reference Group commentary
Continuous Quality Improvement	10. It is recommended that support workers be paid for training at their usual hourly rate.	
	11. It is recommended that training (normally) takes place at work using an embedded (in-house) training model.	workers who have been employed as support workers for some time and have significant experience who may find training requirements challenging for a range of reasons. Support workers should not be disadvantaged. To this end, the DGRG supports work being done to establish mechanisms for assessing current skill and competence levels and recognition of prior learning.
	12. It is recommended that the Health Quality and Safety Commission extend its work on patient experience to HCSS.	The DGRG notes that the Health Quality and Safety Commission is developing a primary care patient experience survey to understand the patient experience in primary settings, and how their care is managed between a range of services. To support wider integration, this work needs to be extended to the HCSS.
	13. It is recommended that a code of ethics for the HCSS workforce be developed as a mechanism to incorporate standards into everyday practice	Protection of both the person receiving HCSS and the worker where the work place is a person's home and the worker is providing services largely unsupervised can be enhanced with the development of a code of ethics. The DGRG notes that good examples are available of approaches used in parts of Australia, which provide confidence for both the person receiving HCSS, and the worker, who is empowered and feels more valued.
	14. It is recommended that standards for HCSS be a requirement for HCSS providers, and should be appropriate for the consumers receiving services and to the services being provided.	The code of ethics should include a requirement for support workers to understand the basic rights of people receiving health and disability services as outlined in the Code of Health and Disability Services Consumers' Rights (1996).
		The DGRG has considered the relevance of the Health and Disability Sector Standards to the HCSS sector and acknowledges that Working Group One recommended that the HCSS sector comply with the Health and Disability Sector Standards.
		The DGRG considers that the standards have been developed for other areas of the sector (residential and hospital levels) and do not align well with the services provided in HCSS. HCSS standards have been developed and there is a need for these standards to be strengthened to ensure improved visibility and compliance with them.
		The DGRG notes that as a regularised workforce becomes implemented over time, the ability to train to, and assess against, the HCSS standards will increase.
		Guidance from the Health Quality and Safety Commission would be

Area	Recommendations	Director-General's Reference Group commentary
Transition	<p>15. It is recommended that a transition group be established with the authority to oversee the implementation of the recommendations, ensure client need is met, monitor progress and assess results to achieve regularisation and a sustainable sector that has appropriate models of care.</p>	<p>useful to guide this work as it develops.</p> <p>Working Group Two has recommended that a transition group be established to ensure a staged all-of-sector approach to transitioning to a regularised workforce. The DGRG sees value in establishing a transition group to oversee, not only the transitioning to a regularised workforce, but also the process of implementing all recommendations relating to the future provision of HCSS.</p> <p>The DGRG recommends that the transition group be small and skills based rather than representative with a mandate from, and direct access to, the Director-General of Health. It would be expected that the transition group would take into consideration the views of relevant parties consumers, Māori and Pacific peoples, the Ministry of Health, ACC, DHBs, HCSS providers, and unions.</p>

Part A: Review of Home and Community Support Services

Key Findings

Area	Background
Review of home and community services	<p>In September 2014 district health boards (DHBs), HCSS providers, unions and the Ministry of Health agreed that from 1 July 2015 home and community care and support workers would be paid for the time they spent travelling between clients. This was formally set out in the In-between Travel Settlement Agreement (the Settlement Agreement) (Ministry of Health 2014).</p> <p>The agreement also established an independent Director-General's Reference Group to oversee two work streams to conduct a review into the health-funded home and community support service, and to develop and oversee the transition to a regularised workforce.</p> <p>Two working groups were established to provide advice to the Director-General's Reference Group, covering:</p> <ul style="list-style-type: none"> • a review of home and community support services (Working Group One) • the impact and affordability of transitioning to a regularised workforce (Working Group Two). <p>This report presents the findings and recommendations of Working Group One.</p> <p>After considering both reports, the Director-General's Reference Group will make a report to the Director-General of Health advising how the Government can achieve:</p> <ul style="list-style-type: none"> • a clear strategy for the delivery of home and community services on a national basis • a flexible framework for the provision of integrated and joined-up care • a strategy for funding nationally consistent, sustainable, stable and equitable services • a plan for transition to a regularised workforce.
Key issues highlighted in the Settlement Agreement	<p>The issues to be addressed in the review of HCSS fall under three broad areas:</p> <p><i>Future demand:</i> a significant increase in the proportion of older people and disabled people is expected to put pressure on service funding and delivery. Working Group One looked at what service models and funding approaches would help meet the increasing demand and ensure sustainable, high-quality and integrated services across a variety of funders.</p> <p><i>Workforce sustainability:</i> there are significant recruitment and retention challenges due to low pay, lack of training options, lack of employment security, competitive market dynamics and an ageing workforce. High turnover of staff makes it difficult for providers to make an enduring investment in their staff and services. The group looked at funding and service models that would support workforce development and build on the initiatives of Working Group Two.</p> <p><i>Sector complexity:</i> well-intentioned programmes to meet demand can span several ministries and directorates and add to system and operational complexity, reduced transparency, client confusion, cost escalation and reduced equity of access for clients. The group looked at models to improve shared information and planning and reduce duplication.</p>
What the review found and what sits behind the recommendations	<p>Working Group One identified three main population groups using HCSS:</p> <ol style="list-style-type: none"> 1. a 'health' group, comprising mostly older people, but also including people under 65 with chronic or long-term conditions, and people needing support after being in hospital, funded by DHBs 2. disabled people funded by the Ministry of Health

Area	Background
Key themes	<p>3. people recovering from injury funded by the Accident Compensation Corporation (ACC).⁴</p> <p>A client may be in more than one group; for example, an older person may have a fall and require additional support to recover from the injury; an older disabled person may experience age-related health issues and require a different range of services.</p> <p>The support workforce delivers services to all client groups. This raises issues about workforce training to meet the different needs of clients, the different contracting approaches and outcomes sought by the different funders, and how well HCSS are integrated into wider health and disability services.</p> <p>Alongside HCSS, many populations also engage with community-based Māori and Pacific health providers, Whānau Ora providers, mental health providers, drug and alcohol services, telemedicine services, and other non-government organisations (NGOs) or non-profit agencies, in addition to their primary care provider.</p> <p>Four key 'stakeholder groups' were identified, who are participants in the sector but have differing, but inter-related, concerns and interests. The four groups and their main concerns are:</p> <ul style="list-style-type: none"> • <i>clients</i> – who want services that meet their needs (including culturally) and that are easily accessible, transparent, effective, integrated and coordinated • <i>care and support workers</i> – who want to be respected by other health care providers as part of the health team, supported to deliver services and have sustainable conditions of employment • <i>providers</i> – who want certainty in their income stream, the ability to forward plan and invest for demand and sector changes, flexibility to meet client need, and the ability to incentivise, recognise and reward staff with higher qualifications • <i>funders</i> (and government) – who want service delivery that is effective and efficient, meets client need, and contributes to wider government objectives (such as reducing avoidable hospital admissions).
	<p>We grouped our work under four broad headings, as described below.</p> <p>1. <i>Embedding a client, and a population focus</i></p> <p>There are clear trends across the health and disability sector towards greater client involvement, choice and control over the supports they receive. These considerations need to be reflected across the sector and throughout the care and support pathway, from assessment to service delivery, funding and reporting.</p> <p>No single model of care will apply to all three population groups included in this review of HCSS. Therefore, rather than endorse a single model, the group endorsed the principles of:</p> <ul style="list-style-type: none"> • client-directed care • support being provided in a holistic way • better information sharing across services to reduce multiple plans. <p>We use the term 'client-directed care' to mean an approach where the client is an active participant in planning their care, setting their own goals, determining the services they need, and owning the outcomes of their care plan. The degree of control will vary according to the client, with some wishing to take full control – including over their individual budgets. We acknowledge that, especially among older people, it is likely that agencies will manage on the client's behalf. Our key point here is that as far as possible the provider should be the</p>

⁴ Although ACC was not a party to the Settlement Agreement, the nature of the topic draws them into its scope because the support workforce works across all client groups.

Area	Background
	<p>client's agent, and the client regarded as an active participant, not a passive recipient of care.</p> <p>Our preferred approach is not a particular model but a pathway of care that begins with a standard assessment tool (appropriate to each type of need, such as aged care, disability or injury), and incorporates a client-directed approach that enables the client to identify their needs, preferences and goals or outcomes they wish to achieve. A standard service allocation tool should identify the level of resources available so that each client can develop an appropriate 'package of care' for their own circumstances.</p> <p>This thinking led to recommendations to embed a client-directed approach for HCSS, and for tools such as information technology (IT) to improve service coordination, transparency, outcome measurement and the sharing of information (including for clients). The Health Quality and Safety Commission is developing a primary care patient experience survey to find out what patients' experience in primary care is like and how their overall care is managed between their general practice, diagnostic services, specialists and/or hospital staff. Working Group One would like to see this work extended to include HCSS.</p> <p><i>2. Improving sector planning, coordination and alignment</i></p> <p>Getting the best outcomes for clients means reviewing all aspects of service delivery, including the over-arching policy settings and approach to service delivery. Our review indicates that it is necessary to improve planning, integration and coordination and reduce duplication. Client engagement and choice are meaningless concepts if there is no ability to look at the totality of an individual's needs and at how different service elements can best form an integrated package of care in the most efficient manner. 'Client directed' also means clients being part of the process that drives the formulation of the overall services.</p> <p>Furthermore, providers are faced with significant variations in objectives, practices and reporting standards from a multitude of different contracts with 20 DHBs, the Ministry of Health, primary health organisations (PHOs), ACC and other providers. Although well intentioned, these variations in processes, reports and goals can distract providers from focusing on the key issues (such as the delivery of care or workforce initiatives), and result in an unnecessarily high administrative burden or duplication of activities that ultimately increases costs to the sector.</p> <p>We believe that an integrated Community Health and Disability Strategy should be developed to take a broad view of the range of services or domains that need to play a role in supporting people to live at home, outline how to improve the alignment of these services and best facilitate the connection of clients to their community, family and whānau.⁵ The use of better joint planning tools, data, and/or technologies such as shared care plans is also relevant here, as is the need to ensure staff have appropriate training and support infrastructure.</p> <p><i>3. Contracting and funding approaches that balance a desire for consistency and flexibility</i></p> <p>Various contracting and funding approaches are currently in place, and each has strengths and weaknesses. The outcomes of all these approaches are variable for clients, workers, providers and funders, and there is no clear evidence supporting one funding model over another. We have looked at the desirable characteristics of a funding approach, including the need for the Government to prioritise funding to the care and support workforce.</p> <p>The union and provider representatives believe that to provide quality and consistency of service for clients, and enable regularisation of the workforce and certainty for providers, there need to be a national quality standard, a national agreement and a national costing methodology. The agreement requirements would need to be varied, based on population group, given the substantive differences between the population's and the funder's expectations. Standardising these aspects for DHBs would create savings in back office functions, improve efficiency and reduce the total market cost of procurement processes, remove regional differences that do not improve</p>

⁵ This is consistent with the United Nations Convention on the Rights of People with Disabilities (2006), Article 3(a): 'respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons'.

Area	Background
	<p>performance, and would mean providers would not have to maintain multiple models. Unions and providers consider that some scope for regional innovation can be maintained within a national agreement framework.</p> <p>This approach would identify consistent national service-level standards with a national pricing structure based on an agreed costing methodology, negotiated between funders and providers annually. This agreement would have local variations within an <i>alliancing</i> approach to ensure DHBs retain flexibility to meet individual population need and ensure service integration with other health and disability services across the care continuum. Alliancing has been used nationally and internationally to enable good conversations between funders and providers, and to promote better outcomes for clients.</p> <p>DHB representatives were unable to commit to a national agreement or national pricing structure without further engagement with all DHBs. Although a national structure may provide benefits, there was limited time to fully understand the implications within current frameworks. Once further engagement has occurred on these issues, a more informed position can be settled on.</p> <p>4) <i>Information on quality and service efficiency is needed to inform policy and practice</i></p> <p>As noted above, there is significant variation in the way services are delivered, and it is difficult to compare the quality and efficiency of different models or providers. Work is needed to ensure that quality can be measured and improved – for clients, funders and referrers.</p> <p>To get the best outcomes for clients, funders should look at the value of the home support services they purchase, not just the lowest possible price. The lowest-price service would miss opportunities to add worthwhile value by achieving better outcomes. Higher prices enable providers to pay higher wages and the workforce to be better trained, which, up to a point, will be worthwhile for clients and for reducing demand on other parts of the health and disability system.</p> <p>These points led to a discussion of the need to:</p> <ul style="list-style-type: none"> • streamline assessment, service coordination and case management • ensure sector standards and evidence-based models are applied consistently • develop information systems and indicators to measure quality, effectiveness and client experience and satisfaction. <p>Currently, the national Home and Community Support Standards are not mandated, but they are included in contracts. There was discussion whether the Standards should be regulated to ensure coverage where services are provided outside of contract arrangements. We did not come to a clear view on this but wish to see the use of the Standards enforced across the sector. Better information will enable funders to better understand the best balance between the price paid for services and the value of the services purchased.</p> <p>Our recommendations are given below, with indicative timelines for their implementation.</p>
Future review and next steps	<p>This initial review of HCSS has developed key recommendations drawing on a core group of stakeholders and preliminary data analysis. It is a significant event and marks the first time funders, providers, workers and client representatives have discussed these issues around the same table. Given the breadth and complexity of the sector (in addition to the difficulty of accessing the limited centralised data), it is recommended that further research, planning and engagement be conducted as part of the development of the recommended Community Health and Disability Strategy. It is essential that clients be involved in this process.</p>

Recommendations for home and community support services

Broad area of concern	Recommendations	Timeframe
Sector planning, coordination and alignment	We recommend that:	
	1. engagement on preliminary recommendations occur, including with client representatives and Māori and Pacific communities	August 2015
	2. the Ministry of Health develop an integrated Community Health and Disability Strategy, ideally across DHBs, ACC and relevant ministries, and with Māori and Pacific communities, clients, providers and unions	December 2016
	3. the Ministry of Health lead the requirement for cross-agency integration of needs assessment functions and service coordination processes to improve effectiveness and efficiency for the client and the system	December 2018
Client and population focus	4. population information be captured and shared for the purposes of measuring outcomes to inform future planning	December 2016
	5. all home and community support services support a client-directed approach that can be demonstrated and measured	December 2016
	6. the National Health Information Technology Board prioritise the development of a shared care record to be owned by individuals	December 2017
Contracting and funding	7. the Health Quality and Safety Commission extend its work on client experience to include home and community support services	December 2016 for agreement of the tool December 2017 for implementation
	8. the Government prioritise funding to invest in the further development of the workforce to ensure the support workforce is recognised and valued to reflect the skill, responsibility, and complexity of care and support work	December 2016
	9. all procurement of home and community support services use alliancing arrangements	2015/16 for new arrangements 2017 for existing arrangements
	10. DHBs and providers move to a national agreement that reflects individual population needs, and that: <ul style="list-style-type: none"> a. identifies national service-level standards b. has a national pricing structure based on an agreed costing methodology c. has a national minimum base price that is reviewed and negotiated annually d. enables flexibility to reflect individual population need. 	2017
Quality and service excellence	11. the home and community support sector meet the requirements of the Health and Disability Sector Standards.	2018/19

1. Background

Area	Description
Purpose	<p>The purpose of this document is to provide advice to the Director-General's Reference Group on the future provision of Vote: Health-funded home and community support services (HCSS) in New Zealand. The In-between Travel Settlement Agreement (the Settlement Agreement) required a review of HCSS, including a</p> <p><i>comprehensive analysis and response to the wider issues, including but not limited to levels of future demand, complexity of future demand, service changes and levels of funding required within sustainable Government funding and any other system or environmental constraints associated with ensuring a sustainable home and community based support sector.</i> (Ministry of Health 2014)</p> <p>The overarching purpose is to provide recommendations to ensure high-quality services for all people receiving Vote: Health-funded HCSS that meet the needs of the consumers in a cost-effective way and are based on best practice and evidence, and enable flexibility in service provision.</p>
Background to and nature of this report	<p>In 2014 the providers, employees and funders of HCSS agreed that from 1 July 2015 support workers would be paid for the time they spent travelling between clients, at a rate based on the Minimum Wage. The Settlement Agreement between the parties also provides for a minimum travel allowance.</p> <p>Settlement Agreement negotiations led to discussions about the sustainability of HCSS under the current employment model. As a result, the parties agreed to investigate the impact and affordability of a sustainable regularised workforce. A Director-General's Reference Group was established to conduct a review of Vote: Health-funded HCSS in one work stream, and to report on the impact and affordability of transitioning to a regularised workforce within two years of ratification of the Settlement Agreement in a second work stream.</p> <p>Both working groups included representatives of the Settlement Agreement parties. In addition, representatives from ACC joined the discussions and took an active part in the deliberations of both groups. Both working groups were required to report to the Director-General's Reference Group, which will in turn make combined recommendations to the Director-General of Health.</p> <p>This report presents the summarised findings of Working Group One. Each member of Working Group One brought views and perspectives based on their experiences in their respective roles in the sector. Members have sought some informal feedback from their communities on the issues under discussion by Working Group One, but there has not been sufficient time for formal consultation on the content and recommendations.</p> <p>In most areas we agreed on the general directions but sometimes disagreed over details. In some cases the ideal scenario for one settlement party could not be supported by other settlement party representatives. It was generally felt that most differences were not insurmountable, but instead represented issues that need further working through in the implementation process. Where significant differences of view remained, these are indicated in this report.</p>
Scope of the report	<p>Working Group One was required to provide information, advice and recommendations to the Director-General's Reference Group, including identifying:</p> <ul style="list-style-type: none"> the changing nature and complexity of current and future demand service changes and the levels of funding required to meet future demand within sustainable government funding any other systemic or environmental constraints associated with ensuring a sustainable home and community sector. <p>The main objectives were to develop recommendations on how the Government can achieve a clear mandate for the delivery of HCSS that:</p> <ul style="list-style-type: none"> comply with the Home and Community Support Sector Standards

Area	Description
Link with Working Group Two: regularisation	<ul style="list-style-type: none"> • are effective and efficient, and provide value for money • lead to better outcomes for service users • are sustainable over the longer term. <p>Although there is some overlap, the report does not specifically cover clients or the workforce in:</p> <ul style="list-style-type: none"> • services or activities provided in Vote: Health-funded residential facilities (including residential facilities for people with disabilities) • respite or day-care services • mental health services • privately purchased services. <p>Working Group Two's focus was on the implications of regularising the workforce, including consideration of training issues. It strongly supported the development of a national service-level contract and a case-mix funding model. Working Group One had a higher-level focus on the whole HCSS sector, and the primary consideration was the needs of the client rather than the workforce.</p> <p>Working Group One completed an analysis of the current HCSS environment, and also completed a literature review of models in operation in New Zealand and internationally. It found that the models used in New Zealand have not been in operation for long enough, or have not been sufficiently evaluated, to enable the working group to recommend one service model over another. However, there was a general consensus among the working group representatives to support a recommendation to move to a national service-level agreement for HCSS, underpinned by an agreed costing methodology. In particular, working group members agreed that it is important to develop a minimum service level to ensure both clients and HCSS staff live and operate in a safe environment.</p> <p>We believe that our recommendations are not inconsistent with those of Working Group Two for moving towards a regularised workforce.</p>
Application of this report to ACC	<p>This report relates to Vote: Health-funded services providing home-based care to disabled clients and those aged 65 and over. The same workforce supports and provides care for ACC clients recovering from a short-term injury or requiring ongoing home-based care. ACC was not a party to the Settlement Agreement because it relates to Vote: Health funding only. However, ACC has agreed to negotiate arrangements, subject to the satisfaction of all relevant parties, that will have the effect of ACC paying for in-between travel at similar rates to those agreed in the Settlement Agreement.</p> <p>In principle, ACC supports the recommendations made by Working Group One with regard to supporting an effective and sustainable home-based support sector. ACC has provided advice on and support for the development of these recommendations and is committed to supporting an effective and sustainable home-based support sector, but notes that because ACC is not party to the Settlement Agreement, ACC is not bound by these recommendations.</p> <p>Once the Director-General's Reference Group has finalised its recommendations, ACC will consider what further work will be needed to support effective and sustainable ACC-funded home-based support services. This process will be subject to approval from ACC's Executive and Board, as well as the Minister for ACC, and may require further engagement with the sector.</p>
Stakeholder engagement	<p>Although there was some informal engagement during the development of the report, there has been no formal consultation with DHB, provider, consumer or union constituencies. Furthermore, there was no time for engagement with Māori and Pacific groups, other than that provided by Ministry of Health teams. Recommendations made to, and by, the Director General's Reference Group therefore require further testing among affected parties and communities before being formally adopted.</p>

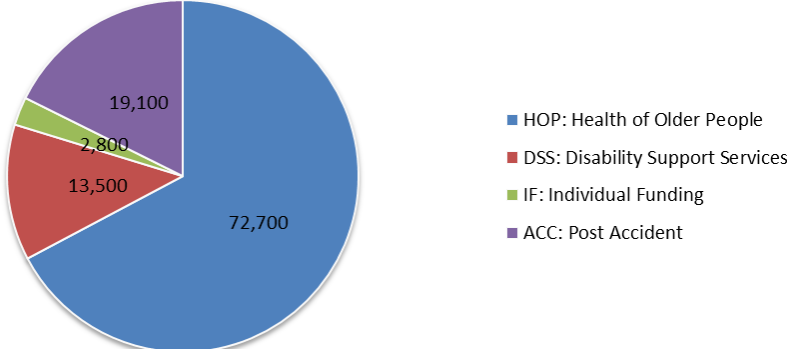
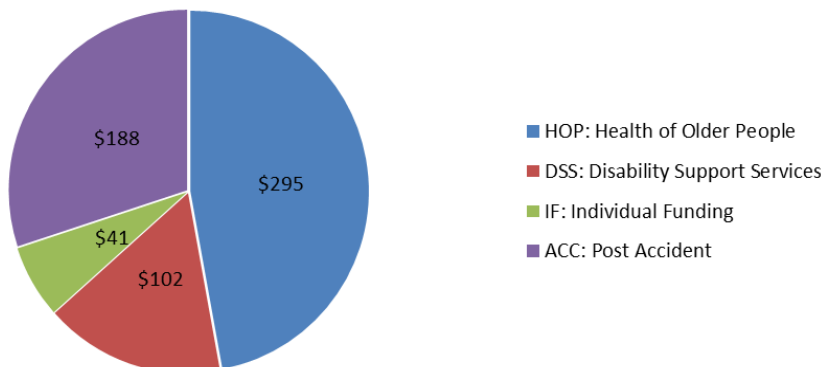
2. Current situation

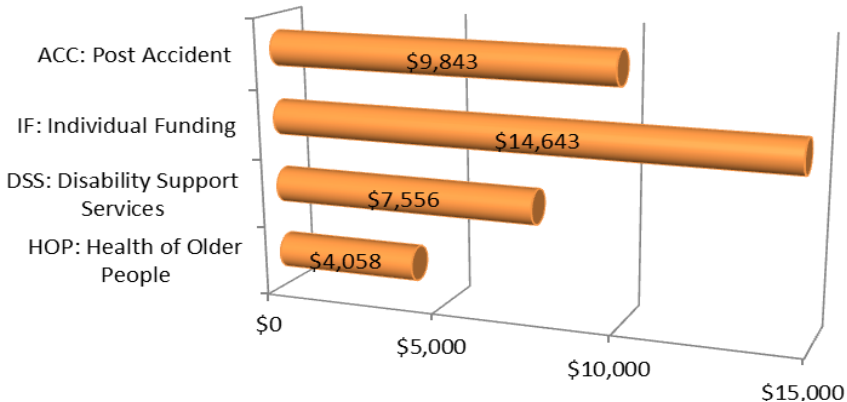
Area	Key observations														
Strategic context	The delivery of HCSS occurs in the context of a legislative and policy framework that binds, guides or limits funders, providers and workers. The strategic context under which the HCSS operate is set out in Table 1.														
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Area	Key observations	
Other key influences within the wider health system		are: improving outcomes, better support for whānau, good partnerships, and monitoring and reporting.
	Pacific Health and Disability Action Plan 2002	The Pacific Health and Disability Action Plan sets out the strategic direction and actions for improving health outcomes for Pacific people and reducing inequalities between Pacific and non-Pacific people. It is directed at the health and disability service sectors and Pacific communities, and aims to provide and promote affordable, effective and responsive health and disability services for all New Zealanders
	Home and Community Support Sector Standards Health and Disability Services Standards	Various sector standards have been established to ensure consistent high-quality service delivery in various sectors. Some are regulated (eg, the Health and Disability Services Standards) while others, such as the Home and Community Support Sector Standards, are enforced through contractual requirements. The advantage of regulated standards is that they apply irrespective of the contractual arrangements under which services are provided.
	Positive Ageing Strategy	The Positive Ageing Strategy is a comprehensive strategy setting out 10 goals and actions that span many areas, including income, health, housing, transport and employment. The Office of Senior Citizens reports annually on progress against all 10 goals.
	Several initiatives are under way that have some bearing on the HCSS sector, as shown in Table 2.	
	Table 2: Health initiatives relevant to the HCSS sector	
	Review of health funding	This review will look at what funding arrangements are appropriate and how funding is allocated within the health and disability system. It will also consider how the Ministry of Health can improve its internal review and prioritisation processes for Vote: Health (it will not look at the total funding available for Vote: Health).
	Review of capability and capacity	This review will look at progress made to ensure the New Zealand health and disability system improves its adaptability and responsiveness to meet future needs. In particular, the review will consider how the contracting environment, capacity and relationship management between the DHB sector and NGOs are best placed to meet health system and user needs.
	Kaiāwhina Workforce Action Plan	A five-year action plan has been prepared to support the development needs of the non-regulated workforce (kaiāwhina) to meet future requirements. A key goal is that kaiāwhina workers are regarded as valued members of an integrated service delivery team seeking to improve health and wellbeing outcomes.
	Streamlined contracting	The Ministry of Business, Innovation and Employment (MBIE) is leading a cross-agency project to streamline government–NGO contracts. This is expected to reduce the variation between government agencies in their contracting approaches, and standardise reporting requirements, which should reduce

Area	Key observations	
	the burden on providers when negotiating, and reporting against, contracts.	
	<table border="1"> <tr> <td>Pay equity legal action</td><td>A case was presented to the Employment Court in 2014 arguing that care/support workers in the aged residential care sector receive lower than average wages because they are in a female-dominated occupation. The outcome of this action may have implications for the home and community support workforce.</td></tr> </table>	Pay equity legal action
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<p>HCSS: what are they, how are they funded and what is the volume of service?</p>	<p>Home and community support services (HCSS) have historically included:</p> <ul style="list-style-type: none"> personal care (including meeting personal hygiene and dressing needs), mobilisation (including assistance with mobility aids, hoist transfers, exercise programmes), feeding, medications, socialisation and integration in the community, and observing and reporting changes household management (including cleaning, laundry, meal preparation and other activities that support people to remain in their homes). <p>Care models have changed over time and there is now greater diversity. In some areas HCSS have expanded to include supervision (the presence of support to be safe in the home or community), education (support to build individual capacity), respite (the presence of support to give the full-time care giver a break), facilitating community access and participation, and education and employment through the presence of supervisory or personal care support.</p> <p>As part of the review of HCSS, Working Group One also looked at needs assessment and service co-ordination (NASC) and services to support people discharged from hospital (or to prevent admission to hospital).</p> <p>People who use HCSS can be grouped into three population groups,⁶ broadly reflecting differing needs and differing funding arrangements:</p> <ul style="list-style-type: none"> people with health needs, including older people (aged 65 and over), people with long-term medical conditions, and those requiring short-term care following discharge from hospital (funded through DHBs) disabled people (funded directly through the Ministry of Health) people recovering from injury, or living with the long-term effects of injury (funded by ACC). 	
<p>Number of people receiving services</p>	<p>Figure 6 gives an indication of the relative size of each population group. Note, however, that there is some fluidity, as clients can receive funding from more than one funder.</p>	

⁶ While some clients receive home support due to mental health problems, and some care workers provide services to these clients, we did not consider mental health clients as a separate population group. Most community- and home-based mental health services are delivered by salaried staff, who are therefore not affected by the Settlement Agreement.

Area	Key observations										
Expenditure across service funders	<p>Figure 6: Number of people receiving HCSS, 2013/14</p>  <table><tr><th>Funder</th><th>Number of people</th></tr><tr><td>HOP: Health of Older People</td><td>72,700</td></tr><tr><td>ACC: Post Accident</td><td>19,100</td></tr><tr><td>DSS: Disability Support Services</td><td>13,500</td></tr><tr><td>IF: Individual Funding</td><td>2,800</td></tr></table>	Funder	Number of people	HOP: Health of Older People	72,700	ACC: Post Accident	19,100	DSS: Disability Support Services	13,500	IF: Individual Funding	2,800
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	<p>Source: DHB, Ministry of Health and ACC.</p> <p>Note: There is some double counting of DSS clients (possibly up to a third) because clients who receive both household management and personal care services may be counted twice.</p> <p>Older people are by far the greatest service users numerically, which clearly drives a large part of the cost, as noted below. It also means that most of the workforce will need the skills to work with older people. In addition, there are significant numbers of clients of all ages with disability and injuries, requiring differing skill sets. Some clients may have combined needs.</p>										
	<p>Figure 7 shows the general expenditure across funders. Again there is some overlap as some clients will have contributed to costs for more than one funder.</p>										
	<p>Figure 7: Expenditure on HCSS (\$million), 2013/14</p>  <table><tr><th>Funder</th><th>Expenditure (\$million)</th></tr><tr><td>HOP: Health of Older People</td><td>\$295</td></tr><tr><td>ACC: Post Accident</td><td>\$188</td></tr><tr><td>DSS: Disability Support Services</td><td>\$102</td></tr><tr><td>IF: Individual Funding</td><td>\$41</td></tr></table>	Funder	Expenditure (\$million)	HOP: Health of Older People	\$295	ACC: Post Accident	\$188	DSS: Disability Support Services	\$102	IF: Individual Funding	\$41
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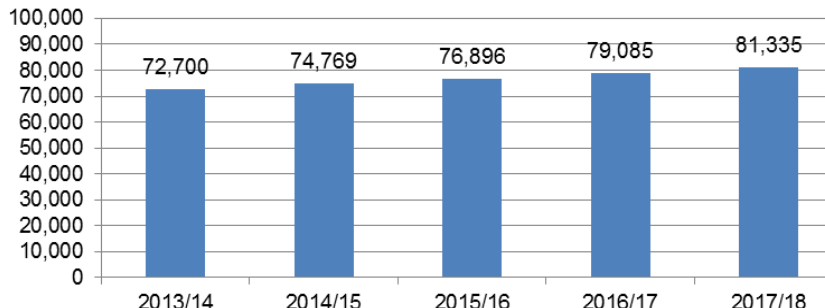
Area	Key observations										
<p>Average cost of care per person per year across main service types</p>	<p>Across DHBs, Ministry of Health and ACC expenditure on HCSS amounted to \$626 million in 2013/14, which was 4.5% of Crown health expenditure. By way of comparison, approximately \$939 million was spent by DHBs to fund aged residential care for around 31,000 older people.</p> <p>As can be seen, although almost 60% of the people receiving HCSS are older people, expenditure on services for this group accounts for barely 40% of the total spending.</p> <p>The higher expenditure for disability and injury reflects the greater complexity of care needs in these population groups</p> <p>The cost of care per person per year is given in Figure 8. It shows that, although more older people receive HCSS overall, they have the lowest cost per person. The highest cost per capita is for disabled people, closely followed by ACC clients. The high per capita cost for ACC results from a small proportion of clients with serious injury (especially spinal and head injuries) requiring high levels of ongoing care.</p> <p>Figure 8: Average cost of care per person per year, by population group, 2013/14</p>  <table border="1"> <thead> <tr> <th>Population Group</th> <th>Average Cost of Care per Person per Year (\$)</th> </tr> </thead> <tbody> <tr> <td>ACC: Post Accident</td> <td>\$9,843</td> </tr> <tr> <td>IF: Individual Funding</td> <td>\$14,643</td> </tr> <tr> <td>DSS: Disability Support Services</td> <td>\$7,556</td> </tr> <tr> <td>HOP: Health of Older People</td> <td>\$4,058</td> </tr> </tbody> </table> <p>Source, DHB, Ministry of Health and ACC data and contract information.</p> <p>This graph clearly shows the higher per-person costs for disabled and injured clients. Individualised funding costs are significantly higher due to the need for a wider variety of services, and possibly due to the newness of the programme.</p>	Population Group	Average Cost of Care per Person per Year (\$)	ACC: Post Accident	\$9,843	IF: Individual Funding	\$14,643	DSS: Disability Support Services	\$7,556	HOP: Health of Older People	\$4,058
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<p>Forecast of future demand among older people</p>	<p>Statistics New Zealand forecasts that the over-65 population will grow at around 3.5% a year over the next five years, a similar rate of growth as has occurred over the last five years. This amounts to an expected growth of close to 20% in the demand for HCSS over the coming five years if utilisation rates increase at the same rate as the projected population growth of older people. However, growth in utilisation of HCSS may not occur at the same rate, because each age cohort is healthier than the one before. Offsetting that will be continuing efforts by DHBs to enable people to remain at home.</p> <p>Figure 9 shows the predicted increase in HCSS use by older people, based on Statistics New Zealand population projections.</p>										

Area

Key observations

Projected increase among older people by age

Figure 9: Projected number of HOP clients, 2013/14–2017/18



Year	Number of HOP clients
2013/14	72,700
2014/15	74,769
2015/16	76,896
2016/17	79,085
2017/18	81,335

Table 3 shows projected increases in the use of HCSS by older people, by age group. For the next five years the largest numerical increase is in the 65+ years age group.

Table 3: Projected growth in number of older people and proportion accessing HCSS, 2014/15–2019/20

Population projections					
	2014/15		2019/20		5-year increase
Age	Number	Percent of NZ Popn	Number	Percent of NZ Popn	
65+	662,595	14.6%	784,123	16.4%	18%
75+	278,825	6.1%	332,355	6.9%	19%
85+	78,668	1.7%	90,650	1.9%	15%

Source: Statistics New Zealand

A trend affecting aged care is the increasing number of people with dementia. Currently an estimated 50,000 older people have dementia, and this is predicted to increase to 78,000 by 2026. This increase will affect the training needs of support workers and may have an impact on rostering and case-loads.

Disability forecasts

Based on current patterns of service use, it is projected that DSS client numbers will grow by a little over 10% over the next five years, while annual expenditure is expected to grow by around 8.5% (assuming no other changes).

ACC forecasts

ACC does not forecast demand in the same way as health and disability funders do, because injuries cannot be predicted in the same way as demographic change. ACC’s provision and funding of HCSS is demand driven. ACC provides HCSS on an entitlement basis, which means that clients are entitled to receive HCSS if they have an assessed injury-related need. This approach to providing care means that ACC does not operate within the same funding and provision constraints as the Ministry of Health and DHBs, where funding is subject to capitation.

Funding for ACC’s HCSS clients comes from a combination of levies (eg, on earnings and the Motor Vehicle Account) and government funding (eg, for the Non-Earners’ Account), depending on the nature of the client’s injury. The significance of this is that it is not capped in

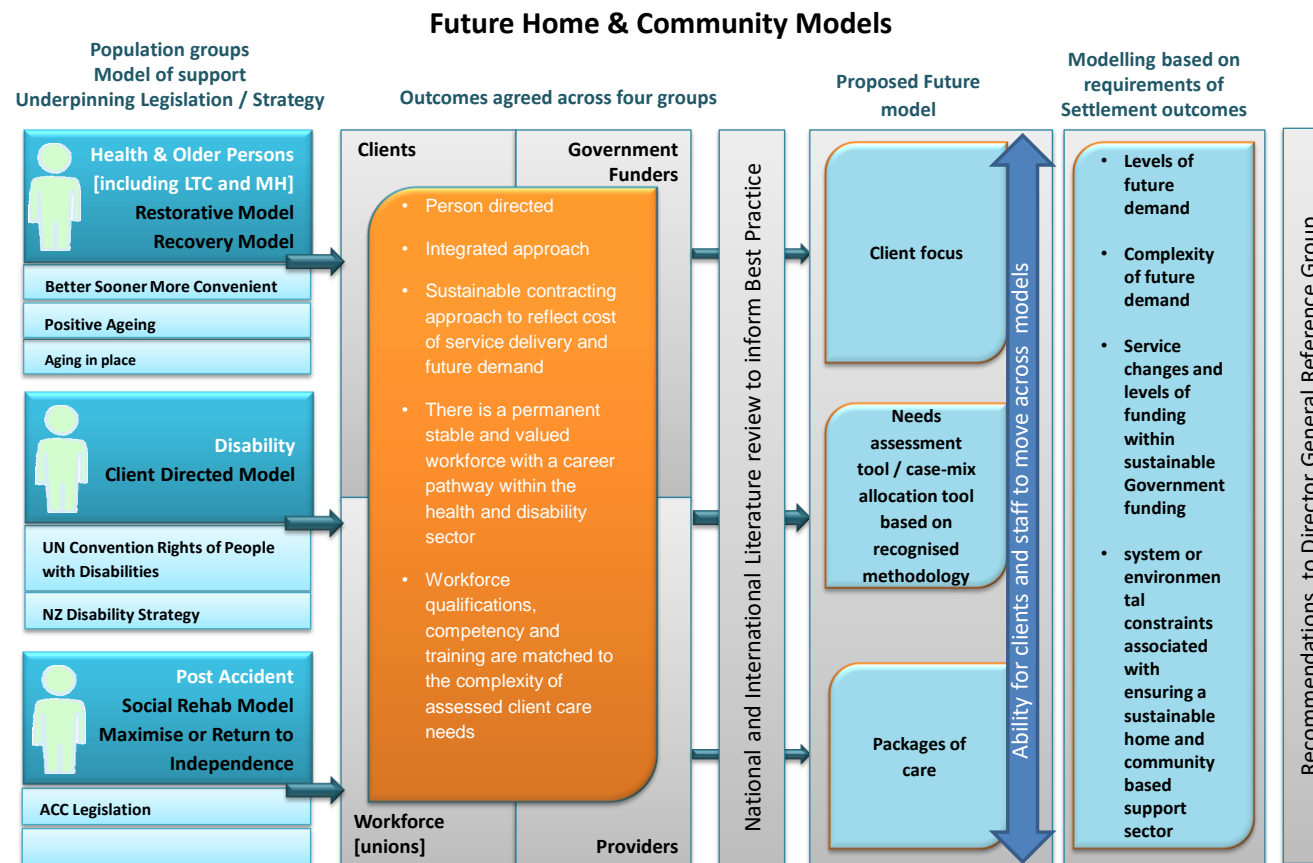
Area	Key observations
<p>What does the increasing demand mean?</p> <p>HCSS providers</p>	<p>the way health funding is.</p> <p>Over the past five years the number of ACC clients with serious injuries receiving HCSS has stayed relatively stable. ACC expects the number of these clients to continue to stay relatively stable (+/- 3% per annum) in the future. However, the average cost of HCSS per serious injury client has increased slightly over the past two years, which may be, in part, due to the shift from non-contracted HCSS to contracted HCSS. Over the past year average care hours have declined, but due to the difference in pricing, costs have increased. ACC expects this trend may continue (an average 6% increase in cost per serious injury client).</p> <p>The number and total cost of non-serious injury clients receiving HCSS has been variable in the past. ACC's provision of HCSS is demand driven, and ACC has little control over – and little ability to predict – the number of people who will have an accident and who will require HCSS. However, the average cost of HCSS per non-serious injury client has stayed relatively stable over the past five years, and ACC expects this long-term trend to continue.</p> <p>In summary, ACC expects:</p> <ul style="list-style-type: none"> • around 3% growth in the number of clients with serious injury • decreasing average hours of care • increasing average cost of services. <p>Taken together, these scenarios show that significant increase in client demand is likely. Retaining and upskilling existing staff will be critical for the short to medium term. Creating an attractive work environment to encourage new workers with appropriate skills is needed, as is sufficient expenditure to meet demand.</p> <p>There are approximately 70 providers of HCSS, of which approximately half are not-for-profit providers. Over recent years there has been a trend towards more for-profit providers, and several acquisition programmes involving a few of the larger providers acquiring smaller providers. This has caused some rationalisation of the HCSS sector in terms of the number of providers. However, it is not possible to say whether or not this trend towards fewer HCSS providers will continue in the coming years.</p> <p>The two largest for-profit HCSS providers (Healthcare New Zealand Limited and Access HomeHealth Limited) currently share over half the market. There are also several other large/medium-sized private and charitable organisations (Geneva Healthcare, Nurse Maude Association, Presbyterian Support, Salvation Army New Zealand Trust). The remainder of HCSS providers are smaller private, charitable, and iwi-based organisations.</p> <p>Most providers have agreements with both DHBs and the Ministry of Health. Several providers also contract (or sub-contract) to provide services for ACC. Providers may have differing service requirements, payment rates and methods, and differing reporting obligations arising from separate contracts.</p> <p>Providers and unions have indicated that the variability in pricing across DHBs for the delivery of HCSS to older people can be problematic. Currently, providers are paid an average of \$25.50 for every hour of care and support delivered, with payments ranging between \$22 and \$28 per hour, representing a 27% variation.</p> <p>The contracting picture from the perspective of providers is also complicated further because they might also hold parallel contracts with the Ministry of Health and ACC to deliver disability support services and post-accident care and support, respectively.</p> <p>ACC has moved to a limited supplier model for purchasing contracted HCSS care, whereby it holds strategic contracting relationships with six providers (down from 200), who in turn sub-contract with others to provide HCSS. This model was developed to improve ACC's ability to work with suppliers to drive quality, training and innovation and achieve greater consistency. All providers are required to comply with the Home and Community Support Sector Standards.</p>

Area	Key observations
Workforce sustainability	<p>disease in the population, a greater number of disabled people living into older age, and higher rates of dementia are likely to lead to greater complexity of needs among people requiring support to remain at home.</p> <p>Counterbalancing these driving factors of future utilisation rates of HCSS use are:</p> <ul style="list-style-type: none"> • a general health improvement among future comparable population age cohorts • better use of technology and tele-care within HCSS • improved integration of related health care services – HCSS, hospital care and residential care • increasing use of community-based support services. <p>Although these changes will take time to flow through the system, there is a sense of urgency around a need for improvement, because it will take time to build and maintain the workforce and configure services for the future.⁷</p> <p>Rates of entry into aged residential care have been slowly but steadily declining, and this trend is not expected to change. This means that additional older people (that is, over and above demographic increases) are likely to require support in their own homes. The policy objective of 'Ageing in Place' will require greater levels of investment to keep clients with potentially more complex needs at home.</p> <p>High turnover in the sector results from very low wages, little training, insecure employment and lack of a career path. Working Group One expressed the view that HCSS are something of a 'Cinderella' service: marginalised and not well regarded.</p> <p>High staff turnover increases recruitment costs and reduces profitability for service providers. High turnover also acts as a disincentive to invest in staff development and training. These factors reduce the potential to improve productivity and have a negative impact on the quality of services provided. The majority of workers have casual terms of employment, and may only work in the sector for a short time, especially if other employment opportunities arise in the community with better pay and/or conditions.</p> <p>The 2012 Human Rights Commission Report <i>Caring Counts</i> noted that the low pay for carers reflects the low priority given to supporting older people. It advocated for greater training of the workforce to reflect the increasing complexity of need, and noted that greater security of employment would lead to increased productivity and improvements in quality. It also noted that the need for flexibility arising from a client focus can be a challenge for rostering, and that funding models can inhibit flexibility.</p>
	<p>The increasing pressure to deliver health services to people in their own homes, coupled with increasingly complex health needs, will require a highly skilled and responsible workforce to ensure a reduction in turnover and high-quality services for clients. Investment in the HCSS workforce is needed to ensure a workforce capable of practising across all client populations. These investments include secure employment, pay rates that reflect the nature and value of the work, career pathways, and an ethical framework.</p> <p>Individual clients may need care and support services due to age, chronic ill health, disability, injury or any combination of these. Care and support workers must be able to provide services across all these domains. Service funding, however, comes through three separate streams: DHBs, Ministry of Health (disability) and ACC. This has led to differing approaches to funding, contracting and reporting, multiple points of assessment and assessment tools, and different ways to allocate services.</p> <p>Needs assessment and service co-ordination (NASC) exemplifies this issue. Each funder pays for separate NASC. Each funder uses different tools to calculate the volume of assistance an individual may require. Several different processes are in place to determine how</p>

⁷ Working Group Two reports on a proposal to ensure consistent levels of qualification for all staff within two years of their initial employment as a way to improve workforce capability.

Area	Key observations										
Sense of urgency around the need for attention to HCSS	<p>much funding is allocated to match the level of assessed need.</p> <p>Another layer of complexity derives from the differing approaches taken by 20 DHBs, which is associated with a lack of consistency in access to services. DHBs also vary in the models of care they use and the way in which they fund them (discussed further in sections 4 and 5 below).</p> <p>In its 2011 review of home-based services for older people, the Office of the Auditor-General noted that the overall delivery of home and community support was generally adequate, but it did not consider that the Ministry of Health and DHBs could be confident that services were effective and efficient, or capable of meeting the expected future increase in demand (Office of the Auditor General).</p> <p>A report on provider sustainability shows that some providers are struggling financially after several years of under-investment, and that urgent attention to this is required in the short term (Deloitte 2015). The increased funding for travel between clients resulting from the Settlement Agreement will ease some of the pressure. However, it is clear that additional funding will be required to ensure ongoing sustainability of the sector (discussed in Section 5 of this report).</p>										
What overall outcomes do we want to see?	<p>Collectively there are four distinct stakeholder groups that have related but differing aspirations. We have identified high-level outcomes for each of the stakeholder groups that relate back to issues raised in the Settlement Agreement. These are set out in Table 4.</p> <p>Table: 4 Outcomes sought across key stakeholder groups</p> <table> <tr> <th>Group</th><th>Outcomes sought</th></tr> <tr> <td>Clients (and their family/whānau)</td><td> <ul style="list-style-type: none"> Client-directed care and support, measured through client experience Equity of service access for each population group nationally Service models that are responsive to varying needs and preferences </td></tr> <tr> <td>Workforce</td><td> <ul style="list-style-type: none"> A permanent, stable workforce with guaranteed hours Workforce qualifications, competency and training matched to complexity of assessed client need Ability to attract suitable people to the role Remuneration is comparable to equivalent-sized occupations </td></tr> <tr> <td>Providers</td><td> <ul style="list-style-type: none"> Services are provided that meet client need Services are integrated to ensure HCSS providers do not work in isolation – care/support workers are part of a wider team There is sufficient funding to invest in staff and service development </td></tr> <tr> <td>Funders/government</td><td> <ul style="list-style-type: none"> Procurement of sustainable services to meet assessed population need Service quality and efficiency can be demonstrated and measured Wider social objectives are met, especially around supporting people to remain healthy and independent in their own homes and minimising their need for acute or residential care Integrated service delivery. </td></tr> </table>	Group	Outcomes sought	Clients (and their family/whānau)	<ul style="list-style-type: none"> Client-directed care and support, measured through client experience Equity of service access for each population group nationally Service models that are responsive to varying needs and preferences 	Workforce	<ul style="list-style-type: none"> A permanent, stable workforce with guaranteed hours Workforce qualifications, competency and training matched to complexity of assessed client need Ability to attract suitable people to the role Remuneration is comparable to equivalent-sized occupations 	Providers	<ul style="list-style-type: none"> Services are provided that meet client need Services are integrated to ensure HCSS providers do not work in isolation – care/support workers are part of a wider team There is sufficient funding to invest in staff and service development 	Funders/government	<ul style="list-style-type: none"> Procurement of sustainable services to meet assessed population need Service quality and efficiency can be demonstrated and measured Wider social objectives are met, especially around supporting people to remain healthy and independent in their own homes and minimising their need for acute or residential care Integrated service delivery.
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Framework for HCSS	<p>We developed a framework for looking at the HCSS sector (Figure 10), starting with the three population groups and four key stakeholders, and the outcomes noted above. Other elements of the framework are explained in the rest of the document.</p>										

Figure 10: Future home and community models



Moving from left to right in Figure 10, we have identified the population groups and their overarching philosophies. The orange box identifies high-level outcomes for each of the stakeholder groups. Our review of national and international literature and best practice led us to recommend a broad approach that can apply across all population groups, rather than recommend a particular model of care. The high-level outcomes required of the Settlement Agreement are identified and informed our recommendations.

3. Client and population focus

Area	Key observations
Client choice as the central focus	<p>Over the last decade there has been an increasing focus on the client (and family) as central to the assessment of care and support needs, and in determining the type, level and timing of support provided. This is especially well developed in the disability sector, drawing on its rights-based foundation. There is an expectation that future clients (eg, baby boomers) will expect to have greater input and choice in determining the care and support they need and receive.</p> <p>Internationally and nationally an evidence base is building on the positive effects of increasing client choice and control. Despite the wide-ranging models of home-based support services that exist, relatively few have been systematically evaluated, or have published data on their clinical experiences or their model of care (Beck et al 2009).</p> <p>In many countries, moves to a greater client focus are occurring alongside increasing demand and a need to maximise cost-effectiveness, particularly by reducing spending on acute hospital care, long-term care and residential care. Irrespective of whether the evidence supports cost-effectiveness, however, increased client choice and control fairly consistently deliver increased client satisfaction.</p> <p>Logically, if an outcomes focus is adopted, then a central outcome for services to support people in their homes has to be aligned to the needs of the individual client. This focus, therefore, needs to be reflected in the structures that surround the client.</p> <p>In its review of home-based support for older people, the Productivity Commission reviewed the evidence and sought the views of clients, providers and funders. It concluded that 'more client choice is generally better, but needs to be accompanied by systems that provide guidance and information for ...people exercising choice, and that guard against abuse' (New Zealand Productivity Commission 2015, Appendix E).</p> <p>Increasing client choice can have benefits at the individual and system level, leading to a better match between individual needs and the care and support people are offered, the training that staff receive, and the way service quality and effectiveness are measured. Increased client choice can strengthen incentives for providers to look for new ways to deliver their services. And client choice can be a driver of integration and coordination among providers and funders.</p> <p>Various terms are used to describe client choice. Working Group One chose the term 'client-directed' to mean that the client is an active participant, rather than a passive recipient, in the processes of assessment, service allocation and service delivery. Individual clients will vary in the extent to which they exercise choice and control, and providers will adjust their services accordingly.</p> <p>In the context of this report, client-directed care is not a new model for the delivery of HCSS, nor does it relate solely to individualised funding packages. It signals a direction underpinning a change in mind set by both providers and clients to ensure a more flexible partnership is established. Providers and their clients will need to work together to ensure clients have more choice and control in the delivery of their support than is currently the case. The shift is from a provider-controlled service delivery, where the person's problems are the focus of services delivered, to one that is client-directed, where individuals are actively involved in the assessment and care planning process to identify their strengths, values and life goals, and the support needed to overcome any barriers to achieving them.</p>

Area	Key observations					
Models of care	<ul style="list-style-type: none"> • funders with sufficient resources to ensure a sustainable sector, using national tools and local alliancing approaches to meet the assessed needs of their client populations • the Government prioritising the provision of care and support to enable people to remain in their homes and communities, and collecting information on client experience and system efficiency • the communities where clients live, work and engage with others being recognised as important partners in the care and support of people who need HCSS. 					
	<p>Working Group One was required to consider service design, or models of care, as part of the review of HCSS. Several models of care are currently in use for the different populations under consideration, and they each have their strong and weak points. A brief description of the key models is provided below.</p> <p>Supportive care</p> <p>In broad terms, the traditional model for the older people health group is a supportive approach that provides assistance with household management and personal care, with the care/support worker providing hands-on care. It is task-based, and is often characterised as <i>doing for</i> rather than assisting or supporting. A provider is funded to provide a specified amount of time, and the care and support worker is allocated particular tasks to carry out. There is some flexibility to vary the tasks/support within allocated hours.</p> <p>Restorative care</p> <p>A restorative model is an approach to care that seeks to: promote independence, restore function and/or prevent decline, ensure the comfort of the person, and help them attain set goals. The model integrates principles from medicine, rehabilitation, goal facilitation and nursing to improve functional outcomes for people. The role of the worker is changed from a traditional tasked based approach to an approach where workers take a trainer/facilitator approach to assist a client to return to independence (Parsons et al 2015).</p>					
	<p>Table 5: Key elements of a restorative approach</p> <table border="1"> <tr> <td data-bbox="600 898 1057 1058">Goal facilitation</td><td data-bbox="1057 898 1906 1058">A key concept of restorative care is to base a support programme on the goals and aspirations of the older person. This requires the identification of both a long-term goal and the short-term goals required to attain the long-term goal.</td></tr> <tr> <td data-bbox="600 1058 1057 1150">Function and repetitive activities of daily living (ADL) exercises</td><td data-bbox="1057 1058 1906 1150">Functional exercises involve working on muscle groups used in everyday activities, and programmes are undertaken by the person, under the supervision of the support worker.</td></tr> <tr> <td data-bbox="600 1150 1057 1243">Support worker training and enhanced supervision</td><td data-bbox="1057 1150 1906 1243">Restorative home support relies on support workers to collaborate with clients to maximise their independence. In addition, restorative home support encourages enhanced health professional integration.</td></tr> </table> <p>Evidence shows that individuals who receive restorative home care show greater improvement in their self-care, home management and mobility scores at discharge than those receiving traditional home care, and the quality of service provision is enhanced and benefits both the older client and the support worker (Tinetti et al 2002; Auckland Uniservices Ltd 2006; King 2010).</p> <p>Restorative models are currently used by some DHBs for older people, for people post-hospital discharge, and for people recovering</p>	Goal facilitation	A key concept of restorative care is to base a support programme on the goals and aspirations of the older person. This requires the identification of both a long-term goal and the short-term goals required to attain the long-term goal.	Function and repetitive activities of daily living (ADL) exercises	Functional exercises involve working on muscle groups used in everyday activities, and programmes are undertaken by the person, under the supervision of the support worker.	Support worker training and enhanced supervision
Goal facilitation	A key concept of restorative care is to base a support programme on the goals and aspirations of the older person. This requires the identification of both a long-term goal and the short-term goals required to attain the long-term goal.					
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Support worker training and enhanced supervision	Restorative home support relies on support workers to collaborate with clients to maximise their independence. In addition, restorative home support encourages enhanced health professional integration.					

Area	Key observations
Disability models Individualised funding approaches Care for injured people	<p>from injury. Some DHBs use what might be called Restorative-Plus, where additional interventions are delivered by a community-based workforce to improve health outcomes.</p> <p>Early supported discharge models (to speed the transition from hospital to home), such as START (Supported Transfer and Accelerated Rehabilitation Team) and CREST (Community Rehabilitation Enablement and Support Team), have been shown to reduce length of stay in hospital, prevent hospital readmission and lower costs overall. Te Whiringa Ora is a long-term condition management programme that has been shown to improve people's health and wellbeing, and by doing so reduce the number of emergency department presentations, hospitalisations and outpatient visits for people with complex health needs. (For more information about these initiatives, see Appendix 2.) These prevention initiatives support restorative care models.</p> <p><i>Restorative model for people with dementia</i></p> <p>Historically, restorative home-based support services for people with advanced dementia have not been widespread, and as a result there is limited evidence and evaluations of models to support these individuals. Some advances have been made internationally and show improvements in the daily function of the person, quality of life, mood and health status. The rate of institutionalisation is reduced, and improvements are recorded in caregiver confidence and overall wellbeing (Graff et al 2008; Gitlin et al 2000; Eloniemi-Sulkana et al 2001).</p> <p><i>Care/support worker views</i></p> <p>Surveys of support workers in New Zealand have shown they enjoy working in a restorative approach, but that there are challenges, including lack of adequate information on new clients and resistance from some clients and families. Most of those interviewed said they had not received training in how to determine which clients should receive restorative care, rehabilitative care or supported care interventions.⁸</p> <p>Models of care for disabled people are rights based (stemming from the UN Convention on the Rights of Persons with Disabilities) and focus on enabling a person to 'live an ordinary life'. They are therefore necessarily broader in nature than personal care and household management, and may include assistance with accessing social activities, education and wider community life. New ways of organising support are being trialled, including models where the clients take the lead in coordinating their support needs and managing their budgets. Currently over 2000 disabled people are using individualised funding.</p> <p>Individualised funding approaches give clients direct control of a personal budget for their care and support needs. In New Zealand, individualised funding is available to disabled people who meet the eligibility criteria. Internationally this approach is also used for older people. Generally it is younger people who take up this option, however, and locally it is expected that up to around 20% of disabled people may eventually take up this option.⁹ Being actively involved in the management of their own health and wellbeing, and being supported to take opportunities to provide feedback on health services used, is particularly important for Māori and provides a mechanism to contribute to quality improvement programmes (Ministry of Health 2015a).</p> <p>Care and support for injured people fall into two main streams:</p> <ul style="list-style-type: none"> • return to independence, which focuses on restoring people to their pre-injury state • maximising independence, which focuses on assisting a person (usually with a longer-term need) to reach and maintain as high

⁸ Information drawn from the PSA Survey

⁹ Australia has recently mandated the use of client-directed care for the provision of HCSS to older people, where clients direct decisions about how their needs will be met within a certain budget. Currently it appears that only a small proportion of clients take on full financial management, preferring instead to use an agency.

Area	Key observations
<p>What does the evidence say in general about models of care?</p>	<p>a level of functioning as possible.</p> <p>These approaches are similar to the disability and restorative models, and also include supportive care for those clients who require greater support with their activities of daily living.</p> <p>ACC clients have had the ability to choose a model similar to individualised funding for HCSS for over 15 years (called non-contracted care). More recently, in 2013 ACC introduced self-management for serious injury clients with stable needs and living conditions. Since the introduction of the new HCSS contract (September 2012), large numbers of clients have shifted from non-contracted (private) care to contracted care. While some of this shift is financially driven, it can also be attributed to the administrative burden that non-contracted care places on the client and their carer. As of February 2015 there were only 33 seriously injured clients using self-management.</p> <p>The international literature on cost-effectiveness of home care appears relatively conclusive, with researchers reporting that home care is cost-effective compared to alternative care options such as acute care and residential care (Hollander 2001; Elysium Services Ltd 2008; Beck et al 2009; Smith et al 2006; Kellog and Brickner 2000; Martin-Matthews and Sims-Gould 2008).</p> <p>Beyond this finding, the evidence supporting particular models of care and funding approaches is patchy and uneven, with very mixed results. Some studies demonstrate positive outcomes for clients and/or budgets, while others do not. Many studies do not focus on workforce needs and implications. Several themes can, however, be distilled from international literature on models of care that describe the elements of an ideal model of care. These are consistent with our belief that HCSS need to:</p> <ul style="list-style-type: none"> • be client directed • use team-based approaches • take account of the wider family and community context. <p>In addition, care and support should be delivered in a way that is :</p> <ul style="list-style-type: none"> • personalised and flexible • accessible and equitable • integrated and coordinated. <p>There also need to be processes to ensure:</p> <ul style="list-style-type: none"> • access to relevant information • effective prioritisation • a collaborative approach • ongoing sustainability of services. <p>Overall, the international evidence on individualised funding is mixed, and shows there is:</p> <ul style="list-style-type: none"> • strong evidence to suggest this approach improves client wellbeing and satisfaction • little evidence to suggest health outcomes are better or worse than under agency-directed approaches • little evidence to link client direction to increasing or decreasing levels of social isolation • some evidence that costs can be higher than alternatives, though this may result from poor eligibility criteria and latent demand

Area	Key observations
	<ul style="list-style-type: none"> little evidence to suggest the risk of abuse is higher or lower with client-directed care little evidence on the impacts on care/support staff, and the evidence that exists is mixed.¹⁰ <p>Working Group One notes the findings of an evaluation of Te Whiringa Ora (or TWO), which provide clear evidence of improved health outcomes, quality of life for the client, as well as a decreased frequency of outpatient usage and decreased presentations to emergency departments through a community-based approach that facilitates interdisciplinary care. Assessment of client experience indicates that TWO is appropriate across all cultural groups, including Māori. This is important, because only 2% of aged residential care residents are Māori, compared with 92.4% European. Kuia and kaumātua are more likely to be cared for at home by whānau, meaning that an appropriate, culturally appropriate response from HCSS is very important (Human Rights Commission 2012).</p> <p>CREST is a multidisciplinary approach to HCSS for older people that demonstrates a reduced load on acute occupied bed days and reduces readmission to hospital. This is an intensive, short-term programme, specifically targeted at people coming out of hospital. Its utility and cost as a programme for longer-term care/support has not been tested, nor has client experience been explored. One of Working Group One's consumer representatives was not supportive of some of these models because of their short-term nature and the fact that client experience was not evaluated.</p> <p>Decreasing use of aged residential care (ARC) and increasing rates of older people remaining in their homes were noted in a survey of 389 ARC facilities. There has been a low rate of growth in ARC bed numbers, despite the growth in the over-65 population. Between 2001 and 2005 subsidised home support service hours increased from 6.5 million to 10.2 million, representing an increase of 56%. During the same period, the over-65 population increased by only 9%. The increased availability of home support has led to 15% more older people accessing 36% more home support hours per client (Thornton 2010). An increasing body of New Zealand-based research shows that the development of integrated community solutions is essential for enabling older people to retain their independence and functioning as long as possible (Parsons et al 2008).</p>
Ideal components for models of care	<p>Each model of care has strengths and weaknesses, and has evolved within a complex and evolving procurement environment and in response to the different needs of particular populations of clients. For this reason we felt it was not possible to recommend a single model of care that would be applicable across the three population groups. However, we agreed on key components that must underpin any care model to ensure HCSS clients receive optimal care outcomes, as follows.</p> <ul style="list-style-type: none"> Clients requiring HCSS have access to high-quality care, support and information, which are tailored to meet their needs. Services are client-directed, and people are supported to live safely at home, where appropriate, while maintaining independence and personal choice. Needs assessment, service co-ordination and allocation, and funding are informed by evidence and best practice. Care and support are provided in a holistic, integrated way that recognises the interconnected nature of HCSS requirements. Workforce qualifications, competency and training are matched to the complexity of assessed client needs. The quality of care and effectiveness of service delivery can be measured. <p>These are high-level outcomes that are universal across the different service models and funders. It is not always easy to measure these things, but information collection will be critical for providers and funders to know whether progress is being made towards achieving these outcomes. This is discussed further in the following sections.</p>
Tools to support integrated care	<p>If clients are the focus, and care and support workers are the eyes and ears of the wider multidisciplinary team, there needs to be a way</p>

¹⁰ Summarised evidence from New Zealand Productivity Commission 2015, pp. 228–37.

Area	Key observations
	to facilitate information sharing and care planning. For this reason, Working Group One recommends that the National Health Information Technology Board give priority to shared-care technology development that includes home and community services.

4. Sector planning, coordination and alignment

Area	Key observations
Why is sector planning an issue?	<p>Strategies, policy settings and service organisation shape and direct the focus, content and delivery of services. If a client focus is to be implemented, it needs to be woven through all parts of the system. As noted above, there are differing pieces of overarching legislation, policies and strategies that define and shape the delivery of services. These differing drivers contribute to what are commonly referred to as separate 'silos', whereby services often work alongside each other.</p> <p>At one level, silos make it easy to direct and monitor government expenditure: accountability lines are clear and spheres of influence are clearly defined. But from the client and provider perspective they often don't make sense. Starting from the point at which clients enter the system, these silos mean there is duplication of effort, such as multiple plans and assessments. As well as complicating the lives of clients, this has a cost to the system. Also, previous planning has not always included client voices at every level.</p>
Starting at the beginning: needs assessment and service co-ordination	<p>As noted, there is considerable duplication across needs assessment and service co-ordination (NASC) services.</p> <p>Older people are assessed for home and community support services using the InterRAI tool, including when they are being discharged from hospital. InterRAI is an internationally validated tool modified for use in New Zealand. It gives a comprehensive clinical assessment that helps staff select appropriate support requirements for older people. It was introduced to DHBs from 2008, and while it is supposed to be used for all assessments of older people, this is not always occurring. In many areas an initial screening is done by the NASC, which then determines if the client requires a complex or non-complex assessment. In some DHBs the client is referred to a provider who completes non-complex assessments. There are various methods of determining the level of service and the associated funding required for each individual (service funding allocation is discussed further in section 5 below).</p> <p>Disabled people are assessed by separate NASC using a separate needs assessment tool, which uses a strengths-based approach (rather than a deficit approach) and includes a broader range of topics, such as wider educational and social needs. Supported self-assessment tools are being trialled for use also. The service coordination part of the service (which may be a separate service) then determines the amount of assistance a person can receive, and this is the basis for a discussion with the client about how best to organise support.</p> <p>Injured people also undergo assessments delivered by separate assessors using their own assessment tools. People with long-term conditions may also have varying assessments, carried out by their general practitioner or specialist, who may also develop a care plan.</p> <p>Clearly, the needs of people will differ when they result from disability, chronic ill health, ageing or injury. We are not advocating a single assessment tool, but there is merit in investigating the extent to which NASC systems could be improved within, and across, the population groups. This would reduce multiple assessments for clients, and should result in some system efficiencies. A key facilitator in this regard could be a shared care record,¹¹ with the details worked through locally. Some PHOs have developed shared care plans that allow multidisciplinary sharing of information and involvement in care planning.</p> <p>Care and support workers are well placed to be the eyes and ears of the broader care team, but they need to be appropriately trained and trusted to take this role, and there needs to be a mechanism or process for providing feedback to the wider care team. Technology and systems have a role here, and Working Group One recommends priority be given to how HCSS services can link to shared care plans.</p>

¹¹ The Ministry of Health has developed resources to provide guidance in relation to the development of shared care plans.

Area	Key observations
Service integration	<p>Service integration (ie, joining up or coordinating services) is integral to the delivery of a seamless service to clients, and should reduce duplication and gaps. Integration at the policy level is also required. As observed by the World Health Organization (2002):</p> <p><i>Patients need integrated care that cuts across time, settings and providers, and patients need self-care skills for managing problems at home. Patients and their families need support within their communities and support from broader policies to effectively manage or prevent long-term conditions. Optimal care for long-term conditions requires a different health care system.</i></p> <p>We see integration as the wiring board that sits behind the façade of ‘seamless services’. The word ‘façade’ is not meant to imply that it is a fake; rather that a seamless service is what the client wants to see: easy access to coordinated delivery of care and support. At its best, the concept implies there is no wrong door, as any entry point leads into the system, and – irrespective of the funding flows, assessment tools, contract forms and payment methods – results in co-ordinated, responsive, high-quality, personalised care/support.</p> <p>The Productivity Commission also supports a need for integration, defining it as:</p> <p><i>the management and delivery of social services so that clients receive the right mix of preventive and curative services according to their needs over time. Service delivery is co-ordinated within the social services system to make it timely and convenient for clients.</i> (New Zealand Productivity Commission 2015: 208)</p> <p>This definition suits our purposes, especially because it implies co-ordination of a range of primary-care-level services, and contemplates both more complex health care and care beyond the health sector.</p> <p>The main benefits of integration are improved effectiveness for clients, and cost-effectiveness for funders and providers. Integration works best where services are linked in a chain (eg, community, primary and secondary care) and for clients who have a complex set of needs. It also requires all parties to be willing.</p> <p>As part of the work being done to update the New Zealand Health Strategy, the Ministry of Health is testing a set of 10 to 12 key integration attributes. Although this work has been led in the primary care sector, the aim is to develop ‘non-denominational’ guidance that can be applied to different parts of the health and disability sector. Consultation on the draft revised strategy will occur within the next few months, and we would expect the HCSS sector to be involved in this process.</p>
Community health and disability strategy	<p>To systematically address the issue and impact of separate service silos, and the marginalised status of the home and community sector, and to achieve better coordination of services, Working Group One recommends the development of an integrated community health and disability strategy. Such a strategy would sit over the separate health of older people, disability and primary care strategies and would provide a broad view of the priorities and inter-relationships that are needed across all services delivered in the community to provide coordinated and seamless care.</p> <p>By way of example, Canterbury DHB has developed a variety of ‘care pathways’ that map out diagnostic and treatment paths for people with particular conditions. They provide general practitioners with information, advice and access to various specialists and other services to provide coordinated care for their patients. This is an example of integration being built from the bottom up. A community health and disability strategy would promote integration from the top down, and should facilitate a much broader view of providing care in the community.</p> <p>Our view is that a community health and disability strategy would provide much greater visibility of the place of the home and community support sector in the provision of primary-level care.</p>

5. Contracting and funding

Area	Key observations
Contracting or procurement approaches	<p>Each year the Government funds DHBs through the Crown Funding Agreement (CFA), which is the agreement between the Minister of Health and DHBs. Through the CFA the Crown agrees to provide funding in return for specified services. Currently DHBs are required to provide home and community support services as part of a suite of older people's services (others include, carer support, residential respite, age-related residential care, community health services, rapid response and discharge services, rehabilitation and stroke services).</p> <p>In order to plan and deliver HCSS in accordance with the CFA, DHBs must provide:</p> <ul style="list-style-type: none"> • needs assessment • service coordination • personal care services, delivered primarily in a person's home (eg, assistance with dressing, bathing, eating and toileting). <p>DHBs are allowed to income test for household management services (eg, assistance with meal preparation, laundry and cleaning). Household management services are free for Community Services Card (CSC) holders. If a person does not have a CSC, a part or full charge can apply. In practice, DHBs often charge CSC holders who receive only household management services; clients with a CSC receiving both personal care and household management might not be charged.</p> <p>It is against this backdrop that DHBs engage in procurement processes to meet the HCSS demands of their respective populations. Procurement of HCSS requires DHBs to consider population needs, funding availability and methodology, pricing, risk management, quality, eligibility, performance measurement, information flows, provider market sustainability and interactions with other services, and to choose an appropriate service model. Procurement of HCSS is also affected by the funding DHBs make available; there is a view that provider arm services attract more funding than community services.</p> <p>Any change to the HCSS service model is likely to affect other services provided across the care continuum. Therefore, procurement not only considers the model of care being purchased and associated funding and contracting arrangements, but also the broader context of other services operating to support older people and what other changes will need to occur to ensure both cost and service effectiveness across the whole health of older people environment.</p>
Alliancing approaches to procurement	<p>Since 2010, alliance agreements have been used in the health sector by the Better, Sooner, More Convenient (BSMC) businesses. Alliances promote integrated resource management, with decisions about health care services being made by all the relevant professionals and organisations. An alliancing approach is essentially a discussion between funders and providers on the population needs to be addressed, the likely volume of service, and the level of funding, goals and outcomes sought.</p> <p>This approach provides a more 'fit for purpose' arrangement that promotes and facilitates integration, regional service planning, and alliance funding and planning, all of which supports service development and integrates this with funding and financial risk management in a shared risk framework. Alliance agreements create a high-trust, low bureaucracy environment with high quality and accountability. They also provide a mechanism for clinical leadership in the development of health services. Within these alliancing relationships, both DHBs and providers continue to face huge challenges to deliver high-quality and safe patient care that is financially sustainable in the long term.</p> <p>In principle, alliances support shared decision-making and shared accountability to deliver high-quality, results-based outcomes. Alliances vary between DHBs, and one of the key issues is how authority and risk are to be shared. Not all alliances include social support services, and it is not clear how vested interests are dealt with.</p>

Area	Key observations
	<p>There is no clear set of operating procedures, but the Ministry of Health has developed some broad guidance.¹² The aspects of procurement for HCSS that are important to DHBs include:</p> <ul style="list-style-type: none"> • a model of care that: <ul style="list-style-type: none"> - is directed in the first instance at people with high and complex needs - is responsive to Māori, and other locality-specific ethnic groups - enables the home and community support workforce to be part of the wider primary care team, including taking a key role as the <i>eyes and ears</i> in the home to recognise a person's deteriorating condition (either physical or social) and linking into other support services - takes pressure off other parts of the system (eg, unnecessary presentations to hospital) • being supported by a funding and contracting model that: <ul style="list-style-type: none"> - recognises complexity and acuity - shares risk appropriately between funder and provider¹³ - incentivises performance and can measure effectiveness - maximises certainty for providers (this will support the regularisation of the workforce) - maximises economies of scale within a district or locality - provides HCSS providers with annual funding increase adjustments similar to providers with national contracts, including PHOs, ARC and Community Pharmacy¹⁴ - includes the principles of alliancing. <p>Future enablers include:</p> <ul style="list-style-type: none"> • the use of technology – an electronic shared care record that can be accessed by all providers involved in a person's care, including the person themselves • a national community care strategy (rather than a primary care strategy based largely on PHOs) that recognises the important contribution of the home and community sector to improving health system performance and health outcomes • a review of national policy settings • implementation of continuous improvement strategies. <p>A costing model was developed jointly between DHBs and providers, with input from the Ministry of Health. For funders, the use of such a tool provides an 'order of magnitude' indication of service price. It can also help identify providers that have greater economy of scale, or other factors that make them more efficient than others. For providers, such a tool helps identify the variable and fixed costs of its service.</p> <p>The assumption was, perhaps, that DHBs would adopt the prices arrived at in the modelling and apply them to service contracts. This has not occurred for a variety of reasons. The first reason is affordability. With constrained funding and multiple priorities it is difficult for</p>

¹² This is available on the Ministry's website.

¹³ Risk is allocated and borne by the entity best able to mitigate it. For example, the population growth risk (change in the total number of people or average acuity) should sit with the funder. Allocation risk (the risk that support is over or under allocated) should sit with whoever controls the allocation (providers or NASCs).

¹⁴ Unlike other primary care providers, home and community support providers cannot charge a co-payment for publicly funded services and have not had the benefit of guaranteed annual funding increases, such as those received by PHOs, ARC and Community Pharmacy.

Area	Key observations						
Funding allocation tools: strengths and weaknesses	DHBs to increase service prices over and above the real annual increases they receive in the funding package each year, especially as funding increases must cover demand and cost growth. From the provider point of view, the gap between their current prices and the modelled price is significant.						
	The second reason is that, at the time this work occurred, DHBs were increasingly moving away from unit price models towards bulk-funded models. DHBs were re-contracting for services in a competitive market, and in many cases stayed within their current funding envelope for HCSS.						
	The third reason is that price alone does not take into account the logistics of efficiency. Some DHBs believe they have too many providers operating in their district, which contributes to diseconomies of scale. Services with diseconomies require a higher price to operate sustainably. It is worth noting that the size of the provider does not necessarily determine economies of scale – a small or local provider can achieve economy of scale in the delivery of home and community support services if it has other (complementary) services. And a large national provider may not have economies of scale in a district if they are one of many operating in an area with small volumes.						
	We therefore recommend that HCSS funders adopt an alliancing approach to better align incentives for organisations to work together towards a common goal.						
	Funding allocation tools take the assessment information (scores, categories or levels) and convert this into a level of support, such as hours per week or dollars per client. It is not just a mechanical formula, however: it is a combination of technical tools that calibrate the quantity of support required, along with clinical judgement.						
	It is important to note that the funding model does not necessarily determine the service delivery model. The choice of funding model does, however, affect service delivery through how much flexibility the provider has and who bears the risk of under- or over-delivery. There are a variety of funding models operating across the sector, which are broadly described in Table 6.						
Table 6: Comparison of common funding allocation approaches							
<table><tr><th>Funding approach</th><th>How it works</th><th>Strengths and weaknesses</th></tr><tr><td>Payment per hour of care delivered (fee for service)</td><td><p>Following needs assessment, the funder allocates hours of specific tasks, such as dressing, showering and feeding. Providers are paid in blocks of time (usually fortnightly) for services actually delivered at agreed rates per hour. Increases in hours of care, week to week, need to be approved by the funder</p><p>Where the funder does not specify the hours or services closely, the 'payment per hour' approach comes close to the 'payment per person' approach (discussed below).</p></td><td><p>The payment per hour of care approach:</p><ul style="list-style-type: none">• is simple to administer and provides good volume and expenditure data• lacks flexibility to address changing client needs unless the funder very quickly responds to provider reassessments• provides no incentive to discharge, or reduce service for, clients that no longer need them (which may lead to over-servicing)• may make it more difficult for providers to introduce new ways of meeting client needs, as agreement with the funder is required</td></tr></table>		Funding approach	How it works	Strengths and weaknesses	Payment per hour of care delivered (fee for service)	<p>Following needs assessment, the funder allocates hours of specific tasks, such as dressing, showering and feeding. Providers are paid in blocks of time (usually fortnightly) for services actually delivered at agreed rates per hour. Increases in hours of care, week to week, need to be approved by the funder</p> <p>Where the funder does not specify the hours or services closely, the 'payment per hour' approach comes close to the 'payment per person' approach (discussed below).</p>	<p>The payment per hour of care approach:</p> <ul style="list-style-type: none">• is simple to administer and provides good volume and expenditure data• lacks flexibility to address changing client needs unless the funder very quickly responds to provider reassessments• provides no incentive to discharge, or reduce service for, clients that no longer need them (which may lead to over-servicing)• may make it more difficult for providers to introduce new ways of meeting client needs, as agreement with the funder is required
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Area	Key observations		
			<ul style="list-style-type: none"> • can make it difficult for care and support workers to maintain their income when clients change, go on holiday etc, and may create a disincentive for providers to guarantee hours or make greater long-term investment in training and qualifications (unless the rate of payment accounts for potential non-service days and training) • means that clients' needs may not suit the half-hour blocks of time allocated, potentially using service time inefficiently.
	Payment per person per week (or longer period) with people assigned to payment categories	<p>Funders allocate clients to a category (eg, by case-mix algorithm from interRAI data, or other means, such as eligibility for 'supported living').</p> <p>Each category is a broad group that shares similar levels of need, and payment to the provider is a set amount each period. Providers determine the specific tasks and hours provided each week.</p>	<p>The payment per person approach:</p> <ul style="list-style-type: none"> • gives the provider greater flexibility to manage overall costs across a pool of clients • provides greater scope to develop a regularised workforce and the ability to offer guaranteed hours of work and greater investment in training and qualifications (unless the rate of payment accounts for the expected level of non-service days); more frequent changes in service hours may make regularised hours more difficult • provides an incentive to reduce unnecessary services, and to match staff skill to client need, but also creates an incentive to reduce <i>all</i> service levels, which must be managed; also regularisation reduces the incentive to reduce unnecessary services because in some cases the provider will be paying for the hours • current case-mix tools derive from hospital inpatient services and do not translate easily to community services, so it cannot completely account for differences in clients' 'natural supports', but with large numbers in each category it may be adequate for setting an average payment rate; a 'package of care' approach better accounts for individual circumstances • allows trade-off between time integrating with other health services (when they are required) and time directly meeting client needs

Area	Key observations		
			<ul style="list-style-type: none"> means greater flexibility (potentially), which allows for greater client involvement in determining packages of care to suit their individual circumstances.
	Bulk funding	<p>Providers are allocated a fixed sum per year (based on an estimate of the volume and complexity of client need the provider will have to manage). Providers determine how to allocate the funds across their entire client group. Any changes in the payments need to be negotiated.</p> <p>Bulk funding arrangements with end-of-year wash-up for differences between actual numbers or levels of need bring the approach closer to the payment per person per week.</p>	<p>The bulk funding approach:</p> <ul style="list-style-type: none"> caps costs for the funder, and provides funding certainty for the provider (depending on arrangements for end-of-year wash-ups) means the risk of larger numbers or higher average client needs falls on the provider, in the first instance, to prioritise services or raise prioritisation or extra funding with the funder provides an incentive to reduce unnecessary services, and to match staff skill to client need, but also creates incentives to reduce all services that must be carefully managed rewards innovation and substitution provides greater scope to develop a regularised workforce and the ability to offer guaranteed hours of work and greater investment in training and qualifications allows a trade-off between time integrating with other health services when they are required and time directly meeting client needs provides greater flexibility (potentially), which allows for greater client involvement in determining packages of care to suit their individual circumstances.
	Individualised funding	<p>The client is allocated a budget, which they manage either in its entirety or with assistance from a host agency.</p> <p>ACC also funds some clients directly through its 'non-contracted' stream.</p>	<p>The individualised funding approach:</p> <ul style="list-style-type: none"> means the client takes responsibility for identifying the range of services, employing their support worker and paying for services, thereby more closely matching their needs makes it more difficult for the funder to monitor quality and performance potentially gives insecure status to the care/support worker and no formal training or support mechanisms, which means a potential risk for the

Area	Key observations		
			support worker when the client is also the employer.
	<p>Rather than recommend a single funding model, Working Group One has developed a proposed pathway of care for older people that can be funded by any of the funding models discussed above. The model below is proposed for services funded through DHBs in the first instance, because there is more variation in this sector.</p>		

Area	Key observations
<p>Proposed care pathway for the health of older people</p>	<p>Figure 12: Proposed model for health of older people</p> <p>Individual clients' assessment, resource allocation and package of care agreement through case-mix</p> <p>Client assessment and resource allocation</p>
<p>Contracting approaches</p>	<p>Working Group One discussed the option of a national agreement (with national prices) as a way to improve consistency and certainty in the sector. Minimum standards for quality and workforce should be adopted to ensure that price competition does not undermine quality. Further work needs to be done to investigate how quality could be reflected in a national price, and how prices can be maintained (eg, when wage rates change). The benefits of this national approach are that it could:</p> <ul style="list-style-type: none"> • provide national consistency – for some providers still on fee for service the increase in funding could be substantial in some districts where prices are lower

Area	Key observations			
Ideal funding approach	<ul style="list-style-type: none"> • guarantee an annual price increase, noting that sectors with national contacts such as PHOs, ARC providers and Community Pharmacy have been guaranteed price increases each year, often in excess of the contribution to cost pressures received by DHBs in their annual funding package (up until the 2015/16 planning year this was set as an expectation by the Minister; annual price increases to HCSS have been at the discretion of DHBs, with variability in approach across DHBs from year to year) • provide a national negotiation process, which could provide more leverage for the sector • have the potential to resolve difficulties of the pay rates and practices of support workers who move across DHB boundaries • aid a national approach to workforce development • reduce transaction costs (especially for national providers). 			
	<p>Challenges with a national agreement approach include:</p> <ul style="list-style-type: none"> • <i>affordability</i> – particularly for any transition, in a severely constrained environment • <i>acceptability</i> – it is unlikely that a national price would be the highest price currently paid across all DHBs, and this would be difficult to promote across the sector • <i>autonomy</i> – some loss of freedom for providers in a more regulated environment, which may stifle innovation, and smaller providers are sometimes disadvantaged in a national negotiation process, particularly if they are not represented by an association • DHBs would lose the flexibility to respond to local priorities and funding pressures • other options are available to improve consistency, such as the requirement that DHBs and providers use an agreed costing tool as a basis for local discussions, and to work to develop an agreed case-mix algorithm to categorise need and use alliancing approaches to guide procurement. 			
	<p>We are aware that Working Group Two recommends a national contract. Working Group One provider and union representatives support a recommendation for a national-level agreement between DHBs and providers to identify standards and a national pricing structure, as well as a recommendation for the adoption of local alliancing relationships to enable flexibility to take account of local population needs and integration with other services for the benefit of the client.</p> <p>We also identified several characteristics for an ideal funding approach. These are described in Table 7.</p> <p>Table 7: Characteristics of an ideal funding approach</p> <table border="1"> <tr> <td data-bbox="598 1114 808 1313">Services meet client needs</td><td data-bbox="808 1114 2045 1313"> <p>To be person-directed, the services needed should be what the person wants, and up to the level the funder (or its agent) judges is needed (to be a good use of public resources, given the other health and disability needs of the population).</p> <p>The type of service should be what the person wants, within the limits of the type of service it is publically acceptable to fund. The funder (or its agent) should offer advice on what will best meet needs, and the person may choose to follow that advice or direct otherwise.</p> </td></tr> <tr> <td data-bbox="598 1313 808 1369">Flexible</td><td data-bbox="808 1313 2045 1369"> <p>The level and type of service should be able to be changed from week to week for clients who have changed needs.</p> </td></tr> </table>	Services meet client needs	<p>To be person-directed, the services needed should be what the person wants, and up to the level the funder (or its agent) judges is needed (to be a good use of public resources, given the other health and disability needs of the population).</p> <p>The type of service should be what the person wants, within the limits of the type of service it is publically acceptable to fund. The funder (or its agent) should offer advice on what will best meet needs, and the person may choose to follow that advice or direct otherwise.</p>	Flexible
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Flexible	<p>The level and type of service should be able to be changed from week to week for clients who have changed needs.</p>			

Area	Key observations	
	Minimum waste	Services that are not needed or valued should not be provided
	Budgetary control	The funder should be able to accurately budget what costs it will incur to provide the service, and have the knowledge and ability to change service settings during the year to keep within its budget allocation.
	Agreed prioritisation	Where service levels need to be changed to maintain budgetary control, the approach to prioritisation of service delivery should be agreed between funder and provider
	Viable business	Funding should enable the provider to operate a financially viable business.
	Regularised workforce	Funding and service allocation processes should enable a regularised workforce.
	Timeliness of service	Services should be provided with minimum delay.
	Integration	The level and type of home-based support services provided should integrate with other health and disability services (eg, hospital discharge services, primary care, allied health, probably with non-health community services).
	Administrative costs	Funders should use similar funding and allocation processes where that will significantly reduce the costs for those who provide services to multiple funders. The cost of operating the assessment, coordination and payment system should be minimised (eg by avoiding duplicated service planning).
	National consistency	HCSS services should be nationally consistent, sustainable, stable and equitably funded with a nationally consistent contracting framework that supports integrated joined up care.
Amount of funding	<p>A survey of HCSS providers found evidence of impending financial hardship among some providers, resulting (in part) from a lack of movement in funding levels to account for changes in the Minimum Wage and other cost pressures (Deloitte 2015). It also noted that the average provider has had to achieve year-on-year overhead savings of 7% for the past seven years to maintain their margins, and that this would increase to 12.5% over time.</p> <p>Some providers are facing considerable financial challenges, though others are in a stronger position, for various reasons. Nevertheless, Working Group One believes that financial assistance, or reprioritisation, will be needed in the near future. The amount is not yet known, but by way of example, the Deloitte report suggested that the 50% increase in the Minimum Wage in April this year (from \$14.25 to \$14.75) equates to an overall (unfunded) increase in expenditure of around 3.5% (Deloitte 2015: 10).</p> <p>As noted in a BERL report, investment in the HCSS sector will reduce spending elsewhere in the health sector as long as services are provided in an efficient and effective manner. Better work conditions, terms and status, including regular hours, will help improve staff retention and thereby reduce recruitment costs. However, savings will only occur if the HCSS workforce is appropriately trained and qualified to meet the increasingly diverse needs of clients (BERL 2014).</p> <p>Working Group One therefore recommends that the Government prioritise funding to invest in the further development of the workforce to ensure the support workforce is recognised and valued to reflect the skill, responsibility and complexity of care and support work.</p>	

6. Quality and service excellence

Area	Key observations
Information is needed to measure service quality and effectiveness	<p>As noted in the sections above, there is significant variation in the way services are delivered and funded, and there is varying ability to measure and compare client outcomes, system inputs and service costs. The ability to benchmark, or compare the quality and efficiency of services, needs to be improved.</p> <p>Starting from our client focus, the collection of client experience, satisfaction and outcome information needs to be embedded in service contracting and delivery. This information can inform the matching of workers to clients, workforce training and service rostering.</p> <p>Home-based support services should contribute to outcomes of reduced need for residential care, reduced need for acute care, good-quality home care, and a positive patient experience.</p> <p>A community health and disability strategy could provide some structure to and guidance for the collection of information across the wider sector, so that investment in one area might be realised in benefits to another area. It is difficult, for example, to attribute HCSS use to lower rates of acute hospitalisation, but a broader view and finer-grained measures might detect improved health outcomes, such as reduced prescriptions, or better management of chronic conditions.</p>
System indicators	<p>System-wide quality information can contribute to service and policy development. Home-based support services should contribute to the outcomes of reduced need for residential care, reduced need for acute care, good-quality home care and a positive patient experience.</p> <p>We examined whether DHBs that have moved to case-mix and bulk funding have seen better outcomes. We looked at the amount of resources each DHB put into HCSS and the use of residential care and acute care. The hypothesis is that, other things being equal, higher HCSS will reduce the need for residential and acute care.</p> <p>However there was no demonstrated consistency of outcome. The DHBs using case-mix or bulk funding fare no better than other DHBs (see the map in Appendix 3). For example, Auckland has average costs and poorer results than other DHBs.. Accounting for inter-district flows into Auckland ARC facilities does not change the picture. Canterbury has high inputs, which produces lower than average acute care use ,but still high ARC use (although ARC use has reduced more than the average over the last five years). Southern has low HBSS inputs and poor outcomes. Hutt, which has similar inputs and outcomes to Southern, uses a traditional funding model. On the other hand Capital & Coast, using bulk funding, has just as low inputs, but low acute care use and only a bit higher-than-average ARC use. Capital & Coast has had one of the fastest reductions in acute care over the last five years.</p> <p>Nelson Marlborough looks to have the best outcomes, with low inputs while achieving low acute care and average ARC use. Northland also achieves good outcomes (low ARC, lower-than-average acute) but with high inputs. South Canterbury has lower-than-average inputs and better-than-average outcomes. Whanganui has the same level of inputs as South Canterbury with better (low) ARC use and worse (average) acute care use</p> <p>Overall, there is no clear pattern to the resources committed to HCSS and the outcomes of low use of residential care and low acute care. Admittedly this is partly because attribution (ie, cause and effect) is problematic due to other factors that influence the use of residential and acute care (eg, demographics, geography, the general health of the population and utilisation of other primary care services). Even if a single funding model were used it would not remove these effects.</p> <p>Currently our information sources are not sensitive enough to paint a reliable picture of the overall effects of HCSS on wider health</p>

Area	Key observations
Value for money	<p>services. Data collection and coding differences between DHBs may be the cause of some differences; perhaps the DHB populations differ significantly, or there may be important differences in training or team dynamics, or perhaps it is too soon to expect to see flow-on effects. Whatever the reasons, there appear to be stark differences that are difficult to understand. Some conclusions we can draw from this are that:</p> <ul style="list-style-type: none"> • it is difficult to predict wider system impacts from changes in HCSS • different starting places and local contexts are likely to play a role in the outcomes that can be achieved • standard indicators can highlight differences, <p>In its review of government commissioning of social services, the Productivity Commission noted the challenges of providing social services in the context of an ageing population, increasing demand, and growing social expectations for which services should be provided and how they should be delivered. At a high level, it considers that a well-functioning social services system should:</p> <ul style="list-style-type: none"> • target public funds at areas with the highest net benefit to society • match the services provided to the needs of clients • ensure decision-makers (at all levels) have adequate information to make choices • respond to changes in client needs and the external environment • meet public expectations of fairness and equity • be responsive to the aspirations and needs of Māori and Pacific people • foster continuous learning and improvement (Deloitte 2015) <p>The Productivity Commission makes the point that public funds should be directed towards areas with the highest net benefit to society. This means that funders should consider both the cost of services and the value the services generate. Ideally, funders should purchase services that achieve the maximum value (to the person and throughout the health and disability system) for the cost of the service. A higher price enables the provider to pay higher wages, offer greater training and undertake better coordination. That would, up to point, provide value for money.</p> <p>However, in this context the value of the outcomes from purchasing better-quality home support for the client and for other health and disability services is difficult to measure, so funders need to judge the value of better-quality services compared to the extra cost.</p> <p>Working Group One agrees with these points and notes that good information is needed to measure progress towards these goals. We therefore recommend that population-level information be captured and shared for the purposes of measuring outcomes and informing future planning. Some developmental work on identifying useful and sensitive indicators is likely to be needed.</p> <p>We also suggest the support and promotion of a continuous improvement approach to improve systems and processes across the health and disability sector. Continuous improvement approaches fit alongside alliancing approaches, where open and constructive discussions are used to identify areas of service quality improvement and efficiency gains.</p>
	<p>Standards and codes of ethics</p> <p>There are agreed Home and Community Support Sector Standards that require providers to have client satisfaction and complaints systems in place. The standards are audited, but the audit reports pertain to the individual provider. Working Group One believes there needs to be a more comprehensive collection of client satisfaction information, and therefore recommends that the Health Quality and Safety Commission extend its work on client experience to the HCSS sector.</p> <p>A useful way to incorporate standards into everyday practice is through the development of a code of ethics, owned by the workforce.</p>

Area	Key observations
	Voluntary codes of ethics are in place in Australia, and may be a useful model for the HCSS workforce. This is an area that may be able to be developed through the Kaiāwhina Action Plan.

Part B: Regularising the home and community support services workforce

The reality for a support worker today

Penny is a middle aged woman who has limited employment history because she has focused on being a stay at home mum while her children were at school. To help supplement the family income she has taken on many part-time jobs across a range of industries. This means that her employment history can look a bit unsettled to prospective employers.

Penny has always avoided educational settings because she finds bookwork challenging and doesn't like to sit in a classroom. She would much rather get on with things practically. This means that she has no formal qualifications.

Now that her children have left home, she has joined the home and community health sector because she wants to use her life experience and caring nature within her own community.

Penny loves her job and the people she supports; she knows she makes a real difference. Her employer tries to give her the same clients each week but sometimes she is asked to support people she hasn't met and this can be really challenging as she doesn't always know what the client likes.

Penny understands why her hours move up and down every week but really wishes they didn't. She finds it really hard when her hours reduce because she gets less money that week. It makes a real difference when petrol prices rise quickly or something unexpected happens like when her car broke down last week. She has also noticed that it's a lot harder to get things on hire purchase when you can't say for sure what your income is.

This story helps illustrate that the majority of Support Workers:

- are women, over the age of 45 with no qualifications
- find the prospect of gaining a qualification challenging
- have the right values and attitude to support and provide services within the community.

Future vision

Penny loves her job. She still thinks of herself as a practical person but is proud of her level 3 certificate and knows she is just as qualified as the young ones coming into the business. The extra money that comes with being qualified helps as well.

She really appreciates the support her employer gave her when she finally decided she would give studying a go. She got paid for her time, had a colleague who had done the course available to help with anything she was unsure of and, best of all, most of the course involved on-the-job assessments and not classroom learning. She can't wait for there to be enough clients to justify doing the Level 4 certificate – her employer has already said that she's the next one they'll put through the course.

Penny is a valued team member and enjoys the weekly team meetings and exchanging knowledge and experiences with the other team members. She knows so many clients who benefit from what she and others learn from these weekly discussions. She also knows clients gain a lot more from the support they get now to help them achieve their goals than they ever did from having their oven cleaned every second week. She still has to clean an oven every now and then, but is glad that much more of her time is focused on delivering what her clients need to be active in their home and wider community.

Penny is still sometimes asked to support people she hasn't met and knows this will happen from time to time because her employer makes sure there is work for her to do in her guaranteed hours. It's still a bit challenging but it is much easier with the handover notes and discussion on care plans with her supervisor.

Penny has encouraged her son and a couple of friends to become Support Workers. She knows it's a good career and getting qualified will help her brother's boy get into nursing.

This story illustrates that regularising the support workforce will mean:

- a different demographic of worker will be attracted into the sector
- increased benefits to the client, Support Worker and community,

About Part B: Regularising the home and community support services workforce

Area	Key observations
Summary	<p>Settlement Agreement negotiations led to discussions about the sustainability of the HCSS model of service delivery under the current employment model. As a result, the parties agreed to investigate the impact and affordability of a sustainable, regularised workforce. A Director-General's Reference Group was established to conduct a review of Vote: Health-funded HCSS (the first work stream), and to report on the impact and affordability of transitioning to a regularised workforce within two years of ratification of the Settlement Agreement (the second work stream).</p> <p>A 'regularised' workforce was described by the Settlement Agreement parties as one that provides:</p> <ul style="list-style-type: none"> • guaranteed hours for the majority of the workforce • paid training to enable Support Workers to gain Level 3 New Zealand Certificate qualifications • wages based on the required levels of training for Support Workers • a case-load and case-mix workload mechanism to ensure a fair and safe allocation of clients to Support Workers.
Scope of Part B	<p>Part B relates to Vote: Health-funded Support Workers who deliver home-based care to disabled clients and those aged 65 and over. The same workforce supports and provides care for ACC clients recovering from a short-term injury or requiring ongoing home-based care. ACC was not a party to the Settlement Agreement because it relates to Vote: Health funding only. However, ACC has agreed to negotiate arrangements, subject to the satisfaction of all relevant parties, which will have the effect of ACC paying for in-between travel at similar rates to those agreed in the Settlement Agreement.</p> <p>The report does not cover the workforce that works in:</p> <ol style="list-style-type: none"> 1. services or activities provided in Vote: Health-funded residential facilities (including residential facilities for people with disabilities) 2. mental health services 3. services funded through an individualised funding package.

Area	Key observations
Caveats	<p>The following caveats apply:</p> <ol style="list-style-type: none"> 1. All three funders (Ministry of Health, ACC and the DHBs) apply a national pricing model that is sufficient to support a regularised workforce. 2. The DHBs take a consistent price/cost approach to the funding of HCSS under a national contract. 3. All recommendations in this report are fully funded (to avoid future risks to the safety of clients, or to the workforce, or to the sustainability of the service providers). <p><i>Implementation of regularisation will not be possible without national pricing and national contracting.</i></p> <p>In addition, it should be noted that, in principle, ACC supports the recommendations for moving towards a regularised HCSS workforce as it relates to Vote: Health funding. ACC has provided advice on and support for the development of these recommendations and is committed to supporting the regularisation of the HCSS workforce, but notes that because ACC is not a party to the Settlement Agreement, ACC is not covered by these recommendations.</p> <p>Once the recommendations have been finalised by the Director-General's Reference Group and the Minister of Health, ACC will consider what operational, contractual and pricing changes will be needed to support their providers to move towards a regularised HCSS workforce. This process will be subject to approval from ACC's executive and board, as well as the Minister for ACC.</p>
Potential risks to be mitigated to support the transition to regularisation	<p>Before implementation of regularisation, there are a number of potential risks that must be considered and mitigated:</p> <ol style="list-style-type: none"> 1. the impact of client choice on a regularised workforce (ie, the more client choice, the greater the impact on service delivery and provider costs) 2. workers' preference for guaranteed hours, as not all will wish all or part of their hours to be guaranteed 3. ACC has not yet undertaken work relating to non-utilisation rates 4. should ACC not offer guaranteed hours, this will have a significant impact on providers' ability to deliver guaranteed hours in accordance with the recommendations set out in the report.

Key Findings

Area	Description
Summary	<ol style="list-style-type: none"> 1. Regularisation of the home and community support service (HCSS) workforce is both feasible and desirable for all parties and will support all service delivery models. 2. The benefits of regularisation include: <ol style="list-style-type: none"> a. increased quality and consistency of services delivered to clients b. increased worker capability to be responsive to client needs, greater certainty of employment and income for workers, support for worker training, recognition of training for workers, and a better articulated career pathway for Support Workers c. enhanced provider capacity to be able to recruit and retain their workforce, to be responsive to fluctuations in client needs, and to respond to changing models of care d. increased consistency and transparency in the basis for determining service delivery funding, increased accountability of providers for the use of allocated funding, and access to improved workforce and service delivery. 3. There are risks for all parties in regularising the HCSS workforce. <ol style="list-style-type: none"> a. <i>For clients:</i> clients may have less choice about who delivers services to them and, potentially, when those services are delivered, although these disadvantages are expected to be offset by enhanced quality and consistency of services. b. <i>For Support Workers:</i> Support Workers may lose the flexibility of being able to agree a variation to rostered service delivery times at short notice in order to accommodate unplanned events (depending on rostering and organisational practices). c. <i>For providers:</i> providers may not have sufficient ongoing client volumes or funding to support a regularised workforce, although this can be managed through change management processes to review the number of guaranteed hours individuals have across the workforce. d. <i>For funders:</i> funding to support a regularised workforce will be increased in the short term (and on an ongoing basis). However, the expected benefits in service consistency and quality and the positive impact on supporting people to remain in the home longer may only become evident in the long term. 4. A staged whole-of-sector approach to the transition to a regularised workforce is recommended. This includes setting up a transition group to have oversight of, and manage, the transition process. The Transition Group must include the participation, as equal partners, of: the Ministry of Health (in its role as manager of Crown funding), the Ministry of Health (as funder of Disability Support Services), ACC, DHBs (in their capacity as funders and providers), and provider, union and client representatives. 5. This report recommends a suite of interventions that must be implemented in their entirety if regularisation (as described in the Settlement Agreement) is to be achieved. The interventions set out here must not be implemented separately over a period of time, irrespective of the proposed length of time. To do so would jeopardise the potential success of the initiative and, importantly, prompt the loss of good will on the part of the DHBs, providers and unions as parties to the Settlement Agreement.

Area	Description								
	<p>6. A separate initial Crown Budget bid is necessary to ensure the sustainability of the sector in advance of regularisation and retention of the current workforce. This budget bid should be sufficient to ensure that all providers are able to allocate \$27.76 per hour per Support Worker (exclusive of in-between travel payments) as a baseline. With payment of the baseline, providers should be expected to pay a minimum of \$15 per hour per Support Worker prior to regularisation and prior to the application of wage rates linked to qualifications. Further work is required to determine the level of funding recommended.</p> <p>7. To support regularisation, sufficient additional Crown funding must be allocated to enable funders and providers to implement each stage of transition to a regularised workforce. An expectation of funding for regularisation is that funding allocation should be linked to contractual performance.</p> <table border="1" data-bbox="562 539 2096 1062"> <tr> <td data-bbox="562 539 1021 592">The cost implications of:</td><td data-bbox="1021 539 2096 592">have been estimated at an increase to current baseline funding of:</td></tr> <tr> <td data-bbox="562 592 1021 711">i) Support Worker wages being paid on the basis of the required levels of training</td><td data-bbox="1021 592 2096 711">between 5.87% and 14.6 % (with the higher rate aligned to a remuneration framework comparable to that applicable to DHB-employed Health Care Assistants)</td></tr> <tr> <td data-bbox="562 711 1021 831">ii) providing paid training time to enable obtaining the Level 3 New Zealand Certificate qualification</td><td data-bbox="1021 711 2096 831">1.17%</td></tr> <tr> <td data-bbox="562 831 1021 1062">iii) the majority of support workers being employed on guaranteed hours</td><td data-bbox="1021 831 2096 1062">2.49%, which includes: <ul style="list-style-type: none"> a. a time allowance of 0.5 hours per week per Support Worker of non-revenue-generating time (meetings, supervision, quality control, mentoring) b. a 3% addition to price, in recognition of the risk of being required to pay workers for non-revenue-generating time (where 51% of Support Workers are employed on guaranteed hours)(may increase up to an estimated 20% when 80% are employed on guaranteed hours). </td></tr> </table> <p>The cumulative cost implications are an increase to baseline of between 11.54% (\$60.23 million) and 20.74% (\$108.26 million), with the higher rate aligned to a remuneration framework comparable to that applicable to DHB-employed Health Care Assistants.</p> <p>The 2013/14 DHB and Ministry of Health Disability Support Services (DSS) actual spend, plus budgeted In-Between Travel funding, has been used to determine baseline costs of \$522 per annum (\$295 million DHB costs, \$189 million DSS costs and \$38 million In-Between Travel funding).</p> <p>8. Should regularisation not be implemented, many commentators (including Deloitte Touche Tohmatsu Limited in their 2015 <i>Financial Review & Risk Analysis of the Home and Community Support Sector</i>) have argued that the HCSS sector will be unsustainable. This will have a serious ongoing negative impact on service delivery and maintenance of service quality.</p>	The cost implications of:	have been estimated at an increase to current baseline funding of:	i) Support Worker wages being paid on the basis of the required levels of training	between 5.87% and 14.6 % (with the higher rate aligned to a remuneration framework comparable to that applicable to DHB-employed Health Care Assistants)	ii) providing paid training time to enable obtaining the Level 3 New Zealand Certificate qualification	1.17%	iii) the majority of support workers being employed on guaranteed hours	2.49%, which includes: <ul style="list-style-type: none"> a. a time allowance of 0.5 hours per week per Support Worker of non-revenue-generating time (meetings, supervision, quality control, mentoring) b. a 3% addition to price, in recognition of the risk of being required to pay workers for non-revenue-generating time (where 51% of Support Workers are employed on guaranteed hours)(may increase up to an estimated 20% when 80% are employed on guaranteed hours).
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Recommendations proposed by Working Group 2 for regularisation

Area	Recommendations
Establishment of the Transition Group Wage rates consistent with those in the established remuneration scale for workers performing similar tasks and requiring similar qualifications Majority of workers employed on guaranteed hours	<ol style="list-style-type: none"> 1. A cross-sector transition group should be established to implement, assess, monitor and review progress towards the achievement of regularisation, ensuring employees have adequate independent representation, and employers are supported to comply with the settlement and legal requirements. The transition group should include representatives of the Settlement Agreement parties, including the Ministry of Health, ACC, DHBs, providers, unions, and clients. Consideration should be given to ensuring the interests of Māori, Pacific people and rural and small providers are taken into full account. 2. It is recommended that: <ol style="list-style-type: none"> a. wage rates be consistent with those contained in an established remuneration scale, whereby workers are expected to have comparable skills, responsibilities and knowledge to meet the needs of similar clients and undertake similar tasks (eg, Health Care Assistants working for DHBs) b. funding be included in a consistent price/cost model to enable paid training to Level 3 for all Support Workers. 3. It is recommended that: <ol style="list-style-type: none"> a. provisions covering employment status, guaranteed hours and changes to employee hours of work be included in employment agreements b. the initial level of guaranteed hours be set at the 51% model, taking into consideration the associated caveat regarding funding availability [Under the 51% model, providers are expected to achieve the following <i>minimum</i> targets for guaranteed hours by the end of the first year: <ul style="list-style-type: none"> a minimum of 51% of each provider's total workforce has guaranteed hours a minimum of 51% of each provider's contracted hours will be guaranteed each Support Worker with guaranteed hours will have their last three months of hours reviewed, and the hours deemed to be permanent will make up the number of hours guaranteed, to a maximum of 40 hours per week.] c. the percentage of workers on guaranteed hours increase over time to meet staged implementation milestones [Over a three-year period from the date of the signing of the Settlement Agreement, all providers will be required to work towards the aspirational goal of 80% of their workforce being on guaranteed hours (taking into account the requirements of the Employment Relations Act 2000).] d. the price/cost model include a percentage to recognise provider risk (nominally set at 3%). [Australian reports indicate the level of risk increases up to 20% depending on the percentage of a worker's hours that are guaranteed and the degree of client choice taken into consideration.] e. more work be undertaken to ascertain the level of risk that needs to be included in the price/cost model for providers before implementation, because the current figure of 3% is an estimate developed to illustrate the price/cost model and needs to be subject to further consideration f. further investigation be undertaken into the impact of guaranteed hours on client choice and what can be done to address this

Area	Recommendations
<p>Enable training to Level 3 within two years</p> <p>Implementation of a national service-level contract</p> <p>Determining the funding envelope for service delivery</p> <p>Application of a price/cost model to identify service delivery costs</p> <p>Price/cost to be reviewed annually</p> <p>Reporting, monitoring and compliance</p>	<p>g. change management processes be agreed in advance of the introduction of guaranteed hours.</p> <p>4. It is recommended that the following arrangements for training be implemented:</p> <ul style="list-style-type: none"> a. all Support Workers are enabled to undertake training for a Level 3 qualification within two years of commencing work b. Support Workers are paid for training at their usual hourly rate c. training (normally) takes place at work using an embedded (in-house) training model. <p>5. A national service-level contract that includes service delivery specifications similar to the Aged Related Residential Care Agreement (ARCC) model be implemented.</p> <p>6. It is recommended that:</p> <ul style="list-style-type: none"> a. progress towards implementation of the Health of Older Persons' client assessment model (InterRAI) assessment be accelerated, with full implementation expected by the end of 2016 b. funders determine their funding envelope for HCSS based on identified packages of care and service volumes c. funders determine packages of care for recipients of HCSS, based on assessment outcomes d. funding is based on agreed national average inputs per case-mix category. <p>[Each client is allocated a 'package of care' based on their InterRAI-assessed case-mix category. Each case-mix category funding would be based on agreed national average inputs (with nationally agreed maximum inputs per case-mix category), calculated at the agreed national pricing level. Those clients requiring services above the nationally agreed maximum inputs per case mix are agreed between the parties and funded on a 'fee-for-service' basis.]</p> <p>7. It is recommended that:</p> <ul style="list-style-type: none"> a. the HCSS Costing Template (the 'price/cost model'), jointly developed by the DHBs through the Health of Older People Steering Group and the New Zealand Home Health Association¹⁵ in 2014, be used to determine the price of service delivery for aged care HCSS services, and that this form the basis of negotiation for the annual review of the national HCSS contract (noting that this would be under a sector representative framework and would use a process similar to the annual aged residential care contractual review). b. the price set in funder/provider negotiations be reviewed annually c. providers and funders meet contractual expectations relating to the implementation of regularisation and provide regular data in accordance with compliance requirements.

¹⁵ DHB Shared Services. 2015. Home based support services costing template. Available at: health.nz/Site/Health-of-Older-People/-HBSS-Template.aspx, accessed 12 June 2015.

Transitional arrangements to achieve regularisation

Area	Key observations
Objective	The viability of HCSS depends on the transition, at one time, of all the measures that make up a regularised workforce (ie, paid training; wages linked to the required levels of training; guaranteed hours; and safe and fair workloads, in accordance with the timetable set out here). Implementation of a complete package will enable recruitment and retention problems to be addressed and will create a more experienced and stable workforce, well placed to meet increasing demand in the future.
Timeframe for implementation	Transitioning to a fully regularised workforce, as defined by the Settlement Agreement, is only achievable within 36 months of the signing of the Settlement Agreement and will require a careful and consistent approach, provider by provider, to ensure no disadvantage to the workforce, and buy-in by employers, workers and providers through education and robust consultation.
Essential prerequisite: sufficient funding and accountability mechanisms	<p>The following paragraphs set out the transitional arrangements required to enable regularisation within a 36-month period from the date of the Settlement Agreement having been signed.</p> <p>A separate initial Budget bid for new Crown funding must be made to ensure:</p> <ol style="list-style-type: none"> providers' ability to support the allocation of baseline funding equivalent to \$27.76 per worker (excluding in-between travel payments) and \$32.50 per worker (including in-between travel payments) and payment of an initial minimum entry wage rate of \$15 per hour support for transition to a regularised workforce.
Staged approach to transition	<p>Funders and providers will need to be assured that sufficient funding is available to support regularisation of the home and community support workforce.</p> <p>Providers will need to demonstrate accountability through meeting staged contractual obligations before full funding is allocated.</p> <p>The total quantum required for implementation of regularisation has been estimated at between \$60.23 million and \$108.26 million, with the higher rate aligned to a remuneration framework comparable to that applicable to DHB-employed Health Care Assistants. This funding is <i>additional</i> to that appropriated for payment of in-between travel.</p> <p>It is not anticipated that the total quantum of funding to support regularisation will immediately be available to funders for allocation to providers, but that sufficient funding to support each stage of transition to a regularised workforce be made available to providers to support implementation in accordance with an agreed timeframe for the implementation of each stage.</p>

Area	Key observations
Transition Stage One (anticipated to take at least 12 months)	<p>Transition Stage One requires:</p> <ol style="list-style-type: none"> any suggested rates or funding estimates included in this report to be peer reviewed and verified by an independent party before this report is published and verified by the parties to the Settlement Agreement consideration of the impact of client choice on a regularised workforce, because this will have an impact on service delivery and provider costs completion of all InterRAI assessments for persons aged over 65 the development and agreement of contract service specifications for persons aged over 65, for inclusion in a national contract a review of the experience of other health sectors, such as the Australian introduction of guaranteed hours for the home and community support workforce, and/or New Zealand experiences, to analyse the risk of non-utilised (non-revenue-generating) time the Ministry of Health, in conjunction with all stakeholders (including funders, DHBs, providers and unions), to establish a national contract similar to the current Aged Related Residential Care (ARRC) agreement, which will include service specifications that: <ul style="list-style-type: none"> mandate the use of the price/cost model (developed in 2014 by the DHB Health of Older People Steering Group and the (now) Home and Community Health Association) for HCSS as a basis for negotiations between DHBs and providers with respect to aged care services include annual contracting mechanisms that enable statutory requirements that affect price to be taken into account the establishment of an education and support programme that will inform funders, providers, unions, workers and clients of the purpose of regularisation, the processes of transitioning to a regularised workforce, and their role and obligations in relation to this transition providers to complete a stocktake of current workers' hours, rostering, existing qualifications and casework allocation reporting on the delivery of associated milestones and outcomes.
Transition Stage Two (to be undertaken concurrently with Stage One and completed within six months of Stage One's completion)	<p>Transition Stage Two requires:</p> <ol style="list-style-type: none"> changes to individual and collective employment agreements to be negotiated and agreed in accordance with employment law DHBs to transition to the funding allocation being determined on a case-mix volume basis: the formula for determining this will be identified/agreed in Transition Stage One allocation of up-front funding to DHBs to transition to a 51% guaranteed hours model and link wages to qualifications [Under the 51% model, providers are expected to achieve the following <i>minimum</i> targets for guaranteed hours by the end of the first year: a minimum of 51% of each provider's total workforce has guaranteed hours a minimum of 51% of each provider's contracted hours will be guaranteed each Support Worker with guaranteed hours will have their last three months of hours reviewed, and the hours deemed to be permanent will make up the number of hours guaranteed, to a maximum of 40 hours per week (noting the associated caveat that this will depend on appropriate funding which must be based on analysis of non-utilisation rate and other factors, such as turnover (of clients and staff)). providers to recognise current qualifications, link wages to qualifications, and demonstrate through completion of regular reporting that this

Area	Key observations
Transition Stage Three (to be undertaken concurrently with the latter six months of Stage Two and completed within a further six months)	<p>expectation has been met</p> <ul style="list-style-type: none"> e. allocating required funding to support training to enable all Support Workers to have access to Level 3 qualifications f. reporting on the delivery of associated milestones and outcomes. <p>Transition Stage Three requires:</p> <ul style="list-style-type: none"> a. implementation of increases in each element of the 51% guaranteed hours model b. reporting on the delivery of associated milestones and outcomes.

1. Background

Area	Key observations
Purpose	<p>The purpose is to provide advice to the Director-General's Reference Group on the impact and affordability of a transition to a regularised home and community support service workforce. A regularised workforce is one that has:</p> <ul style="list-style-type: none"> the majority of workers employed for a guaranteed number of hours paid training to enable Support Workers to gain Level 3 New Zealand Certificate qualifications wages paid on the basis of required levels of training a case-mix / case-load mechanism to ensure a fair and safe allocation of clients to Support Workers. <p>The benefits of moving to a regularised Support Worker workforce are transferable across all service delivery models. A well-trained workforce, working guaranteed hours (with support from a casual, fixed-term workforce), will be able to deliver high-quality health care and respond to future fluctuations in demand. A regularised workforce will be well placed to accommodate any changes in service delivery models.</p> <p>The terms of reference for the report are set out in Part B to the Settlement Agreement between the providers of HCSS, the unions representing Support Workers, and the DHBs and the Crown as funders of those services.</p>
Costing model	<p>In 2014 the DHB Health of Older People Steering Group in conjunction with the (now) Home and Community Health Association developed a Home Support Services Costing template to articulate the costs and service inputs of a home-based service on a per-hour basis. The costing model template is published on the DHB Shared Services website to inform discussions and decision-making on service investment and pricing decisions to ensure that sustainable, cost-effective home and community services are maintained across the country.</p> <p>This template is suitable for all funding arrangements, including fee-for-service, restorative care and a case-mix approach to funding. It is intended to make provider and DHB funding decisions transparent, and to itemise the standard costs associated with the delivery of HCSS. The template has been used throughout the report to illustrate the cost implications of regularising the HCSS workforce. A copy of the template and the assumptions underpinning it can be found in Appendix 4.</p> <p>The Ministry of Health uses a similar costing template to discuss and agree the contract price for providing home-based services to disabled people (currently \$26.10 per hour), not taking into account the costs of in-between travel.</p> <p>Providers operate within a competitive environment and may choose to offer higher wage rates to attract and retain staff and to compete for DHB contracts on the basis of workforce skill mix and quality of service provision. Alternatively, they may wish to compete on the basis of reduced overhead and/or margin costs. DHBs may choose to make strategic decisions to invest more in home and community services in the immediate term in anticipation of longer-term savings generated as a result of people being able to continue to live in their homes.</p>

Area	Key observations																																		
Ministry of Health Home and Community Support Service Workforce Survey 2015	<p>The principal source of workforce data in this report is the Ministry of Health 2015 Home and Community Support Service Workforce Survey. The 76 providers listed in the In-Between Travel Settlement Agreement were asked to supply workforce demographic data, including Support Worker hours worked, for the four-week period from 9 February to 8 March 2015. The results of the survey are incorporated in the various sections of this report.</p> <p>The Ministry received 33 responses to a standard questionnaire from a variety of small and large providers, a response rate of 42%. Collectively, the responses provide wage data covering 11,288 community support service workers. Not all providers were able to supply all of the requested information, and the analysis varies for each component. The applicable sample size is noted in each section. The data is considered to be representative of the sector, and therefore conclusions can be drawn on the demographics of the workforce and, in particular, the probable impact of transitioning to a regularised workforce.</p> <p><u>Table 8:</u> Number of Home and Community Support Workers, by employer size*</p>																																		
	<table><tr><th rowspan="2">Provider size (number of Home and Community Support Workers on payroll)</th><th rowspan="2">Number of providers</th><th colspan="2">Average number of Home and Community Support Workers (3-week average)</th></tr><tr><th>Employed by each provider</th><th>Worked during the survey period</th></tr><tr><td>1–50</td><td>12</td><td>26</td><td>24</td></tr><tr><td>51–100</td><td>7</td><td>62</td><td>59</td></tr><tr><td>101–200</td><td>5</td><td>161</td><td>156</td></tr><tr><td>201–300</td><td>3</td><td>248</td><td>180</td></tr><tr><td>301–600</td><td>3</td><td>415</td><td>408</td></tr><tr><td>1501+**</td><td>12</td><td>2344</td><td>2680***</td></tr><tr><td>Total</td><td>33</td><td>N/A</td><td>N/A</td></tr></table>	Provider size (number of Home and Community Support Workers on payroll)	Number of providers	Average number of Home and Community Support Workers (3-week average)		Employed by each provider	Worked during the survey period	1–50	12	26	24	51–100	7	62	59	101–200	5	161	156	201–300	3	248	180	301–600	3	415	408	1501+**	12	2344	2680***	Total	33	N/A	N/A
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	<p>* 33 providers, 11,288 Home and Community Support Workers.</p>																																		
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2. Growing demand and more complex care for HCSS

Area	Key observations
Growing demand for home and community support services	<p>The demand for HCSS is expected to grow as the proportion of New Zealanders aged 65 and over increases faster than ever before relative to the rest of the population. People in the over-85 years age group are often living with chronic long-term conditions and comorbidities. The Ministry of Health reports that in 2012/13 approximately one in four people aged 85 years and over lived in aged residential care, which means that an estimated 75% of this age group were still living in their own homes. Government policy supports older people staying in their homes for as long as they can safely do so. The opportunity to live at home is the preferred option for many disabled clients as well.</p>
The high cost of hospital and residential care	<p>The generally higher cost of health care delivered in hospital and residential settings, together with increasing demand, has highlighted the importance of fit-for-purpose, sustainable HCSS health care services for people with long-term conditions and age-related illnesses.</p>
Addressing service delivery risks	<p>Safe and high-quality home and community support services are achievable if the sector is funded at a level that reflects the actual costs of delivering home and community support services, and attention is paid to putting in place efficient infrastructure to support the delivery of high-quality services. This means the introduction of a sustainable funding model, a national contracting arrangement across the DHBs for the funding of services to older people, and a national pricing model (which spans DSS and ACC, though it may result in a different price). Future models of service delivery will need to respond efficiently to meet a range of client outcomes, including the growing demand for complex care.</p>
The need for regularisation	<p>To be sustainable the sector needs to develop and retain a workforce that is capable of delivering care to more clients, and to more clients with complex care needs. The Ministry of Health <i>2014 Briefing to the Incoming Minister</i> identified the need to build and support this workforce. The Ministry noted that:</p> <p>“In particular, an ageing population with increasingly complex needs will require more and better-trained home-based and residential carers to support older people with long-term conditions, either living in their own homes or in residential care.</p> <p>Good home-based care reduces demand for aged residential care and can be lower cost, depending on the level of support required.</p> <p>Implementing new ways of working requires the ability to influence key decision-making across that whole system and an explicit ability to incentivise the shift. It requires an integrated approach to align the different moving parts, such as workforce, models of care, information systems, clinical and corporate governance arrangements, regulatory and funding settings” (p.2).</p> <p>The parties to the In-between Travel Settlement Agreement agreed that (clause 1.4):</p> <p>A regularised employment model is expected to be beneficial for all parties involved and will ensure continued viability of HCSS as a cost effective alternative to residential care. Regularisation of the HCSS workforce will allow the majority of home care workers to be paid wages based on a regular employment model. This model will help ensure that there are no reductions to client hours as a result of travel time.</p>

Area	Key observations
The need for regularisation (continued)	<p>The 2015 BERL report <i>Improving the Productivity of Home and Community Support Services</i>, prepared for the Aged Care Industry Training Organisation (ITO) Careerforce, notes that:</p> <p><i>“The workforce is not engaged for regular hours of work, with the burden of training in many instances being placed on the worker. The work lacks status, with many on close to the minimum hourly rate and little exposition of any career path or opportunities to progress in the sector. Better work conditions, terms and status, including regular hours, will help improve staff retention and therefore reduce recruitment costs. Any long-term improvements in the quality and continuity of care spells wider savings for the health and community care budget by keeping people out of hospital beds or residential care settings for longer. However, these savings will only occur if the home and community support workforce is appropriately trained and qualified to meet the increasingly diverse needs of clients. Without properly functioning home and community support services, additional costs will fall on other components of the health system (or on other community support agencies). In essence, spending even more money on hospitalisation and residential care instead is the alternative”</i> (p. 2)</p>
Implications for clients	<p>Several principles need to underpin service delivery, regardless of the funder. The workforce must be trained to deliver safe and competent care that recognises the cultural needs of the individual and whānau/family, bearing in mind that this is not a 'one size fits all' model of care. This also applies to any substitute worker who steps in when a regular worker is away. That person should be briefed on the needs of the client so that the client is not required to update the Support Worker on the content of their care plan at the beginning of a visit.</p> <p>Support Workers need to be reliable, responsible and respectful. They need to protect a client's right to privacy and recognise the consequences for the client of any failure to keep an appointment or to arrive late. Providers are encouraged to coordinate the transport arrangements of a disabled client who wants to travel to work; for example, at the appropriate time and not two or three hours later.</p> <p>This puts pressure on providers to meet the needs of clients at busy times of the day, such as between 7 and 9 a.m. It means that providers must prioritise service delivery when insufficient numbers of staff are available to meet demand. Not all clients will be able to have personal care services delivered at a preferred time at these times of the day (although services critical to a client's health would be a matter of priority).</p> <p>Providers are also responsible for providing each client with a seamless 'invisible' service even if a regular Support Worker is unavailable. Clients do not want to be involved in rostering or rescheduling rearrangements resulting from Support Worker availability. They want care to be delivered at the agreed time to a high standard by a competent Support Worker. Some degree of flexibility is required on the part of providers delivering a client-centred service that allows clients to have varied routines and take part in community activities.</p>

3. The home and community support workforce

Area	Key observations
Future workforce	<p>Treasury's <i>2014 Briefing to the Incoming Minister</i> pointed out that the success of a shift towards home-based care depends on the workforce that delivers it. In relation to the home and community care workforce, Treasury said that:</p> <p style="padding-left: 40px;">We need to look more closely at the role of the care and support workforce in the aged care and disability support sectors. This workforce is important to the health sector's capability to respond to the ageing population and the increasing prevalence of chronic disease. It is important to the wider workforce because it allows other health workers such as nurses to concentrate on tasks that make better use of their training. A well-functioning, appropriately trained care and support workforce enables people with more complex health needs to be cared for in their home for longer and facilitates earlier discharge from hospital, freeing up hospital beds with a positive impact on patient flows and efficiency.</p>
Long-term vision for the Support Worker workforce	<p>A long-term vision for the Support Worker workforce is that:</p> <ul style="list-style-type: none"> (i) levels of turnover reduce to align with general workforce trends (generally between 8 and 15%) (ii) Support Workers will be qualified and work as part of a multidisciplinary team (iii) there is a career path for Support Workers (iv) a wider demographic, including young people, join and remain in the workforce (v) the scope of practice of experienced staff is extended to meet the demand for increasing acuity of care (vi) there are appropriate levels of supervision and client assessment to avoid the risks to clients, Support Workers, providers and funders from inadequate service delivery.
Current workforce profile and dynamic	<p>The Ministry of Health 2015 HCSS Workforce Survey confirms that, compared with the total New Zealand labour force, the current Support Worker workforce is female dominated (91% are women) and has an older age profile (54% are aged between 45 and 64). The largest identifiable ethnic group is European (28%), followed by Pacific people (11%). Ethnicity was reported as 'unknown' for 42% of respondents to the survey. As this cohort ages it is not being replaced by younger workers, who are more likely to seek employment with a guaranteed income and potential career path.</p> <p>The home and community service sector operates 24/7, with higher client demand at certain times of the day, particularly in the early morning and late afternoon. This variability of demand has driven an employment model that relies heavily on assignment workers (incorrectly treated as casuals) working split shifts, supported by agency temp staff. The Ministry of Health 2015 Workforce Survey shows that most of the estimated 24,000 Support Workers work part-time, at an average of 21 hours per week (based on an analysis of the hours worked by 7877 workers over a four-week period).</p> <p>The Deloitte Report found that providers were finding it difficult to recruit and retain staff because of an improving economy and perceived superior opportunities elsewhere.¹⁶ Historically, high turnover leads to a loss of investment in Support Worker training on the part of providers, who find it difficult to recruit trained Support Workers. The work lacks status, and there are few opportunities for career development or progress for Support Workers within the sector. Some clients and the condition of their homes can create a challenging working environment for Support Workers.</p>

¹⁶Deloitte, 2015. *Financial Review & Risk Analysis of the Home and Community Support Sector*. Commissioned by the Home and Community Health Association.

Area	Key observations
Current workforce profile and dynamic (continued)	<p>As a consequence, many Support Workers are drawn away by other job opportunities that offer higher wages in less demanding conditions.¹⁷ Some Support Workers move in and out of home and community support services and hold down more than one job to make ends meet. A high degree of knowledge and skill is often acquired by Support Workers who remain in the sector, and this is lost when they leave for better-paid work.¹⁸</p> <p>The employment model is based on the assigned client's needs, which may be ongoing or short term. In the course of a day the same Support Worker might provide services to clients who are funded from one or more of three funding streams (the Ministry of Health for people with disabilities, DHBs for people over 65 years of age, and ACC for people with injuries).</p> <p>Support Workers work independently in vulnerable people's homes with very little supervision or oversight. Provider representatives report that the sector is not funded to put in place suitable performance management and supervisory systems to support and check on Support Workers operating in these conditions. They also advise that they are not compensated to meet increasing compliance costs when, for example, new legislation imposes requirements on funders and providers relating to the health and safety of their workforces.</p> <p>Funding and wages are linked to service provision, and a worker's income is likely to be lower in any week when a regular client does not require the service (eg, because the client is away or in hospital) and the employer is unable to set up an alternative client visit to make up the shortfall. This also results in the worker using annual leave entitlements to make up their wage, leaving little for adequate rest and recreation. Providers report frustration that current funding arrangements limit their opportunities to provide additional workforce support through regular team meetings, ongoing access to supervision, and mentoring/buddy arrangements for inexperienced staff.</p> <p>The Ministry of Health 2015 Workforce Survey shows that the HCSS workforce:</p> <ul style="list-style-type: none"> (i) is becoming more highly qualified but continues to be paid at or close to the Minimum Wage: 46% have a Level 2 or 3 NZQA qualification, of whom 62% are paid under \$15 per hour (41% at the current Minimum Wage of \$14.75 per hour), and generally there is no specific recognition of qualifications in wages, although some receive an allowance (ii) increasingly works consistent hours but has no guaranteed hours of work on a weekly or annual basis: over a four-week period (9 February to 8 March 2015) 41% of those who worked had consistent hours for two of the four weeks; a further 20% had consistent hours for three of the four weeks; and a further 19% had consistent hours for each of the four weeks. <p>Note: the survey did not report on whether there was any consistency in the time of day or days the hours were worked.</p>

¹⁷ CL Stacey. 2011. *The Care Self- the Work Experiences of Home Care Aides*. Ithaca, NY: Cornell University Press.

¹⁸ Ibid.

4. Current funding arrangements

Area	Background information
Overview	<p>DHBs and the Ministry of Health pay a range of prices for the delivery of home-and community-based care. The Ministry pays the same rate (\$26.14 per hour plus rural travel) for household support and personal care. The price paid for the delivery of household support (assistance with housework) and personal care varies from DHB to DHB, with the price for household management ranging from \$21.26 to \$25.99, and personal care rates ranging from \$24.21 to \$34.06.</p> <p>Many DHBs have shifted their focus from household support to personal care, in line with a restorative and person-centred approach to home-based care. Fifteen DHBs pay providers on the basis of a 'fee-for-service' model (where a provider is paid for the number of hours it delivers). Five have moved to a bulk-funding model that applies what is referred to as a case/load case/weighted approach. This approach is explained in subsequent paragraphs.</p> <p>The variation in pricing and funding models reflects strategic decisions made by DHBs.</p> <p>A provider of HCSS contracted by the Ministry of Health, DHBs and ACC is paid different rates by each funder, yet may send the same worker to deliver care to a disabled client, an older client or an injured client on the same day. Some providers 'cross-subsidise' in order to pay Support Workers the same hourly rate, irrespective of the funder. Others are concerned about the risks attached to this approach and pay different hourly rates depending on the funder.</p> <p>Historically (and currently) DHB pricing for HCSS has not been based on a fully costed model. DHB funding increases have not kept up with increases in the Minimum Wage and other inflationary pressures. Over the past seven years only three DHBs, ACC and the Ministry of Health have provided increases in the price for HCSS of more than the Minimum Wage.¹⁹</p>
Addressing problems with the current pricing model	<p>To meet Minimum Wage, Kiwisaver contributions and ACC rates obligations, providers have reduced costs by: reducing coordinator to Support Worker ratios; discontinuing pay increases and performance reviews; delaying investment in capital expenditure and maintenance; and not replacing administrative or infrastructure staff. An accumulation of funding shortfalls over time means that some providers are now operating with negative margins. The general picture is of a sector that is not sustainable at the current levels of funding.</p> <p>The price/cost model provides an opportunity to objectively illustrate the baseline costs of providing HCSS to older people. Applying actual values, where known, industry averages and the median Support Worker wage (\$15 per hour) and a 6% return on investment (margin) indicates that the baseline cost is \$27.76 per hour (increasing to \$32.50 with the addition of costs for in-between travel payments).</p> <p>This analysis indicates that additional funding is needed to lift the current price paid for HCSS (between \$21.26 and \$25.99 for household support and between \$24.21 and \$34.06 for personal care) to a fully costed model in advance of transitioning to regularisation. Provider representatives have indicated that moving to a fully costed funding model in advance of transitioning to a regularised Support Worker employment model will support a minimum pay rate of \$15 per hour per Support Worker.</p> <p>Further work is required to determine the level of funding needed to move to a fully costed model in advance of regularisation and the implications for funders.</p>

¹⁹Deloitte. 2015. *Financial Review & Risk Analysis of the Home and Community Support Sector*. Commissioned by Home and Community Health Association.

Area	Background information
Problems with fee-for-service and bulk funding arrangements	<p>Provider representatives report that the fee-for-service funding model is not well aligned to a restorative model of care. Clients' requirements for care are identified in the Needs Assessment and Service Coordination (NASC) assessment and defined as specific support to be provided in specified hours of service delivery. This approach promotes the delivery of services as tasks to be completed within a set number of hours, and there is minimal flexibility to vary either the tasks or the number of hours to reflect a client's changing needs without a further NASC assessment.</p> <p>Bulk funding can pose a greater risk to providers because funding is independent of volumes. If contractual agreements (ie, expected volumes and volume conditions and pricing increase adjustments) are not negotiated fairly or monitored correctly, providers can be at greater risk than under the 'fee-for-service' model.²⁰</p>
Addressing problems with fee-for-service and bulk funding arrangements (case mix)	<p>The funding risks for DHBs and providers are distributed more appropriately under the case-mix model. DHBs become responsible for the impact of their decisions with regard to both service entry and the 'related services' that have an impact on home support service levels (volume). DHBs are responsible for:</p> <ul style="list-style-type: none"> • the total volume of clients serviced (volume) • variations in the case mix of the client population (change in mix of client population complexity) • service referrals for non-standard clients, outside of normal case-mix variations (volume). <p>Providers manage the risk for:</p> <ul style="list-style-type: none"> • variation of inputs for a known number of appropriately allocated clients within case-mix categories (efficiency) • safe services by utilising appropriately competent and trained personnel (safety). <p>Nationally agreed minimum safety and service standards and worker competency criteria can be established for each case-mix category. Case mix also encourages Support Workers to work with older clients to maintain or regain a higher level of independence.</p>

²⁰Deloitte. 2015. *Financial Review & Risk Analysis of the Home and Community Support Sector*. Commissioned by Home and Community Health Association.

5. Impact and affordability of Support Worker wages being paid on the basis of the required levels of training of the worker

Area	Key observations
In-between Travel Settlement Agreement	<p>The parties to the Settlement Agreement agreed to explore the impact and affordability of Support Worker wages being paid on the basis of the required levels of training of the worker as part of regularising the home and community support workforce.</p> <p>The impacts of Support Worker wages being paid on the basis of the required levels of training within an attractive remuneration framework comparable to other workforces applying similar levels of skill, knowledge and expertise include:</p> <ol style="list-style-type: none"> 1. incentivising workforce development and career planning 2. increasing the visibility of workforce skill levels, improving Support Workers perceived status and value 3. addressing ongoing significant recruitment and retention pressures 4. aligning the value of the workforce with the value of the service the workforce provides in delivering home and community support services to older and disabled clients. <p>One caveat is that:</p> <p style="padding-left: 40px;">Funding levels must be sufficient and regularly reviewed to ensure that providers can sustain the ongoing cost of maintaining wage differentials based on training.</p>
Current state	<p>Generally there is no specific recognition of training or qualifications in Support Worker wages, and most Support Workers are paid at or close to the Minimum Wage, irrespective of any qualification they have. Providers who have introduced some recognition of skill differentials in wage rates report that differentials are rapidly eroded through unfunded increases in statutory minima (the Minimum Wage, Kiwisaver contributions and ACC rates). Based on information from the Ministry of Health 2015 Workforce Survey, the increase in the Minimum Wage from \$14.25 per hour to \$14.75 per hour improved or matched the existing pay rate of 43% of the workforce.</p> <p>The Ministry of Health 2015 workforce survey shows that the HCSS workforce is becoming qualified but continues to be paid at or close to the Minimum Wage. Thirty-one providers covering 4913 Support Workers (20% of the workforce) provided information on Support Worker wage rates and qualifications.</p>

Area	Key observations																																																								
Current state (continued)	<p>Figure 13: Percentage of Home and Community Support Workers with a recorded qualification, by hourly rate</p> <table border="1"><caption>Estimated data for Figure 13: Percentage of Home and Community Support Workers with a recorded qualification, by hourly rate</caption><thead><tr><th>Qualification</th><th>\$14.25</th><th>\$14.26-\$14.75</th><th>\$14.76-\$15.00</th><th>\$15.01-\$16.00</th><th>\$16.01-\$17.00</th><th>\$17.01+</th></tr></thead><tbody><tr><td>None</td><td>23%</td><td>18%</td><td>2%</td><td>1%</td><td>0%</td><td>0%</td></tr><tr><td>On the Job</td><td>38%</td><td>38%</td><td>40%</td><td>55%</td><td>18%</td><td>25%</td></tr><tr><td>NZQA Level 2</td><td>30%</td><td>20%</td><td>28%</td><td>15%</td><td>32%</td><td>20%</td></tr><tr><td>NZQA Level 3</td><td>8%</td><td>20%</td><td>20%</td><td>18%</td><td>38%</td><td>25%</td></tr><tr><td>NZQA Certificate</td><td>1%</td><td>1%</td><td>1%</td><td>2%</td><td>5%</td><td>15%</td></tr><tr><td>Graduate PostGrad</td><td>0%</td><td>0%</td><td>2%</td><td>1%</td><td>0%</td><td>2%</td></tr><tr><td>Other</td><td>0%</td><td>0%</td><td>5%</td><td>5%</td><td>5%</td><td>10%</td></tr></tbody></table>	Qualification	\$14.25	\$14.26-\$14.75	\$14.76-\$15.00	\$15.01-\$16.00	\$16.01-\$17.00	\$17.01+	None	23%	18%	2%	1%	0%	0%	On the Job	38%	38%	40%	55%	18%	25%	NZQA Level 2	30%	20%	28%	15%	32%	20%	NZQA Level 3	8%	20%	20%	18%	38%	25%	NZQA Certificate	1%	1%	1%	2%	5%	15%	Graduate PostGrad	0%	0%	2%	1%	0%	2%	Other	0%	0%	5%	5%	5%	10%
Qualification	\$14.25	\$14.26-\$14.75	\$14.76-\$15.00	\$15.01-\$16.00	\$16.01-\$17.00	\$17.01+																																																			
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NZQA Certificate	1%	1%	1%	2%	5%	15%																																																			
Graduate PostGrad	0%	0%	2%	1%	0%	2%																																																			
Other	0%	0%	5%	5%	5%	10%																																																			
Qualification framework	<p>The sector has worked closely with the ITO Careerforce to develop the New Zealand Health and Wellbeing qualification framework.²¹ This is the only measure of the required levels of support-worker training that is objective, transparent and able to be consistently applied across the sector. Three levels of support-worker skills, knowledge and expertise are recognised, with New Zealand Qualifications Authority certificates creating a career path towards attaining higher-level, more specialised qualifications.</p> <p>The three qualification levels recognise differences in the levels of support that clients may require. Level 2 recognises proficiency in the provision of person-centred support; Level 3, Health Assistance, recognises the skills and knowledge required to support and empower people in their home; and Level 4²² recognises expertise in advance support work, spinal injury support, or traumatic brain injury support.</p> <p>Anecdotally, staff turnover rates are between 20 and 40%, and the average tenure is 3.3 years. Providers report that higher starting rates of pay in roles that require similar levels of skills, knowledge and expertise available in other industries create recruitment and retention pressures. Recruitment and retention pressures reduce when entry rates, opportunities for pay increases and career development opportunities are comparable with other workforces applying similar skills, knowledge and expertise and providing comparable services.</p>																																																								

²¹The New Zealand Certificate in Health and Wellbeing qualification framework replaced the National Certificate in Health, Disability, and Aged Support qualification framework.

²²Currently under consultation with the sector and expected to be introduced in 2016.

Area	Key observations																																		
Potential remuneration framework	Within the health sector, DHB entry rates for comparable workforces are generally between \$1 and \$2.50 above the Minimum Wage and provide between \$0.75 and \$1.20 wage-step increases that recognise differences in performance, skills or qualifications. Increases are annual up to a maximum rate payable. The comparable turnover rates in DHBs are around 10% per annum.																																		
	The joint DHBs/industry cost and pricing tool was used to assess the effect of moving the support-worker workforce to a remuneration framework comparable to that of a similar DHB-employed workforce. The cost implications are illustrated below.																																		
	Table 9: Cost implications of wages linked to qualifications																																		
	<table><tr><th rowspan="2">Step increase</th><th colspan="2">\$1 above Minimum Wage</th><th colspan="2">\$2.50 above Minimum Wage</th></tr><tr><th>\$0.75 (comparable to DHB Home Aides)</th><th>\$1.20</th><th>\$0.75</th><th>\$1.20 (comparable to DHB Health Care Assistants)</th></tr><tr><td>No qualification rate</td><td>\$15.75</td><td>\$15.75</td><td>\$17.25</td><td>\$17.25</td></tr><tr><td>Level 2 Certificate rate</td><td>\$16.50</td><td>\$16.95</td><td>\$18.00</td><td>\$18.45</td></tr><tr><td>Level 3 Certificate rate</td><td>\$17.25</td><td>\$18.15</td><td>\$18.75</td><td>\$19.65</td></tr><tr><td>Level 4 Certificate rate</td><td>\$18.00</td><td>\$19.35</td><td>\$19.50</td><td>\$20.85</td></tr><tr><td>Increase in baseline cost</td><td>5.87%</td><td>8.53%</td><td>11.57%</td><td>14.6%</td></tr></table>	Step increase	\$1 above Minimum Wage		\$2.50 above Minimum Wage		\$0.75 (comparable to DHB Home Aides)	\$1.20	\$0.75	\$1.20 (comparable to DHB Health Care Assistants)	No qualification rate	\$15.75	\$15.75	\$17.25	\$17.25	Level 2 Certificate rate	\$16.50	\$16.95	\$18.00	\$18.45	Level 3 Certificate rate	\$17.25	\$18.15	\$18.75	\$19.65	Level 4 Certificate rate	\$18.00	\$19.35	\$19.50	\$20.85	Increase in baseline cost	5.87%	8.53%	11.57%	14.6%
	Step increase		\$1 above Minimum Wage		\$2.50 above Minimum Wage																														
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Increase in baseline cost	5.87%	8.53%	11.57%	14.6%																															
Notes	<p>The increase in baseline costs of Support Worker wages being paid on the basis of the required levels of training under the remuneration framework(s) in Table 2 above has been estimated using the price/cost model in Appendix 4.</p> <p>National qualification rates are assumed to be consistent with the Ministry of Health 2015 Workforce Survey results (see Figure 2 below).</p> <p>The assumption is that increase in baseline cost is from a baseline that has all Support Workers paid at \$15.00 per hour, which is the median rate calculated from the Ministry of Health 2015 Workforce Survey.</p>																																		

Area	Key observations
Comparative health sector wage rates	<p>The HCSS providers, DHBs and unions consider the DHB-employed Health Care Assistant workforce provides a comparable service to Support Workers and applies very similar skills, knowledge and expertise. Due to the isolation and lack of support and supervision, the demands on home Support Workers is much greater. The three parties consider that support-worker wage rates need to be aligned to the DHB-employed Health Care Assistant role in order to attract and retain a high-quality workforce on an ongoing basis. This is consistent with the recommendation of the Human Rights Commission in the 2012 report on equal employment opportunities in the aged care sector, <i>Caring Counts</i>.²³</p> <p>Current rates paid to DHB-employed Health Care Assistants range from \$17.02 to \$19.65 gross per hour over a four-step scale that does not have a requirement to hold a qualification to progress. These rates closely align with a support-worker remuneration framework with an entry rate at \$2.50 above the Minimum Wage and step increases of \$1.20 over four steps.</p> <p>DHB-employed home aides have similar roles to Support Workers. Rates paid range from \$15.48 to \$18.15 gross per hour over six steps linked to the level of qualification held. These rates closely align with a Support Worker remuneration framework with an entry rate at \$1.00 above the Minimum Wage with no qualifications and step increases of \$0.75 over four steps.</p> <p>The unions consider the DHB-employed home aide workforce applies skills, knowledge and expertise comparable to those of the DHB-employed Health Care Assistants. It advises that it has sought parity in rates over successive bargaining processes. The workforce is small, and the union contends that wage rates are principally driven by the larger orderly, cleaning and kitchen/laundry workforces, and the move by all but a handful of rural DHBs to exit their in-house services in favour of the work being taken over by providers contracted to the DHB funder arms.</p> <p>The providers and unions both consider a support-worker remuneration framework closely aligned to rates paid to DHB-employed home aides is not high enough to address recruitment and retention pressures on an ongoing basis. Both cite the DHB-employed Health Care Assistant role as the main health sector source of recruitment and retention pressures. Providers report that many of their most skilled and valued Support Workers leave at the first opportunity to move into these higher-paying roles.</p> <p>The unions have a pay equity proposal that uses an independently developed gender-neutral job evaluation of the Support Worker role to demonstrate that Support Worker skills, knowledge and expertise closely align with those of correction officer roles. Current Correction Officer rates range from \$23.33 to \$28.73 gross per hour over four steps linked to the level of qualification held.</p>

²³Human Rights Commission. 2012. *Caring Counts: Tautiaki tika*. Human Rights Commission.

6. Impact and affordability of providing paid training time to enable Support Workers to obtain Level 3 New Zealand Certificate qualifications

Area	Key observations
Background	<p>In 2011 the Auditor-General noted in the <i>Report on Home-based Services for Older People</i> that Support Workers were generally viewed as unskilled, and that better levels of training are required to develop staff and ensure they are able to provide the increasingly complex level of home and community support services that older people need. In a 2014 review of progress, the Auditor-General commented that the Ministry of Health and DHBs had made some progress in strengthening management contracts as a way of ensuring service providers' staff are adequately trained and supervised.</p> <p>Since 2011 the sector has worked closely with the sector Industry Training Organisation Careerforce to develop the New Zealand Health and Wellbeing qualification framework. This New Zealand Qualification Authority-recognised framework comprises the:</p> <ol style="list-style-type: none"> 1. New Zealand Health and Wellbeing Level 2 certificate, recognising proficiency in the provision of person-centred support 2. New Zealand Health and Wellbeing Level 3 certificate, recognising the skills and knowledge required to support and empower people in their home or community setting 3. New Zealand Health and Wellbeing Level 4 certificate, recognising expertise in one of three specialist areas of care: spinal injury, traumatic brain injury or advanced support work. <p>See Appendix 5 for detailed information about the content of Level 2 and Level 3 qualifications.</p> <p>Learning and assessment occur in the workplace, with support from providers. In general, funding is linked to service provision, and providers are not funded for time spent training or the costs of support, classroom training, verification and ITO costs. The workforce and the majority of Support Workers are not paid for their time being trained. The current model of self-directed learning takes the average Support Worker 18 months to two years to complete. Well under 50% of Support Workers are currently offered the opportunity to complete formal qualifications. Low rates of qualified Support Workers affect providers' ability to arrange travel rosters efficiently and to meet increasing demand for high-end care cases.</p> <p>Over the past five years the number of Support Workers achieving qualifications and the level of achievement has grown. In 2012 ACC introduced a requirement for specific worker qualification into contracts with lead suppliers, with the specific intention of increasing workforce skill level. This and any future investment in training will contribute to a training culture within the sector.</p> <p>The Ministry of Health 2015 Workforce Survey shows that the home and community support-worker workforce is becoming increasingly more qualified, although the overall percentages are still low. Thirty-two providers covering 8324 Support Workers (34.6% of the estimated 24,000 support-worker workforce) provided information on workforce qualifications (see Figure 14 and Table 10).</p>

Area

Background
(continued)

Key observations

Figure 14: Percentage of Home and Community Support Workers with a recorded qualification

Qualifications of Home and Community Support Workers

Source: Ministry of Health 2015 Home and Community Support Service Workforce Survey

Table 10: Number of Home and Community Support Workers with a recorded qualification, by employer size

Employer size	None	On the job	New Zealand Qualifications Authority			Graduate/ postgrad	Other	Total
			Level 2	Level 3	Certificate			
1–50	0	84 (39%)	33 (15%)	17 (8%)	5 (2%)	2 (1%)	72 (34%)	213 (100%)
51–100	36 (7%)	269 (54%)	78 (16%)	89 (18%)	11 (2%)	8 (2%)	5 (1%)	496 (100%)
101–200	108 (14%)	100 (13%)	272 (35%)	266 (34%)	19 (2%)	16 (2%)	2 (0%)	783 (100%)
201–300	134 (25%)	132 (24%)	92 (17%)	16 (3%)	1 (0%)	10 (2%)	154 (29%)	537 (100%)
301–600	0	511 (42%)	335 (27%)	337 (28%)	38 (3%)	1 (0%)	1 (0%)	1223 (100%)
1501+*	0	1742 (34%)	1919 (38%)	1281 (24%)	128 (2%)	0	0	5070 (100%)
Total	278 (3%)	2838 (34%)	2729 (33%)	2006 (24%)	202 (2%)	37 (0%)	234 (3%)	8324 (100%)

Source: Ministry of Health 2015 Home and Community Support Service Workforce Survey

* There are no or very few employers who have between 601 and 1,500 employees in 2015.

Area	Key observations											
In-between Travel Settlement Agreement	<p>The parties to the Settlement Agreement agreed to explore the impact and affordability of providing paid training time to enable Support Workers to obtain the Level 3 New Zealand Certificate qualification within two years of Support Worker commencing work, in line with the service needs of the population as part of regularising the home and community support workforce.</p> <p>The implications of providing workers with paid training time are that:</p> <ol style="list-style-type: none">1. funding levels need to be sufficient to ensure providers can sustain the ongoing cost of a proportion of the workforce being paid for time that is not generating revenue2. the 'hours of work' definition in Support Workers' employment agreements needs to include time rostered to attend required training.											
Impact and affordability	<p>The average cost to train a Support Worker has been estimated and is outlined in Table 11.</p> <p><u>Table 11:</u> Training Costs for Level 2 and Level 3 Certificate per Support Worker</p> <table><tr><th rowspan="2">Qualification</th><th colspan="2">Average per Support Worker</th></tr><tr><th>Training Time</th><th>Cost</th></tr><tr><td>New Zealand Health and Wellbeing Level 2 Certificate</td><td>2–9 hours</td><td>\$647</td></tr><tr><td>New Zealand Health and Wellbeing Level 3 Certificate</td><td>30 hours</td><td>\$1403</td></tr></table> <p>The model that was used to determine the average time and cost to train a support worker to obtain the Level 2 and 3 qualifications has been reviewed by Careerforce and is considered by the union, DHB and provider representatives to be fair, reasonable and practicable. The assumptions are that:</p> <ol style="list-style-type: none">1. all Support Workers will gain the Level 2 qualification as part of their pathway to the Level 3 qualification to address literacy and numeracy skill levels and provide the confidence for Support Workers to achieve academically2. providers will continue to internally assess workers against the qualification requirements and Support Workers to achieve qualifications3. the average time includes consideration of any additional literacy support that may be required for an individual Support Worker. <p>The positive impacts of paid training are expected to be:</p> <ol style="list-style-type: none">1. higher levels of confidence on the part of Support Workers – more skilled, better valued2. for the funder, confidence that the Support Worker is the right person to deliver care to a client3. for the provider, a reduction in risk to the quality of services, and an ability to acknowledge the value of the worker4. for the client, a better standard of care. <p>The cost implications of providing paid training time to enable the Support Worker workforce to obtain the Level 3 New Zealand Certificate qualification has been estimated at 1.17% of current baseline costs using the price/cost model in Appendix 4.</p>	Qualification	Average per Support Worker		Training Time	Cost	New Zealand Health and Wellbeing Level 2 Certificate	2–9 hours	\$647	New Zealand Health and Wellbeing Level 3 Certificate	30 hours	\$1403
Qualification	Average per Support Worker											
	Training Time	Cost										
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New Zealand Health and Wellbeing Level 3 Certificate	30 hours	\$1403										

7. Impact and affordability of the majority of workers being employed on guaranteed hours

Area	Key observations
In-between Travel Settlement Agreement	<p>The parties to the Settlement Agreement agreed to explore the impact and affordability of moving to an employment model where the majority of Support Workers are employed on guaranteed hours. The impacts of moving to such an employment model Support Worker include:</p> <ol style="list-style-type: none"> 1. easing the ongoing significant recruitment and retention pressures through certainty of work (and income) 2. continued employment of a flexible, casualised workforce available to respond to workload fluctuations 3. potentially reduced flexibility for Support Workers and clients to agree to deviate from rostered service delivery times at short notice in order to accommodate unplanned events, depending on rostering and organisational practices 4. the risk of less client choice of time of service delivery, and of Support Worker, as providers seek to optimise their rostering practices to reduce travel costs and increase efficiencies. <p>[Mitigation strategies could include setting up a cluster of Support Workers working as a team within a defined geographical area and supporting a common group of clients. This would mean quality care is delivered to each client, but not always by the same person and within a time range. The team-based approach requires sufficient numbers of qualified staff as well as a change in service expectations.]</p> <ol style="list-style-type: none"> 5. avoiding the need for Support Workers to work more than one job, or rely on alternative income 6. minimising the potential legal risk that follows from a union view that not providing ongoing work/employment when work patterns may suggest that employment is of a more permanent nature and the provider has an ongoing contract to provide services. <p>The caveats include:</p> <ol style="list-style-type: none"> 1. funding levels being sufficient to mitigate the financial risk to providers of guaranteeing a Support Worker a set number of paid hours of work when there is no guarantee that work is available for that Support Worker to do 2. acceptance across the sector that flexibility to vary from rostered services to accommodate unplanned events is likely to be reduced 3. Support Worker employment agreements clearly outlining employment definitions aligned to the Employment Relations Act 2000 and provisions relating to the administration of guaranteed hours of work.

Area	Key observations										
Current state	<p>Generally, the hours worked by Support Workers are based on the assigned client's needs and remunerated on a piecemeal basis (ie, payment is per client hour), with no guaranteed hours of work or workloads. While rosters are developed (generally up to a fortnight in advance of service delivery), Support Workers and clients sometimes agree to vary from the roster to accommodate unplanned events.</p> <p>The needs of clients fluctuate and workloads are affected when an assigned client is on holiday, in hospital, enters residential care or no longer requires the service. In addition, some clients only need services on a short-term basis. The degree of variability in client need and funding linked to service provision is regularly cited as the rationale for Support Worker hours not being guaranteed.</p> <p>The Ministry of Health 2015 Workforce Survey asked providers to provide the hours worked by each employee in each week over a four-week period (8 February to 9 March 2015). Thirty-one providers, covering 4913 workers (20% of the estimated workforce), provided the information requested (see Figure 15 and Table 12).</p> <p>Figure 15: Percentage of Home and Community Support Workers who worked consistent hours for the period 8 February to 9 March 2015</p> <table border="1"> <caption>Data for Figure 15: Percentage of Home and Community Support Workers who worked consistent hours</caption> <thead> <tr> <th>Duration of Consistent Hours</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>No consistency</td> <td>~21%</td> </tr> <tr> <td>Consistency in 2 weeks</td> <td>~41%</td> </tr> <tr> <td>Consistency in 3 weeks</td> <td>~19%</td> </tr> <tr> <td>Consistency in all 4 weeks</td> <td>~18%</td> </tr> </tbody> </table> <p>Source: Ministry of Health 2015 Home and Community Support Service Workforce Survey</p> <p>Notes</p> <ol style="list-style-type: none"> Workers were deemed to have consistent hours if the number of hours worked each week varied by less than 5%. The survey did not collect information on consistency of actual hours or days worked. 	Duration of Consistent Hours	Percentage	No consistency	~21%	Consistency in 2 weeks	~41%	Consistency in 3 weeks	~19%	Consistency in all 4 weeks	~18%
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Area	Key observations																																																
Current state (continued)	<p><u>Table 12:</u> Number of Home and Community Support Workers who worked consistent hours, by employer size, for the period 8 February to 9 March 2015</p> <table><tr><th>Employer size</th><th>No consistency</th><th>2 weeks</th><th>3 weeks</th><th>4 weeks</th><th>Total</th></tr><tr><td>1–50</td><td>18 (8%)</td><td>75 (35%)</td><td>29 (14%)</td><td>90 (43%)</td><td>212 (100%)</td></tr><tr><td>51–100</td><td>72 (15%)</td><td>196 (40%)</td><td>65 (13%)</td><td>162 (33%)</td><td>496 (100%)</td></tr><tr><td>101–200</td><td>163 (21%)</td><td>289 (37%)</td><td>199 (25%)</td><td>133 (17%)</td><td>783 (100%)</td></tr><tr><td>201–300</td><td>63 (12%)</td><td>185 (34%)</td><td>112 (21%)</td><td>177 (33%)</td><td>537 (100%)</td></tr><tr><td>301–600</td><td>335 (27%)</td><td>586 (48%)</td><td>201 (16%)</td><td>101 (8%)</td><td>1222 (100%)</td></tr><tr><td>1501+*</td><td>386 (23%)</td><td>678 (41%)</td><td>354 (21%)</td><td>246 (15%)</td><td>1664 (100%)</td></tr><tr><td>Totals</td><td>1036 (21%)</td><td>2008 (41%)</td><td>960 (20%)</td><td>909 (19%)</td><td>4913 (100%)</td></tr></table>	Employer size	No consistency	2 weeks	3 weeks	4 weeks	Total	1–50	18 (8%)	75 (35%)	29 (14%)	90 (43%)	212 (100%)	51–100	72 (15%)	196 (40%)	65 (13%)	162 (33%)	496 (100%)	101–200	163 (21%)	289 (37%)	199 (25%)	133 (17%)	783 (100%)	201–300	63 (12%)	185 (34%)	112 (21%)	177 (33%)	537 (100%)	301–600	335 (27%)	586 (48%)	201 (16%)	101 (8%)	1222 (100%)	1501+*	386 (23%)	678 (41%)	354 (21%)	246 (15%)	1664 (100%)	Totals	1036 (21%)	2008 (41%)	960 (20%)	909 (19%)	4913 (100%)
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Union perspective	<p>The unions acknowledge the variability in client need and the impact of funding linked to service provision, but consider that an unknown but significant proportion of Support Workers have regular and consistent work patterns, suggesting a high percentage of the workforce can be employed with ongoing guaranteed hours of work.</p> <p>The unions consider that the fewer the number of Support Workers who have guaranteed hours and the smaller the percentage of hours guaranteed, the greater the risk that a Support Worker’s rights under the Employment Relations Act to an ongoing expectation of work and good faith consultation (in regard to changes in hours of work) are being breached. The unions consider that an ongoing risk will remain for any Support Worker who is not specifically employed on a casual or fixed-term basis and whose work pattern is not consistent with that employment arrangement (as defined in the Employment Relations Act and case law).</p> <p>The unions acknowledge that in many circumstances it is not appropriate for Support Workers to vary from rostered clients and service delivery times; for example, where clients require medication or require support in order to be ready to start work at a specific time. However, the unions also consider that with teams of Support Workers, where possible in less critical situations, Support Workers and their clients could maintain some flexibility to vary rosters to accommodate unplanned events.</p>																																																

Area	Key observations
Provider perspective	<p>In general, providers favour a high percentage of the workforce having regular, ongoing guaranteed hours of work. The providers expect that guaranteeing a percentage of the Support Worker hours will generate efficiencies in training, rostering, administration and ability to meet unplanned immediate client need, and may increase the average hours worked per Support Worker (currently 21 hours per week).</p> <p>The providers note that the financial implications of being required to pay Support Workers for time spent travelling between clients (from 1 July 2015) and reimbursing a proportion of travelling costs (from 1 March 2016) will have a significant impact on Support Workers' ability to vary from rostered times and clients. In general, providers do not support rosters being changed without their knowledge and agreement (for health and safety, service quality, administrative and efficiency reasons).</p> <p>The providers consider that the higher the number of Support Workers who have guaranteed hours and the higher the percentage of hours guaranteed, the greater the potential financial risk of being required to pay a Support Worker, irrespective of whether or not the hours guaranteed have been worked (and therefore have generated revenue).</p> <p>The providers propose that the financial risk of increasing the percentage of Support Workers being employed on guaranteed hours be recognised specifically in the price/cost model recommended for use in provider–DHB contract negotiations (set at present at a nominal level of 3%, which is subject to change), and that the price/cost model be used as the basis of negotiations between DHBs and providers.</p>
Agreed approach to measurement	<p>In discussions, provider and union representatives agreed that a transition to guaranteed hours would be required, as follows.</p> <ol style="list-style-type: none"> 1. Implementing the In-between Travel Settlement Agreement would require at least 51% of Support Workers being employed on guaranteed hours within 12 months of implementation. 2. The model for measuring implementation would involve three variables: <ol style="list-style-type: none"> i) a minimum of 51% of the provider's total workforce is to have guaranteed hours (ie, the number of Support Workers with guaranteed hours is a function of the provider's total workforce and is not limited to a proportion of the permanent workforce), which is to ensure the intent of the In-between Travel Settlement Agreement is adhered to in that a majority of Support Workers will have guaranteed hours ii) each Support Worker with guaranteed hours will have had their last three months of hours reviewed and the hours deemed to be permanent will make up the number of hours guaranteed, to a maximum of 40 hours per week iii) a minimum of 51% of the provider's contracted hours are to be guaranteed (which minimises the risk of the provider guaranteeing hours to the Support Workers with the least number of regular hours in order to comply). 3. Transition to guaranteed hours, as set out in clause ii above, will depend on the allocation of appropriate funding based on the analysis of non-utilisation rates and other factors (eg, turnover of clients and staff). 4. A move towards 80% of Support Workers being employed on guaranteed hours is considered to be a realistic goal for the majority of providers to work towards over the three-year period (which will result in a core workforce working regular, guaranteed hours, supported by a casualised/fixed-term workforce to assist in dealing with variability in client volume and need).

Area	Key observations
Implications of the introduction of guaranteed hours	<p>The provider view is that:</p> <ol style="list-style-type: none"> 1. funding levels need to be sufficient to mitigate their ongoing financial risk of paying for non-utilised or non-revenue-generating Support Worker time 2. the price/cost model should include a percentage to recognise the financial risk of increasing the percentage of Support Workers being employed on guaranteed hours (currently set at a nominal rate of 3%), to be subject to further investigation. <p>The cost implications of moving to an employment model where at least 51% of Support Workers are employed on guaranteed hours has been estimated at a nominal 3% of current baseline costs and has been factored into the price/cost model Appendix 4.</p> <p>Note: Australian reports indicate that the cost implications may increase up to an estimated 20% when 80% of Support Workers are employed on guaranteed hours, in recognition of the increased risk that providers will be required to pay staff for non-utilised or non-revenue-generating time. The rate is also influenced by the degree of client choice of Support Worker and/or time of service delivery factored into service delivery models.</p>

8. A case-load and case-mix workload mechanism to ensure a fair and safe allocation of clients to Support Workers

Area	Key observations
Goal	The parties to the Settlement Agreement agreed to explore the impact and affordability of moving to a case-mix and case-load mechanism to ensure fair and safe client allocation at a safe staffing level.
Principles guiding workload allocation	<p>A system of workload allocation for home Support Workers should:</p> <ul style="list-style-type: none"> • be fair and objective, and minimise the opportunities for favouritism • support the health and safety of both staff and clients • enable Support Workers to know as far in advance as is practicable what their workload is and what clients they are supporting • reflect career development pathways (including specialisation where applicable), with workloads that acknowledge the stage of development of the worker • match worker skill levels to client needs • allocate realistic and manageable timeframes for each client visit, consistent with funding arrangements and service agreements • allocate realistic and manageable timeframes to cover travel time (as it is described in the In-between Travel Act) and break times, consistent with funding arrangements • create efficiencies by minimising travel (except where client needs for a particular Support Worker competency require otherwise).
Proposed intended outcomes	<p>In order to give effect to these principles the following is required.</p> <ol style="list-style-type: none"> 1. There should be fair distribution of both complex and non-complex tasks to all home Support Workers. For 'package of care' clients (ie, clients who receive a package of HCSS services to meet both their non-complex and complex care needs), all assignments contributing to this client should be allocated as a package to the one Support Worker, where practicable, or to the team working around that client. 2. Support Workers new to the sector should be allocated non-complex tasks until qualified to complete more complex tasks. 3. A time allowance of 0.5 hours per week per Support Worker has been factored into the price/cost model as non-revenue-generating time to allow the opportunity for providers to provide additional workforce support through regular team meetings, ongoing access to supervision, quality and peer review meetings, and mentoring arrangements for inexperienced staff. This cost (along with the 3% [nominal] cost of guaranteeing hours to 51% of the workforce) is shown in the 'Additional SW Costs' column of the price/cost model in Appendix 4. <p>Union representatives see merit in providers allocating to experienced Support Workers a mixture of non-complex and complex tasks to minimise fatigue, reduce the number of Support Workers going into a client's home, and create efficiencies in relation to travel time.</p> <p>Providers consider that high standards of care can be provided in a variety of ways; for example, telephone checks on clients to ensure they are taking their medication, the delivery of complex care by suitably qualified staff, and household support from less qualified staff, as necessary.</p>

Area	Key observations
Case mix	<p>Under the case-mix model, nationally agreed minimum safety and service standards and worker competency criteria can be established for each case-mix category. Suitably qualified Support Workers are allocated according to the objectively assessed health care needs and a case-weighted determination of the number of hours required to meet those needs.</p> <p>Using the case-mix model, the care needs of a client over the age of 65 are determined using the InterRai assessment tool. InterRAI is designed to identify an older person's medical, rehabilitation and support needs. An InterRAI assessment covers a number of factors, including mobility and self-care. It results in a package of care for each person and the assignment of a case-mix category reflecting the required level of care.</p> <p>For example, in the non-complex category, Category 3a refers to clients whose condition is stable. Using a case-weighted approach, these clients require fewer hours of care. A client with significant rehabilitation requirements will fall into Category 8, the highest category of complex care, requiring more hours of care delivered by a suitably qualified and skilled Support Worker.</p> <p>Provider hours can then be allocated according to the case-weighted number of the hours required for each category of client. Although a smaller proportion of home- and community-based clients have complex care needs, providers need to allocate a higher number of hours to their care.</p> <p>In summary, the case-mix model is more efficient because provider hours are allocated according to an objective determination of a client's health care needs. Also, there is a decrease in service hours inherent in the case-mix model, which will produce cost savings due to a decrease in bed days and emergency department admissions.</p> <p>Under the case-mix model, only 35% of assessments (the complex cases) are completed by the NASC service. The provider completes the rest. In line with a restorative model of care, annual reviews of clients are undertaken and Support Workers are encouraged to communicate changing levels of client need to the provider. There is no disincentive to do this, because pay is not linked to time spent with each client.</p>

9. Structuring future service delivery

Area	Key observations
Changes needed to sustain a regularised workforce and fit-for – purpose HCSS	<p>The transition to a regularised workforce must be supported by a number of infrastructural changes, without which the sustainability of HCSS will continue to be at risk. Nor will the sector be well placed to meet the increasingly complex care requirements of the anticipated number of clients seeking home- and community-based care in future.</p> <p>The proposed changes are to:</p> <ol style="list-style-type: none"> 1. funding arrangements, so that the price paid by the funder to the provider: <ul style="list-style-type: none"> reflects the cost of delivering the service is based on a consistent price/cost model (use of the 2014 Price/Cost model set out in Appendix 4 is recommended) is reviewed on an annual basis to take into account statutory minima requirements 2. the contract model relevant to engagement between funders and providers 3. service specifications. <p>Addressing the current variability in funding models and service delivery models through a national contract, national quality standards (service specifications) and a national costing methodology will reduce back-office effort, improve efficiency and reduce the total market cost of procurement processes. It will also remove regional differences that don't improve performance and remove the need for providers to maintain multiple models.</p>
Funding arrangements	<p>The price paid by funders to providers needs to reflect an objective assessment of the costs of delivering the services, as determined through the price/cost model.</p> <p>The price paid needs to be subject to review on an annual basis to take into account any increase in statutory minimums. These arrangements are fundamental to the successful regularisation of the workforce and the ongoing sustainability of services.</p> <p>A national contracting arrangement similar to the Aged Residential Care Contract is recommended as a basis for a consistent service delivery model and common funding approach across the DHBs.</p>

Area	Key observations
Objective of the funding methodology	<p>The objective of a nationally consistent service delivery model is to provide appropriately funded, safe, effective and cost-efficient home and community support services via a model whereby both the DHBs and providers assume risks over which they have control, and can therefore influence the cost inputs.</p> <p>Case mix is a model widely supported by the provider sector. Under such a model, the allocation of risk is related to the matters over which the parties exercise control. Providers are responsible for the delivery of safe (safety), efficient and cost-effective operations (efficiency), and DHBs for the impact of their decisions on both service entry and 'related services' that affect home support service levels (volume).</p> <p>Under case mix, nationally agreed minimum safety and service standards and worker competency criteria are established for each case-mix category. Funding is then based on agreed national average inputs per case-mix category. Each client is allocated a package of care based on their InterRAI-assessed case-mix category. Case-mix category funding is based on the agreed national average inputs (with nationally agreed maximum inputs per case-mix category) calculated at the agreed national pricing level.</p> <p>Clients requiring services above the nationally agreed maximum inputs per case mix are agreed between the parties and funded on a fee-for-service' basis.</p> <p>Although a national InterRAI assessment process ensures a national consistency of assessment, it requires a national contracting framework to ensure national consistency in the client service response to that assessed need. Having nationally agreed minimum safe and average funded inputs for each case-mix category provides assurance that clients will receive a consistent, safe service irrespective of their location in New Zealand.</p>
Benefits of the recommended case-mix approach under a national framework	<p>DHBs retain flexibility in that:</p> <ol style="list-style-type: none"> 1. the case-mix model will automatically reflect individual DHB client demographic mix 2. they can transparently target services, by case-mix category, to assist in meeting other DHB priorities (eg, residential bed numbers) and budgetary considerations; for example, they may decide not to deliver some lower-level non-complex categories if it was deemed that this would not adversely affect other DHB services 3. the funding methodology, with pricing based on case-mix average inputs, would retain the flexibility to be addressed on an individual client fee-for-service, client package of care, or bulk-funded model.
Quality standards and service standards	<p>The support-worker workforce is unlike comparable workforces working in DHB or residential settings in that they have no immediate access to support and advice from experienced co-workers, or nursing or medical staff. Quality standards that align policy and quality, employment and training, and service delivery are required to provide a framework for the management of the risks associated with home-based care.</p>

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Appendix 1: Acknowledgements

Area	Description
Summary	<p>The Director-General's Reference Group acknowledges the significant work of the two Working Groups which engaged in robust and challenging discussions to develop consensus on a future focused sustainable home and community services support sector to meet the needs of consumers with a fully supported and suitably qualified support workforce.</p> <p>HCSS stakeholders were involved in providing the Director-General's Reference group with additional information and/or presented at Director-General Reference Group meetings and members are grateful for the information shared.</p>
Working Group 1	<p>Andrea McLeod: General Manager, Enliven, Presbyterian Support Northern</p> <p>Bronwyn Hayward: Consumer representative, Disabled Persons Assembly New Zealand</p> <p>Donna Mitchell: Director Planning and Service Development, Healthcare of New Zealand Holdings Ltd</p> <p>Jason Power: Portfolio Manager, South Canterbury District Health Board</p> <p>John Ryall: National Secretary, Service and Food Workers Union</p> <p>Kathryn Maloney: Manager, Policy and Health Promotion, Age Concern, New Zealand</p> <p>Kerry Davies: Assistant Secretary Public Service Association</p> <p>Tracey Scheibli: General Manager, Funding and Planning, Whanganui District Health Board</p> <p><u>Ministry of Health:</u></p> <p>Kathy Brightwell (Co-chair): Group Manager, Ministry of Health</p> <p>Karina Kwai (Co-chair): Manager, Health of Older People, National Health Board, Ministry of Health</p> <p>Penny Hanning: Senior Advisor, Health of Older People, National Health Board, Ministry of Health</p> <p>Ross Judge: Principal Analyst, Health of Older People, Ministry of Health</p> <p>Christy Richards: Disability Support Services, Ministry of Health</p> <p>Julia Tinga: Senior Analyst, Health of Older People, Ministry of Health</p> <p>Mark Hodge: Accident Compensation Corporation</p> <p>Kereana Buchanan: Accident Compensation Corporation</p>

Area	Description
Working Group 2	<p>Anita Guthrie: Healthcare of New Zealand Holdings Ltd</p> <p>Sam Jones: Service and Food Workers Union</p> <p>Melissa Woolley: Public Service Association</p> <p>Graeme Titcombe: Access Home Health</p> <p>Virginia Brind: General Manager Planning and Funding, Tairāwhiti District Health Board</p> <p>Laurie Biesiek: District Health Board Shared Services</p>
DG Reference Group engaged with the following	<p>Ruth Anderson (Chair): Manager, Health Workforce New Zealand</p> <p>Tony O'Rourke: Employment Relations Specialist, National Health Board</p> <p>David Darling: Relationship Manager, DSS, Ministry of Health</p> <p>Julie Haggie: Chief Executive, Home and Community Health Association</p> <p>Bill Halkyard: CEO, Te Hiku Hauora</p> <p>Lyn Jones: Capital and Coast Care Coordination Centre Manager</p> <p>Melissa Loumachi: Manager, Lavender Blue Nursing and Home Care Agency</p> <p>Andrea McLeod: Chair, Home and Community Health Association</p> <p>Brigitte Meehan: Programme Manager for interRAI, Health of Older People, Ministry of Health</p> <p>Deb Nind: Nurse Maude</p> <p>Professor Matthew Parsons: Clinical Chair in Gerontology: University of Auckland / Waikato District Health Board</p> <p>Julie Rickett: Manager, Home Support, Te Hiku Hauora</p>

Appendix 2: Three particular models of restorative care considered by Working Group 1

START Waikato

START (Supported Transfer and Accelerated Rehabilitation Team) is part of Waikato DHB's older persons and rehabilitation service and provides intensive rehabilitation for up to six weeks in clients' homes following a stay in hospital or presentation to the emergency department.

Registered nurses, allied health and health care assistants work together with the client to develop specific goals and to build a home-based rehabilitation programme. The health care assistants provide HCSS with a rehabilitation focus to help the client become more capable and.

START began in 2011 with the aim to:

- provide and promote rehabilitation of clients in their home environment, in collaboration with community therapy services and specialist geriatric medical care
- provide and coordinate continuing clinical assessment to recognise deterioration and need for change in nursing or medical treatment or hospital admissions
- work collaboratively with long-term care providers
- provide and improve education to patients, carers and family
- undertake a collaborative and individualised programme of health promotion for each client, with particular emphasis placed on the role of fitness and prevention of de-conditioning.

The second component of START is the admission avoidance process, where a START-registered nurse works with emergency departments to avoid unnecessary admissions and ensures a person is transferred back into their homes with intensive support.

Case study:

An 86-year-old woman wished to go back to her club five days a week for lunch. This was important for her because it provided nutrition, socialisation, motivation, confidence and exercise. The START team developed the steps necessary to achieve this goal. In the first week the programme included daily exercise with the health care assistant until she was confident. To go to the club she needed to shower and dress. The health care assistants coached her daily to do this until she was able to perform these functions independently. Over the next four weeks the client achieved all the steps to enable her to achieve her goal.

Evaluation shows that the START programme reduces the length of stay in hospital and the risk of readmission following discharge. The increased time the clients then spent recuperating at home under START care reduced costs for the DHB over six months. When comparing costs, per-participant costs in the usual care group were on average \$16,943 compared to \$10,836 in the START group (which included \$1,618 of START costs) in the six months following initial hospital discharge.

However, while the case study alludes to greater client satisfaction, the evaluation did not highlight improved client outcomes. So while the early results are promising, further use of such models should specifically track client outcomes and experience.

CREST (Canterbury DHB)

CREST (Community Rehabilitation Enablement and Support Team) was planned prior to the February 2011 Christchurch earthquake, but its implementation was launched quickly following the earthquake to help cope with the loss of hospital and residential care beds.

The aim of CREST is to reduce the length of stay once the person is in hospital, reduce the chances of readmission, and delay admission to aged residential care. The model was rolled out over a three-week period and is based on a model used in Waikato, and similar to many

intermediate care programmes used in the United Kingdom.

CREST provides varying levels of support to clients depending on their needs, which could be up to four visits a day, seven days a week. Goals are agreed with clients and, depending on the needs of the client, the service lasts between two and six weeks (with an average of four to six weeks).

The focus is on rehabilitation, with support not limited to medical and nursing, but aimed at assisting clients to become independent in order to manage everyday activities on their own (eg, being able to shop again, reconnect with friends and rebuild social networks): 'Why scrub the shower to death once a week when it has only been used twice? Do that once a fortnight and use the time to get them walking to the post box again, or the shop, or reconnecting with friends.'²⁴

Table A1: Example of basic programme and goals

1	Long-term goal: to walk to fish-and-chip shop once a week to buy meal
1	Have a robust plan to manage chronic symptoms: <ul style="list-style-type: none">• weekly weigh• respiratory education, domiciliary oxygen• prompt to do breathing exercises
2	Walk to letterbox each day
3	Take medication each day at the correct times Key support worker to check daily for 3 days and then observe
3	Eat 3 meals per day Key support worker to check he has eaten each time they visit
3	Wash and dress independently each day

We also note that this is an intensive, short-term programme, specifically targeted at people coming out of hospital. Its utility and cost as a programme for longer-term care/support has not been tested.

²⁴ CREST case worker

Te Whiringa Ora

Te Whiringa Ora (TWO) is an integrated care service in the Eastern Bay of Plenty, based in the community. TWO facilitates interdisciplinary care and a web of care around patients (and their whānau) who have complex, long-term health needs and a high use of hospital services. An evaluation of the service included impacts on client health outcomes, experience and access, as well as utilisation of secondary services, aspects that support success, and where improvements may be needed.

Findings (Appleton-Dyer et al 2013) included an improved quality of life for the client. The service contributes to improved primary care management of chronic conditions and long-term conditions, including a 10% reduction in hospital bed days (while the control group had an increase of 47% in hospital bed days).

TWO clients used inpatient services less frequently, had a decrease in the frequency of outpatient usage and decreased presentations to emergency departments. Overall, TWO clients experienced a better management of their condition.

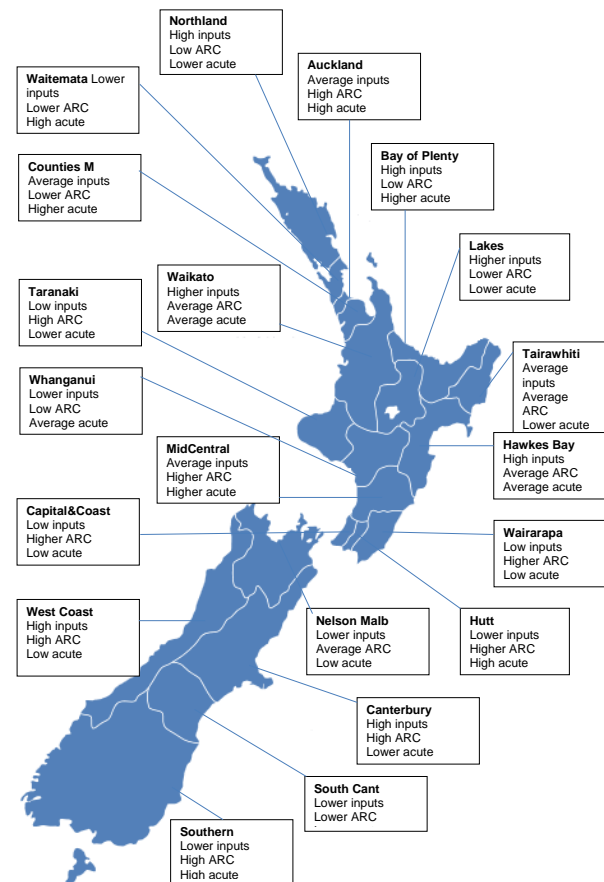
An assessment of the client experience indicated that the TWO approach was appropriate across all cultural groups (including Māori). It looks beyond the immediate health needs of the client to broader and more holistic needs, and supports the client to navigate the health system. Clients found they had improved access to health and social services and a better understanding of their condition, and the capacity to 'self-manage'. Clients were supported to achieve an outcome of a better quality of life.

Improvements noted were that there could be a more graduated discharge process, improved communication with general practitioners, and a broadening of the catchment of care.

Overall, Working Group One considered that this model provides a good example of improved health outcomes for clients, as well as improvements in their quality of life.

Appendix 3: DHB health of older people home and community support services – costs and outcomes

DHB Health of Older People Home-based Support Services: Cost and Outcomes



Appendix 4: Costing and pricing model

Area	Key observations
Costing and pricing model	<p>The assumptions in the costing template were updated to reflect current rates and sections added to the tool to incorporate other elements that need to be accommodated. The tool was then used to model the cost and pricing scenarios flowing from the Settlement Agreement. The following sections were revised or added:</p> <p>Travel</p> <p>To reflect the In-between Travel Settlement Agreement, the average travel distance of 4.45 km is reimbursed at \$0.50 cents per kilometre, and a time allowance of 11.2 minutes is added. This is fully funded through Settlement Agreement funding.</p> <p>Training</p> <p>Training costs are factored into the model. Costs to back-fill paid training time are not included because these would be covered by the employer within the costing/pricing model.</p> <p>Additional Support Worker Costs</p> <p>Regularising the workforce with guaranteed hours requires the employees to be flexible and for them to be informed. The model allows for 1.25% (two hours per month) paid meeting time, for quality improvement and client peer review discussions.</p> <p>In addition, an allowance of 3% is added in recognition that there will be time when client hours change to reduce employee utilisation before changes can be reflected in the guaranteed hours.</p> <p>Differential for Qualifications</p> <p>The model allows for stepped wage rates along with the proportionate staff mix per step. To model the costs of moving to paid training and guaranteed hours, a \$0.75 differential was used between steps, and the minimum wage as the entry level.</p> <p>Industry average values were used as the default value for overheads. Actual values were used where known. A 6% return on investment (margin) is used.</p> <p>Scenario Modelling</p> <p>Using the tool to model the cost and pricing scenarios flowing from the Settlement Agreement provides indicative increases to the baseline costs, as measured after paid travel has been factored in.</p> <p>Basis Cost/Price</p> <p>Zero values for travel, additional support-worker costs, training or differential for qualifications.</p> <p>Baseline for Costing</p> <p>Agreed values from the Settlement Agreement were added for in-between travel to set the starting point for measuring the effect of introducing the new provisions.</p>

Cost and Price Modelling Scenarios																		
Scenario	Basic Cost		Baseline with Travel funded			Add Additional SW Costs			Add Training			Add Differential- Current Mix						
		% Mix		% Mix	% Change on Base		% Mix	% Change on Base		% Mix	% Change on Base		% Mix	% Change on Base				
Entry Rate	\$ 15.00	100	\$ 15.00	100		\$ 15.00	100		\$ 15.00	100		\$ 14.75	40					
Level 2	\$ 15.00		\$ 15.00			\$ 15.00			\$ 15.00			\$ 15.50	35					
Level 3	\$ 15.00		\$ 15.00			\$ 15.00			\$ 15.00			\$ 16.25	25					
Additional SW Costs	No		No			Yes			Yes			Yes						
Travel	No		Yes			Yes			Yes			Yes						
Training	No		No	Increase		No	Increase		Yes	Increase		Yes	Increase					
Direct SW Wage	\$ 17.89		\$ 20.21	12.97	12.97	\$ 20.21	0.00	0.00	\$ 20.21	0.00	0.00	\$ 20.67	2.28	2.28				
Total Direct Costs	\$ 22.48		\$ 26.70	18.77	18.77	\$ 27.47	2.88	2.88	\$ 27.84	1.35	4.27	\$ 28.34	1.80	6.14				
Price with O/H and Margin	\$ 27.76		\$ 32.50	17.07	17.07	\$ 33.31	2.49	2.49	\$ 33.70	1.17	3.69	\$ 34.24	1.60	5.35				
Scenario Descriptions and Assumptions						Min Wage + \$1 and \$0.75 Inc			Min Wage + \$1 and \$1.20 Inc			Min Wage + \$2.50 and \$0.75 Inc		Min Wage + \$2.50 and \$1.20 Inc				
Baseline	DHBSS Pricing Model defaults or industry average used						% Mix	% Change on Base		% Mix	% Change on Base		% Mix	% Change on Base				
	All SWs paid minimum wage					\$ 15.75	15		\$ 15.75	15		\$ 17.25	15		\$ 17.25	15		
	No travel included					\$ 16.50	30		\$ 16.95	30		\$ 18.00	30		\$ 18.45	30		
	No paid training time included					\$ 17.25	50		\$ 18.15	50		\$ 18.75	50		\$ 19.65	50		
	Paid Tea breaks but No additional support worker costs					\$ 18.00	5		\$ 19.35	5		\$ 19.50	5		\$ 20.85	5		
	Margin at 6%					Yes			Yes			Yes			Yes			
Add Travel	Paid travel added in addition to each client visit					Yes			Yes			Yes			Yes			
	Agreed in the IBT Settlement					Yes	Increase		Yes	Increase		Yes	Increase		Yes	Increase		
	Average Rates as per the agreement					\$ 22.40	8.37	10.84	\$ 23.18	12.14	14.70	\$ 24.19	17.03	19.69	\$ 24.97	20.80	23.55	
Add Additional SW Costs	NB: Additional travel funding set aside for IBT					\$ 30.23	6.67	13.22	\$ 31.08	9.67	16.40	\$ 32.19	13.59	20.56	\$ 33.04	16.58	23.75	
	Allowance for regular quality and client peer review meetings					\$ 36.25	5.87	11.54	\$ 37.16	8.53	14.34	\$ 38.34	11.97	17.97	\$ 39.24	14.60	20.74	
	Allowance for downtime from guaranteed hours					Base for measuring new costs for regularising the SW workforce												
Add Training	Training costs calculated and amortised over 3.3 yrs					New costs flowing through the transition to a regularised workforce												
	Calculated using the weighted average SW hourly rate					Additional cost of moving to rates with entry level above minimum wage												
						Shows percentage increase in costs and price from Baseline with Travel funded												
Add Differential Current Mix	Qualification differential of \$0.75 per hour for Level 2 and 3 qualifications																	
	Current Mix calculated from the data provided																	
Min Mage + \$1 and \$0.75 inc	Sets the entry level rate \$1 above the minimum wage and \$0.75 added for each qualification level																	
Min Wage + \$1 and \$1.20 Inc	Sets the entry level rate \$1 above the minimum wage and \$1.20 added for each qualification level					Purpose and Caveats: These scenarios have been built using the Costing/Pricing model jointly developed by the DHBs and providers. Industry average rates have been used in the main and actual values if applicable. The Model has been updated through discussion within Working Group 2. The updated model has not been audited, peer reviewed or otherwise validated as part of the working group process. The purpose of this work is to demonstrate the impact on costs and price through implementing the components within the settlement agreement, and using an average wage as a start point for the modelling. It is not intended to indicate a rate for funding services.												
Min Mage + \$2.50 and \$0.75 inc	Sets the entry level rate \$2.50 above the minimum wage and \$0.75 added for each qualification level																	
Min Wage + \$2.50 and \$1.20 Inc	Sets the entry level rate \$2.50 above the minimum wage and \$1.20 added for each qualification level																	
Future framework	The scenarios modelling the future framework have 4 qualification levels and realistic distribution																	

Area	Key observations
Explanation of Cost and Price Modelling Scenarios	<p>The following provides explanation of elements of the Cost and Price Modelling Scenarios table (previous page):</p> <ul style="list-style-type: none"> • adding the additional support-worker costs arising from guaranteed hours adds 2.49% to the price • adding paid training costs and time adds 1.17% to the price • adding a differential for attaining qualifications at Level 2 and Level 3 adds 1.6% to the price • the cumulative increases amount to 5.35% to the price • the basic cost/price-level price exceeds the price some DHBs currently pay prior to the In-between Settlement Agreement, and there is current variability in how DHBs fund services • the methodology applied requires peer review and further discussion with stakeholders if it is to form the basis of future funding decisions.

Appendix 5: Level 2 and 3 Qualification Programme structure

Level 2

Outcome	Unit standards	Level	Credit
1. Work within the responsibilities and boundaries of own role	Compulsory:		
	23451 Describe the role of a Support Worker in a health or wellbeing setting	2	5
	Optional:		
	23686 Describe a person's rights in a health or wellbeing setting	2	1
2. Perform entry-level person-centred tasks and functions in a health or wellbeing setting	Compulsory:		
	28519 Maintain a safe and secure environment for people and Support Workers in a health or wellbeing setting	2	6
	28529 Identify the impact of culture on support in a health or wellbeing setting	2	5
	Minimum of 14 credits selected from the following:		
	23386 Support a person to meet personal care needs in a health or wellbeing setting	3	5
	28545 Apply personal plan requirements to meet the needs of people in a health or wellbeing setting	2	5
	20826 Describe infection control requirements in a health or wellbeing setting	2	3
	23452 Describe the principles for moving equipment and people in a health or wellbeing setting	2	3
	23685 Describe pre-packaged medication and the process for its use in a health or wellbeing setting	2	2
	26978 Support a person to eat and drink in a health or wellbeing setting	2	4
	26979 Describe the immediate response to the death of a person in a health or wellbeing setting	2	2
	28546 Describe incontinence and interventions to assist a person in a health or wellbeing setting	3	5
	28548 Support a person's wellbeing and quality of life in a health or wellbeing setting	2	3
3. Recognise and report risks and/or changes in a person and/or family/whānau	Compulsory:		
	28517 Recognise and report risks and changes for a person in a health or wellbeing setting	2	5
4. Communicate to support a person's health or wellbeing	Compulsory:		
	28518 Interact with people to provide support in a health or wellbeing setting	2	5

Level 3

Outcome	Unit standards	Level	Credit
1. Recognise and respond to signs of vulnerability and abuse in a health or wellbeing setting	Compulsory:		
	28521 Recognise and describe responses to vulnerability and abuse in a health and wellbeing setting	3	5
2. Demonstrate ethical and professional behaviour in a health or wellbeing setting	Compulsory:		
	28542 Demonstrate and apply knowledge of professional and ethical behaviour in a health or wellbeing setting	3	5
3. Provide person-centred support to maximise independence	Minimum of 56 credits from the following:		
	1810 Provide information about resources and support services in a health and wellbeing setting	3	2
	1818 Describe the value of relationships in people's lives in a health or wellbeing setting	3	3
	1828 Identify services available to people with disabilities	3	4
	9694 Demonstrate and apply knowledge of communication process theory	3	5
	16870 Describe intellectual disability and the support needs of a person with an intellectual disability	3	4
	16871 Describe physical disability and the support needs of a person with a physical disability	3	4
	20827 Support a person to use prescribed medication in a health or wellbeing setting	3	3
	20965 Describe epilepsy and the support needs of a person with epilepsy in a health or wellbeing setting	3	4
	23371 Support personal planning to enhance individual lifestyles with a person with disability	3	5
	23372 Describe law in relation to intellectual disability and high and complex needs and legal services available to people	3	3
	23374 Describe autism spectrum disorders (ASD) and support strategies	3	3
	23375 Describe hearing impairment	3	5
	23377 Use visual strategies for communicating with Deaf and hearing impaired people	3	3
	23382 Support a person to participate as a member of the community in a health or wellbeing setting	3	3
	23385 Demonstrate knowledge of advocacy and self-advocacy in a health or wellbeing setting	3	4
	23386 Support a person to meet personal care needs in a health or wellbeing setting	3	5
	23387 Demonstrate the ageing process and its effects on a person's lifestyle and wellbeing	3	7
	23388 Provide support to a person whose behaviour presents challenges in a health or wellbeing setting	3	4
	23389 Describe risk management planning in a health or wellbeing setting	3	3
	23391 Respond to loss and grief in a health or wellbeing setting	3	2

Outcome	Unit standards	Level	Credit
3. Provide person-centred support to maximise independence (continued)	23925 Support, mentor, and facilitate a person to maximise independence in a health or wellbeing setting	3	6
	24895 Describe the visual system and vision impairment	3	5
	25987 Describe culturally safe principles and Pacific values for people in a health or wellbeing setting	3	6
	26801 Describe the benefits of breastfeeding, available support services, and Baby Friendly Initiatives	3	3
	26802 Describe information, interactions, and strategies to protect, promote and support breastfeeding	3	3
	26971 Describe factors that contribute to mental health wellbeing and mental health problems	3	3
	26974 Describe interaction, supports and reporting for people with dementia in a health or wellbeing setting	3	8
	26977 Move a person using equipment and care for equipment in a health or wellbeing setting	3	4
	26980 Provide comfort cares, and report changes in the condition of a person with a life-limiting condition	3	3
	26981 Describe risks, impacts and actions for falls and minimise risk of falls in a health or wellbeing setting	3	3
	27455 Conduct nutrition screening with, and provide education to, adult clients in an aged care, health or disability context	4	6
	27457 Describe the anatomy and physiology of systems and associated organs of the human body	3	6
	27458 Support a person to develop and achieve goals in a health or wellbeing setting	3	3
	27460 Describe a person's nutritional requirements and feeding issues in a health or wellbeing setting	3	3
	27461 Describe indicators of wellness, interventions, care and support for people at different human lifespan stages	3	5
	27468 Apply safe swallowing strategies in a health or wellbeing setting	3	5
	27504 Describe tobacco use and dependence and smoking cessation treatments	3	5
	27505 Assess a person for tobacco dependence and support a person to develop a stop-smoking plan	3	6
	27506 Support a person to implement a stop-smoking plan and provide ongoing support to assist a person to remain smoke free	3	6
	27507 Describe tobacco control and health promotion as ways of enhancing health through smoking cessation	3	5
	27833 Support people to use assistive equipment and move in a health or wellbeing setting	3	5
	28520 Demonstrate knowledge of specific conditions and their impacts when providing support in a health or wellbeing setting	3	9
	28523 Describe community values and attitudes and their impact on people with disabilities	3	2
	28524 Describe a person's holistic needs and their impact on a person's health and wellbeing	3	5
	28528 Describe and apply a person-centred approach in a health and wellbeing setting	3	3
	28535 Demonstrate knowledge of procedures for infection control in a health and wellbeing setting	3	4

Outcome	Unit standards	Level	Credit
3. Provide person-centred support to maximise independence (continued)	28536 Apply health, safety and security practices in a health or wellbeing setting	3	5
	28543 Describe culturally safe Māori operating principles and values, and their application in a health or wellbeing setting	3	5
	28544 Provide support to people from different cultures in a health or wellbeing setting	3	5
	28546 Describe incontinence and interventions to assist a person in a health or wellbeing setting	3	5
	28547 Support a person with diabetes in a health or wellbeing setting	3	3
	28550 Support a person with chronic obstructive pulmonary disease (COPD) in a health or wellbeing setting	3	3
	28557 Communicate to support people's health and wellbeing	3	5
	28563 Provide person-centred care when supporting a person with early-stage dementia	3	8
	28737 Demonstrate knowledge of pressure injuries and pressure care	3	4
4. Recognise and respond to change	28738 Describe the key principles of palliative care and a Support Worker's role in a palliative approach to care	3	3
	Compulsory:		
	27459 Observe and respond to changes in people in a health or wellbeing setting	3	4