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

Wednesday, 4 March 2015 at 1.30pm – 4.30pm, Manukau Boardroom, Lambie Drive

Time	Item			Page No
1.30pm – 1.35pm	**1.0**	**Welcome**		
1.35pm – 1.45pm	**2.0**	**Governance**		
		2.1	Attendance & Apologies	2
		2.2	Disclosure of Interests/Specific Interest	3-5
		2.3	Acronyms	6
		2.4	Confirmation of Public Minutes (21 January 2015)	7-11
		2.5	Action Items Register	12-13
	3.0	**Presentation**		
1.45pm – 2.15pm		3.1	Healthy Families Initiative – Mr Alan Wilson & Ms Rachel Enosa-Saseve, Alliance Health+	-
2.15pm – 2.30pm		3.2	Vision & Values Refresh Strategy – Margie Apa & Marianne Scott	-
2.30pm – 2.45pm	**4.0**	**Director of Primary Health & Community Services Report** – Mr Benedict Hefford		
		Glossary/Contents / Executive Summary		14-15
		4.1	Actions from previous CPHAC meeting/s	16-17
2.45pm – 2.55pm		4.2	National Health Targets – Louise McCarthy	18-22
2.55pm – 3.05pm		4.3	Primary Health – Louise McCarthy	23-24
3.05pm –3.15pm		4.4	Child Youth & Maternity – Carmel Ellis	25-31
		4.5	Mental Health & Addictions	32-35
		4.6	Adult Rehabilitation & Health of Older People	36-41
		4.7	Intersectoral Initiatives	42-43
		4.8	Progress with Systems Integration	44-46
3.15pm – 3.25pm		4.9	Locality Reports – Lynda Irvine	47-54
		4.10	Financial Report	55-56
	5.0	**For Information**		
		5.1	Stoptober Smokefree Campaign Evaluation	57-60
		5.2	Integrated Mental Health & Addictions Leadership Group Expression of Interest	61-68
		5.3	Establishing a Whaanau Ora Model of Care for CMH	69-100
		5.4	The Kings Fund – Population Health Systems	101-140
	6.0	**Resolution to Exclude the Public**		141
	7.0	**Confidential Items**		
3.25pm - 3.30pm		7.1	Confirmation of Confidential Minutes (21 January 2015)	142-147
3.30pm – 3.45pm		7.2	Annual Planning Update/2015-16 First Draft Annual Plan/First Draft Maaori Health Plan	148- 268
3.45pm – 4.00pm		7.3	Otahuhu Boundary Change – Dr Doone Winnard	269 - 277

Next Meeting: Wednesday 15 April 2015, Lambie Drive

BOARD MEMBER ATTENDANCE SCHEDULE 2015 – CPHAC

Name	21 Jan	Feb	4 Mar	15 Apr	27 May	June	8 July	19 Aug	30 Sept	Oct	11 Nov	16 Dec
Lee Mathias (Board Chair)	✓	No Meeting				No Meeting				No Meeting		
Colleen Brown	✓											
Sandra Alofivae (CPHAC Chair)	✓											
David Collings	✓											
George Ngatai	X											
Dianne Glenn	✓											
Reece Autagavaia	✓											
Mr Sefita Hao'uli	✓											
Ms Wendy Bremner	X											
Mr Ezekiel Robson	✓											

COUNTIES MANUKAU HEALTH

BOARD MEMBERS' DISCLOSURE OF INTERESTS 4 March 2015

Member	Disclosure of Interest
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

Colleen Brown	• Chair Parent and Family Resource Centre Board (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
George Ngatai	• Arthritis NZ – Kaiwhakahaere • Chair Safer Aotearoa Family Violence Prevention Network • Director Transitioning Out Aotearoa • Director BDO Marketing • Board Member, Manurewa Marae
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
Sefita Hao'uli	• Trustee Te Papapa Pre-school Trust Board • Member Tonga Business Association & Tonga Business Council • Member ASH Board Advisory roles: • Toko Suicide Prevention Project (Ministry of Health) • Tala Pasifika (NZ Heart Foundation Pacific Tobacco Control) • Member Pacific Advisory Board, Auckland Council Consultant: • Government of Tonga: Manage RSE scheme in NZ • NZ Translation Centre: Translates government and health provider documents.
Ezekiel Robson	• Department of Internal Affairs Community Organisation Grants Scheme Papakura/Franklin Local Distribution Committee • Be.Institute/Be.Accessible 'Be.Leadership 2011' Alumni
Wendy Bremner	• CEO Age Concern Counties Manukau Inc • Member of Auckland Social Policy Forum • Member of Health Promotion Advisory Group (7 Age Concerns funded by MOH)

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 4 March 2015

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 or decisions.
Mr Sefita Hao'uli	Rheumatic Fever national campaign	Mr Hao'uli is currently undertaking some work with the Ministry of Health on the Pacific campaign on Rheumatic Fever.	Updated 21 January 2015	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 or decisions.
Mr Geraint Martin	Renewal of the Regional After Hours Agreement	Mr Martin's wife is the Executive Director of Takanini Care Medical Services Limited Partnership. The company comprises 2 A&M clinics and 2 general practices at the same location.	21 May 2014 and 20 August 2014	That Mr Martin's specific interest is noted and the Committee agree that he may participate in the deliberations of the Committee in relation to this matter because he is able to assist the Committee with relevant information, but is not permitted to participate in any decision making.
Ms Colleen Brown	Richmond NZ Trust Ltd	Ms Colleen Brown has been involved with the family involved with this Trust.	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 he is able to assist the Committee with relevant information, but is not permitted to participate in any decision making.

Glossary

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

Minutes of the meeting of the Counties Manukau District Health Board

Community & Public Health Advisory Committee
Wednesday 21 January 2015

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 Colleen Brown
Ms Dianne Glenn
Mr Apulu Reece Autagavaia
Mr Ezekiel Robson
Mr Sefita Hao'uli

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 Kathy Maxwell, CMDHB Board member
Mr John Wong, Asian Family Services & Problem Gambling Foundation
Ms Linda Irvine, GM Manukau Localities
Ms Claire Garbutt, Transformation Manager, Integrated Care
Ms Rebecca Stevenson, Business Manager, Primary Health & Community Services
Ms Carol Slade, Service Manager, ARHoP

APOLOGIES: Apologies were received and accepted from Ms Wendy Bremner and Mr George Ngatai.

WELCOME Apulu Reece Autagavaia opened the meeting with a prayer.

2.2 DISCLOSURE OF INTERESTS

There were no additions or amendments to the Disclosures of Interest.

2.2 SPECIFIC INTERESTS

The Committee noted that Mr Sefita Hao'uli's interest in the Rheumatic Fever national campaign remains ongoing.

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 17 December 2014.

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

That the public minutes of the Counties Manukau Health Community & Public Health Advisory Committee meeting held on 17 December be approved with the following amendments:

Page 10 Clause 4.2 – add action point onto Action Item Register.

Page 10 Clause 4.3 – change "we don't know if Strep throats cause RF".to "we don't know why some Strep throats cause RF".

Page 10 Clause 4.4 Mental Health – add two action points onto Action Item Register.

Carried

2.5 ACTION ITEMS REGISTER

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

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

Carried

3. PRESENTATION

3.1 Integrating Locality Community Services

Mr Benedict Hefford took the Committee through his presentation. A copy of the presentation is available on the CMH website.

(Mr Ezekiel Robson arrived 1.46pm)

Mr Hefford took some time to walk the Committee through the integrated services model.

On one level this is about creating a multi-disciplinary team approach within localities based around clusters of general practice and getting that up and working but it is also about changing the way we respond to patient/client need so we are intervening early, enhancing prevention, enhancing rehabilitation and we are keeping people independent and healthy.

A business case will be formulated which consolidates a lot of the pilots and smaller scale changes that have been made and consolidate them into what it might look like if we scale up and reorientate the system, what the savings are, what the costs are and how the work flows.

Mr Hefford confirmed that there will be baseline measures set out in the business case to report against that will assist to evaluate the success of this model. It is also not about evaluating after

two year's time and deciding to turn it off, it's more about collecting information as we go and making shifts and changes to the model, more of a continuous improvement to the model.

In response to a question from Ms Kathy Maxwell in regards to the strategy to integrate primary and secondary (ie) doctors, to make them understand and believe that each half can deliver suitable care, Ms Garbutt advised that it is all about the cluster approach of GP practices that is being introduced at the moment and building relationships. General practice is also clearly pointing out to us the skill set that they need that they don't have and pushing us in terms of timeframe, particularly around mental health community workers. The other approach being looked at is around developing a strong change management package around organisational development and training around ways of working together as a team, leadership and change management. Two other key enablers are care pathways and systems.

Mr Sefita Hao'uli asked if we are looking to train staff to prepare for the next stage. Mr Hefford advised that work is currently underway with Ko Awatea to get a programme to up-skill and support the capability over time of our workforce. This is absolutely crucial to have the hearts and minds of the workforce.

Resolution

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

- Note progress made with integrating community health services in localities; and
- Note that a business case will be submitted to CMH Board in March 2015 to progress the proposed programme of work.

Carried

4. PRESENTATION

4.1 Safety in Practice Update

Dr Campbell Brebner took the Committee through his presentation. A copy of the presentation is available on the CMH website.

Why Safety in Practice – it was becoming increasing apparently that equally as much harm occurs in the primary care setting as in the hospital setting. Thankfully most are minor but it is thought that 70% of incidents could be preventable therefore there was good justification to look at improving safety in primary care.

The Safety in Practice collaborative objectives are to:

- **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; and
- **Promote** a culture of safety within General Practice working environments.

There are 23 practices currently enrolled in the programme. They have been asked to identify a safety champion and the programme has developed three focus areas (management of warfarin, medication reconciliation and results handling). The practices are also being asked to perform a trigger tool audit (audit clinical notes and look for triggers that might indicate that harm has occurred) and undertake a safety climate survey of practice staff. All this activity is being supported with facilitators from the PHOs and a clinical lead from within CMDHB. All the practices come together once a quarter to share their learning's.

Where to from here, next steps are to:

- Improve audits & the trigger tool audits
- Test the safety climate surveys
- Evaluate
- Phase 2 to commence June 2015; 50-70 practices
- ? National roll out
- Can the same methodology support IPIF?

In response to a question from Dr Mathias on how many more practices we could get on board, Dr Brebner advised he thought that another 50-70 practices is possible but it would depend on the PHOs providing dedicated PHO facilitator time. They have been hesitant to commit that to the programme at the moment.

5.0 RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved Ms Dianne Glenn/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:

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 the CPHAC Meeting with public excluded 17.12.2014	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.
6.2 Mana Kidz Evaluation ELT Paper 16.12.2014	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	**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

	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)]	activities. [Official Information Act 1982 S9(2)(i)]
6.3 Mana Kidz Evaluation Report	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)]	**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. [Official Information Act 1982 S9(2)(i)]

Carried

3.25pm Public excluded session.

3.37pm Open meeting resumed.

The meeting concluded at 3.38pm.

The minutes of the Counties Manukau Community & Public Health Advisory Committee meeting held 21 January 2015 be approved.

(Moved /Seconded)

Chair _____ _____

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 Register – 4 March 2015

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
26.2.2014	4.0	Update from Auckland Regional Public Health Service every 6 months on current issues.	~~March~~/April	Mr Hefford		
20.8.2014	3.1	Follow-up presentation on the St John's 111 Clinical Hub	~~March~~/May	Mr Hefford	Postponed to May when a clinical audit of the trial will be available.	
20.8.2014	4.0	Healthy Families Initiative presentation from the collective	March	Mr Hefford	On this month's agenda.	✓
22.10.14	4.0	Director's Report –The Committee would like to hear from some of the staff/people out in the community at the cutting end of change who are actually doing the work (ie) 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 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.	May & ongoing	Mr Hefford/Ms Sangster		
22.10.14	4.2	Smokefree 2025 strategy. Stoptober campaign update.	 March	 Mr Hefford	This strategy was presented to CPHAC on 26 March 2014. On this month's agenda.	 ✓
26.11.2014	4.0	Rheumatic Fever – Ms Ellis to provide some data on the practices that are part of this programme.	March	Mr Hefford/Ms Ellis	In Director's report this month.	✓
26.11.2014	5.0	Mr Nia Nia to provide an update on the Te Kaahui Ora service review. NHC integrated service agreement work.	March ~~March~~/April	Mr Hefford/Ms Apa	On this month's agenda.	✓
17.12.2014	3.1	Immunisation – Is there a group of older vulnerable people who would benefit from immunisation for Shingles & Whooping Cough (Varicella & Boostrix). Are Pharmacists & LMCs able to claim under s88 as well as GPs.	March March	Mr Hefford/Ms Sangster Mr Hefford	In Director's report this month. In Director's report this month.	✓ ✓

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 ✓
17.12.2014	4.2	Primary Care –Ms Apa to see is she can assist in getting access to the national database on cervical screening.	March	Ms Apa	In Director's report this month.	✓
17.12.2014	4.4	Mental Health – Copy of the Leadership Group Terms of Reference for the integrated mental health services. Expressions of Interest for the Leadership Group to be provided to CPHAC when available.	March March	Mr Hefford/Ms Ahern Mr Hefford/Ms Ahern	On this month's agenda. On this month's agenda.	✓ ✓
17.12.2014	5.1	Pacific Health Development – report back on Pacific Workforce development in relation to students not passing their examinations.	Date TBC	Ms Powell		
17.12.2014		Vulnerable Adults - what are our current practices and policies for vulnerable adults to ensure our services respond appropriately.	March	Mr Hefford	In Director's report this month.	✓

Counties Manukau District Health Board
Director Primary Health & Community Services 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: Benedict Hefford, Director Primary Health & Community Services

Glossary of Terms

Acronyms	Description
A&D / AOD	Alcohol and Drug
ACP	Advanced Care Plan
AH+	Alliance Health Plus
ARDS	Auckland Regional Dental Service
ARI	At Risk Individuals
ARPHS	Auckland Regional Public Health Service
ARRC	Aged Related Residential Care
AT&R	Assessment, Treatment and Rehabilitation
AWHHI	Auckland Wide Healthy Housing Initiative
B4SC	Before School Checks
CCM	Chronic Care Management
COPD	Chronic Obstructive Pulmonary Disease
CSW	Community Support Worker
DHS	Director Hospital Services
DNA	Did Not Attend
EOI	Expression of Interest
GAS+	Group A Streptococcal Positive
GP	General Practitioner
hA	healthAlliance
HBSS	Home Based Support Services
HBT	Home Based Community Team
HHC	Home Health Care
HOP	Health of Older People
IDF	Inter District Flows
IFHC	Integrated Family Health Centre
IPIF	Integrated Performance & Incentives Framework
LTCF	Long Term Conditions Facilities
MOH	Ministry of Health
NGO	Non-government organisation
PHN	Public Health Nurse
POAC	Primary Options to Acute Care
PRIMHD	Project for the integration of mental health data
PSAAP	Primary Services Agreement Amendment Protocol
SUDI	Sudden Unexplained Death of Infant
VHIU	Very High Intensive User
VLCA	Very Low Cost Access

Contents

1.	**Actions from Previous CPHAC Meetings**
2.	**National Health and IPIF Targets**
3.	**Primary Health**
4.	**Child, Youth and Maternity**
5.	**Mental Health and Addictions**
6.	**Adult Rehabilitation & Health of Older People**
7.	**Intersectoral Initiatives**
8.	**Progress with Systems Integration**
9.	**Locality Reports**
10.	**Financial Report**

Summary

- Although we remain largely on track for delivery of all National Health Targets, the new IPIF target for cervical screening will be a challenge to meet in 2014/15. Our current performance is 71.5% against a target of 80%. Additional free smears have been funded by CMH and the National Screening Unit (MoH) to ensure our high needs women can access free smears. There are also regional, national, and district level actions being taken to improve performance, including agreement by the National Screening Unit to supply monthly data updates to PHOs and practices so they can identify unscreened and under-screened women.

- A review of PHO delivery against their core requirements has commenced, with all PHOs now completing self-assessments against the 'PHO Minimum Requirements'. Peer review panels will give independent feedback to the PHOs, and there will then be a national moderation process.

- A range of initiatives are underway to improve outcomes for mothers and babies, including:
    - 200 pepi-pods are being distributed along with safe sleep workshops and online training for clinical and support workers
    - Workbase Education Trust have been contracted to deliver training initiatives to improve infant nutrition support, particularly breastfeeding
    - Manakidz continues to reach very large numbers of children at risk of rheumatic fever – data on the rapid response clinics and patient numbers is included in this report as requested
    - we are making steady progress with improved access to oral health services for children and adolescents.

- New initiatives are underway in mental health in the areas of home, school, and maternity based care. The outcomes from this activity are informing a broader work programme for integration of mental health and addiction services with 'physical' healthcare.

- The At Risk Individuals programme now has over 4,000 enrolled patients, and an additional 2,000 patients have e-shared care plans through input from specialist services such as the Spinal, Memory Geriatric and Respiratory teams. The Community Health Integration programme continues to be a key focus for the coming months, particularly in terms of pulling together the final service model and supporting business case. The aim is to have some tangible additional capability in place by July to help address winter demand pressures on the hospital and primary care.

1. Actions from Previous CPHAC Meetings

Action/Description:

Are Pharmacists & LMCs able to claim under s88 as well as GPs (17.12.2014 CPHAC meeting):
Pharmacists cannot currently claim under s88 and all vaccinations through pharmacies are currently self-funded. It is possible to add funding of vaccinations to the pharmacy contract as a schedule, or create a separate contract. This is a possibility we will discuss with PHOs as part of winter demand preparations.

LMC's cannot claim under s88 and administering vaccinations is not currently a routine part of their practice. The potential role of midwifes in improving immunisation rates will be considered through the Maternity Review and 1st 2,000 Days projects.

What are our current practices and policies for vulnerable adults to ensure our services respond appropriately (17.12.2014 CPHAC meeting):
There are policies, procedures and guidelines in place to assist staff in the identification and on-going support of vulnerable adults to ensure our services respond appropriately. In addition to this there are assessment tools, staff training related to supporting vulnerable people, and information pamphlets to assist staff with communication of relevant information.

A comprehensive initial assessment should identify a vulnerable adult patient, for example because of a significant physical or intellectual disability. The policies, procedures and guidelines then provide a systematic approach for staff to ensure services are tailored to respond to individual needs.

Guidelines and Policies and Procedures:
- Family Violence Elder Adult Abuse and Neglect Intervention – *Policy*
- Family Violence Intervention – *Procedure*
- The Management of Acute Behavioural Disturbance in Adults in Inpatient Mental Health Services – *Guideline*
- Risk Assessment and Management - *Policy*
- Police Involvement – *Policy & Procedure*
- Professional and Cultural Supervision Guide for Practice – *Guideline*
- Research – *Policy*
- Safe Sleep Inpatient and Community – *Guideline*
- Social Work Alert - *Policy*
- Enduring Power of Attorney and Welfare Guardians

Risk Assessment and Management Tools:
- InteRAI tool (over 65)
- Needs Assessment Service Coordination (over 65)
- Vulnerable from harm form
- Risk from others including abuse and exploitation
- Vulnerability and 'Other Risk' – MHS for Older People

- Protection Issues, Culture and 'Other' – Whirinaki Services
- HoNOS *(Health of the Nation Outcome Scale)*
- HEeADSSS Assessment *(Home, Education/employment, eating, activities, drugs & alcohol, sexuality, suicide & depression, safety - Assessment tool for Adolescents)*

Training Related to Supporting Vulnerable People

- Acute Behavioural Guidelines
- Anxiety and Depression
- CALD Training Programme
- Child Protection Training (Whirinaki CMHS)
- Discrimination – Barriers to Recovery
- HEeADSSS Assessement
- HoNOS
- MH Act Training
- Pacific Cultural Competencies
- Patient Safety Training
- Risk Training
- Suicide and AOD
- The Safe Practice & Effective Communication
- Toolkit/CD for Assessment & Management of Risk to Others
- Trauma Informed Care & AOD
- Violence Intervention Programme

2. National Health & IPIF Targets

INDICATOR TABLE

Target	14/15 Target	13/14 Q4	14/15 Q1	14/15 Q2	On Track
More Heart and Diabetes Checks	90.0%	91.3%	91.1%	**91.3%**	**Yes**
Better Help for Smokers to Quit	90.0%	98.9%	98.0%	**95.5%**	**Yes**
Increased immunisations - 8 months	95.0%	92.0%	95.0%	**94.0%**	**Yes**
Increased immunisations - 24 months	95.0%	93.6%	96.0%	**96.0%**	**Yes**
Cervical screening coverage	80.0%	74.8%	74.0%	**71.5%(NSU)**	**Improvement required**

Table One: IPIF results to December 2014

PROGRESS

Performance against the IPIF targets (including National Health Targets) to December 2014 indicates that CM Health is strongly positioned to achieve the targets for More Heart and Diabetes Checks, Smoking, and 8 and 12 months immunisations by June 2015. Improvement is required to reach 80% coverage for cervical screening. PHOs and the DHB are currently implementing a number of activities in support of this target. These are further outlined in the cervical screening progress section of this report.

More Heart and Diabetes Checks

PHO	December PHO results – total population
ProCare	91.7%
East Health	91.1%
Alliance Health+	90.4%
NHC	89.6%
Total Healthcare	89.0%
CMDHB	91.3%
National average (MoH data)	86.4%

Table Two: Number of heart and diabetes checks, Dec 2014, by PHO

- The result for December 2014 is 91.3% for CMH Total Population (Table Three)
- PHOs have also received additional funding to maintain and increase the skills of practice nurses in phlebotomy which assists the collection of blood results for CVDRA (HBA1c and Lipids).
- Continuing Medical Education (CME) sessions for primary care clinicians on CVDRA are planned for the IPIF targets with a full session booked in March which will cover all IPIF measures.
- Cell group education sessions are held for all PHOs. Benchmarking of performance is used as a learning opportunity for practices by PHOs.

- The CMH monthly IPIF meetings include a focus on the National CVDRA target, where PHOs share issues and learning to assist each other to achieve the targets
- PHOs continue to use practice advisors to assist practice staff to use the decision support tools and to collect data for CVDRA
- Non face-to- face assessments are conducted with the assistance of test safe data
- Initiatives including after-hours clinics, nurse led clinics, weekend clinics and provision of transport for high needs patients are being offered by general practices
- Improved data collection with systems enhancements such as "Dr Info" – one click and appointment scanner functions, queries and recall systems enable more accurate reporting of data and identification of patients who are overdue for an assessment
- CMH has two clinical champions who assist PHOs and practices with all IPIF targets
- Exploration of the possibility of offering CVDRA through pharmacies has begun. This would involve the use of Point of Care (POC) testing.

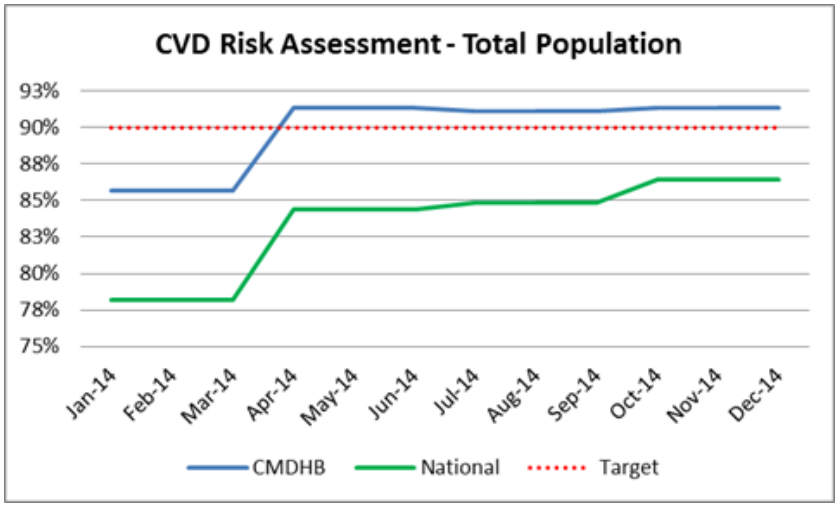


Table Three: Counties CVD risk assessment vs national data to Dec 2014

Better Help For Smokers To Quit

- CMH continues to exceed the target for brief advice for smokers at 95.5% (MOH adjusted figures), against a target of 90%.
- The focus for smokefree targets in the 2014/15 year is on cessation support, in particular local cessation support services tailored to the CMH population
- A paper is to be submitted to the Metro Auckland Clinical Governance Group proposing that the cessation target is 50% across the region. A replacement for the Primary Care smoking coordinator position is being currently advertised
- PHOs have received additional funding to assist them with call centre functions
- PHOs have agreed to supply adjusted monthly smoking data to the DHB from Feb 2015
- Face to face consultations and group cessation sessions are being offered to patients through general practice and PHO support services

- Practice facilitators and PHO Smokefree Target Champions spend time at low performing practices and encourage these practices to implement quality processes that will ensure sustainable activity towards the 90% target.

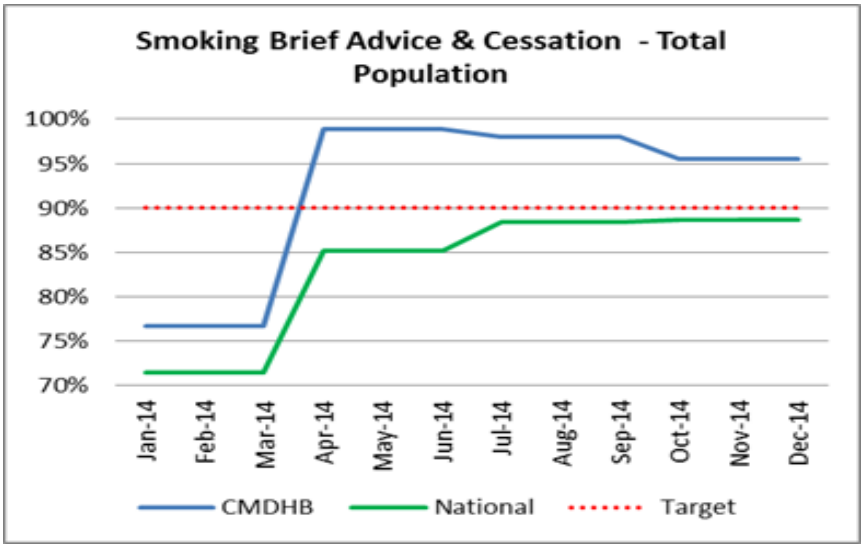


Table Five: CMH Smoking Cessation vs. National data to Dec 2014

Childhood Immunisation

The 8-month immunisation target for the period ending December 2014 requires 95% of all eligible children eight months of age to have completed their scheduled course of immunisation.

After maintaining an overall coverage of 95% for the October and November 2014, the three month period ending 31 January 2015, coverage rate for CM Health for all 8-month old babies suffered a setback and is at 94%, a drop of 1% compared with November 2014. The coverage for Maaori babies is at 90%. Coverage for Pacific babies at eight months of age dropped by 1% to 97%. The festivities of the holiday period and the movement of our children during this time has historically seen a drop in coverage over the December to January months.

The Immunisation Nurse Leader is working with PHOs to improve the timeliness of immunisation by continually improving the coverage at six months of age and our Outreach Immunisation Service plans to catch up with 10 week old babies who are overdue for their six week immunisation.

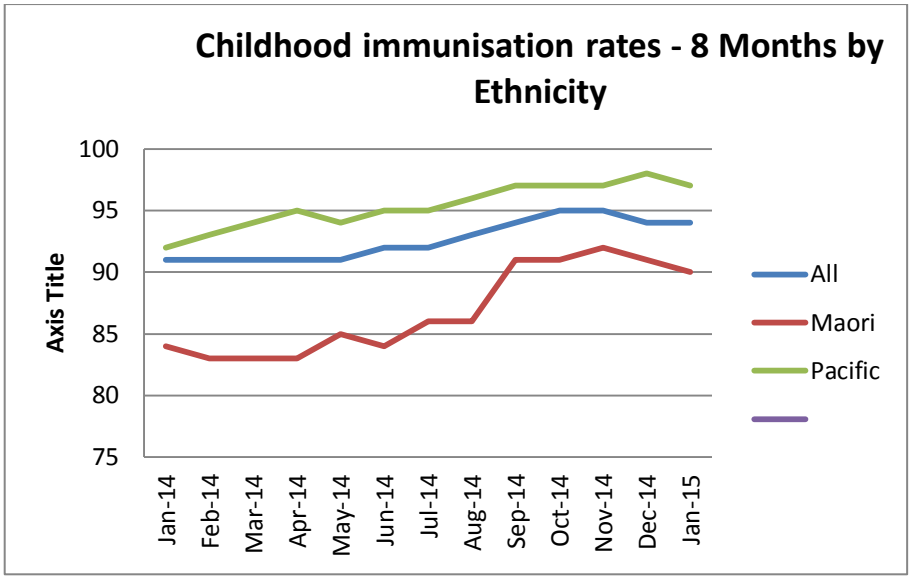


Table Six: CM Health 8 month immunisation to January 2015

The 24 month immunisation rate has been maintained above target at 96%.

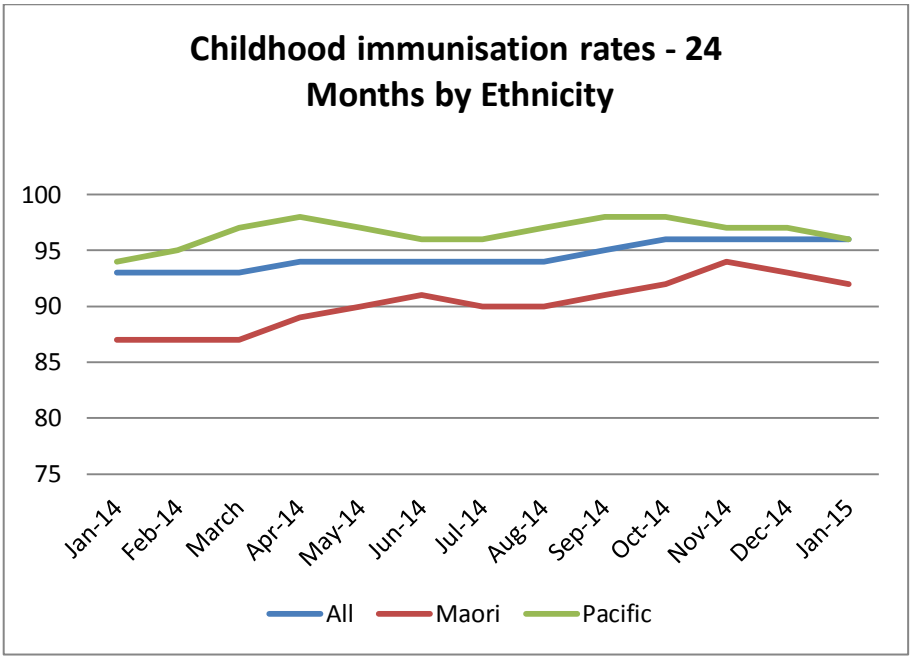


Table Seven: CM Health 24 month immunisation to January 2015

Cervical Screening

	Total 3 year coverage	Maori	Pacific	Asian	European/Other
CMDHB	**71.5%**	**62.0%**	**73.2%**	**61.3%**	**80.3%**
National	**76.5%**	**62.5%**	**72.6%**	**62.2%**	**82.5%**

Table Eight: National Cervical Screening Programme results – women aged 25-69 years– CMDHB/National Dec 2014

Progress

- The cervical screening target for 2014-15 is 80% coverage.
- Additional volumes for free smears for high needs women have been agreed to by the MoH for the CMH district. CMDHB has also agreed to commit additional funds for free smears for priority women. This means more of our high needs women can access free smears.
- The NSU have agreed to increase capacity in the National Cervical Screening Programme Register agreement which means all PHOs can now access six monthly data matches and monthly updates from the NSU to assist them to identify unscreened and underscreened women.
- The Metro Auckland Cervical Screening Operations group is working on improved referral processes to assist all Independent Service Providers (ISPs), DHBs and PHOs to work together to target hard to reach women. The group is also working with PHOs and ISPs to organise workshops to improve the health literacy and communication skills of staff who have a role in contacting / engaging women to complete cervical smears

- The PHO and DHB partners at the CMH IPIF meeting are currently focusing on the following activities to improve cervical screening coverage:
  - Supporting PHOs to enrol nurses in smear taker training
  - Supporting PHOs to register with the National or Regional Cervical Screening Register for data matches
  - Provision of after hours and outreach smear taking by practice nurses
  - Cervical smear clinical champions who can support practices especially the poorer performing practices
  - Implementation of the 'How To' Guide for Cervical Screening
  - Planning and development of roles and resource to support engagement of unscreened and underscreened women.

3. Primary Health

OBJECTIVE:
To deliver comprehensive in and out of hours primary health care which is 'Better, Sooner, and More Convenient'.

PROGRESS

IPIF
Phase 1 of IPIF is well underway. The current focus is on finalising the system level measures for the next year and implementation of the PHO Minimum Requirements self-assessment and peer review. PHOs are currently completing the self-assessments which are due for submission in late March 2015. The Northern Region has nominated two DHB representatives, from CM Health and Auckland / Waitemata DHBs, to participate in development of the peer review process for the assessment. Completed self-assessments will be reviewed by Peer Review Panels to give an independent view across the PHO's self-assessment. All PHOs have the opportunity to provide members for the Peer Review Panels. After the Panels have reviewed all the self-assessments, a national moderation process will take place to ensure consistency.

The peer review results will be provided to PHOs along with any feedback for business improvement or to highlight examples of good practice. There will be an opportunity for PHOs to comment and clarify any aspects of the feedback before the peer review results are finalised and shared with DHBs and the Ministry. The whole process reflects the sector's focus on collaboration and quality improvement.

Zero Fees for Under 13s
The terms and conditions for the Zero Fees for Under 13s scheme will be finalised at the PHO Services Agreement Protocol (PSAAP) meeting in February 2015. CM Health PHOs are currently carrying out modelling based on the proposed policy. Although it is voluntary for practices to opt in, it is likely that the majority of CM Health practices will adopt the scheme which is due for implementation on 1 July 2015.

Patient Portals
Implementing patient portals is one of the Government's priority eHealth initiatives. Over 35,000 New Zealanders now access their health information via a patient portal. General practitioners report that patients feel empowered by having access to their health information and to functions that allow them to book appointments or order repeat medications electronically. In general practice, portals improve workflow, free up time and reduce the administrative burden. All portals have tight security controls in place to protect the privacy and security of health information.

One-off funding has been provided by the MoH to support patient portal implementation within general practices. PHOs are required to submit high level plans to the MoH and CM Health, describing their strategies for patient portal implementation. It is expected that milestones for implementation will be met by June 2015.

Community Pharmacy Services Agreement (CPSA)
The DHBs are consulting with pharmacy to extend the current CPSA which is in its fourth phase from the 1st of July 2015. The extension will need to account for the introduction of free under 13 care and will be used to make some minor adjustments. The Sector believes that the margin pharmacy is paid to offset distribution and stock costs is in decline, and they want to see this addressed in this extension. A CPSA Pharmaceutical Margin Taskforce has been established with members from the sector, MoH, DHBs and Pharmac along with support from the Community Pharmacy Services Programme. It is hoped to see some short term options introduced for the 15/16 year with longer term solutions 16/17+. The options will be reviewed by the Community Pharmacy Services Governance Group (CPSGG), DHBs and Pharmacy.

Regional Clinical Pathways Development
Clinical Pathways provide locally agreed best practice guidance and resource information to clinicians to optimise the patient's healthcare journey for a variety of health conditions, as well as giving clear resource and investigation pathways. 52 pathways for common conditions are currently held on the HealthPoint platform.

In addition, 22 general practice sites are testing "dynamic pathways" which are embedded into the GP computer systems so that they can give guidance in real time to the clinician. Pathways being tested through this platform are: COPD, Gout, Dyspepsia, Cognitive Impairment, DVT and cellulitis, with three others soon to be added.

Regional Data Sharing
This project is about combining information from general practitioners and hospitals across Auckland to better allow research, monitoring, clinical audit, resource allocation, and service planning for healthcare system improvement. Underlying this is a need to ensure patient privacy and appropriate use of this data is maintained.

A 'Metro Auckland Data Stewardship Group' has been formed and is responsible for "protecting and being responsible for the careful and ethical management of the shared data". It is currently in the process of formulating agreed Policies and Processes to provide the right level of privacy protection whilst affording an ability to utilise data for service development. The stewardship group is currently seeking consumer representation to provide a patient privacy perspective. The project goals are:

1. Regional agreement on policies and processes
2. Establishment of a "HealthSafe Manager" to oversee the operational day to day management of data user requests.
3. Defining and coordinating the 3 existing data sets already in existence for the above purpose
4. Development of the technical requirements for receiving encrypted data sets, and the subsequent de-identification for storage.
5. Development of the tools to access and analyse the data to provide data users with the necessary tools to query the information received.

4. Child, Youth and Maternity Services

OBJECTIVE(S)

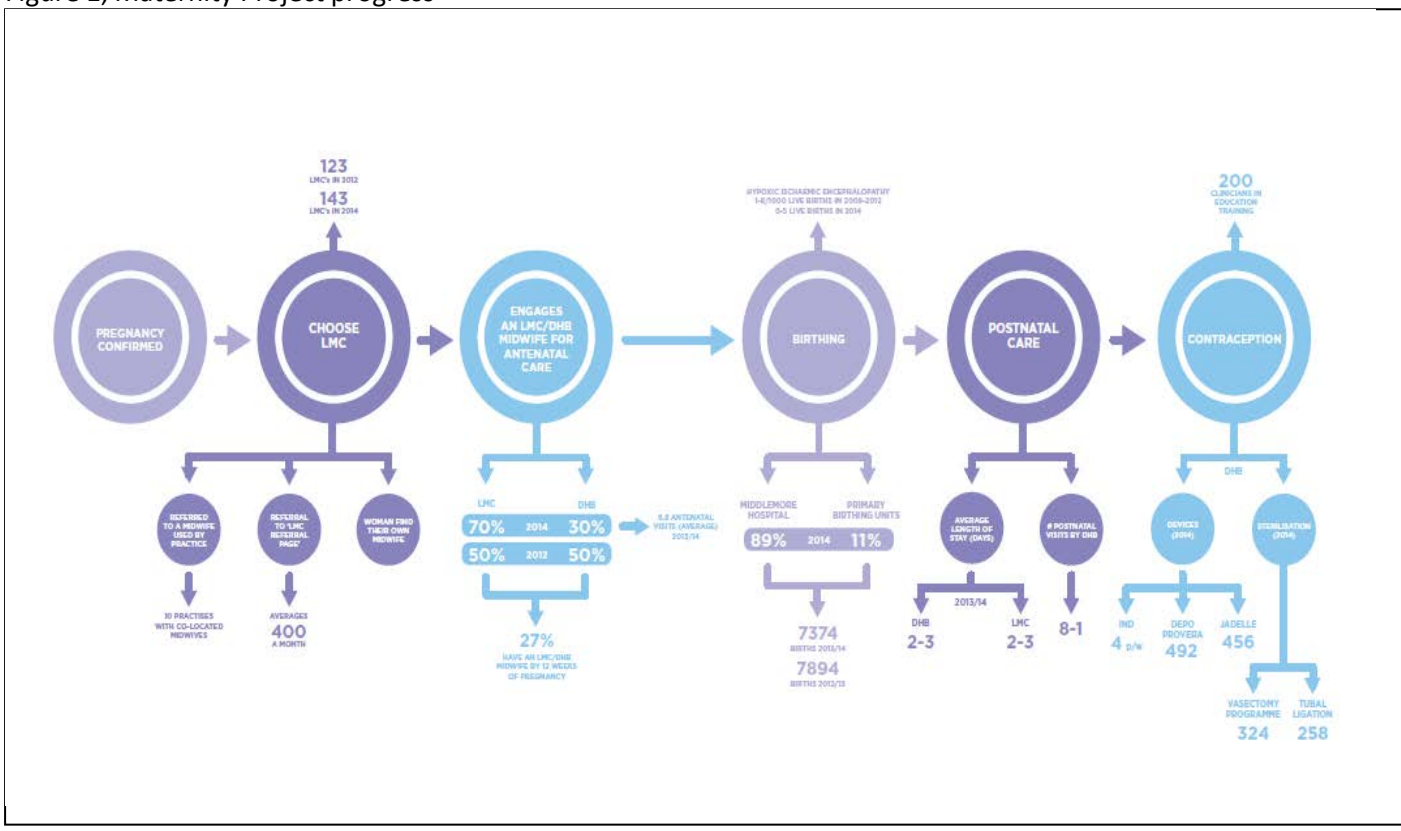
To integrate maternal and child health services; reduce perinatal mortality; improve care in the First 2,000 Days of life; intervene early to support vulnerable children; reduce Rheumatic Fever by two-thirds to 1.4 cases per 100,000; and improve youth services.

1st 2000 days - Maternity

Over past two years the Maternity Programme Board has led the implementation of the Maternity Action Plan. The action plan was developed in response to the findings of the external review of Maternity Care, led by Professor Ron Patterson in 2012.

In January, the Maternity Programme Board were invited to the CMH Board meeting to provide an update on the progress and accomplishments made over the past two years and provide detail on the transition plan as the project moves into business as usual.

Figure 1, Maternity Project progress



The CMH Board acknowledged the progress made by the project board. They requested the project remain on the Board's agenda and receive quarterly updates.

Over the next six months, the accountability for the project will be transitioned to the Director of Hospital Services and Director of Primary Care and Community Services.

1st 2000 days - Sudden Unexpected Death in Infancy (SUDI)

Safe Sleep Education

In 2014 staff education in SUDI prevention became a priority throughout CMH facilities and with our providers. CMH hosted 16 Safe Sleep workshops to facilitate engagement opportunities for all Counties staff, from within the facilities and the wider community, including NGO organisations. The education sessions were provided by Whakawhetu (National SUDI prevention for Maaori) and TAHA (Well Pacific Mother & Baby service). The training and workshops offered were made accessible to all staff working directly with pregnant women, new Mothers, Babies and their Whaanau. We had 315 enthusiastic participants during the year, including Maternity and Kidz First staff, Smokefree Teams, Fanau Ola, Social Work, Lead Maternity Carers, Tamariki Ora/Well Child services and Practice Nurses from Taonga Teen Parent service, Otara Health and Raukura Hauora.

The 2015 Safe Sleep Education plan for staff includes two online programmes, due to be released in March. Both programmes will have professional accreditation points. The Ministry of Health website will host the online 'SUDI e-Toolkit' and the Whakawhetu website will host their e-learning Safe Sleep Workshop. Whakawhetu have a SUDI Symposium planned within each region with 8th April booked for Auckland region to update on the latest evidence and progress.

Safe sleep devices

Over December and January the Safe Sleep team continued to provide Pepi-pods to babies and their whaanau. Referrals are received through the midwifery network and maternity facilities. In 2015 we plan to train more nurses and midwives as Pepi-pod distributors to enable more timely delivery of the programme for whaanau in need. A further 200 Pepi-pods have been ordered for distribution.

1st 2000 days - Improving Infant Nutrition Project

The workforce development workstream of the project is on track and progressing well. Following an RFP, Workbase Education Trust have been contracted to develop and deliver a workforce training and development initiative to maternity, child health, primary and secondary care providers in Counties Manukau to:

- Improve health providers understanding and awareness of the barriers and challenges identified in the needs assessment for the three ethnic groups regarding breastfeeding and the introduction of first foods;
- Improve the responsiveness and sensitivity of the health providers to provide non-judgemental and culturally appropriate care and information to Mothers and their whaanau/family with a focus on infant and toddler feeding and nutrition;
- Improve health providers engagement with the wider whaanau/family when discussing infant and toddler feeding and nutrition;
- Improve the consistency of key message delivered by health providers to parents and whaanau/family around breastfeeding, the introduction of first foods and other issues impacting on infant and toddler feeding and nutrition; and
- Improve health providers understanding of health literacy approaches to build their capability to discuss infant and toddler feeding and nutrition with parents and whaanau/families.
- Develop culturally appropriate key project messages using a health literacy approach that will be delivered in both work streams of the project.

Workbase are currently in a planning and engagement phase and will have completed training of 100 priority 1 workforce by Quarter 1 2015/16.

A suitable provider to develop and implement the community initiatives work stream of the project was not identified in the RFP and alternative options for the delivery of this work stream are currently being explored and a proposal will be developed by late March.

1st 2000 days - Healthy Attachment Development and Parenting Skills

The four areas under this work stream include:

- Universal screening during pregnancy and postpartum for mental health and AOD (Alcohol and Addiction) issues
- Training for Primary Care and Well Child/Tamariki Ora providers for universal screening of infants / children for mental health difficulties
- Improved coordination of the various parenting programmes in Counties Manukau
- Improved primary mental health services to address the mild to moderate mental health and AOD needs of pregnant women and mothers with infants

All four work streams are progressing well and are being well supported by all providers, including our intersectorial partners.

Before School Checks (B4SC)

Coverage as at the end of January is 15% behind target. December and January are traditionally the lowest periods for completion of B4SC's due to the statutory holidays, staff annual leave, and low attendance at Early Childhood Centres.

The Saturday clinics at Manukau Super Clinic continued up to 20 December 2014 (and remain well attended) and will recommence Saturday 14 February 2015. The Saturday clinics target low income children and incorporate Plunket Nurses and Hearing and Vision Testers.

Children's Action Plan (CAP)

The CAP Directorate held an intersectorial meeting February to provide an update on the status on the Children's Teams in South Auckland. The meeting was attended by Health, Education, Social Development, Justice and Council. The CAP Team have acknowledged the complexities in implementing a large scale site and have agreed that the enabling infrastructure and information systems will need to be 'live' prior to implementation. Therefore, the decision from the centre is to defer the implementation of the South Auckland site/s until December 2015. Waikato will be the next site to go live, with a tentative timing for their 'go live' around September 2015.

An interim South Auckland Planning Group will be established to initiate the cross sector engagement. South Auckland will work very closely with Waikato to assist with the planning of our site/s.

Mana Kidz - Rheumatic Fever Prevention Programme: Rapid Response coverage

CPHAC has requested further more detailed information about the clinics and numbers involved in this initiative People aged 4-19 who are Maaori, Pacific and/or from lower socio-economic areas have higher rates of rheumatic fever than other populations. The Ministry of Health requires CMH to provide access to rheumatic fever prevention services for this high risk population; this equates to approximately 65,424 children and young people. Free and effective sore throat management is an important tool in reducing rheumatic fever in CMH.

This high risk group live mainly in Manurewa/Papakura and Mangere/Otara but also across Franklin and Eastern localities. This is broken down as follows;

	Manurewa/Papakura	Mangere/Otara	Franklin	Eastern	Total
Total high risk population	25,171	34,855	3,722	1,676	65,424

The rapid response initiative involves the implementation of sore throat clinics in both decile 1-5 secondary schools and primary care (GP) clinics across CMH. The primary care clinics were identified based on a minimum enrolment of 600 high risk patients on their enrolment register as at 30 June 2013. Additional clinics were identified to maximise coverage across all areas and localities.
The coverage across each locality (by clinic type) is as follows;

High risk pop coverage	Manurewa/Papakura	Mangere/Otara	Franklin	Eastern[1]	Total
Primary care	13,512	12,617	3,569	-	29,698
Secondary schools	5,776	10,194	1,024	-	16,994

The rapid response clinics had a total of 10,297 presentations for the period April – December 2014 with an average (mean) of 1,144 presentations each month.

Note that the rapid response service delivery model means that all children and young people aged 4-19 years old have free access to the primary care rapid response clinics, regardless of their enrolment status. In effect, this means coverage is 100% across all localities and particularly in the three key localities where rheumatic fever rates are highest (i.e. Manurewa/Papakura, Mangere/Otara, and Franklin).

This coverage is in addition to the Mana Kidz school-based programme which provides daily sore throat clinics to children in the following localities;

High risk pop coverage	Manurewa/Papakura	Mangere/Otara	Franklin	Eastern	Total
Mana Kidz	10,779	14,230	-	-	25,009

A high percentage of the high risk population receive rheumatic fever prevention services at the school they attend. The primary care clinics provide additional coverage for those children not attending one of these schools or for access for all children out of school hours. As noted above, all 4-19 year olds can access any of the primary clinics, regardless of whether they are enrolled with that clinic or not. The percentage of the total high risk population with access to free sore throat management via their usual GP or at their school can be seen in the following table;

High risk pop coverage	Manurewa/Papakura	Mangere/Otara	Franklin	Eastern
% in primary care (enrolled)	54%	36%	96%	0%
% in school programmes	66%	70%	28%	-
Secondary schools	*23%*	*29%*	*28%*	-
Mana Kidz	*43%*	*41%*	-	-

[1] The Eastern locality is serviced by a single clinic that does not have an enrolled population.

Locality coverage by primary care clinic:

Locality	Primary Care	High risk pop	PHO
Manurewa/Papakura	Rosehill Christian Health Centre	809	ProCare
	Fellbrook Medical Centre	682	ProCare
	Te Manu Whare Oranga Community Clinic	293	NHC
	Clendon Medical Centre	1,909	ProCare
	Manukau City and Medical	1,775	ProCare
	Papakura Marae Health Clinic	1,382	NHC
	Clendon Family Health Centre	1,068	ProCare
	Manukau Medical Associates	971	ProCare
	Takanini Family Health Care	869	ProCare
	Greenstone Family Clinic	842	AH+
	Manurewa Healthcare Medical Group	759	ProCare
	Manurewa Family Doctors Ltd	747	ProCare
	Leabank Health Centre	732	ProCare
	Manurewa Medical	674	ProCare
	Bader Drive Healthcare Trust - Manurewa		
Mangere/Otara	Mangere Health Centre	3,126	ProCare
	Otara Family + Christian Health Ctr	2,638	ProCare
	Bader Drive Healthcare Trust - Mangere	1,675	AH+
	Otara Union Health Centre	611	NHC
	Turuki Health Care	1,509	ProCare
	South Seas Healthcare Trust	1,177	AH+
	Dr Kala Magan	1,016	ProCare
	Mangere East Medical Centre	865	ProCare
Franklin	Pukekohe Family Health Care	1,052	ProCare
	Tuakau Health Centre Ltd	935	ProCare
	Seddon Street Medical Centre	799	AH+
	Waiuku Heath Centre	783	AH+
Eastern	East Care	-	East Health
Total		29,698	

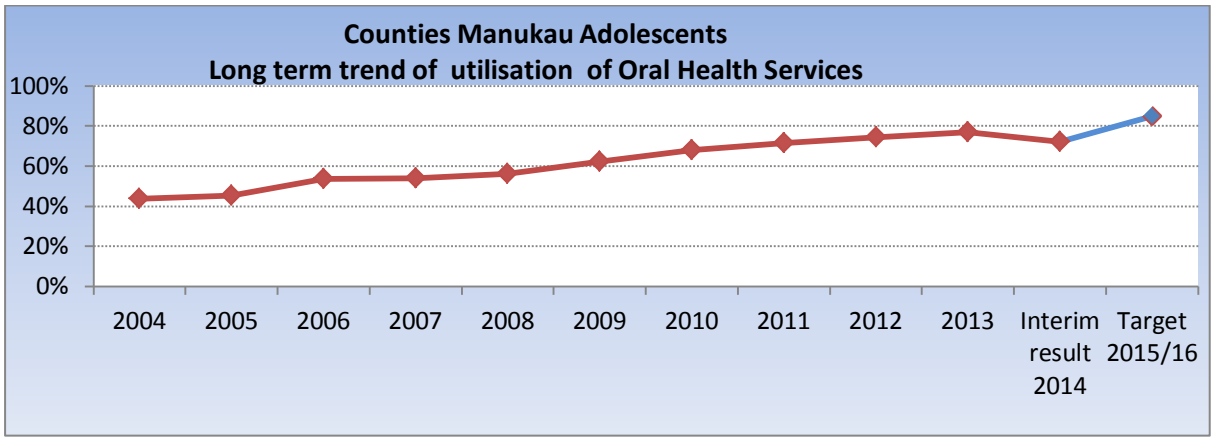
Oral Health Services

Increase Enrolment of Preschool Children aged 0-4 years

Preschool children are required to be enrolled at nine months through the Well Child/ Tamariki Ora providers however most preschool children have been enrolled from two years. As tooth decay requiring fillings has been starting in high risk population groups at as young as 18 months the plan for 2015/16 is for focus on enrolling the baby at five months at the latest so the child can be examined by their 1st birthday, with oral health education and preventative care given. Preschool education programmes with supervised tooth brushing continue in targeted preschool centres with high proportions of Maaori and Pacific children.

Adolescent Oral Health Services

The target for 2014-15 Adolescent utilisation of dental services is 85%, 2014 interim result achieved 72.3%. Note the final result for 2014 will be confirmed in July 2015 and may increase achievement of up to 5% due to late processing of provider claims. Growth in utilisation has come from providing dental services at secondary schools where prior utilisation has been as low as 50%. The last large Counties Manukau secondary schools to receive on-site dental services are Howick College, and private schools Kings College, St Kents, Elim College.



Oral Health Pilot for Women with Diabetes in Pregnancy

The MOH funded dental pilot continues to progress well to end of December 2104 quarter with 333 women under treatment out of a cohort of 400, and 67 on a waiting list. Many of the women need a higher volume of complex clinical treatments and this has caused extended treatment plans, and impacted on capacity. The pilot ends in December 2015 and evaluation is underway to review the impact of service provision, and develop a sustainable funding and delivery model for oral health services for medically compromised pregnant women.

Youth Health

Elements of the Youth Health Model of Care have been approved in principle by the Youth Expert Advisory Group. However, the model of care requires further work to ensure it encompasses the 'Whole of System' approach and is inclusive of speciality services. The Model of Care will also align with existing commitments such as the Prime Minister's Primary Mental Health Initiative and local multi-disciplinary team development.

The work programme will focus on the following areas:

- Implementing comprehensive school based health services, building sustainable relationships between schools and primary care;
- Joined up youth services across mental health and addictions, specialist medical and surgical services, and specialist sexual health services, by streamlining service referral processes;
- A collaborative high risk youth model for a group of young people who are disconnected from families or put at risk by families and other associations, who suffer chronic physical and mental health conditions or who are out of education or employment. This approach is about developing shared and collaborative systems with other agencies, with a focus on lead co-ordination, better information sharing, reduced referral/assessment barriers and timely wrap-around support and follow-up.

- Improved quality care across all settings, with minimum standards for all youth providers in Counties Manukau. This will include implementation of the Ministry of Health's standards for secondary schools and a focus on workforce competency and training.

5. Mental Health and Addictions

VISION: That the communities of Counties Manukau will support mental health and wellbeing and be able to get support when they need it, quickly and easily, in their local community.

PROGRESS

Service Development Manager – Integrated Mental Health and Addictions
We are delighted to announce the appointment of Wendy Brown to Service Development Manager - Integrated Mental Health and Addictions. Wendy joins us after working for the last 16 years in the UK where she has worked extensively in Central Government and the National Health Service (NHS).

Wendy will have a key role in the design, planning and implementation of service development and improvement programmes to enable the transformation to a fully integrated "whole of system" mental health and addiction service within Counties Manukau.

She will act as a change agent who will work across the whole of system which includes Primary, Community and Secondary care providers, to implement service changes that will result in improved health outcomes for service users.

Integrated Mental Health and Addictions Leadership Group
'Expressions of Interest' are currently being sought for membership of the new Integrated Mental Health and Addictions Leadership Group. The group's focus will be to provide strategic oversight for the CMH mental health and addictions system, guiding and actively supporting progress towards a system transformation that delivers a more connected, co-ordinated and integrated mental health and addictions service, as part of the broader healthcare system.

The initial planning stages are underway for a co-design process that will ensure that the views of service users, their family/whaanau, and health/community partners are integral to the design and delivery of integrated MH&A services.

Service Access Rates and Waiting Times
Total access rates to Mental Health services for child and youth and adult have been exceeded. Whilst older adults are below target there continues to be no wait times for these services indicating that demand for clinical services is being met.

All wait times have shown improvement in the most recent months depicted, with all areas on or above set targets. The nature of addictions means that low to no wait times are important. This is an area that we will continue to monitor closely with our NGO partners.

Note that there is a 3 month report lag due to national data assurance requirements:

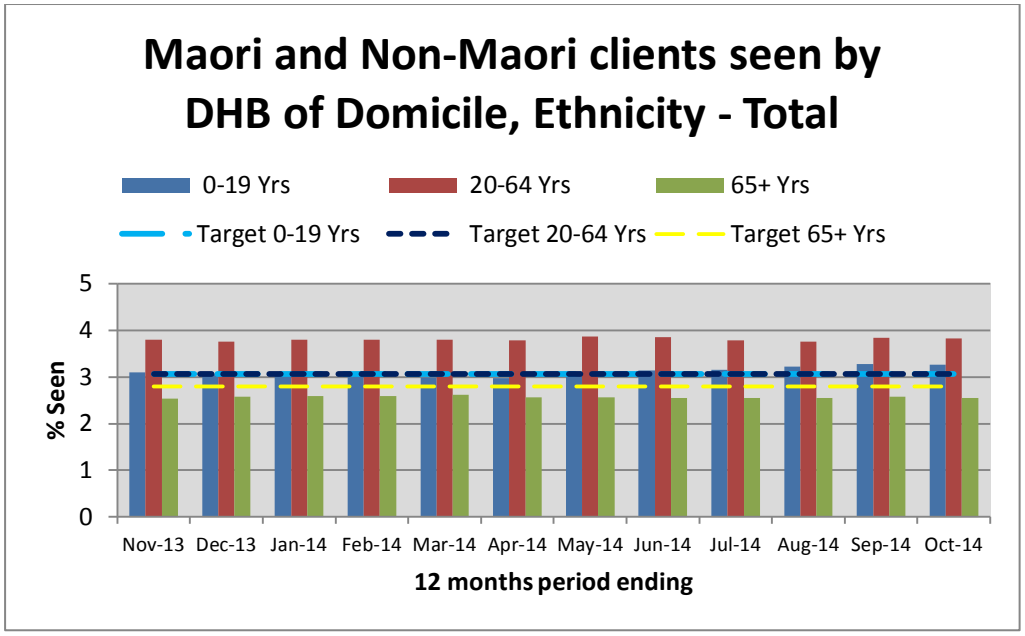


Figure 1: Graph showing access rates for mental health services from Nov to Oct 2014 (NGO & DHB services).

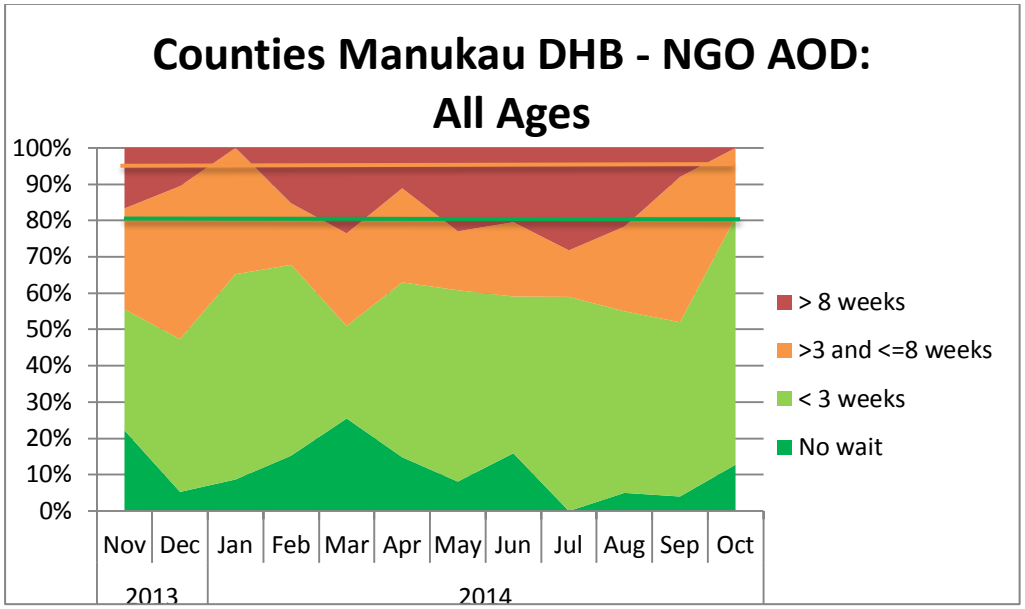


Figure 2: Graph showing waiting times for NGO AOD services from Nov to Oct 2014 (NGO & DHB services).

Home Based Treatment / NGO pilot update

The Home Based Community Team, provides intensive support to people who are experiencing a mental health crisis to remain in their own homes. Since its inception in August 2014 the service has provided clinical based support services and potentially prevented a number of admissions to Tiaho Mai, the Mental Health Acute Unit. More recently we have identified that the service and its clients would also benefit from non-clinical Community Support Workers. We have subsequently engaged with NGO providers to launch a six month pilot that will enable community support workers to be co- located with their clinical colleagues working with home based clients. The pilot will commence in March with two mainstream and three Kaupapa Maori NGOs.

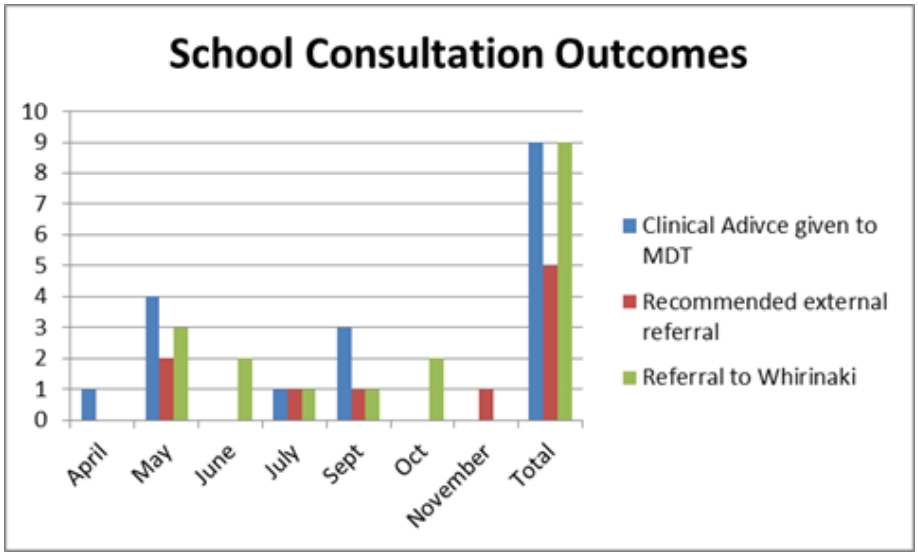
Regional Maternal Mental Health acute continuum
The Regional Mother and Baby unit is now operational with a Counties client being one of the first to use this facility which is based at Auckland Hospital Child and Family Unit. Our SMO attends regular regional MDTs and participates in the implementation of the regional model of care.

The Affinity Services Maternal Respite opening and blessing took place in December giving Counties clients access to an additional respite bed.

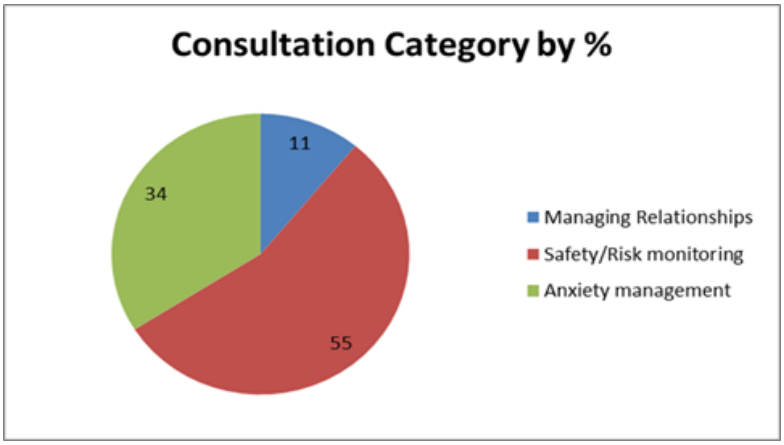
System Integration: Child and Youth
The following two initiatives are examples of integration between child and adolescent mental health services and primary care settings. These initiatives are in their infancy and clinicians are adapting to capturing accurate Consult Liaison activities.

1. *School Based Mental Health Services*: Targeting early intervention for vulnerable Young People who may not access CAMHS in the traditional way and supporting schools to facilitate early and seamless access to services. Pilot project in two secondary schools, Manurewa High and Aorere College - Senior Clinicians attend both of these school pastoral care MDT meetings twice weekly and provide:

    - Consultation and liaison regarding young people of concern who are not known to the service. These contacts are entered into HCC as Consult Liaison so that the volume of this activity is monitored.
    - Facilitate appropriate and timely referrals to into Child and Adolescent Mental Health (CAMHS)
    - Facilitate a shared care approach- Learning's from these two pilots will inform subsequent school based services.



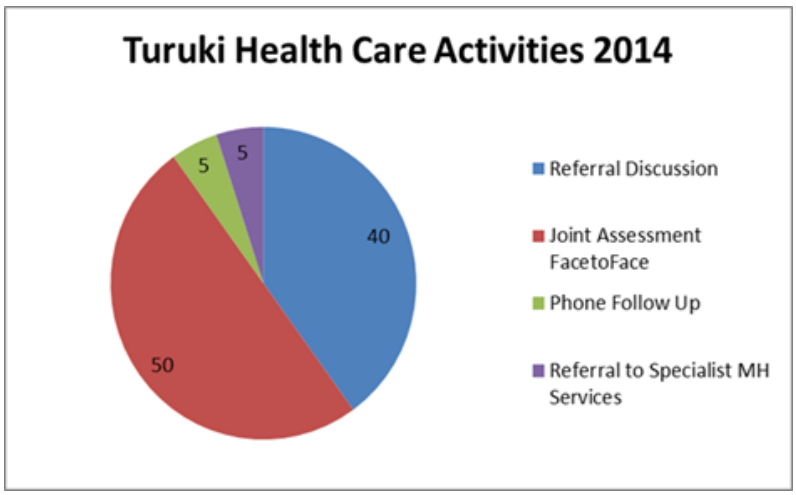
The above graph indicates the outcomes following consultation and liaison input into the pilot schools over 2014. There is a need to consult and give professional advice to primary care to manage young people as well as refer to specialist mental health services.



The graph above shows the main consultation requirement from schools MDT are around managing and monitoring safety and risky young people followed by anxiety management and then managing relationships with peers or family/whanau.

2. *Turuki Health Care and Maternal Mental Health*: Turuki Health services include General Practice, Midwifery, Whanau Ora, Family start, Mana Kidz, Rheumatic Fever Prevention Team Baby, Mama & Pepe, Parents as first Teachers and Domestic Violence Prevention. Whirinaki CAMHS works on site with Turuki staff on a weekly basis providing consultation liaison, shared care and clinic based services to:

   · mothers to be and mothers of infants/young children who are reluctant to be referred to MHS
   · facilitate referrals to Maternal Mental Health, Whirinaki or Adult mental Health Services



The graph above is the consultation liaison outcomes from CAMHS input into Turuki Health Care Services by %. Majority of the input has been joint primary care/CAMHS face to face assessments for service users of Turuki followed by MDT referral discussion.

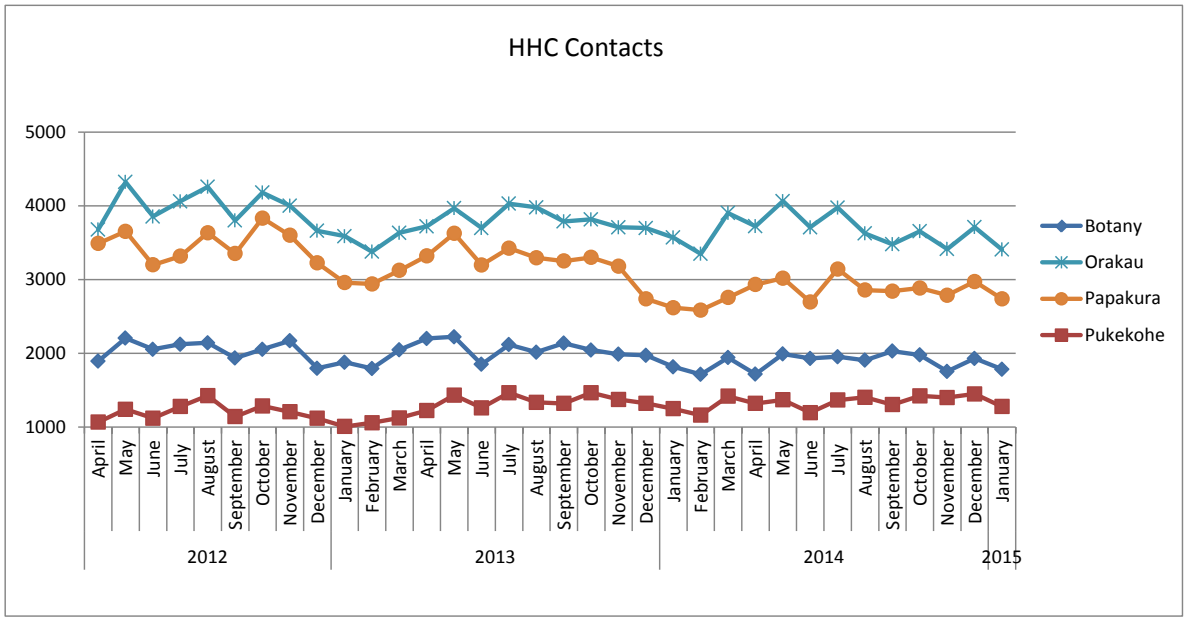
6. Adult Rehabilitation and Health of Older People

OBJECTIVE: To support older people in their homes and communities with integrated, locality based services that maximise independence through rehabilitation and quality care.

PROGRESS

Home Health Care - Community District Nurses and Allied Health Teams
The Home Health service is available to people in their own home or at a clinic facility at four sites aligned to the four localities. The Home Health teams consist of allied health, district nursing, care assistants and other locality based staff with professional, clinical and cultural skills.

Home Health Care received 984 referrals; discharged 1,067 clients and completed 9,209 contacts across all bases for the month of January. Additional cars to support the Needs Assessment teams in Eastern and Manukau Localities will be leased for six months from February.



Community Allied Health - *(delivered from Home Health Care)*
Occupational Therapy and Physiotherapy waitlists in Manukau have not increased. All waitlist numbers in the Eastern Locality have been affected by planned and unplanned leave during January.

	Previous month	Total	Orakau	Manukau	Franklin	Eastern
Waiting list Dietetics	**5**	**14**	0	4	5	5
Contacts Dietetics	**89**	**83**	24	28	8	23
Waiting list Occ Therapy	**179**	**182**	112	33	8	29
Contacts Occ Therapy	**261**	**247**	95	62	52	38
Waiting list Physiotherapy	**97**	***59***	14	15	3	27
Contacts Physiotherapy	**291**	**233**	33	82	83	35
Waiting list Continence	**39**	**40**				40
Contacts Continence	**102**	**84**				84

Waitlist - Acute Allied Health Outpatients Waitlist Activity

The main persistent issue with the waitlist has been Musculoskeletal Outpatients with the waitlist remaining very high at around 400 patients. Despite this the priority one patients are being seen within the desired target timeframe but the priority 2 patients are waiting up to 15 weeks to be seen. Additional resource has been pushed in to the team to get the waitlist down to within the clinical target levels. Referrals to the MSOP service have increased 37% over the past 3 years.

Acute Allied Health Outpatients	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
MSOP	231	208	259	249	243	225	298	296	304	314	346	380	407	421	397	431	416
Obstetrics/Gynae*	231	200	254	301	288	317	297										
Gynae*								253	214	196	168	127	128	130	79	71	49
Obstetrics*								35	50	37	29	27	25	37	19	18	11
MORRSA	54	71	49	59	61	59	67	55	64	56	56	53	30	46	41	43	38
Physio Hyperventilation	64	70	78	96	97	97	106	112	103	94	106	107	112	115	112	121	127
Cardiac Rehabilitation	12	14	25	21	22	17	7	10	17	28	29	24	22	29	28	29	24
Pulmonary Rehabilitation	147	150	134	89	152	124	64	80	56	49	33	94	99	112	133	168	186
OT Rheumatology	29	16	12	8	4	26	29	18	15	25	22	18	42	38	37	30	30
Total AAH Waitlist	768	729	811	823	867	865	868	859	823	799	789	830	865	928	846	911	881

*reported separately from April 14

Assessment and Coordination of Care for Older People – (Reported Quarterly in arrears)

At 16 October 2014 100% of facilities were either training or booked for training:

- 34 (81%) facilities are trained or actively involved in training
- 8 (18%) facilities are engaged and awaiting confirmation of the training timetable.

Three of the currently untrained facilities have a training plan through national processes (Bupa and Selwyn). Four small stand-alone Rest Homes have not yet commenced training.

Early Supportive Discharge – Supporting Life after Stroke

The Early Supportive Discharge (ESD) remains stable at its current level. The focus for the next three months will be around completing the final elements of the project; the business case for sustainable funding and the implementation package to spread to full service. No further active project changes are in progress at present.

National and Regional Spinal Strategy

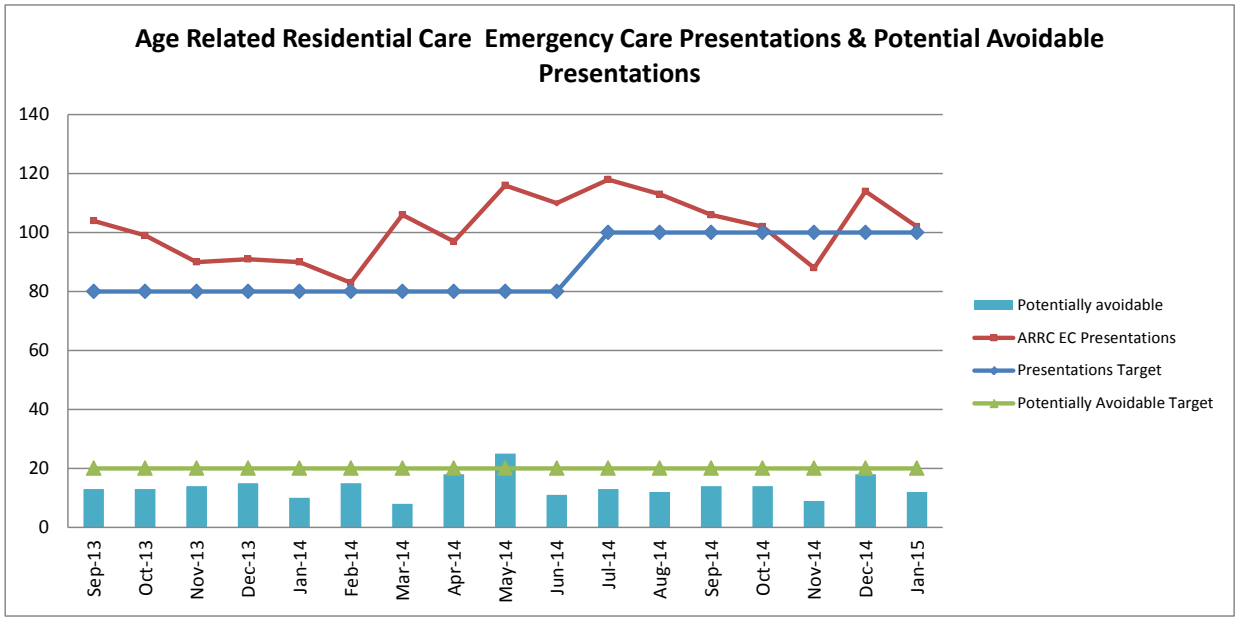
Focus continues on implementing the acute spinal pathway (referral and transport to acute surgical services). We have had 36 acute patients through the acute spinal service since 1 July 2014 with a continuing high number of complete cervical injuries. Not all patients admitted to acute services go on to receive rehabilitation at the Auckland Regional Spinal Unit. Progress is being made in seeking financial support for the purchase of the o-arm with support from the Rugby Foundation looking possible. Work is continuing to establish clinical pathways for urology, psychology and tracheostomy, and embed these across acute and inpatient rehabilitation services.

Community Geriatric Services (CGS)

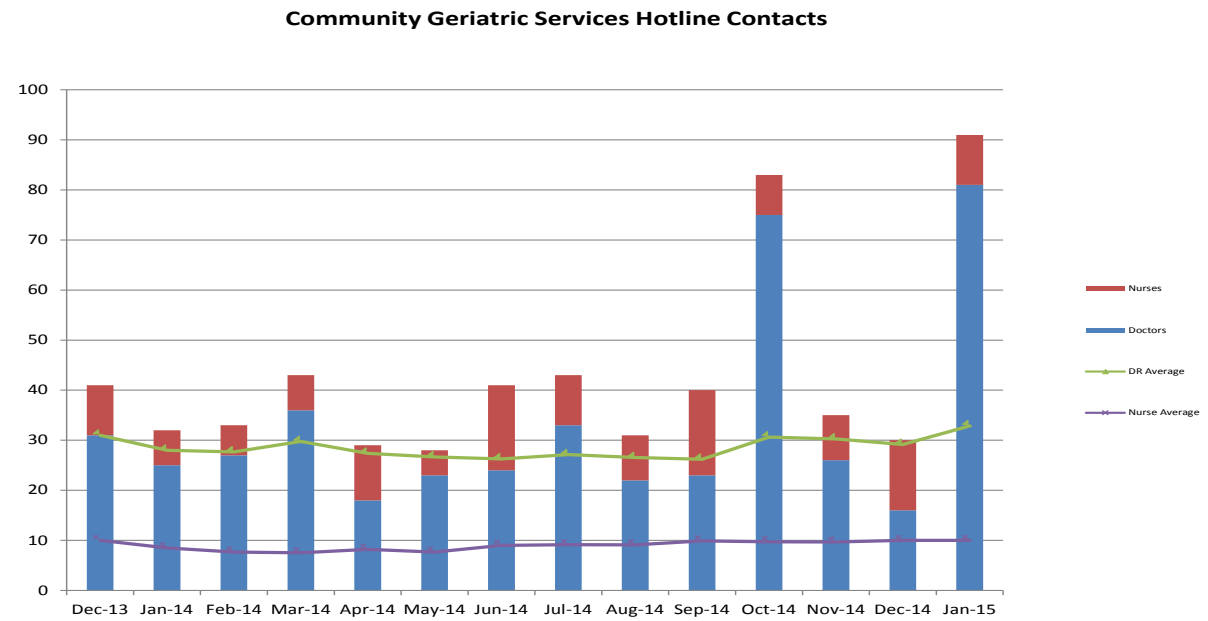
An important component of the Systems Integration/Locality development is to provide additional Geriatrician support to primary care practices and aged residential care. The CGS team continued to provide support to five GP practices during the month of January.

Target <100 Emergency Care presentations from residential facilities per month

- January 2015 saw 102 Aged Related Residential Care (ARRC) Clients present to Emergency Care. Of these, 10 presentations were falls related and 12 were potentially avoidable admissions.



Community Geriatric Services Hotline Contacts Total: 91 Hotline Calls. Average hotline contact time for the month of January was 2.4 minutes for Doctors and 2.6 minutes for nurses.



Community Specialists Health of Older People Teams (reported quarterly)

Continue to provide proactive support to ARRC and primary care by Gerontology Clinical Nurse Specialists and Geriatricians. The monthly ARC education session for facility staff continues to be well attended, with 175 Registered nurses attending education forums during the last six months.

The ATRACT education program for Registered Nurses in facilities continues to be promoted by the CMDHB Community Geriatric team.

- Target: Provide 25 hours Gerontology Clinical Nurse Specialists (CNS) and Geriatrician support per month to 5 primary care practices including clinics and education sessions with GPs

Geriatrician	Number of Primary Care Clinics Visited	Primary Care Hours
Quarter 1	5	31.5 hours
Quarter 2	5	23.5 hours

- Provide 26 hours Geriatrician support per month to 6 Age Related Residential Care Providers for medication review case conferences

Geriatrician	Number of ARRC Providers Visited	ARRC Provider Hours
Quarter 1	6	Average 42 hours per month
Quarter 2	6	Average 54 hours per month

Percentage of Home Based Support Services (HBSS) client interRAI assessments complete by locality
Each of the locality teams continue to roll out interRAI assessments for all clients receiving home based support services. Between October 2014 and December 2014, 82.8% of patients have had an InterRAI assessment at some point.

Locality	Clients	# w/InterRAI	Percentage
Eastern	1105	864	78.2%
Franklin	683	600	87.8%
Mangere/Otara	611	527	86.3%
Manukau	1546	1275	82.5%
CMDHB	3945	3266	82.8%

Memory Team (Dementia Care Pathway) January 2015
The Memory Team are keen to develop a model to enable the service to be offered to the remaining Counties Manukau Health population. To address the number declined due to out of catchment area, an out-reach primary care model has been proposed and is now at the stage where we would like to engage with a General Practitioner or Practice in the Franklin Locality to work in partnership to take the proposal to a proof of concept and trial phase. A meeting has been arranged with a General Practitioner Clinic in February to progress this initiative. Alzheimer's Auckland Charitable trust are keen to continue their partnership with the Memory Team to develop an alternative model of service delivery, initially in the Franklin Locality where they have an active presence and some capacity to assist with the Service development.
From July to December 2014 The Memory Team received 42 referrals from the Franklin Locality which were declined due to being out of their catchment area

Number of referrals (all for cognitive assessment this month)	41	498 cumulative accepted referrals (June 2013)
Number declined (due to out of Memory team catchment area)	13	
Referrals managed by Memory Team	28	68% (target 30%)
Referrals from General Practice	15	54%
Contacts	490	From 57 GP Practices
Caseload	209	
Cases under Alzheimer's Auckland	77	
Number of clinicians	6	
Diagnosis made	235 dementia, 29 no dementia, 162 other diagnoses 72 pending	Total 498

Long Term Support Chronic Health Conditions (LTS CHC) Update on service mix provided – (Reported Quarterly)

Counties Manukau Health LTS-CHC utilisation as at 30 September 2014

There are 204 clients receiving long term supports for chronic health conditions and who are receiving the following services:

Service	Number of clients
Community Residential Services	
Dementia	4
Hospital and Specialised Continuing Care	22
Rest Home	17
Respite	3
Rehab and Community	-
Carer support	14
Household Management	54
Personal Care	78
Individualised Funding	11
Dementia Day Care	1
Total	**204**

7. Intersectoral Initiatives

OBJECTIVE

Target populations/communities with high health, housing, social, employment and education needs to improve the health status and reduce health inequalities.

PROGRESS

Warm Up – Counties Manukau (Retrofitting Home Insulation Project)

Warm Up Counties Manukau is a free home insulation programme that retrofits insulation into the homes of low income families with high health needs. This programme is funded and delivered through a working partnership between the Energy Efficiency Conservation Authority (EECA), Autex Industries Limited, The Insulation Company, Counties Manukau Health and the Middlemore Foundation. We insulate the homes of low-income families with health issues that may be related to housing, creating 'healthier homes' which are more energy efficient, thus ensuring that the home contributes to the health of the family. In addition, we offer a comprehensive health and social assessment for participating families to ensure that they are accessing appropriate health and social services. This approach ensures that we can address both housing and health issues.

Referral Generation

Counties Manukau Health is responsible for referral generation. Families/households can self-refer or may have the programme suggested to them by their health professional. We target the programme through information accompanying outpatient clinic appointments and by working in partnership with health professionals, government agencies, the non-government sector and the local community.

Project Outcomes for the Warm up – Counties Manukau Project (1 July 2014 to 30 June 2015)

Month	Total Number of Referrals	Total Number of Homes Insulated	Total Number of Home Visits completed post install
July 2014	313	98	48
August 2014	251	107	47
September 2014	169	83	48
October 2014	148	139	27
November 2014	81	143	43
December 2014	64	116	15
January 2015	42	103	21
Total number of referrals generated	**1,068**	**789**	**249**

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

The PATHS (Providing Access to Health Solutions) Programme

PATHS is an intersectoral programme resulting from a partnership between Counties Manukau Health, and the Ministry of Social Development (MSD) that was established in 2004 in an effort to help tackle the growing problem of long-term benefit dependency. The aim of the PATHS 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. The key objective of the PATHS programme is to reduce health barriers to employment by providing an appropriate health intervention, which enables participants to return to employment.

109 participants have been enrolled in the PATHS programme since 1 July 2014.

8. Progress with Systems Integration

PROGRESS

At Risk Individuals (ARI) Programme

The third tranche of practices are now underway with their transition to the ARI programme. There are 4343 patients enrolled in the programme (an increase of 1,641 since last reporting period) equating to 1% of Counties Manukau enrolled population. Locality based performance is as follows:

Locality	Number of enrolments	Minimum contracted numbers
Eastern	1219	1100
Franklin	661	925
Mangere/Otara	1122	2261
Manukau	1341	2252

An ARI Programme development workshop was held in late January with representatives from PHOs, clinical leads from Localities as well as clinicians from Mental Health and Addictions and Child Health. Small group discussion focused on the following target populations as key areas for aligning with the philosophy of the ARI programme:

- Complex families
- Diabetes
- Mental Health and addiction
- Frail elderly, dementia and palliative
- Children and infants

Other considerations for review raised at the workshop were how to transition ARI into business as usual going forward with supportive IT systems, and creation of a quality framework. To capitalize on the high energy level demonstrated within the workshop, it is planned that smaller group sessions to frame up specific opportunities for development will be initiated in March.

Community Health Service Integration

The development of the four localities within Counties Manukau aims to integrate community health services with general practice. 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. This programme will be delivered through three streams of work:

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:
   - Integrated with primary care practice clusters
   - Patient and whaanau centred care plans
   - Maximising patient's strengths, function and ability to maintain life roles
   - Focus on health literacy and self-management
   - Focus on health promotion and minimising disease progression
   - Equity of access
   - Redesign of the district nursing role to enable increased capacity to participate in the reablement approach

Implementation of this new model includes the core functions of:

- Supported discharge for adults (18 +) 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.

2. **Re-design and procurement of contracted long term home and community support services under a restorative services model**

   A review and procurement of currently contracted home and community support services is required to align care delivery with the integration and service delivery approach going forward.

3. **Community Central**

   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

A project board for the programme of work has been operating since October 2014, as have workstream groups for a reablement and restorative model of care. The first consultation workshop in relation to early supported discharge and admission avoidance functions was held in January 2015. The workshop included a wide range of stakeholders from both primary, community and specialist services. The group supported the intent of the service response but felt that this should be developed not as separate teams but a core function within the locality based community health teams.

Focus for the next month is to continue to consult with appropriate stakeholder groups, further develop the key concepts into key messaging documents to inform the development of the business case. This will also include development of a Target Operating Model document, service specification for restorative and working in partnership with workstreams for SWIFT to further develop the model of care and Community Central concept.

9. Locality Reports

Eastern Locality Dashboard - December 2014

1. Acute Demand

Indicator	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	CMDHB Avg Last 12 mths
1.1 Unplanned readmission rate (28 days)	5.2%	6.1%	5.5%	6.4%	5.1%	6.2%	6.6%
1.2 ASH rate per 1,000 enrolled patients	1.6	1.4	1.7	1.5	1.4	1.3	2.1
1.3 Average bed day usage in last 6 months of life	12.1	10.6	7.8	7.5	9.3	13.6	12.0

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	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	CMDHB Avg Last 12 mths
2.1 Children fully immunised at 8 months (Target = 90%)	94.6%	95.1%	95.2%	95.2%	95.0%	94.9%	91.2%
2.2 Children fully immunised at 24 months (Target = 95%)	95.0%	95.2%	95.0%	95.5%	95.6%	95.5%	93.8%
2.3 Middlemore Radiology < 6 week wait time for GP referrals	88.2%	97.0%	95.6%	92.0%	96.7%	92.9%	92.9%
2.4 CCM+++ CVD patients on triple therapy	70.7%	69.1%	75.5%	75.0%	69.1%	63.6%	76.7%
2.5 DAR and CCM+++ Diabetes patients with HBA1c <= 64 mmol/mol	74.1%	71.5%	77.8%	81.8%	76.5%	78.8%	62.4%

+++ We are using CCM data pending availability of robust whole of population data

3. Shared Accountability Services

Item	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Last 12 Mths
3.1 ED presentations not admitted	203	221	237	203	224	235	2694
3.2 Acute medical bed days	1519	1647	1305	1278	1249	1259	15060
3.3 Acute casemix-funded non-medical bed days	941	778	863	868	763	1097	10306
3.4 Medical outpatient attendances	1995	1833	1741	1998	1687	1684	22724

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

4. Other

Indicator	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	CMDHB Avg Last 12 mths
4.1 Percentage e-Referrals	14.1%	12.8%	15.4%	16.8%	17.0%	16.1%	13.2%
4.2 Medical Outpatient DNA rate	3.9%	3.7%	3.5%	2.2%	1.7%	1.1%	8.4%

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

Osteoarthritis / falls prevention interventions

The Falls Prevention Programme continues, with addition of the two early osteoarthritis intervention groups also showing positive results for strength and balance.

The proof of Concept for the Physiotherapist-Led, Inter-Professional Joint-Replacement Alternative Pathway system is established and enrolment of patients should start in February as we obtain a list of people from Orthopaedics.

Youth

The development of a Youth Plan is underway after our stakeholders' meeting, and we have started working with Julia Shaw as she has taken up her role as Youth Services Development Manager.

Self management

We have met with the steering committee to progress a social marketing campaign around self management / self-directed care. The time line for this is to have a plan by June 30th 2015.

At Risk Individual (ARI) programme
The ARI programme is progressing with 1007 people enrolled in the programme. The principles of care planning / self directed care is becoming embedded in the practices, though there is still some disruption when patients previously enrolled in the Care Plus and / or Chronic Care Management programmes are dis-enrolled.

Canadian visitors
We have entertained two groups of Canadian visitors who were interested in our health care system and the initiatives underway in CMH.

Dynamic pathways
Five more general practices will be participating in the pilot of the dynamic pathways. The improvements in the pathways since the Proof of Concept have been very well received.

Integrated Care Coordinator (ICC)
The Eastern Locality Integrated Care Coordinator (ICC) has met with St John's so that they can re-direct relevant calls to this service for the small number of people who require a visit relatively quickly, but not an ambulance.

Similarly the ICC is working closely with the Acute Patient Assessment Team (APAT) and medical wards to be a point of contact for people the APAT have some concerns about at discharge.

In the six months from July 1st to December 31st 2014 there were 100 people who fulfilled the Very High Intensive User criteria and were reviewed by the Locality multidisciplinary team (ICC, SMO, clinical advisory pharmacist, mental health coordinator, Eldercare coordinator, general practitioner, practice nurse), led by the ICC. Twenty-seven of these people were over 80 years old; 42 were over 70 years old. For the younger people, many were under the care of, and well known to, specialists in mental health, surgery and medicine, plus a number were known to Home Health Care. We are working towards having virtual technology for these meetings.

Mangere-Otara Locality Dashboard - December 2014

1. Acute Demand

Indicator	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	CMDHB Avg Last 12 mths
1.1 Unplanned readmissions (28 days)	7.7%	8.1%	8.9%	8.0%	6.5%	7.1%	6.6%
1.2 ASH rate (per 1,000 enrolled patients)	2.8	2.9	2.7	2.7	2.4	2.1	2.1
1.3 Average bed day usage in last 6 months of life	13.6	12.8	13.0	14.1	13.2	19.9	12.0

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	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	CMDHB Avg Last 12 mths
2.1 Children fully immunised at 8 months (Target = 90%)	91.5%	91.6%	92.2%	92.7%	93.2%	93.6%	91.2%
2.2 Children fully immunised at 24 months (Target = 95%)	94.3%	94.5%	94.9%	95.0%	95.0%	94.9%	93.8%
2.3 Middlemore Radiology < 6 week wait time for GP referrals	91.9%	93.5%	91.3%	91.6%	92.9%	90.3%	92.9%
2.4 CCM+++ CVD patients on triple therapy	79.7%	80.9%	80.4%	82.3%	82.3%	77.8%	76.7%
2.5 DAR and CCM+++ Diabetes patients with HBA1c <= 64 mmol/mol	60.9%	61.3%	60.0%	60.1%	61.3%	61.5%	62.4%

+++ We are using CCM data pending availability of robust whole of population data

3. Shared Accountability Services

Item	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Last 12 Mths
3.1 ED presentations not admitted	597	617	609	652	569	690	7,427
3.2 Acute medical bed days	2,154	2,308	2,493	2,307	1,886	1,978	24,914
3.3 Acute casemix-funded non-medical bed days	1,293	1,142	1,194	1,764	1,418	1,368	17,189
3.4 Medical outpatients	2,828	2,784	2,904	2,962	2,668	2,426	32,339

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

4. Other

Indicator	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	CMDHB Avg Last 12 mths
4.1 E-referrals as % of all referrals	9.6%	9.8%	12.4%	14.8%	15.6%	15.2%	13.2%
4.2 Medical Outpatient DNA rate	13.6%	14.6%	14.8%	12.2%	16.2%	12.2%	8.4%

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

Otara/Mangere Locality Projects

Facilities in Mangere

We are working with Sapere to progress planning for the shared services hub in Mangere. The focus is to obtain information on service mix to complete the business case for the fit-out of a shared services hub facility in Waddon Place. A five year plan of a progressive rollout of services for community delivery is dependent on collection of data from both primary and secondary care. Extracting information from hospital systems, practice registers, pharmacy warehouses and POAC is apparently proving more challenging than anticipated and timeframes are behind schedule.

Multi-disciplinary Teams

There are now nine different multidisciplinary team meetings held each month across practices in Mangere and Otara. We are testing the Cluster Co-ordinator role. The Cluster Co-ordinator works with all stakeholders in a cluster to co-ordinate their meetings (shared assessment, care planning, implementation plans and patient progress monitoring). As many of the smaller general practices in the locality enrol more patients in ARI and see the benefits of the multidisciplinary approach in finding solutions for patients with complex needs, it is hoped that they will combine with the practices who are now hosting Operational MDTs and bring cases to a shared forum. This works extremely well at the specialist level meetings.

NGO Social Service Providers Otara Health Trust and the Mangere East Family Service Centre are both playing key roles with practice teams by providing Social Worker and Community Health worker input into MDT meetings. The large majority of issues associated with cases reviewed in the MDT environment are underpinned by significant social problems. Increased access to social workers and community health workers is proving invaluable for practice teams.

Community pharmacists are now attending MDT meetings at most of the practices which host operational MDT meetings. The contribution made by the Pharmacist gives practices better insight into medication compliance issues. It is useful to understand whether prescriptions are being picked up and the patterns of dispensing associated with the patient being reviewed.

Locality Leads

A draft agreement between CMH and Alliance Health + for Locality support services in Mangere and Otara has now been received by AH+. This has provided the confidence and mandate to begin recruitment for the outstanding Clinical Lead roles in the Locality. Recruitment is underway for the unfilled Clinical Lead roles. Clinical Leads are actively engaging their clinical networks groups in the service design and development work through face to face forums.

Locality Leadership Group Meetings

The representation on the Otara-Mangere Locality Leadership Group has been agreed and includes each Clinical Lead position as well as management position for each PHO. GM Integration and a provider arm GM are also on the group. Newly agreed positions are for a community lead, one person from Otara and one from Mangere. One of these position holders will put their name forward for the CMH Consumer Panel to better connect the LLG to the CMH at another important level.

Manukau Locality Dashboard - December 2014

1. Acute Demand

Indicator	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	CMDHB Avg Last 12 mths
1.1 Unplanned readmission rate (28 days)	7.7%	7.8%	7.1%	7.1%	5.8%	7.1%	6.6%
1.2 ASH rate (per 1,000 enrolled patients)	2.8	2.5	2.2	2.3	2.2	1.9	2.1
1.3 Average bed day usage in last 6 months of life	14.4	8.6	15.8	12.7	12.3	11.1	12.0

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	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	CMDHB Avg Last 12 mths
2.1 Children fully immunised at 8 months (Target = 90%)	89.7%	90.4%	90.6%	91.5%	91.8%	91.9%	91.2%
2.2 Children fully immunised at 24 months (Target = 95%)	93.3%	93.5%	93.5%	93.7%	94.5%	94.4%	93.8%
2.3 Middlemore Radiology < 6 week wait time for GP Referrals	94.2%	92.5%	94.2%	91.5%	94.5%	90.2%	92.9%
2.4 CCM+++ CVD patients on triple therapy	76.9%	73.8%	73.0%	66.2%	78.0%	55.6%	76.7%
2.5 DAR and CCM+++ Diabetes patients with HBA1c <= 64 mmol/mol	64.6%	67.1%	58.8%	64.7%	66.7%	66.6%	62.4%

+++ We are using CCM data pending availability of robust whole of population data

3. Shared Accountability Services

Item	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Last 12 Mths
3.1 ED presentations not admitted	690	665	610	672	584	730	7,838
3.2 Acute medical bed days	2,701	2,942	2,586	2,779	2,439	2,158	29,924
3.3 Acute casemix-funded non-medical bed days	1,994	1,595	2,180	1,776	1,987	1,785	23,199
3.4 Medical outpatient attendances	4,140	3,801	3,859	3,845	3,490	3,251	43,956

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

4. Other

Indicator	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	CMDHB Avg Last 12 mths
4.1 Percentage e-referrals	14.5%	13.7%	17.0%	19.5%	18.6%	18.6%	13.2%
4.2 Medical outpatient DNA rate	7.7%	7.3%	7.4%	8.0%	7.7%	6.9%	8.4%

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

Manukau Locality Projects

Home Health Care Team

The Home Health redesign project team have completed the trial of clinics for physiotherapy and occupational therapy and are in the process of developing a report recommending implementation of clinics within GP practices in the locality who have indicated physical capacity for this. Key points of success and costing will be provided in the Manukau report next month. The team have completed trials of the new assessment tool and this is ready for electronic use in Community Forms online. A guide on how to answer the questions to obtain the right information has also been developed.

ARI

The At Risk Individuals program continues to progress with the locality sitting at 34% enrolment against minimum contracted numbers and 1% of the required 3% of practice population. The Christmas and New Year period have had an impact on enrolment rates with the remainder of the financial year being a key time to improve enrolments to the required level. A care planning support session will be hosted next week by the Manukau Locality and Health Navigator, facilitated by Dr Janine Bycroft. This will provide opportunity for care co-ordinators to further develop their skills and share success's and challenges in a group setting.

Locality Co-ordinators

The development of GP practice clusters for the locality has been finalised and engagement to begin the implementation of enhanced primary care teams is scheduled this week with Alliance Health Plus, East Tamaki Health Care and Procare. The locality co-ordinator's will also be introduced to the PHO's at this time so they can begin liaising directly with practice teams to support appropriate enrolments onto ARI for those patients presenting to the emergency department 3 – 4 times in the last 12 months.

Good progress is being made by the Locality Co-ordinators who commenced their roles in mid January 2015. Initially there was one role within the Very High Intensive User's team to be responsible for triaging the daily lists from the emergency department and 2 positions of 0.5 who would initiate the patient interventions as appropriate.

It became apparent quickly that this was going to involve duplication and unnecessary hand over of the patient between co-ordinators as well as some duplication from other roles such as the APAC nurses. The roles have now been merged so everyone can do all of the job and work with the patients in each locality GP practice cluster consistently. The staff have been flexible in adapting to this change and process's and workflows are being adapted to reflect this.

Early indication from small patient numbers suggests that the best point of intervention is with the group who have presented three times. Some of the patients who have presented four times quickly develop to five presentations and trigger the criteria for the VHIU team. For those presenting three times there is opportunity to intervene, to educate and encourage different health seeking behaviours, immediate follow up for health needs that require a more pro-active plan such as ARI, immediate support and advice on symptom management, and ensuring patients are able to achieve recommended interventions following discharge from ED. Progress with work to date will be fed back to the wider Manukau Unplanned Care group in the next two weeks. The Co-ordinators are supported by Harry Rea.

Self Management Campaign

The locality has re-oriented it's self management proposal to ensure that all members of the home healthcare team will have the skill and confidence required to assess health literacy, engage in motivational interviewing and support patients to manage their own health needs in the way that is important to them. We will continue to support the Counties Care proposal in relation to high users of accident and medical centres and have had the first joint meeting to define how this will work. The first step will be for practices aligned to the A&M clinics to review their top ten frequent users of A&M centres and for the home health care team to support a multidisciplinary approach to meeting their needs. In the first group of patients there are a lot of older people with social isolation and anxiety and this process can offer a lot to support this group of patients.

Franklin Locality Dashboard - December 2014

1. Acute Demand

Indicator	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	CMDHB Avg Last 12 mths
1.1 Unplanned readmissions (28 days)	6.1%	6.5%	6.3%	6.1%	5.2%	7.0%	6.6%
1.2 ASH rate (per 1,000 enrolled patients)	1.8	2.1	2.2	2.7	2.5	1.7	2.1
1.3 Average bed day usage in last 6 months of life	14.6	18.7	12.2	16.1	16.4	17.1	12.0

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	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	CMDHB Avg Last 12 mths
2.1 Children fully immunised at 8 months (Target = 90%)	86.7%	86.9%	87.4%	88.2%	89.4%	88.9%	91.2%
2.2 Children fully immunised at 24 months (Target = 95%)	91.9%	91.6%	91.6%	92.2%	92.3%	92.3%	93.8%
2.3 Middlemore Radiology < 6 week wait time for GP Referrals	90.5%	91.9%	91.9%	100.0%	92.7%	86.2%	92.9%
2.4 CCM+++ CVD patients on triple therapy	70.3%	72.0%	73.1%	82.2%	63.2%	100.0%	76.7%
2.5 DAR and CCM+++ Diabetes patients with HBA1c <= 64 mmol/mol	70.9%	76.7%	65.8%	69.6%	80.3%	66.7%	62.4%

+++ We are using CCM data pending availability of robust whole of population data

3. Shared Accountability Services

Item	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Last 12 Mths
3.1 ED presentations not admitted	107	98	98	116	105	145	1,348
3.2 Acute medical bed days	830	1,137	1,069	932	806	721	9,833
3.3 Acute casemix-funded non-medical bed days	735	521	750	629	604	632	7,215
3.4 Medical outpatient attendances	1,175	1,105	1,121	1,226	1,201	933	12,854

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

4. Other

Indicator	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	CMDHB Avg Last 12 mths
4.1 E-referrals as % of all referrals	14.0%	15.9%	17.4%	20.8%	21.0%	20.5%	13.2%
4.2 Medical Outpatient DNA rate	5.9%	4.1%	3.5%	9.7%	5.0%	3.0%	8.4%

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

Franklin Locality Projects

Franklin Community Healthcare Re-design Project

Over 40 people attended the first of a series of four workshops planned for February facilitated by Martin Chadwick using the *Appreciative Enquiry* methodology. A wide range of stakeholders attended including St Johns, Aged Residential Care, Home Based Support Services, Franklin Hospice, Community Pharmacies, General Practice, Community Specialist Nurses and the Homes Health Care Team. The Home Health Care Team explained their roles and activity numbers. Recent workshops facilitated by John Baird have produced a direction which will assist in these re-design sessions.

50,000 Self-Management Campaign

Help You, Help Me (HYHM)

The collaborative met again this month and is making good progress with detail of the collaborative. Measures and a driver diagram have been commenced and will continue to evolve. The objective is to improve information availability and accessibility for all.

Clinical Advisory Network

Rapid Response

The total number of referrals managed by the Rapid Response Team from commencement in August 13 to 31st January 2015 is 338, with 68 referrals in December and January. Statutory holidays and staff leave has impacted on the referral numbers over this period.

Progress with Memory Team (Dementia Pathway)

A briefing paper has been has been presented to the February Clinical Advisory detailing the Franklin Out-Reach Dementia Care Pathway integrating the current Memory Team Model with the ARI, and existing Franklin Community Services including Alzheimer's Auckland Trust. Next steps are developing the proof of concept with a local GP Practice.

Locality GP Lead Role

The current Locality GP lead has resigned to return to Wellington. Approval has been received to recruit to this vacancy, applications have been received and an interview process is underway.

ARI Implementation & Self Management Courses

Practices in Franklin continue to progress with the enrolment of patients on to this programme.

Green Prescription plus

The proposed programme has been extended out to later in February due do the small number of enrolments. The programme is the "traditional" Green Prescription but for groups and augmented with nutrition, dietetic and a "mindfulness' components.

10. Finance Report

This report highlights net exceptions from agreed budget with a focus on full year variances.

CPHAC Financial Report As at 31 January 2015	Mth Actual $000	Mth Budget $000	Mth Var. $000	YTD Actual $000	YTD Budget $000	YTD Var. $000	FY Actual $000	FY Budget $000	FY Var. $000
Total Revenue	32,795	32,513	282	226,394	227,592	(1,198)	390,939	390,158	782
Expenditure									
Pharmaceuticals	9,005	8,337	(668)	59,591	58,362	(1,228)	101,750	100,050	(1,700)
PHO/GMS/Rural Retention	6,929	6,902	(27)	48,658	48,311	(347)	83,413	82,818	(595)
Primary Care & Service Development	310	318	7	2,372	2,224	(149)	4,067	3,812	(255)
Planning & Funding - Governance	19	138	119	1,048	967	(81)	1,796	1,658	(138)
Primary Care NGOs	872	914	42	6,418	6,401	(18)	11,003	10,972	(31)
Chronic Health Conditions Programme (CCM)	923	923	0	6,165	6,462	297	11,115	11,079	(36)
After Hours Regional Service	620	566	(53)	4,304	3,965	(339)	7,379	6,797	(581)
Child, Youth & Mortality	1,282	588	(695)	4,934	4,115	(819)	7,528	7,055	(473)
Oral Health	463	464	1	3,243	3,249	6	5,560	5,570	11
Localities/20k initiatives	566	575	9	4,264	4,026	(237)	7,198	6,902	(295)
LTS - Chronic Health Conditions	302	347	45	2,445	2,426	(19)	4,192	4,159	(33)
Immunisations	243	246	2	1,717	1,719	2	2,943	2,947	4
Primary Options for Acute Care (POAC)	181	181	0	1,213	1,270	57	2,079	2,178	98
Intersectorial	70	110	40	559	770	211	958	1,320	362
Healthy Lifestyles	(37)	91	128	419	637	217	719	1,091	372
> 65 Home Based Support Services	1,568	1,715	147	11,627	12,006	380	19,931	20,582	651
> 65 Aged Residential Care	5,907	6,038	131	40,701	42,264	1,563	70,673	72,452	1,779
> 65 Other	270	441	172	2,660	3,089	429	4,560	5,295	736
Mental Health NGOs	3,814	4,194	380	26,828	29,361	2,534	50,321	50,333	12
Other - incl. Budget Savings Target	(701)	(699)	2	(4,946)	(4,893)	54	(8,510)	(8,387)	123
Total Expenditure	**32,608**	**32,390**	**(217)**	**224,220**	**226,733**	**2,513**	**388,675**	**388,686**	**11**
Net contribution	187	123	64	2,174	859	1,315	2,264	1,472	792

The seven months of 14/15 Primary and Community budgets as a whole, are on target with a net favourable contribution variance of $1,315k and $792k favourable position as a full year forecast.

Other than the two main variances highlighted below and in prior months, most unfavourable expense variances have corresponding and matching favourable revenue variances. A departure from this is a recent trend, as localities/integration implementation matures, for unbudgeted FTE and contractor costs to arise where previously these costs were budgeted as different expenditure types i.e. via PHO contracts or in the localities contingency budget line.

Community Pharmaceuticals (FY $1.7m unfavourable variance)
40% of the $100m pharmaceuticals budget consists of pharmacy funding relating to drug dispensing and added value services. This expenditure has been under constant change over the last couple of years as we move from a pure volume dispensing arrangement to a hybrid of volume dispensing coupled with greater patient health management. This transition has been a complex programme of 1) ensuring consistent pharmacy income, 2) maintaining access to appropriate drugs and 3) implementing greater managed healthcare for patients with long term conditions. Under the implementation management by the Ministry the total country dispensing cost has been controlled and capped but that has not prevented variation at DHB level. CMH is one DHB with forecasted dispensing growth greater than average and greater than our budget. Complexity of the changes have meant forecast detail was not available at budget time and consequently dispensing budget has been under estimated by $2m or 5%. Changes in co-pays and rebates net the variance down to a $1.7m overspend.

Reasons why CMH differs from the average DHB are complex but relate to how well DHBs have managed their pharmacies dispensing activity. DHB's with pharmacies with historically excessive repeat dispensing have seen their costs reduce as the incentive for dispensing volume decreases. Consequently, DHBs like CMH with well managed dispensing have had to take an increased share in maintaining the total capped dispensing budget.

Health of Older People (HoP) (FY $3.2m favourable variance)
These costs include Home Based Support and Aged Residential Care for over 65s. CMH over 65s population is growing at over 4% pa and HoP budgets have been fixed to this growth. Recent forecasts have revealed growth utilisation of these services are below population growth and on current trends will result in a cost under spend of $3.2m. Reasons why this is happening are a combination of controllable and uncontrollable variables.
Variables like;

- Winter severity
- Net worth threshold for rest home subsidies have been impacted by Auckland house price increases resulting in reduced number of clients receiving a subsidy
- Economic family hardship
- Managed strategies to keep the aged well and more self-managing.
- InterRAI assessments and reassessments have been resulting in reduced Home Based Support Service cost.

Counties Manukau District Health Board
Smokefree Counties Manukau by 2025 Population Health Initiative
Update on Stoptober Campaign

Recommendation

It is recommended that the Community & Public Health Advisory Committee **receive** this update.

Prepared and submitted by: Vicki Evans, Portfolio Manager Smokefree

1. Purpose

The purpose of this paper is to provide an overview to the Community and Public Health Advisory Committee of the process and impact of the 2014 'Stoptober' stop smoking campaign. This is a national campaign that took place in September and October 2014 with the purpose of encouraging people to commit to stopping smoking for the month of October. In 2014, CMDHB invested additional funding to enhance and tailor the campaign for Maaori and Pacific communities in our district. The learnings from this campaign are likely to be applicable across a range of public health priority areas.

2. Background

Summary of the 2014 'Stoptober' campaign

Supporting the 'Stoptober' campaign was a key innovation initiative for CMDHB during 2014. Stoptober aims to inspire people that smoke to stop smoking for the month of October, and use support to do so. The national campaign was delivered by Action on Smoking and Health (ASH) and Inspiring Limited, and funded via Ministry of Health Smokefree innovation funding. CMDHB partnered with Inspiring Limited and invested additional funds to deliver an enhanced local version of the campaign that was tailored to suit South Auckland's communities.

In summary, the campaign provided a novel means of raising awareness about stopping smoking and engaging with a wide range of settings and with the community to do so. It generated significant momentum and visibility as a Smokefree initiative, more so than other campaigns delivered recently, such as World Smokefree Day. In terms of impact, measured by the number of people accessing support to stop smoking, the evaluation has shown mixed findings. It has also highlighted a number of learnings that need to be built into planning for future campaigns.

Campaign Purpose

The purpose of the Counties Manukau initiative was to:

- Increase awareness of local stop smoking support options
- Increase access to local stop smoking support
- Increase the number of quit attempts amongst the Counties Manukau population (particularly Maaori and Pacific, and the Manurewa, Papakura, and Mangere-Otara localities)

The initiative sought to achieve this by:

- Developing local capacity and capability in the provision of stop smoking support
- Tailoring national Stoptober marketing and communications to the Counties Manukau context, with priority given to Maaori and Pacific audiences
- Coordinating additional or enhanced local promotional activity in support of the national campaign.

Key activity included:

- Local promotion of the national campaign, tailored to target key communities in the CMDHB region
- The creation of partnerships with non-health organisations to support people to quit
- Recruitment and training of community members (particularly youth) to further promote the campaign's aims to communities and to facilitate community access to local quit support.

Process

- Networks of local health providers, volunteers, local employers, community groups and individuals were mobilised to reach as many people that smoke as possible in the community and engage them in the Stoptober campaign
- Campaign co-design sessions were held with community groups and the organisational network. This provided valuable input into the health promotion approaches to be used in the region and on the 'look' of the campaign collateral. The network for rollout selected five health promotion strategies during the campaign period:
    - Student Army,
    - Schools Quit Promotion,
    - Fence Quit Promotion,
    - Whanau Quit Promotion,
    - Quit Bus Quit Promotion.

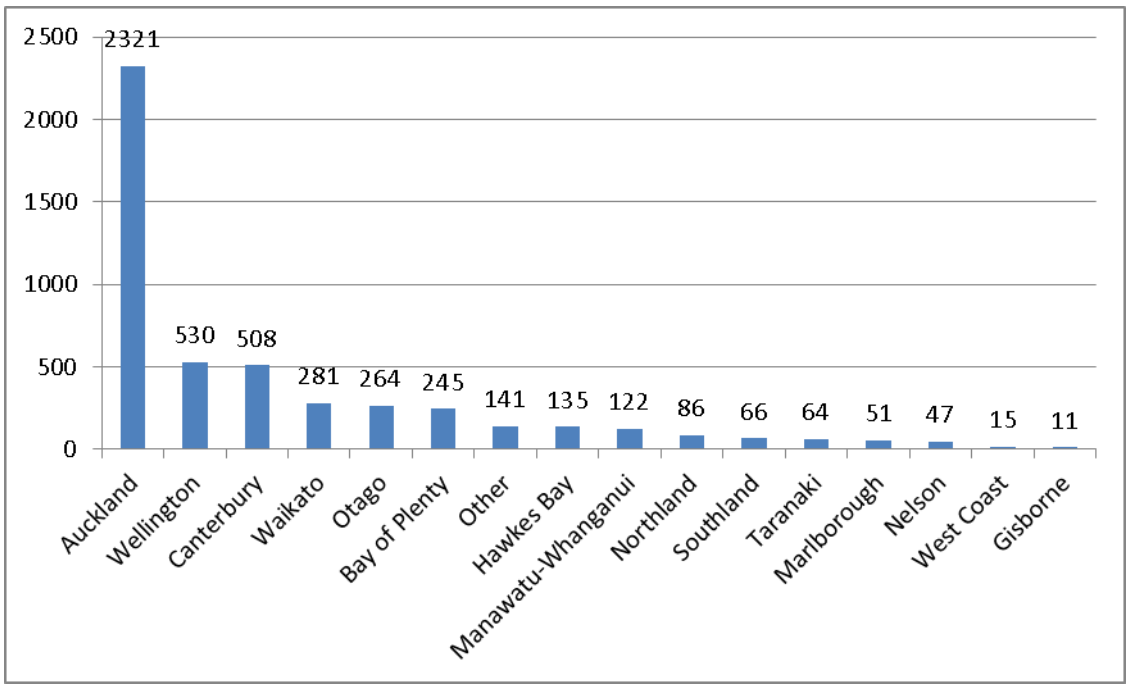
- Printed campaign material was developed in collaboration with the network and was produced in the four largest languages groups of the key localities; English, Tongan, Samoan and Te Reo Maori.
- Whereas the national campaign directed people to the national website to register and find contact details for their local stop smoking service, the localised CMDHB campaign directed people to the CMDHB Smokefree Service (0800 number, text, and email) or to the national website.
- The campaign network actively promoted the campaign, using the localised Stoptober collateral, in worksites, hospitals, clinical settings, community hubs, tertiary institutes, schools, markets and shopping strips in key localities.
- Local smoking cessation service providers used the campaign as a springboard to increase registration and referral to their programmes. Providers incorporated the Stoptober campaign into existing work and in particular, provided group based treatment (GBT) groups for smokers referred to their services as a result of the enhanced health promotion strategies.
- More than twenty Stoptober 'events' were held amongst high density smoking populations within the key localities and incorporated on-site quit support. These settings promoted the campaign and provided access for members of the public to local, regional and national quit smoking options. Events ranged in size, duration and intensity from large entertainment driven promotions to small community health booth information portals. Settings include Work and Income, The Warehouse, markets, shopping centres, health events and primary schools.
- Over seventy-five hospital, community services, and PHO's promoted the campaign
- Eight 7-week stop smoking groups were held in venues across South Auckland
- Eleven local organisations signed up to promote the campaign, including Churches, Marae, hospitality venues, sporting facilities and tertiary institutes.

- A 'Student Army' was recruited to assist with health promotion, publicity and to further increase the reach of the campaign into wider community networks.
- Two part-time Stoptober employees were hired to recruit 'Pledges of Support' for the campaign from churches, hospitality settings, employers, recreational organisation and other jurisdictions not normally associated with quit smoking projects.

Impact

- A total of 2,321 people from the Auckland region registered on the national Stoptober website. This was dramatically more than any other region in New Zealand, as shown in the graph below. It was a major limitation of the national campaign that this data could not be broken down according to the three metro Auckland DHB's. Given the significant presence of the campaign in South Auckland, it may be reasonable to assume that CMDHB is over-represented in this total compared to other DHB's. If this is the case, it may be that the combination of the local and national campaign presence was effective at directing local people to the national website, but less so to local services.

Number of Registrations to the National Stoptober Website (by region)



- There was a small but likely insignificant increase in the number of referrals to CMDHB's triage service (this provides a proxy measure for total referrals for support in the district) (408 in September-October 2014 compared with 365 in the same period in 2013)
- Importantly, the campaign appeared to generate a considerable increase in the proportion of people that self-referred to CMDHB's Smokefree Service (12.6% of all referrals during July to September 2014 compared to 3% in the same period in 2013).
- Through community outreach and health promotion events, brief advice was provided to a further 1,310 people that smoked, and 2,872 people that had friends, whaanau or neighbours that smoked
- An additional 51 people accessed support through group-based treatment, 39 CMDHB staff received support, and 18 people signed up through workplaces. 201 people accessed support through the Quit Bus, compared to 169 (July/August 2014) and 115 (November/December 2014) (2013 data is not available as the service was not in operation).

- 81 people utilised the local text number that was trialled for the campaign ('TEXT NOW to 226')
- There was no increase in the number of people that accessed the local Maaori Smokefree Services (Mangopare Smokefree Service and Aukati Kai Paipa, both based at Raukura Hauora O Tainui). Data for the Pacific service was unavailable at the time of the evaluation.
- There was no increase in the number of people from Counties Manukau that accessed Quitline's services during the campaign. The campaign did not actively promote Quitline contact details so we would not expect a significant increase in access to this service. However, the Quit Group reported an increase in access to its services of 30.9% nationally.

Learnings

A considerable amount of activity took place for the Stoptober campaign, particularly considering the short lead time for planning. Key learnings for this campaign, that will be built into any future activity, are presented below:

- Engaging with local communities to tailor the national Stoptober campaign ensures the campaign is tailored to local needs
- Establishing good communication systems and processes across the network of providers is important to maintain good information flows
- Design, develop and test as many ideas as possible to test, trial and evaluate those ideas in order to identify what best works for your communities
- There is more work required to identify what makes some ideas more successful and others not so successful
- Early planning and engagement is critical to ensure buy-in from across the District
- Encourage a flexible workforce that meets the needs of the District
- Use local knowledge and networks
- Phase activities in a way to avoid provider fatigue.

Summary

The Smokefree 2025 Initiative is committed to identifying and continually improving upon strategies to reduce smoking prevalence in Counties Manukau, particularly for those groups most likely to smoke. Whilst there have been considerable reductions in smoking prevalence since the 2006 Census, for certain groups (e.g. Maaori, people aged 20-34 years, Pacific, pregnant Maaori women, and people with mental health and addictions), smoking remains a norm more than for the overall Counties Manukau population. We welcome feedback and advice to assist in achieving this goal.

Integrated Mental Health and Addictions Leadership Group

Request for Expressions of Interest (EOI): Group Membership

For further information please contact: Wendy Brown, Service Development Manager, Integrated Mental Health and Addictions on (09) 262 9541 or 021 582 301

Please respond by:
Thursday, 26 February 2015 to wendy.brown@middlemore.co.nz

EOI Purpose

The purpose of this request for 'Expressions of Interest' is to identify representatives from the health and community sectors in Counties Manukau who are interested in taking on an active leadership role in the strategic direction of the 'whole of system' transformation agenda for mental health and addictions. Membership of the newly created Integrated Mental Health and Addictions Leadership Group will be selected from the list of individuals who respond to this request.

Context

It is clear through financial and service demand forecasts that we cannot continue with the way we provide services now, if we wish to protect and further improve the mental health and well-being of our people. The gains made in Counties Manukau to date include increased service access, enhanced workforce capability, expanded scope, and the development of a wide range of community-based services to improve the range and quality of access for more people. Building on this, the next big transformational change to take us to 2020 will be an integrated mental health and addictions (MH&A) system.

CM Health intends to reconceptualise our MH&A system from a mental health 'illness system' to one that looks to better intervene earlier in the life course, with more proactive, planned care as part of a wider integrated health team. This includes a significant drive to integrate MH&A services with NGO, primary care and other specialist and locality based health services across the life course.

Future Vision

The vision for the future is that the communities of Counties Manukau will support mental health and well-being, and be able to get support when they need it, quickly and easily, in their local community[1]. To achieve this, MH&A will be an integral part of the broader health team.

By 2020, the promotion of positive mental health will be part of the community 'psyche' and we will know that the population well-being is improved because people tell us this. We will have a clear focus on early intervention in the life-course and in the course of mental health disorders; and we will be deliberate, systematic and proactive at identifying, assessing and treating people with the most serious and acute mental health disorders. We will have a highly capable, mobile, fully IT-enabled and effective mental health workforce working as an integrated team with other parts of the health system.

[1] Counties Manukau Health. Better Mental Wellbeing for All – Making every contact count. Mental Health and Addictions Strategic Action Plan 2013-2018; December 2013

Purpose, role and function of the Leadership Group

The IMH&A Leadership Group will be a key leadership and advisory group for Counties Manukau Health (CMH). Its purpose will be to provide oversight of the strategic direction of the CMH mental health and addictions system, and to guide and actively support joined-up 'whole of system' transformational change.

Members of the group will need to bring with them significant credibility amongst their peers and the ability to identify, promote and effect real change. You will be an innovator with the enthusiasm and/or experience of working in new and different ways. Your experience should enable you to contribute to the group in three key areas: sector leadership, quality of care and outcomes, and planning/performance management.

Interested parties need to be able to commit to membership of the group for a minimum of 12 months and be available to attend eight meetings over the course of a year.

The attached 'Terms of Reference' provide a more detailed description of the group and its functions.

Next steps

The closing date for expressions of interest to be submitted is Thursday 26 February. The selection panel will review the applications and, if necessary, may seek further information. The selection panel will include:

Benedict Hefford	Director, Primary Health and Community Services
Margie Apa	Director, Strategic Development
Tess Ahern	General Manager, Integrated Mental Health and Addictions
Peter Watson	Clinical Director, Integrated Mental Health and Addictions
Wendy Brown	Service Development Manager, Integrated Mental Health and Addictions

Applicants will be advised of the outcome by early March 2015, with a view to convening the first meeting of the group at the end of March 2015.

Integrated Mental Health & Addictions Leadership Group Terms of Reference

GUIDING PRINCIPLES

- Taking a 'whole of system' approach to integrate Mental Health & Addiction (MH&A) as part of the broader health team
- Focussing on people, their families and communities, keeping them at the centre of everything we do;
- Enabling community and clinically-led, culturally capable service development; and working more closely across the sector in particular NGO support and Primary Care services whilst
- Living within our means.

1. Purpose and Scope

The Integrated MH&A Leadership Group is a key leadership and advisory group for CMH. Its purpose is to provide oversight of the strategic direction of the CMH mental health and addictions system and to guide and actively support joined up whole of system transformation change over the next 5 years.

The aim is to develop a CMH service user centred, whole of system approach to MH&A services. The group will work towards enhancing the development of a more connected, co-ordinated and integrated mental health and addictions system by:

- Providing leadership in MH&A and propose transformational service improvement, and care underpinned by a client centred, outcomes based model of care.
- Bringing together data and ideas on the needs of a defined population, balancing the demands on the system for patient care and wellbeing and the need for sustainable services and business practices, and ensuring culturally appropriate service delivery
- Identifying areas requiring redesign and innovation to achieve locality based Mental Health & Addiction integration,
- Linking with other Whole of System activity and undertake joint work as appropriate
- Oversight of contributing MH&A group activities/initiatives

<u>Mandate and Scope</u>

1.1. In Scope

The leadership group has the mandate to review current service activities for mental health and addiction across the whole of population and across clinical, support and

primary care services; with the intention of identifying and recommending opportunities to improve service quality, level of care and efficiency.

Members have the authority to meet with relevant stakeholders and service providers to gain information and ideas for improvements.

1.2 Out of Scope

It is not within the scope of the group to contract with service providers or directly change existing contractual terms;

The group does not have the mandate to manage a programme of service delivery nor is it responsible for developing and delivering on the programme budget.

2. Role and Functions

2.1 Leadership

- To provide a range of knowledge and expertise from across CMH MH&A sector to support Integrated MH&A leadership decision making
- To guide acceleration of locality based MH&A service integration into the broader health team
- To embed innovation as an integral enabler for transformational change
- To reduce inequalities and fragmented patterns of care
- To advise on investment and dis-investment choices that improve the overall system's efficiency and effectiveness.
- To enhance the delivery of culturally appropriate services that reflect the CMH population

2.2 Quality

- To identify actions that will improve outcomes for service users across the system
- To increase capability and capacity of the whole of MH&A workforce including DHB, NGO and Primary Care
- Planning and Performance
- To prioritise the annual actions and related performance outcomes aligned to national and regional expectations
- To leverage available evidence to support decision-making
- Contribute to the review of MH&A funding models that better enables integration
- To determine and monitor whole of system MH&A performance outcome indicators
- To actively develop preventative and corrective actions for escalated issues and risks

3. Membership

- This Group shall include a range of leaders from across the whole of system view of MH&A service delivery within the Counties Manukau district. The Group may agree to augment its membership from time to time to ensure appropriate expertise informs long term direction setting.

- This group will be supported and informed by financial and non-financial data, information and expertise as required.
- For the first 6 months the Chair shall be the GM Integrated MH&A.
- Members are selected not as representatives of specific organisations or communities of interest, but because collectively they provide the range of competencies required for the leadership group to achieve success.
- The group will review membership annually to ensure it remains appropriate.
- It is the expectation that a member will be able to attend two-thirds of scheduled meetings annually, unless discussed and agreed with chair.
- When a member is absent for more than two consecutive group meetings without prior apology, or if the member is not able to contribute to the good of the group, the chair will consider their membership status for revocation, following discussion with the member or reasonable attempts to contact the member.

Selection of Members

An Expressions of Interest process will be used to identify and select the relevant mix of skills/expertise to ensure representation from across the Counties Manukau Health MH&A sector. New or replacement members will be identified for their required skills/expertise.

4. Delegations

Except with permission of the Chair, members of the Group cannot delegate their attendance at meetings to any other individual. The Chair may appoint another member of the Group to act as Chair on their behalf.

5. Meeting Structure

- Quorum - the Group quorum will be eight members
- Secretariat - secretariat and support will be provided by CM Health
- Meeting Frequency - eight meetings per annum
- Minutes & Agenda - agenda and pre-reading will be distributed to members at least five working days prior to each meeting. Minutes will be distributed within five working days of the meeting. The Secretariat support will be responsible for contacting members seven working days prior to the meetings to ask for agenda items.
- Decision-making - decisions made by Group will be binding on members. Once a decision is reached, each member is bound by collective responsibility.
- Communications - key messages from each meeting will be communicated to the sector.

6. Member Responsibilities

- Take an expansive perspective and stake in making gains for the overall population outcomes as outlined in New Zealand's national MH&A planning documents including Blueprint 2 and the MoH Service Development Plan – Rising to the Challenge
- Recognise and consider the impact of known health system funding constraints and national expectations

- To provide perspective, opinion, and recommendations, that are reflective of people with MH&A needs, and the sector and NOT purely interest of the member's own team/service/organisation
- Take personal responsibility for ensuring that information is freely shared within the group and respect confidentiality as appropriate
- To support communication with colleagues locally, consult and represent the collective views of their respective areas
- When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed
- Prepare for the meeting, read the agenda and circulated papers and be prepared to report on actions taken

These terms of reference will be reviewed within 12 months of group initiation.

CONFLICTS OF INTEREST

6.1. Prior to the start of any new programme of work, conflict of interests will be stated and recorded on an Interest Register;

6.2. Where a conflict of interests exists, the member will advise the chair and withdraw from all discussion and decision making;

6.3. The Interests Register will be a standing item on the leadership agenda.

EOI Response Form – response due 26/02/15

Name	
Current employment and role	
What skills and experience do you have that would support the Leadership Group in achieving its purpose, and delivering on its roles and functions?	
Please list organisations and groups that you are affiliated with and in what capacity.	
Are there any groups or organisations, other than your own, that you would be representing as a member of the Leadership Group? (Are you mandated to speak on that group's behalf?)	

Counties Manukau District Health Board
Te Rapunga Paeora
Establishing a Whaanau Ora Model of Care in Counties Manukau Health

Recommendation

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

- **Note** this paper and activities to date
- **Note** and/or **provide feedback** on the proposed Whaanau Ora model of care

Prepared and submitted by: Riki Nia Nia, GM Maaori Health Development

1. Purpose

The purpose of this paper is to provide an update on the development of a robust Model of Care for Whaanau Ora services that will accelerate Maaori health gain and better health outcomes for Maaori. A 'model of care' is a multifaceted concept, which broadly defines the way health services are delivered. The key objective is to establish a new model of care for patient and whaanau care services currently provided by Te Kaahui Ora Services[1] at Middlemore Hospital. Ultimately, the new model will be a catalyst for the delivery of whanau-centred care across the organisation.

2. Background

In 13/14 He Korowai Oranga – the Maori health strategy was expanded from 'whaanau ora' to 'pae ora' – healthy futures. Pae ora has three elements: mauri ora – healthy individuals; whaanau ora – healthy families; and wai ora – healthy environments. Pae ora encourages everyone in the health and disability sector to work collaboratively, to think beyond narrow definitions of health, and to provide high quality and effective services. The development of this Model of Care has been titled 'Te Rapunga Paeora' to reflect the pursuit of '*pae ora'*.

The development of a new Model of Care for Whaanau Ora services commenced in October 2014 and has involved a series of key stakeholder meetings and workshops to identify priority populations; design principles; care delivery processes and service outcomes. In December 2014, a draft Whaanau Ora Model of Care was presented to the Expert Advisory Group (EAG) established to oversee and provide guidance for this initiative. Following consultation during January 2015, a decision document will be completed in February. It is anticipated that the new model of care will be in effect from 1 July 2015.

3. Proposal

The proposed Model of Care focuses on two parts of the population; Tamariki-Mokopuna (including antenatal/ maternal care) and whaanau from 'Rangatahi to Kaumatua' with high health needs including whaanau with a disability. The proposed model of service delivery will introduce a new case management approach for consenting whaanau to meet whaanau-directed goals from '1 day up to 1 year' that will include an appropriate transition (exit) plan.

[1] Te Kaahui Ora Service (15fte) inpatient team provides support to Maaori inpatients and has a small community team to follow up referred patients in the community. The service is also responsible for Te Whare Rapu Ora the emergency accommodation for whaanau from outside of the Auckland region.

The service will revise and centralise all referrals, apply prioritisation criteria and utilise standardised whanau ora assessment/ self-assessment tools that will determine the interventions required.[2] While it is envisaged that the service will primarily be hospital-based, follow up in the community will also be required as well as collaboration with primary care and community providers. An evaluation framework will be developed to capture longitudinal outcomes. Options for an appropriate IT system to record and track whaanau progress and activity across the system are being explored.

Summary of proposed Whaanau Ora Model of Care	
Mama, Pepi, Tamariki • Includes conception to 14 yrs.	**High needs whaanau** • Includes rangatahi to kaumatua. • Includes whaanau with a disability.
Rationale • Approximately 25% of the babies born in Counties Manukau facilities are born to Maaori women. • Maaori women make up a significant proportion of women who would be classified as vulnerable and high risk of poor maternal health outcomes due to a range of clinical and social factors. • Tamariki aged 0-14 yrs estimated to make up 36% of CM Health Maaori resident population[3] • Tamariki 0-14 yrs admitted to hospital make up a significant proportion of top 5 ASH conditions. • That high numbers of avoidable admissions relate to social and economic factors amenable to intervention. • Not covered by VHIU service. • Tamariki 0-4 yrs highest rate of PHO un-enrolment post discharge. • Opportunity to engage preventative services for whole whaanau. • All tamariki-mokopuna should have the best start in life and that early intervention has an impact on life expectancy (LE)	**Rationale:** • Current service primarily focused on adults. • No clear criteria for assessing high needs. • One in four Maaori (all ages) are living with a disability. • That intervention will have an impact on quality of life. • A number of criteria are already in use to prioritise high needs including: o 5 flags: four or more EC presentations in past 12 mths. o Frequent Adult Medical Admissions (FAMA): 2 or more medical admissions totalling 5 or more days past 12 mths. o Patients At Risk of Readmission (PARR) score > 30%.[4] o 3 or more LTC's (incl gout). o 2 or more DNA's in past year.
Priority outcomes • Improved patient/whaanau experience • Whaanau goals achieved • Antenatal indicators • Smokefree whaanau • Breastfeeding rates • Immunisations rates • Healthy home • B4 School checks • PHO enrolment • ECE enrolment	**Priority outcomes** • Improved patient/whaanau experience • Whaanau goals achieved • Reduction in ED presentations • Reduction in acute admissions • Reduction in bed days • Increased engagement with primary care & community providers. eg PHO enrolment

[2] Common interventions include but are not limited to: discharge planning, whaanau hui; health literacy; service navigation and/or coordination; education; housing/ accommodation; budgeting; advocacy; engagement with health/ community providers and/or programmes; cultural support, etc

[3] Population data based on projections from 2013 Census

[4] Patients with a PARR score of 30% or higher are classified as high risk.

There is extensive population and public health data that provides the context for focusing service delivery and intervention efforts in a new model of care. While much of the data is focused on hospital admissions, illness and/or rates of potentially avoidable hospital admission for Maaori (which are higher compared to non-Maaori), this data supports the prioritisation of whaanau ora interventions to support whaanau to manage their own health care needs and consequently reduce the risk of avoidable admissions.

Next steps

The key milestones and timelines are described below. Implmentation to commence 1 July 2015.

Process	**Timeframe**
Consultation	9th to 27th Feb 2015
Final decision document	Mid-March 2015
Implementation commences	End of March 2015
New model of care takes effect	1 July 2015

Te Rapunga Paeora

CMH Whānau Ora Model of Care – Proposal for Change

9 February 2015

Contents

Executive Summary 5
Summary of changes 6
Introduction 7
Background 7
Terms of Reference 9
Current service 9
Current service interventions 10
Current referral processes 11
Where do we need to focus our efforts? 11
Mama, Pepi, Tamariki 12
High needs whānau 13
Exclusions 14
The proposed model of care 15
Values and design principles 15
Target population and outcomes 15
Service delivery 17
Whānau Ora Practitioners 19
Changes to team structure 19
Whānau Ora tools 22
Implementation 23
Impact on roles and individuals 23
Cost of service 23
Consultation process and timeframes 24
Staff support 24
Giving feedback 24
References 25
Appendix 1: New Roles Proposed 26
Feedback Form: Te Rapunga Paeora – Proposal for Whānau Ora Model of Care 28

Table of Tables

Table 1: Summary of key changes 6
Table 2: Values and design principles 15
Table 3: Summary of proposed Whānau Ora Model of Care 17
Table 4: Skills and experience required 20
Table 5: CMH cultural imperatives 21
Table 6: Summary of role changes 23

Table of Figures

Figure 1: Māori health service structure 7
Figure 2: Te Kaahui Ora structure (current) 10
Figure 3: Te Kahui Ora activity data for the 2013/14 FY 10
Figure 4: Current referral process 11
Figure 5: Population risk stratification 13
Figure 6: CH Health Māori population aged 15 yrs and over – cross sectional view - 2013 14
Figure 7: Mama, pepi, tamariki system model 16
Figure 8: Proposed Whānau Ora Model of Care 17
Figure 9: Proposed referral process 18
Figure 10: Proposed service structure 20

Glossary of Terms

Term	Definition[i]	Abbreviation	Definition
aroha	Love, compassion	ARI	At Risk Individual
Hapū/ hapuu	Sub-tribe, people, pregnant	AWHI	Affordable Whānau Housing Initiative
hauora	Health or wellness	CMDHB	Counties Manukau District Health Board
iwi	People, tribe	CMH	Counties Manukau Health
karanga	To call, call	DHB	District Health Board
Kaumatua / kuia	Elders	DNA	Did not attend
kohanga	Māori language ECE	DRG	Diagnostic related group
korero	Talk/ discuss	EAG	Expert Advisory Group
Kura kaupapa	Māori language school	ED/ EC	Emergency Department/ Emergency Care
Mama	Mother	ECE	Early Childhood Education
Manaaki/ tanga	To care for, to uplift mana	FTE	Fulltime equivalent
ora	Well	HPCAA	Health Practitioners Competence Assurance Act 2003
Pepi	Infant/ baby	HUHC	High User Health Card
rangatiratanga	Independence /self-determining	LE	Life expectancy
rawa	Best	LMC	Lead Maternity Carer
Rangatahi	Young person/ adult	LTC	Long term condition
rohe	District/ area	MDT	Multi-disciplinary team
Tamariki	Children	NHC	National Hauora Coalition
tikanga	What is correct, ethics, custom, culture	NGO	Non-government organisation
Te reo	Māori language	PHO	Primary Health Organisation
wairua	Spirit, soul	RN	Registered Nurse
wananga	To learn, reflect, discuss	VHIU	Very High Intensive User
whakapapa	Genealogy, ancestry, relationships	VHT	Vision Hearing Technician
Whānau / whānau	Family, kinship		

[i] Sourced from the Ngata Online Dictionary - http://www.learningmedia.co.nz/ngata/

Executive Summary

This proposal is part of operationalising a bespoke model of Whānau Ora care for CMH that integrates service provision for whānau *across* the health care system. This proposal focuses on the provider arm Whānau Ora services only (currently referred to as Te Kaahui Ora) delivered within the hospital environment and how the service should support care transitions and journeys through the healthcare system for whānau.

Based on hospital utilisation and population data, the proposed Whānau Ora Model of Care takes a population focus prioritising the needs of:

1. **Mama, Pepi, Tamariki** (including antenatal/ maternal care) and whānau from;
2. **Rangatahi to Kaumatua** with high health needs including whānau with a disability.

For Mama, Pepi, Tamariki the approach is inclusive and entry into the service will adopt an 'opt-off' principle for all tamariki-mokopuna Māori and pregnant women admitted to CM Health inpatient services who are CM Health residents. For identifying high needs whānau, a set of criteria to support prioritisation of intervention activity commencing on admission to hospital is proposed.

The proposed Whānau Ora model of service delivery starts with an admission to hospital and follows a process of engagement – assessment – implementation – evaluation and transition to self-management by whānau (or an alternative provider). The model introduces a new case management approach for consenting whānau to meet whānau-directed goals from '1 day up to 1 year' that will include an agreed transition (exit) plan.

For some whānau, brief intervention may suffice whereas some whānau may benefit from longer intervention. The exit timeframe should be identified at the action planning stage; assessed as part of the review process; and aligned with the achievement of action plan goals. Whānau may also opt 'in and off' at any point of the journey if their circumstances change or if needs escalate.

The service will centralise all referrals, apply prioritisation criteria and utilise standardised whānau ora assessment/ self-assessment tools that will determine the interventions required.[ii] While it is envisaged that the service will primarily be hospital-based, follow up in the community will be required and collaboration with primary care and community providers will be essential.

Central to the delivery of Whānau Ora case management services are Whānau Ora Practitioners. The new service model will require changes in the current team structure, roles and the skill mix to deliver the new service. All team members will need to meet identified cultural competencies and undertake training regarding the whānau ora model and associated assessment tools.

The attribution of health outcomes to Whānau Ora service interventions is problematic. From a systems perspective, there are processes within the model of care, which can be measured and are considered to contribute to better outcomes for whānau. These outcomes are already used for driving activity in similar support services such as the CM Health Fanau Ola service. Outcomes also include the achievement of whānau-defined goals and priorities.

An implementation plan outlining key activity and workstreams will support the establishment of the new service. The timeframe for implementation of the new model of care by the 1st July is 26 weeks commencing in January 2015. The plan includes a reduced level of current service activities while new

[ii] Common interventions include but are not limited to: discharge planning, whānau hui; health literacy; service navigation and/or coordination; education; housing/ accommodation; budgeting; advocacy; engagement with health/ community providers and/or programmes; cultural support, etc

model of care tasks are undertaken. Feedback on the strengths of the proposal and options for improvement are currently invited prior to the release of a final decision document in February.

Summary of changes

The following table summarises key changes between the current and the proposed model of care (Table 1).

Key changes	Current	Proposed
Population focus	• Inpatient/hospital services • Community services	• Mama, pepi, tamariki • High needs whānau (Rangatahi – Kaumatua) • System wide
Service operating hours	• 0800 – 1630 Mon - Fri	• 0800 – 2000 Mon – Fri • Oncall weekends
Method of prioritisation / triage	• No consistent approach	• New criteria and assessment processes
Method of allocation	• Based on individual assigned to designated ward or clinical service	• Based on allocation to team and matched to appropriate team member
Model of intervention	• Episodic intervention based on referral and/or ward/service visits	• Centralised referral system and implementation of case management and/or shared care model
Assessment tools	• No formal assessment tool	• Standardised wholistic whānau ora assessment tool(s)
Client	• Individual patient as client	• Whānau as client
Evaluation method	• Count of service activity • No formal evaluation methodology	• Formal evaluation framework to be established • Systematic collection of process and outcome data
Collaboration & engagement with primary care & community providers	• Engagement via Hauora Whānau team only	• Engagement via both teams

Table 1: Summary of key changes

Introduction

Improvement in Māori health is the responsibility of the healthcare system as a whole and a statutory requirement for all District Health Boards.[iii] Accelerating Māori health gain requires a 'whole of system' approach that recognises the impact of social, cultural and economic factors on Māori health and wellbeing. The introduction of Whānau Ora policy and translation into a clear and agreed outcomes framework, that is supported by shared and direct accountability mechanisms which are used to monitor and measure system-wide success with effective leadership and influence over decision-making, strategy and resource allocation, is the challenge for all DHB's.

> *Whānau ora is an inclusive approach to providing services and opportunities to families across New Zealand. It empowers families as a whole, rather than focusing separately on individual members and their problems.*

In 13/14 He Korowai Oranga – the Māori health strategy was expanded from 'whānau ora' to 'pae ora' – healthy futures. Pae ora has three elements: mauri ora – healthy individuals; whānau ora – healthy families; and wai ora – healthy environments. Pae ora encourages everyone in the health and disability sector to work collaboratively, to think beyond narrow definitions of health, and to provide high-quality and effective services. The development of this proposal has been titled 'Te Rapunga Paeora' to reflect the pursuit of '*Pae ora'*.

Background

In November 2013, Health Partners Consulting Group and Shea Pita and Associates undertook a review of Counties Manukau Health (CMH). The purpose of the review was to consider CMH's Māori health capacity and provide recommendations as to how it should be organised – including configuration and skills. The review was requested to inform how CMH could meet its strategic objectives and deliver on its vision to advance Māori health gain.[1] In March 2014, the following structure for CMH Māori Health was finalised:

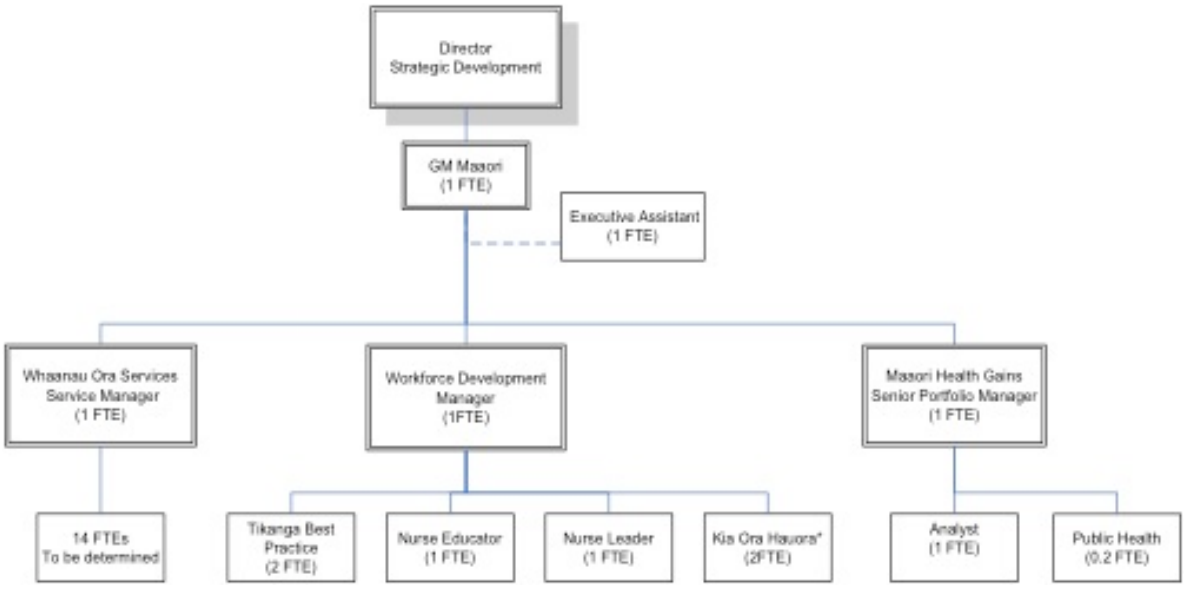


Figure 1: Māori health service structure

[iii] Refer to New Zealand Public Health & Disability Act 2000 s 4; s 22; s 23

Within this new structure a Māori Workforce Development Team and Māori Health Gains Team has been established. In terms of the model of care for the remaining Māori Health provider team - Te Kaahui Ora Service, the 2013 review suggested that:

> *'the team should adopt a more proactive stance linked to Whānau Ora and use an agreed definition and strategy to enhance future roles and responsibilities. Bespoke operationalisation of Whānau Ora will need to be designed and linked to planning and funding roles vs. service delivery roles within the hospital environment. For example, the use of a whānau ora model that supported improved care transitions and journeys for whānau through the system (and as a minimum through the hospital environment), was noted as a potential whānau ora approach for CMH'*[1]

During the review several stakeholders commented about Whānau Ora and the role this concept or approach might play in the future. Some stakeholders suggested that CMH needed to define Whānau Ora and use this definition to drive new strategy, initiatives and service provision. As a concept, stakeholders were keen to explore what whānau/family wellbeing "looked like" for CMH and how this might be translated into practice.

Other stakeholders noted the potential for Whānau Ora to support a new way of delivering services to whānau who utilise the hospital. Several comments were made about reconfiguring the Māori provider team to respond more effectively to whānau and the care episodes or transitions of care they experienced in and out of hospital. Stakeholders also spoke to improving Māori Health's ability to deliver services linked to a defined continuum of care that was based on whānau wellbeing with an outcomes focus (compared to a 'frequent fliers' focus only).

The first efforts to redesign Te Kaahui Ora Māori health services were in April – July 2014 where Te Kaahui Ora staff were engaged in an improvement methodology process to determine the final structure of the service.[iv] Feedback from this work has informed the current proposal. In August 2014, a new General Manager for Māori Health Development was appointed. In October 2014, terms of reference for the current proposal for a new model of care were developed.[v]

This proposal is part of operationalising a bespoke model of Whānau Ora care for CMH that integrates service provision for whānau *across* the health care system. This proposal focuses on the provider arm Whānau Ora services only (currently referred to as Te Kaahui Ora) delivered within the hospital environment and how the service should support care transitions and journeys through the healthcare system for whānau.

> *Whānau Ora seeks to reflect the aspirations of whānau, support them to be self-managing, and to take responsibility for their own social, economic and cultural development.*
>
> *This approach requires a profound change in the way in which policies, programmes and services are currently designed and delivered across the social sector.*
>
> Hon Tariana Turia, Minister Responsible for Whānau Ora (2011)

[iv] The methodology integrated four specific improvement methodologies and tools; Appreciative Inquiry (AI); Calderdale Framework Principles; Experienced Based Design (EBD) and Rapid Cycles of Change.
[v] Terms of Reference are available on request

As well as improving the experience of patient and whānau-centred care, it is anticipated that the new model of care will align with proposed system-level changes; integrate with services such as the Very High Intensive Users (VHIU) team and initiatives such as the At Risk Individual (ARI)[vi] programme being implemented in primary care, collaborate with primary care and community-based providers and contribute to the Whānau Ora Outcomes framework and performance measures.[2]

Terms of Reference

A 'model of care' is a multifaceted concept, which broadly defines the way health services are delivered. The key objective of this proposal is to establish a new model of care for patient and whānau care services at Middlemore Hospital. The focus of the proposal is on the current CMH provider arm Te Kaahui Ora Services and improving integration within the wider Māori health development team. Ultimately, the new model will be a catalyst for the delivery of whānau-centred care across the organisation. The aim of the proposal is:

> *To develop a robust Model of Care for Whānau Ora services that will accelerate Māori health gain and better health outcomes for Māori.*

The review commenced at the beginning of October and will conclude with a decision document. Taking feedback on this consultation document into consideration, a final decision document will be completed in preparation for implementation commencing in March 2015. It is anticipated that the new model of care will be in effect from 1 July 2015.

Current service

To prepare for the future, it's useful to take a look back and assess the past. The current services provided by Te Kaahui Ora (as at Sept 2014) include:

1. **Te Whare Rapu Ora**: Emergency accommodation 8 bed service priorities for Whānau from outside of Auckland region. Currently averaging 68% occupancy rate.
2. **Whānau Support:** Inpatient support to patients and Whānau admitted into Middlemore Hospital. Prioritising frequent readmissions in past 6mths.
3. **Hauora Whānau Community Team:** Community follow up team from inpatient to community. On average receive 25 new patient referrals a month.
4. **Hearing & Vision Technician (VHT):** Screen tamariki in Kohanga Reo and Kura Kaupapa as per the national hearing and vision screening programme.

There are approximately 17 FTEs within the service providing interventions for whānau. The service manager for Te Kaahui Ora reports to the General Manager – Māori Health Development establishing vertical integration within the structure or a link between policy and the implement of strategy 'on the floor'. Within the service there are two teams, a hospital-based team covering wards and clinical services and a small community-outreach team (2 fte). The service is supported by a coordinator, kaumatua/ kuia and personal assistant (Figure 2).

[vi] The ARI programme promotes early identification and intervention for patients at risk in order to deliver planned, proactive, patient centred care, which will result in improved health outcomes, including reduced unplanned bed-days. Once enrolled eligible patients will have a designated care coordinator responsible for developing individual care plans (based on a patient's goals) and monitoring progress in consultation with other providers of health and social services.

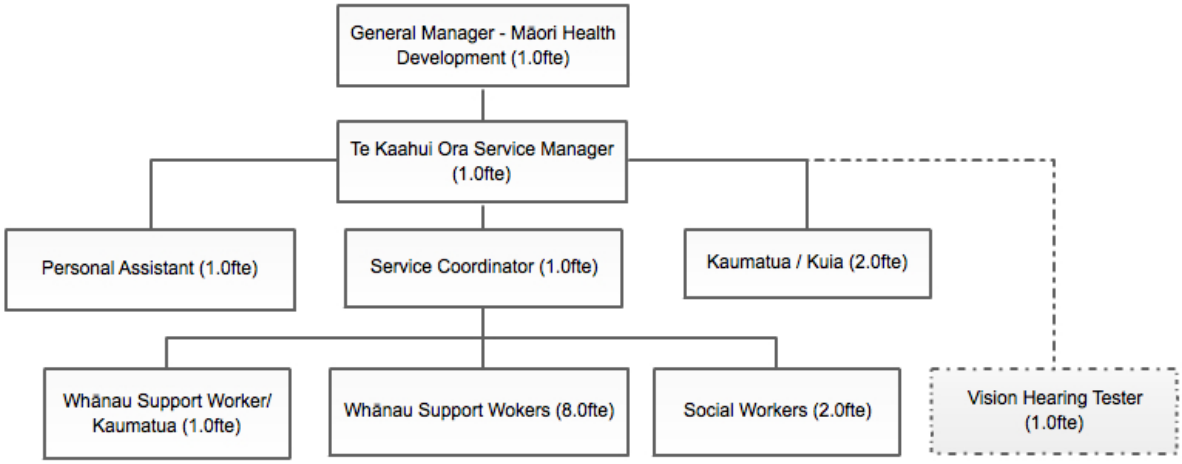


Figure 2: Te Kaahui Ora structure (current)

The Vision Hearing Technician role is a historical arrangement between Te Kaahui Ora and Kidz First community health services.[vii] The role contributes to the national hearing and vision-screening programme assessing tamariki in kohanga and kura kaupapa. The role is based in Te Kaahui Ora for cultural support purposes. Due to this pre-existing service arrangement – this role has been ring-fenced.

Current service interventions

Members of Te Kahui Ora team are allocated to designated wards and/or clinical areas. They provide a range of interventions to whānau from introduction and promotion of the service to whānau, cultural support during an admission, to active participation in discharge planning and follow up in the community. They do not work in a case management model. Analysis of the activity data for 2013/14 FY is summarised in Figure 3. There is limited qualitative data and whānau feedback for evaluating the impact of these interventions on whānau.

It should be noted that:

- 21000 interventions were provided to over **3000** patients by approx. 12fte or a ratio of **1fte: 250** patients (based on volume not caseload).
- A single patient may receive 1 to a number of interventions on a single admission.
- Many patients were provided many interventions (up to 84 for an individual) over a period of time
- Of the 153 Māori patients seen by the VHIU team in the 2013/14 FY, 100 of these patients also had a contact with the Te Kaahui Ora service or, **65%** were known to both services

In addition to these interventions, the Te Kaahui Ora team are involved in a number of service and organisation-wide initiatives.

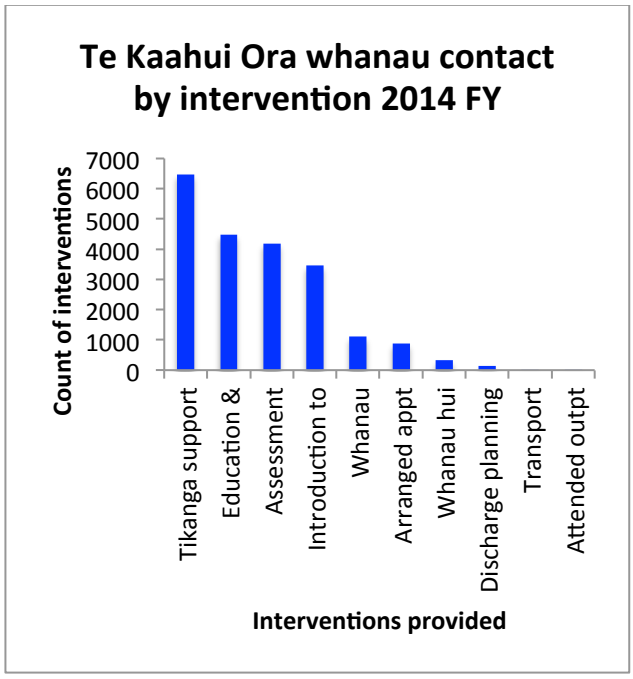


Figure 3: Te Kahui Ora activity data for the 2013/14 FY

[vii] The Kidz First Hearing and Vision Team delivers services to 300 pre-schools and 167 schools within the Counties Manukau region.

Current referral processes

Whānau Support workers are currently allocated to a designated ward or clinical service. The current system for identification of Māori inpatients and the referral process is described in Figure 4. There is currently no consistent approach to the triaging or prioritising of Māori patients to be seen and assessed by the Whānau Support team.

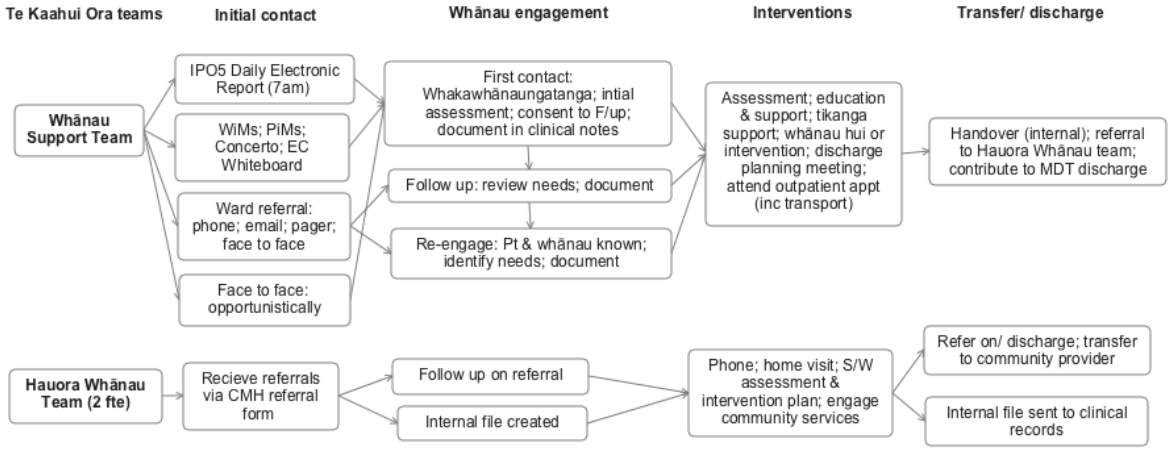


Figure 4: Current referral process

Where do we need to focus our efforts?

There is extensive population and public health data that provides some context for focusing service delivery and intervention efforts in a new model of care.[viii] While much of the data is focused on hospital admissions, illness and/or rates of potentially avoidable hospital admission for Māori (which are higher compared to non-Māori), this data supports the prioritisation of whānau ora interventions to support whānau to manage their own health care needs and consequently reduce the risk of avoidable admissions.

What we know:

- 36% of Māori population in CMDHB are aged 0-14 yrs[ix].
- Based on the 2013 Census, 58% of Māori were living in NZDep13 Decile 9 & 10.
- 23,000 Māori or over **60 people a day** have been admitted to CM Health facilities[x] over the last 3 financial years. The average length of stay for an acute admission is 3 days.
- The majority of Māori admissions were for **medical** (as distinct from surgical) reasons.
- The largest volume of medical single acute admissions by age group was for **0-4 yr** olds (18%).
- Between the age of 0-4 years **respiratory conditions** were the most common reason for admission.
- Infants in the first year of life and people 50 years and older had a higher proportion of people with high health care cost than the other age groups.
- Children aged 0 to 4 years who along with 20 to 29 year olds have among the highest rates of **PHO un-enrolment** within a month of discharge in 2013
- Almost **50%** of all Māori whānau living in the CM Health rohe are enrolled with the ProCare PHO network
- **50%** of all Māori who have acute admissions identify that they reside in the Manukau locality.
- Of the 153 Māori patients seen by the VHIU team in the 2013/14 FY, 100 of them also had a contact with Te Kaahui Ora teams, this equates to **65%** known to both services.

[viii] Data is available on request.
[ix] Population projections based on Census 2013
[x] This includes Manukau Surgical Centre and other CM Health hospital facilities as well as Middlemore Hospital; acute, acute arranged and elective admissions; and some people who live outside the CM Health rohe but are admitted to CM Health facilities (e.g. for regional or national services such as the Burns Unit)

Mama, Pepi, Tamariki

The focus on Tamariki Māori from conception to 14yrs of age is based on the high number of children in the CM Health population living in socioeconomic deprivation with high rates of avoidable hospital admissions. Evidence suggests that early intervention and engagement of a range of social and health services to meet the needs of whānau is beneficial for children. [3 4] The focus builds on initiatives that are already in place such as the CM Health First 2,000 Days, Auckland-Wide Healthy Homes Initiative AWHI programme; the *Rheumatic Fever Prevention Programme*; the Well Child Tamariki Ora Programme including *B4 School Checks* and alignment with the National Hauora Coalition Mama, Pepi, Tamariki work programme.

The inclusion of Māori women during the antenatal period recognises that out of the 6,500-7,000 deliveries each year in CM Health facilities to women living in CMDHB, approximately one in four are born to Māori women who predominantly live in areas of high socioeconomic deprivation and need. In the 2013/14 year there were 1,285 deliveries to CM Health resident Māori mothers at MMH[xi]; 212 (16%) of these women were aged under 20 years. The birth rate for young teenagers (mothers 15 years and under) is highest for young Māori women (72/100,000).[4 5] Māori preterm births in CMDHB (7.6%) is higher than the national rate of Māori preterm birth (6.7% for NZ Māori).[5] Smoking is associated with preterm birth, low birth weight and perinatal mortality. This is a particular risk factor for Māori women, who have much higher rates of smoking than the general population.[5] In the report by the External Review of Maternity Care in Counties Manukau DHB the panel stated that:

> *Given the extent of social problems faced by many in the CMDHB community, it is unacceptable that dedicated social work input is not readily available to those who most need it. Urgent consideration needs to be given to ways in which more support can be provided to women at one of the most important times of their lives - External Review of Maternity Care in the Counties Manukau District (2012).*

It is argued that a hospital admission presents an opportunity to address barriers to antenatal care for Māori women and/or to connect Māori mothers to an LMC, primary care provider, whānau ora and social support services in the community for the benefit of the whole whānau. This approach recognises the important role Māori women play in determining health outcomes for their tamariki and recognises that the needs of vulnerable pregnant Māori women are not being met. Further, evidence suggests that investment in the early years of life have high rates of returns where benefits accrue over the life span of children, whereas from an inequities perspective disadvantage that begins at birth accumulates throughout life.[3]

In 2013/14 there were 620 CM Health resident Māori women who had one or more antenatal admissions to MMH; a quarter of these women comprised half of the total number of antenatal admissions for Māori women. Many of the admissions were of short duration – nearly three quarters were for less than a day. In relation to care in the postnatal period, 22% of Māori women delivering at MMH in 2013/14 had a Caesarean section; this figure was only 16% for those aged under 20 years. The highest rate of Caesarean section was in those aged 30-39 years.

In 2013/14 there were 1,930 CM Health resident Māori children admitted to MMH. 80% of these children had one admission; 390 children had 2 or more admissions – i.e. 20% of the children comprised 40% of the total number of admissions. Respiratory conditions (both upper and lower respiratory tract), cellulitis, gastroenteritis and injuries feature among the common and potentially preventable conditions leading to hospital admission.

[xi] There are also Māori women who deliver their babies at primary birthing units in Papakura and Pukekohe; at present it is not feasible to have the Whānau Support team service these units so the data here focuses on events at Middlemore Hospital

High needs whānau

The focus on High Needs Whānau from 'Rangatahi to Kaumatua' is based on the high number of Māori who are frequently admitted acutely to hospital. There are various ways to stratify the population to try to identify the quantum of people who might be considered to have 'high needs' and who might benefit from a whānau ora intervention. Given the starting point for the Te Kaahui Ora team is an inpatient admission at Middlemore hospital, 'flags' such as those used by the Fanau Ola team (e.g. number of admissions to hospital in the last 6 and/or 12 months, number of presentations to EC in the last 12 months) might be considered as an indication of 'need' and potential future hospital presentation or admission. Services can be implemented to work to reduce the risk of hospitalisation; improve access to health care closer to the patient/ whānau home; improve self-care management of long term conditions and/or to address the social and economic causes of illness such as poor housing or poverty to meet the needs of whānau.

A risk stratification triangle such as that below is often used to illustrate how the population might be categorised into various levels of need, with the intention that these categories be quantified to give context for service planning (Figure 5). The definition for each category needs to be explicit to enable such quantification. Historical service utilisation is often used as a proxy for health care need although clearly that has many limitations, especially in relation to broader Māori concepts of hauora.

It is also important to remember that stratification is a 'cross sectional' process – i.e. it describes the situation at one point in time. For most people, their 'need' is dynamic, with or without service intervention, and the people categorised in each part of the triangle will not be the same people over a longer period of time. Some will shift to a state of 'higher need' while others will shift to a lower need[xii] with new people shifting into the identified state of need.

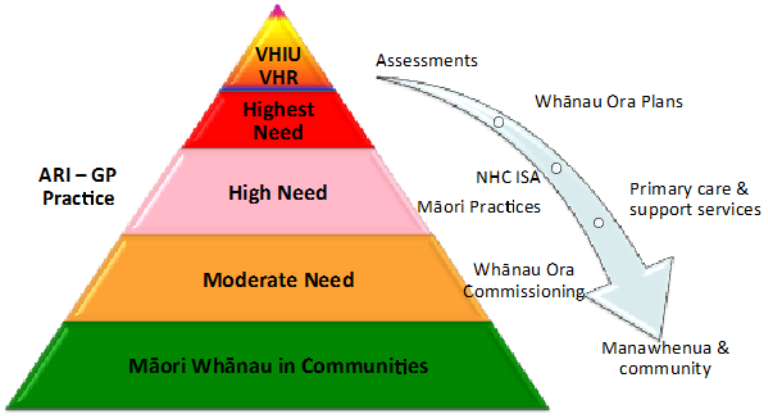


Figure 5: Population risk stratification

If previous hospitalisation were used as an indicator of need, along with health service use for selected long term conditions[xiii], the graph below gives an example of how the Māori population aged 15 years and over living in Counties Manukau might be spread across various categories (Figure 6).

[xii] Chan WC, Papa D, Black L, Winnard D (2014) Retrospective cohort study of 5,000 people who had the highest health care cost in 2010 in Counties Manukau Health. CM Health: Internal Memo

[xiii] MacLeod G, Chan WC, Winnard D, Papa D (2014) People identified with selected long term conditions in CM Health in 2013. CM Health: Internal Memo.

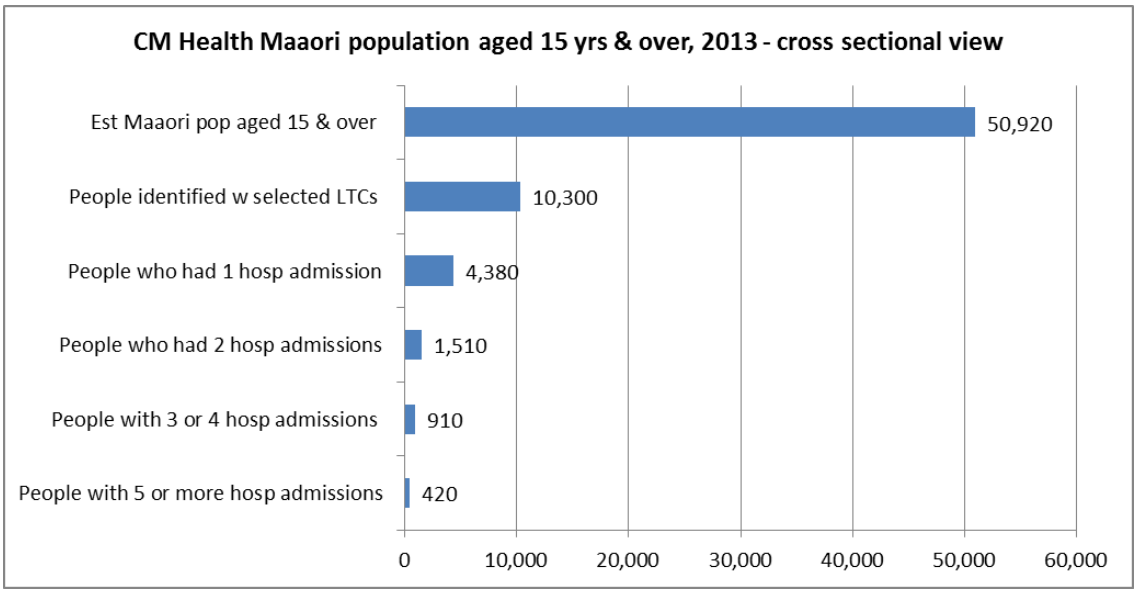


Figure 6: CH Health Māori population aged 15 yrs and over – cross sectional view - 2013

What does not feature in the current ways of determining need is the inclusion of whānau with a disability. Disability is the process which happens when one group of people create barriers by designing a world that does not take into account the impairments other people may have (New Zealand Disability Strategy, 2000). The 2013 New Zealand Household Disability Survey indicated that disability was a significant issue for Māori, with one in four Māori (all ages) reporting they had a disability. Applying national disability survey results to the Counties Manukau population estimates just over 16,000 Māori aged 15 years and over with disability in 2014. Feedback from whānau on the Expert Advisory Group recommended that the needs of whānau with a disability should be a criterion for inclusion. As discussed further subsequently, this will require a systematic way of identifying whānau with disability in the hospital patient information system; this does not happen at present.

Exclusions

The majority of whānau will have their needs met by the health professionals and/or multi-disciplinary teams who they will engage with during their hospitalisation or on return to their home. For whānau where admission to hospital is planned or part of a plan of care/ treatment, it is assumed that there is already engagement with an identified clinical service and that strategies are in place to address whānau needs, therefore duplication is not warranted. These services include but are not limited to:

- Elective surgical admissions
- Renal dialysis patients
- Where teams/ services are already in place, to avoid duplication eg. VHIU, Oncology Services, mental health
- Services where specialised skills and expertise are required and not available within the Whānau Ora service such as mental health or alcohol and addictions. Depending on these needs and the expertise of the team, decisions on how to best meet the needs of these whānau will be made on a case-by-case basis.

The proposed model of care

Values and design principles

The following section outlines the components that make up the proposed model of care. Through a series of workshops, the following vision mission and values have been developed by the Kaahui Ora team to guide the future model of care. The design principles adopted for the proposed model of care have been informed by the information collected, discussion with key stakeholders and tested with the Expert Advisory Group (EAG) (Table 2).

Tirohanga Whakamua **Vision**[xiv]	*"He Iwi ngoi, he hapū pakari, he whānau ora"* "Whānau, Hapū and Iwi who are strong, vibrant and prospering"	**Design Principles:** The service will: • Be whānau-centred • Focus on outcomes that matter to whānau • Be part of a bigger team and wider system • Reduce 'risk' by addressing need • Utilise common tools, processes and enablers across the system
Whāinga Matua **Mission**	*He whakatairanga i ngā āhuatanga e ū ai te hā o te ora* To realise, sustain and enjoy wellness in all of its forms	
Ngā Ūaratanga **Values**	*Aroha; Manaakitanga; Wairua; Whakapapa; Rangatiratanga; Te Reo me ōna Tikanga*	

Table 2: Values and design principles

Target population and outcomes

Based on hospital utilisation and population data, the proposed Whānau Ora Model of Care takes a population focus prioritising the needs of two parts of the population:

1. **Mama, Pepi, Tamariki** (including antenatal/ maternal care) and whānau from;
2. **Rangatahi to Kaumatua** with high health needs including whānau with a disability.

For Mama, Pepi, Tamariki the approach is inclusive and entry into the service will adopt an 'opt-off' principle for all tamariki-mokopuna Māori admitted to CM Health inpatient services who are CM Health residents. Opt off criteria will include but not be limited to:

- Refusal, withdrawal and/or non-consent to engagement or participation in the service.
- Pre-existing relationship and/or planned transition back to Tamariki Ora/ LMC or community-based provider on discharge.
- Evidence of satisfactory support and community services in place to support the whānau to be self-managing
- Whānau not a CM Health district resident

For identifying high needs whānau, a set of criteria to support prioritisation of intervention activity commencing on admission to hospital is recommended. Inclusion criteria will include but not be limited to:

- Whānau living with a disability
- Whānau who meet agreed high needs criteria or triage scale
- Whānau resident in CM Health district
- Whānau who consent to participation in the service

The attribution of health outcomes to Whānau Ora service interventions is problematic. From a systems perspective, there are processes within the model of care, which can be measured and are

[xiv] Developed by Te Kahui Ora Team

considered to contribute to better outcomes for whānau (Figure 7). These outcomes are already used for driving activity in similar support services such as the CM Health Fanau Ola service.

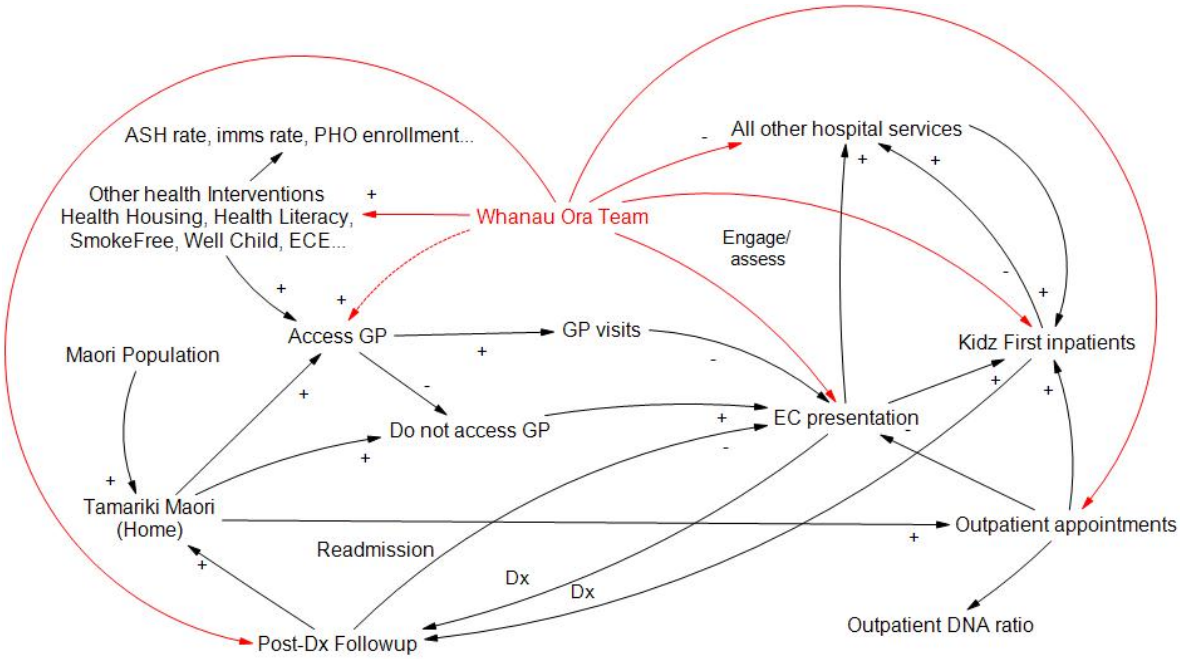


Figure 7: Mama, pepi, tamariki system model

Adopting existing process and outcome measures will enable benchmarking and assessment of effectiveness that can be built into a service evaluation framework to capture longitudinal outcomes.[xv] Outcomes also include the achievement of whānau-defined goals and priorities. These outcomes are summarised in Table 3. Options for an appropriate IT system to record and track whānau progress and activity across the system are being explored.

Summary of proposed Whānau Ora Model of Care	
Mama, Pepi, Tamariki • Includes conception to 14 yrs.	**High needs whānau** • Includes rangatahi to kaumatua. • Includes whānau with a disability.
Rationale • Approximately 25% of the babies born in Counties Manukau facilities are born to Māori women. • Māori women make up a significant proportion of women who would be classified as vulnerable and high risk of poor maternal health outcomes due to a range of clinical and social factors. • Tamariki aged 0-14 yrs estimated to make up 36% of CM Health Māori resident population[xvi] • Tamariki 0-14 yrs admitted to hospital make up a significant proportion of top 5 ASH conditions. • That high numbers of avoidable admissions relate to social and economic factors amenable to intervention. • Not covered by VHIU service. • Tamariki 0-4 yrs highest rate of PHO un-enrolment post discharge. • Opportunity to engage preventative services for	**Rationale:** • Current service primarily focused on adults. • No clear criteria for assessing high needs. • One in four Māori (all ages) are living with a disability. • That intervention will have an impact on quality of life. • A number of criteria are already in use to prioritise high needs including: ○ 5 flags: four or more EC presentations in past 12 mths. ○ Frequent Adult Medical Admissions (FAMA): 2 or more medical admissions totalling 5 or more days past 12 mths. ○ Patients At Risk of Readmission (PARR) score > 30%.[xvii] ○ 3 or more LTC's (incl gout). ○ 2 or more DNA's in past year.

[xv] Lessons from the recent evaluation of Fanau Ola Services will also inform the development of performance measures.
[xvi] Population data based on projections from 2013 Census
[xvii] Patients with a PARR score of 30% or higher are classified as high risk.

whole whānau. • All tamariki-mokopuna should have the best start in life and that early intervention has an impact on life expectancy (LE)	
Priority outcomes • Improved patient/whānau experience • Whānau goals achieved • Antenatal indicators • Smokefree whānau • Breastfeeding rates • Immunisations rates • Healthy home • B4 School checks • PHO enrolment • ECE enrolment	**Priority outcomes** • Improved patient/whānau experience • Whānau goals achieved • Reduction in ED presentations • Reduction in acute admissions • Reduction in bed days • Increased engagement with primary care & community providers. eg PHO enrolment

Table 3: Summary of proposed Whānau Ora Model of Care

Service delivery

The proposed Whānau Ora model of service delivery starts with an admission to hospital and follows a process of engagement – assessment – implementation – evaluation and transition to self-management by whānau (or an alternative provider) (Figure 8). The values and design principles underpin the process of engagement and interaction with whānau within the model.

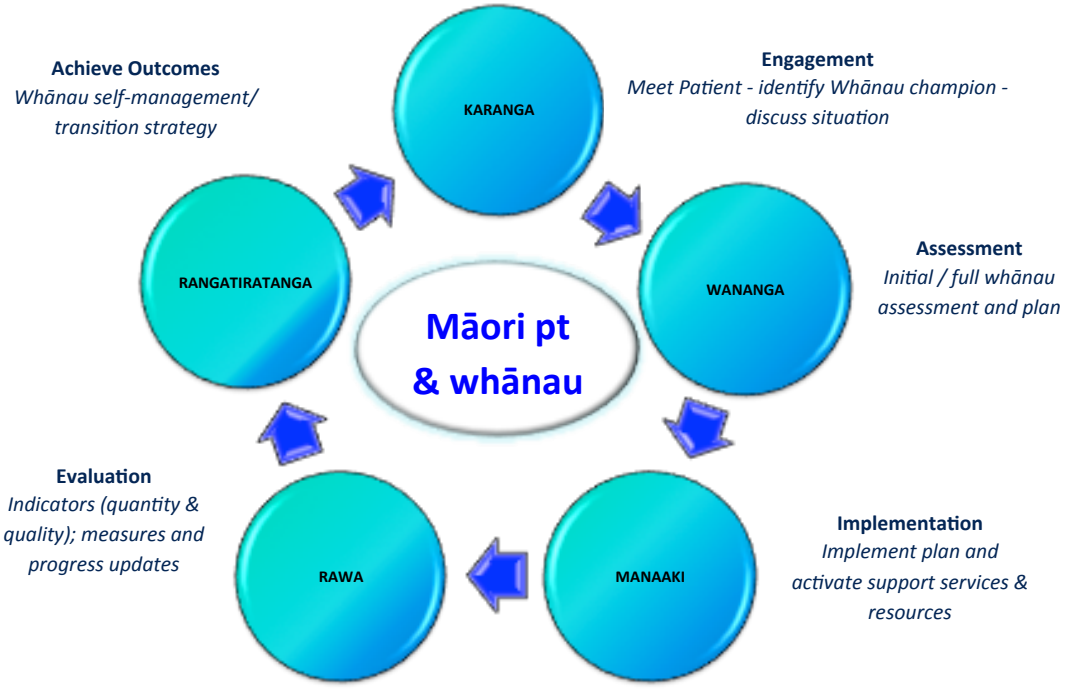


Figure 8: Proposed Whānau Ora Model of Care

The model introduces a new case management approach for consenting whānau to meet whānau-directed goals from '1 day up to 1 year' that will include an agreed transition (exit) plan. Exit from the service will be planned and mutually agreed from the outset of engagement. A planned exit point is necessary to ensure that whānau become self-managing and may include: the transfer of care to a primary care or community provider; achievement of whānau goals or whānau move or leave the area.

For some whānau, brief intervention may suffice whereas some whānau may benefit from longer intervention. The exit timeframe should be identified at the action planning stage; assessed as part of the review process; and aligned with the achievement of action plan goals. Whānau may also opt 'in and off' at any point of the journey if their circumstances change or if needs escalate.

The service will revise and centralise all referrals, apply prioritisation criteria and utilise standardised whānau ora assessment/ self-assessment tools that will determine the interventions required (Figure 9).[xviii] While the service will be hospital-based, follow up in the community will be required and collaboration with primary care and community providers will be essential.

The model of care assumes that:

- Not all whānau have the same level of need
- That whānau may have a mix of immediate; short term; med term and long term needs
- That whānau will transition back to their primary care provider
- That whānau will be able to access community services within their locality

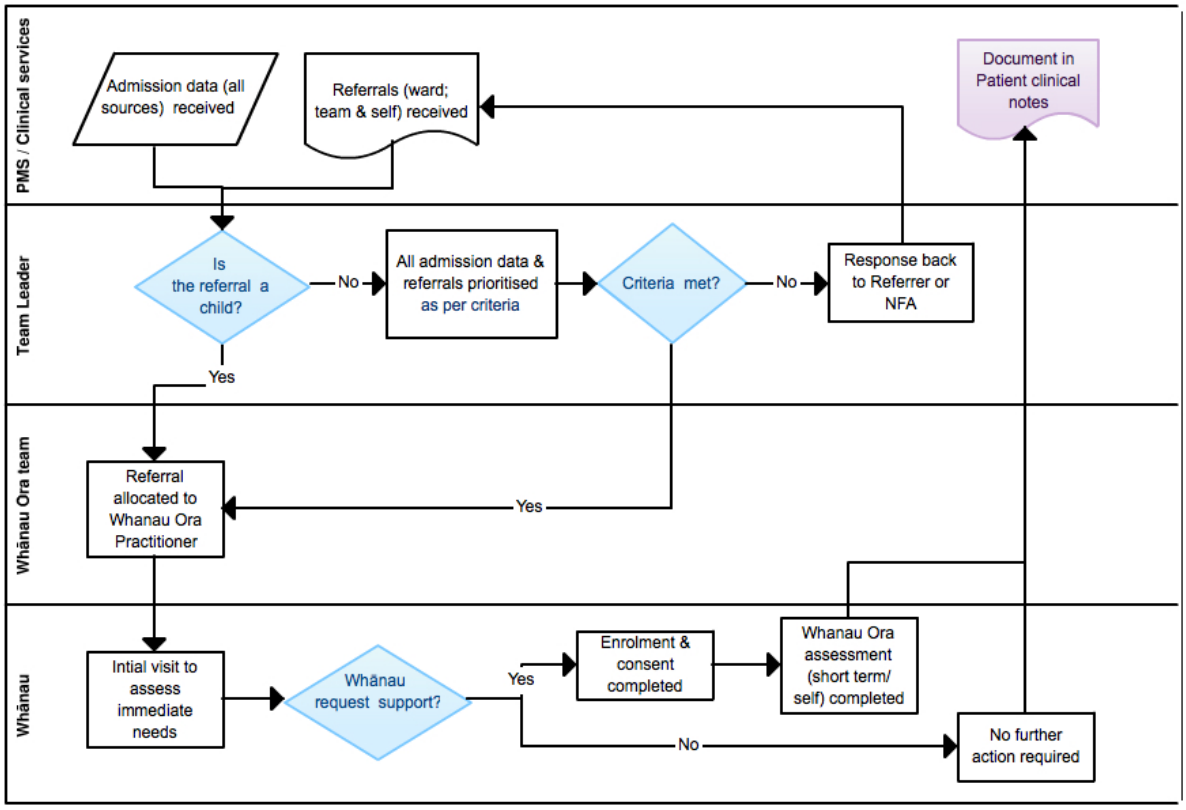


Figure 9: Proposed referral process

It is also assumed within the model, the Whānau Ora Practitioners may also work in a 'shared care' model with other teams such as VHIU or ARI (general practice) providers. It is also recognised that Whānau Ora Practitioners may be part of a wider multi-disciplinary team either in the CM Health or in the community depending on whānau need.

[xviii] Common interventions include but are not limited to: discharge planning, whānau hui; health literacy; service navigation and/or coordination; education; housing/ accommodation; budgeting; advocacy; engagement with health/ community providers and/or programmes; cultural support, etc

Whānau Ora Practitioners

Central to the delivery of Whānau Ora case management services are Whānau Ora Practitioners, who support achievement of whānau ora by working alongside whānau to enhance and enable the strengths of whānau to achieve rangatiratanga – the level of independence where whānau self-determine success.[2] The practitioner fulfils a case management role that includes:

- Being a whānau facilitator, enabling whānau to draw on family strengths and aspirations to develop whānau plans and solutions to resolving barriers to the achievement of aspirations; this includes working with whānau leaders.
- Providing a personalised process with core elements to ensure whānau are supported to address social determinants and support whānau to be independent;
- Engaging in opportunities to ensure whānau are supported by core public health initiatives to improve long term health gain for the whānau.

Central to effective case management is the ability to establish trusting relationships with whānau, so the settings in which these services are delivered will be varied and ideally, should be undertaken in an environment where whānau are comfortable.

Whānau Ora practitioners are trained to support and facilitate whānau, assess safety and risk for all whānau, encourage public health interventions and ensure whānau are progressing towards goals that support independence. They assist whānau to:

- Self-identify specialised goals and aspirations that create opportunities and lead to the achievement of positive outcomes;
- To support each other and utilise their own whānau resources or community resources effectively;
- Participate in coordinated, standardised activities (immunisation, screening etc);
- Access multiple intersectoral services and alternative resources;
- Successfully participate in whānau ora and clinical and social programmes where they will support the whānau;
- Access alternative resources and/or informal supports.

The primary skill of a Whānau Ora Practitioner is working with whānau and the expertise to facilitate whānau to achieve their goals. This skill strongly supported by health literacy training.[2]

Changes to team structure

The new service model will require changes in the current team structure, roles and the skill mix to deliver the new service. The new service will operate from 0800 to 2000 Monday to Friday and will include a rostered oncall service on weekends (0800 – 1300)[xix]. The change in service hours is designed to better meet the needs of whānau particularly after school and after work. It is anticipated that the change in service coverage hours will be achieved through staggered start and finish times.

[xix] The inclusion of after hours service coverage will be part of phased implementation. Detail on how this might work needs to be discussed further with the Te Kaahui Ora team so the practical implications for individual staff are clear.

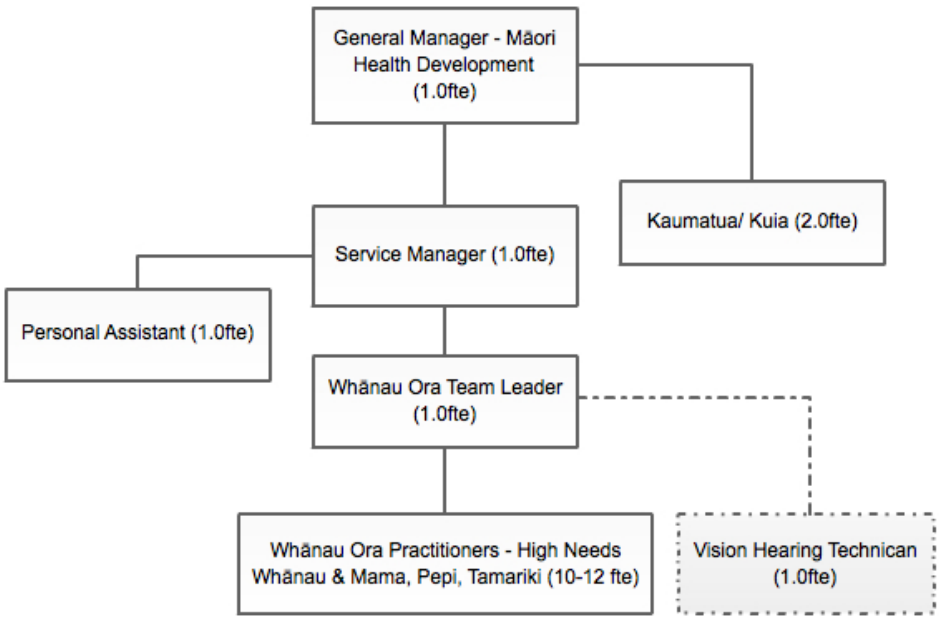


Figure 10: Proposed service structure

The new model will be lead by a Team Leader (reporting to the Service Manager) to coordinate a team of Whānau Ora Practitioners allocated to either the Mama, Pepi, Tamariki or High Needs Whānau team (Figure 10). To support implementation and ongoing development of the model of care, a Team Leader with clinical experience and proven clinical leadership skills will be required. The Whānau Ora Practitioner role will be a generic job title that may be fulfilled by individuals from a range of health/clinical or social service disciplines. More detail on these changes is included in Table 6 and Appendix 1.

Skills required	**Experience desired/ required**
• Ability to whakawhānaungatanga • Whakawhitiwhiti korero (facilitation) • Knowledge of Te reo me ona tikanga • Whānau assessment and problem-solving • Health literacy and good understanding of health terminology • Ability to develop effective relationships with clinical teams, primary care, community providers/ NGO's • Knowledge of patient rights, health and financial entitlements and ability to access such as HUHC; grants and subsidies • Knowledge of government agencies and responsibilities such a CYF's; MoE; WINZ	• Clinical expertise • Clinical assessment and documentation • Case management experience • Community and social service development • Understanding of hospital/ health system • Quality improvement and system change • Technology savvy • Experience in health promotion, motivational interviewing or health lifestyles coaching such as smoking cessation or exercise • Experience in screening and intervention such as child safety; family violence • Experience working in South Auckland / CMH • Experience working in a multi-disciplinary team

Table 4: Skills and experience required

All team members are expected to be culturally competent (see Table 4 & 5) and undertake training regarding the whānau ora model and associated assessment tools. Ongoing professional development and supervision (clinical and cultural) will be included as part of a workforce development plan. Support from clinicians or teams such as VHIU may be sought as required.

Proposed cultural competencies[xx]	
Tikanga Tangata - Cultural Competence	The ability to engage with people who are 'culturally unique'. A combination of critical analysis skills and attributes that enable authentic and intelligent engagement with service consumers in a way that ensures the cultural safety of patients, whānau and other alliances in a patient/whānau centred service.
Pūkenga Whakawhanaungatanga - Relationship Management	Strong community networks with service providers, NGOs, government agencies, iwi agencies, marae, schools and all other relevant organisations which impact patients and whānau. The ability to develop, maintain and grow strong strategic and operational relationships to ensure strong health/wellness outcomes for patients and whānau.
Tātakitanga - Leadership	The ability to lead critical discussions within multi-disciplinary teams where-in relevant patients and whānau and related strategies are discussed as part of in-patient care and discharge planning. The ability to facilitate professional discussions with peers of affiliated service units. The ability to present and facilitate learning events to imbue the CMDHB organisation and its affiliates with the notion and value of cultural competence in healthcare practice.
Te Reo me ōna Tikanga	An intermediate to advanced fluency in Te Reo and modes of Māori customary behaviour.
Ūnga ki te Kaupapa - Commitment	A demonstrated commitment to whānau and community development. Proven recent success at engaging with patients, whānau and relevant community entities, individuals and organisations. A commitment to the team ethos, vision, mission and shared values and recent success as a team player, contributor and leader within the team (when required).

Table 5: CMH cultural imperatives

The Team Leader will be responsible for the assessment of all referrals and allocation to relevant team members. The Team Leader will be responsible for day-to-day management of the team, monitoring and reporting of service outcomes, quality standards and improvement plans, supervision (clinical and cultural), training and professional development. It is anticipated that the Team Leader will be a registered health professional and have experience in case management, however the role is not expected to carry a caseload.

For team members who carry a caseload, the expected volume is anticipated to be approximately 100 patients per fulltime equivalent per annum or approximately 30 whānau at any one time. When the whole whānau is considered to be the 'client' this may translate into approximately 400 people assuming a minimum of 4 people per whānau a year.

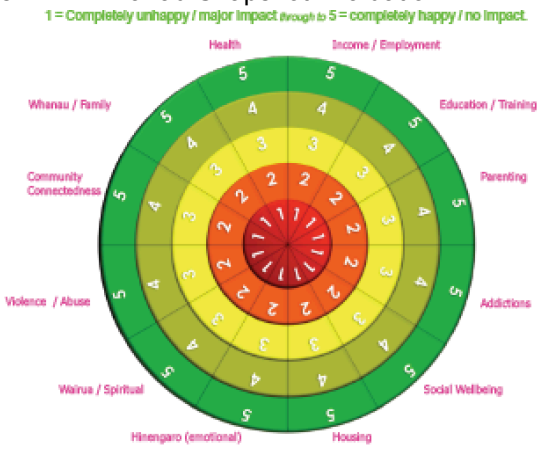
Caseload goal:
1 whānau: 4 whānau members (inc index patient)
1fte: carries 30 whānau on caseload at one time
1 fte : 100 patients & their whānau / yr
10fte : 1000 patients & their whānau/ yr

It is anticipated that approximately 80% of the Whānau Ora practitioner's time will be allocated to case management activities (direct and indirect activities) and the remaining 20% allocated to service and organisation-wide quality improvement activities. Due to the new model, activities that are currently undertaken be Te Kaahui Ora will reduce or cease in order to implement a more robust model of care.

[xx] The Te Kāhui Ora team developed the vision, mission and values for the service. These underpin the cultural imperatives which will be required to realise the model of care being developed for and with the service.

Whānau Ora tools

A toolkit including Whānau Ora assessment tools will need to be developed and tested. The toolkit may include, but not be limited to:

• Information materials (pamphlets / presentations)
• Consent/enrolment forms
• Primary Client – Initial Whānau Ora Assessment *(as inpatient)*
  – Whānau Genogram / Identification of Whānau Champion
  – Discharge Summary Notation (PIMS – Notify Primary Care / ARI Coordinator)
• Whānau Ora Plans (one for Primary Client; one for Whānau; others as needed)
• Referrals system
• Whānau Ora Sustainability Plan
	Te AWA Whānau Snapshot Evaluation[6] [xxi]
	 
	
	itrok - te runanga o kirikiriroa ©

The Whānau Ora practitioner will use a standardised whānau ora assessment tool. This tool will be based on current best practise that will be linked to the outcomes framework. The action plan is a critical part of the model of care. It is an active plan that requires regular follow through and support. All whānau will have ownership of their Whānau Ora assessments and plans.

[xxi] This tool has been developed to get a snapshot of the needs of whānau who access Whānau Ora programmes and initiatives. It measures a comprehensive set of markers for health and wellbeing that include not only physical health, but economic factors (housing, environment, amenities and finances) as well as social involvement (community engagement, traditional knowledge and customs) and whānau behaviour (e.g. parenting and relationships).

Implementation

An implementation plan outlining key activity and workstreams will support the establishment of the new service. The timeframe for implementation of the new model of care is by the 1st July 2015. The plan includes a reduced level of current service activities while new model of care tasks are undertaken. Some components of the model of care may be subject to phased implementation. The Service Manager for Te Kaahui Ora will be responsible for implementation.

Impact on roles and individuals

To implement the new model a number of changes to the current roles within the Te Kaahui Ora Team are proposed. The key changes for roles within the current service based on the proposed model of care are summarised in Table 6. An outline of the new roles and functions are included in Appendix 1.

Current	Proposed	Rationale
Coordinator role (1.0 fte)	Role disestablished.	• New role requires a clinical qualification and clinical experience / expertise
Whānau Support Worker (7.8 fte)	Reconfirmed in Whānau Ora Practitioner role	• Skills and experience required are similar. • Responsibilities of the new role are similar to current with greater capability expected to be achieved from introducing the new model of care.
Kaumata / Whānau Support Worker (1.0 fte)	Reconfirmed in Whānau Ora Practitioner role	• Skills and experience required are similar. • Responsibilities of the new role are similar to current with greater capability expected to be achieved from introducing the new model of care.. • All team members are expected to be culturally competent
Social Workers (2.0fte)	Reconfirmed in Whānau Ora Practitioner role	• Skills and experience required are similar. • Responsibilities of the new role are similar to current with greater capability expected to be achieved from introducing the new model of care.. • The new role is a generic job title that may be fulfilled by individuals from a range of health/clinical or social service disciplines.
Kaumatua role (2.0fte)	Change in reporting line: transfer to GM Māori Health Development	• To provide cultural support for whole Māori Health Development team • All Whānau Ora team members are expected to be culturally competent
Vision Hearing Technician role (1.0fte)	No change	• Role ring-fenced.
Personal Assistant (PA)	No change	• Out of scope (non service delivery role)
Service manager	No change	• Out of scope (non service delivery role)

Table 6: Summary of role changes

Cost of service

It is anticipated that the new model of care will be FTE neutral, however the cost per budgeted FTE may increase. Direct costs associated with the service such as vehicle use, equipment or supplies may also increase along with one-off costs associated with establishment of the service. Depending

on the final outcome, implementation of some components of the model of care such as the introduction of weekend oncall hours, may be phased

The development of an IT platform to track, monitor and evaluate the outcomes of service activity will be explored alongside Project SWIFT (System Wide Integration For Transformation). Options to adopt e.shared care which is being rolled out as part of the At Risk Individual (ARI) programme will be explored. Following the consultation phase, a budget for the agreed service will be developed.

Consultation process and timeframes

In addition to the release of this document, meetings with staff potentially impacted by the proposal will be met with individually and/or as a team. The proposal will also be shared with the relevant union representatives will be held. It is important that staff take the time to review the content of this document. The timeframe for consultation and development of a final decision document include:

Process	Timeframe
Consultation	9th to 27th Feb 2015
Final decision document	Mid-March 2015
Implementation commences	End of March 2015
New model of care takes effect	1 July 2015

Staff support

Change is always challenging. If members of the team wish to access the Employee Assistance Programme for external support, they may do so by phoning 0800 327669 or by visiting their website www.eapservices.co.nz

The proposal will also be provided to the relevant unions for feedback and to enable delegates/ organisers to support staff. The PSA will be the main union involved and work is underway to identify which PSA Organiser will be providing support and input throughout the process. Contact details are:

PSA Organiser Joe McCrory
Free phone: 0508 367 772
Email: joe.mccrory@psa.org.nz

Giving feedback

You can provide feedback on any aspect of the proposed changes as a group or as individuals. You are invited to comment on the strengths of the proposal and suggest options for improvement. There are **3** ways to give feedback:

1. A feedback form is attached for providing written feedback
2. An electronic survey (via Survey Monkey) which can be accessed from this link: https://www.surveymonkey.com/r/whanauora
3. Attendance at stakeholder meetings (To be confirmed)

Please feedback in writing to:

Ian Kaihe-Wetting - Service Manager
Te Kaahui Ora Māori Health Services
Ian.Kaihe-Wetting@middlemore.co.nz

Building 38B Middlemore Hospital,
Private Bag 93311, Otahuhu, Auckland 1640.

The closing date for submissions is 5pm on the 27th February 2015

References

1. Health Partners Consulting Group Ltd, Shea Pita & Associates Ltd. Counties Manukau Health Maaori Health Review – Final Draft Report. Auckland: Counties Manukau District Health Board, 2013.
2. National Hauora Coalition. Whānau Ora System - At a Glance Auckland: National Hauora Coalition, 2012.
3. Childrens' Commissioner. Choose kids: Why investing in children benefits all New Zealanders. Wellington: Office of the Childrens' Commissioner, 2014.
4. Paterson R, Candy A, Lilo S, et al. External Review of Maternity Care in the Counties Manukau District. Auckland, New Zealand: Counties Manukau District Health Board, 2012.
5. Jackson C. Perinatal Mortality in Counties Manukau. Report for Counties-Manukau District Health Board (CMDHB). Auckland, New Zealand, 2001.
6. National Hauora Coalition. Māori Health Innovation Programme. Auckland: National Hauora Coalition, 2012.

Appendix 1: New Roles Proposed

It is anticipated that all roles in the proposed model of care will be able to fulfil the following skills and experience requirements.

Skills required

- Ability to whakawhānaungatanga
- Whakawhitiwhiti korero (facilitation)
- Knowledge of Te reo me ona tikanga
- Whānau assessment and problem-solving
- Health literacy
- Ability to develop effective relationships with clinical teams, primary care, community providers
- Knowledge of patient rights, health and financial entitlements; grants and subsidies
- Knowledge of government agencies

Experience desired/ required

- Case management experience
- Community and social service development
- Understanding of hospital/ health system
- Experience in health promotion, motivational interviewing or health lifestyles coaching
- Experience in whānau screening and intervention
- Experience working in South Auckland / CMH
- Experience working in a multi-disciplinary team

In addition, there are functions and requirements more specific to the following roles:

Position	Purpose of the role	Key functions	Requirements
Team Leader	To provide clinical leadership and effective operational (human resource, administrative and financial) management of the Whānau Ora Service To deliver outcomes through the active engagement and collaboration with CMH clinical services, general practice teams; locality teams and community health and social service providers. To develop the capability of Whānau Ora service team members as part of a wider Māori health workforce development strategy .	• To develop, implement, monitor and evaluate all policies, processes and resources required to deliver the service. • To monitor and evaluate service activity delivery and outcomes • Monitor and evaluate quality systems and processes to facilitate effective service delivery • Ensure standards of practice are in alignment with the HPCAA; NZ Health and Disability standards and the CMH policies and procedures • Monitor and report on clinical indicators and whānau outcomes as part of service evaluation framework • Develop and maintain functional relationships with key stakeholders within CMH, primary care and the wider community • Support and develop team skills and capability to meet complex whānau needs	• Qualified registered health professional / clinician with post graduate tertiary qualification in a relevant clinical speciality eg. long term conditions management • Case management experience • Experience in operational management of a clinical team/ service • Excellent people management and interpersonal skills • Technology savvy • Data analysis skills

Whānau Ora Practitioner	• To engage, support, facilitate and work with whānau to achieve whānau directed goals using a case management approach • To encourage personal and public health interventions that support whānau towards goals that support self-management.	• Engage with whānau to establish mutually agreed goals and priorities for outcomes of care • Promoting the concept of self care and inclusion of whānau in provision of care • Communicating clearly and effectively with client, whānau and the interdisciplinary team to ensure appropriate interventions within the context of Māori cultural norms and practices • To undertake whānau ora assessments for clients and their whānau • Working in partnership with client/ whānau other health care providers to assess, plan, deliver and evaluate outcomes of care • Provide advocacy, education and information in a way that is understood to clients/whānau	• Qualification in a relevant health or social service field • Degree or tertiary qualification in a Health related discipline (desired) • Case management experience • Community and social service development • Understanding of hospital/ health system • Experience in health promotion, motivational interviewing or health lifestyles coaching such as smoking cessation or exercise • Experience in screening and intervention such as child safety; family violence

Feedback Form: Te Rapunga Paeora – Proposal for Whānau Ora Model of Care

This form provides an opportunity for key stakeholders to provide written feedback on the proposal. Please type or write legibly and send to:

Ian Kaihe-Wetting - Service Manager
Te Kaahui Ora Māori Health Services
Ian.Kaihe-Wetting@middlemore.co.nz

Building 38B Middlemore Hospital,
Private Bag 93311
Otahuhu, Auckland 1640.

The closing date for submissions is 5pm on the 27th February 2015.

Personal information: *(this is optional)*

Name	
Role	
Email	
Phone	
Service or organisation:	
I am responding: (please select one) • As an individual • On behalf of a service/ organisation • Other_____	

Please feel free to respond to some or all of the following questions, or provide feedback on any aspect.

1. Does the proposal provide a clear reason for change and direction for the future?
2 The proposal identifies 2 areas of the population where we intend to focus our efforts. • Mama, Pepi & Tamariki (conception to 14yrs); • Whānau with High Needs (Rangatahi to Kaumatua) Do you agree or disagree with the prioritisation of these groups? Please state your reasons.
3. Does the proposal describe a robust Whānau Ora service delivery model?

4. What are the interventions that you believe are most likely to make a difference to whānau?
5. What measures or indicators should matter most in this model of care?
6. A planned exit point is necessary to ensure whānau become self-managing. Do you have suggestions on exit criteria or ways to transfer care?
7. Central to delivery of Whānau Ora case management services are Whānau Ora Practitioners. What skills and experience do you believe are required to work successfully with whānau?
8. While the service is hospital-based, follow up in the community will be required and collaboration with primary care and community providers will be essential. What are your suggestions for a) avoiding service duplication and b) fostering effective collaboration?
a) Avoiding duplication b) Fostering effective collaboration
9. What impact will the impact of this proposal have on you personally or as a provider of services for Māori?
10. Do you have any other comments on the strengths of the proposal or any opportunities for improvement?

Ngā mihi

The King's Fund

Ideas that change health care

Population health systems

Going beyond integrated care

Authors

Hugh Alderwick

Chris Ham

David Buck

February 2015

Contents

1 **Summary** 2

2 **From integrated care to population health** 3

Integrated care 3

Population health 4

Joining up the dots 6

3 **Examples of emerging population health systems** 11

Kaiser Permanente, United States 11

Nuka System of Care, Alaska 14

Gesundes Kinzigtal, Germany 15

Counties Manukau, New Zealand 17

Jönköping County Council, Sweden 19

Summary of these approaches 20

4 **Implications for England** 23

Where next? 27

References 29

About the authors and acknowledgements 36

1 Summary

Integrated care has become a central part of the language of health service reform in England in recent years due to the challenges posed by an ageing population and the changing burden of disease. Policy initiatives introduced by the coalition government have sought to accelerate integration of services both within the NHS and between NHS and social care, and some areas are making progress in co-ordinating care for older people and those with complex needs.

While this shift marks progress from the fragmentation that has come to characterise the NHS and social care system, these efforts have not typically extended into a concern for the broader health of local populations and the impact of the wider determinants of health.

Just as with integrated care, there is a long history of public health policy initiatives in England. Yet the paths of integrated care and public health have rarely crossed.

The central purpose of this paper is to challenge those involved in integrated care and public health to 'join up the dots'. This challenge recognises that population health is affected by a wide range of influences across society and within communities. Improving population health is not just the responsibility of health and social care services, or of public health professionals. Instead, we argue that it requires co-ordinated efforts across *population health systems*.

This means thinking of integrated care as part of a broader shift away from fragmentation and heading towards population health. Making this shift will require action and alignment across a number of different levels, from central government and national bodies to local communities and individuals.

There are a small number of examples from other countries where organisations and systems have sought to go beyond simply integrating care services to focus on improving the health of the populations they serve. These examples provide lessons for us in England as the development of integrated care continues.

2 From integrated care to population health

Integrated care

There is a long history of policy initiatives in England designed to promote integrated care, dating back at least to the 1960s. Most recently, amendments to the Health and Social Care Bill (following the unprecedented 'listening exercise') created legal duties to promote integrated care, a programme of integrated care pioneers has been established, and the Better Care Fund has been set up to pool some of the funding for health and social care. Health and wellbeing boards were created by the Health and Social Care Act 2012 to provide a local forum for the development of integrated care, and some areas are planning to go much further than required under national policy initiatives. The Care Act 2014 also includes a duty for local authorities to promote integrated working.

There are very clear reasons why integrated care has attracted growing attention and support. Population ageing and the changing burden of disease (especially the increased prevalence of long-term conditions) require care to be co-ordinated within the NHS and between health and social care. Nowhere is this more important than in the case of people with multiple long-term conditions (multi-morbidity), many of whom are in regular contact with several health and social care professionals as well as receiving care from families, friends and volunteers. Unless these professionals work together in responding to people's needs, and treat the person as a whole rather than the presenting medical condition, there is a risk that care will be fragmented and deliver poor outcomes.

The experience of organisations and systems that have achieved high levels of integration illustrates the benefits of this way of working for patients and populations (Curry and Ham 2010). A well-known example in England is Torbay, where health and social care services have been working together in the community for more than a decade, delivering particular benefits for older people (Thistlethwaite 2011). Many other areas of England have followed Torbay's example by creating

integrated health and social care teams in the community aligned with general practices and, increasingly, with hospitals. A number of these areas are beginning to realise the benefits of integration by helping people to remain living independently in their own homes for longer and reducing the use of some hospital services.

Similar experiences have been reported from initiatives in other parts of the world, including Canada, the United States, Europe and New Zealand (Timmins and Ham 2013; Curry and Ham 2010). Some organisations and systems in these countries have sought to go beyond the integration of care for patients and service users to explore how they can use their resources to improve the health of the populations they serve. Examples include long-established integrated systems such as Kaiser Permanente in the United States (often referred to as a health maintenance organisation), which is described in more detail later in this paper.

Population health

Efforts to improve the health of populations often use the language of public health or population health. Like integrated care, population health means different things to different people, but can be broadly defined as 'the health outcomes of a group of individuals, including the distribution of such outcomes within the group' (Kindig and Stoddart 2003).

While access to traditional health and care services plays an important part in determining the health of a population, evidence suggests that this is not as important as lifestyle, the influence of the local environment, and the wider determinants of health – that is, the conditions in which people are born, live and work (Canadian Institute for Advanced Research *et al*, cited in Kuznetsova 2012; Booske *et al* 2010; Marmot *et al* 2010; McGinnis *et al* 2002; Bunker *et al* 1995). This means that improving population health requires efforts to change behaviours and living conditions across communities. It also means that accountability for population health is spread widely across these communities, not concentrated in single organisations or within the boundaries of traditional health and care services.

Following the lead of organisations like Kaiser Permanente and the influence of the 'Triple Aim' – defined by the Institute for Healthcare Improvement (IHI) as improving patient experience, improving the health of populations, and reducing

the costs of health care – there has been growing interest in population health in the United States in recent years from accountable care organisations and other integrated health systems.

Because of the way the US health care system works, these organisations and systems have typically focused on improving the health of specific groups of people covered by health plans rather than the whole of a population living within a defined area (Noble *et al* 2014; Jacobson and Teutsch 2012). They have also often focused on improving the health of these populations 'one person at a time' – with patients as the primary unit of intervention rather than broader populations (Noble *et al* 2014). This means that these approaches can quickly lose their connection with population health, focusing primarily on medical interventions for patients and neglecting the wider determinants of health and the distribution of health outcomes across populations (Sharfstein 2014).

In England, there has been a succession of initiatives over the past 40 years designed to give greater attention to preventing ill health and rediscovering the role of public health. However, an important difference in the English context is the definition of the population group whose health is being managed or improved. Unlike in the United States, where the focus is on members or attributed patients, in England the focus is on all those who live in a defined area and who are served by the local 'health authority' (to use the overarching term). The importance of the wider determinants of health has long been recognised following the analysis of health inequalities presented in the Marmot, Acheson and Black reports (**Marmot *et al* 2010**; Acheson 1998; Department of Health and Social Security 1980). From this perspective, population health management focused on individuals has a place (for example, through 'making every contact count'), but needs to be underpinned and complemented by interventions designed to tackle the underlying social, economic and environmental determinants of health across populations (*see* Figure 1, p 8).

Approaches to population health are beginning to gain traction in different parts of the world. In the United States, some accountable care organisations and other integrated systems are emulating Kaiser Permanente's approach, and some of these systems are transforming into accountable health communities based on collaboration across sectors and geographies (Magnan *et al* 2012). Similar approaches can be found in New Zealand and the Nordic countries, where the role of regional and local government in funding and providing health care creates

a favourable environment for partnerships across the public sector to promote population health. Closer to home, the transfer of public health responsibilities to local authorities has led to renewed interest in their role in improving the health of the populations they serve. Examples of some of these systems are explored later in this paper.

Joining up the dots

Returning to the English context, the main focus of integrated care has been on bringing different parts of the NHS closer together, as well as building bridges between health and social care. These efforts have centred on co-ordinating care services for older people and those with long-term conditions, in line with international evidence and national policy initiatives. While there are some examples of this extending into a concern for population health, most of the current initiatives have started with local government (as in the case of the health commissions established in Liverpool and London), and the role of public health is not yet well articulated within work on the Better Care Fund and the integrated care pioneer programme.

In view of the scale of the challenges involved in moving from fragmented care to integrated care – both within the NHS and between health and social care – this narrow focus is entirely understandable, but there is a risk of a much bigger opportunity being missed unless stronger connections are made between different strands of activity. This is particularly the case in the context of the *NHS five year forward view* and its emphasis on the dual role of the NHS in prevention and lifestyle support as well as developing new models of care (NHS England *et al* 2014). In writing this paper, our principal purpose is therefore to challenge those involved in integrated care and in public health to 'join up the dots'. Put simply, this means thinking of integrated care as part of a broader shift away from fragmentation and towards population health.

The need to make this shift is clearly articulated by the body of evidence about our population's health, lifestyles and the impact of the wider determinants of health. This evidence is well known and includes the following.

- The persistence of large and avoidable differences in health outcomes between social groups, which are, in many cases, widening (Marmot *et al* 2010). This includes large differences in health outcomes within local populations.

- The prevalence of multi-morbidity increases with deprivation (Barnett *et al* 2012; Department of Health 2012). A recent study of patients in around 500 general practices found that 29 per cent of people with three long-term conditions were from the most deprived quintile of the population, compared with only 14 per cent from the least deprived (Charlton *et al* 2013).

- The development of single and multiple morbidities is clearly linked to lifestyle (Sabia *et al* 2012). Yet seven out of ten adults in England fail to adhere to two or more government guidelines in four areas of behaviour that affect health (smoking, alcohol, diet and physical activity) (Buck and Frosini 2012).

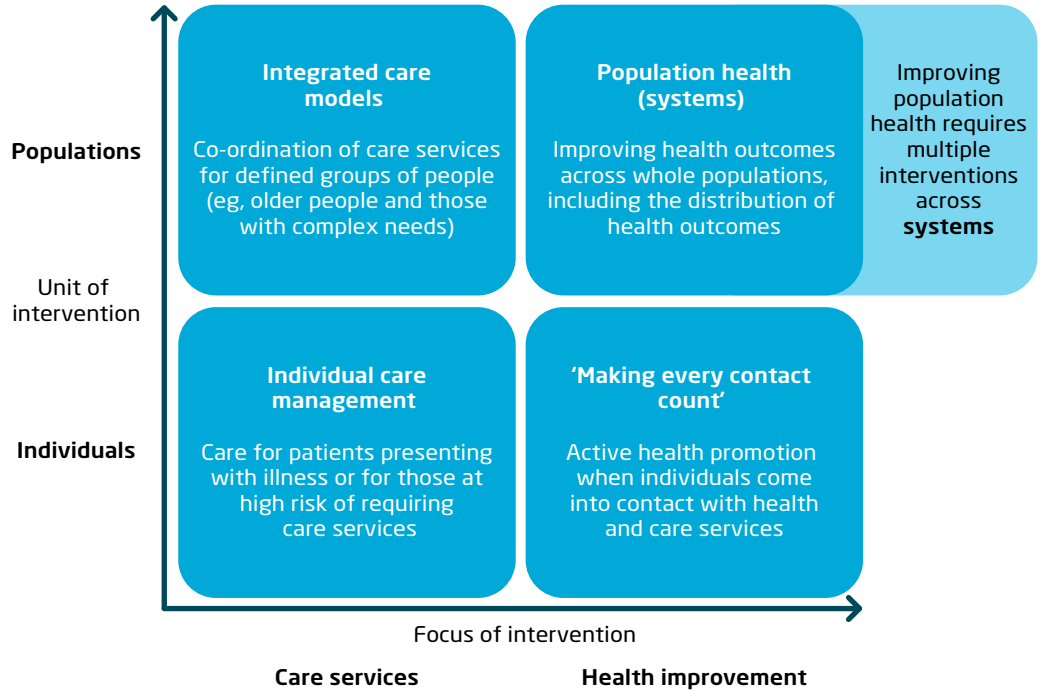
- Unhealthy lifestyles are increasingly clustering and polarising within the population. Between 2003 and 2008, the relative risk of men from unskilled backgrounds in England displaying unhealthy behaviours in these four areas compared to professionals increased from a ratio of 3:1 to 5:1 (Buck and Frosini 2012).

- Early life experiences in the womb, home and school are critical to health and wellbeing over the life course (Giesinger *et al* 2014; Allen 2011a, 2011b; Marmot *et al* 2010). However, evidence suggests that child health and wellbeing may have worsened in recent years, and in the current decade England is likely to face the first rise in absolute child poverty since records began in the 1960s (Social Mobility and Child Poverty Commission 2014; Taylor-Robinson *et al* 2014; UNICEF 2014).

Making this shift towards population health will require collaboration across a range of sectors and wider communities – between NHS organisations, local authorities, the third sector and other local partners, as well as patients and the public (Foot *et al* 2014), working together as *population health systems.* Thinking about this shift in relation to systems rather than organisations is crucial because of the complex range of influences on population health.

As outlined in Figure 1, what we are describing here as population health systems have a wider focus than most of the approaches to integrated care in England to date. While interventions focused on individuals and integrating care services for key population groups are important, these must be part of a broader focus on promoting health and reducing health inequalities across whole populations.

Figure 1 The focus of population health systems



Elements of this approach are already in place in some parts of England. A well-known example is the Bromley by Bow Centre in east London. Established in 1984 and now serving around 2,000 people every month, its work is based on collaboration across services and sectors to improve the health and wellbeing of vulnerable young people, adults and families across the local community – one of the most deprived wards in London. Alongside GP services, the centre is home to a range of activities and services including social welfare and legal advice, adult skills and employment programmes, money management services, social groups and other community activities, as well as healthy lifestyle programmes. Local GPs refer people to these services and others like them in the borough.

Other areas have developed similar initiatives that connect the NHS to a range of local services focused on specific aspects of people's health and wellbeing. This includes service models where social welfare, legal and debt advice are provided alongside traditional health and care services, and close links are made between the

two. In Derbyshire, for example, the Citizens Advice Bureau provides support to individuals and families in 98 out of 102 general practices in the county. In 2013/14, around 6,500 people received advice through the service, dealing with nearly 30,000 problems (Buck and Jabbal 2014, p 69).

Elsewhere, some professional groups are starting to play new roles in promoting public health and wellbeing. In Wigan, 70 community pharmacists offer smoking cessation and sexual health advice services, as well as referring people to relevant services if they spot early signs of issues like isolation, dementia or the risk of falls. The approach is now being extended to dental practices in the area. Wigan Council has also established a community investment fund to provide support for ideas from the community sector that will improve people's health and wellbeing.

In other parts of the country, programmes are being established that recognise the connections between people's health and their living environments. One example is Liverpool City Council's Healthy Homes Programme, which uses targeted assessments of people's health needs and the conditions in their homes to identify interventions to improve health and wellbeing. Interventions include 'health-proofing' homes from damp and excess cold, removing hazards in the home to reduce accidents, and giving advice on fuel poverty and keeping homes warm, as well as referrals to a range of local partner organisations. The programme has achieved reductions in the number of excess winter deaths and financial savings for the NHS, among other things (Public Health England 2013).

A similar example can be found in the West Midlands Fire Service, which delivers a range of programmes that recognise the links between keeping people safe in their homes and the impact of poverty, deprivation and lifestyle. The fire service works with partners across the community to help make homes safer, tackle anti-social behaviour, and support people to live healthier lives (*see* www.wmfs.net/).

As well as joining up local services, some parts of the country are also beginning to harness the power of local communities in shaping their health and care services and improving community health and wellbeing. In some areas, volunteers have been trained to become 'community health champions', supporting people in their neighbourhoods and broader communities to lead healthier lives, as well as working with commissioners and providers to improve the quality of services available in their local area (*see* www.altogetherbetter.org.uk; NHS Confederation and Altogether Better 2012).

Taking a broader focus, various recent national initiatives have tried to encourage the development of place-based approaches to funding and designing public services. The coalition government has piloted whole-place community budgets in an attempt to bring together budgets and services for families with complex needs in different parts of the country. Despite a number of challenges, some of these areas are beginning to show progress in building partnerships across the public sector (House of Commons Communities and Local Government Committee 2013). Before that, the Total Place pilots established by the previous government also sought to reshape resources according to local population needs rather than separate organisational funding models (**Humphries and Gregory 2010**).

At a city-wide level, the recently established Mayoral Health Commissions in Liverpool and London have ambitious plans for services to work together across their cities, boroughs and local communities to improve the health of their populations and tackle the wider determinants of health (**London Health Commission 2014**; **The Mayoral Health Commission 2014**). Some health and wellbeing boards are also growing into their roles and starting to design plans to join up local services to improve population health.

By highlighting these examples, we are recognising some of the building blocks that are already in place across the country to support the shift that we have described towards population health (and more examples can be found in **Local Government Association 2015**; **Local Government Association and Public Health England 2014**; **Buck and Gregory 2013**). The challenge for local areas is how to build on and join up these often small-scale initiatives to create a systemic approach to improving population health across services and sectors. Those areas that have already developed system-wide plans for improving population health face a further challenge: putting the right foundations in place to make these plans a reality.

In the next section, we describe examples of organisations and systems in other countries that have started to make this shift towards population health. Then we explore what needs to happen to support these developments in the English context.

3 Examples of emerging population health systems

To help articulate the shift described in the first part of this paper, we now discuss some examples from different parts of the world where systems are emerging that are focusing on improving population health. Rather than offering a comprehensive review of the way these systems work, the examples simply aim to illustrate how population health has been interpreted in different systems and the interventions that have been used or proposed. These examples were selected based on the authors' knowledge of developments in other countries and the views of a small number of international experts. Taken together, they provide a picture of the shift being made towards population health in different countries and provide lessons for local areas in England as the journey towards integrated care continues.

After describing each example at a high level, we outline a broad framework to help interpret the approaches taken by these organisations and systems to improve the health of the populations they serve. The framework explores similarities in their approach at macro, meso and micro levels.

Kaiser Permanente, United States

Kaiser Permanente started out in the 1930s as a prepaid health care system for workers building dams in the Californian desert, where there was a strong incentive to reduce injuries through prevention. The apocryphal story of Sidney Garfield (the first doctor who worked for Kaiser Permanente) hammering down rusty nails to avoid workers being injured and requiring expensive medical care illustrates what this meant at the time. Today, Kaiser Permanente is a non-profit health maintenance organisation serving around 9.5 million members, their families and wider communities across the United States.

Kaiser Permanente's structure and its longstanding efforts to integrate services are well known and described in detail elsewhere (Curry and Ham 2010; McCarthy and Mueller 2009). Key organisational features include its role as both insurer and provider of care (within and outside of hospitals), and the use of capitated budgets for members' care across regions. Among other things, integration of care at Kaiser Permanente is supported by population risk stratification, an emphasis on prevention and self-management, disease management and the use of care pathways for common conditions, case management for patients with complex needs, extensive use of technology and population data, and a model of multispecialty medical practice where unplanned hospital admissions are seen as a 'system failure'.

Over the past decade, Kaiser Permanente has shifted its focus from people with long-term conditions with the most complex needs 'at the tip of the triangle' to all of those for whom it has responsibility. It uses data about the population it serves, available through its system-wide electronic health record, to understand members' health needs and the distribution of health outcomes. Using these data, Kaiser Permanente offers a range of interventions tailored to the needs of different individuals and population groups to support people to remain healthy and to deliver the right treatments when they become ill.

One example of this is Kaiser Permanente's approach to preventing and treating heart disease. It has focused heavily on preventive interventions like smoking cessation, promoting exercise and other lifestyle changes to reduce the risk of developing heart disease across member populations. Between 2002 and 2005, in Northern California, Kaiser Permanente helped reduce prevalence of smoking among its members by 25 per cent, compared with a 7.5 per cent reduction across California as a whole (Levine 2011). Smoking cessation interventions have been combined with a range of other interventions – from primary and secondary prevention through to acute care and the management of chronic illness – to form a systematic approach to the prevention and treatment of heart disease across Kaiser Permanente member populations. Among its members in Northern California, the rate of heart disease mortality decreased by 26 per cent from 1995 to 2004, and members were 30 per cent less likely to die from heart disease than other Californians in 2004 (McCarthy and Mueller 2009).

Across Kaiser Permanente as a whole, the success of this approach to improving members' health is evidenced by the organisation's consistent high performance

in national Healthcare Effectiveness Data and Information Set (HEDIS) measures (Kaiser Permanente 2015c; Kaiser Permanente 2014), as well as its strong performance compared with other health systems across the world, including the NHS (Ham *et al* 2003; Feachem *et al* 2002).

As well as focusing on improving members' health, Kaiser Permanente has been involved for a number of years in efforts to improve the 'total health' of the broader communities it serves. For example, to help improve the availability of healthy food, Kaiser Permanente supports food stores in deprived areas to stock fresh fruit and vegetables, sets up farmers' markets at Kaiser Permanente facilities and in the community, and works with local schools to offer healthier food and drink options for pupils. It also provides financial support for food banks and other food assistance programmes. In schools and community centres, Kaiser Permanente runs a range of educational theatre programmes using music, comedy and drama to help educate children and adults about their health and wellbeing. These programmes have reached around 15 million children over the past 25 years (Levi *et al* 2013).

As part of these efforts, Kaiser Permanente has also established a range of Community Health Initiatives to support the development of place-based interventions to improve population health. It has sponsored or co-founded more than 40 Healthy Eating Active Living (HEAL) collaboratives since 2006, typically focused on:

- ensuring that health is considered in local government plans and policies (for example, through creating bike paths or walking trails)
- improving access to green spaces and community gardens
- improving access to healthy food in schools, workplaces and deprived areas
- promoting physical activity across the whole population
- utilising community assets to support and sustain initiatives (*see* Kaiser Permanente 2015b).

These initiatives involve collaboration between a range of organisations and groups across different sectors working in partnership with their local communities. They

have had some positive results – for example, increasing levels of physical activity and improving aerobic fitness among school-age children (Cheadle *et al* 2012; Kaiser Permanente 2012). Evaluation of these place-based initiatives continues, and findings and key lessons are shared online (Kaiser Permanente 2015a).

Nuka System of Care, Alaska

Southcentral Foundation is a non-profit health care organisation serving a population of around 60,000 Alaska Native and American Indian people in Southcentral Alaska, supporting the community through what is known as the Nuka System of Care (Nuka being an Alaska Native word meaning strong, giant structures and living things).

Nuka was developed in the late 1990s after legislation allowed Alaska Native people to take greater control over their health services, transforming the community's role from 'recipients of services' to 'owners' of their health system, and giving them a role in designing and implementing services (Gottlieb 2013). Nuka is therefore built on partnership between Southcentral Foundation and the Alaska Native community, with the mission of 'working together to achieve wellness through health and related services'. Southcentral Foundation provides the majority of the population's health services on a prepaid basis.

The Nuka System of Care incorporates key elements of the patient-centred medical home model, with multidisciplinary teams providing integrated health and care services in primary care centres and the community, co-ordinating with a range of other services (Driscoll *et al* 2013; Graves 2013; Johnston *et al* 2013). This is combined with a broader approach to improving family and community wellbeing that extends well beyond the co-ordination of care services – for example, through initiatives like Nuka's Family Wellness Warriors programme, which aims to tackle domestic violence, abuse and neglect across the population through education, training and community engagement. Traditional Alaska Native healing is offered alongside other health and care services, and all of Nuka's services aim to build on the culture of the Alaska Native community.

Alaska Native people are actively involved in the management of the Nuka System of Care in a number of ways. These include community participation in locality-based advisory groups, the active involvement of Alaska Native 'customer owners'

in Southcentral Foundation's management and governance structure, and the use of surveys, focus groups and telephone hotlines to ensure that people can give feedback that is heard and acted on. As well as building strong relationships with the population it serves, the Nuka System of Care depends on collaboration between Southcentral Foundation and a range of local, regional and national partners. New collaborations are being established each year as gaps in services are identified and filled.

Since it was established, the Nuka model of population-based care has achieved a number of positive results, including:

- significantly improved access to primary care services
- reductions in hospital activity, including:
  - 36 per cent reduction in hospital days
  - 42 per cent reduction in urgent and emergency care services
  - 58 per cent reduction in visits to specialist clinics
- performance at the 75th percentile or better in 75 per cent of HEDIS measures
- customer satisfaction, with respect for cultures and traditions at 94 per cent (**Gottlieb 2013**).

Gesundes Kinzigtal, Germany

Gesundes Kinzigtal (meaning 'healthy Kinzigtal') is a joint venture between a network of physicians in Kinzigtal and a Hamburg-based health care management company, OptiMedis AG. Gesundes Kinzigtal is responsible for organising care and improving the health of nearly half of the 71,000 population in Kinzigtal in south-west Germany.

Since 2006, Gesundes Kinzigtal has held long-term contracts with two German non-profit sickness funds to integrate health and care services for their insured populations, covering all age groups and care settings. Around a third of this population has actively enrolled in Gesundes Kinzigtal – free to all those insured – which allows access to a number of health improvement programmes offered by the organisation. Health care providers in Kinzigtal are directly reimbursed

by the sickness funds for their services, but Gesundes Kinzigtal holds 'virtual accountability' for the health care budget for this population group. If the sickness funds spend less on health care than the population budget, Gesundes Kinzigtal shares the benefits (Hildebrandt *et al* 2010; 2012).

To help keep the population of Kinzigtal healthy and reduce care costs, Gesundes Kinzigtal contracts with traditional health and care providers as well as collaborating with a range of community groups including gyms, sports clubs, education centres, self-help groups and local government agencies. Through these collaborations, Gesundes Kinzigtal offers gym vouchers to encourage people to stay active as well as dance classes, glee clubs and aqua-aerobics courses. It also runs health promotion programmes in schools and workplaces and for unemployed people, and 'patient university' classes to offer health advice to support prevention and self-management.

As with many other integrated care systems, Gesundes Kinzigtal has developed targeted care management and prevention programmes for particular high-risk population groups, such as older people, those living in nursing homes, people with specific conditions, and those with high body mass index. Health professionals are trained in shared decision-making to ensure that patients are actively involved in their own care when they do require input from health services. Professionals also benefit from the availability of a system-wide electronic health record to ensure that information about patients is available across providers and care settings to support effective co-ordination of care.

External and internal evaluation has shown that this approach is improving health outcomes – most notably, reducing mortality rates for those enrolled in Gesundes Kinzigtal compared with those not enrolled (Busse and Stahl 2014; Hildebrandt *et al* 2012). There have been improvements in the efficiency of services, as well as people's experience of care. Gesundes Kinzigtal has also been successful in slowing the rise in health care costs for the population it serves (not simply those who have actively enrolled in Gesundes Kinzigtal). Between 2006 and 2010, it generated a saving of 16.9 per cent against the population budget for members of one of the sickness funds, compared with a group of its members from a different region. One of the main drivers of this saving related to emergency hospital admissions. Between 2005 and 2010, emergency hospital admissions increased by 10.2 per cent for patients

in Kinzigtal, compared with a 33.1 per cent increase in the comparator group (Hildebrandt *et al* 2012).

Counties Manukau, New Zealand

Counties Manukau Health (CMH) is responsible for commissioning health and care services for the whole population of 500,000 people living in South Auckland, New Zealand, and providing hospital and specialist services in the area. CMH works with a range of local and national partners to integrate services and improve the health of the population living in Counties Manukau.

As with many other integrated care systems, CMH has worked with local providers to develop locality-based integrated health and care teams aligned with networks of general practices and working in partnership with hospital services. Capitated budgets are allocated to primary care organisations to deliver care in their localities, and alliance agreements are used to share responsibility between locality partners and CMH. Services are tailored to the needs of different population groups within each locality, based on population risk stratification, ranging from primary prevention services and lifestyle support through to active case management for patients with complex health and social care needs, with the emphasis on supporting people to manage their own health. Each locality is served by a wider social care network to provide help and support to families with complex needs whose living environments are impacting their health.

While these locality networks are relatively embryonic, early indicators reported by CMH show improving trends in a number of areas. For example, immunisation, cardiovascular risk assessment and smoking cessation support rates have all increased from around 65 per cent to more than 90 per cent in the past two years, while acute hospital and care home utilisation rates are now below demographic growth rates.

Alongside these locality networks, CMH also runs a number of other well-established programmes with local partners designed to improve population health. One example is its Healthy Housing Programme – a joint initiative between CMH, neighbouring district health boards and Housing New Zealand, the government-owned social housing provider – which ran from 2001 to 2013. The programme

was open to all people living in rented Housing New Zealand accommodation, and focused on:

- improving access to health and care services
- reducing the risk of housing-related health issues
- identifying social and welfare issues and providing a link to relevant agencies.

After a joint visit and assessment from local health and housing teams, typical interventions included educating families about their health and health risks, referrals to health and social care services, installing insulation to make houses warmer and dryer, modifying houses to meet health and disability needs, and transferring families to alternative houses in cases of overcrowding. These interventions were tailored to the needs of different families and population groups – particularly the Māori and Pacific Island groups, which are disproportionately affected by poor housing conditions. The programme took a locality-by-locality approach to ensure that every eligible household was reached systematically and to reduce the potential for stigmatisation of families involved in the programme.

The programme had a clear impact on the health of families involved. An evaluation involving 9,736 residents in 3,410 homes found that the programme was associated with reductions in acute hospital admissions of 11 per cent (among 0- to 4-year-olds) and 32 per cent (among 5- to 34-year-olds), while housing-related hospital admissions fell by 12 per cent and 27 per cent respectively for these age groups (Jackson *et al* 2011). Qualitative evaluation found strong links between the programme and tenants' self-reported household wellbeing (Bullen *et al* 2008).

Other interventions run by CMH and its partners include the Providing Access to Health Solutions programme, which supports people in receipt of jobseeker support and other benefits to access appropriate health and vocational services to help them return to employment, and Smokefree 2025, which involves action across multiple sectors to meet the national policy goal of being a smoke-free nation by 2025.

Jönköping County Council, Sweden

Jönköping County Council is an elected regional health authority serving around 340,000 people in southern Sweden. Over the past 20 years, Jönköping County Council has pursued a population-based vision for its citizens of 'a good life in an attractive city'. It plans, funds and provides health services for this population, working in partnership with local government in the county's municipalities. It has considerable autonomy and tax-raising powers by virtue of Sweden's system of devolved government.

Jönköping County Council is best known for its work on quality improvement and developing integrated health and care services (**Ham 2014**). Staff and clinical teams have been encouraged to work together to think about how they can deliver the best outcomes for a fictional elderly resident, Esther, enabling them to map services that people receive across different settings and explore how they can be improved across systems. The benefits of this approach have included significant reductions in hospital admissions, days spent in hospital and waiting times for specialist appointments (Baker *et al* 2008).

Other services aimed at improving older people's health include Jönköping's Passion for Life programme, which recently won the European award for social innovation in ageing. It is based on a series of group meetings called 'life cafés', where people come together to collectively discuss how they can improve different aspects of their health and wellbeing. Life cafés are held in different locations depending on the topics being discussed – for example, in a gym if the topic is physical activity, or in a restaurant if the theme is diet and nutrition. Some of these life cafés have also focused on intergenerational activities and the specific needs of minority groups.

As well as integrating care and prevention services for older people like Esther, Jönköping County Council has taken a broad approach to planning and delivering services across the whole of the population it serves. It uses population-level data to understand the needs of different population groups, and uses a dashboard of indicators to monitor health outcomes across and within local populations. These indicators focus on a range of areas, including rates of obesity, alcohol consumption, physical activity, quality of diet, social deprivation, violent crime, school truancy and educational outcomes, as well as a range of measures of people's physical health. The Council then works in partnership with local government in Jönköping's

municipalities to plan and deliver services to improve population health in each locality.

In particular, Jönköping County Council has developed targeted strategies for four main population groups: children and young people, people with mental health conditions, people living with drug and alcohol addiction, and older people. Professionals from different sectors are brought together to design and implement new approaches to improving people's health across each of these groups. One example is Jönköping's collaborative programme for younger people with mental health conditions, which involves primary care and social care services, schools and the police, as well as a range of other local partners. Public health is seen as a core part of designing and delivering interventions across each of these population groups, rather than a separate strand of activity.

To support people to manage their own health across the population, 'learning cafés' (similar to the life cafés described above) have been set up that connect people with similar conditions and draw on the expertise of 'expert patients'.

The impact of Jönköping County Council's population-based approach is evidenced by its consistent high performance across a range of public health indicators when compared with other parts of Sweden – including in relation to life expectancy, self-reported health status and emotional wellbeing (Socialstyrelsen *et al* 2014).

Summary of these approaches

In their different ways, the examples described in this section paint a picture of the shift that is being made in different parts of the world from integrated care to population health. While they take a variety of forms and are at different stages of development, these examples share a number of similarities in their approach and methods. In particular, the approaches taken by these systems can be described across three broad levels: macro, meso and micro.

At a **macro level**, the examples involve organisations working together across systems to improve health outcomes for defined population groups. Unlike typical approaches to integrated care that focus primarily on groups that are frequent users of health and care services, these systems aim to improve people's health across the whole of the populations they serve, as well as targeting specific interventions on the

most deprived groups. This population-level lens is used to plan programmes and interventions across a range of different services and sectors.

Key features that have supported these systems at a macro level include:

- population-level data to understand need across populations and track health outcomes
- population-based budgets (either real or virtual) to align financial incentives with improving population health
- community involvement in managing their health and designing local services
- involvement of a range of partners and services to deliver improvements in population health.

At a **meso level**, these systems have developed different strategies for different segments of the populations they serve, depending on people's needs and level of health risk. By grouping people with similar needs and tailoring services and interventions accordingly, this approach recognises that improving the health of older people and children, or healthy adults and those living with multiple long-term conditions, will require a different set of approaches, and involvement from different system partners to be effective.

Key features that have supported these systems at a meso level include:

- population segmentation and risk stratification to identify the needs of different groups within the population
- targeted strategies for improving the health of different population segments
- developing 'systems within systems' with relevant organisations, services and stakeholders to focus on different aspects of population health.

At a **micro level**, the examples deliver a range of interventions aimed at improving the health of individuals within the populations they serve. These interventions are many and varied, and involve input from a number of organisations and services

depending on their focus. In the examples described above they include housing support, education programmes, vocational services and employment advice, exercise programmes, smoking cessation services and other lifestyle support, as well as more traditional health and care services like care planning and individual case management for people with complex health and care needs.

Key features that have supported these systems at a micro level include:

- integrated health records to co-ordinate people's care services
- scaled-up primary care systems that provide access to a wide range of services and co-ordinate effectively with other services
- close working across organisations and systems to offer a wide range of interventions to improve people's health
- close working with individuals to understand the outcomes and services that matter to them, as well as supporting and empowering individuals to manage their own health.

Across these three levels, the examples that we have described illustrate what the shift towards population health means in practice, as well as the range of benefits that can be achieved from pursuing this way of working. In the final section of the paper, we build on these ideas to ask how we can support the development of this type of approach in England.

4 Implications for England

Making the shift from integrated care to population health in England requires NHS organisations to work much more closely with local authorities, third sector organisations and the private sector. It also requires alignment at all levels, starting in central government, cascading through local systems, and ultimately reaching into localities and neighbourhoods. Previous attempts to prioritise population health have met with partial success at best, and the challenges involved in acting on the ideas set out in this paper should not be underestimated.

To help provide clarity in meeting these challenges, the government and other national bodies need to develop a population health strategy for England that sets out goals for population health improvement, how these goals will be delivered and by whom. In some cases, this will mean national action through legislation or regulation; in other cases, it will require action by NHS organisations, local authorities and their partners.

While central government and statutory agencies must provide leadership for population health, third sector organisations and community groups also have a critical role to play. As we described in the first part of this paper, the health of a population is influenced by numerous factors, many of which are outside the control of the NHS and local government. Drawing on the expertise held within communities is therefore essential.

At a local level, the Mayoral Health Commissions in Liverpool and London illustrate how local authorities are embracing the enhanced role of local government in public health (London Health Commission 2014; The Mayoral Health Commission 2014). Elsewhere, health and wellbeing boards are beginning to act as a forum through which NHS organisations and local authorities can develop joint approaches to integrating health and social care and improving population health. While the impact and influence of these boards to date has been limited (Humphries and Galea 2013; Humphries *et al* 2012), their role as a forum for local leadership should be encouraged. These initiatives are embryonic examples of local system leadership in which leaders from different organisations work together on issues of common concern.

The transfer of responsibility for public health from the NHS to local government helps to explain the growing interest of local authorities in population health, but equally it risks detaching public health expertise from the NHS. This illustrates one of Leutz's original laws of integration, to the effect that 'your integration is my fragmentation' (Leutz 1999). Strengthening the role of public health in the NHS, while realising the potential of public health responsibilities being co-located with other local authority services, is critical in order to embed a population health perspective at local level.

As these ideas are taken forward, there are lessons to be learnt from the Total Place and Whole Place community budget initiatives established under the current and previous governments. These lessons include the need to overcome barriers (real or perceived) to data sharing between different organisations, as well as the vital role of leadership across local areas (House of Commons Communities and Local Government Committee 2013; **Humphries and Gregory 2010**). Experience of partnership working in public services is distinctly mixed, and the challenges in delivering results are considerable. At the same time, the potential gains are significant if the barriers can be overcome, especially when public services face further cuts in funding. This is particularly relevant in the context of the current government's plans to devolve greater responsibility for public sector spending and decision-making to cities and other local areas – as in the case of the planned devolution of powers to Greater Manchester (**Topping 2014**).

Much will depend on visible and consistent leadership at a local level by elected mayors and others, programme management arrangements to support implementation of local strategies, and an ability to find and retain the common high ground of a shared concern for the health and wellbeing of the population, regardless of organisational or professional loyalties. National bodies must also play their part by ensuring their actions do not create barriers to joint working at a local level and by aligning the requirements they place on the NHS and local government.

Aligning requirements means having a common outcomes framework to which different central government departments are fully committed – especially the Department of Health and the Department for Communities and Local Government – and which incentivises local areas to work to achieve common goals. This means trying not to place conflicting demands on NHS organisations and local government, and realising the links between the NHS, social care and public health.

It also means developing new ways of organising budgets and paying for services at a local level to incentivise investment in population health and joint working between organisations across systems.

The same need for alignment applies within the NHS itself, where fragmentation at the centre means that national bodies do not always work in a way that creates a coherent policy framework to support partnership working at a local level.

Public Health England and the National Institute for Health and Care Excellence (NICE) have a specific contribution to make in providing advice and guidance to the NHS and local government on evidence to support local decisions – for example, on the interventions that will have the greatest impact on health improvement. They could play a similar role in identifying ways in which central government can assess the health impact of its decisions and promote health in all policies. As a result of the recent reforms to the NHS and public health system, there is a lack of clarity about who is responsible for holding policy-makers across government departments to account for the impact of their decisions on population health (Gregory *et al* 2012).

For NHS organisations, a key question they must consider when approaching partnership working is what kind of business they are in. In this regard, there is much to be learnt from the transformation of the US Veterans Health Administration (VA) in the 1990s. The man who led the transformation, Ken Kizer, has described to us how the VA was traditionally seen as a hospital system before it reinvented itself as an integrated health and long-term care system. Subsequently, it faced the challenge of becoming a system focused on promoting the health and wellbeing of the veterans it served.

Kizer's reflection on the experience of the VA is that all health care organisations have to ask themselves what business they are in; are they running hospitals and other health services, seeking to deliver integrated care, or promoting health and wellbeing? His formulation of the challenge in this way is directly relevant to the challenges facing the NHS today and is, in essence, just a different way of defining the shift in thinking we have described in this paper. The answer to this question will determine the future direction of the NHS and its partners at a time of unprecedented challenges, as set out in the *NHS five year forward view*.

Whatever the answer, it is increasingly clear that the future depends on joint working between agencies in different sectors to create systems that are capable of transforming health and care in the direction set out in the Forward View. System working is needed to achieve this because, to invoke Atul Gawande, we are in *the century of the system* (Gawande 2014). By this, he means that delivering high-quality care and outcomes requires systems that support those responsible for care to make the right choices.

Particularly now, in the information age, it is no longer possible to rely on skilled craftspeople using their experience and professional judgement. System working is also important in the case of population health, where improved outcomes can be delivered only through collaboration between a variety of agencies and the many professionals who work in them. As Senge and colleagues have recently described, system leadership is critical for the times in which we live, and there needs to be active support for its development (Senge *et al* 2014).

Without system leadership, the problems facing our society will remain as intractable as ever. In health care, these problems include persistent and widening inequalities in health, the challenge of multi-morbidity, and increasing numbers of frail older people who account for a high proportion of need and demand for health and care services. There is little prospect that unco-ordinated action by multiple public and private agencies will be effective in tackling these problems, underlining the arguments we have advanced in this paper.

In emphasising the need for a broad-based approach to population health, it is important not to overlook the wider contribution of statutory agencies themselves. As the Forward View argues, these agencies could do much more by supporting staff to adopt healthy behaviours as a contribution to population health improvement (NHS England *et al* 2014). Beyond that, the NHS and local government need to recognise the significant contribution (either consciously or unconsciously) that they, as major employers, already make to population health, and the impact this has on local economies. The NHS is not only a treatment or prevention system; it also actively influences the wider determinants of health through its massive economic and social power in every community (Buck and Jabbal 2014).

As these ideas are taken forward in the NHS, the crucial role of primary care in supporting a population health approach must also be recognised (Thorlby 2013).

Community-oriented primary care has been debated for many years, and the strength of general practice in the NHS – notwithstanding recent pressures – offers an opportunity to show what this could mean in practice.

At a practical level, developing a population health systems perspective requires the following elements as a minimum:

- pooling of data about the population served to identify challenges and needs
- segmentation of the population to enable interventions and support to be targeted appropriately
- pooling of budgets to enable resources to be used flexibly to meet population health needs, at least between health and social care but potentially going much further
- place-based leadership, drawing on skills from different agencies and sectors based on a common vision and strategy
- shared goals for improving health and tackling inequalities based on an analysis of needs and linked to evidence-based interventions
- effective engagement of communities and their assets through third sector organisations and civil society in its different manifestations
- paying for outcomes that require collaboration between different agencies in order to incentivise joint working on population health.

Where next?

The history of well-intentioned public health strategies that have promised much but delivered less – dating as far back as *Prevention and health: everybody's business* in 1976 (Department of Health and Social Security 1976) – suggests caution in claiming that things will be different this time around. If there are reasons for optimism, they can be found in the major challenges facing public services in the next parliament, requiring responses that go well beyond tried and tested initiatives.

To help meet these challenges, the incoming government in 2015 should work with national bodies and local areas to take forward the ideas described in this paper. The permissive framework set out in the *NHS five year forward view*, with its emphasis on integrated care and health improvement, also provides a favourable policy context for the ideas set out here. Acting on these ideas should be seen as part of the health and care system's efforts to achieve the 'fully engaged' scenario outlined by Derek Wanless more than a decade ago (**Wanless 2002**).

References

Acheson D (1998). *Inequalities in health: report of an independent enquiry*. London: The Stationery Office.

Allen G (2011a). *Early intervention: smart investment, massive savings. The second independent report to Her Majesty's Government*. London: Cabinet Office. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/61012/earlyintervention-smartinvestment.pdf (accessed on 30 December 2014).

Allen G (2011b). *Early intervention: the next steps. An independent report to Her Majesty's Government*. London: Cabinet Office. Available at: http://media.education.gov.uk/assets/files/pdf/g/graham%20allens%20review%20of%20early%20intervention.pdf (accessed on 30 December 2014).

Baker GR, MacIntosh-Murray A, Porcellato C, Dionne L, Stelmacovich K, Born K (2008). *High performing healthcare systems: delivering quality by design*. Toronto: Longwoods Publishing Corporation.

Barnett K, Mercer S, Norbury M, Watt G, Wyke S, Guthrie B (2012). 'Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study'. *The Lancet*, vol 380, no 9836, pp 37–43.

Booske BC, Athens JK, Park H, Kindig DA, Remington PL (2010). *Different perspectives for assigning weights to determinants of health*. County Health Rankings Working Paper. University of Wisconsin, Population Health Institute. Available at: http://uwphi.pophealth.wisc.edu/publications/other/different-perspectives-for-assigning-weights-to-determinants-of-health.pdf (accessed on 19 January 2015)

Buck D, Frosini F (2012). *Clustering of unhealthy behaviours over time: implications for policy and practice*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/clustering-unhealthy-behaviours-over-time (accessed on 19 January 2015).

Buck D, Gregory S (2013). *Improving the public's health: a resource for local authorities*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/improving-publics-health (accessed on 9 February 2015).

Buck D, Jabbal J (2014). *Tackling poverty: making more of the NHS in England*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/articles/tackling-poverty (accessed on 19 January 2015).

Bullen C, Kearns RA, Clinton J, Laing P, Mahoney F, McDuff I (2008). 'Bringing health home: householder and provider perspectives on the healthy housing programme in Auckland, New Zealand'. *Social Science & Medicine*, vol 66, no 5, pp 1185–96.

Bunker J, Frazier H, Mosteller F (1995). 'The role of medical care in determining health: creating an inventory of benefits' in Amick III B, Levine S, Tarlov AR and Chapman Walsh D (eds), *Society and health,* pp 305–41. New York: Oxford University Press.

Busse R, Stahl J (2014). 'Integrated care experiences and outcomes in Germany, the Netherlands, and England'. *Health Affairs*, vol 33, no 9, pp 1549–58.

Canadian Institute for Advanced Research, Health Canada, Population and Public Health Branch AB/NWT 2002, cited in Kuznetsova D (2012). *Healthy places: councils leading on public health*. London: New Local Government Network.

Charlton J, Rudisill C, Bhattarai N, Gulliford M (2013). 'Impact of deprivation on occurrence, outcomes and health care costs of people with multiple morbidity'. *Journal of Health Services Research & Policy*, vol 18, no 4, pp 215–23.

Cheadle A, Rauzon S, Spring R, Schwartz PM, Gee S, Gonzalez E, Ravel J, Reilly C, Taylor A, Williamson D (2012). 'Kaiser Permanente's Community Health Initiative in Northern California: evaluation findings and lessons learned'. *American Journal of Health Promotion*, vol 27, no 2, pp e59–e68.

Curry N, Ham C (2010). *Clinical and service integration: the route to improved outcomes*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/clinical-and-service-integration (accessed on 19 January 2015).

Department of Health (2012). *Long term conditions compendium of information*, 3rd ed. London: Department of Health. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf (accessed on 13 January 2015).

Department of Health and Social Security (1980). *Inequalities in health: report of a research working group chaired by Sir Douglas Black*. London: The Stationery Office.

Department of Health and Social Security (1976). *Prevention and health: everybody's business*. London: The Stationery Office.

Driscoll DL, Hiratsuka V, Johnston JM, Norman S, Reilly KM, Shaw J, Smith J, Szafran QN, Dillard D (2013). 'Process and outcomes of patient-centred medical care with Alaska Native people at Southcentral Foundation'. *Annals of Family Medicine,* vol 11, suppl 1, pp 41–9.

Feachem RG, Sekhri NK, White KL (2002). 'Getting more for their dollar: a comparison of the NHS with California's Kaiser Permanente'. *British Medical Journal*, vol 324, no 7330, pp 135–43.

Foot C, Gilburt H, Dunne P, Jabbal J, Seale B, Goodrich J, Buck D, Taylor J (2014). *People in control of their own health and care: the state of involvement.* London: The King's Fund. Available at: www.kingsfund.org.uk/publications/people-control-their-own-health-and-care (accessed on 19 January 2015).

Gawande A (2014). Reith lectures: 'The century of the system'. Available at: www.bbc.co.uk/programmes/b04sv1s5 (accessed on 21 January 2015).

Giesinger I, Goldblatt P, Howden-Chapman P, Marmot M, Kuh D, Brunner E (2014). 'Association of socioeconomic position with smoking and mortality: the contribution of early life circumstances in the 1946 birth cohort'. *Journal of Epidemiology & Community Health*, vol 68, pp 275–9.

Gottlieb K (2013). 'The Nuka system of care: improving health through ownership and relationships'. *International Journal of Circumpolar Health*, vol 72. Available at: www.circumpolarhealthjournal.net/index.php/ijch/article/view/21118 (accessed on 19 February 2014).

Graves B (2013). 'Lower costs and better outcomes: a system of care built on relationships'. *British Medical Journal*, vol 347, f5301.

Gregory S, Dixon A, Ham C (eds) (2012). *Health policy under the coalition government: a mid-term assessment*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/health-policy-under-coalition-government (accessed on 19 January 2015).

Ham C (2014). *Reforming the NHS from within: beyond hierarchy, targets and inspection*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/reforming-nhs-within (accessed on 9 February 2015).

Ham C, York N, Sutch S, Shaw R (2003). 'Hospital bed utilisation in the NHS, Kaiser Permanente, and the US Medicare programme: analysis of routine data'. *British Medical Journal*, vol 327, p 1257.

Hildebrandt H, Timo S, Stunder B (2012). 'The triple aim in Kinzigtal, Germany: improving population health, integrating health care and reducing costs of care – lessons for the UK?'. *Journal of Integrated Care*, vol 20, no 4, pp 205–22.

Hildebrandt H, Hermann C, Knittel R, Richter-Reichhelm M, Siegel A, Witzenrath W (2010). 'Gesundes Kinzigtal integrated care: improving population health by a shared health gain approach and a shared savings contract'. *International Journal of Integrated Care*, vol 10, pp 1–15.

House of Commons Communities and Local Government Committee (2013). *Community budgets: third report of session 2013–14*. HC 163. London: The Stationery Office Limited.

Humphries R, Galea A (2013). *Health and wellbeing boards: one year on*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/health-and-wellbeing-boards-one-year-on (accessed on 19 January 2015).

Humphries R, Galea A, Sonola L, Mundle C (2012). *Health and wellbeing boards: system leaders or talking shops?*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/health-and-wellbeing-boards (accessed on 19 January 2015).

Humphries R, Gregory S (eds) (2010). *Place-based approaches and the NHS: lessons from Total Place*. London: The King's Fund. Available at: www.kingsfund.org.uk/sites/files/kf/place-based-approaches-nhs-seminar-highlights-richard-humphries-sarah-gregory-kings-fund-october-2010.pdf (accessed on 25 January 2015).

Jackson G, Thornley S, Woolston J, Papa D, Bernacchi A, Moore T (2011). 'Reduced acute hospitalisation with the healthy housing programme'. *Journal of Epidemiology & Community Health,* vol 65, no 7, pp 588–93.

Jacobson DM, Teutsch S (2012). *An environmental scan of integrated approaches for defining and measuring total population health by the clinical care system, the government public health system, and stakeholder organizations*. Washington DC: National Quality Forum.

Johnston JM, Smith JJ, Hiratsuka VY, Dillard DA, Szafran QN, Driscoll DL (2013). 'Tribal implementation of a patient-centred medical home model in Alaska accompanied by decreased hospital use'. *International Journal of Circumpolar Health*, vol 72. Available at: www.circumpolarhealthjournal.net/index.php/ijch/article/view/20960 (accessed on 10 February 2015).

Kaiser Permanente (2015a). 'Community health initiatives: evaluation and learning'. Kaiser Permanente Share website. Available at: http://share.kaiserpermanente.org/article/evaluation-and-learning/ (accessed on 10 February 2015).

Kaiser Permanente (2015b). 'Community health initiatives: place-based collaboratives'. Kaiser Permanente Share website. Available at: http://share.kaiserpermanente.org/article/place-based-collaboratives/ (accessed on 10 February 2015).

Kaiser Permanente (2015c). 'Healthier outcomes'. Kaiser Permanente Thrive website. Available at: http://thrive.kaiserpermanente.org/healthier-outcomes (accessed on 9 February 2015).

Kaiser Permanente (2014). Measuring care quality: Southern California region. California: Kaiser Permanente. Available at: https://healthy.kaiserpermanente.org/static/health/pdfs/quality_and_safety/sca/sca_quality_HEDIS.pdf (accessed on 9 February 2015).

Kaiser Permanente (2012). *Kaiser Permanente's HEAL-CHI initiative: summary of evaluation findings*. Available at: http://share.kaiserpermanente.org/media_assets/pdf/communitybenefit/assets/pdf/our_work/global/chi/HEAL-CHI%20overall%20results%20summary%2011-14-11.pdf (accessed on 30 December 2014).

Kindig D, Stoddart G (2003). 'What is population health?'. *American Journal of Public Health*, vol 93, no 3, pp 380–3.

Leutz W (1999). 'Five laws of integrating medical and social services: lessons from the United States and the United Kingdom'. *Milbank Quarterly,* vol 77, no 1, pp 77–110.

Levi J, Segal LM, Miller AF, Lang A (eds) (2013). *A healthier America 2013: strategies to move from sick care to health care in the next four years*. Washington DC: Trust For America's Health. Available at: http://healthyamericans.org/assets/files/TFAH2013HealthierAmericaFnlRv.pdf (accessed on 22 January 2015).

Levine S (2011). 'Multispecialty group practice: leveraging integration, partnership and physician responsibility to deliver performance'. Conference presentation, 31 March. Available at: www.kingsfund.org.uk/audio-video/sharon-levine-integrated-care (accessed on 30 December 2014).

Local Government Association (2015). *Public health transformation twenty months on: adding value to tackle local health needs*. London: Local Government Association. Available at: www.local.gov.uk/publications/-/journal_content/56/10180/6995080/PUBLICATION (accessed on 13 February 2015).

Local Government Association, Public Health England (2014). *Public health transformation nine months on: bedding in and reaching out. London: Local Government Association*. Available at: www.local.gov.uk/documents/10180/5854661/Public+health+transfornation+nine+months+on+-+bedding+in+and+reaching+out+-+publication/ce0b8b36-c81d-44f7-ba91-b0836a9b4822 (accessed on 4 February 2015).

London Health Commission (2014). *Better health for London*. Available at: www.londonhealthcommission.org.uk/wp-content/uploads/Better-Health-for-London-report-revised-November-2014.pdf (accessed on 30 December 2014).

Magnan S, Fisher E, Kindig D, Isham G, Wood D, Eustis M, Backstrom C, Leitz S (2012). 'Achieving accountability for health and health care'. *Minnesota Medicine*, vol 95, no 11, pp 37–9.

Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, Geddes I (2010). *Fair society, healthy lives: the Marmot review. Strategic review of health inequalities in England post-2010*. London: The Marmot Review. Available at: www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review (accessed on 13 January 2015).

McCarthy D, Mueller K (2009). *Kaiser Permanente: bridging the quality divide with integrated practice, group accountability, and health information technology*. New York: The Commonwealth Fund. Available at: www.commonwealthfund.org/publications/case-studies/2009/jun/kaiser-permanente (accessed on 25 January 2015).

McGinnis J, Williams-Russo P, Knickman J (2002). 'The case for more active policy attention to health promotion'. *Health Affairs*, vol 21, no 2, pp 78–93.

Noble DJ, Greenhalgh T, Casalino LP (2014). 'Improving population health one person at a time? Accountable care organisations: perceptions of population health – a qualitative interview study'. *BMJ Open,* vol 4, e004665.

NHS Confederation and Altogether Better (2012). *Community health champions: creating new relationships with patients and communities*. London: NHS Confederation. Available at: www.altogetherbetter.org.uk/SharedFiles/Download.aspx?pageid=36&mid=57&fileid=89 (accessed on 13 January 2015).

NHS England, Care Quality Commission, Health Education England, Monitor, Public Health England, NHS Trust Development Authority (2014). *NHS five year forward view.* London: NHS England. Available at: www.england.nhs.uk/ourwork/futurenhs (accessed on 10 November 2014).

Public Health England (2013). *Health and care integration: making the case from a public health perspective*. London: Public Health England. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/268181/Health_and_care_integration.pdf (accessed on 7 January 2015).

Sabia S, Singh-Manoux A, Hagger-Johnson G, Cambois E, Brunner E, Kivimaki M (2012). 'Influence of individual and combined healthy behaviours on successful aging'. *Canadian Medical Association Journal*, vol 184, no 18, pp 1985–92.

Senge P, Hamilton H, Kania J (2014). 'The dawn of system leadership'. *Stanford Social Innovation Review*, winter, pp 27–33.

Sharfstein J (2014). 'The strange journey of population health'. *The Milbank Quarterly*, vol 92, no 4, pp 640–3.

Social Mobility and Child Poverty Commission (2014). *State of the nation 2014: social mobility and child poverty in Great Britain*. London: Social Mobility and Child Poverty Commission. Available at: www.gov.uk/government/publications/state-of-the-nation-2014-report (accessed on 30 December 2014).

Socialstyrelsen, Folkhälsomyndigheten, Sveriges Kommuner och Landsting (National Board of Health and Welfare of Sweden, The Public Health Agency of Sweden, the Swedish Association of Local Authorities and Regions) (2014). *Öppna jämförelser: folkhälsa* (Open comparisons: public health). Stockholm: Socialstyrelsen. Available at: http://www.socialstyrelsen.se/publikationer2014/2014-12-3 (accessed on 29 January 2015).

Taylor-Robinson D, Whitehead M, Barr D (2014). 'Great leap backwards'. *British Medical Journal,* vol 349, g7350.

The Mayoral Health Commission (2014). *All change – the platform to a healthier Liverpool.* Liverpool: Liverpool City Council. Available at: http://liverpool.gov.uk/media/770697/healthcommissionerport2.pdf (accessed on 13 January 2015).

Thistlethwaite P (2011). *Integrating health and social care in Torbay: improving care for Mrs Smith.* London: The King's Fund. Available at: www.kingsfund.org.uk/publications/integrating-health-and-social-care-torbay (accessed on 19 January 3015).

Thorlby R (2013*). Reclaiming a population health perspective: future challenges for primary care.* London: Nuffield Trust. Available at: www.nuffieldtrust.org.uk/publications/reclaiming-population-health-perspective (accessed on 19 January 2015).

Timmins N, Ham C (2013). *The quest for integrated health and social care: a case study in Canterbury, New Zealand*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/quest-integrated-health-and-social-care (accessed on 19 January 2015).

Topping A (2014). 'Manchester to get elected mayor'. *The Guardian*, 3 November, www.theguardian.com/uk-news/2014/nov/03/manchester-directly-elected-mayor (accessed on 22 January 2015).

UNICEF Office of Research (2014). *Children of the recession. The impact of the economic crisis on child well-being in rich countries*. Innocenti Report Card 12. Florence: UNICEF Office of Research. Available at: www.unicef-irc.org/publications/pdf/rc12-eng-web.pdf (accessed on 30 December 20).

Wanless D (2002). *Securing our future health: taking a long-term view*. London: HM Treasury. Available at: http://webarchive.nationalarchives.gov.uk/+/http:/www.hm-treasury.gov.uk/consult_wanless_final.htm (accessed on 13 February 2015).

About the authors and acknowledgements

Hugh Alderwick joined The King's Fund in 2014 as Senior Policy Assistant to Chris Ham and Programme Manager for our integrated care work.

Before he joined the Fund, Hugh worked as a consultant in PricewaterhouseCooper's health team. At PwC, Hugh provided research, analysis and support to a range of local and national organisations on projects focusing on strategy and policy. Hugh was also seconded from PwC to work on Sir John Oldham's Independent Commission on whole-person care, which reported to the Labour party at the beginning of 2014. The Commission looked at how health and care services can be more closely aligned to deliver integrated services.

Chris Ham took up his post as Chief Executive of The King's Fund in April 2010. He was Professor of Health Policy and Management at the University of Birmingham between 1992 and 2014 and Director of the Health Services Management Centre at the University between 1993 and 2000. From 2000 to 2004 he was seconded to the Department of Health, where he was Director of the Strategy Unit, working with ministers on NHS reform.

Chris has advised the World Health Organization and the World Bank and has served as a consultant on health care reform to governments in a number of countries. He is an honorary fellow of the Royal College of Physicians of London and of the Royal College of General Practitioners, and a companion of the Institute of Healthcare Management. He is a founder fellow of the Academy of Medical Sciences.

Chris was a governor and then a non-executive director of the Heart of England NHS Foundation Trust between 2007 and 2010. He has also served as a governor of the Canadian Health Services Research Foundation and the Health Foundation and as a member of the advisory board of the Institute of Health Services and Policy Research of the Canadian Institutes of Health Research.

Chris is the author of 20 books and numerous articles about health policy and management. He is currently emeritus professor at the University of Birmingham

and an honorary professor at the London School of Hygiene & Tropical Medicine. He was awarded a CBE in 2004 and an honorary doctorate by the University of Kent in 2012. He was appointed Deputy Lieutenant of the West Midlands in 2013.

David Buck is Senior Fellow, Public Health and Inequalities at The King's Fund. Before joining the Fund, David worked at the Department of Health as Head of Health Inequalities. He managed the previous government's PSA target on health inequalities and the independent Marmot Review of inequalities in health, and helped to shape the coalition's policies on health inequalities. While in the Department he worked on many policy areas including diabetes, long-term conditions, the pharmaceutical industry, childhood obesity and choice and competition.

Prior to working in the Department of Health, David worked at Guy's Hospital, King's College London and the Centre for Health Economics in York, where his focus was on the economics of public health and behaviours and incentives.

Acknowledgements

We would like to thank Benedict Hefford, Goran Henriks, Geraint Martin, Molly Porter and Timo Schulte for helping us learn more about their health and care systems. We would also like to thank Jim McManus and John Middleton for their helpful comments on an earlier draft of the paper. We alone are responsible for the final version.

Published by
The King's Fund
11–13 Cavendish Square
London W1G 0AN
Tel: 020 7307 2568
Fax: 020 7307 2801

Email:
publications@kingsfund.org.uk

www.kingsfund.org.uk

© The King's Fund 2014

First published 2014 by
The King's Fund

Charity registration number:
1126980

All rights reserved, including the right of reproduction in whole or in part in any form

ISBN: 978 1 909029 46 0

A catalogue record for this publication is available from the British Library

Edited by Kathryn O'Neill

Typeset by Peter Powell

Printed in the UK by
The King's Fund

The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

www.kingsfund.org.uk **@thekingsfund**

The King's Fund

Ideas that change health care

'Integrated care' has become a key phrase in the language of health service reform in England. How can we move beyond simply integrating services to focus on improving the health of the wider population?

Population health systems: going beyond integrated care challenges those involved in integrated care and public health to 'join up the dots'. It argues that integrated care should be seen as part of a broader shift away from fragmentation and towards a population health systems approach, and uses examples from other countries where organisations and systems have started to make this shift to highlight lessons for the English NHS.

The report concludes that adopting a population health systems approach requires:

- NHS organisations to work much more closely with local authorities, third sector organisations and the private sector, and to engage more effectively with patients, local communities and the wider public
- new ways of organising budgets and paying for services at a local level to incentivise investment in population health and joint working
- greater pooling of population data, as well as the use of population segmentation and risk stratification, to identify the needs of different groups and develop targeted strategies
- place-based leadership, drawing on skills from different agencies and sectors based on a shared vision, strategy and goals.

With the permissive framework set out in the *NHS five year forward view* providing a favourable policy context, the incoming government in 2015 should work with national bodies and local areas to ensure that the NHS in England does not miss this opportunity to go beyond integrated care.

The King's Fund
11-13 Cavendish Square
London W1G 0AN
Tel: 020 7307 2568

Charity registration number: 1126980

www.kingsfund.org.uk

ISBN 978-1-909029-46-0

Counties Manukau District Health Board
Community & Public Health Advisory Committee Meeting – (4 March 2015)

6.0 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
7.1 Minutes of the CPHAC Meeting with public excluded 21 January 2015	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.
7.2 Annual Planning Update	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)]	**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. [Official Information Act 1982 S9(2)(i)]
7.3 Otahuhu Boundary Change	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)]	**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. [Official Information Act 1982 S9(2)(i)]