Counties Manukau District Health Board
Community & Public Health Advisory Committee Meeting Agenda

Wednesday, 17 August 2016 at 1.30 – 4.30pm, Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau

Time	Item
1.30pm	1. **Welcome**
1.30 – 1.45pm	2. **Governance** 2.1 Attendance & Apologies 2.2 Disclosure of Interests/Specific Interest 2.3 Confirmation of Public Minutes (6 July 2016) 2.4 Action Items Register
1.45 – 2.10pm 2.10 – 2.50pm 2.50 – 3.30pm	3. **Presentations/Reports** 3.1 Health of Older People Draft Strategy/ ARHoP Report (Dana Ralph-Smith) 3.2 Mangere/Otara Locality (Sarah Marshall) 3.3 Plunket Presentation (Ana Tom, Shobna Singh, Annette King, Plunket Clinical Leads)
	Afternoon Tea
3.45 – 4.15pm	4. **Primary Health & Community Services Directorate Report** (Benedict Hefford) 4.1 Executive Summary/Responses to Action Items 4.2 National Health & IPIF Targets (Rochelle Bastion & Kate Dowson) 4.3 Primary Health 4.4 Progress with Systems Integration 4.5 Locality Reports 4.6 Child Youth & Maternity 4.7 Mental Health & Addictions 4.8 Intersectoral Initiatives 4.9 Finance Report
4.15 – 4.20pm	5. **Resolution to Exclude the Public**
4.20 – 4.30pm	6. **Confidential Items** 6.1 Confirmation of Confidential Minutes (6 July 2016)

Next Meeting: Wednesday 28 September 2016
Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau

BOARD MEMBER ATTENDANCE SCHEDULE 2016 – CPHAC

Name	20 Jan	Feb	2 Mar	13 Apr	25 May	June	6 Jul	17 Aug	28 Sept	Oct	9 Nov	21 Dec
Lee Mathias (Board Chair)	✓	No Meeting	✓	✓	✓	No Meeting	✓			No Meeting		
Colleen Brown	✓		✓	✓	✓		X					
Sandra Alofivae (CPHAC Chair)	✓		✓	✓	X		✓					
David Collings	✓		✓	✓	✓		X					
George Ngatai	✓		✓	✓	X		X					
Dianne Glenn	✓		✓	✓	✓		✓					
Reece Autagavaia	✓		X	✓	X		✓					
Mr Sefita Hao'uli	✓		X	✓	✓		X					
Ms Wendy Bremner	✓		✓	✓	✓		✓					
Mr Ezekiel Robson	✓		✓	✓	✓		✓					
Mr John Wong	✓		✓	✓	✓		✓					

COUNTIES MANUKAU HEALTH

COMMITTEE MEMBERS' DISCLOSURE OF INTERESTS 17 August 2016

Member	Disclosure of Interest
Dr Lee Mathias, Chair	• Chair Health Promotion Agency • Chairman, Unitec • Deputy Chair, Auckland District Health Board • Acting Chair, New Zealand Health Innovation Hub • Director, healthAlliance NZ Ltd • Director, New Zealand Health Partners Ltd • External Advisor, National Health Committee • Director, Pictor Limited • Director, John Seabrook Holdings Limited • MD, Lee Mathias Limited • Trustee, Lee Mathias Family Trust • Trustee, Awamoana Family Trust • Trustee, Mathias Martin Family Trust
Colleen Brown	• Chair, Disability Connect (Auckland Metropolitan Area) • Member of Advisory Committee for Disability Programme Manukau Institute of Technology • Member NZ Down Syndrome Association • Husband, Determination Referee for Department of Building and Housing • Chair IIMuch Trust • Director, Charlie Starling Production Ltd • Member, Auckland Council Disability Advisory Panel • Member, NZ Disability Strategy Reference Group
Sandra Alofivae	• Member, Fonua Ola Board • Director, Housing New Zealand • Member, Ministerial Advisory Council for Pacific Island Affairs • Member, Social Housing Reference Group • Independent Chair, Social Investment Board
David Collings	• Chair, Howick Local Board of Auckland Council • Member Auckland Council Southern Initiative
George Ngatai	• Chair Safer Aotearoa Family Violence Prevention Network • Director Transitioning Out Aotearoa • Director BDO Marketing • Board Member, Manurewa Marae

	• Conservation Volunteers New Zealand • Maori Gout Action Group • Nga Ngaru Rautahi o Aotearoa Board • Transitioning Out Aotearoa (provides services & back office support to Huakina Development Trust and provides GP services to their people). • Chair of Restorative Practices NZ.
Dianne Glenn	• Member – NZ Institute of Directors • Member – District Licensing Committee of Auckland Council • Life Member – Business and Professional Women Franklin • Member – UN Women Aotearoa/NZ • President – Friends of Auckland Botanic Gardens and Chair of the Friends Trust • Life Member – Ambury Park Centre for Riding Therapy Inc. • Vice President, National Council of Women of New Zealand • Member, Auckland Disabled Women's Group • Member, Pacific Women's Watch (NZ) • Justice of the Peace
Reece Autagavaia	• Member, Pacific Lawyers' Association • Member, Labour Party • Member, Auckland Council Pacific People's Advisory Panel • Member, Tangata o le Moana Steering Group • Employed by Tamaki Legal • Board Member, Governance Board, Fatugatiti Aoga Amata Preschool • Trustee, Epiphany Pacific Trust
Sefita Hao'uli	• Trustee Te Papapa Pre-school Trust Board • Member Tonga Business Association & Tonga Business Council • Member ASH Board • Board member, Pacific Education Centre Advisory roles: • Tongan Community Suicide Prevention Project (MoH) • Tala Pasifika (NZ Heart Foundation Pacific Tobacco Control) • Member Pacific People's Advisory Panel, Auckland Council Consultant: • Government of Tonga: Manage RSE scheme in NZ • NZ Translation Centre: Translates government and health provider documents. • Promotus GSL on Rheumatic Fever campaign (HPA) • Taulanga U Society Rheumatic Fever Innovation project (MoH). • Member, Ministerial Advisory Council for Pacific Island Affairs.

Wendy Bremner	• CEO Age Concern Counties Manukau Inc • Member of Health Promotion Advisory Group (7 Age Concerns funded by MOH) • Member Interagency Suicide Prevention Group
Ezekiel Robson	• Department of Internal Affairs Community Organisation Grants Scheme Papakura/Franklin Local Distribution Committee • Be.Institute/Be.Accessible 'Be.Leadership 2011' Alumni • Member, CM Health Patient & Whaanau Centred Care Consumer Council
John Wong	• Director, Asian Family Services at The Problem Gambling Foundation of New Zealand (PGF), also part of the PGF national management team • Member, National Minimising Gambling Harm Advisory Group • Chairman and Trustee, Chinese Positive Ageing Charitable • Chairman, Chinese Social Workers Interest Group of the Aotearoa New Zealand Association of Social Workers • Chairman, Eastern Locality Asian Health Group • Founding member and council member, Asian Network Incorporation (TANI) • Board member, Auckland District Police Asian Advisory Board • Member, Auckland and Waitemata DHBs Suicide Prevention Advisory Group • Board member, Manukau Institute of Technology (MIT) Chinese Community Advisory Group • Member, CADS Asian Counselling Service Reference Group • Member, Waitemata DHB Asian Mental Health & Addiction Governance Group • Member, Older People Advisory Group (ACC) • Member, University of Auckland Social Work Advisory Group • Member, Community Advisory Group of Health Care New Zealand • Member, Auckland Regional Public Health Service – Asian Public Health External Reference Group • Member of the Advisory Committee for the School of Social Sciences &Public Policy at AUT University

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE MEMBERS' REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS

Specific disclosures (to be regarded as having a specific interest in the following transactions) as at 17 August 2016

Director having interest	Interest in	Particulars of interest	Disclosure date	Board Action
Mr George Ngatai	CMH Quit Bus	Mr Ngatai is a Director of Transitioning Out Aotearoa who is a partner provider along with CMDHB and Waitemata PHO in the Quit Bus.	26 March 2014	That Mr Ngatai's specific interest is noted and the Committee agree that he may remain in the room and participate in any deliberations of the Committee but is not permitted to participate in any decision making.
Ms Colleen Brown	Emerge Aotearoa (formerly Richmond NZ Trust Ltd)	Ms Colleen Brown has been involved with the family.	22 October 2014	That Ms Brown's specific interest is noted and the Committee agree that she may remain in the room and participate in any deliberations of the Committee in relation to this matter because she is able to assist the Committee with relevant information, but is not permitted to participate in any decision making.
Ms Dianne Glenn	Liqour Licensing	Ms Glenn is a member of the District Licensing Committee of Auckland Council	15 April 2015 8 July 2015 2 March 2016 6 July 2016	That Ms Glenn's specific interest is noted and the Committee agree that she may remain in the room and participate in any deliberations of the Committee but is not permitted to participate in any decision making.
Ms Margie Apa	Integrated Home & Community Support Services Redesign	Ms Apa is Chair of the Northern Presbyterian Support Services Network who are a current provider of home-based services.	8 July 2015	Ms Apa specific interest is noted and the Committee agreed that she will excuse herself from the room if and when any items in relation to this Conflict are discussed.
Mr Sefita Hao'uli	Suicide Prevention	Mr Hao'uli is a paid advisory for the Toko Collaboration Project (suicide prevention for Tongan community) funded under MOH Innovation.	20 January 2016	That Mr Hao'uli's specific interest is noted and the Committee agree that he may remain in the room and participate in any deliberations of the Committee but is not permitted to participate in any decision making.

Director having interest	Interest in	Particulars of interest	Disclosure date	Board Action
Mr Ben Hefford	After Hours Services	Mr Hefford's brother is a GP and Procare Board member	25 May 2016	That Mr Hefford's specific interest is noted and the Committee agree that he may remain in the room and participate in any deliberations of the Committee but is not permitted to participate in any decision making.
Dr Campbell Brebner	After Hours Services	Dr Brebner is a Procare shareholder.	25 May 2016	That Dr Brebner's specific interest is noted and the Committee agree that he may remain in the room and participate in any deliberations of the Committee but is not permitted to participate in any decision making.

Minutes of Counties Manukau District Health Board Community & Public Health Advisory Committee

Held on Wednesday, 6 July 2016 at 1.30 – 4.30pm, Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau

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Present: Dr Lee Mathias (Board Chair), Ms Sandra Alofivae (Committee Chair), Ms Dianne Glenn, Mr Ezekiel Robson, Ms Wendy Bremner, Mr John Wong and Apulu Reece Autagavaia.

In attendance: Ms Karyn Sangster (Chief Nurse Advisor, Primary Care), Ms Margie Apa (Director Strategic Development) and Ms Dinah Nicholas (Minute Taker).

Apologies: Mr Sefita Hao'uli, Ms Colleen Brown (Deputy Committee Chair), Mr George Ngatai, Mr David Collings, Mr Geraint Martin, Mr Benedict Hefford and Dr Campbell Brebner.

1. Welcome

Ms Alofivae opened the meeting with a quote noting it was Maaori Language Week and reflected that so much of our work is around families, children, vulnerable children and our communities. One of the most famous phrases we are all familiar with is:

"He aha te mea nui o te ao
He tangata, he tangata, he tangata"

"What is the most important thing in the world
It is the children, It is the children, It is the children"

And the following quote from Dane Whina Cooper which we should all reflect on as we go through today's meeting:

Take care of our children, take care of what they hear, take care of what they see, take care of what they feel for how the children grow, so will be the shape of Aotearoa".

2. Governance

2.1 Attendance & Apologies

Noted.

2.2 Disclosure of Interest/Specific Interests

Ms Alofivae advised the Committee that she has now retired from the Board of Pasifika Futures.
Ms Dianne Glenn disclosed a Specific Interest in relation to Item 3.1 on today's agenda.

2.3 Confirmation of Public Minutes (25 May 2016)

Resolution
That the Public Minutes of the Counties Manukau District Health Board Community & Public Health Advisory Committee meeting held on Wednesday 25 May 2016 were taken as read and confirmed as a true and accurate record.

Moved: Dr Lee Mathias **Seconded:** Ms Dianne Glenn **Carried:** Unanimously

2.4 Action Item Register Public

Noted.

3. Presentations/Reports

3.1 Auckland Regional Public Health Service 6-Monthly Report

Ms Jane McEntee and Dr Julia Peters took the Committee through the report highlighting the following:

BCG Vaccine - ARPHS provide BCG vaccination to 4,000-5,000 infants per year. There is currently a worldwide shortage of the vaccine and from the beginning of December 2015 to mid-March this year, eligible babies were unable to receive the vaccine. The vaccine distributor is unable to provide any information regarding future vaccine supply, and it appears unlikely that a new supply of vaccine will become available in New Zealand before 2017. Whilst it is not the main TB control strategy in New Zealand, it is a reasonably important component for children born in high risk counties or who do a lot of travelling back and forth. The World Health Organisation is continuously updating the level of risk in various countries around the world. There is likely to be an impact here and clinicians will need to be more alert for the signs and symptoms of TB in children but we are just one of many countries in this situation. The Ministry of Health has communicated to DHBs and Lead Maternity Carers about this shortage.

In response to a question about whether there is a register of those children who have missed out getting the vaccine, Dr Peters advised that ARPHS undertook a catch-up recently and currently they are not aware of anybody who wanted the vaccine but couldn't have it. They are meeting the MoH tomorrow to discuss whether the MoH think there needs to be any change in the overall TB strategy and will raise the issue of a register and whether a plan needs to be in place to follow up those groups of children who have missed out.

Sale of Parks – Ms Glenn advised that Auckland Council are intending to sell 14 reserves around the Auckland-region and would like to see them kept for the community to assist with physical activity to help in reducing obesity. Ms McEntee advised that ARPHs will pick this up.

Fluoride Briefing - the Government intends to move the decision-making on community water fluoridation from Territorial Local Authorities to DHBs. The aim of the change is to increase the proportion of New Zealanders with access to community water fluoridation. DHBs have two years to consider their approach but in the first instance should aim to contribute to the development of the new legislative provisions. Community water fluoridation remains a key strategy for improving oral health. It is effective, safe, and highly cost-saving.

Once legislation is passed, ARPHs will bring that back to the CPHAC Committee with all the updated research so we have all the information we need to make an informed decision. Implementation would occur in 2018. Much of the process for implementation still needs to be determined.

3.2 Q3 2015-16 Non-Financial Summary Report

This report was taken as read.

3.3 Locality Presentation

This presentation was deferred to the next meeting (17 August).

4. Primary Health & Community Services Directorate Report

Ms Claire Naumann took the Committee through some highlights of the Report.

4.1 Executive Summary

Confident the More Heart and Diabetes, Immunisation and Better Help for Smokers to Quit health targets will be achieved for Q4 and working with PHOs with increased focus on successful strategies to improve coverage across all health target areas. In relation to Cervical Screening, quarterly coverage is slowly increasing. Focussed efforts in June are on the lowest performing PHOs. Additionally a Cervical Screening Health Promoter is supporting this work by engaging with under or un-screened Maaori women. ProCare has developed a guide using data-match lists showing women who are overdue for cervical screening which will prove beneficial to other PHOs moving forward.

Mobility tablets with new clinical notes software, access to the patient management system and email have now been distributed to 150 clinical community staff.

Locality hub development is progressing. The Eastern locality has held a site planning event with stakeholders and are meeting with the architect this month to confirm the base proposal. Franklin has completed phase two scoping following a workshop with key stakeholders, and has also met the architect and Master Planner to reach the concept stage. The facility development plans for Otara/Mangere are in the detailed design stage and there has been active interest in the development of services in the Mangere hub from within CM Health services, particularly medicine and paediatrics. A recent audit of patients referred to ED by GPs from the Eastern locality showed that 80% could have been treated in the community. Ms Naumann to include this data in the next Director's Report.

Actions & Responses – Summary of Initiatives – Children's Team, SIB, Healthy Families, Kootuitui - each of the initiatives have different drivers and different agency funding. The galvaniser will be the SIB as we will have all the agencies around the table locally we will be in a better position to all agree on the benefits and how we measure and track them and add more value as we will be able to tell a better story about where one sector has invested somewhere but we've seen the benefit somewhere else. For example, the Children's Team is an MSD driven initiative but we are all contributing to it and the outcome is that the children start school with all their hearing and vision sorted, ready to learn and they do better at school and have consistency in education. That's the sort of holistic story we'd like to be able to tell.

The one anomaly is the Healthy Families NZ initiative. This is not a service delivery programme but more of a public health intervention. The initiative will bring together partnerships of key individuals and individuals who can influence transformational change in their communities and aims to create health promoting environments that support

physical activity and healthy nutrition. The conversation we would want to have around outcomes is are they pushing their resources in the places that concern us the most. We would like to see a lot of support around Mangere, Otara and Manukau if healthy environments are going to be beneficial for that community.

4.2 National Health & IPIF Targets
This report was taken as read.

4.3 Primary Health
The report was taken as read.

4.4 Progress with Systems Integration

We are doing well but need to keep the pressure on for referrals onto the Reablement pathway. Reablement is initially designed to last for up to a period of six weeks then at the end of that time an assessment is carried out and the long term support needs for that individual are worked out.

4.5 Locality Reports
The report was taken as read.

The Committee asked Ms Naumann to come up with an alternative way of reporting the data in the localities report (ie) dashboard- type reporting so the figures provided can be compared to the baseline.

4.6 Child Youth & Maternity
The report was taken as read.

4.7 Mental Health
The report was taken as read.

4.8 Adult Rehabilitation & Health of Older People
The report was taken as read.

4.9 Finance Report
The report was taken as read.

Page 71 notes that the Health of Older People variable variance of $1.3m will fund the investment now underway in the Community Integration implementation. There is a concern that this is a big variance and there is high demand in the health of older people. We need to ensure that the services for health of older people are not suffering because the money is needed for the community integration implementation. It's also not obvious or clear in the reports where the favourable variance is under community integration implementation. Ms Naumann confirmed that it is all being managed through the underspend but will provide more information in terms of how this spend is tracking and where it is being managed.

Resolution
That the Community and Public Health Advisory Committee **receive** the report of the Director of Primary Health & Community Services.

Moved: Ms Sandra Alofivae **Seconded:** Ms Dianne Glenn **Carried:** Unanimously

5. Resolution to Exclude the Public

Individual reasons to exclude the public were noted.

Resolution

That in accordance with the provisions of Schedule 3, Clause 32 and Sections 6, 7 and 9 of the NZ Public Health and Disability Act 2000, the public now be excluded from the meeting as detailed in the above paper.

Moved: Dr Lee Mathias **Seconded:** Apulu Reece Autagavaia **Carried:** Unanimously

2.50pm Public Excluded session.

3.05pm Open meeting resumed.

6. **General Business**

Mr Robson asked that he be provided with the number of people currently waiting for treatment for glaucoma.

The meeting closed at 3.06pm. The next meeting of the Community & Public Health Advisory Committee will be held on **Wednesday, 17 August 2016** in the Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau.

The Minutes of the meeting of the Counties Manukau District Health Board Community & Public Health Advisory Committee held on **Wednesday, 6 July 2016** are approved.

Signed as a true and correct record on **Wednesday, 17 August 2016.**

(Moved: /Seconded:)

Chair _____ 17 August 2016

Ms Sandra Alofivae Date

Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

Community & Public Health Advisory Committee Meeting – Action Items/Resolution Register – 17 August 2016

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
19.8.2015	5.10	Localities Presentations: Mangere/Otara Franklin Eastern Manukau	 17 August 28 September 9 November 21 December	 Sarah Marshall Kathryn du Luc Penny Magud Lynda Irvine		✓
20.1.2016	2.3	Plunket Society presentation.	17 August	Mr Hefford/Ms Sangster		✓
20.1.2016	3.5	ARHOP – national Health of Older People Strategy draft.	17 August	Mr Hefford/Ms Ralph-Smith		✓
25.5.2016	3.1	UpdateThe Southern Initiative(Gael Surgenor)	28 September	Mr Hefford		
25.5.2016	3.2 & 3.3	Asian Health Plan – Q1 2016/17 quarterly reporting update. Pacific Health Plan – Q4 2015/16 quarterly reporting. Maaori Health Plan – Q4 2015/16 quarterly reporting.	9 November 28 September 28 September	Ms Apa		
6.7.2016	3.1	ARPHS - six-monthly update.	21 December	Mr Hefford		
6.7.2016	4.1	Executive Summary – provide the data from a recent audit of patients referred to ED by GPs from the Eastern locality that showed that 80% could have been treated in the community.	17 August	Mr Hefford	Refer Item 4.5 on this agenda.	✓
6.7.2016	4.5	Locality Reports – data to be reported in a dashboard-style reporting going forward.	17 August	Mr Hefford	Refer Item 4.1 on this agenda.	✓
6.7.2016	4.9	Finance Report – provide more information on the $1.3m variable variance for HoP showing how this spend is tracking and where it is being managed.	17 August	Mr Hefford	Refer Item 4.1 on this agenda.	✓

Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
6.7.2016	7.0	General Business – provide the number of people currently on the wait list for treatment for glaucoma.	17 August	Mr Hefford	Refer Item 4.1 on this agenda.	✓
Deferred from 15.6.2016 HAC meeting		PHO practices running a 6min consultation – to be followed up through CPHAC/Mr Hefford who will have a very firm conversation with those practices running this type of consultation, it is not acceptable.	28 September	Mr Hefford	17.8.16 - This matter will be followed up at the next Alliance Leadership meeting on 18 August and a report will be available at the 28 September CPHAC meeting.	
Resolutions						
20.1.2016	2.3	**Resolution** That the Board request of Ministry of Health that all Well Child providers are required to meet defined breastfeeding targets as indicated by Government policy which is underpinned by the Innocenti Declaration. **Moved** Dr Lee Mathias/S**econded** Ms Sandra Alofivae/C**arried** Unanimously	Pending		27.1.2016 - Passed to Board Secretary. 25.5.2016 – Ms Ellis & Dr Pip Anderson are meeting with Dr Mathias on 15 June to discuss. 6.7.2016 – Dr Mathias has written to MoH and is awaiting a response.	

Counties Manukau District Health Board
Community and Public Health Advisory Committee
Health of Older People Strategy – Draft

Recommendation

It is recommended that the Community and Public Health Advisory Committee:

Receive the draft Health of Older People Strategy.

Provide feedback on the draft Health of Older People Strategy.

Note that the feedback period is from July through September 2016

Prepared and submitted by Dana Ralph-Smith, GM Adult Rehabilitation and Health of Older People on behalf Benedict Hefford, Director of Primary and Community Directorate

Purpose

The purpose of this paper is to inform CPHAC of the public consultation on the draft Health of Older People Strategy.

Background

Following the update of the New Zealand Health Strategy the 2002 Heath of Older People Strategy has been refreshed. The Ministry of Health released the draft Health of Older People Strategy for public consultation on 13 July 2016.

Feedback on the draft Strategy is invited via written submission and by discussion in both meeting and online format, with the closed date for submissions being 7 September 2016.

The draft vision for this Strategy is that older people live well, age well and have a respectful end of life in age-friendly communities. It has a strong focus on prevention and support for independence, and recognises the importance of family, whanau and community in older people's lives.

The five outcome areas forming the framework for this Strategy are:

- prioritising **healthy ageing** and resilience throughout people's older years
- enabling high-quality **acute and restorative care**, for effective rehabilitation, recovery and restoration after acute events
- ensuring people can **live well with long-term conditions**
- ensuring better **support people with high and complex needs**
- providing **respectful end-of-life** care that caters to personal, cultural and spiritual needs.

Healthy ageing considers maximising physical and mental health and wellbeing, independence and social connectedness as people age. The actions are to encourage resilience in older people, healthy environments and age-friendly communities.

Acute and restorative care considers maximising independence after an older person has had an acute event, and ensuring that coordinated service provision is in place to recognise, minimise or manage any significant change or deterioration.

Living well with long-term conditions considers the needs of people with who have long term chronic health conditions or disabilities, and whose needs become more complex as they age.

Supporting people with high and complex needs considers the needs of the older people with high and complex needs that become dependent as they age. This includes health and social sector coordination to reduce inequities and provide quality care in the right setting at a sustainable cost.

Respectful end-of-life care focuses on tailoring care to meet the physical, emotional, social and spiritual needs of the individual and their family and whanau.

CM Health of Older People team will participate in a workshop discussion of the draft Health of Older People Strategy as part of the national Health of Older People Programme Managers' meeting on 12 August 2016.

Appendix

The draft Strategy can be found in the Diligent Resource Library.

Health of Older People Strategy

Consultation draft

Citation: Ministry of Health. 2016. *Health of Older People Strategy: Consultation draft*. Wellington: Ministry of Health.

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Minister's foreword

Older New Zealanders are a large and growing proportion of our population. They deserve our best support to live healthy, independent lives and to have a respectful end of life.

I commissioned the refresh of this Strategy to follow the updated New Zealand Health Strategy, which provides a framework for the health and disability system to achieve equitable outcomes for all New Zealanders. To be able to provide for the growing number of older New Zealanders, we need to ensure our health and disability services are sustainable. We have the opportunity to embrace changes to the system and the way it operates that will improve its sustainability and add life to years, not just years to life.

This draft Strategy intends to provide a clear direction for the sector and outlines the actions needed to improve the health outcomes and independence of older people in a sustainable way. This will require an innovative and responsive system that is person centred and that appropriately supports older people to make informed choices about their health and wellbeing.

This draft Strategy has strong links to the Positive Ageing Strategy. Older people make a significant contribution to and have an integral role in our society. The Government is committed to the goals of positive ageing and a vision where older people age well and are healthy, connected, independent and respected.

A multi-faceted and coordinated approach is needed to improve the health, independence and wellbeing of our older people, particularly those who are living with long-term conditions, have high and complex health needs or are in population groups that are experiencing poorer outcomes from the health system. This will require the health and social sectors to work collaboratively and for everyone in New Zealand to recognise the important role that family, whānau and 'āiga carers play in supporting our older people in their homes and communities.

As well as enabling and supporting older people to age well, this Strategy focuses on ensuring older people have a respectful end of life. Older people need to feel safe and supported to openly discuss and plan their end-of-life care. The health system also needs to be coordinated and responsive to older people's wishes.

The draft Strategy is the result of a highly collaborative process, involving many people and organisations with a stake in how we maintain and improve the health older people. This reflects the multiple influences on older people's health and wellbeing, and illustrates a shared understanding, responsibility and commitment to the vision of the Strategy and to making the changes to maintain and improve the health of older people.

I would especially like to acknowledge the contribution of older people and family and whānau carers to the draft Strategy. Your input has been important as it will help to shape and improve the system and services to better respond to your needs and circumstances so that you can live well and age well, and so that your wishes are respected.

Hon Peseta Sam Lotu-Iiga
Associate Minister of Health

Director-General of Health's foreword

With the release of the refreshed New Zealand Health Strategy, it is an appropriate time to review the Health of Older People Strategy.

The existing strategy, launched in 2002 has delivered many successes, including greater choice in long-term health care services. We can all be proud of that.

However, the social and demographic picture in our country has changed over the past 14 years. In 2002, when the current strategy was published, people 65 and older made up 11.5 percent of the New Zealand population. That figure is now 15 percent and by 2033 is expected to reach 22 per cent.

We must ensure that our health system provides the care, support and treatment that older New Zealanders need and, is sustainable. We want a health system that works for every older New Zealander. This means taking into account all the factors that impact on peoples' health and wellbeing.

The New Zealand Health Strategy recognises the challenges and opportunities we face. Its five themes – people-powered, closer to home, one team, smart system and value and high performance – are further developed in this draft Health of Older People Strategy.

It has a strong focus on prevention and support for independence. It also recognises the importance of family, whānau and community in older people's lives. In addition, it signals the need for Government agencies, healthcare providers and all those who make a difference to health and wellbeing to work better together. Better integrating health and social responses will help them be more responsive to New Zealanders' needs and choices.

Following everyone's input, this draft Strategy's priorities are adding 'life to years', and a future oriented around healthy ageing, living well with long-term conditions, recovery from acute events, better support for people with high and complex needs, and ensuring people can experience a respectful end of life.

The actions outlined in the draft Strategy have been organised around the five New Zealand Health Strategy themes to make it easier to measure and review progress, performance and quality.

This draft Strategy provides us with a clear focus and vision for where we want to head. As with the New Zealand Health Strategy, the Ministry of Health will provide the leadership needed to help all the organisations involved play their part in the actions, changes and focus needed.

Leadership in this context is not about being in charge or having all the answers. Many people and organisations have been involved in developing this draft strategy: from individuals to families and whānau, carers, health professionals, service providers, government and non-governmental organisations. I'd like to thank everyone who has contributed. Your insights are vital.

So I encourage you to stay involved with this process and make a submission on this draft. Your feedback will help us to prioritise the right actions to build a manageable programme of work that gets results.

Chai Chuah
Director-General of Health

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About this document

This document sets out a draft strategy for the health and wellbeing of older people for the next 10 years. It will benefit older people, family and whānau of older people, those who work with older people, and those who plan and fund services.

This is a consultation document. The Ministry of Health is seeking your views on the direction we take and the actions we propose.

There are four parts to this document. The first part is introductory, and sets out the need for a new strategy. The second proposes an overarching direction for the system for 2016–2026. The third section is the 'Action Plan': it proposes a set of specific actions we want to take. The fourth part, 'Have Your Say', tells you about how to make a submission and make sure it reaches us in time, and includes questions to guide your submissions.

Older people are by no means a homogenous population group. We don't become 'old' at any particular age or age in the same way. Ageing is only partially associated with chronological ageing and there is no 'typical' 65- or 75-year-old. The choices we make, our intrinsic biology and abilities, our social, environmental and economic circumstances and the activities we engage in can greatly influence the pace at which we age. Not all people will become dependent on others as they age.

This draft Strategy takes an inclusive approach. It is not limited to people with health conditions and disabilities that need treatment and management. It will benefit:

- people who are independent and competent, both physically and mentally, throughout their older years
- people with acute health conditions who need short-term support or rehabilitation to return to their previous level of independence
- people who had long-term or chronic health conditions or disabilities during their earlier adult years, and whose needs become more complex as they age
- people who develop disabilities and become dependent as they age, due to cognitive and physical decline, and conditions such as dementia
- people in the last stages of life.

The draft Strategy supports a person-centred approach. Our system and services aim to keep people in good health for longer, recognising that older people have different needs at different times. People with the highest need may be those who have the fewest resources and the least capacity to address that need.

The draft Strategy takes a preventative approach to illness and disability associated with the ageing process. It also focuses on older people who have had long-term disabilities, who may be living independently and competently in their older years. It also recognises that some people with life-long disabilities may have more unique and complex health and disability needs as they age.

Strategy development and consultation process

This draft Strategy is the result of extensive engagement with older people and their families, whānau, ’āiga and carers, aged care providers, health care professionals, professional bodies, researchers, Māori and Pacific service providers, government agencies, district health boards (DHBs), primary health organisations (PHOs) and other non-governmental organisations representing and supporting older people.

We held workshops with these key stakeholders that helped to establish the key priorities for the Strategy, along with a wide range of potential actions. We held additional focus groups with older people and carers of older people, which helped us to understand what’s important to older people, and how they currently experience and want to experience the health system. During this time, we received suggestions for the Strategy by email and through the Ministry’s website.

The image below shows the values most commonly identified in the engagement workshops regarding the ‘ultimate goal’ for the Strategy. All of the input has helped us develop this consultation document. We are now seeking your feedback on this draft Health of Older People Strategy, and encourage you to make a submission.

The need for a new strategy for the health of older people

Everyone is ageing and wants to age well. That New Zealanders are living longer than ever before is a major success story, and most older people are fit, healthy and active.

Older people contribute greatly to our society as family and whānau, carers, neighbours, mentors, leaders, volunteers, employees and employers, tax payers and consumers.

Remaining in good health, ageing well and being able and supported to live well with long-term conditions is critical to enable older people to continue participating and feeling valued, which in turn is important for health and wellbeing.

Building a health system that can deliver good health outcomes requires us to take stock of our achievements, challenges and opportunities, our policies, the way we currently fund and deliver care, our performance and the tools and resources we need to reach our goals.

Building on our achievements

Since the release of the 2002 Health of Older People Strategy, we have made significant improvements. We substantially implemented that Strategy's more than 100 actions, which has led to:

- more consistent and comprehensive assessment of people's needs for home and community support and residential care
- greater choice in long-term health care and disability support services; we are supporting more people than ever to remain in their homes for longer with long-term health conditions and disabilities
- increased funding for home and community support services (this has doubled over the last eight years) and residential care, especially for those who need it most
- a significant improvement in the quality of health care in aged residential care; and we are making improvements in home and community support services
- implementation of the Dementia Care Framework, which aims to increase people's understanding and acceptance of dementia and to better equip primary health care services to diagnose uncomplicated dementia earlier
- a greater understanding of the factors that can help older Māori remain healthy and independent into old age
- projects to improve older people's strength and balance; to prevent frailty, fractures and harm from falls; and to increase older people's mental wellbeing, mobility and quality of life
- a better understanding of various risk factors for poor health, including social isolation and loneliness, certain neurological conditions, and frailty. We know more about the potential of technology to combat these issues
- better quality information on health services tailored for older people

- improved access to elective surgery, which results in greater levels of activity and independence
- improved discharge planning, aiming to strengthen connections between acute hospital services and health services in the community such as CREST and START.[1]

Fourteen years on from the 2002 Strategy, our operating environment has changed, and our priorities continue to evolve.

The refreshed New Zealand Health Strategy has set new directions for our health system into the future. It is driving how we organise ourselves and behave, with a stronger focus on prevention, independence and wellness, people-centred services, trust, cohesion and collaboration, and integrated social responses.

We need to apply those principles to our approach for improving and maintaining older people's health and wellbeing.

Part of this is making sure that we are getting the best value we can from our funding. As we age, we are more likely to develop long-term chronic health conditions and disabilities requiring support on a daily or regular basis.

We currently spend 42 percent of the $11,000 million health budget on people aged 65 years and older, who make up 15 percent of population. Based on population growth alone, this could rise to 50 percent of DHB expenditure by 2025/26. However, cost increases do not need to mirror demographic growth. Recently, the percentage of older people requiring some of the most expensive health services, such as acute care and aged residential care, has decreased. This indicates that older people are increasingly healthy and better supported to live well at home.

We want to maintain the positive changes we have seen over the last 14 years and improve on them in the current context.

We also want a system that is truly person-centred, supporting and empowering people to make informed choices about their health and wellbeing, and is coordinated and integrated around people's needs and aspirations, providing high-quality services that deliver value for people.

[1] 'CREST' is Canterbury DHB's Community Rehabilitation Enablement and Support Team. 'START' is Waikato DHB's Supported Transfer and Accelerated Rehabilitation Team. These teams provide intensive home-based rehabilitation following a stay in hospital or presentation to an emergency department.

Strategic context

The Health of Older People Strategy sits under the New Zealand Health Strategy 2016, released on 18 April 2016, which provides the overarching framework and directions for the health system. The New Zealand Health Strategy describes the future we want, identifies the culture and values that underpin this future, and sets out five strategic themes for changes we can make that will take us toward the vision:

> All New Zealanders **live well**, **stay well**, **get well**, in a system that is **people-powered**, provides services **closer to home**, is designed for **value and high performance**, and works as **one team** in a **smart system**.

The Health Strategy provides the building blocks for this Health of Older People Strategy. Together, the two strategies set out how we will work toward maintaining and improving healthy ageing and independence, regardless of people's health status, and provide better support for people with high and complex needs and at the end of life.

The New Zealand Disability Strategy 2001 also feeds into this Health of Older People Strategy. It presents a long-term plan for an inclusive society that highly values disabled people and continually enhances their full participation. This Strategy is undergoing a refresh in 2016 and will be informed by the Convention on the Rights of Persons with Disabilities, ratified in 2008. The Health of Older People Strategy is consistent with the articles of the Convention.

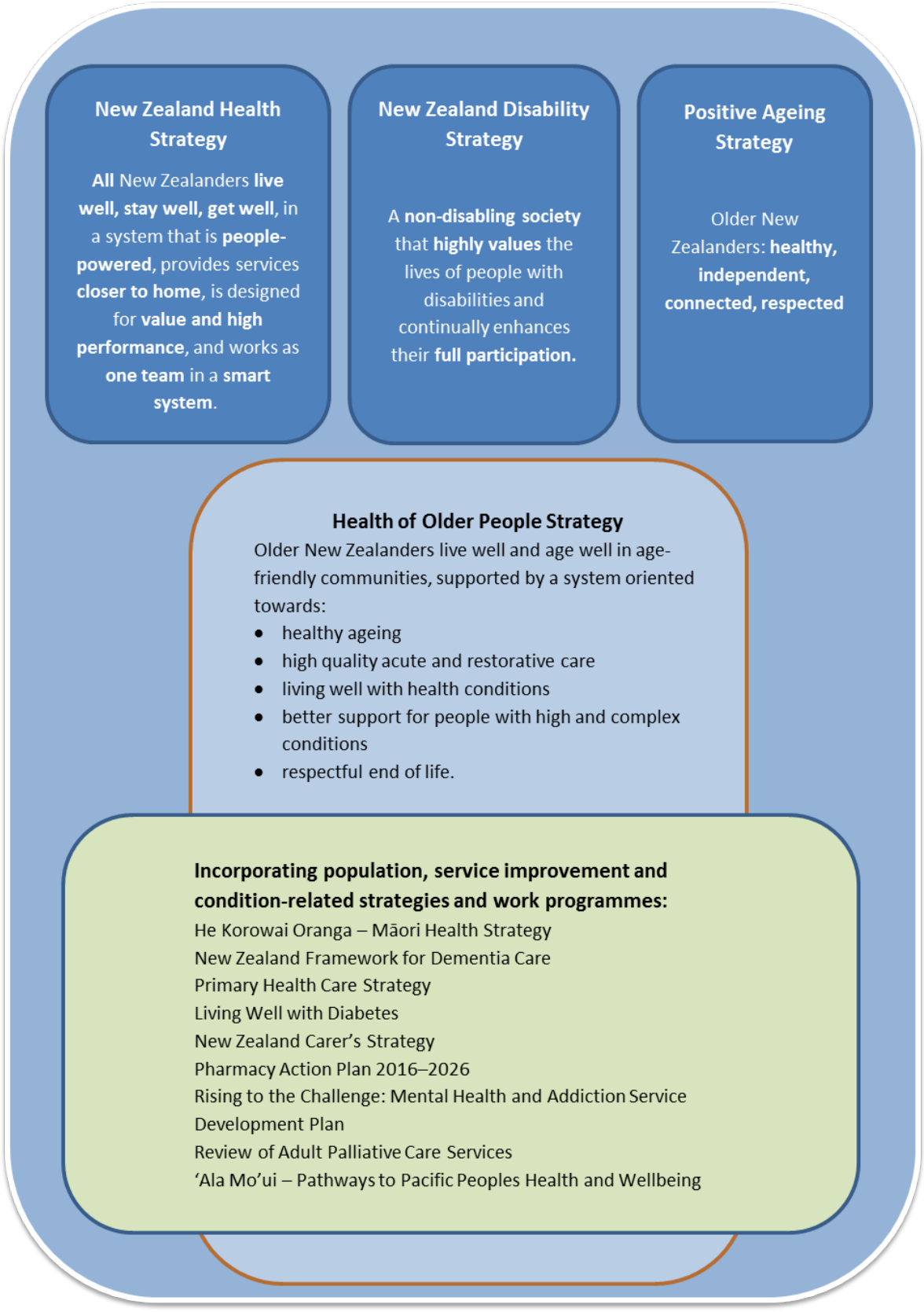
Government has a long-standing commitment to the vision and principles of the cross-government New Zealand Positive Ageing Strategy 2001, as reiterated in 2013 in *Older New Zealanders – Healthy, Independent, Connected and Respected*. Together, government agencies, including local government, are working towards a 'vision of a society where people can age positively and where older people are highly valued and recognised as an integral part of families and communities'.

We recognise and respect the special relationship between Māori and the Crown through the principles of the Treaty of Waitangi. In the health and disability sector, this involves more support to participate in the sector and in making decisions on services. Given the poorer health experienced by Māori, this also involves delivering services that are effective for Māori. He Korowai Oranga, the Māori health strategy, guides the government's and the health system's approach to Māori health, in line with the Treaty, and including for the health of older people. This Strategy was last updated in 2014.

Other specific national strategies, action plans and work programmes influence the health of older people and provide guidance for services on meeting their needs. The diagram below sets out some of these, and the Action Plan section of this document includes some of their priorities and actions.

The priorities and actions under these strategies are complex and dynamic and more specific details are included alongside the Health of Older People Strategy actions. It is our intention to regularly review progress towards these actions alongside progress towards the health of older people strategic directions, to ensure we remain on track.

The Health of Older People Strategy in its government context



Taking a life course approach

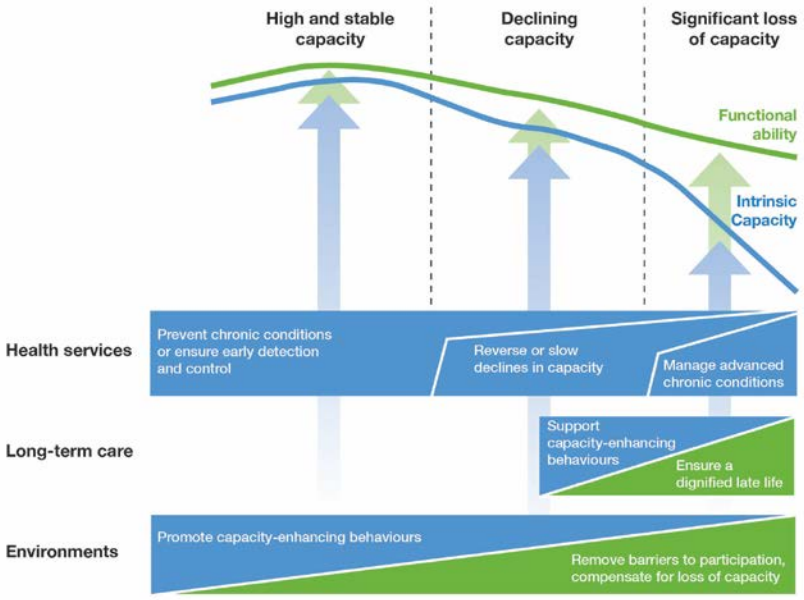
How well we age is influenced by our genetics, our upbringing, how healthily we live in younger years and throughout our adult life and our exposure to health risks including poor housing, workplace discrimination and family violence. Also highly influential are our physical and mental capabilities; our access to resources and opportunities; our resilience including in the face of adversity; our relationships; our personal circumstances, including our occupation, level of wealth, educational attainment and gender; our potential for personal growth; and our sense of identity, security, value and wellbeing.

This Strategy applies a life course approach to achieving the aim of healthy ageing. This recognises that we age in different ways and have different needs at different times, and that our health is affected by our environment. The approach involves enhancing growth and development, preventing disease and ensuring the highest capacity possible throughout life.

'Healthy ageing' does not refer to the absence of disease or physical or mental ill health. The World Health Organization defines healthy ageing as 'the process of developing and maintaining the functional ability that enables wellbeing in older age.'

Initiatives for older people that take a life course approach, promoting 'healthy ageing', focus on building and maintaining people's physical and mental function and capacity, maintaining independence and preventing and delaying disease and the onset of disability. Such initiatives aim to maintain quality of life for older people who live with some degree of illness or disability requiring short or long-term care. They enable disabled people to do the things that are important to them, enhancing their participation, social connection and appropriate care and ensuring their dignity in later years.

Figure 1: A life course framework for healthy ageing



Source: World Health Organization

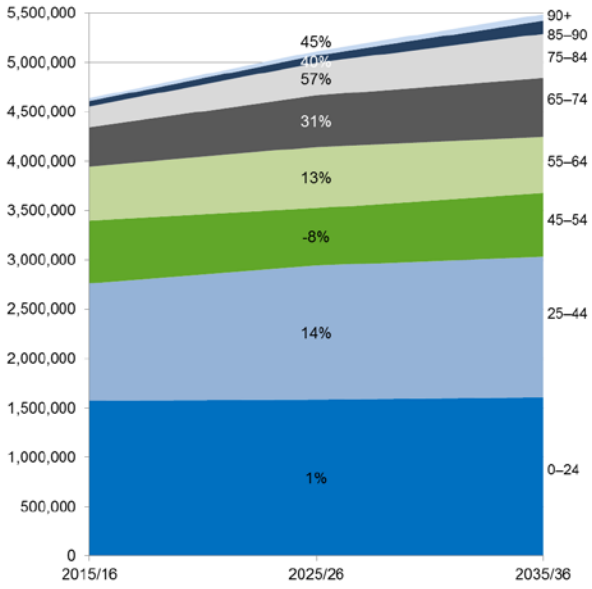
Challenges and opportunities

An ageing population

New Zealand's population is ageing. There will be a substantial increase in the number of older people in the next decade. The older population will also be more diverse. The Maori population of people aged 65 years and older is projected to increase by 115 percent in the 15 years to 2026. The older Pacific population is expected to grow in number by 110 percent, and older Asian population by 203 percent in this same period.

The changing population has major policy, funding and planning implications. We need to plan well to make sure we are well equipped nationally, regionally, economically and socially. We need to have the right infrastructure in place to keep people in good health and provide for those who are not.

Figure 2: Population projections by age group with 10-year percent change

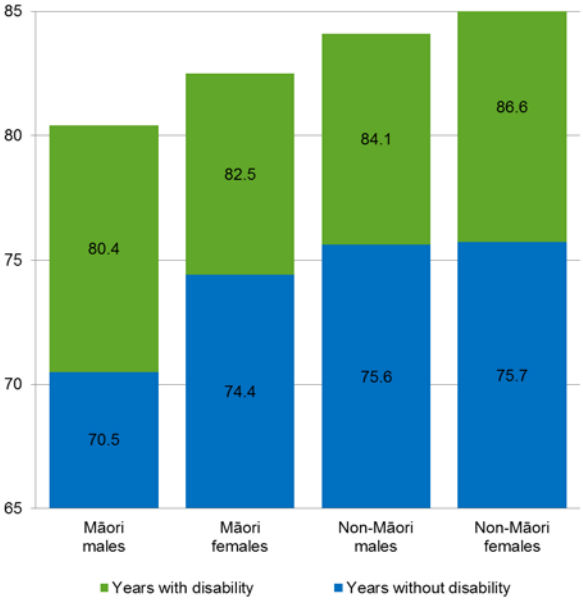


Source: Statistics New Zealand

Currently, over one in six older people are living with three or more long-term conditions. Based on existing trends, an increasingly older population will mean steadily increasing health care needs. As a population group, older people have much higher rates of long-term chronic health conditions, and disabilities requiring support on a daily or regular basis.

We are living longer, but the age to which we are likely to live in good health and without disability is not increasing at the same rate as life expectancy. At the age of 65 years, we can expect to live half of our remaining lives either free of disability or with functional limitations that we can manage without assistance.

Figure 3: Māori and non-Māori life expectancy at age 65



Source: Ministry of Health

This is not the same for all population groups. Māori males at age 65 can expect the shortest remaining time of living without disability or long-term illness (5.5 years on average) and the highest proportion of remaining years lived with dependency (64 percent). People with intellectual

disabilities have some of the poorest health outcomes, and can develop dementia at a younger age.

Health inequities

We need to continue our efforts to reduce inequities in health, so that all population groups can enjoy good health and participate fully in family and community life. In this respect, the Ministry of Health focuses specifically on Māori, Pacific peoples, migrant and refugee communities, people with disabilities, people with long-term mental health conditions or addictions and people with low incomes, who experience persistent inequities.

Achieving equity is a core component of the 'value and high performance' theme. This is underpinned by the New Zealand Triple Aim Framework for a whole-of-system approach to achieving, balancing and measuring better health and equity, better value for public health system resources and improved quality, safety and experience of care.

Figure 4: New Zealand Triple Aim Framework

To achieve equity, we need to understand and remove the barriers that prevent groups from experiencing equitable health outcomes, and build the factors that enable equity. We need to work together with other sectors to address a range of barriers. The existing barriers we know about are infrastructural, financial and physical. Others can be difficult to articulate or identify.

We need to better understand how well our services are working for different population groups, and why problems arise. This has implications for the way that the sector conducts research, collects data and evaluates the effectiveness of services. To improve the health of different groups, we need to draw on the experience and expertise of community leaders. In this way we can inform the design of services, tailoring them to specific populations so that they are more easily available, more culturally appropriate and tailored to individual circumstances.

He Korowai Oranga

Improving the health of older Māori is a priority for this Strategy, and our approach is guided by He Korowai Oranga, the Māori Health Strategy. He Korowai Oranga has an overarching goal of pae ora, which translates to healthy futures for Māori, and comprises wai ora (healthy environments), whānau ora (healthy families) and māuri ora (healthy individuals). The Strategy aims to:

- build Māori capacity to actively contribute to their own iwi, hapū and whānau
- improve Māori participation and decision-making in the health and disability sector
- ensure that health and disability services are effective for Māori as well as all New Zealanders
- ensure that we think beyond narrow definitions of health and work across

sectors to achieve a wider vision of good health for everybody.

Staying healthy and independent in older age

We have an opportunity to reinforce and accelerate the positive trends we have seen in recent years. By focusing on preventing illness and by making it easier to choose healthy options (like eating healthy food, not drinking alcohol or only drinking at low-risk levels, and undertaking regular physical activity), we can help people to avoid developing long-term health conditions or slow the development of those conditions. Most importantly, we can do this by providing universal health services and public health initiatives that cover the whole population, and having services in place to intervene early, help people to return to good health and remain independent. As part of this, we need tailored approaches for some individuals and population groups, to help them access the same level of service and enjoy the same outcomes as others.

New investment approaches

If the health system continues to fund services the way it currently does, expenditure on older people will account for 50 percent of DHB expenditure by 2025/26, up from 42 percent. It is vital that we ensure that we are getting the best value from the investments and resources across the health system and the social sector.

Currently, the Ministry of Health and other government departments are taking new 'social investment' approaches to funding services. These approaches provide significant opportunities for improving the health of New Zealanders in general and older New Zealanders in particular. One example of a social investment approach might be a concerted effort to reduce social isolation and loneliness, which we know have a strong relationship with poor mental and physical health outcomes and with increased problematic alcohol use.

Workforce development

The health system faces some significant workforce challenges. The health of older people workforce is itself ageing and some key workforce groups have been difficult to recruit. Forecasts show, for example, that we will have trouble maintaining the necessary number of geriatricians and some other medical specialties, as well as registered and enrolled nurses in aged care.

As people live longer with long-term conditions and complex needs, either at home or in residential care, we will increasingly need to support and develop the skills of our nursing, allied and kaiāwhina workforces. Some initiatives to sustain and grow the workforce are underway, including incentives for graduate nurses to come into the sector and programmes to support teams working together across all settings. However, these are not yet achieving significant gains. We need to be smarter in terms of the way we make use of different parts of the workforce, such as the well-qualified pharmacist and allied health workforces.

We need to prioritise attracting, retaining and making best use of the skills of all in the health workforce to meet the needs of an older population.

Families and communities

We also need to ensure that family and whānau carers receive support and information to be able to appropriately and safely care for older people. Family and whānau carers should be supported to maintain good health, and undertaking a caring role should not exacerbate any existing health conditions or disabilities.

We are starting to see the development of age-friendly communities in New Zealand. This term refers to an initiative to build communities that enable positive ageing, and healthy, respected, connected and independent older populations. The Office for Seniors has undertaken to promote the development of age-friendly communities. Many are led by older people, together with local councils and a variety of organisations, who work towards local solutions to optimise older people's opportunities for healthy ageing, participation, security and quality of life. Age-friendly communities provide a new opportunity for developing knowledge about and skills for healthy ageing, and for the health sector to partner with older people to develop health and resilience.

Integration across the health and social sectors

Our approaches to the health and care of older people need to change at multiple levels. We need better communication between health service users and providers, to ensure that services are as effective and efficient as they can be, and to ensure that people are better able to stay well and manage their own health, and engage in the design and delivery of their services. We need to improve the abilities of families, whānau, carers and communities to support and help care for older people. The health system needs to work with other sectors to take joint action on the social, environmental and economic determinants of people's health. Housing and transport, for example, are critical to keeping people well in their own communities.

Investment approaches present opportunities to work in more integrated and longer-term ways across the health and social sectors, for improvements in both health and social outcomes.

More collaborative approaches will make best use of those with specialist skills, such as nurse practitioners, clinical nurse specialists and all health professionals including allied, pharmacists and paramedics, to improve outcomes and enable innovative models to develop in home care, primary care and residential care. We will be better able to manage the growing need when our entire workforce is appropriately trained and working to their full scope.

Smart system

Today's health system is a data-rich environment; that is to say, there is a tremendous volume of data that can be harvested to create a much smarter system.

The value and high performance theme of the Health Strategy places an emphasis on measuring the performance of the whole system and recommends the development of an outcomes-based approach to performance measurement. The Ministry has worked closely with the sector to co-develop a suite of system-level measures that provide a system-wide view of performance. Three of the measures: acute hospital bed days per capita, patient experience of care and amenable mortality rates, in particular, highlight significant opportunities to improve the health outcomes of older people.

We're also able to make use of new technologies and information improvements. These technologies and improvements include initiatives that enable information to flow quickly and freely to older people themselves and to health workers, providers and families and whānau; apps that provide immediate information on an older person's health status; and social media, which enables health professionals to better reach older people, families, whānau and carers in diverse or isolated communities and help them to more easily connect with the services and information they need. Improved information flows will also help agencies to collaborate more widely.

Vision and objectives

The workshops and discussions held prior to preparation of this draft Strategy gave us a clear picture of the values and principles we needed to focus on. We formulated the draft vision for this Strategy after careful consideration and analysis of the discussions.

The draft vision for this Strategy is that:

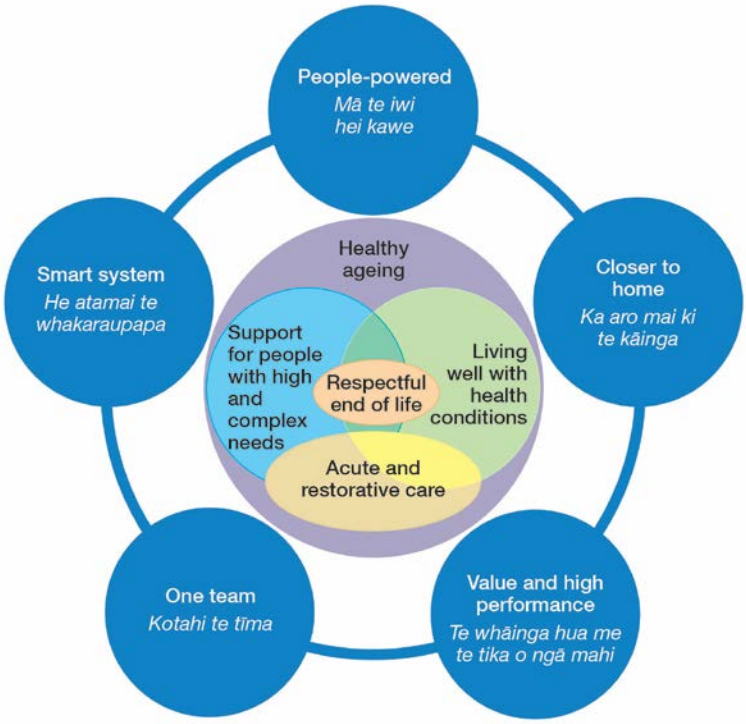
> Older people live well, age well and have a respectful end of life in age-friendly communities.

In order to achieve this vision, we need to ensure our policies, funding, planning and service delivery:

- prioritise **healthy ageing** and resilience throughout people's older years
- enable high-quality **acute and restorative care**, for effective rehabilitation, recovery and restoration after acute events
- ensure people can **live well with long-term conditions**
- better **support people with high and complex needs**
- provide **respectful end-of-life** care that caters to personal, cultural and spiritual needs.

These five outcome areas form the framework for this Strategy. We will set out to achieve our vision in these five areas within a system that, as the New Zealand Health Strategy requires, is people-powered, delivers services closer to home, is designed for value and high performance and works as one team in a smart system.

Figure 5: Strategic framework for the health of older people



Healthy ageing

This outcome area is about:

- older people being health smart and developing and maintaining functionality that enables physical and mental wellbeing throughout older ages
- building resilience, and preventing illness and disability
- addressing the physical, social and environmental risks to healthy ageing
- achieving equity for Māori and vulnerable population groups
- growing age-friendly communities that enable older people to positively age.

Why this is important

Getting older is often perceived as a person's inevitable decline into illness and frailty and becoming a burden on their family and whānau and society. Yet most older people are well and healthy and lead active lives.

Healthy older people make a significant contribution to our society, including as mentors, leaders, skilled workers, carers, and volunteers. They are active and engaged with the community, contributing economically, socially and intellectually to society. A healthy older population is a key feature of our commitment to positive ageing.

While there may be some loss of strength and mobility over time as we age, many of the conditions associated with ageing, such as frailty, are not inevitable. The World Health Organization estimates that more than half of the health conditions older people experience are potentially avoidable through lifestyle changes. There is increasingly clear evidence that healthy lifestyles and physical and mental resilience are determinants of health in older age.

Healthy ageing is about maximising physical and mental health and wellbeing, independence and social connectedness as people age. Healthy ageing is determined by individuals' own physical, emotional and mental capacity, the social, economic and environmental factors that influence people's health and wellbeing, and the strengths, exposure and vulnerabilities that accumulate over time. With the overarching goal of wellbeing, healthy ageing approaches act on the social determinants of health, the environments in which people live and can access, and actions to enhance equity.

Investing in healthy ageing has clear potential to increase the proportion of healthy, active and independent older people, prevent long-term conditions and their impacts on people's lives and result in long-term savings to the heath system. A healthily ageing and robust population would help enable individuals to continue participating in their communities and contributing economically, socially and intellectually to a greater extent. Fewer would require acute health interventions and would be able to stably maintain themselves if they developed chronic health conditions.

Resilience

To achieve healthy ageing, we need to focus on resilience and equity. Resilient people flourish in the face of negative events, overcome stressful obstacles and recover from events that might tip a less resilient person into a state of poor health. Resilient people are more likely to age well and to avoid cognitive decline or loss of function until very late in life.

We need to increase physical activity and other healthy behaviours among older people – for example, good nutrition, not drinking alcohol or only drinking at low-risk levels, not smoking tobacco, and mentally stimulating activities that build people's strengths and resilience. We need a strong shift of focus from treating illness and addictions to preventing them and optimising older people's health, through healthy lifestyles and behaviours, improved strength and balance, improved oral health and improved health literacy.

Enabling people to stay active and connected community participants as they grow older is critical. There is strong evidence of the links between social isolation or loneliness and poor health outcomes. We will take action to increase awareness of this across the health system, and join with social sector agencies, community and voluntary organisations in an effort to reduce this risk factor and increase social interaction and connectedness.

We must also improve mental wellbeing among older people. Social connectedness, nutrition, physical health and activity all contribute to mental health, as does an environment that promotes older people's sense of self-worth and value to others. We need to continue to reduce the stigma of depression and anxiety, which is still quite high among older populations, and promote the factors and supports for greater mental wellbeing. Positive psychology approaches that build people's strengths and capabilities are another important element to building mental resilience, increasing optimism and hope and reducing the potential and impact of depression, anxiety and cognitive decline.

We know that financial security is also important for mental wellbeing and healthy ageing. Linking people with budgeting advisors and resources and programmes, such as those offered by the Commission for Financial Capability, can assist people to prepare financially for their years following retirement.

There are a number of ways in which we can minimise the harm of sensory loss and the loss of functional ability in older people. Timely recognition of emerging sight and hearing issues, for example, appropriate assessments for functional impact and better approaches to enablement can make a signficiant difference to how well people are able to live and participate in everday life and remain independent.

Healthy environments and age-friendly communities

Together with other government sectors and communities, the health system will work to improve the social, economic and physical environment factors for healthy ageing and achieve equity, removing barriers to participation. There are many opportunities to benefit long term from investments in social and environmental factors that influence health.

As well as taking joint action with partners outside the health sector on loneliness, key areas for improvement include:

- prevention, identification and reduction of elder abuse and neglect
- the quality and range of age-friendly housing for older people, with a focus on rental housing stock, which older people are increasingly likely to live in, and supported living housing options
- an increase in alternative means of transport for older drivers, especially for those who are no longer permitted to drive, to help prevent isolation and an increase in the flexibility of social services in areas where transport options are most limited
- an increase in age-friendly communities.

We will work with social housing providers to ensure that social housing is warm, safe and dry, and with others to promote options for housing that meet the needs of an ageing population. In partnership with the social and justice sector, we will work to reduce family violence and sexual violence to older people and the impacts of such violence on wellbeing.

There has been a recent surge of interest in age-friendly communities among older people and local government workers in particular. Age-friendly communities directly aim to improve social and environmental factors that also influence health – access to transport, initiatives to improve the physical environment (eg, accessible shops and dementia-friendly libraries), better housing, opportunities for civic participation and employment, improved community support and health services and positive perceptions of ageing. Health agencies will partner with older people and local governments to support the development of age-friendly communities and build networks and run initiatives that promote healthy ageing.

Our vision for healthy ageing

- Older people are physically, mentally and socially active; and healthy lifestyles and greater resilience throughout life mean that we spend more of our lives in good health and living independently.
- Everyone in the health system understands what contributes to healthy ageing, and takes part in achieving it.
- Older people are health smart, able to make informed decisions about their health and know when and how to get help early.
- All older populations are supported to age well in ways appropriate to their needs.
- Communities are age-friendly with initiatives to keep people healthy, well-connected, independent, respected and able to participate fully in their communities and with family and whānau.

Acute and restorative care

This outcome area is about:

- restoring, maintaining or adapting function after an older person has had an acute event
- coordinating care across specialities and across ACC and the health sector, to improve rehabilitation and restoration outcomes
- ensuring support is in place to reduce further hospitalisations among older people, and to recognise, minimise or manage any significant change or deterioration
- looking for ways to weave family and whānau and wider community support into recovery, especially for those with cognitive impairments such as dementia.

Why this is important

Older people are high users of hospital services, both planned and unplanned, and can be especially vulnerable to rapid deterioration.

When older people experience delayed discharge from hospital they face a slower recovery and three particular risks: too much medication, reduced physical activity (leading to loss of muscle tone and the risk of bed sores) and increased confusion. These factors in turn are strong predictors of increased length of stay, complications or death, long-term cognitive impairment, and higher costs of care. They can mean a slow recovery for the individual.

Delayed discharge from hospital that is the result of preventable factors (such as delayed access to home and community support) puts extra costs on the system. On the other hand, premature discharge can cause significant stress for family and whānau carers who feel unprepared and unsupported.

We are looking for a shift in philosophy away from simply doing things *for* people, to working *with* people to help them regain or maintain their ability to manage their day-to-day needs. Finding out an individual's goals and motivations is a key part of developing a personalised care plan, and provides a way to recognise and respect cultural preferences.

Health services for older people currently use numerous assessment tools, and there is scope to share information from these tools, and reduce duplication. Quality assessments are central to good planning, coordination and communication, and can maximise the speed, effectiveness and durability of a person's recovery.

Rehabilitation is an ongoing process. Family and whānau involvement should form part of any rehabilitation plan, especially where an older person returns to their own home.

Supported discharge and restorative care

'Restorative rehabilitation' refers to the process by which health providers assist a person to recover after an acute event. It aims to build a person's capacity and resilience, for example through strength and balance training following a fall or fracture. Waikato DHB and Canterbury DHB make use of dedicated teams, START and CREST respectively, for this purpose. In other areas, district nursing services provide clinical care and oversight of rehabilitation – sometimes home based, sometimes in a community clinic. Studies show that using a single person to coordinate care across primary, hospital and community-based services provides a single point of contact and accountability, increases patient confidence and satisfaction, and can improve communication with family.

Emergency services in Kāpiti are trialling an 'extended paramedic model', in which ambulance staff (paramedics) can provide basic frontline treatment, make referrals for blood tests or other specialist tests, or make a decision not to transport someone to hospital but refer them back to their general practitioner (GP). The trial has resulted in reduced admissions, including subsequent admissions and improved patient experience, especially for older people and those with mobility problems.

Similarly, guidelines have been developed for nurses in emergency departments to assess and 'redirect' people coming to emergency departments back to their GP if there is no urgent need to admit them to hospital.

Quality

Quality measures in this area need to include individual outcomes; for example, can the person now dress themselves? Was the person satisfied with their recovery? Did their family and whānau feel supported to help with rehabilitation? They can also include 'system' measures, such as acute bed days, and contributory measures, such as whether discharge was timely and support services were in place, and whether the person was readmitted to hospital within a short time.

Integration in the health sector and across agencies

Funding for rehabilitation and recovery services is currently spread across different parts of the health, ACC and social sectors and through Veteran's Affairs. This can lead to duplication of services, or, alternatively, gaps and delays in coordinating care: for example, a person needing home care, district nursing, nutrition advice and equipment may face four different assessments. If we can streamline assessments, standardise the use of shared care plans and routinely use multidisciplinary teams, we should be able to make any funding differences invisible to the person needing services.

Internationally, there is not a large body of consistent evidence on the best way to transition people from hospital to home. But there are promising models already in use and plenty of scope for further trials. We need to support innovation, collect data and share results to build the body of evidence and develop best-practice approaches.

Workforce

Acute care, rehabilitation and longer-term recovery and maintenance services involve a variety of different workforces. Ideally, there should be some degree of overlap between their responsibilities, to provide the workforce with greater flexibility to meet people's needs, and potentially greater continuity of care.

Allied health staff (such as occupational and speech language therapists, dieticians and physiotherapists) offer a range of skills to support people's rehabilitation, recovery and restoration, but access to them can be limited. Allied health staff can play important roles working directly with patients, and helping home and community support workers and family carers involved in rehabilitation.

Home and community support workers and family carers are often involved in rehabilitation. Information sharing, training and other means of support could enhance the range of activities they undertake.

Our vision for acute and restorative care

- Older people requiring urgent or planned hospital treatment benefit from best practice restorative rehabilitation strategies, discharge planning and follow-up support.
- Health, ACC, social and community services work together to support people through recovery and the return home.
- Family and whānau receive support to assist older people to recover from acute events.
- Quality measures include patient experiences as well as clinical outcomes.
- The number of people readmitted to hospital following hospital treatment reduces.

Living well with long-term conditions

This outcome area is about:

- giving individuals the tools and support they need – including guidance, information and access to technology – to manage their long-term conditions to a comfortable level, and reduce the impact of those conditions on their lives
- ensuring all health professionals and social services have the tools and support they need – including information and resources, training, models of care and technology – to detect long-term conditions at the early stages and treat, rehabilitate and manage them early
- investing in social assistance, primary and home and community services and family and whānau carers to assist older people with long-term conditions to stay well closer to home
- improving our ability to slow or stop the progress of long-term conditions towards frailty.

Why this is important

The World Health Organization has referred to long-term health conditions as 'the health care challenge of this century'. Long-term conditions include diabetes, cardiovascular and chronic obstructive pulmonary disease, cancer, asthma, arthritis and musculoskeletal diseases, stroke, chronic pain, obesity, dementia, mental illness and addiction.

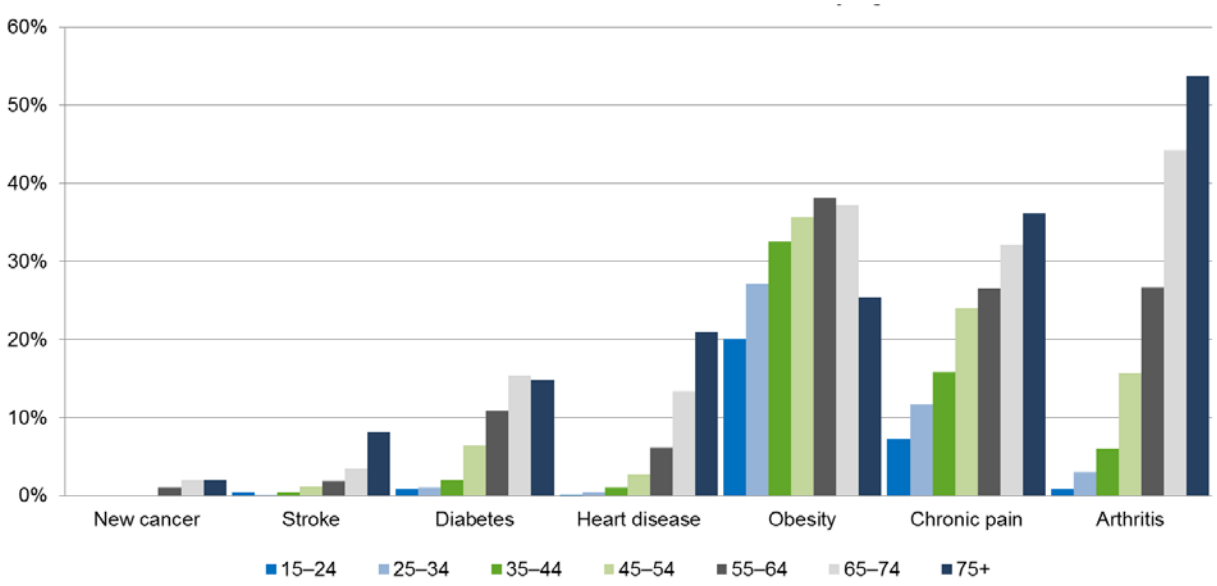
Long-term conditions can occur at any age, but become more prevalent as people get older. They are often complex, with multiple causes. They can lead to a gradual deterioration of health and mobility but can also become acute suddenly, resulting in hospitalisation and, in some cases, dependence on long-term support services or family and whānau. Some population groups tend to experience long-term conditions at earlier ages, and therefore need more targeted services.

As the graph overleaf shows, some long-term conditions are more common among older people. Currently one in six older New Zealanders are living with three or more long-term conditions. We can expect the numbers of people living with long-term conditions to increase as our population ages.

This will impact on the workload of the health and social sector workforce and will also mean that increasing numbers of people will be caring for and supporting family and whānau members.

Dementia is an increasing priority for the New Zealand health system. We expect the numbers of New Zealanders with dementia to rise to 78,000 by 2026, from an estimated 50,000 currently. *Improving the Lives of People with Dementia*, identifies nine action areas from the *New Zealand Dementia Framework* for implementation in the next three years. We need to work across the dementia sector and with people with dementia to strengthen implementation of these actions.

Figure 6: Prevalence of certain health conditions by age



The New Zealand Health Strategy has set a goal of a health system that supports people to spend more of their lives in good health. With this in mind, we want to ensure that older people with long-term conditions retain the highest level of mental and physical function possible; that they enjoy life, and that their communities respect them.

To achieve this goal, we will take steps to improve the detection of long-term conditions, particularly where mental health and addiction issues are involved, which may mask as well as contribute to symptoms of other long-term conditions. We will help New Zealanders to become more health smart, so that they are better able to manage their conditions and get the help they need to stay well. We will improve the workforce's ability to work in partnership with older people with long-term conditions so that they live well with their condition, and we will strengthen home and community support services so that they are better equipped to support people with long-term conditions and their family and whānau.

Prevention and detection

New Zealanders becoming more health smart is a major theme of the New Zealand Health Strategy. To create a health smart population, we need to provide individuals, as well as family and whānau and carers, with information about preventing long-term conditions. For those living with long-term conditions, we need to provide information about specific conditions, symptoms, medication and management, and the importance of healthy lifestyles. We also need to enable people to connect with groups and organisations that can help them to manage their conditions.

Long-term conditions can progress to a point where they significantly reduce an individual's resilience. We will improve our ability to prevent and better manage long-term conditions that lead to the development of frailty. Initially, this will be through research to better understand the issue of frailty in New Zealand and the mechanisms for prevention and to reduce its severity.

Enabling technology

Technological tools such as smartphones, apps and wearable devices have many valuable applications in the area of health. They will become increasingly important as a way of allowing older people to maintain autonomy, dignity and a better quality of life, including through the ability to remain living in their own home for as long as they wish. The pace at which older people adopt such tools will vary. We need to ensure that late adopters continue to have equal access to the services they require.

Health workforce

As the proportion of older people in our society grows, the health workforce will need to become more adept at caring for older people, and more knowledgeable about what keeps older people healthy and resilient. We will expand the capability of the workforce through professional development and smarter models of working.

Primary health and home and community support services are well placed to take a greater role in the care and support of people who need assistance to remain living at home. However, in the case of home care, we could better align service models, funding methods and levels of training, to allow a greater level of involvement. At present, the home and community workforce is fragile. Jobs in this sector are generally characterised by low pay, irregular working hours and variable access to training, which contributes to high staff turnover.

We will invest in this workforce, and develop service and funding models that support a sustainable, culturally appropriate and person-centred approach to the support of older people, including people with long-term conditions.

Family and whānau

Family and whānau carers play a vital role in providing support for older people with long-term conditions. We will ensure that such carers receive the support they need. This will include training and information, as well as respite care so that they can look after their own wellbeing, particularly in relation to their mental health. Family and whānau carers should not be in a position in which they become isolated because of their caring role.

Priority populations

Long-term conditions contribute to the higher rates of illness, disability and death experienced by Māori, Pacific peoples, people on low incomes and people with disabilities. We will prioritise reducing health inequalities and other adverse outcomes for people with long-term term conditions for those agencies funding and delivering services to this group.

Our vision for living well with long-term conditions

- Improved methods of early detection and prevention mean that fewer older people are affected by long-term conditions or frailty.
- Older people with long-term conditions retain the highest level of mental and physical function possible; they enjoy life, and their communities respect them.
- Older people with long-term conditions have a range of tools and primary health care coordination and support to enable them to live well with their conditions.
- Older people with long-term conditions are 'health smart' and are actively self-managing their conditions to a practical and comfortable level, making living well with long-term conditions closer to home more accessible.
- The workforce that supports older people and their families to manage their long-term conditions, including the primary and wider health workforce, home and community support services and family and whānau carers, has appropriate resources, structures and training.
- Health outcomes for vulnerable older populations with long-term conditions are equitable with outcomes for the population as a whole.

Support for people with high and complex needs

This outcome area is about:

- ensuring people are in the right place to receive the care and support that most appropriately meets their needs
- individuals maintaining choice and control when they need significant support
- helping family and whānau to provide the best support they can while maintaining their own wellbeing
- coordinating, integrating and simplifying health and social services for people with high and complex needs
- having flexible home and residential care services that suit the needs of the increasingly diverse older population
- reducing avoidable visits to emergency departments and acute care among a group of potentially high users
- enabling all people with high and complex needs to easily access care and support, irrespective of their financial position
- promoting innovative models of complex care that better support older people, their family and whānau and carers.

Why this is important

Older people with high and complex needs are one of the most vulnerable groups in society. They are more likely to become 'frail'; that is, to deteriorate markedly after an event that would otherwise have a minor effect on their health.

The number and complexity of conditions in older people with high and complex needs makes treatment and care more difficult, as conditions and treatments affect each other.

This part of the Strategy expands on the goals and actions relating to long-term conditions.

Knowledge and communication

Older people with high and complex needs need more information than usual to make choices about the care or support they want to receive; clarity of communication is vital.

Some older people with high and complex needs have lost or are losing mental capacity to fully make choices, so health care providers need to communicate with a wider group, including family and whānau and caregivers.

People with high and complex conditions have to navigate their way through more parts of the health and support system than usual; coordination of these services, including communication between services, is important.

Technology

Increasingly, technological tools such as smartphones and wearable devices are making communicating health information and monitoring health easier. Health service providers need to pay particular attention to individuals' ability to use such devices and accommodate a range of technical literacy levels.

Services closer to home

Older people value their independence highly. They do not want to be seen as a burden on spouses, family and whānau or social services. They want to stay in their communities, and access services closer to home.

Health and social sector coordination

Older people who need to see a variety of health professionals want their individual health information to be available to all the clinicians they see, so they don't have to repeatedly tell their story. They expect clinicians to be informed about their other treatments, conditions and current medicines they may be taking.

Health services for older people with high and complex needs can be very expensive. The more careful we are with our use of resources, the more people we can help. It is therefore very important that we design care for older people with high and complex needs with value and high performance in mind. Our approach needs to take into account the full range of influences on older people's outcomes, including the various resources across the health and social systems, service users' experience, service quality and the impact of services on family and whānau.

To achieve best value and high performance, district health boards need to commission services in a way that will provide older people with quality care in the right setting at a sustainable cost. If we can achieve this, we will reduce inequities in access to these services, and their effectiveness.

New Zealand's health system needs to better support the older population groups that do not enjoy the same health as New Zealanders as a whole. These groups include Māori and Pacific peoples, disabled people and those with long-term mental health issues and alcohol and other drug addiction.

Our focus must be on removing barriers to delivering high-quality health services, within the health sector and between it and other sectors. Improving the health of vulnerable groups may involve tailoring services so that they are more accessible, available at more suitable times, or delivered in more culturally appropriate ways.

People working in teams containing a range of health specialties need to see themselves as part of one team supporting integrated care that is provided closer to home. We also need to reduce the barriers that currently prevent people from using their skills flexibly and fully.

Support workers make up a large part of the workforce for people with high and complex needs. It is important that we pay, train and value these workers as part of the integrated 'one team'.

Beyond the formal workforce, we need to support family and whānau and others in their roles as carers of older people with high and complex needs. This support could involve health literacy education, information and training specially tailored for the carer role, and looking after the carers' own health needs (particularly in relation to mental health).

Older people with complex needs often have comprehensive clinical assessments of their needs electronically recorded in the interRAI database. As well as people and their care provider using this information to develop care plans, the information should be a rich resource for the range of health professionals dealing with each person and for PHOs and DHBs learning about the outcomes of older people receiving support services in a location or population group.

Our vision for support for people with high and complex needs

- Older people with high and complex needs:
  - have the information and freedom to make good choices about the care and support they receive
  - know that health care workers understand their wishes and support needs
  - are assured that information about their circumstances and their needs flows easily between health care workers
  - from different ethnic groups and in rural locations have equitable access to services, and experience equitable outcomes
  - move easily to and through care settings that best meet their needs
  - have reduced need for acute care.
- Families and whānau have the support, information and training they need to assist older family members, and the stress of caring does not damage their own health.
- District health boards bring together data from various sources and know the value and quality of the care they provide for older people in their district. Where it is falling short, they are easily able to learn from other DHBs.

Respectful end of life

This outcome area is about:

- a respectful end of life, tailored to the physical, emotional, social and spiritual needs of an individual and their family and whānau
- making discussions of death and dying, and preparing for death and end-of-life care, more common
- making sure that people at the last stages of their life are in control of all aspects of their care as much as they're able – from deciding on their clinical treatment to fulfilling their cultural needs
- preparing the health system for future palliative care needs.
- providing coordinated care that meets individuals' needs
- supporting family and whānau and friends to support dying older people.

Why this is important

Death is a universal experience, and also a deeply personal one; our experience in the last stages of life can be profoundly important for us and for our loved ones.

In the last stages of life, what matters most to people is being accompanied by their loved ones, the control of symptoms and pain, good communication and well-coordinated care that doesn't put unnecessary strain on the family and whānau. We should expect, and take steps to ensure, a respectful, high-quality palliative service at the end of life.

Planning in advance

Some people take action to protect their wishes in their final stages by delegating an enduring power of attorney and working with health professionals and others to create an advance care plan expressing their goals and wishes for treatment at the end of life. Evidence shows that advance care plans significantly improve the experience of end-of-life care; their use across clinical disciplines is an integral part of a dying person's coordination of care.

Although advance care plans are effective, society's discomfort with the subject of death may be compromising their effective delivery. As a society, we need to become more comfortable with conversations about death and dying; we need to see death and dying as part of life. These conversations are easier when they begin well before the end of life.

The New Zealand Health Strategy includes a commitment to supporting people and their clinicians to develop advance care plans by building on existing national and international resources and networks.

It is vital that we continue to focus on the foundational elements that underpin high-quality end-of-life care, such as shared patient information and support for advance care plans.

Future demand

As the population ages, more people will die each year. People will die at older ages, and increasingly with comorbidities, including dementia. Many will have uncomplicated deaths, but as we live longer there will be increasing numbers of people with more complex conditions requiring more specialised care.

To meet our future needs, the health system will have to take a fresh and widespread approach to palliative care. We will need to make the most of our health workforce by ensuring that the core components of end-of-life care are an integral part of everyone's practice. We will need to support and upskill communities and family and whānau carers in providing palliative care, and we will require a sufficient specialist palliative care workforce to provide support, advice and education. The current Review of Adult Palliative Care Services focuses on these necessary changes.

Our vision for enabling a respectful end of life

- People die where they feel comfortable and safe, and are able to have their loved ones provide support. Dying older people are able to identify and articulate their fears, goals and care needs, and how they wish family and whānau and caregivers and friends to be involved in their end-of-life care. Individualised care plans, advance care planning and enduring power of attorney are much more widespread practices, and the health workforce, family and whānau and friends respect and uphold the needs and wishes of older people.
- Technology improves end-of-life care. Providers know if advance care plans are in place, routinely check whether medicines need to be reviewed, and support monitoring at home.
- Health service providers coordinate palliative care in such a way that all of those who support people dying in old age are aware of plans, and know their role in carrying them out.
- All teams are responsive to the cultural needs of different groups.
- People talk comfortably about dying and preparing for death.
- The health sector educates, supports and advises family and whānau of dying people and the health workforce in meeting the needs of people receiving end-of-life care.

Turning the Strategy into action

Building the action plan

Achieving the vision and goals set out in this Strategy will require the commitment of a vast range of players across and throughout the health and social system, working in partnership with non-governmental organisations, communities, older people and their families. It also requires that we identify the right set of actions for immediate implementation, and the longer list of actions for the remainder of the 10-year period, and that we have the right leadership and systems in place to implement those actions and keep us on course.

A set of actions have been identified to implement the Strategy, and these are presented in draft form in the following pages. The actions have been developed in discussion with older people and their representatives and with a wide array of stakeholders from across the country throughout the health and social system.

Each action has a proposed lead, who would be accountable for the action. The implementation of the actions would involve a wide variety of stakeholders from across the health and social sectors, as well as older people and their family and whānau.

Draft actions for the first two years of implementation are shown with an asterisk (✸) in the Action Plan. A review every two years will draw from the other draft actions in determining the programme of action appropriate for the following two years.

The actions are organised under the Strategy's goals, so that the action plan is appropriately outcome oriented in accordance with a life-course approach. There are links and inter-dependencies across the actions and common themes that will mean that some of the actions are developed and implemented together through cross- and inter-sectoral teams. These include:

- actions focused on vulnerable and high-needs population groups
- actions focused on information, tools and resources and other enablers
- actions including referral pathways and other aspects of systems for integration, which would be linked for a system-wide approach to integration.

Similarly, equity is a consideration across all actions, as is workforce.

We are seeking your feedback on this set of actions to help us make a manageable programme of action that can be delivered by the sector within available resources.

The actions published in the final Strategy document will reflect the views of many different organisations and actors in the health and other social systems gathered throughout the final consultation process.

A system of continuous improvement

Within the first months after finalising the Strategy, the Ministry of Health will develop an implementation plan with our major partners, setting out the timing, sequencing, responsibilities and resourcing required for achieving the actions.

Implementing these actions will rely on skilled leadership, solid partnerships and participation across the system. We need the Strategy to represent a shared vision for the future, and we need to work together to achieve our aims.

The health system is, and operates in, a complex and dynamic environment, and operates within a highly networked system with multiple inter-dependencies. We are limited in our ability to predict the future, and we need to be mindful and flexible, and willing to adapt in order to stay on track.

This Strategy is therefore a living document. The Ministry of Health will review it every two years. The review will look at delivery of the actions. We may need to adjust some actions, to replace them or to combine them with other initiatives, to strengthen their chance of success.

The Ministry of Health and DHBs will be primarily responsible for implementing the Strategy, and regional service plans, annual plans and annual progress reports will reflect the actions set out in the final Strategy.

The Ministry will develop systems for ensuring that our programmes and services are informed by and built around the needs and desires of the people they're designed for.

We have a wealth of data and knowledge to inform our next steps, through our investment in interRAI and research initiatives, such as the Ageing Well Science Challenge. In addition, the development of New Zealand's first health research strategy will help us build a more cohesive and effective health research and innovation system. We need to harness these opportunities to ensure that we make the best use of our information, and improve our understanding of ageing well.

Ultimately, we want to ensure that knowledge, information and the investment in and outcomes of research and development inform policy development and service improvement.

Action plan

Healthy ageing

Goals

- Older people are physically, mentally and socially active; and healthy lifestyles and greater resilience throughout life mean that we spend more of our lives in good health and living independently.
- Everyone in the health system understands what contributes to healthy ageing, and takes part in achieving it.
- Older people are health smart, able to make informed decisions about their health and know when and how to get help early.
- All older populations are supported to age well in ways appropriate to their needs.
- Communities are age-friendly, with initiatives to keep people healthy, well-connected, independent, respected and able to participate fully in their communities and with family and whānau.

			Lead
1.	**Build social connectedness and wellbeing in age friendly communities**		
a.	✸ Establish age-friendly communities in line with the Positive Ageing Strategy.		Office for Seniors
b.	Build strong partnerships between DHBs, Healthy Families NZ and age-friendly communities projects for effective healthy community initiatives.		Office for Seniors, HFNZ
c.	Work across government and with local interest groups to improve access to, and coordinate assistance to socially isolated older people and develop initiatives that better address the physical and social determinants of health.	☑	Ministry of Social Development, DHBs
d.	Promote volunteering, networking and paid work among older people, as a means to support their self-worth and encourage social connection.		Non-governmental organisations

Key: = people powered; = closer to home; ☑ = value and high performance; = one team; = smart system; ✸ = implement in the first two years

Acronyms: ACC Accident Compensation Corporation; DHBs District Health Boards: HFNZ Healthy Families New Zealand; interRAI International Resident Assessment Instrument (comprehensive clinical assessment for aged care needs)

			Lead
2.	**Increase resilience through local initiatives**		
a.	✸ Increase the availability of strength and balance programmes in people's homes and community settings.		ACC, Health Quality & Safety Commission, Ministry of Health, DHBs
b.	Expand the provision of targeted health promotion initiatives, and services to increase resilience among Māori and other vulnerable older populations who have poorer health status.		Government agencies
c.	Review the Green Prescription programme, including the potential for other health professionals to prescribe.		Ministry of Health, DHBs, primary health care
3.	**Work across government to prevent harm, illness and disability and improve people's safety and independence**		
a.	Health and social sector agencies partner to share information and improve the identification of vulnerable older people, and coordinate services to better meet their needs.		Government agencies
b.	✸ Participate in the cross-government Ministerial Group on Family Violence and Sexual Violence Work Programme.		Ministry of Social Development
c.	Update the *2007 Family Violence Intervention Guidelines: Elder Abuse and Neglect*, and promote their uptake by a wider range of health professionals.		Ministry of Health
d.	Work with local government to increase understanding of, and local direction of age- and disability-friendly housing models.		Ministry of Health, LGNZ
e.	✸ Support initiatives that maximise healthy ageing through supported housing and age-friendly communities where this will also contribute to regional economic and social development.		Ministry of Business and Innovation, Te Puni Kōkiri, Ministry of Health
4.	**Improve health literacy and communication systems**		
a.	Strengthen the capability of provider organisations to understand the range of health literacy needs of older people, and improve the accessibility and responsiveness of services.		DHBs
b.	Encourage services and providers to promote healthy eating, physical activity and healthy lifestyles and prevent alcohol-related harm.		DHBs, Health Promotion Agency
c.	Enhance health promotion and service information to Māori, Pacific and other ethnic communities and priority groups to enable greater accessibility and engagement.		DHBs, primary health care
d.	Improve the effectiveness of health literacy information distributed by health and social sector agencies.		Ministry of Health, Health Promotion Agency
e.	✸ Support older people's uptake of technology for communication with health providers and their family and whānau.		DHBs, primary care
f.	✸ Increase the accessibility of information on healthy ageing and health and social services through govt.nz, yourhealth, SuperSeniors and links to other websites, so that people can be more 'health smart'.		Government agencies

Key: = people powered; = closer to home; = value and high performance; = one team; = smart system; ✸ = implement in the first two years

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			Lead
5.	**Improve oral health in all community and service settings**		
a.	Develop referral pathways for optimal dental care throughout ageing and into the end of life, to maintain independence and minimise pain.		Ministry of Health and sector
b.	Identify and promote innovative care arrangements for oral health care of people living in aged residential care.		Ministry of Health and sector
c.	Disseminate updated information and advice on dental care to older people family, and carers in communities, and aged care organisations.		Ministry of Health and sector

Acute and restorative care

Goals

- Best practice restorative rehabilitation strategies, discharge planning and follow-up support are in place for older people requiring urgent or planned hospital treatment.
- Older people are supported through recovery and the return home.
- Family and whānau receive support to assist older people to recover from acute events.
- The number of people readmitted to hospital following hospital treatment reduces.

			Lead
6.	**Support effective rehabilitation closer to home**		
a.	Promote rehabilitation partnerships with primary care workers, allied health, nurse practitioners, pharmacists, kaiāwhina and family and whānau to support discharge planning for and ongoing rehabilitation and restoration of older people at home.		Ministry of Health, DHBs
7.	**Improve outcomes from injury prevention and treatment**		
a.	✸ Develop, implement and review prevention and treatment of injuries for ACC and health clients, including: • enhancing fracture liaison services to prevent secondary injury • implementing a national hip fracture registry • enhancing rehabilitation services for injured older people, including through supported discharge and home and community support to achieve maximum independence and recovery closer to home • work with local health systems to integrate prevention and rehabilitation services into existing service models.		Ministry of Health, ACC, Health Quality & Safety Commission and DHBs
b.	Make use of big data to identify older people at risk of falls and fractures, to target and coordinate investments and interventions.		ACC, Ministry of Health, Health Quality & Safety Commission, DHBs

Key: = people powered; = closer to home; = value and high performance; = one team; = smart system; ✸ = implement in the first two years

Acronyms: ACC Accident Compensation Corporation; DHBs District Health Boards: HFNZ Healthy Families New Zealand; interRAI International Resident Assessment Instrument (comprehensive clinical assessment for aged care needs)

			Lead
8.	**Reduce acute admissions**		
a.	Support other initiatives to reduce acute admissions, for example by extending paramedic roles, improving after-hours triage for aged residential care facilities, developing acute geriatric care pathways and applying technological solutions.		DHBs

Living well with long-term conditions

Goals

- Improved methods of early detection and prevention mean that fewer older people are affected by long-term conditions or frailty.
- Older people with long-term conditions retain the highest level of mental and physical function possible; they enjoy life, and their communities respect them.
- Older people with long-term conditions have a range of tools and support to enable them to live well with their conditions.
- Older people with long-term conditions are 'health smart', and are actively self-managing their conditions to a practical and comfortable level, making living well with long-term conditions closer to home more accessible.
- The workforce that supports older people with long-term conditions, including the health workforce, home and community support services and family and whānau carers, has appropriate resources, structures and training.
- Health outcomes for vulnerable older populations with long-term conditions are equitable with outcomes for the population as a whole.

			Lead
9.	**Ensure that those working with older people with long-term conditions have the training and support they require to deliver high-quality, person-centred care**		
a.	✸ Regularise and improve training of the kaiāwhina workforce in home and community support services.		Ministry of Health

Key: = people powered; = closer to home; = value and high performance; = one team; = smart system; ✸ = implement in the first two years

Acronyms: ACC Accident Compensation Corporation; DHBs District Health Boards: HFNZ Healthy Families New Zealand; interRAI International Resident Assessment Instrument (comprehensive clinical assessment for aged care needs)

		Lead
b.	Ensure undergraduate and graduate curricula support an integrated model of care that: • enables all health professionals to work as one team • works in partnership with older people and their family and whānau • promotes healthy ageing and restoration • addresses risk factors for social isolation and mental health and problematic alcohol use.	Ministry of Health
c.	✸ Progress training packages to enhance the capacity and capability of kaiāwhina to support people with long-term conditions and their families and whānau, as part of the *Kaiāwahina Action Plan*.	Careerforce
d.	✸ Develop a range of strategies to improve recruitment and retention of those working in aged care.	Ministry of Health, DHBs
e.	Better utilise the allied health workforce to enhance care for older people in primary care, home care and residential care.	Ministry of Health, DHBs
f.	✸ Enhance workforce capability and training pathways to encourage more entry and retention of the workforce among Māori and Pacific peoples.	Ministry of Health
g.	Improve training and information for family carers that helps them to safely and competently carry out their caring role and keep well themselves.	Ministry of Health
10.	**Enhance cross-sector, whole-of-system ways of working**	
a.	Make better use of common points of contact across the health and social sectors to identify and support older people with mental health and alcohol and other drug problems earlier.	Government agencies
b.	Share educational resources and good practice on effective ways to increase physical activity levels among older people with debilitating health conditions to support service improvement.	Providers
c.	As part of the implementation of the *Pharmacy Action Plan 2016 to 2020* (Ministry of Health 2016), improve medicines management and encourage better liaison across pharmacists and other health professionals including through: • increased use of brief interventions, screening, assessment and referral in primary care, including by pharmacists • shared examples of innovative models of care that can be adopted to support pharmacist and pharmacist prescribers' delivery of medicines management.	DHBs
11.	**Expand and sharpen the delivery of services to tackle long-term conditions**	
a.	✸ Strengthen the implementation of the New Zealand Dementia Framework, and the actions specified in *Improving the Lives of People with Dementia* (Ministry of Health 2014).	DHBs
b.	✸ Encourage health, social services and communities to become more dementia-friendly.	Office for Seniors, Government agencies, DHBs

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Acronyms: ACC Accident Compensation Corporation; DHBs District Health Boards: HFNZ Healthy Families New Zealand; interRAI International Resident Assessment Instrument (comprehensive clinical assessment for aged care needs)

			Lead
c.	✸ Reduce the instance of complications from diabetes, particularly for people in aged residential care in line with *Living Well with Diabetes: A plan for people at high risk of or living with diabetes 2015–2020* (Ministry of Health 2015), by providing tools, resources and quality standards.		DHBs, primary care, providers
d.	✸ Develop commissioning and funding approaches for home and community support services that describe core aspects for national consistency, but allow for flexibility at the local and individual level.		Ministry of Health, DHBs
e.	✸Use interRAI assessment data to identify quality indicators and service development opportunities including with health providers.		Ministry of Health, DHBs
f.	Work with Māori, Pacific and other population groups to develop culturally appropriate home and community support service models.		DHBs, providers
g.	✸ Better coordinate and integrate rehabilitation for people recovering from a stroke by identifying improvements to business models, workforce and models of care.		DHBs
h.	✸ Provide community-based, early intervention programmes for people with musculoskeletal health conditions (eg, the Mobility Action Programme).		DHBs
i.	Improve the early identification of mental illness and other conditions and addictions, such as problematic alcohol use, that can mask or contribute to other long-term conditions.		DHBs, primary health care
12.	**Inform individuals and the community so that they are better able to understand and live well with long-term conditions and get the help they need to stay well**		
a.	✸ Promote community support for older people with mental illness and substance misuse issues, to both reduce stigma among older people and helping them to seek treatment.		All
b.	Ensure home and community support models of care cover advice to and support for older people to remain physically and mentally active, and strengthen skills they may have lost.		DHBs
13.	**Use new technologies to assist older people to live well with long-term conditions**		
a.	✸ Include health apps targeting older people with long-term conditions in the health app library currently being developed.		Ministry of Health
b.	✸ Promote use of tele-monitoring to monitor conditions and alleviate social isolation, especially among rural and remote locations.		DHBs, primary health care
c.	Promote the use of assistive technology to support home-care workers to achieve good outcomes.		DHBs

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Support for people with high and complex needs

Goals

- Older people with high and complex needs:
  - have the information and freedom to make choices about the care and support they receive
  - know that health professionals understand their wishes and support needs
  - are assured that information about their circumstances and their needs flows easily between health professionals
  - from different ethnic groups and in rural locations have equitable access to services, and experience equitable outcomes
  - move easily to and through care settings that best meet their needs
  - have reduced need for acute care.
- Families and whānau have the information and training they need to best assist family members and the stress of caring does not damage their own health.
- District health boards have data from various sources and know the value and quality of the care they provide for older people in their district. Where it is falling short, they are able to learn from other DHBs.

		Lead
14.	**Reduce frailty in the community**	
a.	✸ Explore possibilities for a frailty identification tool to enable primary and other health professionals to identify frail older people earlier.	Primary health care, DHBs
b.	Build responsiveness to frailty in primary health care settings and improve links to all necessary support, treatment and rehabilitation services.	Primary health care, DHBs
15.	**With service users, their families and whānau, review the quality of home and community support services and residential care in supporting people with high and complex needs and involving family and other caregivers**	
a.	Identify models that are person-centred and needs-based and provide a choice of care that maximises independence and sustainability.	Ministry of Health, DHBs
b.	Ensure needs assessment and care planning are culturally appropriate and meet the needs of Māori and other priority population groups.	DHBs
c.	Promote contracting models that enable people to move freely to different care settings most suited to their need.	DHBs, Ministry of Health

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			Lead
16.	**Integrate funding and service delivery around the needs and aspirations of older people, to improve health outcomes of priority population groups**		
a.	In specific locations, trial commissioning one organisation to coordinate health and support services for frail elderly people that: • are strongly person centred and take account of family and whānau carer needs • assist older people to meet their individual objectives • provide timely, flexible and innovative contracting approaches to meeting the needs of specific groups, such as Māori, Pacific populations and ethnic communities • minimise the need for the most expensive health and support services • could include primary care, pharmacy, ambulance, home and community support, residential care and acute care services.	☑	Ministry of Social Development, Ministry of Health
b.	Ensure that some trials focus on population groups that currently have poorer health and social outcomes or are not well catered for in current approaches.	☑	Ministry of Social Development, Ministry of Health
c.	Develop referral systems for older people at risk of or experiencing social and economic isolation through their contact with primary care, aged care needs assessors, social housing, the ACC and the New Zealand Transport Agency.		Government agencies
d.	Improve the coordination of social services to vulnerable older people across the social sector.		Government agencies
17.	**Improve the physical and mental health outcomes of older people with long-term mental illness and addiction**		
a.	Improve access to mental health and addiction services among older people with high physical health needs, and improve integration of these services with residential care or home care services.		Ministry of Health, DHBs
18.	**Better integrate services for people living in aged residential care**		
a.	✸ Develop standard referral and discharge protocols between aged residential care facilities, pharmacists, primary care (including providers of after-hours services and medicines advice), ambulance and hospital services.		DHBs
b.	Explore options for providing telephone advice and triage for aged residential care facilities, especially after hours.	☑	Ministry of Health
c.	Ensure systems, resources and training are in place allowing aged residential care facilities to communicate with and involve family and whānau at the point of discharge from hospital or where urgent care is needed.		DHBs
d.	Explore options for aged residential care facilities to become providers of a wider range of services to older people, including non-residents.		Ministry of Health

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			Lead
19.	**Improve integration of information from assessment and care planning with acute care services, and with those responsible for advance care planning**		
a.	Develop systems that collate relevant information and make it readily available at the point of care, as well as for planning at all levels.		Ministry of Health
b.	Develop tools and resources for health professionals and providers to support the integration of long-term care management, acute care services and advance care planning.		DHBs
c.	Ensure home and community support staff and, where appropriate, social workers, are able to contribute to shared care plans and interdisciplinary teams.		DHBs
20.	**Improve medicines management**		
a.	Develop education partnerships between pharmacists and other health professionals to increase medication adherence and make better use of pharmacists' expertise.		DHBs
b.	Implement pharmacist-led medicines reviews for older people with high needs receiving home and community support services and those in aged residential care.		DHBs
c.	✸ Ensure models of care and contractual arrangements provide equitable access to medicines management services targeting people receiving high-risk medicines and/or polypharmacy, people in aged residential care and older people with complex health needs living in their own homes.		DHBs
21.	**Build the resilience and capability of family and whānau, volunteer and other community groups supporting people with high and complex needs, and those with end-of-life care needs**		
a.	Review and improve the support for informal carers in alignment with the New Zealand Carers' Strategy Action Plan 2014–2018, including in terms of respite care, guidance and information, and training.		Ministry of Health, DHBs
b.	✸ Examine options to reduce work-related barriers to informal care.		Government agencies

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Respectful end of life

Goals

- People die where they feel comfortable and safe, and are able to have their loved ones provide support. Dying older people are able to identify and articulate their fears, goals and care needs and how they wish family, whānau, caregivers and friends to be involved in their end-of-life care. Individualised care plans, advance care planning and enduring power of attorney are much more widespread practices, and the health workforce, family and whānau and friends respect and upheld the needs and wishes of older people.
- Technology improves end-of-life care. Providers know if advance care plans are in place, routinely check whether medicines need to be reviewed, and support monitoring at home.
- Health service providers coordinate palliative care in such a way that all of those who support people dying in old age are aware of plans, and know their role in carrying them out.
- All teams are responsive to the cultural needs of different groups.
- People talk comfortably about the subject of dying and preparing for death.
- The health system educates, supports and advises family and whānau of dying people and the health workforce in meeting the needs of people receiving end-of-life care.

			Lead
22.	**Ensure widespread and early participation in advance care planning**		
a.	✸ Increase public awareness about and use of advance care planning and enduring powers of attorney across the health sector, government and community agencies and amongst older people and their carers.		Ministry of Health, Office for Seniors
23.	**Build a greater palliative care workforce closer to home**		
a.	Work with professional colleges, DHBs and training bodies to ensure that core elements of end-of-life care (such as aligning treatment with a patient's goals, basic symptom management and psychosocial support) are an integral part of standard practice for all relevant health professionals and health care workers.		Ministry of Health
b.	Encourage the use of new technologies to both support people in their homes and enable easy access to specialised support and advice, such as telecare, e-monitoring and assistance home technology.		Ministry of Health, DHBs

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			Lead
24.	**Improve the quality and effectiveness of palliative care**		
a.	Promote the development of national standards and an outcomes framework for palliative care.	☑	Ministry of Health, DHBs
b.	✸ Support the implementation of *Te Ara Whakapiri: Principles and guidance for the last days of life* (Ministry of Health 2015).		Ministry of Health, DHBs
c.	✸ Progress a national collection of patient and whānau carers' experiences of the care provided at the end of life.	☑	Ministry of Health
d.	✸ Work with the Palliative Care Advisory Panel to implement the recommendations from the Review of Adult Palliative Care Services.		Ministry of Health

Implementation, measurement and review

			Lead
25.	**Implement the Strategy**		
a.	✸ With health and social sector partners, complete a Health of Older People Strategy Implementation Plan within the first three months of the Strategy's release.	☑	Ministry of Health
26.	**Include older people in service design, development and review and other decision-making processes**		
a.	Work with older people to identify outcomes they wish to achieve from the services they receive and indicators of these.	☑	DHBs
b.	Ensure health care workers work appropriately and to their full scope with older people, through training to help realise all roles in improving older people's health outcomes, together with family and whānau.		DHBs
c.	Ensure there are feedback loops through which PHOs, DHBs and the wider health system can learn from patient experience, and plan for service and workforce improvement.	☑	DHBs
d.	✸ Incorporate home and community support users' experiences into Health Quality and Safety Commission-led patient experience work.	☑	Health Quality & Safety Commission
e.	✸ Include representatives of older people in DHB regional forums.		DHBs
f.	✸ As part of the Pharmacy Action Plan 2016–2020 implementation, co-design a service model with consumers to support the development and implementation of a minor ailments and referral service.		DHBs
27.	**Establish an outcomes and measurement framework and planning and review processes**		
a.	✸ Develop a system to evaluate progress against the goals of the Health of Older People Strategy and support the health system to be person centred and focused on maximising healthy ageing and independence.	☑	Ministry of Health

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			Lead
b.	As part of the measurement and evaluation system, include an outcomes framework and indicators to assess, support and improve the health outcomes for older people. These indicators will form contributory measures that district alliances can monitor to help them improve on the overall health system level measures.	☑	Ministry of Health
c.	✸ Regularly review the Strategy implementation progress and the prioritisation of actions.	☑	Ministry of Health, DHBs
d.	✸ Publish indicators for each DHB on a regular basis.	☑	Ministry of Health
e.	Research the reasons for differences between DHBs' performance on indicators, and develop strategies for lifting a DHB's performance where its outcomes fall below average.	⌘	Ministry of Health
28.	**Improve the knowledge base**		
a.	Implement a system to collect a minimum dataset on kaiāwhina workforce.	⌘	Health Workforce New Zealand
b.	✸ Increase understanding of links between loneliness and health status, and promote research into building population resilience.	⌘	Research agencies
c.	✸ Ensure alignment between the New Zealand Health Research Strategy, key research initiatives and centres with the identified needs of the ageing population, and that the research informs policy and service development.	⌘	Ministry of Health

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Acronyms: ACC Accident Compensation Corporation; DHBs District Health Boards: HFNZ Healthy Families New Zealand; interRAI International Resident Assessment Instrument (comprehensive clinical assessment for aged care needs)

Your feedback

How to provide feedback

You can provide feedback by:

- making a written submission using the form available from the Ministry (this form also appears below)
- making a written submission in your preferred format
- attending discussions of the Health of the Older People Strategy.

You can download the Ministry submission form at www.health.govt.nz/consultations, or complete the form online.

You can email written submissions to HOPStrategy@moh.govt.nz or mail a hard copy to:

Health of Older People Strategy Consultation
Ministry of Health
PO Box 5013, Wellington

If you are emailing your submission in PDF format, please also send us the Word document.

You can also join in online discussions about the draft Strategy at discuss.health.govt.nz The Ministry will consider discussion posts when analysing feedback.

Publishing submissions

Please note that we have updated how we will publish submissions since the initial release of our consultation documents.

We will publish all submissions on the Ministry's website, unless you have asked us not to. If you are submitting as an individual, we will automatically remove your personal details and any identifiable information. You can also choose to have your personal details withheld if your submission is requested under the Official Information Act.

Closing date for submissions

The closing date for submissions is **7 September 2016**.

Information about the person/organisation providing feedback

We encourage you to fill in this section. The information you provide will be helpful for our analysis. However, your submission will also be accepted if you don't fill in this section.

This submission was completed by: (name) _____

Address: (street/box number) _____

(town/city) _____

Email: _____

Organisation (if applicable): _____

Position (if applicable): _____

This submission *(tick one box only in this section)*:

☐ comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity)

☐ is made on behalf of a group or organisation(s)

We will publish all submissions on the Ministry's website. If you are submitting as an individual, we will automatically remove your personal details and any identifiable information.

If you do not want your submission published on the Ministry's website, please tick this box:

☐ Do not publish this submission

Your submission will be subject to requests made under the Official Information Act. If you want your personal details removed from your submission, please tick this box:

☐ Remove my personal details from responses to Official Information Act requests

Please indicate which sector(s) your submission represents *(you may tick more than one box in this section)*:

☐ Māori
☐ Pacific
☐ Asian
☐ Education/training provider
☐ Service provider
☐ Non-governmental organisation
☐ Primary health organisation
☐ Academic/researcher
☐ Regulatory authority
☐ Consumer
☐ District health board
☐ Local government
☐ Government
☐ Union
☐ Professional association
☐ Other *(please specify)*:

Consultation questions

The following questions focus on what the Strategy is trying to achieve, expressed as vision statements, and on the actions we propose could bring about the desired changes. (*Note: a vision statement is a short description of the state of the world that we want to bring about*).

You don't have to answer all the questions below. We also welcome feedback on any other matters relating to the Strategy or more generally to the health of older people.

You are welcome to include or cite supporting evidence in your submission.

Healthy ageing

1a. The draft Strategy sets out a vision for the goal of healthy ageing: see page 14 in the draft document. Do you have any comments or suggestions regarding this vision?

1b. The draft Strategy includes actions that are intended to achieve the goal of healthy ageing: see page 31 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an ✸ are the right actions to begin with?

Acute and restorative care

2a. The draft Strategy sets out a vision for the goal of high-quality acute and restorative care: see page 17 in the draft document. Do you have any comments or suggestions regarding this vision?

2b. The draft Strategy includes actions that are intended to achieve the goal of high-quality acute and restorative care – see page 33 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an ✸ are the right actions to begin with?

Living well with long-term conditions

3a. The draft Strategy sets out a vision for the goal of living well with long-term conditions: see page 20 in the draft document. Do you have any comments or suggestions regarding this vision?

3b. The draft Strategy includes actions that are intended to achieve the goal of living well with long-term conditions: see page 34 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an ✸ are the right actions to begin with?

Support for people with high and complex needs

4a. The draft Strategy sets out a vision for the goal of better support for people with high and complex needs: see page 24 in the draft document. Do you have any comments or suggestions regarding this vision?

4b. The draft Strategy includes actions that are intended to achieve the goal of better support for people with high and complex needs: see page 37 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an ✸ are the right actions to begin with?

Respectful end of life

5a. The draft Strategy sets out a vision for the goal of a respectful end of life: see page 27 in the draft document. Do you have any comments or suggestions regarding this vision?

5b. The draft Strategy includes actions that are intended to achieve the goal of a respectful end of life: see page 40 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an ✸ are the right actions to begin with?

Implementation, measurement and review

6 The draft Strategy includes proposals for implementing, measuring and reviewing the proposed actions: see page 41 in the draft document. Do you have any comments or suggestions regarding these proposals?

Other comments

Thank you for taking the time to provide feedback.

4.8 Adult Rehabilitation and Health of Older People

The New Zealand Health Strategy refresh that is underway has also initiated the refresh of the National Health of Older People (HOP) Strategy. There has been good engagement from groups. Early themes coming from stakeholders around HOP strategic priorities include: social isolation/social connectedness, oral care needs, flexibility of funding, balance between home support and residential support needs. It is anticipated a draft strategy for HOP will come out in July/August 2016

Percentage of Home and Community Support Services client interRAI assessments completed by locality (reported quarterly in arrears)

Number and percentage of clients who have received home and community support services during the last quarter, and have had an interRAI assessment at some point.

Between March 2016 and May 2016, 95.5% of patients receiving home based support services have had an InterRAI assessment.

Locality	Clients	w/InterRAI	Percentage
Eastern	1081	956	88.4%
Franklin	687	679	98.8%
Mangere/Otara	601	584	97.2%
Manukau	1503	1464	97.4%
CM Health	**3872**	**3683**	**95.5%**

Community Health Service Integration – Reablement

Reablement Clinical Criteria Guidelines are now complete and on the objective repository. Acute Post-Acute Care Services Nurses are working collaboratively with Reablement Services to identify appropriate patients for supported discharge services. Adult Rehabilitation and Health of Older People, and Surgical Services have resourced a Clinical Nurse Specialist in their areas for this activity.

Community Specialists Health of Older People Teams (reported quarterly)

During the month of June the Community Geriatric Services team continued to provide support to multiple Primary Care practices and residential care providers. 50 Aged Residential Care Facility staff attended the June education forum; which focused on Stroke Rehabilitation, presented by the Adult Rehabilitation and Health of Older People Geriatrician and Community Stroke Rehabilitation Physiotherapists.

Community Geriatric Services

Target <100 Emergency Care presentations from residential facilities per month
<15 Potentially Avoidable Admissions

June 2016 saw 73 Age Related Residential Care Clients presented to Emergency Care. Of these, 14 presentations were falls related and 10 were potentially avoidable admissions.

Memory Team (Dementia Care Pathway)

The Memory Team continued to receive a steady number of referrals for cognitive impairment, however there was a reduction in referrals from General Practitioners. No obvious cause for this has been identified at present. Challenges expected for the next financial year will be from impacts of the Community Integration project and the Memory Team are looking at ways to increase coverage

of the other Counties Manukau Health Localities. Business planning for the 2016-2017 year is scheduled for August.

Memory Team (Dementia Care Pathway) Activity June 2016

June 2016		
Number of referrals (all for cognitive assessment this month)	80	1074 cumulative accepted referrals (June 2013)
Number declined (due to out of Memory team catchment area)	44	
Referrals managed by Memory Team	36	45% (target 30%)
Referrals from General Practice	19	24%
Contacts	422	From 35 GP Practices
Caseload – open cases	334	Cases deemed appropriate to keep open for future action. MT monitor and close as appropriate
Caseload – active cases	Not noted	
Cases under Alzheimer's Auckland	126	
Number of clinicians	6	
Diagnosis made	481 – total dementia, 265 - total non-dementia diagnosis	746

Otara-Mangere Locality

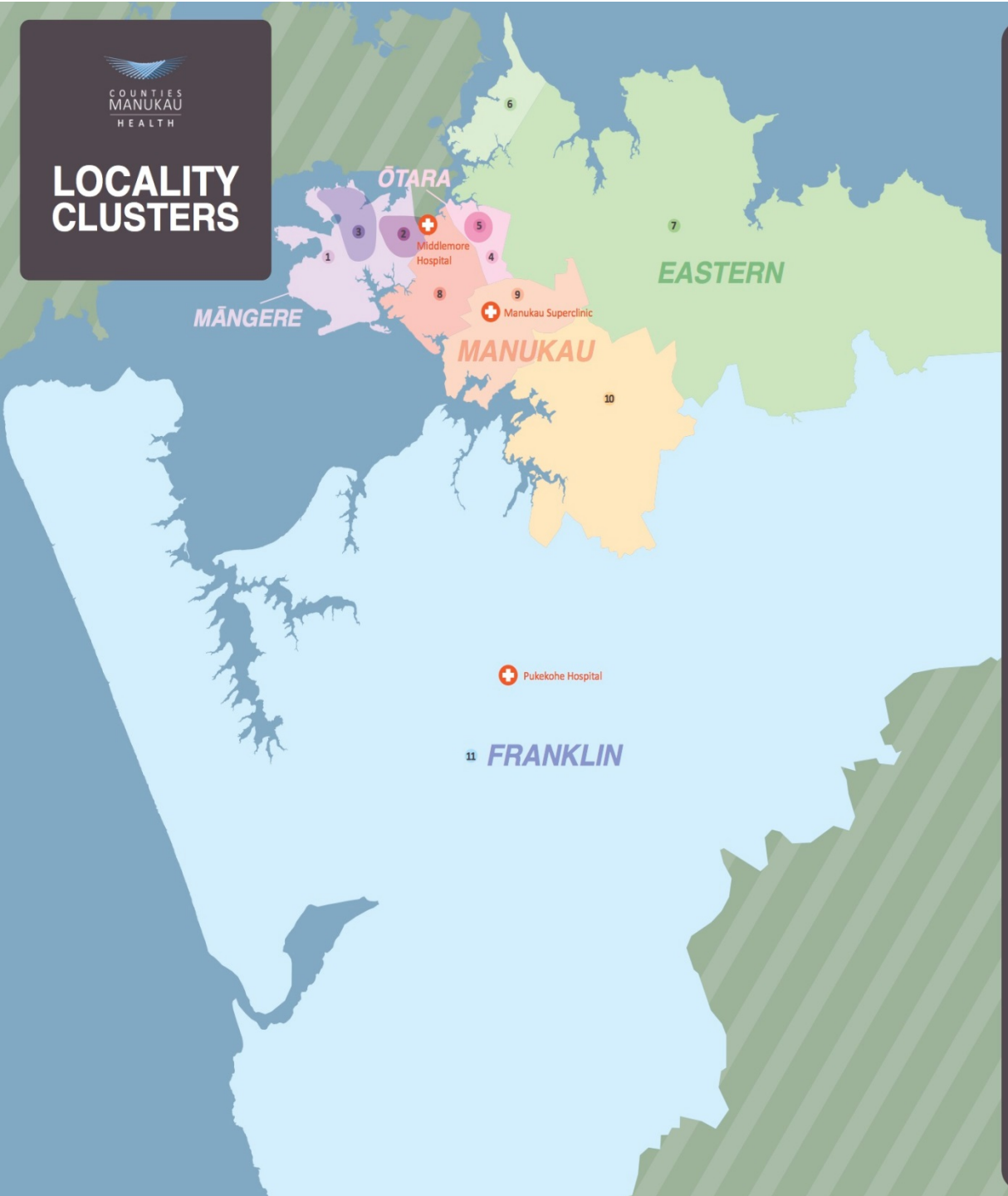
COUNTIES MANUKAU HEALTH

Healthy Together

Update, August 2016

COUNTIES MANUKAU HEALTH

LOCALITY CLUSTERS



MĀNGERE

1 Māngere ETHC Cluster
East Tāmaki Healthcare - Airport Oaks
Te Puea Medical Centre
ETHC Mangere Town
ETHC Mangere Bridge

2 Māngere East Cluster
Dr Kala Magan Surgery
Dr Upsdell's Surgery
Māngere East Medical Centre
Māngere Family Doctors

3 Māngere Town Cluster
Bader Drive Healthcare
Dr Patel's Surgery
Māngere Bridge Surgery
Māngere Health Centre
The Airport Doctors
Turuki Health Care

ŌTARA

4 Ōtara ETHC Cluster
East Tāmaki Healthcare - Bairds Road
East Tāmaki Healthcare - Chapel Park
East Tāmaki Healthcare - Dawson Road
East Tāmaki Healthcare - East Tāmaki Rd
East Tāmaki Healthcare - Ōtara Town Centre

5 Ōtara Central Cluster
Bishop Medical Centre
Ōtara Family and Christian Health Centre
Ōtara Union Health
South Seas Healthcare

EASTERN

6 North Cluster
DW Family Doctors
Eastern Family Doctors
Eastside Family Doctor
Family Health Care Medical Centre
Highland Park Medical
Howick Medical Practice
Juliet Avenue Surgery
Marina Medical
Pakuranga Medical Centre
The Doctors, Ti Rakau
The Family Practice

7 South Cluster
Beachlands Medical Centre
Botany Doctor
Botany Junction Medical Centre
Botany Town Centre Medical Centre
Botany Terrace Medical Centre
Clevedon Village Medical Centre
Highgate Surgery
Howick House Surgery
Howick Health and Medical Centre
Kawakawa Bay Orere Health Clinic Inc
Maraetai Medical Centre
Millhouse Integrative Medical Centre
Picton Street Surgery
Selwyn House Medical Centre
Sommerville Surgery
Vincent Street Family Doctors

MANUKAU

8 Papatoetoe Cluster
AUT Health/Medical Centre
Bakerfield Medical and Urgent Care
East Tāmaki Healthcare - Kolmar Road
Health and Happiness (un) Ltd
Hunters Corner Medical Centre
Manukau Family Doctors, Accident & Medical
Manukau Medical Associates
Onecare Health
Papatoetoe Accident & Medical Centre
Papatoetoe Family Doctors
Papatoetoe Medical Centre
Papatoetoe South Medical Centre
Puhinui Medical Centre
Sandhu Doctors
Southpoint Family Doctors
Rangitoto Medical Ltd
The Puhinui Doctors
Whānau Ora Community Clinic - Lambie Dr

9 Manurewa Cluster
Bader Drive Healthcare
Clendon Medical Centre
Clendon Family Health Centre
East Tāmaki Healthcare - Weymouth
Fellbrook Medical Centre
Gardens Medical Limited
Greenstone Family Clinic
Hillpark Family Medical Centre
Leabank Health Centre
Manukau Medical Associates
Manurewa Family Doctors
Manurewa Healthcare
Manurewa Medical – 157 Great South Rd
Raukura Hauora O Tainui - Clendon Medical Clinic
Raukura Hauora O Tainui - Trust Health Care
Te Manu Aute Whare Oranga
The Fono - Halver Road, Manurewa
Wiri Family Doctors

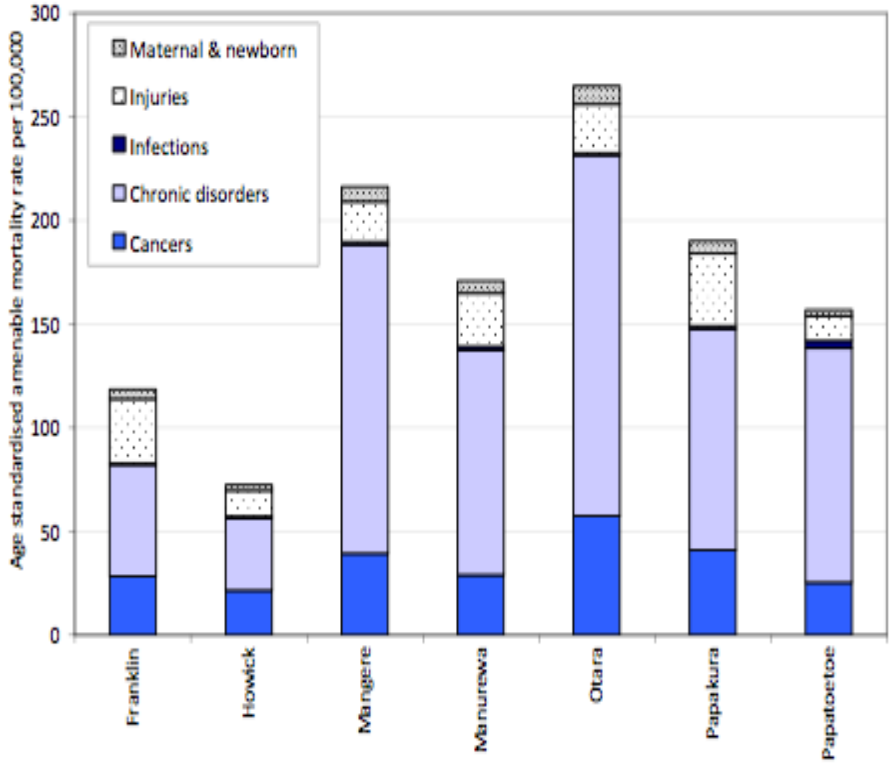
10 Papakura Cluster
Clevedon Road Medical Centre
Conifer Grove Medical Centre
Counties Care Accident & Medical Clinic
Counties Family Health Care
Drury Lane Surgery
Drury Surgery Ltd
East Tāmaki Healthcare - Takanini Medical Centre
Papakura East Medical Centre
Papakura Family Medicine Clinic Ltd
Papakura Family Health Centre
Papakura Family Medical Practice
Papakura Marae Health Clinic
Rosehill Christian Medical Centre
Roselands Doctors
Takanini Care Accident & Medical Clinic
Tiakina Te Ora
The Wood Street Doctors

11 FRANKLIN

Pukekohe Family Doctors
Pukekohe Family Health Care
Pukekohe South Doctors
Seddon Medical
Tuakau Health Centre Ltd
Waiuku Health Centre
Whānau Ora Community Clinic - Roulston St

- Total Otara-Mangere Population = c. 100,000 and projected to grow by 25%
- Otara population = c 45,000
- 80% Maori or Pacific Island
- Highly deprived
- High amenable mortality rate
- High prevalence of diabetes, hypertension, gout, obesity
- High and increasing rates of emergency admissions and use of emergency care
- Significant health inequalities

Amenable Mortality by Cause



People, Families & Communities

Scope: Maori, Pacific, Asian, Migrants, Refugees, Older People, Adults, Youth, Children, Mothers, Dads, Men, Women, Gay, Lesbian, Bi-sexual, Transgender, Homeless, Disabled

Wellbeing

People Living in Otara and Mangere have Better and More Equitable Health

- Healthy Natural and Built Environment
- Nurturing, Empowered People, Families & Communities
- Adequate Income to Meet Needs
- World-class Education System
- Better, Sooner, More Convenient and Integrated Health, Social & Disability System

Healthy Environments

Our ways of working together with people, families and communities champions the health promoting nature of our natural and built environment

Scope: Land, parks, rivers, sea, housing, transport alcohol environment, food environment, Gambling environment

Integrated Self Management Support

Our ways of working together empower our people, families and communities to make healthy choices

Scope: Smoking, healthy eating, healthy action, foot care, mindfulness, primary mental wellbeing, family relationships, financial literacy & budgeting, health literacy, planned healthy pregnancies

Better, Sooner, More Convenient Services

Our health, social and disability services are better, sooner, more convenient for local people, families and communities

- Acute and Urgent Care
- Planned, Proactive Care
- Palliative Care

Facilities

Our ways of working together are enabled by the facilities we agree to utilize for our common purpose

Waddon Place Hub, Otara Hub, SouthSeas MDT Meeting Room, Massey Road MDT Meeting Room

Information System

Information technology enables our ways of working together

- Healthpoint
- Health Navigator
- Patient Management Systems
- Patient Portal
- Locality Website
- E-shared Care
- Community Central

Workforce

Our workforce is well networked and has the values, skills, knowledge and capacity to work together

Scope: Workforce capacity, Workforce capability, Professional practice and development, interdisciplinary practice, multidisciplinary practice

Integrated Models of Care

We identify as one integrated community team by a common purpose and agreed ways of working, together to achieve it

Scope: Geographical cluster based integrated care teams

Collective Impact – Results

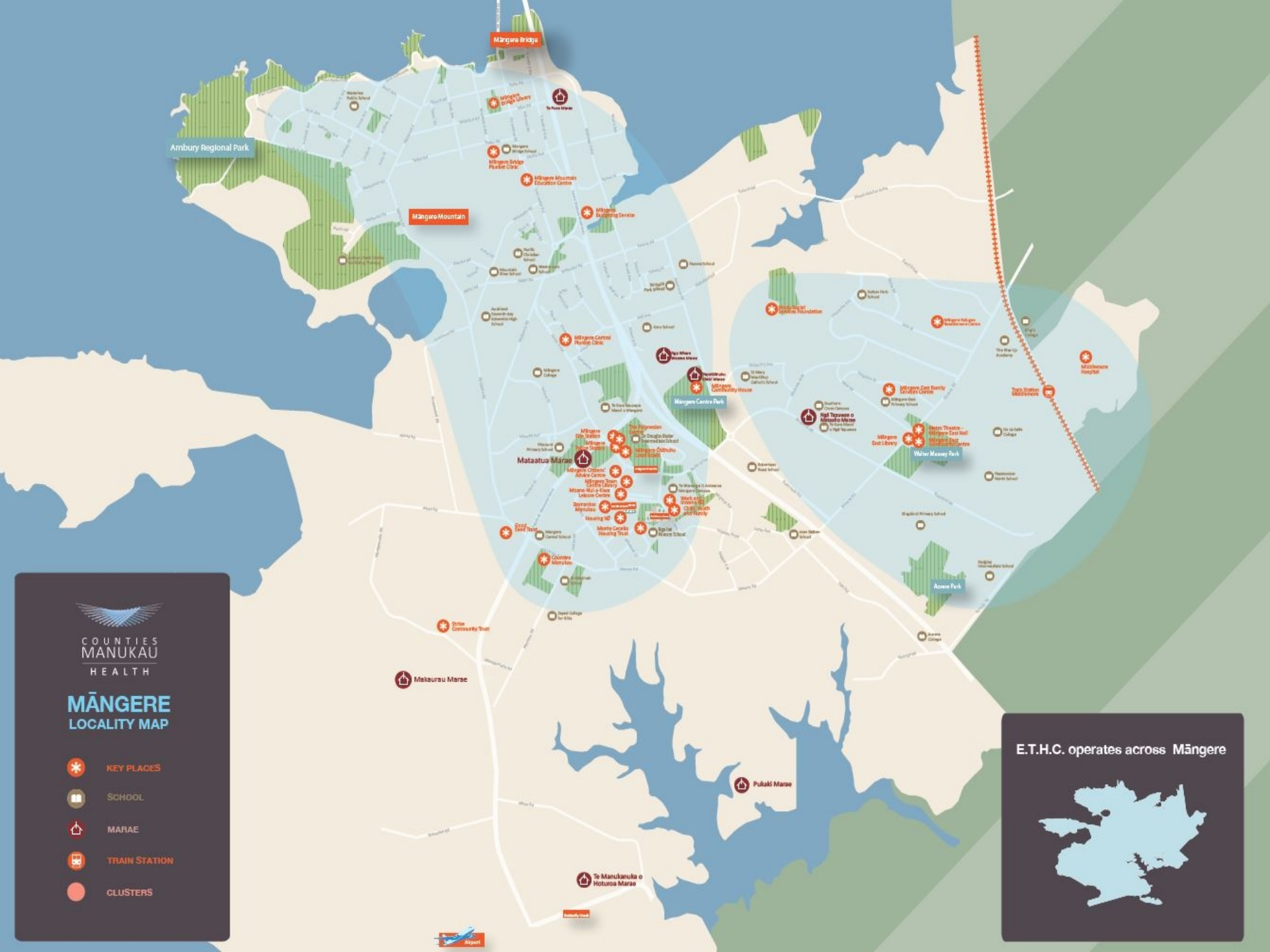
Scope: System Level Measures, Benefits, Locality Dashboard, Consumer satisfaction survey, Localities evaluation

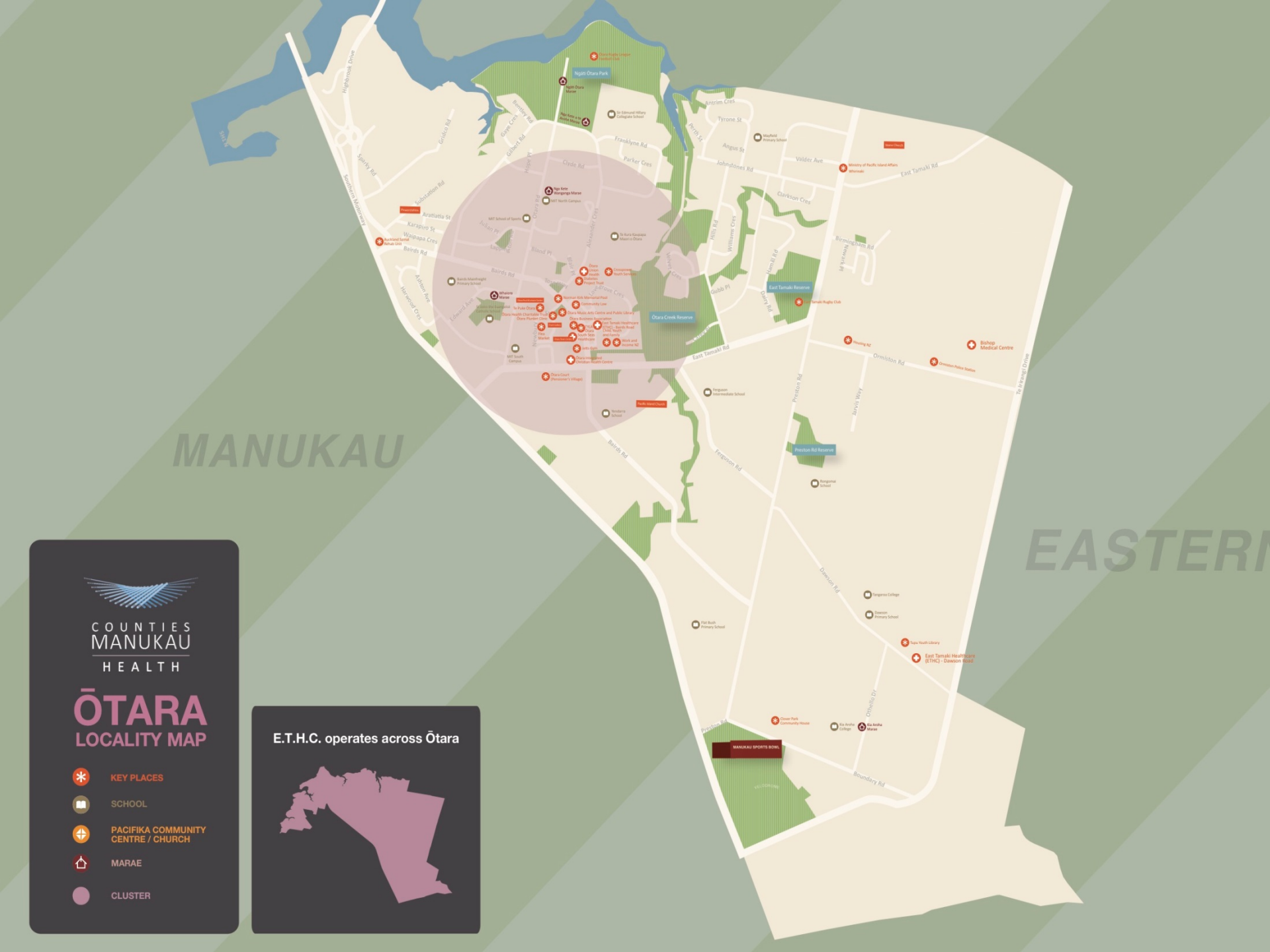
Guiding Team of Local Champions - Locality Leadership Team

CMH Leaders, PHO Leaders, Social Service Leaders, Community Leaders, Clinical Leaders

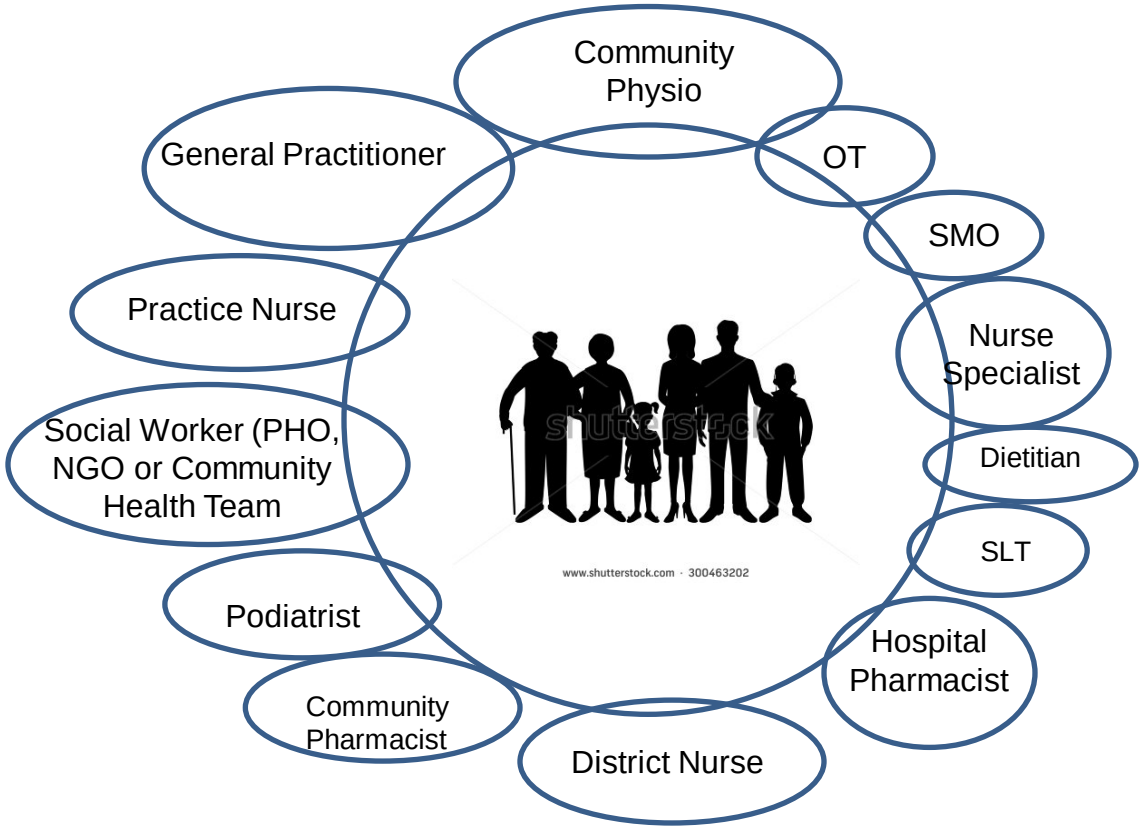
Five Levels of Collaboration

	From Frey, B.B., Lohmeier, J.H., Lee, S.W., & Tollefson, N. (2006). Measuring collaboration among grant partners. *American Journal of Evaluation, 27,* 3, 383-392.				
	Networking 1	**Cooperation 2**	**Coordination 3**	**Coalition 4**	**Collaboration 5**
Relationship Characteristics	▪ Aware of organization ▪ Loosely defined roles ▪ Little communication ▪ All decisions are made independently	• Provide information to each other • Somewhat defined roles • Formal communication • All decisions are made independently	• Share information and resources • Defined roles • Frequent communication • Some shared decision making	• Share ideas • Share resources • Frequent and prioritized communication • All members have a vote in decision making	• Members belong to one system • Frequent communication is characterized by mutual trust • Consensus is reached on all decisions


Māngere Bridge
Ambury Regional Park
Māngere Mountain
Mataatua Marae
Makaurau Marae
Pukaki Marae
Te Manukanuka o Hoturoa Marae
Māngere Centre Park
Walter Massey Park
Aoraki Park
COUNTIES MANUKAU HEALTH
MĀNGERE
LOCALITY MAP
KEY PLACES
SCHOOL
MARAE
TRAIN STATION
CLUSTERS
E.T.H.C. operates across Māngere


MANUKAU
EASTERN
COUNTIES MANUKAU HEALTH
ŌTARA
LOCALITY MAP
KEY PLACES
SCHOOL
PACIFIKA COMMUNITY CENTRE / CHURCH
MARAE
CLUSTER
E.T.H.C. operates across Ōtara
Ngāti Ōtara Park
Ōtara Creek Reserve
East Tamaki Reserve
Preston Rd Reserve
MANUKAU SPORTS BOWL
Bishop Medical Centre
Ormiston Rd
East Tamaki Rd
Bairds Rd
Ferguson Rd
Preston Rd
Dawson Rd
Boundary Rd
Southern Motorway
Highbrook Drive
Te Irirangi Drive
Sparks Rd
Gridco Rd
Substation Rd
Arataitia St
Karapiro Rd
Waipapa Cres
Ashton Ave
Harwood Cres
Edward Ave
Clyde Rd
Franklyne Rd
Parker Cres
Antrim Cres
Tyrone St
Perth St
Angus St
Johnstones Rd
Valder Ave
Clarkson Cres
Hills Rd
Williams Cres
Birmingham Rd
Newark Rd
Gubb Pl
Dairy Rd
Jarvis Way
Othello Dr
Alexander Cres
Bland Pl
Julian Pl
Lapper Cres
Gilbert Rd
Gaye Cres
Bentley Rd
Hope Rd
Ngā Kete Matauranga Marae
Ngāti Ōtara Marae
Ngā Kete Matauranga Marae
Whānore Marae
Kia Aroha Marae
Kia Aroha College
Clover Park Community House
Tapu Youth Library
East Tamaki Healthcare (ETHC) - Dawson Road
Ministry of Pacific Island Affairs Wherewhero
Mayfield Primary School
Sir Edmund Hillary Collegiate School
MIT North Campus
MIT School of Sports
MIT South Campus
Bairds Mainfreight Primary School
Ferguson Intermediate School
Fist Bush Primary School
Dawson Primary School
Tangaroa College
Kongomai School
Tendaris School
Ormiston Police Station
Housing NZ
East Tamaki Rugby Club
Pacific Island Church
Ōtara Court (Pensioner's Village)
Ōtara Community Christian Health Centre
Work and Income NZ
Ōtara Youth Health Centre
Ōtara Health Charitable Trust
Ōtara Business Association
Ōtara Music Arts Centre and Public Library
Community Law
Ōtara Diabetes Project Trust
Crossroads Youth Services
Te Puke Ōtara
Ōtara Plunket Clinic
Flea Market
Auckland Sports Rehab Unit
Te Kura Kaupapa Maori o Ōtara
Ngā Kete Matauranga Marae

Integrated Model of Care



- A foundation of general practice homes and community health teams working together with social and disability sector entities to support coordinated care and linkages with a broad range of services
- A health information infrastructure that includes EMRs, hospital data sources, a health information exchange network, and a centralized care co-ordination system
- An evaluation infrastructure that uses routinely collected data to support services, guide quality improvement, and determine program impact
- Buildings that support integrated ways of working in the community

CM Plunket Clinical Leaders – Ana Tom, Shobna Singh, Annette King

19 August, 2016

whānau. They are all linked to the caring line. The colours signify everybody working together to care for tamariki.

double koru are the parents. The quadruple koru are the grandparents and wider

This design is Whānau Awhina. The continuous line is the caring line and should

never be broken. Plunket caring for whānau and tamariki, whānau caring for tamariki. The small dots are the tamariki. The

Together, the best start for every child.

Ma te ngatahi, e puawai ai a tatou tamariki.

Plunket into 2020

Our purpose

"Together, the best start for every child"
Mā te mahi ngātahi, e puāwai ai ā tātou tamariki

Our philosophy

Relevant
Innovating
Growing

Our values

Trust, Inclusiveness, Quality, Commitment
Te Aroha, Te Mahinga Tahi, Te ūnga,
Te Tautukunga

Strategic Objectives

Business Plan Workstreams 2014/2015

Our People – Tātou Tangata
- Culture – One Plunket
- Structure

Our Customers – Tātou Whanau
- Leadership in child & family health
- Leadership in parenting
- Digitisation

Our Community – Tātou Hāpori
- Enhancing our ability to fundraise
- Volunteer infrastructure implementation
- Advocacy

Growing great kiwi kids

From a twinkle in the eye and for the next 1000 days, the best care and support for families, and by five, the best start for all kiwi kids

Making kids the heart & the spark of our communities

Helping our communities to care for their young

Supporting families & children when they need it most

Working with our communities to make each generation stronger than the last

How is Plunket delivering Well Child Services in Counties-Manukau

Today we will talk about the following

- Universal Services – Free Well Child entitlement for every child < 5yrs
- B4 Sch checks – 4yrs
- Outreach Immunisation Service
- ePHR – Electronic Records

Universal Plunket Service

Core Contacts
Plunket Nurse

1) 2-5 weeks

2) 6-9 weeks

3) 10-15 weeks

4) 4-7 months

5) 8-13 months

6) 14-20 months

7) 21-47 months

8) B4 Sch Check – 4yrs

First time parents & High need families

More visits as required.

Free Universal Well Child Service from Birth to 5yrs

Health Education & promotion

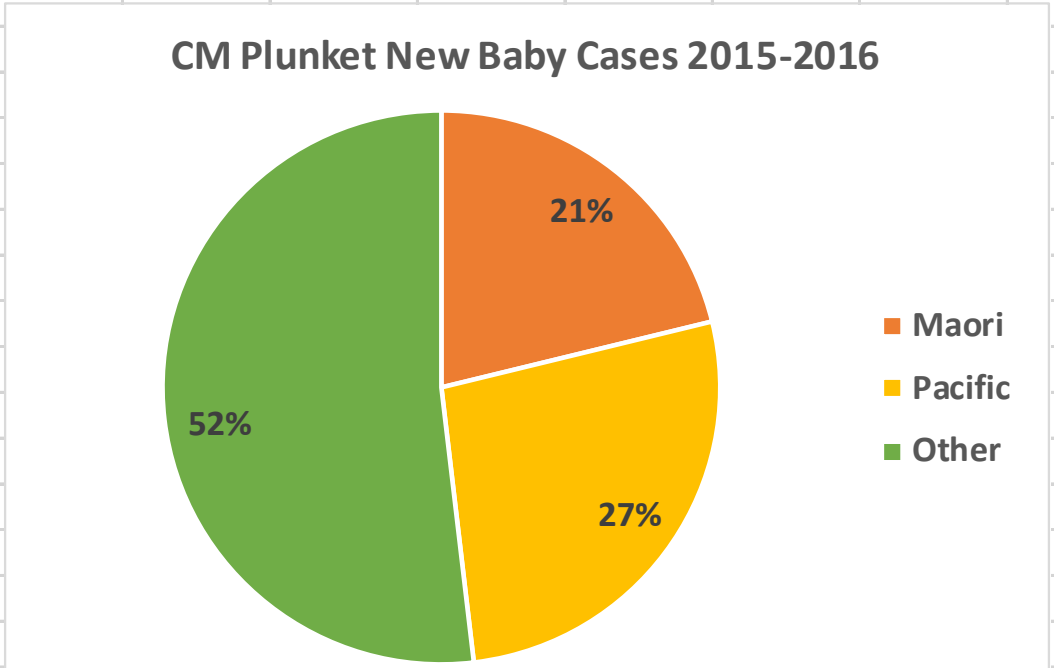
Health Protection & Clinical Assessment

Family or Whanau Care & Support

Plunket in the community

- Enrol 96.3% of all babies born in C-M 2015-16
- South Seas Kids (Pacific), Mokopuna Ora (Maori) & Tamariki Ora (Maori) other well child providers in CM

CM Plunket New Baby Cases 2015-2016			
Maori	Pacific	Other	Total
1640	2089	4017	7746



Plunket in Counties Manukau

- Well-child services - clinic & home visits
- Mobile Bus
- Saturday Superclinic (Manukau)
- Plunketline 0800933922
- B4 School checks
- Family Centre services
- Community Services
  - PEPE – Parenting groups
  - Toy library & Playgroups
  - Education in high schools
  - Car Seat Services

Staff in the CM area team

- Clinical Leaders
- Plunket Nurses
  - B4Sch Nurses
  - OIS Team
  - Plunket Family Worker (MNR)
- Community Karitane (Pacific)
- Plunket Kaiawhina
- Car-seat rental managers
- Admin support
- CSL and Volunteers
- Clinical Services Manager

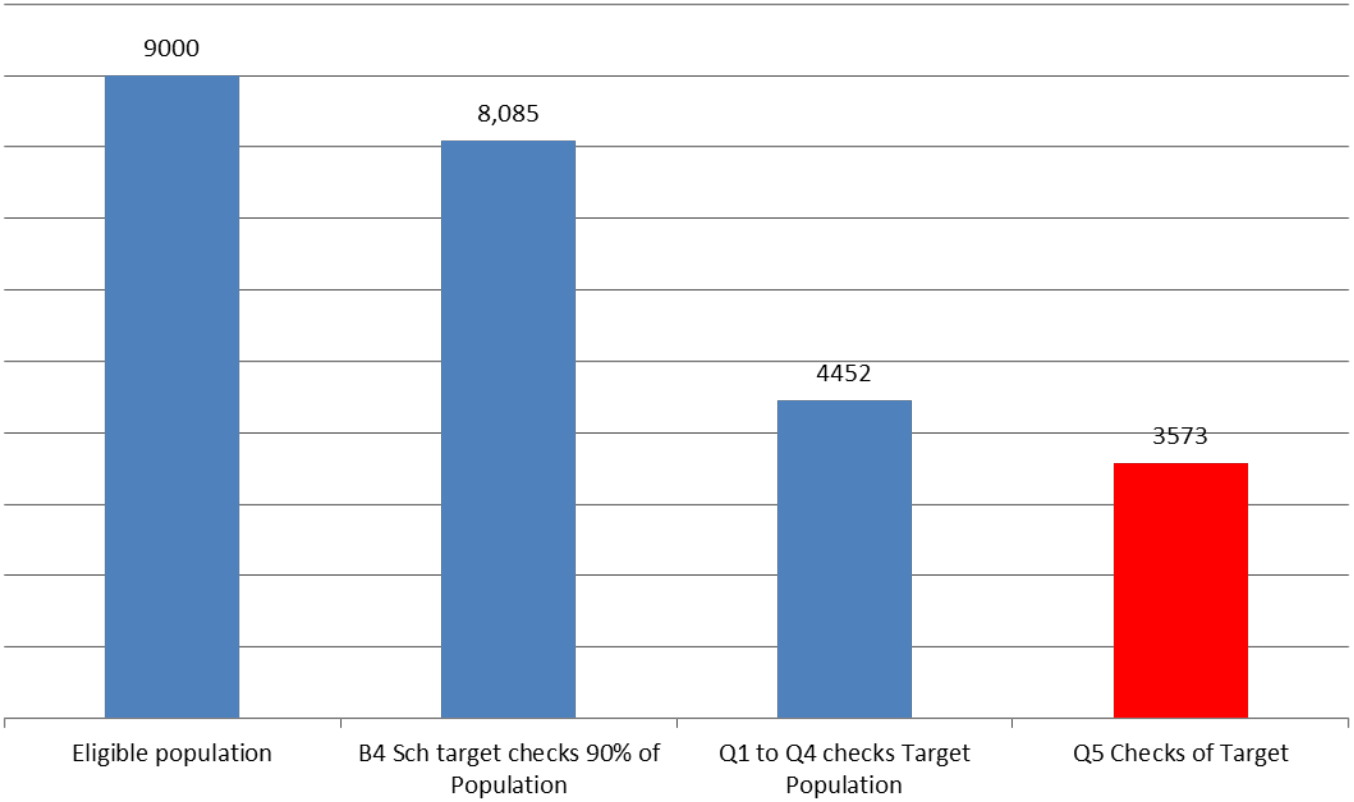
Aims of the B4Sch Check Program

- To provide a comprehensive assessment of the 4 year old cohort in Counties Manukau to identify any health, behavioural, social or developmental concerns which may adversely affect the child's ability to learn in the school environment.

- These assessments include a review of behaviour, development, vision, hearing, oral health , weight/height and immunisation status followed by referral and engagement with appropriate services.

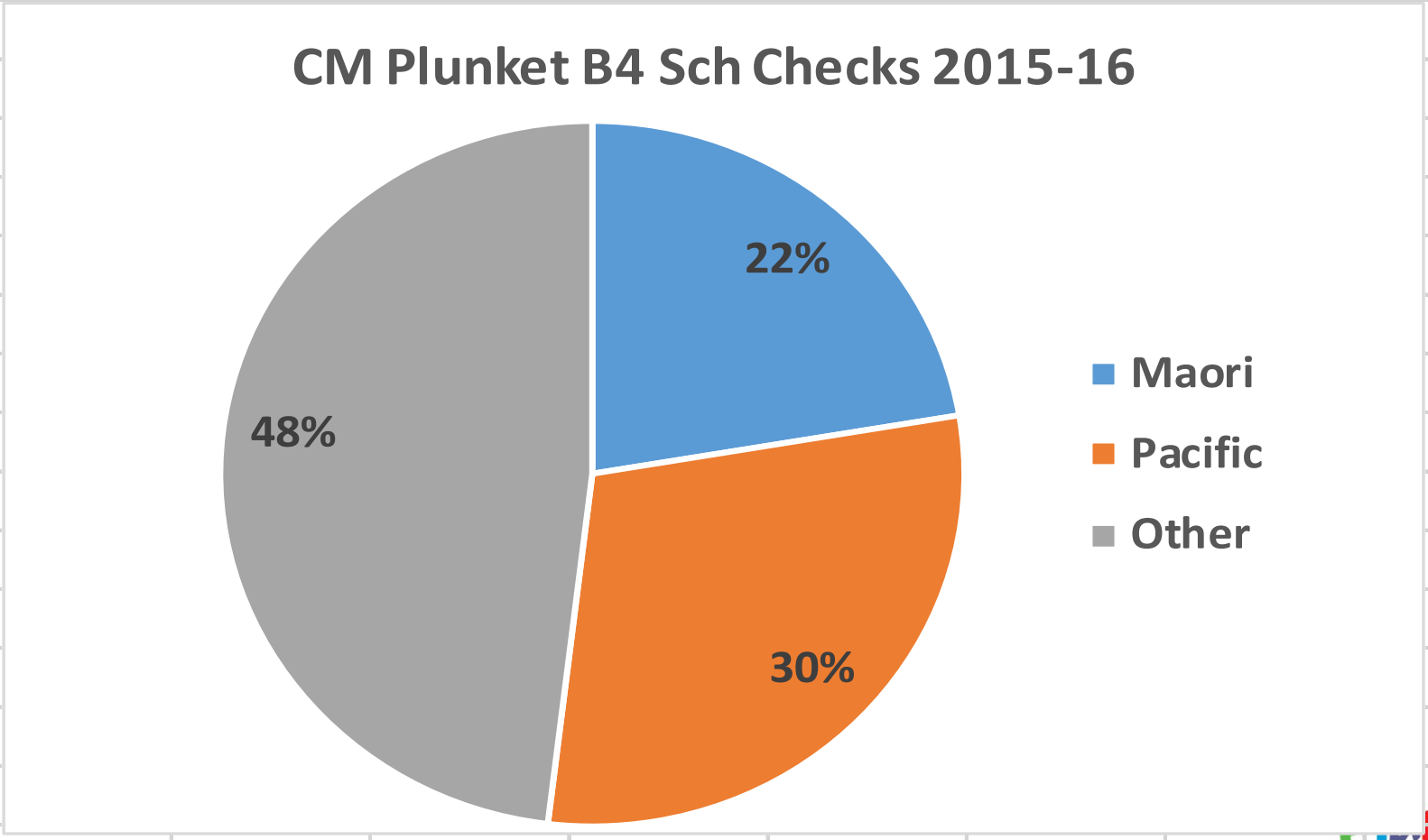
- This screening programme will strive to achieve screening of 100% of 4 year old cohort with priority placed on reaching those children living in low income areas (Quintile 5).

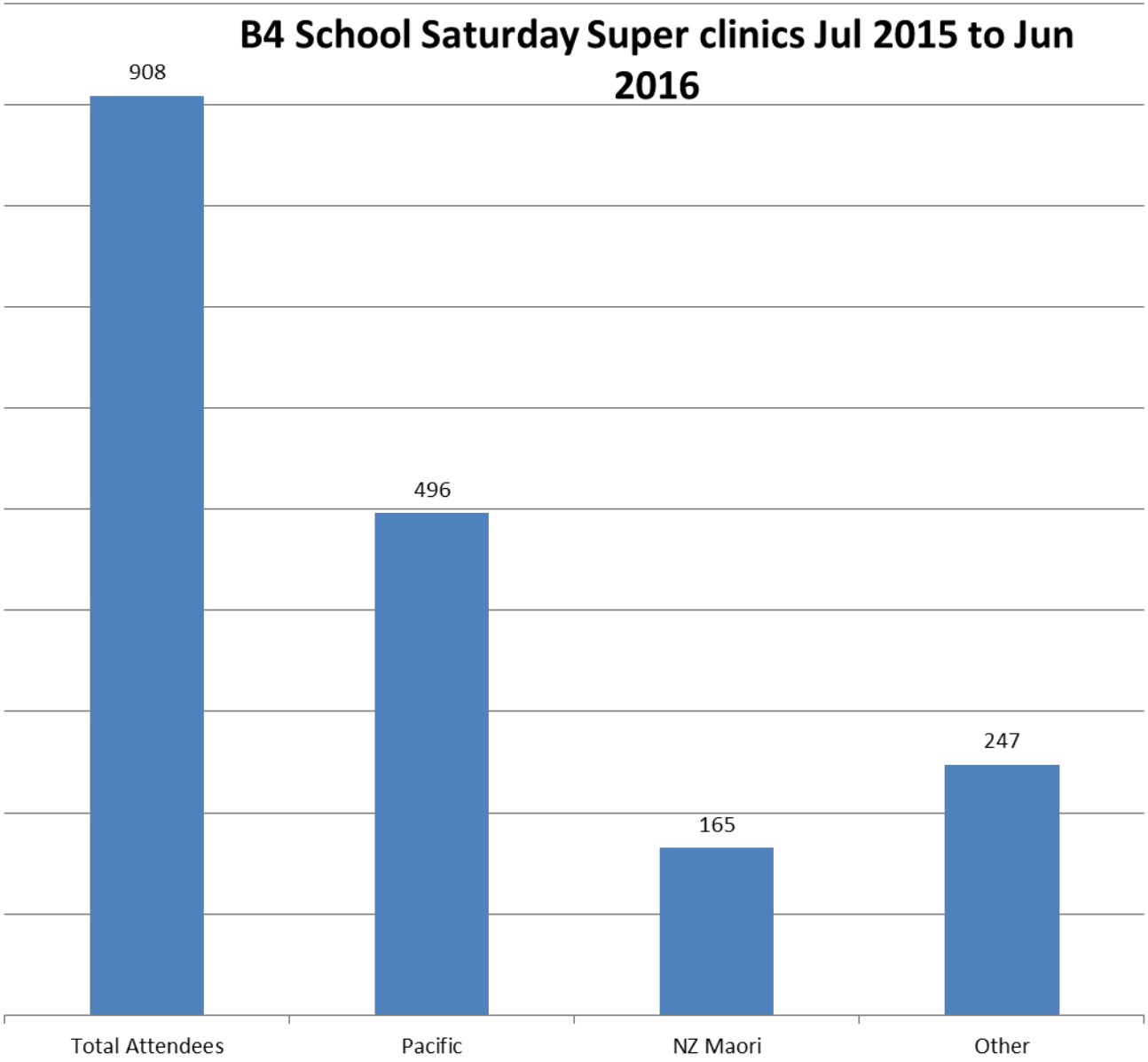
CMDHB B4 School checks July 2015 to June 2016



CM Plunket Completed B4Sch Checks 2015-2016

	Maori	Pacific	Other	Total
	1807	2390	3888	8085




B4 School Saturday Super clinics Jul 2015 to Jun 2016
908
496
165
247
Total Attendees
Pacific
NZ Maori
Other

Plunket Outreach Immunisaton Services (OIS)

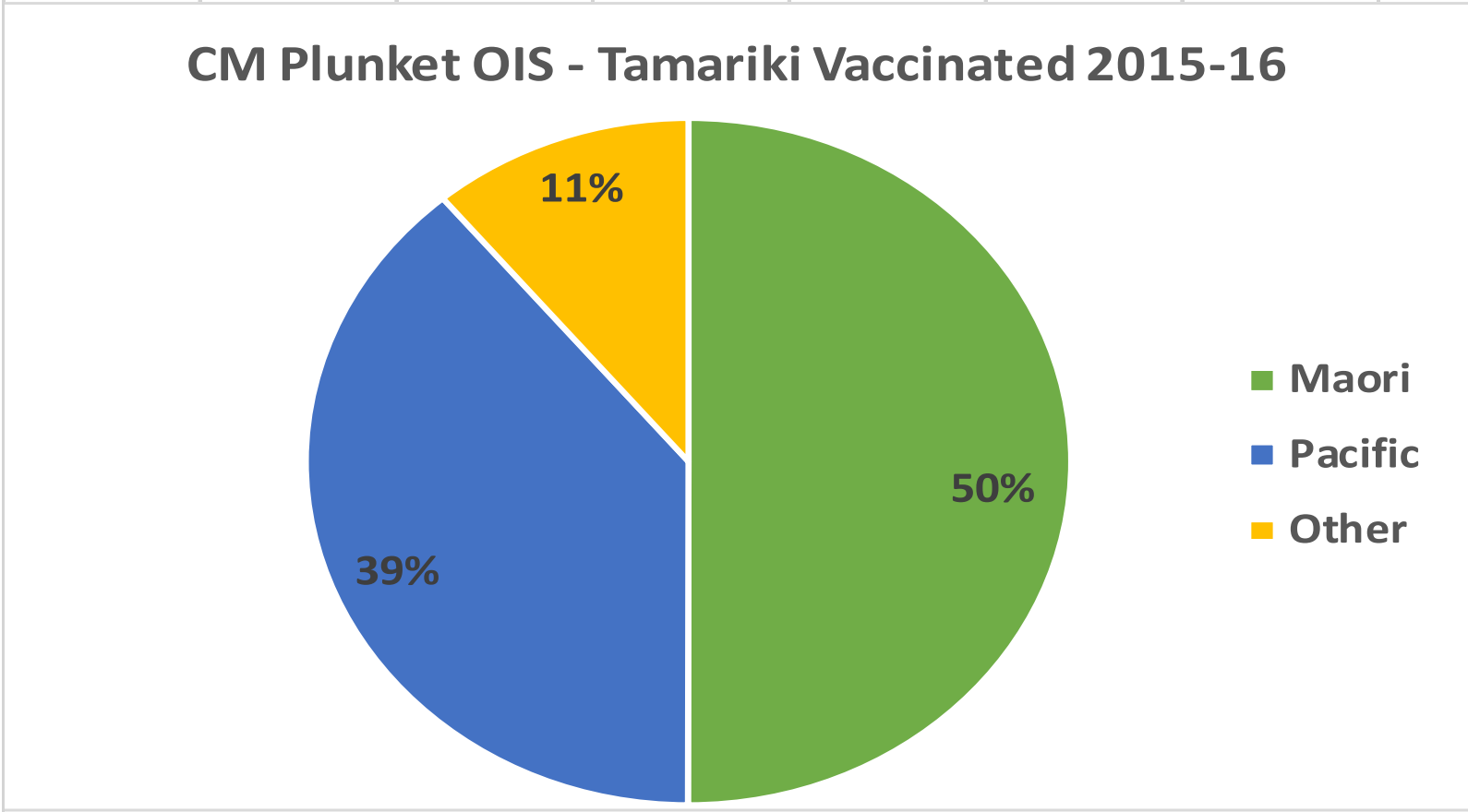
- *OIS **attempts** to immunize those children who have been identified as having missed some or all of the schedule childhood immunisations.*
- *OIS **aims** at improving immunization coverage and ensuring that people have access to services that empower them to make informed decisions regarding immunisations (Ministry of Health August 2007)*

Key Objective

- *Is to improve immunization coverage rates for Maori and Pacific child and other priority groups with high rates of vaccine preventable disease and low immunization coverage.*

CM Plunket Outreach Immunisation - Tamariki Vaccinated 2015-2016

Maori	Pacific	Other	Total
1100	855	244	2199



Ministry of Health (MOH)Targets

The CMDHB Immunisation targets for 2015-16 were measured in 2 cohorts. Overall achievement.

- 95% 8 months
- 95% 2 years
- 88% 4-5 years (added for 2016-17 targets)

The CM Immunisation Cohorts to achieve MOH Targets for 2016-2017

- 95% 8 months
- 95% 2 years
- 95% 4-5 years

Plunket

Plunket OIS Team

- 3 Plunket Nurses, 2 Plunket Kaiawhina & 1 Plunket Healthworker, 1 Admin support

ePHR (Electronic Plunket Health Records)

- *Will enable Plunket staff in their work to find efficiencies and be more effective in service delivery.*

- *Better consistent collation of local & national data will assist staff to identify gaps to focus resources. It will allow us support our most vulnerable families.*

- *ePHR will connect us in new ways with clients & other service providers across NZ. It will transform the way we record & store information.*

New clients

ePHR explained

Existing clients

Well Child data entry

Administrator

Clinical Services Manager

Via web browser
Data entry

Via web browser
Managerial reporting

Reporting

- Management
- Ministry of Health
- Other reporting

Paper based

Plunket Nurse and Health Worker

Contact information

Administrator / Support Services

POND interface

Well Child data

PCIS form & other POND information

Via application and web browser

Data entry

Clinical Leader

Well Child business viewing & monitoring

ePHR

CRM
Customer Relationship Management

POND
Plunket Operation National Data

Via application
Data entry

Paper files

Filing cabinet

Over time you will be doing less and less POND data entry.

Well Child business

Plunket Nurse / Health Worker

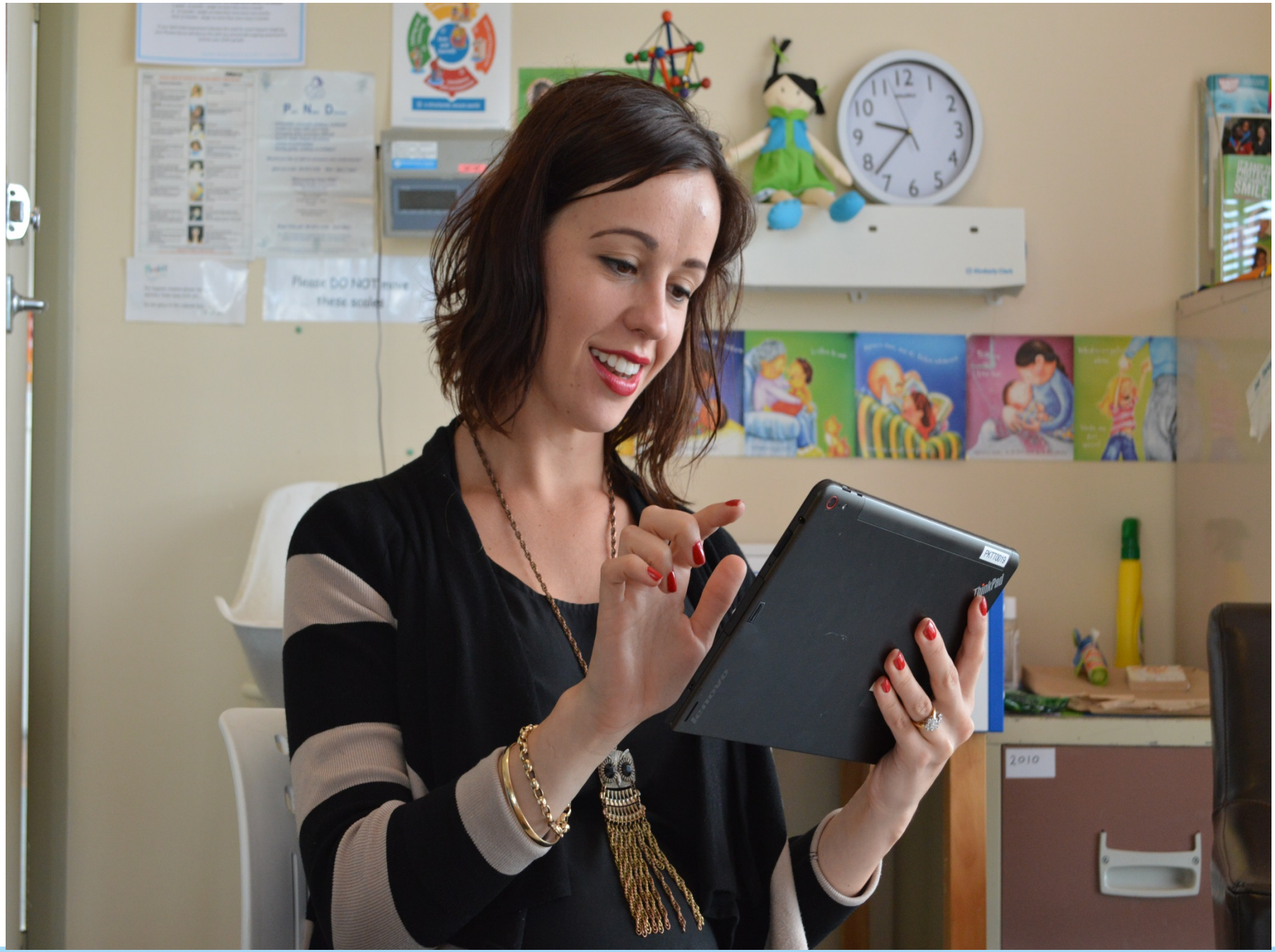
Other information

The name "ePHR" (electronic Plunket Health Record) refers to the whole online system for the Well Child service, and is the digital conversion of the current paper-based system.

The system is accessed either by web browser or an application via a tablet for frontline staff and a tablet/desktop for clinical service managers, clinical leaders, and administration staff – and connects with a database (CRM) that stores Plunket's client health information.

The ePHR captures information and the database stores and retrieves that information.

Plunket


P. N. D.
Please DO NOT move these scales
2010

Contact numbers

Clinical Services Manager (CSM):

caro.watts@plunket.org.nz	Ph 0275665174	Auckland & CManukau

CSM Support

shobna.singh@plunket.org.nz	Ph 0272386305	Auckland & CManukau

Clinical Leaders:

rose.clarke@plunket.org.nz	Ph 0212462176	Mangere
annette.king@plunket.org.nz	Ph 0212462036	Papatoetoe
maeve.fleming@plunket.org.nz	Ph 0212464586	B4 Sch Checks
joanne.udy@plunket.org.nz	Ph 0212467609	Manurewa
ana.tom@plunket.org.nz	Ph 0212464680	Otara, Family Centre & OIS

Administration:

contiesmanukau@plunket.org.nz	Ph 2604032

Counties Manukau District Health Board
Community & Public Health Advisory Committee
Primary Health & Community Services Directorate Report

Recommendation

It is recommended that the Community & Public Health Advisory Committee:

Receive the report of the Director Primary Health & Community Services.

Prepared and submitted by: Claire Naumann, Acting Director, Primary, Community & Integrated Care

Executive Summary

Provisional data shows that we have met all Health Targets at the end of Quarter four, except for Cervical screening coverage which we are still awaiting the data for. Ministry of Health results show Counties Manukau Health is the top District Health Board for Better help for Smokers to Quit and third in the country for More Heart and Diabetes Checks. These are fantastic results and Counties Manukau Health staff, Primary Health Organisations, and General Practices are to be congratulated.

Before School check targets of 8,025 checks (3,565 Quintile five checks) for 2015/2016 were exceeded with a total of 8,085 Before School checks being completed. Saturday outreach clinics at the Manukau SuperClinic are still proving to be very popular for our community, providing a range of universal services including the delivery of immunisations and Well Child checks.

Learning session one for the Diabetes Collaborative was held in July. The practices involved in the modified diabetes care improvement package shared the initiatives they are working on with other practices and secondary care clinical staff, and also used the opportunity for locality cluster networking. The majority of practices were willing to openly share data with each other including their progress against the Collaborative Aim, a 10% reduction in HbA1c for patients with poorly controlled diabetes (HbA1c over 75).

The third year of Safety in Practice – the programme to improve quality and safety in Primary care was launched in July with 40 practices across the Auckland region enrolled in the programme in the coming year. Collaborative visits to all new practices are underway, and the practices are undertaking either a previous care bundle of Medication reconciliation, results handling, warfarin management, and opioid prescribing or choosing from a new care bundle, either managing cervical smears or management of chronic obstructive pulmonary disease.

The review of palliative care services in Counties Manukau Health is in its final phase. 170 responses have been received through surveys conducted across primary care, hospice, age related residential care, community services and secondary care/inpatient settings. Face to face interviews have also been conducted with a broad range of people. Focus groups are being held in each locality this month. A report will then be drafted outlining key themes arising from the review and identifying options for a three year whole of system implementation plan for integrated palliative care services in Counties Manukau.

Dr Clive Bensemann has been appointed to the role of Clinical Leader of Integrated care for Mental Health and Addictions in response to the increased momentum in integration of physical and mental health services. His focus will be ensuring effective integration across primary care, specialist mental health and addictions and Non-government organisation provision of services, including embedding mental health and addictions workforce into enhanced primary care health teams.

Responses to Action Items

CPHAC Meeting 6.7.2016

A recent audit of patients referred to ED by GPs from the Eastern locality showed that 80% could have been trated in the community. Ms Naumann to include this data in the next Director's Report.

Refer to Item 4.5 on this agenda, the information has been provided in the Eastern Locality portion of that report.

CPHAC Meeting 6.7.2016

Come up with an alternative way of reporting the data in the Localities Reports (ie) dashboard-type reporting so the figures provided can be compared to the baseline.

This is being worked through by the Locality General Managers and will be provided in the new format at the next CPHAC meeting.

CPHAC Meeting 6.7.2016

Page 71 noted that the Health of Older People variable variance of $1.3m will fund the investment now underway in the Community Integration implementation. There is a concern that this is a big variance and there is high demand in the health of older people. We need to ensure that the services for health of older people are not suffering because the money is needed for the community integration implementation. It's also not obvious or clear in the reports where the favourable variance is under community integration implementation. Ms Naumann confirmed that it is all being managed through the underspend but will provide more information in terms of how this spend is tracking and where it is being managed.

There is no direct reduction in health of older people services to fund Community Integration, the two are not related but are used together to ensure total Primary and Community budget is achieved. The favourable variance in Health of Older People is the result of budget cost estimates being higher than the actual costs and not from reduction in services. The Health of Older People budget was set based on our over 65 population growth of over 4% pa plus the nationally agreed price increases but because of less demand and the impact of higher property values on asset testing, we are seeing lower costs compared to budget. The Community Integration costs are appearing in, and causing, the unfavourable budget variance in "Planning and Funding - Governance".

CPHAC Meeting 6.7.2016

Mr Robson asked that he be provided with the number of people currently waiting for treatment for glaucoma. He then further requested answers to the following questions:

What does the current eye health pathway look like from a community and patient point of view?

Glaucoma of various types affects 3% of the population 49 years and over and over 11% of the population 80 years plus. Patients do not realise that they have glaucoma until very late in the disease. Glaucoma is a treatable disease but once vision is lost from glaucoma it cannot be regained. Glaucoma, although treatable, remains one of the leading causes of blindness all round the world. Glaucoma is detected by an

eye examination, in NZ that means by going to see a private optometrist. Glaucoma NZ recommends the 45 + 5 approach Mr Robson mentions: examinations should be more frequent if there is a risk factor like glaucoma in the family but there is no public funding for Glaucoma screening.

What is the mean median cost of each treatment?

Treatment in the public health system is free for the patient. Detecting eye examinations at an optometrist generally cost around $60 and is not covered in a standard health insurance policy. In the public health system we are funded for First Specialist Appointments and in Ophthalmology the price for these assessments is the same regardless of which condition/category therefore we cannot cost this specifically for Glaucoma.

What are the actual number of people and segmented timeframes in which people are awaiting and receiving treatment in:

Referral to First Specialist Appointment

At 30 June 2016 all patients are being seen within 120 days of referral to a consultant.

First Specialist Appointment to Treatment

The treatment for glaucoma is most often medical treatment prescribed at the time of the FSA e.g. eye drops. If patients require a surgical intervention, they all receive surgery within 120 days.

4.2 National Health and Integrated Performance & Incentives Framework Targets

Target	15/16 Target	15/16 Q1	15/16 Q2	15/16 Q3	Jun 16	On Track
More Heart and Diabetes Checks	90%	92.1%	92.1%	**92.0%**	**92.1%**	**Yes**
Better Help for Smokers to Quit	90%	86.9%	87.6%	**88.6%**	**92.0%**	**Yes**
Increased immunisations - 8 months	95%	93.6%	94.7%	**94.2%**	**95%**	**Yes**
Increased immunisations - 24 months	95%	95.2%	96.0%	**95.9%**	**95%**	**Yes**
Cervical screening coverage (resident population)	80%	72.6%	73.2%	**74.4%**	*	**Improvement Required**

June results are provisional only, based on calculation from Primary Health Organisation data except for immunisation and cervical screening data

*Cervical screening resident population data is provided by National Screening Unit (one month behind). Primary Health Organisation enrolled population coverage at May 2016 was **78.1%.** June Primary Health Organisation enrolled population data is not yet available.

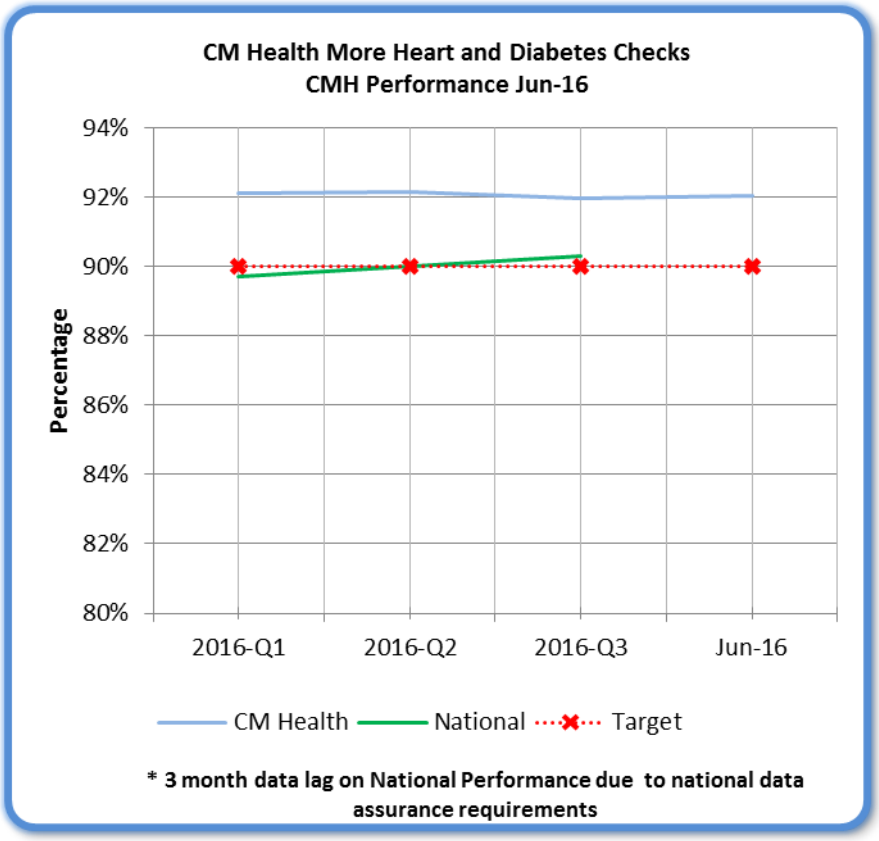
Provisional data from PHOs indicates that Counties Manukau Health has met both the More Heart and Diabetes Checks and Better Help for Smokers to Quit National health targets. The Ministry of Health has confirmed that both the eight and 24 month immunisation targets have been met. This is an excellent result, particularly for immunisations and Better Help for Smokers to Quit due to the difficulty reaching and contacting caregivers of babies and patients who do not routinely visit primary care. All Primary Health Organisations achieved over 89% for the Better Help for Smokers to Quit target. The National Hauora Coalition has performed exceptionally well and is the top-performing Primary Health Organisation for this target, achieving 94.9%.

There is ongoing effort to meet the cervical screening target, with Primary Health Organisations investing significant resource to increase screening rates particularly for priority group women. Primary Health Organisation enrolled population performance for cervical screening total population coverage was 78.1% in May 2016. June cervical screening coverage data is not yet available at either the enrolled or resident population level.

More Heart and Diabetes Checks

	Historical Quarters			Current Month
PHO	2016-Q1	2016-Q2	2016-Q3	**Jun-16**
Alliance Health Plus	93.0%	94.1%	94.3%	92.1%
East Health	91.7%	91.2%	90.6%	91.3%
NHC	89.7%	89.8%	89.7%	91.4%
ProCare	93.2%	92.8%	92.6%	92.8%
Total Healthcare	89.8%	90.5%	90.8%	91.2%
CM Health	92.1%	92.1%	92.0%	92.1%
National	89.7%	90.0%	90.3%	
Target	90.0%	90.0%	90.0%	90.0%

June results are provisional only, based on calculation from Primary Health Organisation data.
Quarterly data for Primary Health Organisations, is Ministry of Health published data as part of National Health Target reporting.



Preliminary results from Primary Health Organisations indicate that Counties Manukau Health has met the 90% target for More Heart and Diabetes Checks. This activity remains business as usual for Primary Health Organisations and their practices.

From 1 July 2016, More Heart and Diabetes Checks will cease to be a health target. However the Ministry has highlighted the expectation that Cardio-Vascular Disease risk assessment and diabetes checks coverage will be maintained at the 90% threshold after the checks target transitions to a contributory measure under the System Level Measures Framework. Primary Health Organisations have noted that they expect that current coverage rates will continue given that this activity is now core business and there are good patient recall systems in place.

Now that 90 percent of the eligible population has been risk-assessed under this target there is an opportunity to focus on that population's risk factor management especially for people with high risk. We will continue to focus on appropriate management for people identified as high risk (for example, dual therapy (cholesterol and blood pressure medication) for those with a risk greater than 20%), and equity (particularly for Maaori men aged 35-44).

Better Help for Smokers to Quit

	Historical Quarters			Current Month
PHO	2016-Q1	2016-Q2	2016-Q3	**Jun-16**
Alliance Health Plus	85.0%	87.1%	86.3%	91.5%
East Health	86.3%	83.9%	84.5%	89.3%
NHC	83.7%	80.9%	81.9%	94.9%
ProCare	88.5%	89.4%	91.0%	92.1%
Total Healthcare	86.3%	87.8%	89.0%	92.5%
CM Health	86.9%	87.6%	88.6%	92.0%
National	83.2%	85.0%	86.0%	
Target	90.0%	90.0%	90.0%	90.0%

June results are provisional only, based on calculation from PHO data.
Quarterly data for PHOs is MoH published data as part of National Health Target reporting.

Preliminary Primary Health Organisation results indicate that Counties Manukau Health has met the 90% target for Better Help for Smokers to Quit. Performance has continued to increase over the quarter due to Primary Health Organisations' sustained focus on this target. They have continued to work with their low performing practices and to provide additional resources to support these practices.

The Counties Manukau Health Smokefree advisor – primary care has been visiting a number of practices to discuss strategies to meet the target, including those sent out recently by the national Target Clinical Champion. She has also provided extra resource to some Primary Health Organisations to call patients with missed interventions.

Immunisations

The Immunisation target for June 2016 requires 95% of all eligible children aged eight months and 24 months of age to have completed their scheduled course of immunisations.

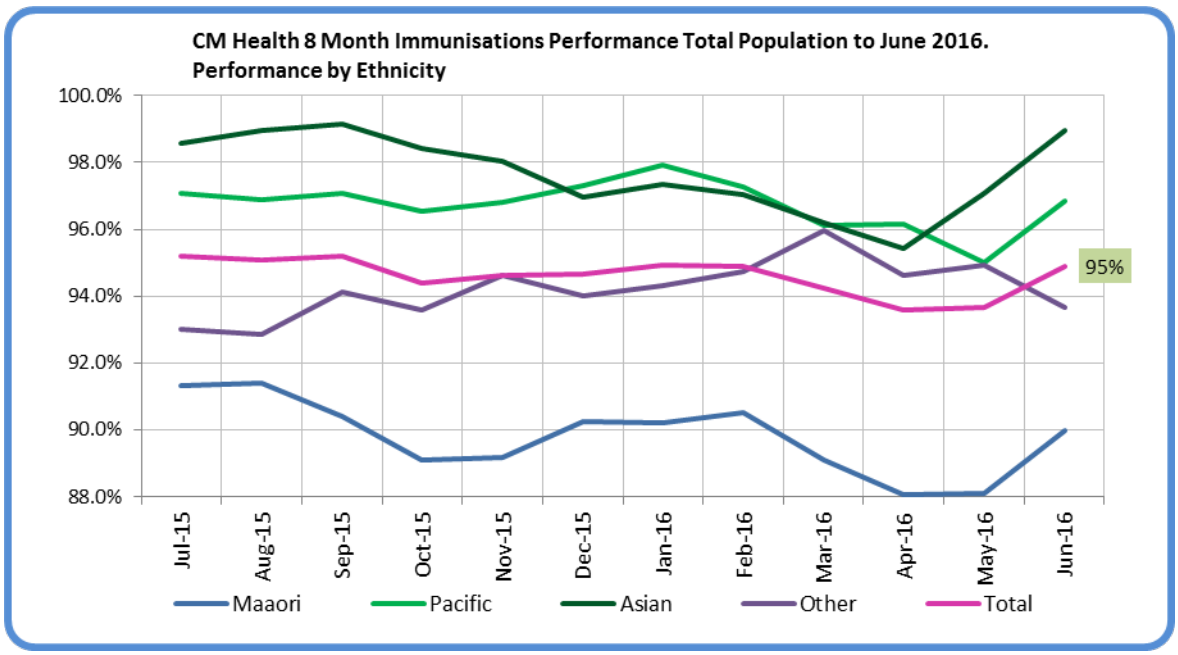
There has been considerable promotion and focus on immunisations in Quarter four to ensure that we immunise all children to provide protection from serious disease. This has assisted us to achieve target of 95% for eight months and 24 months.

Progress is discussed monthly with Primary Health Organisations and at Immunisation working group meetings. Where immunisation is delayed by families they are referred to the outreach immunisations team and where needed to the Well Child Tamariki Ora provider. Overdue reports of all milestone immunisations are sent to General Practices and we are getting faster turnaround from practices to Complete or Decline or Refer to Outreach.

Families of the most at risk babies are under stress of housing issues and real material hardship which means that locating the babies to immunise becomes more difficult for Primary Care and Outreach Immunisations Services. We note an increasing trend in delayed decisions to immunise as many parents are under stress with housing and low incomes. By making use of Outreach Immunisations for home visits and also offering a drop-in Saturday outreach clinic we hope to better meet the needs of families.

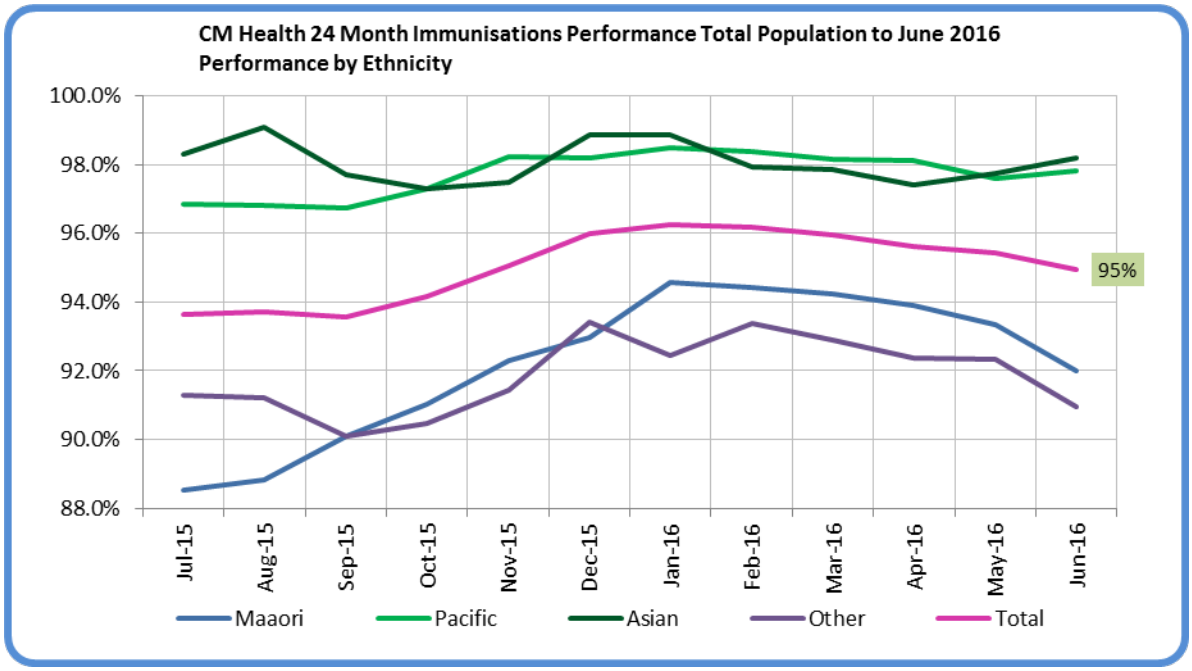
Eight months Immunisations coverage

Quarter four, June 2016 data for immunisation at eight months of age is 95%. By ethnicity, coverage for Maaori is at 90%, Pacific at 97%, and Asian at 99%. There are also very pleasing results for high deprivation levels seven to eight and nine to 10 at 95%.



Twenty-four months Immunisations coverage

June 2016 data for immunisation at 24 months of age is 95%. By ethnicity, coverage shows Maaori at 92%, Pacific at 98% and Asian at 98%. There are also very pleasing results for high deprivation level 7-8 at 95% and level 9-10 at 96%.



Five years Immunisation coverage

The five years immunisation target has had renewed focus through Before School Checks and Primary Care and has improved considerably over the last six months. Quarter four, June 2016 result was 88%. Ethnicity coverage shows Maaori at 82%, Pacific at 88% and Asian at 95%.

Cervical Screening – Total Population three year Coverage

	Historical Quarters			*Current*				
CM Health	**2016-Q1**	**2016-Q2**	**2016-Q3**	**Total Pop at May 16**	**Maaori at May 16**	**Pacific at May 16**	**Asian at May 16**	**European/ Other at May 16**
PHO 'Enrolled' population	76.1%	76.6%	77.4%	78.1%	70.9%	70.1%	79.2%	82.0%
'Resident' population	72.6%	73.2%	74.4%	74.8%	68.4%	81.0%	66.7%	79.4%
National Performance	76.6%	76.7%	76.6%	76.4%	66.0%	76.6%	65.4%	80.9%

Source:
From Quarter two quarterly data will be provided by the Ministry IPIF team. The current 'Enrolled' percentages exclude Total Healthcare. From February 2016 the National Cervical Screening Programme will now use prioritised ethnicity & domicile recorded on the National Health Index instead of the previously sourced demographic information from the National Cervical Screening Programme Register for women aged 25-69 years and resident in Counties Manukau Health. As a result, performance for the District Health Board as a whole and in particular Maaori, Pacific and Asian ethnicities has improved.

Overall coverage for the resident population is slowly increasing and is now at 74.8% for May. This means that coverage is unlikely to meet the 80% national target by June.

However at the Primary Health Organisation level a significant amount of work has been carried out over June as a 'final push' to meet target. For example, Alliance Health Plus saw a large increase in cervical smears carried out using an incentive-based scheme for practices. Primary Health Organisations continue to improve the systems and processes that will ensure cervical screening remains a high priority for practice staff. It is likely that many Primary Health Organisations will meet or be close to meeting 80% coverage for their enrolled population.

The Counties Manukau Health Cervical Screening High Needs Coordinator continues to offer opportunistic screening at practices, providing information at community events, and supporting Primary Health Organisations/practices to recall and contact patients (working in conjunction with the Cervical Screening Maaori Health Promoter). She has also been providing supervision for new nurse smear takers and sole practices nurses.

We are currently working with Primary Health Organisations to refresh their Cervical Screening Action Plans, as committed to under the Maaori Health Plan, in order to keep up momentum during this period of transition.

4.3 Primary Health

After hours services update

The metro Auckland District Health Boards are currently undertaking consultation with the sector on the revised model for after-hours services. This includes determining whether there is support from Primary Health Organisations for the proposal for extended hours in general practices which would complement the after hours and overnight services to be provided by urgent care clinics. The analysis of after hours service utilisation, projected demand and financial modelling is expected to be completed by Sapere Research Ltd within the next two weeks. This report will provide District Health Boards with additional information to support decision making, particularly with regard to service arrangements for urgent care clinics.

Palliative Care – Review of palliative care services in CM Health

The review of palliative care services in Counties Manukau Health is now in the final phase. The Counties Manukau Health Palliative Care Clinical Working Group is overseeing the review which includes stakeholder surveys and face to face interviews. These have recently been completed, with over 110 responses received for the survey distributed to primary care, hospices, age related residential care and community services. More than 60 responses have been received for the secondary care/in-patient survey tool. Face to face interviews have been conducted with a broad range of individuals and groups. Focus groups will be held in early-mid August with consumers, carers and family/whaanau members to better understand their experiences of and recommendations for palliative care services. A focus group will take place in each of the Counties Manukau Health localities to encourage strong local participation. A report outlining key themes arising from the review and identifying options for a three year whole of system implementation plan for integrated palliative care services in Counties Manukau will then be drafted. Consultation on the report will be carried out with key stakeholders and feedback will inform development of the implementation plan.

A national review of Adult Palliative Care Services is also currently being concluded. A draft report was recently circulated to the sector for input. The Counties Manukau Health Palliative Care Clinical Working Group provided feedback on the report. The group will ensure that there is good alignment between the national direction for integrated palliative care services and the local implementation plan.

System Level Measures Framework

'System Level Measures' will replace current Integrated Performance and Incentives Framework health targets in the coming year. A metro Auckland regional steering group has now been established along with working groups for each of the System Level Measures that will be implemented during the 2016-17 year. The working groups each have a Primary Health Organisation lead and a public health physician, along with membership from District Health Board Planning and Funding and hospital teams and from Primary Health Organisations, general practice and other sectors. Working groups are currently completing a stocktake of current measures being used in relation to each of the System Level Measures, analysing data and performance and identifying the potential contributory measures for each System Level Measure which are considered to have the greatest impact on the System Level Measures while also meeting other criteria such as impact on equity and resource considerations. The work is being supported by a project manager who is working with the District Health Board leads to develop intervention logic templates for each of the working groups to use. Once the working groups have completed the initial analysis and have determined potential contributory measures for each System Level Measure, there will be broader

consultation, particularly to allow for input into local action plans. An Improvement Plan with high level milestones and a local implementation plan will then be completed with a requirement for the Counties Manukau Health Alliance Leadership Team to sign off the Implementation Plan for submission to the Ministry of Health by 20 October 2016.

Regional Clinical Pathways Programme

Progress continues on translating all Healthpoint clinical pathways to the Auckland HealthPathways site.

Consumer access to static pathways is being progressed with a workgroup being formed to progress patient information/pathways.

Modified Diabetes Care Improvement Package

Learning Session One for the Diabetes Collaborative was held on the 25th of July at the Grange Golf Club and included a large number of primary and secondary care clinical staff. Two main highlights were the opportunity for locality cluster networking and practices sharing successful initiatives through storyboards. The key themes of the session included the importance of self-management support, the role of the wider care team, how leadership and clinical champion roles can benefit practices and different training opportunities available for diabetes care. Data sharing was discussed and the majority of practices were willing to openly share data with each other including their progress against the Diabetes Collaborative Aim: a 10% reduction in HbA1c for patients with poorly controlled diabetes (HbA1c > 75). Follow up visits have been planned in order to support practices with their change ideas and with how to measure progress towards the collaborative aim.

4.4 Progress with Systems Integration

Planned, Proactive Care

At Risk Individual (ARI) dashboard

Supporting patients with long term conditions to live well through more planned and proactive care and improved self management.

As at 30 June 2016

At Risk Current Snapshot

Key numbers & stats about our current programme:

20,776

PATIENTS BENEFITING FROM ARI PROGRAMME

Patients with long term conditions are receiving more planned, proactive care with care co-ordination and goal based care plans.

MORE THAN

60,000

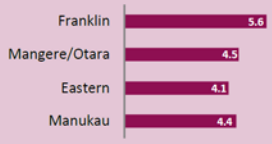
PATIENTS WITH A LONG TERM CONDITION IN COUNTIES MANUKAU

21,274

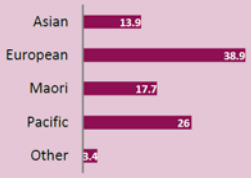
SHARED CARE PLANS

Patients with a goal based care plan that is electronically shared with the care team members.

PERCENTAGE OF ENROLLED POPULATION



ARI ETHNICITY



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SELF MANAGEMENT REFERRALS

Patients have been supported through a formal programme to help them better manage their long term condition.

What does success look like?

21,274	30,000	Patients with a shared care plan **BY December 2016**
20,776	50,000	People living with long term conditions in CM will receive self-management support **BY DECEMBER 2016**
20,776	30,000	Patients per year enrolled in ARI programme **BY JULY 2017**

- MDTs are occurring within general practice cluster networks to support care planning for complex patients.
- General practice clusters have broad networks of healthcare professionals supporting them.
- Improved self-management means patients feel more in control and understand their health condition.

Community Integration

Reablement

Reablement Service Dashboard

Supporting individuals to 'do things for themselves, rather than having things done for them'.

Dashboard # 8: July 2016

Reablement Approach Snapshot

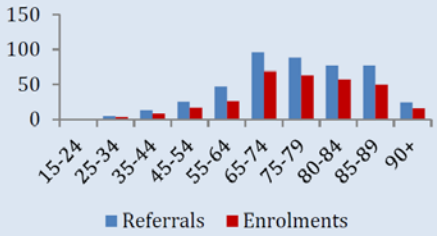
310 Patients Enrolled

234 Transitioned From Reablement

Reablement Enrolments by Locality

Manukau	48%
Eastern	27%
Franklin	23%
Mangere/Otara	2%

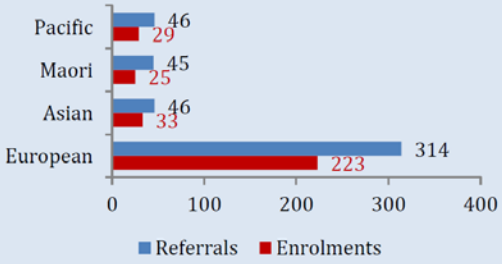
Reablement Referrals & Enrolments by Age



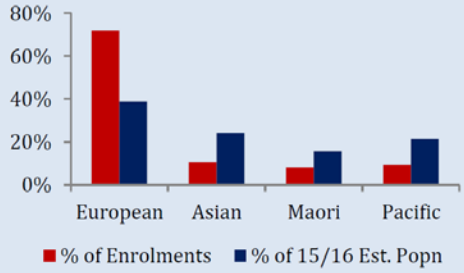
Reablement Enrolments by Gender

Female	62%
Male	38%

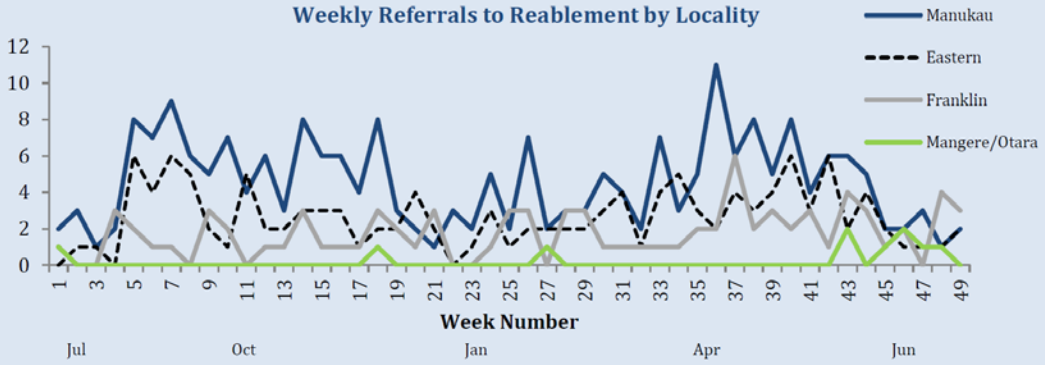
Number of Reablement Referrals & Enrolments by Ethnicity



% of Enrolments compared with % Share of CM Health Est. Population

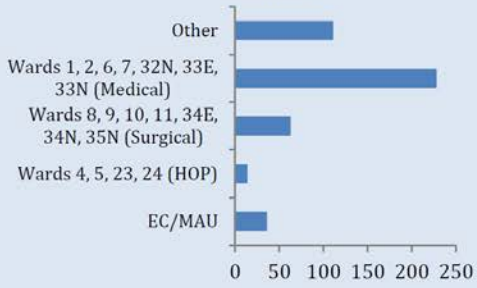


Weekly Referrals to Reablement by Locality



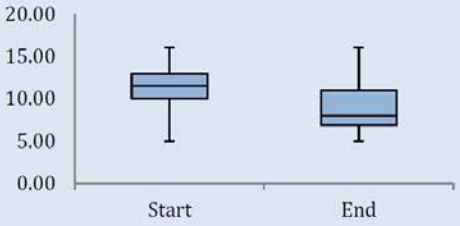
Number of Weeks on Reablement - Transitioned patients

Reablement Referrals by Referral Location



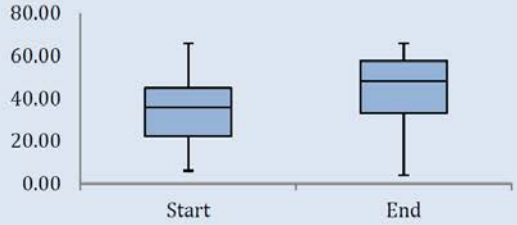
Reablement referrals by ward location 1 May - 1 Jul 2016

EuroQol - Score at Start of Reablement vs. Score at End of Reablement



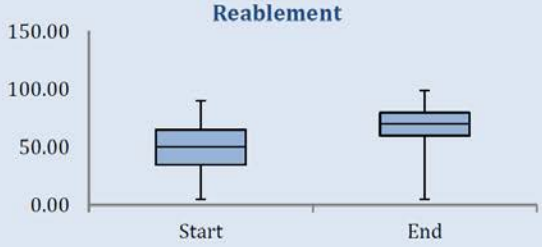
An improvement is indicated by a decrease in the EuroQol score

NEADL - Score at Start of Reablement vs. Score at End of Reablement



An improvement is indicated by an increase in the NEADL score – a high score equals a high level of independence

Visual Analogue Scale - Score at Start of Reablement vs. Score at End of Reablement



An improvement is indicated by an increase in the VAS score

Readmissions

Readmitted within 7 Days:	11
Readmitted within 28 Days:	37
Readmitted within 90 Days:	62

Readmission criteria:
Acute casemix funded admissions only to the same health specialty as initial admission. Transfers are excluded. EC admissions with LOS <1 day are excluded. Only patients who are currently active or who have completed the reablement programme are included.

Note: These numbers are cumulative e.g. the patients who are readmitted within 7 days are also included in the readmitted within 28 days total

Community Central

The planning for the re-launch of the centralized intake and triage for Community Central is progressing well, with the project on track for a key milestone on 1 August to co-locate Counties Manukau Health community central staff with Primary Options for Acute Care. This will enable one single point of contact for all community based requests – including short and long term support. The roll out of the community team tablets is progressing well, with 169 staff now mobility enabled.

The procurement process for a long term (5-10 years) provider to deliver the requirements within Community Central has been initiated. Expressions of Interest have been received and Counties Manukau Health are now entering into competitive dialogue with the three shortlisted providers. It is intended that if a party is successfully identified, transition to this provider with occur from November 2016.

Enhanced Primary Care

The first stage of mobilisation for the Enhanced Primary Care programme has completed, with the ten pilot practices in varying stages of planning and activities. Out of the ten practices, three have an established plan shared with the collaborative, seven have not yet formally shared a plan however are carrying out improvement activities. All practices are focussing on General Practitioner capacity as the primary aim with a secondary focus of reception efficiency. Practices that have been actively running improvement activities around this aim anecdotally have provided feedback that results are promising, and in some cases free up a General Practitioner capacity through one hour of early morning General Practitioner phone triage by 20% for the day through avoidable appointments.

Technology

Initial review of current primary care systems and processes has been completed, with the following initial focus areas decided on.

1. Virtual Consultation Pilot in Franklin
2. Establishment of a HealthSafe Database and HealthSafe manager as per the Metro Auckland Data Sharing Framework
3. Support for the Summary Health Record bulk upload of enrolled patients and associated requirements

Quality and Safety – *Safety in Practice*

Year two of Safety in Practice came to a close with a celebration of achievements at Learning Session four held in late June. Guest speakers included the Health and Disability Commissioner Anthony Hill who was well received as he gave case study examples of where harm or error could have been avoided. Anthony also stayed to chat with individual attendees and was involved in several group discussions. The 32 practices then spent time discussing their experience, findings and highlights within their individual care bundles. David Morgan, Chief Pilot and Chief Flight Operations and Safety Officer from Air New Zealand spoke about the analogies between the aviation industry and health in regards to safety as well as the just culture of safety. It was a well-attended evening showcasing and highlighting the success of the practices involved.

The third year of Safety in Practice launched on Thursday 21 July, with much enthusiasm, at a learning session for the all new practices to the programme and existing practices that have new staff not yet involved in Safety in Practice. We have total of 40 practices across the Auckland region enrolled in the programme for the coming year. The evening was a general introduction to the

programme, introduction to the model for improvement as well as developing systems, processes, and tools to identify, monitor and prevent potentially harmful episodes to patients. Our guest speaker for the evening was Bob Henderson, an Air New Zealand pilot and instructor and board member from Health Quality and Safety Commission. Bob's talk centred on the topic of critical conversations to have during a crisis and he says "it is imperative when faced with a crisis situation that we notice, understand and think ahead".

Collaborative visits to all new practices are now underway with the primary healthcare facilitator, clinical lead and improvement advisors attending across the Auckland region. Each practice is undertaking a care bundle out of our previous four bundles - Medication Reconciliation, Results Handling, Warfarin Management and Opioids Prescribing, or choosing one from our two new care bundles; Reliable System for Managing Cervical Smears and Reliable Management of Chronic Obstructive Pulmonary Disease patients.

4.5 Locality Reports

Eastern Locality

1. Acute Demand

Indicator	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	CMDHB Avg Last 12 mths
1.1 Unplanned readmissions (28 days)	6.9%	7.5%	5.7%	6.0%	6.8%	5.2%	6.9%
1.2 ASH rate (per 1,000 enrolled patients)	0.9	0.7	0.8	1.1	0.9	1.0	2.0
1.3 Average bed day usage in last 6 months of life	10.1	6.0	7.2	6.8	9.3	9.4	10.9

Notes: Numbers for previous months may change as additional mortality data is received for ***1.3*** and as coding is modified for ***1.1*** and ***1.2.***
Aged Residential Care Bed Days in Pukehoke and Franklin Memorial Hospitals are included in the figures for ***1.3*** - this will primarily affect Franklin as ARC facilities are independently located in all other localities.

2. Quality

Indicator	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	CMDHB Avg Last 12 mths
2.1 Children fully immunised at 8 months (Target = 90%)	96.7%	96.8%	96.5%	96.4%	95.7%	97.2%	95.0%
2.2 Children fully immunised at 24 months (Target = 95%)	97.2%	97.2%	96.1%	94.8%	94.6%	94.3%	95.5%
2.3 Middlemore Radiology < 6 week wait time for GP Referrals	89.9%	91.3%	90.5%	93.8%	93.8%	95.9%	93.1%

3. Shared Accountability Services

Item	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Last 12 Mths
3.1 ED presentations not admitted	283	295	267	233	261	246	3277
3.2 Acute medical bed days	1177	1104	1472	1295	1136	1473	16666
3.3 Acute casemix-funded non-medical bed days	916	777	884	1289	1454	1047	13318
3.4 Medical outpatient attendances	1749	1953	2155	1902	2310	2075	26407

Note: All SAS volumes for previous months may change as IDF updates are received and coding is modified

4. Other

Indicator	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	CMDHB Avg Last 12 mths
4.1 E-referrals as % of all referrals	33.4%	33.7%	35.0%	36.8%	36.4%	33.1%	27.9%
4.2 Medical Outpatient DNA rate	2.4%	5.2%	3.4%	3.1%	3.5%	1.3%	9.8%

Note: Numbers for previous months may change as coding is modified for ***4.2***, and additional referrals are included for ***4.1***

The Eastern Locality has a total of 4,640 patients enrolled on the At Risk Individual programme with a shared care plan. This means that the Eastern Locality has enabled 4.1% of its enrolled population to benefit from being enrolled on the At Risk Individuals programme. This percentage is still lower than the other three localities, however is increasing.

Two extended hours Nurse clinics have been established. These morning and evening clinics have had a good uptake, enabling patients who couldn't see Nurses in normal business hours to be seen without taking time off work. This has enabled the weekend Nurses to respond to patients with acute needs instead of chronic.

A short term contract has commenced with a private nursing provider to release capacity whilst we recruit further casual and permanent staff. We have recruited further Physiotherapy staff who are commencing in September which we anticipate will eliminate the wait list. With the commencement of new Physiotherapist's and community health staff reablement options will expand.

Strategic

Accident & Medical service provision

A clinical stakeholder group was formed, and a clinical audit was completed by an Emergency Department Senior Medical Officer along with the Clinical Director's for East Health Primary Health Organisation and East Care.

Between 1st January 2015 and 30th April 2016 22,793 Eastern domiciled patients presented to the Middlemore Hospital Emergency Department. Of those about 7,652 were referred by their General practitioner, and 6,727 of those were triaged as three, four or five. Of these patients 53% were discharged between six to 24 hours later. A clinical audit of 100 of these referrals showed that 83% of these cases could have been treated in the community if a different model of care had been used. Examples were that if Primary options for Acute Care had been used more appropriately, if the General Practitioner could have spoken with a Specialist or fast tracked the patient to an outpatient appointment/rapid access clinic or a different skill mix and/or observation/treatment facility were available in the Accident and Medical, patients' needs could have been met in the Community outside of the Emergency Department or Medical Assessment Unit.

The clinical group is using this information to improve the model of care for Emergency Department patients and will be testing new approaches over the coming months.

Locality Hub Development

In July 2016 members of East Health, Counties Manukau Health and East Care met and reviewed the site plans and made further recommendations which will assist with forming the business case. A locality project manager has been appointed and will lead the phased development of the hub, including accident and medical service provision.

Kawakawa Bay Nurse led clinic

Proposals for sustainable funding were presented to the Kawakawa Bay Nurse led clinic by the General Manager for the Eastern Locality. The Nurse led clinic will present the options to their committee this week for a decision.

Franklin Locality

1. Acute Demand

Indicator	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	CMDHB Avg Last 12 mths
1.1 Unplanned readmissions (28 days)	6.6%	8.1%	5.8%	4.4%	6.4%	6.4%	6.9%
1.2 ASH rate (per 1,000 enrolled patients)	1.3	1.6	1.6	1.6	1.7	1.4	2.0
1.3 Average bed day usage in last 6 months of life	17.0	21.5	14.4	10.9	11.6	17.5	10.9

Notes: Numbers for previous months may change as additional mortality data is received for 1.3 and as coding is modified for 1.1 and 1.2.
Aged Residential Care Bed Days in Pukekohe and Franklin Memorial Hospitals are included in the figures for ***1.3*** - this will primarily affect Franklin as ARC facilities are independently located in all other localities.

2. Quality

Indicator	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	CMDHB Avg Last 12 mths
2.1 Children fully immunised at 8 months (Target = 90%)	92.7%	93.5%	94.6%	95.2%	93.1%	90.4%	95.0%
2.2 Children fully immunised at 24 months (Target = 95%)	94.2%	93.8%	94.7%	91.8%	91.4%	91.0%	95.5%
2.3 Middlemore Radiology < 6 week wait time for GP Referrals	87.0%	69.2%	88.2%	89.7%	97.0%	95.0%	93.1%

3. Shared Accountability Services

Item	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Last 12 Mths
3.1 ED presentations not admitted	145	116	129	136	110	104	1566
3.2 Acute medical bed days	725	694	797	743	740	813	10465
3.3 Acute casemix-funded non-medical bed days	321	612	657	624	714	628	7496
3.4 Medical outpatient attendances	1073	1135	1253	1022	1089	1057	14622

Note: All SAS volumes for previous months may change as IDF updates are received and coding is modified

4. Other

Indicator	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	CMDHB Avg Last 12 mths
4.1 E-referrals as % of all referrals	29.8%	29.9%	30.5%	29.0%	32.3%	29.1%	27.9%
4.2 Medical Outpatient DNA rate	5.1%	2.4%	7.8%	7.4%	7.8%	7.3%	9.8%

Note: Numbers for previous months may change as coding is modified for ***4.2***, and additional referrals are included for ***4.1***

Reducing Unplanned Admissions/ Self-Management:

<u>Winter Planning</u>

Franklin's winter plan has been complimented by Middlemore Central management and promoted as a template for other localities. Our outcomes for last year and our intentions for this year have also been well received.

Pukekohe Rehabilitation and Care have increased their catchment area for access to beds to include Papakura and the surrounding area, to be supportive of the acute services. The roadshows have been completed with the exception of Huakina Practice, which has still to be arranged. Rapid Response referrals have continued to increase reaching the 60 mark for June.

A 'Blue card' neighbourhood initiative proposal has been planned. This will target patients with a diagnosis of Chronic Obstructive Pulmonary Disease, living in the Pukekohe North neighbourhood and enrolled with the Pukekohe Family Health Care practice, who have had multiple Emergency Department admissions. Close links with St Johns Ambulance will be pivotal as will a combined Case Management approach. Presentations to House Officers and the Charge Nurse Managers in the Hospital on this initiative are being considered.

Services Closer to Home

Dementia Pathway Outreach Pilot - Waiuku Health Centre

A proposal to develop General Practitioners with special interests to support primary care in the management of dementia is being explored. There are currently 44 patients enrolled on the pathway with a quarter of those being followed up by Alzheimer's Auckland with home visits and carer support.

Reablement

Recruitment continues for Community Health Assistants with 2.8 FTE offered employment already. Training and orientation are underway. This will increase Franklin's capacity to provide reablement services.

Locality Hub Planning

Phase One has been signed off with more detailed planning for implementation underway. This will be critical to house the new Community Health Assistants and any Mental Health staff ready for relocation to Pukekohe Hospital site. Additional car parking has also been approved which will require staging as it not the ideal time to begin excavation.

Mental Health Service and Social Services Integration

Further meetings have been held to ensure that this work continues to progress. Relationships are being developed and ongoing meetings arranged with the integration staff who are keen to develop a presence in Franklin. Invitations to join the Nursing Network and meet with the Rapid Response team have been made, as has the offer to conduct a joint roadshow with the GP Lead and RR team.

Social Service Integration

This month has been focused on how to engage with the Franklin Social Service Network, the role of Healthpoint and E-Shared Care platforms and the locality utilising existing local networks and groups e.g. Franklin Council of Social Services. A multi-sectoral group including police, justice, education etc. has also been established of which the Locality is a member.

Quality Improvement

Certification audit

Franklin Memorial Hospital was included in this year's Certification Audit. The outcome was excellent with only one partial attainment criterion that related to this service, and this was rated at low risk and has already been remedied regarding InterRai assessment compliance. Two other criterion were partially attained with low and moderate risk and will be addressed with the whole organisation response concerning PRN (as needed) medication documentation and recording of staff training and competencies.

Franklin Locality Key Indicators

Immunisation at eight months fell this month to 93% from 95% last month. Emergency Department admissions from Franklin rose to equal the rate in May 2014 the upper limit of recorded admissions to date There was a slight increase in Primary Options for Acute Care referrals this month, but significantly less than this time last year.

Mangere/Otara Locality

1. Acute Demand

Indicator	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	CMDHB Avg Last 12 mths
1.1 Unplanned readmissions (28 days)	7.4%	7.4%	7.7%	6.0%	7.0%	6.2%	6.9%
1.2 ASH rate (per 1,000 enrolled patients)	2.5	2.8	2.8	2.5	2.5	2.7	2.0
1.3 Average bed day usage in last 6 months of life	14.1	11.0	10.4	10.9	10.9	11.0	10.9

Notes: Numbers for previous months may change as additional mortality data is received for ***1.3*** and as coding is modified for ***1.1*** and ***1.2.***
Aged Residential Care Bed Days in Pukehoke and Franklin Memorial Hospitals are included in the figures for ***1.3*** - this will primarily affect Franklin as ARC facilities are independently located in all other localities.

2. Quality

Indicator	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	CMDHB Avg Last 12 mths
2.1 Children fully immunised at 8 months (Target = 90%)	94.7%	95.4%	96.1%	95.7%	93.6%	94.1%	95.0%
2.2 Children fully immunised at 24 months (Target = 95%)	97.9%	97.3%	96.9%	97.2%	96.6%	97.3%	95.5%
2.3 Middlemore Radiology < 6 week wait time for GP Referrals	91.7%	92.3%	93.7%	91.6%	97.5%	95.3%	93.1%

3. Shared Accountability Services

Item	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Last 12 Mths
3.1 ED presentations not admitted	739	710	760	588	707	623	8924
3.2 Acute medical bed days	1822	2073	2054	1703	1743	2193	27154
3.3 Acute casemix-funded non-medical bed days	1372	1402	1823	1291	1474	1470	18492
3.4 Medical outpatient attendances	2364	2658	3106	2083	2447	2163	34028

Note: All SAS volumes for previous months may change as IDF updates are received and coding is modified

4. Other

Indicator	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	CMDHB Avg Last 12 mths
4.1 E-referrals as % of all referrals	28.0%	25.0%	26.2%	30.1%	26.1%	25.6%	27.9%
4.2 Medical Outpatient DNA rate	16.1%	15.5%	15.0%	13.6%	13.7%	15.2%	9.8%

Note: Numbers for previous months may change as coding is modified for ***4.2***, and additional referrals are included for ***4.1***

Facilities - Shared Service Hubs

The facility building plan for Mangere Hub has been approved by the Integrated Infrastructure Steering Committee and will progress to the Executive Leadership Team for approval in two weeks.

Community Health Service Integration

The Reablement service has started in Otara-Mangere Community Health Team but rate of uptake has been slow due to low numbers of referrals.

Manukau Locality

1. Acute Demand

Indicator	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	CMDHB Avg Last 12 mths
1.1 Unplanned readmissions (28 days)	7.1%	7.7%	6.9%	7.7%	6.8%	6.1%	6.9%
1.2 ASH rate (per 1,000 enrolled patients)	2.0	2.0	1.9	2.0	2.2	1.9	2.0
1.3 Average bed day usage in last 6 months of life	11.3	12.3	11.1	14.5	11.9	17.6	10.9

Notes: Numbers for previous months may change as additional mortality data is received for 1.3 and as coding is modified for 1.1 and 1.2.
Aged Residential Care Bed Days in Pukehoke and Franklin Memorial Hospitals are included in the figures for ***1.3*** - this will primarily affect Franklin as ARC facilities are independently located in all other localities.

2. Quality

Indicator	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	CMDHB Avg Last 12 mths
2.1 Children fully immunised at 8 months (Target = 90%)	95.8%	95.7%	94.1%	93.4%	94.2%	95.5%	95.0%
2.2 Children fully immunised at 24 months (Target = 95%)	95.8%	96.0%	95.8%	95.7%	95.9%	95.7%	95.5%
2.3 Middlemore Radiology < 6 week wait time for GP Referrals	84.9%	89.3%	94.0%	95.1%	97.6%	96.9%	93.1%

3. Shared Accountability Services

Item	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Last 12 Mths
3.1 ED presentations not admitted	842	784	806	732	731	699	9459
3.2 Acute medical bed days	2412	2305	2396	3192	2619	2760	34757
3.3 Acute casemix-funded non-medical bed days	1853	2605	2191	2053	2191	2260	25301
3.4 Medical outpatient attendances	3265	3579	3834	3483	4015	3748	49737

Note: All SAS volumes for previous months may change as IDF updates are received and coding is modified

4. Other

Indicator	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	CMDHB Avg Last 12 mths
4.1 E-referrals as % of all referrals	30.7%	29.4%	29.7%	30.1%	29.5%	29.7%	27.9%
4.2 Medical Outpatient DNA rate	10.5%	8.8%	11.0%	9.0%	12.4%	9.2%	9.8%

Note: Numbers for previous months may change as coding is modified for ***4.2***, and additional referrals are included for ***4.1***

Diabetes Collaborative

The locality team is continuing to engage with general practices around diabetes, with 17 multi-disciplinary team meetings completed in 11 practices. To data 123 people have been discussed at multi-disciplinary team meetings. The team has been working on developing a checklist to ensure that everyone attending gets the most out of multi-disciplinary team meetings. The responsibilities of both the Locality team and the general practice team are stated, as well as guidance around what types of patients are suitable for discussion, and how recommendations should be followed up and documented. This checklist is currently being tested and feedback sought from general practice staff.

The multi-disciplinary team meeting feedback survey results have been collated, with five practices participating in the survey. We had 13 survey responses, which included eight General Practice's, four Practice Nurse and one Nurse Leader. A summary of some of the results: All 13 respondents have found the multi-disciplinary team meeting's useful, with 10 finding them very or extremely useful. 12 out of 13 have been somewhat or very satisfied with the multi-disciplinary team meetings so far. Knowledge of diabetes care has increased in all 13 respondents, and confidence in diabetes care has increased in 12 out of 13 respondents. The project team will meet to discuss the entire survey findings to ensure multi-disciplinary team meetings are optimised.

Huff and Puff Collaborative

The collaborative is working towards achieving its aim of designing a reliable screening pathway for 50 people who smoke aged 45>, in the Manukau locality, to enable early diagnosis of breathing problems. 42

participants have completed the screening so far and there is now a concerted effort to specifically engage Maori and women through the support of the Maori Health Development team.

The team are currently focusing on contributing to the Manaaki Hauora Campaign booklet which will be available at APAC 2016.

Reablement Update

The Locality Care Coordinators are currently focusing their energy on supporting the recently trained Reablement clinicians to complete credentialing. The introduction of the Inpatient Liaison Group has seen an improvement in communication channels; an increase in the number of appropriate referrals being assessed and an increased awareness of the referral pathway in the inpatient setting.

Health and Social Service Integration Workshops

In June three workshops were held in the Manukau locality clusters (Papakura, Manurewa and Papatoetoe). There was good representation of social services and a lot of positive energy at each workshop. Outcomes from the robust work shopping sessions are being used to move the integration process forward. An exercise identifying the baseline level of collaboration taking place between health and socials services, across the locality, indicated minimal collaboration between General Practices and social services. There is much work to be done in moving integration forward; the next workshop is planned for 4th August.

Living Well Centre (Manukau Super Clinic site) – Indicative Business Case

The Manukau Locality team are working with the project planning group for the above business case, in developing a Locality focused "Strawman" of principles and services for the proposed Living Well centre. The Strawman will focus on service development that aligns with the Maaori model of health aimed at empowering and increasing the resilience of whaanau and reducing health inequalities. Consumers from within the Manukau Locality are providing ideas for the Strawman and support the video which is being prepared to support the business case.

Winter Wellness Campaign

The locality has continues to take the winter wellness campaign out to Primary Care (All general practices), community Pharmacists, community organisations and churches. Opportunities for presentations to local organisation have been accepted and where possible the locality has had stands at markets in Manurewa, Papakura, during Pacific Health week and at the Manurewa netball courts. The winter wellness info sheets in a range of languages have been popular with community organisations wellness. General practices have given very positive feedback on the Counties Manukau Health computer mousepads with the hospital specialist numbers which have been provided for a range of specialist services. To date over 50,000 winter wellness information sheets have been shared with over 250 health, education and social service organisations in Manukau locality.

4.6 Child, Youth and Maternity Services

Maternity

The Maternity Quality and Safety Annual report was submitted to the Ministry of Health in July 2016. The report details quality initiatives undertaken as part of the Maternity Quality and Safety programme and measures the District Health Board progress and activity against national maternity clinical indicators. The work of the Maternity Quality and Safety programme encompasses recommendations from the Independent External review, Perinatal Mortality and Morbidity review, and the National Maternity Monitoring Group which forms the work undertaken under the programme. The Maternity Quality and Safety report also details quality improvements undertaken which are not part of the work of the programme but highlight improvements in access to care or services in the District Health Board.

This year's Maternity Quality and Safety Programme Report was a group effort involving input from a wide range of practitioners. It has retained the user friendly design adopted last year aiming for the information to be more engaging, accessible and relevant to key stakeholders such as employed and self-employed midwives, general practitioners, and the women and whaanau who live and/or birth in our district.

Sudden Unexplained Death of Infant

We continue to make progress with implementation of the Sudden Unexplained Death of Infant Action Plan and the Safe Sleep Policy in safe sleep education, safe sleep audits in all birthing and post-natal wards, Neonatal Care, Kidz First Medical and Surgical. We continue to provide baby beds to all newborns identified in high risk environments.

We have commenced our Ministry of Health funded trial initiative of Waananga Haputanga for pregnant women and whaanau with the two providers being appointed to deliver the sessions. The inaugural session will be launched in July and runs until the end of September. We will gain very useful intelligence on outcomes which will assist to inform other programs such as Pregnancy and Parenting and Mama, Pepe Tamariki.

Before School Checks

Before School checks are conducted in Counties Manukau by Plunket and to a lesser extent by Well Child Tamariki Ora Providers. Plunket also provide clinical leadership and professional development training to the Well Child Tamariki Ora providers.
Targets for 2015/16 have been exceeded with a total of 8,085 Before School Checks being completed. Saturday sessions at the Manukau Super Clinic continue to be well supported.

Oral Health

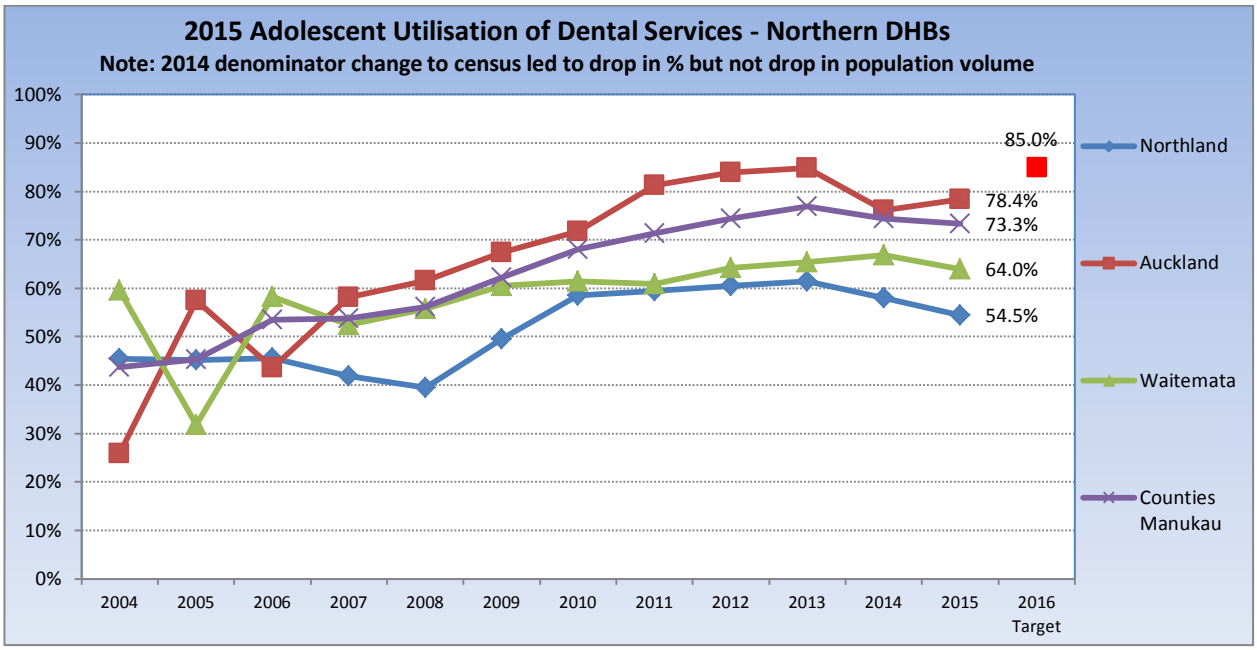
Counties Manukau contract the Auckland Regional Dental Service to deliver free oral health services for children aged zero to 12 years old at community clinics and mobile dental facilities. Governance is through monthly service metrics reports, annual oral health outcome reports, and regional operational meetings.
Preschool enrolments are now at 65% for zero to two years and 95% for three to four year old children. This brings our total preschool enrolment of zero to four years to 77% against the target for 2016 calendar year of 95%. The improvement has been due to strong focus on enrolment from Well Child Tamariki Ora providers.

Adolescent Oral Health

Counties Manukau Health contract 85 Dental Practices to deliver oral health services to adolescents.

The target for 2015/16 was for 85% of adolescents from year nine (12/13 years) up to and including 17 years, to have accessed an adolescent provider. Counties Manukau achieved 73.3% with 57% of adolescents having accessed dental services through on-site mobile dental services.

Growth will be achieved through increased on-site dental services at secondary schools and accessing adolescents out of the school system in workforce, training or alternate education services.



Youth Health

The comprehensive and integrated school-based health service at Papakura High School commenced in full on 1st July 2016. The onsite General Practice clinic and services to the Alternative Education Activity Centre commenced in early May and are already well utilised by students.

A number of existing contracts have been reviewed to provide enhanced nursing or general practitioner services to high schools in Mangere and Manurewa.

The quality improvement initiative for primary care is underway and the Youth Health Quality Improvement Advisor commenced on 4th April. The initiative involves an audit and improvement programme for general practices to improve their 'youth friendly' capability. All Primary Health Organisations are engaged and practices in all localities are interested in participating. The project is aligned with existing quality improvement initiatives in primary care such as At Risk Individuals and Safety in Practice.

The District Health Board has appointed a new provider (Health Connections Ltd) to deliver health services delivered in Child, Youth and Family Care and Protection and Youth Justice residences. The provider commenced on the 1st July 2016.

4.7 Mental Health and Addictions

Whole of System Integration Update

The key to progressing the mental health and addictions integration transformation agenda is engagement with stakeholders, using a process of co-design to guide and inform the design and delivery of an integrated model of care.

The creation of locality integrated care teams for mental health and addictions and the development of a suite of community-based support services in each locality are being designed. Integrated care teams will continue to maintain the current focus on those with the most severe and enduring needs, but will develop strong working relationships with clusters of General Practitioner practices to support early intervention and help maintain our communities' wellbeing. Each single suite of locality-based services will cover a range of functions to complement the work of the locality integrated care team. By functioning as a single suite that, together with the integrated care team, is part of the wider locality mental health and addiction service, people will better supported by comprehensive, continuity of care.

Alongside each locality's integrated care team and single suite of services, will be access to a range of district-wide mental health and addiction services. District-wide services are those where the size, degree of specialism or need for service-wide consistency means that it wouldn't be possible to provide the service at a locality level.

In addition to these district-wide Non-Government Organisation services, there will also be a range of highly specialised district health board mental health and addiction services (e.g. maternal mental health) provided through a district-wide approach but linking to locality teams.

There has also been dedicated work to progress thinking around how best to deliver addiction services within an integrated model of care. A joint workshop brought together representatives from both Counties Manukau Health's and Waitemata District Health's Board mental health and addictions services. The focus of the discussion was to reflect on the strengths, weaknesses and opportunities of current service delivery through the Community Alcohol and Drugs Service and what the options could be for service design and delivery as part of integrated care teams and locality services. The workshop attendees had a shared purpose of determining the best way to meet local need and improve health outcomes for our population, ensuring that both mental health and addictions work together effectively to support wellbeing as part of the broader health team. Ideas were shared around potential options to be discussed in more detail at a follow-up workshop.

Recent Appointments to the Integrated Mental Health and Addictions Team

As the whole of systems integration agenda increases momentum the Mental Health and Addictions team is experiencing a period of growth and change with the appointment of Dr Clive Bensemann to the role of Clinical Leader Integrated Care. Dr Bensemann is a well-known and respected colleague with a wealth of experience and his leadership will be invaluable in working with the Mental Health and Addictions teams in transforming the current system of care through effective integration across primary care, specialist mental health and addictions and Non-Government Organisation provision. Key areas of focus will be delivery of:

- Access to a comprehensive range of mental health and addiction services within each Counties Manukau Health Locality
- Enabling a high performing mental health and addictions workforce embedded in Enhanced Primary Care as part of a comprehensive and responsive health team, reducing the need for formal referrals.

PP8 – Alcohol and Other Drug Wait times for Non-Government Organisations

The Ministry of Health annual Alcohol and Other Drug Non-Government Organisation wait time targets for all age groups have been exceeded. This has been following a great deal of work on data integrity with providers over the past year, with support from the Ministry. A monthly pre-report of raw data is now obtained, risks identified and mitigated with providers to increase the potential that:

- Access to Alcohol and Other Drug Non-Government Organisation services remains responsive
- Data integrity is reliable
- Ministry of Health targets are maintained

4.8 Intersectoral Initiatives

Warm Up – Counties Manukau

The Warm Up-Counties Manukau programme is in the process of closing down as we have no further funding.

Project Outcomes for the Warm up – Counties Manukau Project (1 July 2015-30 June 2016)

Month	Total Number of Referrals	Total Number of Homes Insulated	Total Number of Home Visits completed post install
July 2015	217	39	28
August 2015	172	55	36
September 2015	121	68	28
October 2015	115	61	32
November 2015	162	104	31
December 2015	77	77	13
January 2016	67	77	0
February 2016	58	88	34
March 2016	67	118	36
April 2016	61	27	74
May 2016	27	3	61
June 2016	22	1	39
Total number of referrals generated to date	**1,166**	**718**	**412**

Please note: There is a time delay between referrals being received by the provider and the completion of the insulation install.

The Providing Access to Health Solutions Programme

Providing Access to Health Solutions is an intersectoral programme resulting from a partnership between Counties Manukau Health, and the Ministry of Social Development that was established in 2004 in an effort to help tackle the growing problem of long-term benefit dependency. The aim of the Providing Access to Health Solutions programme is to assist people in receipt of certain benefits to return to work (the programme is voluntary), using an intensive individualised case management model aimed at reducing health barriers to employment.

Total Number of Voluntary Participant Enrolled onto the PATHS Programme

Month	Total Number of Participants enrolled
July 2015	18
August 2015	15
September 2015	16
October 2015	17
November 2015	16
December 2015	11
January 2016	6
February 2016	12
March 2016	11

Month	Total Number of Participants enrolled
April 2016	12
May 2016	14
June 2016	9
Total Number	**157**

4.9 Primary & Community Finance Report

Summary

Primary and Community Services had a small favourable variance to budget for June of $1,890k and favourable $3,516k for the full year.

Service Development and Primary Care (FY favourable $531k)

The following programmes recorded underspends against budget; At Risk Individuals, Primary Options for Acute Care, Ophthalmology, Self Management Education, Clinical Pathways (Regional). These more than offset overspends in After Hours and Enhanced Primary Care programmes.

Planning & Funding – Governance (FY $491k unfavourable)

Community Health Service Integration implementation costs not budgeted covered as planned by Health of Older People, Aged Residential Care and Home Based Support Services underspend (see below)

Health of Older People (FY $1,178k favourable variance)

The 14/15 trend of flat growth against an over 65 population growth of over 4% continues albeit at a slower rate. Savings are mostly the result of variances between actual expenditure versus budgeted forecast expenditure in Aged Residential Care.

Primary Care – NGO/Demand Driven (FY $2,143k unfavourable variance)

Most negative expenditure variances offset by additional revenue as seen in the revenue variance. Mostly relates to Under 13 Ministry of Health funding/spend. Most of the net variance relates to unbudgeted Non Government Organisation contracts put in place to help achieve national health targets and recognition of Mana Kids and Laboratory wash up estimates.

Localities (FY $285k favourable variance)

A mix of overspends more than netted off by underspends. Overspends in Home Healthcare budgets driven by what has been a busy winter with higher acuity from supported hospital discharge, high staff illness, and higher use of casual nursing staff. Supported discharge also has a high cost impact on clinical supplies. Fortunately these have largely been offset by underspends in Mangere facility lease cost delays and Needs Assessment Service Coordination vacancies.

Mental Health (FY $10,607k favourable variance) Primary & Community Savings Programme (FY $6,828 unfavourable variance)

It was envisaged and budgeted that the mental health ring fence would be underspent by close to $6m. See the net of Primary and Community Savings Programme and Mental Health ($3.8m) as this represents savings greater than the budgeted $6m. This surplus will be ring fenced to fund planned mental health capital infrastructure.

CPHAC Financial Report As at 30 June 2016	Month Actual $000	Month Budget $000	Month Var. $000	YTD Actual $000	YTD Budget $000	YTD Var. $000
Service Development & Primary Care						
Revenue	2,338	2,103	235	25,015	25,234	(219)
Expenditure	1,828	2,172	344	25,311	26,061	750
Contribution	510	(69)	579	(296)	(827)	531
Intersectorial						
Revenue	132	73	59	912	872	40
Expenditure	62	69	7	785	830	45
Contribution	69	4	66	127	42	85
Child, Youth & Maternity						
Revenue	1,331	597	734	9,483	7,158	2,325
Expenditure	1,611	903	(709)	13,548	11,516	(2,032)
Contribution	(280)	(306)	26	(4,065)	(4,358)	293
Localities						
Revenue	80	111	(31)	1,383	1,327	56
Expenditure	1,254	1,258	4	14,777	15,006	228
Contribution	(1,174)	(1,148)	(26)	(13,394)	(13,679)	285
Planning & Funding - Governance						
Revenue	9	0	9	101	0	101
Expenditure	346	190	(156)	2,867	2,275	(592)
Contribution	(337)	(190)	(148)	(2,766)	(2,275)	(491)
P&C Savings Programme						
Revenue	0	29	(29)	0	350	(350)
Expenditure	(743)	(850)	(107)	(3,725)	(10,203)	(6,478)
Contribution	743	879	(136)	3,725	10,553	(6,828)
Primary Care - NGO/Demand Driven						
Revenue	19,127	17,177	1,950	211,659	206,130	5,530
NGO Contract Expenditure	1,546	929	(617)	12,963	11,151	(1,812)
Pharmaceuticals	8,614	8,523	(91)	102,864	102,277	(588)
PHO/GMS/PNS	8,047	6,931	(1,116)	87,230	83,173	(4,058)
Other	1,504	777	(727)	10,538	9,323	(1,215)
Contribution	(584)	17	(601)	(1,936)	207	(2,143)
Health of Older People						
Revenue	8,737	8,512	225	101,727	102,144	(417)
LTS - CHC	40	345	305	4,019	4,146	127
Home Based Support Services	2,091	1,651	(440)	19,291	19,810	519
Rest Homes	1,717	1,784	67	20,937	21,406	468
Private Hospitals	4,332	4,276	(55)	51,322	51,315	(6)
Other	443	439	(4)	4,782	5,269	487
Contribution	114	17	97	1,377	198	1,178
Mental Health						
Revenue	4,599	4,539	61	54,968	54,465	503
Expenditure	2,546	4,519	1,973.8	44,128	54,232	10,104.1
Contribution	2,054	19	2,034	10,839	233	10,607
Total Primary & Community						
Total Revenue	36,352	33,140	3,212	405,249	397,680	7,569
Total Expenditure	35,238	33,916	(1,322)	411,638	407,586	(4,052)
Total Contribution	1,114	(776)	1,890	(6,389)	(9,906)	3,516

Counties Manukau District Health Board

5.0 Resolution to Exclude the Public

Resolution:
That in accordance with the provisions of Schedule 3, Clause 32 and Sections 6, 7 and 9 of the NZ Public Health and Disability Act 2000:

The public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

General Subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
6.1 Minutes of CPHAC meeting 6 July 2016 with public excluded	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982). [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confirmation of Minutes** For the reasons given in the previous meeting.