Counties Manukau District Health Board  
Community & Public Health Advisory Committee Meeting  
Agenda  
Wednesday, 21 January 2015 at 1.30pm – 3.30pm, Manukau Boardroom, Lambie Drive

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Page No</th>
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<tbody>
<tr>
<td>1.30pm – 1.35pm</td>
<td>1.0 Welcome</td>
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<td>1.35pm – 1.45pm</td>
<td>2.0 Governance</td>
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<td></td>
<td>2.1 Attendance &amp; Apologies</td>
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<td></td>
<td>2.2 Disclosure of Interests/Specific Interest</td>
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<td>2.3 Acronyms</td>
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<td></td>
<td>2.4 Confirmation of Public Minutes (17 December 2014)</td>
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<td>2.5 Action Items Register</td>
<td>14-15</td>
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<tr>
<td>1.45pm – 3.00pm</td>
<td>3.0 Strategic Workshop – Integrating Locality Community Services</td>
<td>16-21</td>
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<td>3.00pm – 3.25pm</td>
<td>4.0 Presentation</td>
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<td>4.1 Safety in Practice – Dr Campbell Brebner</td>
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<td>3.25pm - 3.30pm</td>
<td>5.0 Resolution to Exclude the Public</td>
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<td>6.0 Confidential Items</td>
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<td>6.1 Confirmation of Confidential Minutes (17 December 2014)</td>
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<td></td>
<td>6.2 Mana Kidz Evaluation ELT Paper 16.12.2014 (for information only)</td>
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<td>6.3 Mana Kidz Evaluation Report – (for information only)</td>
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Next Meeting: Wednesday 4 March 2015, Lambie Drive
# BOARD MEMBER ATTENDANCE SCHEDULE 2015 – CPHAC

<table>
<thead>
<tr>
<th>Name</th>
<th>21 Jan</th>
<th>Feb</th>
<th>4 Mar</th>
<th>15 Apr</th>
<th>27 May</th>
<th>June</th>
<th>8 July</th>
<th>19 Aug</th>
<th>30 Sept</th>
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<td>Lee Mathias (Board Chair)</td>
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<td>Sandra Alofivae (CPHAC Chair)</td>
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<td>David Collings</td>
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<td>Dianne Glenn</td>
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<td>Reece Autagavaia</td>
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<td>Mr Sefita Hao‘uli</td>
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<td>Ms Wendy Bremner</td>
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<td>Mr Ezekiel Robson</td>
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# BOARD MEMBERS’ DISCLOSURE OF INTERESTS
21 January 2015

<table>
<thead>
<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
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</table>
| Dr Lee Mathias, Chair | • MD Lee Mathias Limited  
• Trustee, Lee Mathias Family Trust  
• Trustee, Awamoana Family Trust  
• Chair Health Promotion Agency  
• Deputy Chair Auckland District Health Board  
• Director, Pictor Limited  
• Director, iAC Limited  
• Advisory Chair, Company of Women Limited  
• Director, John Seabrook Holdings Limited  
• Chairman, Unitec  
• External Advisor, National Health Committee  
• Director, Health Innovation Hub  
• Director, healthAlliance Ltd  
• Director, healthAlliance (FPSC) Ltd |
| Sandra Alofivae | • Chair of the Auckland South Community Response Forum (MSD appointment)  
• Member, Fonua Ola Board  
• Board Member, Pacifica Futures |
| David Collings | • Chair, Howick Local Board of Auckland Council  
• Member Auckland Council Southern Initiative |
| Dianne Glenn | • Member – NZ Institute of Directors  
• Member – District Licensing Committee of Auckland Council  
• Life Member – Business and Professional Women Franklin  
• President – National Council of Women Papakura/Franklin Branch  
• Member – UN Women Aotearoa/NZ  
• Vice President – Friends of Auckland Botanic Gardens and Member of the Friends Trust  
• Life Member – Ambury Park Centre for Riding Therapy Inc.  
• CMDHB Representative - Franklin Health Forum/Franklin Locality Clinical Partnership  
• Vice President, National Council of Women of NZ |
<table>
<thead>
<tr>
<th>Name</th>
<th>Roles and Responsibilities</th>
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<tbody>
<tr>
<td>Colleen Brown</td>
<td>• Chair Parent and Family Resource Centre Board (Auckland Metropolitan Area)</td>
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<td></td>
<td>• Member of Advisory Committee for Disability Programme Manukau Institute of Technology</td>
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<td></td>
<td>• Member NZ Down Syndrome Association</td>
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<td></td>
<td>• Husband, Determination Referee for Department of Building and Housing</td>
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<td></td>
<td>• Chair, Early Childhood Education Taskforce for COMET</td>
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<td></td>
<td>• Chair ECE Implementation Team Auckland South</td>
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<td>• Chair IMuch Trust</td>
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<td></td>
<td>• Director, Charlie Starling Production Ltd</td>
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<td></td>
<td>• Member, Auckland Council Disability Advisory Panel</td>
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<tr>
<td>George Ngatai</td>
<td>• Arthritis NZ – Kaiwhakahaere</td>
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<td></td>
<td>• Chair Safer Aotearoa Family Violence Prevention Network</td>
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<td></td>
<td>• Director Transitioning Out Aotearoa</td>
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<td>• Director BDO Marketing</td>
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<td>• Board Member, Manurewa Marae</td>
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<tr>
<td>Reece Autagavaia</td>
<td>• Member, Pacific Lawyers’ Association</td>
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<td>• Member, Labour Party</td>
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<td>• Member, Auckland Council Pacific People’s Advisory Panel</td>
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<td>• Board Member, United Otara Market</td>
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<td>• Member, Tangata o le Moana Steering Group</td>
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<tr>
<td>Sefita Hao’uli</td>
<td>• Trustee Te Papapa Pre-school Trust Board</td>
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<td></td>
<td>• Member Tonga Business Association &amp; Tonga Business Council</td>
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<td></td>
<td>• Member ASH Board Advisory roles:</td>
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<td></td>
<td>• Toko Suicide Prevention Project (Ministry of Health)</td>
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<td></td>
<td>• Tala Pasifika (NZ Heart Foundation Pacific Tobacco Control)</td>
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<td></td>
<td>• Member Pacific Advisory Board, Auckland Council Consultant</td>
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<tr>
<td></td>
<td>• Government of Tonga: Manage RSE scheme in NZ</td>
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<td></td>
<td>• NZ Translation Centre: Translates government and health provider documents.</td>
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<tr>
<td>Ezekiel Robson</td>
<td>• Department of Internal Affairs Community Organisation Grants Scheme Papakura/Franklin Local Distribution Committee</td>
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<td>• Be.Institute/Be.Accessible ‘Be.Leadership 2011’ Alumni</td>
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<tr>
<td>Wendy Bremner</td>
<td>• CEO Age Concern Counties Manukau Inc</td>
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<td></td>
<td>• Member of Auckland Social Policy Forum</td>
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<td></td>
<td>• Member of Health Promotion Advisory Group (7 Age Concerns funded by MOH)</td>
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<tr>
<td>Director having interest</td>
<td>Interest in</td>
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<tr>
<td>Mr George Ngatai</td>
<td>CMH Quit Bus</td>
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<td>Mr Sefita Hao’uli</td>
<td>Rheumatic Fever national campaign</td>
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<tr>
<td>Mr Geraint Martin</td>
<td>Renewal of the Regional After Hours Agreement</td>
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<tr>
<td>Ms Colleen Brown</td>
<td>Richmond NZ Trust Ltd</td>
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## Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ACC</td>
<td>Accident Compensation Commission</td>
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<tr>
<td>ADU</td>
<td>Assessment and Diagnostic Unit</td>
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<td>ARDS</td>
<td>Auckland Regional Dental Service</td>
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<td>BT</td>
<td>Business Transformation</td>
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<tr>
<td>CADS</td>
<td>Community Alcohol, Drug and Addictions Service</td>
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<td>CAMHS</td>
<td>Child, Adolescent Mental Health Service</td>
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<tr>
<td>CNM</td>
<td>Charge Nurse Manager</td>
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<tr>
<td>CT</td>
<td>Computerised Tomography</td>
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<tr>
<td>CW&amp;F</td>
<td>Child, Women and Family service</td>
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<tr>
<td>DNA</td>
<td>Did not attend</td>
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<tr>
<td>ESPI</td>
<td>Elective Services Performance Indicators</td>
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<tr>
<td>FSA</td>
<td>First Specialist Assessment (outpatients)</td>
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<td>FTE</td>
<td>Full Time Equivalent</td>
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<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
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<tr>
<td>iFOBT</td>
<td>Immuno Faecal Occult Blood Test</td>
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<td>MHSG</td>
<td>Mental Health service group</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>MTD</td>
<td>Month To Date</td>
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<td>MOSS</td>
<td>Medical Officer Special Scale</td>
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<td>OHBC</td>
<td>Oral health business case</td>
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<tr>
<td>ORL</td>
<td>Otorhinolaryngology (ear, nose, and throat)</td>
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<td>PACU</td>
<td>Post-operative Acute Care Unit</td>
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<td>PHO</td>
<td>Primary Health Organisation</td>
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<td>PoC</td>
<td>Point of Care</td>
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<td>SCBU</td>
<td>Special care baby unit</td>
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<td>SMO</td>
<td>Senior Medical Officer</td>
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<td>SSU</td>
<td>Sterile Services Unit</td>
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<td>TLA</td>
<td>Territorial Locality Areas</td>
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<td>WIES</td>
<td>Weighted Inlier Equivalent Separations</td>
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<td>YTD</td>
<td>Year To Date</td>
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Minutes of the meeting of the Counties Manukau District Health Board

Community & Public Health Advisory Committee  
Wednesday 17 December 2014

held at Counties Manukau Health Boardroom, 19 Lambie Drive, Manukau  
commencing 1.30pm

COMMITTEE MEMBERS PRESENT:
Dr Lee Mathias (Board Chair)  
Ms Sandra Alofivae (Committee Chair)  
Mr David Collings  
Ms Dianne Glenn  
Mr Apulu Reece Autagavaia  
Mr Ezekiel Robson  
Mr Sefita Hao’uli  
Ms Wendy Bremner

ALSO PRESENT:
Mr Geraint Martin (Chief Executive)  
Ms Margie Apa (Director, Strategic Development)  
Mr Benedict Hefford (Director, Primary Health & Community Services)  
Dr Campbell Brebner (Chief Medical Advisor, Primary Care)  
Ms Karyn Sangster (Chief Nursing Advisor, Primary & Integrated Care)  
Ms Charlie Saunders, Franklin Family Support attended the Public section of the  
meeting.

APOLOGIES:  
Apologies were received and accepted from Ms Colleen Brown and Mr George  
Ngatai.

WELCOME
Apulu Reece Autagavaia opened the meeting with a short prayer.

2.2 DISCLOSURE OF INTERESTS
There were no additions or amendments to the Disclosures of Interest.

2.2 SPECIFIC INTERESTS
There were no specific interests to note with regard to the agenda for this meeting.

2.3 ACRONYMS
The Acronym list was noted.
2.4 CONFIRMATION OF PREVIOUS MINUTES
Confirmation of the public minutes of the Counties Manukau Community & Public Health Advisory Committee meeting held 26 November 2014.

Resolution (Moved Dr Lee Mathias/Seconded Ms Dianne Glenn)

That the public minutes of the Counties Manukau Health Community & Public Health Advisory Committee meeting held on 26 November 2014 be approved.

Carried

2.5 ACTION ITEMS REGISTER
Follow up presentation on the 111 St John’s Clinical Hub deferred to 11 March 2015.

There were no further additions or amendments to the Action Items Register.

Resolution (Moved Ms Colleen Brown/Seconded Dr Lee Mathias)

That the Action Items Register of the Counties Manukau Health Community & Public Health Advisory Committee be received.

Carried

2.6 CPHAC TERMS OF REFERENCE
The Terms of Reference were noted.

3. PRESENTATION

3.1 Influenza Immunisation Strategy
Ms Sarah Sharpe, Public Health Registrar took the Committee through the presentation. A copy of the presentation is available on the CMH website.

Dr Mathias commented on a previous HAC conversation in regard to immunisation of older people and whether this is a group of vulnerable people who would benefit from immunisation for Shingles & Whooping Cough (Varicella & Boostrix). Mr Hefford & Ms Sangster were asked to come back to CPHAC on this.

In response to a question, Ms Sharpe advised that if we are looking to increase uptake within the current eligibility, aged residential care units could do a lot to assist with those people who are not necessarily in touch with their GPs. If people have a disability that makes them medically comprised they are already eligible under the current scheme. The eligibility is quite broad but also quite medically specific. It’s often difficult for people to visit their GP, it can be a real inconvenience, an extra step that they have to take. Increasing access to opportunistic immunisation might be the role of secondary care services in helping primary care.

Dr Brebner confirmed that currently funding goes to general practice, how hard it would be to make an arrangement locally for pharmacies to be included in that general practice would need to be looked into. Mr Hefford was asked to check whether Pharmacists & LMCs can claim under s88 as well as GPs.
In response to a question on how we would measure those immunisations, Ms Sharpe advised that next year they are hoping to get all GPs on the NIR but pharmacies and workplaces, who are giving a lot of vaccinations are not being recorded them anywhere as they are having issues with IT systems not talking to each other so getting them recorded on the NIR is a little way off.

In relation to any special training that is required to give vaccinations, Ms Sangster advised that normally nurses working in general practice are authorised vaccinators, public health nurses do a training programme to vaccinate and aged residential care facilities have authorised vaccinators ‘adults-only’ so there are different training programmes for the different populations. This is not a major barrier.

There was strong discussion about whether we should focus this year on what we are already covered for or whether there is an opportunity to spread to all children or wait for the nasal spray. Mr Hefford confirmed that this was discussed recently at ELT and it was felt that there is an awful lot more we could do within our current eligibility.

Resolution
The Committee:
• **Noted** the burden caused by influenza in the CMDHB region, including:
  o the significant burden of mild through to severe illness on individuals, whaanau, the community and the health system.
  o that, there are important equity issues to consider in relation to the CMDHB population with higher hospitalisation rates for infants, children aged 1-4 years, Māori and Pacific Peoples, and people living in socio-economically deprived areas.
  o that, although influenza viruses are an important preventable (through vaccination) cause of acute respiratory infection hospitalisations and GP consultations, they comprise 24% and 35%, respectively, of the total respiratory cases.
    ▪ Other public health prevention strategies (e.g. improving quality and reducing overcrowding of housing, and reducing poverty) are important in addressing the total burden of infectious respiratory disease.
• **Agreed** that Counties Manukau Health maximise influenza immunisation uptake under current Ministry of Health eligibility criteria by (a) supporting and promoting immunisation via primary care and community networks and (b) increasing visibility and access to opportunistic vaccination across secondary services.

**Carried**

The Chair thanked Ms Sharpe for her presentation.

4. **DIRECTOR’S REPORT**
Mr Hefford took the Committee through the Director’s report.

4.0 **Executive Summary**
Taken as read.

4.1 **National Health Targets**
Taken as read.
4.2 Primary Care
Ms Lisa Gestro, General Manager, Primary Care took the Committee through this section of the Director’s report.

The Integrated Performance and Incentive Framework (IPIF) have 5 key measures for 14/15 consisting of the existing national health targets plus cervical screening and immunisation at 24 months. The main area of concern is cervical screening where we are at 74% against a target of 80%. Action plans at regional, district and locality level are in place to ensure achievement of this target. We have also written to MoH, through healthAlliance, to get access to the national database on cervical screening. Ms Apa undertook to see is she could assist in getting access to this data.

4.3 Child Youth & Maternity

Mr Hefford advised that an interim evaluation of the Mana Kidz prevention programme is available. All indications are that we are getting positive outcomes from the programme but as far as Rheumatic Fever is concerned, it is too hard to tell because of the small numbers. We don’t know if Strep throats cause Rheumatic Fever and we don’t have a test for Rheumatic Fever. The recommendation from the evaluation was to continue for the 2015 calendar year to give us more longitudinal data. Mr Hefford undertook to provide a copy of the evaluation to the Committee on the next agenda.

4.4 Mental Health & Addictions
Ms Tess Ahern, General Manager, Mental Health & Addictions took the Committee through this section of the Director’s report.

Ms Ahern gave an update on the approach CMH is taking to mental health. Looking at having the opportunity to have whole of systems leadership will be the way to move forward and help to join up the system including Mental Health specialist services, NGO, addiction and primary care. Aspiring to have mental health as part of the health system as opposed to a system that is fragmented and sitting out on its own. People with mental health are one of our most deprived groups, their health outcomes are very poor. Our approach is to have a leadership group of integrated mental health services and work with those groups to bring them as part of our journey. Expect to have terms of reference in place early next year and Expressions of Interest for the group by March.

Co-design work is starting in the New Year, implementation plan in place by September.

Dr Mathias asked about the intellectual property of the new design of the service and whether this would be transferrable to other services. Ms Ahern advised that she would hope so but it was essential that they are not doing something separate. Mr Martin undertook to ask Ms Frances Guyett from the Innovation Hub to contact Ms Ahern to see whether there is something innovative in this co-design work that could be written up and passed to other DHBs to get some runs on the board as we regionalise. One of the goals is to have 50% of our staff working alongside primary care.

Ms Glenn noted that people with brain injuries tend to fall in a gap on their own and asked if these people will get picked up with the broadened services. Ms Ahern confirmed that brain injury is a very difficult area as it is not a ‘mental illness’ but some external observation, monitoring and involvement in terms of collaboration should be looked at from the beginning.
4.5 Adult Rehabilitation & Health of Older People

Ms Bremner commented on the number of referrals declined by the Memory Team as they were out of our catchment area and asked why these referrals are being made. Dr Brebner confirmed that these would be patients who were referred by a GP but live outside our catchment area, basically an error by the GP in sending the referral to the wrong DHB.

4.6 Intersectoral Initiatives
Taken as read.

4.7 Progress with Systems Integration

Mr Hefford confirmed that the ARI programme is going well and that we currently have 3,000 enrolled. Target is 3% of the population, around 15,000. The lower numbers are due to taking a rolling start approach rather than a big bang approach and it has been difficult to get some GP practices up and running however, the ground swell is increasing. IT has been a huge barrier but this is also gradually getting better.

4.8 Locality Reports
Ms Linda Bryant, GM Eastern Locality took the Committee through this section of the Director’s Report.

The Otago Exercise programme (musculoskeletal falls prevention) has been running for the last 12 months. This is a physio-led community programme aimed at people over 85 years of age who have had a fall and gives them a set of exercises to do in the home and follows them up at 1 and 2 months. It is a very effective programme that reduces falls and the people become more active and have a better quality of life.

Joint Replacement Alternative Pathway – because there is a backlog for knee and hip replacements, we need to find something that is a conservative treatment. This pathway has been running in the Royal North Shore Hospital, Sydney and has shown a reduction of people having joint replacements. If patients are not seen within the 120 days for a joint replacement, they get put into this pathway. It is a physio-led pathway but uses a multidisciplinary team. We are hoping to start an introductory programme in mid-January 2015 and hope to have a full business case available after completion of the introductory programme. This programme can delay the need for surgery and people present fitter for surgery through undergoing this pathway.

4.9 Financials
Taken as read.

Actions from Previous CPHAC Meetings

It was noted that there are no equivalent regulations for ‘vulnerable adults’ as those released for ‘vulnerable children’. There is however, a general provision in the Crimes Act (s151) that sets out that everyone who cares for a vulnerable adult is under a legal duty to provide that person with necessaries and take all reasonable steps to protect that person from injury.

Mr Hefford advised that a ‘vulnerable adult’ is defined under the Crimes Amendment Bill (no.2)(sections 151, 195, and 195A) as ‘a person unable by reason of detention, age, sickness,
mental impairment or any other cause to withdraw himself or herself from the care or charge of another person”.

We have a response for children and our older population who we might pick up as being potentially vulnerable but we are seeing a gap in a systematic response for adults. As there is no legislation currently available to cover this group, a question was raised whether we should adopt an ‘in principle’ approach to vulnerable adults so we use the same sort of policies that we do around children except the reporting process would be different. Mr Hefford undertook to talk to our staff and teams about what they are observing and what our current practices are and come back to the Committee with an update to make the picture clearer for the Committee.

Resolution (Moved Ms Dianne Glenn/Seconded Dr Lee Mathias)

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

Carried

5. GENERAL BUSINESS

5.1 Pacific Health Development Update
Ms Elizabeth Powell, General Manager, Pacific Health Development gave a verbal update to the Committee on Pacific Health.

Fanau Ola Services – In the last five months the team have seen 1033 primary patients through Fanau Ola, a total of 4022 Fanau including the primary patients. We have identified a Fanau champion for each of patient seen and are on track to reach 2000+ Fanau patients by end June 2015. We are seeing a lot of young children and respiratory issues. The focus over the next few months will be around getting a lot more health literacy into the community working with the Lotu Moui team.

Cultural Competency Training – Seeing on average 40 attendees each month.

AH+ continues to develop the framework where the contracts are going to better aligned to Fanau Ola with the Providers. We still have not got a clear commitment from the Providers yet on what is going to be delivered but a workshop is scheduled with AH+ and the Providers for January which will give a good idea what that will look like come 1 July when the contracts are finalised.

The Pacific Health Plan was approved by the Board and is currently being socialised and will be completed by February 2015.

Pacific Workforce Development – 16 out of 24 Pacific nurses failed their exams with MIT in the last year. This means that we don’t get this workforce into our Organisation. They can resit but they need better English (a lot have English as a second language) and intensive support to understand the questions asked and how to answer them. We will work with MIT and the Director of Nursing to ensure we can support these students better. Ms Powell undertook to report back to the Committee on this topic.

Regional Pacific Programmes – We have 5 countries we currently work with - Samoa (contracted until 2015 working alongside the health services & Government in Samoa to develop their health
services. This contract has been ongoing since 2007), Niue, Cook Islands, Fiji and Kiribati. The programmes are determined by the Governments and are funded by MFAT – we are a contracted Provider. This has brought in an additional $3m over the last 3 years, $1.2m in the last year.

6.0 RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved Ms Sandra Alofivae/Seconded Dr Lee Mathias)

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:

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1 Minutes of the CPHAC Meeting with public excluded 26.11.14</td>
<td>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.</td>
<td>Confirmation of Minutes For the reasons given in the previous meeting.</td>
</tr>
</tbody>
</table>

Carried
3.49pm Public excluded session.

3.50pm Open meeting resumed.

The meeting concluded at 3.35pm.

The minutes of the Counties Manukau Community & Public Health Advisory Committee meeting held 17 December 2014 be approved.

(Moved /Seconded )

Chair _____________________________ Date ____________________

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

<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>26.2.2014</td>
<td>4.0</td>
<td>Update from Auckland Regional Public Health Service every 6 months on current issues.</td>
<td>March</td>
<td>Mr Hefford</td>
<td></td>
</tr>
<tr>
<td>20.8.2014</td>
<td>3.1</td>
<td>St John New Zealand Follow-up presentation on the 111 Clinical Hub</td>
<td>March</td>
<td>Dr Brebner</td>
<td></td>
</tr>
<tr>
<td>20.8.2014</td>
<td>4.0</td>
<td>Director’s Report - Healthy Families Initiative presentation from the collective</td>
<td>March</td>
<td>Mr Hefford</td>
<td></td>
</tr>
<tr>
<td>22.10.14</td>
<td>4.0</td>
<td>Director’s Report – take the committee through the Primary Health integration programme in more detail. The Committee would also like to hear from some of the staff/people out in the community at the cutting edge of change who are actually doing the work (i.e.) where they’re at with their refreshed job descriptions, the changes in the traditional models, the authority and accountability that’s come with this change - 20min presentations spread out over a few months. Some examples given were: a nurse practitioner doing work on a marae, a district nurse, a practice nurse doing care coordination and how things are different in practices now.</td>
<td>January</td>
<td>Mr Hefford</td>
<td>Mr Hefford/Ms Sangster</td>
</tr>
<tr>
<td>22.10.14</td>
<td>4.2</td>
<td>Director’s Report - Health Targets. Smokefree Team to take the committee through the ‘Smokefree by 2025’ strategy.</td>
<td>March</td>
<td>Mr Hefford</td>
<td></td>
</tr>
<tr>
<td>26.11.2014</td>
<td>2.5</td>
<td>Strategic Workshop – clinical hub, community health developments and healthy families and also as follow up from the Board planning day on 11th December in relation to community outcomes and public health perspective.</td>
<td>January</td>
<td>Mr Hefford</td>
<td></td>
</tr>
</tbody>
</table>
Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
<th>COMPLETE</th>
</tr>
</thead>
<tbody>
<tr>
<td>26.11.2014</td>
<td>2.5</td>
<td>Safety in Practice presentation</td>
<td>January</td>
<td>Dr Brebner</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>26.11.2014</td>
<td>4.0</td>
<td>Rheumatic Fever – Ms Ellis to provide some data on the practices that are part of this programme.</td>
<td>March</td>
<td>Mr Hefford/Ms Ellis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26.11.2014</td>
<td>5.0</td>
<td>Mr Nia Nia to provide an update on the Te Kaahui Ora service review. NHC integrated service agreement work.</td>
<td>March</td>
<td>Mr Hefford/Ms Apa</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.12.2014</td>
<td>3.1</td>
<td>Immunisation – Is there a group of older vulnerable people who would benefit from immunisation for Shingles &amp; Whooping Cough (Varicella &amp; Boostrix). Are Pharmacists &amp; LMCs able to claim under s88 as well as GPs.</td>
<td>March</td>
<td>Mr Hefford/Ms Sangster</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.12.2014</td>
<td>5.1</td>
<td>Pacific Health Development – report back on Pacific Workforce development in relation to students not passing their examinations.</td>
<td>Date TBC</td>
<td>Ms Powell</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Counties Manukau District Health Board
Community Health Integration Programme

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

- **Note** progress made with integrating community health services in localities
- **Feedback** on the suggested approach to progressing Community Health integration
- **Note** that a business case will be submitted to CMH Board in March 2015 to progress the proposed programme of work.

Prepared and submitted by: Claire Garbutt, Transformation Manager - Integrated Care

**Glossary**
ARI – At Risk Individuals Programme
MDT – Multi-disciplinary team
NASC – Needs Assessment & Service Co-ordination for older people
VHIU – Very High Intensive User programme
ReaCT – Reablement Community Teams

**1. Background**
The development of the four localities within Counties Manukau aims to integrate community health services with general practice. Central to achieving this is the recognition of the ‘healthcare home’ as the central point of co-ordination for patient care and delivery of services in community settings. Significant achievements have been made within the localities to develop active clinical networks including general practice clusters to support care delivery for complex patients.

As part of the locality development, effort has focussed on integration of community services including district nursing, allied health and needs assessment and service coordination for older people (NASC). There are about 130 staff employed across these existing roles with an annual operational budget of approximately $12M. NASC support approximately 9,000 residents per year and district nursing and allied health delivers approximately 120,000 patient contacts per year across Counties Manukau. In addition to this, needs assessors manage entry to aged residential care (at a current operational cost of around $70M pa) and access to home and community support services for older people and adults with long term chronic health needs (at an operational cost of about $30M pa). This involves working with 17 contracted home and community support providers across the district.

**2. The case for change**
We are faced with significant demand challenges in coming years, with the population of Counties Manukau projected to grow by over 120,000 people (nearly 1/3 will be aged over 65) by 2026. This is equivalent to the population of a city the size of Dunedin. The socio-demographic needs of our population are both diverse and significant which also impacts on demand. Some CMH services, such as the emergency department and renal care, are seeing annual volume increases of more than 4% pa.
Continued development of locality based service integration offers the opportunity to address demand challenges in the following key areas:

- Reduced acute length of stay
- Reduced hospital admission volumes
- Reduced emergency department volumes
- Reduced readmissions to hospital
- Reduced rates of entry to aged residential care
- Appropriate, effective, and timely home and community services utilisation

Integrating locality based community health services is part of the wider programme of change, which includes ensuring early support for At Risk Individuals and supporting a mobile, technology enabled community workforce through delivery of project SWIFT.

3. Progress to date

The implementation of the At Risk Individuals (ARI) programme has introduced a model of care for the wider care team to work collaboratively with a family/whaanau to provide more planned, proactive care for complex patients. Most practices within Counties have transitioned to this model and over 3500 patients are enrolled in the programme. The introduction of the Very High Intensive User (VHIU) programme, followed by the implementation of ARI in 2014 and other locality initiatives, has developed the linkages between primary and secondary clinicians. Senior Medical Officer cover across all localities continues to build these links and identify opportunities for integrated care.

Multidisciplinary community teams are forming around general practice clusters in each locality to better support primary care as the central focus and co-ordinating mechanism of healthcare – the ‘healthcare home’. Locality leadership groups are providing governance locally to implement new models of care and cluster arrangements. Over time, most community services (except those that are highly specialised) will work within integrated, multi-disciplinary locality-based clusters.

A process to redesign the community model of care within district nursing and community allied health teams and NASC is nearly completed. All community based NASC have been relocated within the Home Health Care teams in each locality as of August 2014. This move has seen benefits from accessing the multidisciplinary team, both by participating in MDTs and using the disciplines for support, advice and co-ordination of interventions. The NASC intake process has been redesigned to achieve efficiencies, and the community nursing and allied health intake function will now be merged with that of NASC, providing a single point of access for community referrals and reducing duplication and gaps. Locality specific developments have also progressed including:

- The increase in multi-disciplinary rehabilitation capacity at Pukekohe Hospital using GP and Geriatrician medical support
- Development of Integrated Family Health Centres (IFHCs) in Eastern and Mangere/Otara localities
- The Coordinator of Services for the Elderly model operating across Eastern locality
- Implementation of rapid response models within Franklin and Eastern localities, with Manukau and Mangere/Otara commencing shortly
- Developing the locality coordinator initiative within Manukau locality for patients with three+ emergency department presentations in the past 12 months, and facilitating enrolment into the ARI programme where appropriate.
- The use of clinical advisory pharmacists to attend to complex patients, residential care home patients, and other patients with polypharmacy issues
• Implementation of COPD, falls prevention, and early intervention for osteoarthritis programmes within Eastern locality.
• Deployment of over 50 Care Pathways for common conditions to reduce clinical variation and improve patient experience and outcomes.

4. Community Health Service Integration
The focus of this programme of work is on improving the health and outcomes for people in our community and determining how we can best to support them as they progress through their life journey. For most people the ongoing point of continuity will be their General Practice. We will no longer see episodes of care in other services (such as a hospital admission) as a transfer of care; instead we will see it as a continuous journey that involves episodes where extended care and support is required.

The key principles of this programme of work include
• Remembering that we are here for the people and their whaanau and that everything we do should be geared to support this.
• Valuing those that are working at the frontline to provide the services to support our people and their whaanau.
• Recognising the holistic needs of whaanau and that health determinants are more about social factors than our health services.
• Recognising that we are working in a complex adaptive system with skilled individuals who will evolve care delivery over time if enabled.
• Allowing a variety of operational models to respond to unique population needs but aim to achieve good outcomes and equity. By definition achieving equity for our populations means that some must receive different inputs from others.
• Enablers are critical to the work of integration, in particular information systems development.
• Notwithstanding good system enablers, integration is a ‘contact sport’ between people that are working in the system and is dependent on relationships that develop.
• Finally, our work should be clinically led supported by enabling management.

Proposed approach
This programme will be delivered through three streams of work: (1) Locality Reablement Services; (2) Review of long term home and community care services; (3) ‘Community Central’.

1. Locality reablement services: The locality community teams will aim to assist people to be as well as they can be at home (“reablement”), particularly during and after an acute deterioration. This includes continuation of work commenced to refocus district nursing, allied health and NASC teams to work effectively within the locality model. Key principles include:
   o Integrated with primary care practice clusters
   o Patient and whaanau centred care plans
   o Maximising patient’s strengths, function and ability to maintain life roles
   o Focus on health literacy and self-management
   o Focus on health promotion and minimising disease progression
   o Equity of access
   o Redesign of the district nursing role to enable increased capacity for acute assessments to avoid hospital admission and complex clinical interventions. A funding model will be developed to allow practice nurses to perform some of
the routine follow up care currently performed by district nurses, particularly wound care.

Implementation of this new model includes the core functions of:

- Supported discharge for adults (18 plus) going home from Middlemore Hospital;
- Direct access from primary care and community to avoid an Emergency Centre (EC) attendance or hospital admission; and for sub-acute services to avoid the risk of these outcomes as well as residential care admission;
- Pre-planned interventions to enable at risk adults to receive an intensive Interdisciplinary community rehabilitation programme that will aim to support self-management and reduce hospital admission risk;
- Rapid response for adults at risk of Middlemore Hospital admission
- Intake service for all people referred for long term home care or requiring ‘rest home’ placement, if clinical discretion allows.

The diagram below outlines the model of care for these Re-ablement Community Teams (‘ReaCT’):

![Diagram of Reablement Community Teams (‘ReaCT’) model of care]

**Figure 1: Reablement Community Teams (‘ReaCT’) model of care**

2. **Re-tender of long term home and community care services:** A review and re-tender of currently contracted home and community support services is required to align care delivery with the integration and service delivery approach going forward. Traditionally, home care has been funded by a fee-per-service approach. This very prescriptive approach means that it is difficult to align client needs with the most appropriate response. For instance, a client may be prescribed two hours of input per week, which is fine for two months, but after becoming ill, it may need to increase to six hours for a few weeks. Currently, it is almost impossible to create a flexible response. The new model of funding, called casemix, allows the development of pathways for clients with similar needs but more importantly funds the provider in a way which allows them to be more
flexible in meeting the client’s needs. A restorative model of home and community services is recommended that contains the key elements listed in the table below:

<table>
<thead>
<tr>
<th>Key elements of restorative home care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comprehensive Geriatric Assessment</strong></td>
</tr>
<tr>
<td>Older people with high and complex needs are assessed using the interRAI Home Care Assessment</td>
</tr>
<tr>
<td><strong>Goal facilitation</strong></td>
</tr>
<tr>
<td>A key concept of RHC is to base a support programme around the goals and aspirations of the person</td>
</tr>
<tr>
<td><strong>Functional ADL exercises</strong></td>
</tr>
<tr>
<td>Functional exercises involve working on muscle groups used in every-day activities.</td>
</tr>
<tr>
<td><strong>Support worker training and enhanced supervision</strong></td>
</tr>
<tr>
<td>RHC relies on support workers to collaborate with older people to maximise their independence. The CareerForce Level II and III training programmes integrated promoting independence techniques into the learnings. In addition, RHS adopts enhanced health professional integrated supervision via coordinators. Contact in both a team environment and one-on-one in the presence of a client occurs regularly</td>
</tr>
<tr>
<td><strong>Care management</strong></td>
</tr>
<tr>
<td><strong>Health Professional training</strong></td>
</tr>
<tr>
<td>The role and competencies of the coordinator changes greatly with the evolution of RHC. Roles and duties may include: delegation and supervision of non-regulated staff; comprehensive assessment; care management; goal activity analysis; and grading expertise surrounding community integration for clients</td>
</tr>
<tr>
<td><strong>Casemix</strong></td>
</tr>
</tbody>
</table>

3. *Community Central*: Will be one point of contact and referral for all, enabled by a technology solution that supports a ‘first response’ request for services, triaging, allocating resources, capacity planning and telehealth capability. This is centrally organised, but locality driven including:

- **Intake of all community health services**
  - Referrals management (NASC, Home Healthcare, community mental health, child health), including e-referrals
  - Screen and triage function
  - Communication & co-ordination
  - Re-direct and access DHB and non-DHB services
- **Customer Services or Information Centre**
  - One point of contact, single source of truth
  - 7-day service
  - Information for clients, referrers, social agencies etc.
  - Problem solving and directing
  - Ability to network with health and social agencies
  - Telehealth monitoring and support
- **Workforce capacity and production planning**
  - Visible workforce (geographical position support)
  - Access to inpatient and outpatient services

*Implementation and Change Impact*
Key changes that will be seen by implementation of the programme of work include:
• Integration of elements of NASC, District Nursing, Community Allied Health, and Community Pharmacy

• Develop primary and community nursing into practice/clinic based nursing and mobile nursing functions and extension to coordination activity for people with complex needs (at risk individuals)

• Development and implementation of Community Central, including integration of triage and coordination for primary options for acute care (POAC), district nursing, allied health, short and long term home based support and mechanisms to support efficient specialist service interaction. This will be enabled by the project SWIFT.

5. Proposed next steps

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appoint Rapid Response coordinators to Manukau and Otara/Mangere teams to augment existing capacity in Franklin and Eastern localities.</td>
<td>February 2015</td>
</tr>
<tr>
<td>Merge NASC and Home Health Team intake, screening and triage functions to create a single point of entry for community referrals</td>
<td>March 2015</td>
</tr>
<tr>
<td>Develop a full Business Case outlining costs and benefits for implementation of the integrated community health model.</td>
<td>February 2015 to ELT March 2015 to Board</td>
</tr>
<tr>
<td>As part of the Business Case, an implementation plan will be developed outlining the timeframes and change management processes to achieve the above defined service changes.</td>
<td>February/March 2015</td>
</tr>
<tr>
<td>Home and community based care services will be retendered within an appropriate timeframe, utilising a consultative process.</td>
<td>Tender commenced April 2015</td>
</tr>
<tr>
<td>Implementation/phased transition of community health services to new model of care</td>
<td>April 2015 – June 2017</td>
</tr>
</tbody>
</table>
CPHAC Workshop:
Locality Services Integration

21 January 2015
Growth compared with other DHBs – total, and 65 yrs & over (number)

Projected annual population growth from 2014/15 to 2025/26 by DHB in absolute numbers

- Waitemata
- Canterbury
- Counties Manukau
- Auckland
- Waikato
- Southern
- Bay of Plenty
- Capital and Coast
- Northland
- Nelson Marlborough
- Hawkes Bay
- MidCentral
- Hutt
- Taranaki
- Lakes
- Whanganui
- South Canterbury
- Wairarapa
- Tairawhiti
- West Coast
Where we are now …

PERFORMANCE – a top performing DHB

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Shorter stays in Emergency Departments</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>Improved access to elective surgery</td>
<td>106%</td>
<td>108%</td>
<td>111%</td>
<td>111%</td>
<td>112%</td>
</tr>
<tr>
<td>Shorter waits for cancer treatment radiotherapy</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Increased immunisation - 2 year olds</td>
<td>86%</td>
<td>90%</td>
<td>95%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased immunisation - 8 month olds</td>
<td></td>
<td></td>
<td></td>
<td>90%</td>
<td>92%</td>
</tr>
<tr>
<td>Better help for smokers to quit - hospital</td>
<td>59%</td>
<td>86%</td>
<td>94%</td>
<td>95%</td>
<td>96%</td>
</tr>
<tr>
<td>Better help for smokers to quit - primary</td>
<td></td>
<td></td>
<td></td>
<td>56%</td>
<td>99%</td>
</tr>
<tr>
<td>More heart and diabetes checks</td>
<td></td>
<td></td>
<td></td>
<td>52%</td>
<td>76%</td>
</tr>
</tbody>
</table>

CMDHB Hospital Services Activity

<table>
<thead>
<tr>
<th></th>
<th>FY 2010</th>
<th>FY 2011</th>
<th>FY 2012</th>
<th>FY 2013</th>
<th>FY 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Attendances</td>
<td>132,355</td>
<td>152,142</td>
<td>159,054</td>
<td>152,503</td>
<td>173,074</td>
</tr>
<tr>
<td>Acute Discharges</td>
<td>78,731</td>
<td>80,428</td>
<td>83,505</td>
<td>83,691</td>
<td>84,942</td>
</tr>
<tr>
<td>Emergency Care Attendances</td>
<td>80,253</td>
<td>86,858</td>
<td>88,593</td>
<td>89,791</td>
<td>94,486</td>
</tr>
<tr>
<td>Elective Discharges</td>
<td>14,459</td>
<td>15,308</td>
<td>14,567</td>
<td>14,922</td>
<td>15,134</td>
</tr>
</tbody>
</table>

Financial Position

<table>
<thead>
<tr>
<th></th>
<th>Break-even</th>
<th>$4.9m surplus</th>
<th>$2.9m surplus</th>
<th>$2.9m surplus</th>
<th>$3.0m surplus</th>
</tr>
</thead>
</table>
### Where are we now? Hospital demand - adults

<table>
<thead>
<tr>
<th>Service</th>
<th>2011/12</th>
<th>2013/14</th>
<th>% change FY 2011/12 - 2013/14</th>
<th>Absolute change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Med Acutes</td>
<td>23,203</td>
<td>25,374</td>
<td>2.4%</td>
<td>610</td>
</tr>
<tr>
<td>Renal dialysis</td>
<td>44,682</td>
<td>52,420</td>
<td>17.3%</td>
<td>7,740</td>
</tr>
<tr>
<td>Adult Med OP FSAs</td>
<td>13,002</td>
<td>16,359</td>
<td>25.8% (respiratory, gastro especially)</td>
<td>3,360</td>
</tr>
<tr>
<td>Adult Med OP FUs</td>
<td>37,565</td>
<td>38,466</td>
<td>2.4% (most actually decreasing but renal increasing)</td>
<td>900</td>
</tr>
<tr>
<td>Adult ED</td>
<td>75,004</td>
<td>81,098</td>
<td>8% (partic in those &lt;3 hrs)</td>
<td>6,090</td>
</tr>
<tr>
<td>Adult Surg Acutes</td>
<td>16,476</td>
<td>17,167</td>
<td>4.2%</td>
<td>690</td>
</tr>
<tr>
<td>Adult Surg Electives</td>
<td>10,723</td>
<td>11,494</td>
<td>7.2% (central policy driver)</td>
<td>770</td>
</tr>
<tr>
<td>Adult Surg OP FSAs</td>
<td>22,147</td>
<td>26,251</td>
<td>18.5% (across most services)</td>
<td>4,100</td>
</tr>
<tr>
<td>Adult Surg OP FUs</td>
<td>62,874</td>
<td>66,978</td>
<td>6.5% (most flat but ORL increasing: unseen WL)</td>
<td>4,100</td>
</tr>
</tbody>
</table>
## Where are we now? Hospital demand – children

<table>
<thead>
<tr>
<th>Service Type</th>
<th>2011/12</th>
<th>2013/14</th>
<th>% change</th>
<th>Absolute change</th>
</tr>
</thead>
<tbody>
<tr>
<td>KidzFirst Med Acutes</td>
<td>5,741</td>
<td>5,600</td>
<td>-2.5%</td>
<td>-140</td>
</tr>
<tr>
<td>KidzFirst Med OP FSAs</td>
<td>2,308</td>
<td>2,389</td>
<td>3.5% (From July 14 more increase)</td>
<td>80</td>
</tr>
<tr>
<td>KidzFirst Med OP FUs</td>
<td>2,874</td>
<td>3,232</td>
<td>12.5%</td>
<td>360</td>
</tr>
<tr>
<td>KidzFirst ED</td>
<td>23,882</td>
<td>23,667</td>
<td>-1% (from July 14 more increase)</td>
<td>-215</td>
</tr>
<tr>
<td>KidzFirst Surg Acutes</td>
<td>2,122</td>
<td>2,094</td>
<td>-1.3%</td>
<td>-30</td>
</tr>
<tr>
<td>KidzFirst Surg Electives</td>
<td>1,728</td>
<td>1,427</td>
<td>-17.4%</td>
<td>-300</td>
</tr>
<tr>
<td>KidzFirst Surg OP FSAs</td>
<td>2,911</td>
<td>3,739</td>
<td>28.4% (particular growth in ORL)</td>
<td>830</td>
</tr>
<tr>
<td>KidzFirst Surg OP FUS</td>
<td>8,599</td>
<td>9,472</td>
<td>10.2%</td>
<td>870</td>
</tr>
</tbody>
</table>
Where are we now ...

INNOVATION – Localities & Improvement

Very High Risk (0.5%)
- acutely unwell people needing comprehensive assessment and care

High Risk (5%)
- needing integrated health and social care

Moderate Risk (20%)
- benefit from support for self-care
- benefit from information, advice, support, screening for lifestyle health risks

Low Risk (80%)

Some examples ... there are many more

System Integration and Redesign Approaches
- Improvement collaboratives and campaigns that have looked across the system to reduce acute demand and improve the journey for patients and whaanau.
- Locality infrastructure, service & system changes in primary care
  - A few examples ... 20,000 & Beyond, V:HIU, ARI, SMOOTH, Healthy Hearts, Better Breathing, Rapid Response and many others

Self Management Support Collaborative Community Organising Health Literacy
- .... building on the system integration and redesign programmes and campaigns
- .... working with communities to help them lead and take action in their own health
  - Aligned Healthy Literacy approaches.
Where are we now?

Integrated Locality Services

Secondary specialists provide advice to Primary Care

Hospital and Primary Care professionals working together on complex patient cases

Empowering GPs with easy access to these services, thereby improving patient access to services that they need, when they need it

Quality improvement feedback

LOCALITY CLINICAL PARTNERSHIP
Where are we now: At Risk Individuals

1. GP Enrolled Population
2. Risk stratification
3. Shared protocols & pathways
4. Care planning
5. Care delivery and coordination

- Risk stratification e-tool under development, clinical criteria agreed in the meantime
- Care pathways and agreed clinical protocols are used to inform assessment, care planning, & coordination
- All ‘at risk’ patients should have a plan that is proportionate to their clinical and social needs, risks and ability to benefit: Logged on e-shared care

Day-to-day Non-exhaustive examples:
- Whanau Support
- Community pharmacist
- Practice nurse
- Allied Health
- District nurse
- Community Mental Health
- SME Coordinator
- SMO

Case conferences to be used from time to time for very complex patients who need MDT input to their care plan
Where we are now …

Locality of patients presenting to EC (based on registered GP practice)
But there’s still a way to go...

- Reduce institutionalisation
- Reduce unplanned acute care
- Improve health and independence
- Improve patient experience
- Reduce duplication and inefficiency across services
### Top volume potentially avoidable hospitalisations (65+)

<table>
<thead>
<tr>
<th>Condition</th>
<th>2009</th>
<th>2013</th>
<th>% change 2009-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angina and chest pain (CORD)</td>
<td>888</td>
<td>905</td>
<td>2%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>583</td>
<td>822</td>
<td>41%</td>
</tr>
<tr>
<td>Myocardial infarction (heart attack)</td>
<td>666</td>
<td>569</td>
<td>-15%</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>542</td>
<td>593</td>
<td>9%</td>
</tr>
<tr>
<td>Kidney/urinary infection</td>
<td>424</td>
<td>519</td>
<td>22%</td>
</tr>
<tr>
<td>Stroke</td>
<td>392</td>
<td>469</td>
<td>20%</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>279</td>
<td>459</td>
<td>65%</td>
</tr>
<tr>
<td>Gastroenteritis/dehydration</td>
<td>334</td>
<td>434</td>
<td>30%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>270</td>
<td>387</td>
<td>43%</td>
</tr>
<tr>
<td>(ER Population – old projections)</td>
<td>44,660</td>
<td>53,480</td>
<td>20%</td>
</tr>
</tbody>
</table>

- ‘Double whammy’ – infectious + long term conditions
- Time frame for preventability varies – admission may be appropriate at the time of presentation, but prevention opportunities are often over the long term
“I wish that I had died when I had my last stroke. I don’t have any friends here in this place. I sit at the table with five others and none of them speak. Two are deaf, one just answers in monosyllables and the other sleeps all the time. I just stay in my room and watch television because there is little else that I can do when I have no friends”
“My caregiver went away for Christmas and never came back. Six months later I was sent a new carer who had been sent straight to me from her job interview with the provider; she had no skills and no training.”

“Carers are trained, by the passing of knowledge from old carers. This is a huge safety issue. There is no programme around and no training available to show how people should be cared for.”

“They do silly things like wear three pairs of gloves and say that I should be wearing nappies.”
What are we trying to achieve?
Integrated Community Healthcare:

Community based provider-arm services

Single Point Entry

HHC

NASC

Single Point Entry

ATR

Mental Health

Single Point Entry

NASC
What are we trying to achieve? A Patient Journey...

X = GP visit
Δ = After hours attendance
Δ = A&E Attendance
= District Nursing
Δ = Inpatient Admission
● = Residential Care
★ = NASC assessment
||| = Homecare
What are we trying to achieve?
Prevention & Rehabilitation
Integrated Locality Community Health Care: Four Pillars

1. ‘Community Central’
2. Short Term ‘Reablement’ Services
3. Assessment Care Planning (InterRAI)
4. Longer Term Integrated Community Care
1. ‘Community Central’

- 24/7 Access Point – build on 111
- Patients
- Hospital/Professionals
- Primary care
- Community care
- Out Of Hours/ UC
- Hub
  - Screening
  - Triage
  - Referral Monitoring/Response service
- Short Term Reablement
2. Short Term Reablement Services

Short Term Reablement and Care

Rapid response
2 hrs

Reablement /rehabilitation
Nursing & care up to 6 weeks

Assessment for longer term care

Cluster Networks

Home

Localities
3. Assessment & Care Planning (InterRAI)

- Assessment
  - Triggers for care planning
  - Care plan and goals agreed

- Case Mix
- Outcome Measurement Scales
- Quality Indicators
Clinical assessment protocols identify key issues for care planning

- Activities
- Adherence
- ADLs
- Behaviour
- Bladder
- Bowel
- Brittle support
- Cognitive
- Communication
- Dehydration
- Delirium

- Depression
- Discharge
- Drinking
- Elder abuse
- Environment
- Falls
- Feeding
- IADL
- Institutional risk
- Nutrition
- Oral

- Pain
- Physical activity
- Pressure ulcer
- Prevention
- Restraints
- Skin care
- Smoking
- Social function
- Unsettled relationship
- Vision
4. Long Term Community Care Services

Residential Contracted Services

Age Related Residential Care (42 Contracted Providers)

- Rest Home
- Dementia
- Private Hospital
- Psychogeriatric

Residential Respite

- 35 Contracted Providers
  - 10 Eastern Providers
  - 5 Franklin Providers
  - 16 Manukau Providers
  - 4 Mangere/Otara Providers

- 6 Contracted Providers
  - 1 Eastern Provider
  - 3 Franklin Providers
  - 1 Manukau Provider
  - 1 Mangere/Otara Providers

- 24 Contracted Providers
  - 7 Eastern Providers
  - 3 Franklin Providers
  - 11 Manukau Providers
  - 3 Mangere/Otara Providers

- 1 Contracted Provider
  - 0 Eastern providers
  - 0 Franklin Providers
  - 1 Manukau Provider
  - 0 Mangere/Otara Providers

- Four beds fully funded 365 days
- Adhoc respite provided in vacant beds

Carer Support is a flexible support service which allows the client and full-time carer are able to choose and co-ordinate their relief care

Home Based Support Services

- 2 High, 7 Low Contracted Providers
- Total of 7 contracted providers

Community Activity (Day Care)

- 7 Contracted Providers

Day Activity Programme

- 4 Contracted Providers

Information and Advisory

- 3 Contracted Providers incl:
  - TOKK
  - Alzheimer's CM
  - Age Concern CM
Longer Term ‘Care at Home’ based on case mix

- Following reablement, where people are assessed as needing longer term care at home, a package is purchased based on case mix.
- Package of care depends on category of a person’s need ranging from basic home care to integrated health and long term rehabilitation.
- Clinical support and case coordination/management by locality teams.
- Allows for outcome based payment linked to quality indicators and individual’s goals.

Quality Indicators allow for assessment of service performance, linked to outcomes based payment:

<table>
<thead>
<tr>
<th>Inadequate meals</th>
<th>Negative mood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight loss</td>
<td>Inadequate pain control</td>
</tr>
<tr>
<td>Dehydration</td>
<td>Neglect or abuse</td>
</tr>
<tr>
<td>No medication review</td>
<td>Any injuries</td>
</tr>
<tr>
<td>Difficulty with mobility &amp; no aids</td>
<td>No flu vaccination</td>
</tr>
<tr>
<td>Rehab potential &amp; no treatment</td>
<td>Hospitalization</td>
</tr>
<tr>
<td>Falls</td>
<td>Incontinence</td>
</tr>
<tr>
<td>Social isolation with distress</td>
<td>Skin ulcers</td>
</tr>
<tr>
<td>Delirium</td>
<td>Cognitive function</td>
</tr>
<tr>
<td></td>
<td>Difficulty in communication</td>
</tr>
</tbody>
</table>
Randomised Controlled Trials / Evaluations:

- Reduction in institutionalisation (33%)
- Reduction in mortality (28%), increased independence
- Reduction in acute admissions & LoS
- Place of death, more people dying at home
- No increase in carer stress
- Lower overall system costs


5. Parsons J, & Parsons, M. Evaluation of the impact of implementation of a focused goal facilitation tool for older people receiving homecare. Health & Social Care in the Community. in press.

Integrated Locality Services Development Timeline

- Papakura HHT re-design finalised: May ’14
- NASC staff / function transferred to Home Health Teams: July ‘14
- NASC – HHT SPE merged: March ‘15
- Rapid Response & Re-ablement capability in place; Re-tender of homecare: May ‘15
- Basic Community Central capability; phased implementation across teams starts: June ’15 onwards
27 WORKSHOP PARTICIPANTS

Name | Position
--- | ---
Allan Moffitt | Clinical Director, East Health and Alliance Health Plus
Benedict Hefford | Director, Primary Health & Community Services
Beven Telfer | GP Liaison - MMH
Brad Healey | GM, Medicine
Campbell Brebner | Chief Medical Advisor – Primary Health - MMH
Denis Lee | GP Pakuranga Medical Centre and Chair of East Health Trust
Dot McKeen | Manager, Middlemore Central
Geraint Martin | CEO
Gillian Cossey | GM Surgical & Ambulatory Care
Jenni Coles | Director, Hospital Services
John Baird | Facilitator
Linda Bryant | GM Eastern
Lisa Gestro | GM Primary Care & Service Dev.
Lynda Irvine | GM Manakau Locality
Martin Chadwick | Director, Allied Health - MMH
Denise Kivell | Director of Nursing – MMH
Karyn Sangster | Acting Nurse Leader, Primary Health
Paulina Baird | Facilitator
Peter Didsbury | Chair, Procare Networks
Peter Gow | Clinical Director - MMH
Peter Watson | Clinical Director – Mental Health - MMH
Harry Rea | Consultant – MMH and Professor of Integrated Care
Simon Bowen | GM Otara/Mangare
Tim Hou | GP – Mangere Health Centre
Willem Landman | Palliative Care Physician - MMH
I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone.

Hippocrates (460-377 BC)
Safety in Practice

YOU ARE HERE...BUT WHY?
Why S.i.P

Open
For Better Care
Hāpai ake te toiora

First do No Harm
www.firstdonoharm.org.nz

Aiming for Zero Patient Harm
S.i.P Objectives

**Enhance** quality improvement capability of General Practices within the Northern region, by focusing on patient safety.

**Augment** General Practice capability in quality and patient safety improvement methods and processes.

**Prevent** and/or reduce harm for patients through safer and better management of medications.

**Improve** and develop General Practice systems and processes, to ensure critical high risk processes are carried out safely and reliably.

**Promote** a culture of safety within General Practice working environments.
S.i.P Ingredients

- Safety champions
  - Safety audits (3 focus areas)
  - Trigger Tool
  - Safety climate survey
  - PDSAs
- PHO facilitators
- Improvement advisors
- Clinical Lead
- Learning Sets
Warfarin Management

- Is there evidence that the last advice on Warfarin dosing given to patient followed current local guidelines or used computer assisted decision making?

- Is the target INR and duration of treatment clearly documented in the notes?

- Since the last blood test, has the patient been taking the correct dose as ordered by the treating GP?

- Has the INR been taken within 7 days of the planned date?

- Is it recorded that the patient has received education about warfarin in the last 12 months?

- Overall Compliance
Practice experience

• Clinical staff positive, can see the value of what is trying to be implemented...
  ...Pukekohe Family Health Care

• Patient feedback has been very positive so far...
  ...Manukau City Accident and Medical

• Improved patients outcomes/compliance...
  ...Bader Drive Healthcare

• Patient Safety processes part of clinical meetings...
  ...Papakura Marae Health Clinic

• One patient has been involved in the changes...
  ...Waiuku Health Centre
Next moves

- Improve audits & TT
- Test Safety Climate Survey
- Evaluation
- Phase 2
  - Commence June 15
  - 50-70 practices
- ? National roll out
- Can the same methodology support IPIF?
Thank you

... and remember ...

Safety won’t happen by accident!

Website

## 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:

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Minutes of the CPHAC Meeting with public excluded 17 December 2014</td>
<td>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.</td>
<td>Confirmation of Minutes For the reasons given in the previous meeting.</td>
</tr>
<tr>
<td>6.2 Mana Kidz Evaluation ELT Paper 16.12.2014</td>
<td>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.</td>
<td>Commercial Activities The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.</td>
</tr>
<tr>
<td>6.3 Mana Kidz Evaluation Report</td>
<td>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.</td>
<td>Commercial Activities The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.</td>
</tr>
</tbody>
</table>