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

**Wednesday, 13 April 2016 at 1.30 – 4.30pm, Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau**

<table>
<thead>
<tr>
<th>Time</th>
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<tr>
<td>1.30pm</td>
<td><strong>1. Welcome</strong></td>
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<tr>
<td>1.30 – 1.45pm</td>
<td><strong>2. Governance</strong></td>
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<tr>
<td></td>
<td>2.1 Attendance &amp; Apologies</td>
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<td>2.2 Disclosure of Interests/Specific Interest</td>
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<td>2.4 Action Items Register</td>
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<td>1.45 – 2.10pm</td>
<td><strong>3. Presentations/Reports</strong></td>
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<tr>
<td>2.10 – 2.40pm</td>
<td>3.1 Rapid Response Presentation (Franklin Primary Care Practices)</td>
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<td>3.2 Mental Health - Integration Transformation/Deep Dive Presentation (Tess Ahern)</td>
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<td><strong>Afternoon Tea</strong></td>
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<td>2.55 – 3.45pm</td>
<td><strong>3. Presentations/Reports (continued)</strong></td>
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<td>3.45 – 3.55pm</td>
<td>3.3 Clinical Pathways - Demonstration/Presentation (Dr Campbell Brebner)</td>
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<td>3.4 DCIP Changes (Dr Campbell Brebner)</td>
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<td>3.55 – 4.20pm</td>
<td><strong>4. Director of Primary Health &amp; Community Services Report</strong></td>
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<td></td>
<td>4.1 Executive Summary</td>
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<td>4.2 National Health &amp; IPIF Targets</td>
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<td>4.3 Primary Health</td>
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<td>4.4 Systems Integration</td>
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<td>4.5 Locality Reports</td>
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<td>4.6 Child Youth &amp; Maternity</td>
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<td>4.7 Mental Health</td>
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<td>4.8 Adult Rehabilitation &amp; Health of Older People</td>
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<td>4.9 Intersectoral Initiatives</td>
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<td>4.10 Finance Report</td>
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<td>4.20 - 4.25pm</td>
<td><strong>5. Resolution to Exclude the Public</strong></td>
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<td>4.25 – 4.30pm</td>
<td><strong>6. Confidential Items</strong></td>
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<td>6.1 Confirmation of Confidential Minutes (2 March 2016)</td>
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<td>6.2 Action Items Register Confidential</td>
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**Next Meeting:** Wednesday 25 May 2016  
Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau
<table>
<thead>
<tr>
<th>Name</th>
<th>20 Jan</th>
<th>Feb</th>
<th>2 Mar</th>
<th>13 Apr</th>
<th>25 May</th>
<th>June</th>
<th>6 Jul</th>
<th>17 Aug</th>
<th>28 Sept</th>
<th>Oct</th>
<th>9 Nov</th>
<th>21 Dec</th>
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<tr>
<td>Lee Mathias (Board Chair)</td>
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<td>Colleen Brown</td>
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<td>Sandra Alofivae (CPHAC Chair)</td>
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<td>David Collings</td>
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<td>George Ngatai</td>
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<td>Dianne Glenn</td>
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<td>Reece Autagavaia</td>
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<td>Mr Sefita Hao’uli</td>
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<td>Ms Wendy Bremner</td>
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<td>Mr Ezekiel Robson</td>
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<td>Mr John Wong</td>
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## COMMITTEE MEMBERS’ DISCLOSURE OF INTERESTS
### 13 April 2016

<table>
<thead>
<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
</tr>
</thead>
</table>
| Dr Lee Mathias, Chair | - Chair Health Promotion Agency  
- Chairman, Unitec  
- Deputy Chair, Auckland District Health Board  
- Director, Health Innovation Hub  
- Director, healthAlliance NZ Ltd  
- Director, New Zealand Health Partners Ltd  
- External Advisor, National Health Committee  
- Director, Pictor Limited  
- Director, John Seabrook Holdings Limited  
- MD, Lee Mathias Limited  
- Trustee, Lee Mathias Family Trust  
- Trustee, Awamoana Family Trust  
- Trustee, Mathias Martin Family Trust |
| Colleen Brown | - Chair, Disability Connect (Auckland Metropolitan Area)  
- Member of Advisory Committee for Disability Programme Manukau Institute of Technology  
- Member NZ Down Syndrome Association  
- Husband, Determination Referee for Department of Building and Housing  
- Chair IImuch Trust  
- Director, Charlie Starling Production Ltd  
- Member, Auckland Council Disability Advisory Panel  
- Member, NZ Disability Strategy Reference Group |
| Sandra Alofivae | - Member, Fonua Ola Board  
- Board Member, Pasifika Futures  
- Director, Housing New Zealand  
- Member, Ministerial Advisory Council for Pacific Island Affairs |
| David Collings | - Chair, Howick Local Board of Auckland Council  
- Member Auckland Council Southern Initiative |
| George Ngatai | - Chair Safer Aotearoa Family Violence Prevention Network  
- Director Transitioning Out Aotearoa  
- Director BDO Marketing  
- Board Member, Manurewa Marae  
- Conservation Volunteers New Zealand  
- Maori Gout Action Group |
<table>
<thead>
<tr>
<th>Dianne Glenn</th>
<th>Reece Autagavaia</th>
<th>Sefita Hao‘uli</th>
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</thead>
</table>
| • Nga Ngaru Rautahi o Aotearoa Board  
  Transitioning Out Aotearoa (provides services & back office support to Huakina Development Trust and provides GP services to their people).  
  Chair of Restorative Practices NZ. | • Member – NZ Institute of Directors  
  Member – District Licensing Committee of Auckland Council  
  Life Member – Business and Professional Women Franklin  
  Member – UN Women Aotearoa/NZ  
  President – Friends of Auckland Botanic Gardens and Chair of the Friends Trust  
  Life Member – Ambury Park Centre for Riding Therapy Inc.  
  Vice President, National Council of Women of New Zealand  
  Member, Auckland Disabled Women’s Group  
  Member, Pacific Women’s Watch (NZ)  
  Justice of the Peace | • Trustee Te Papapa Pre-school Trust Board  
  Member Tonga Business Association & Tonga Business Council  
  Member ASH Board  
  Board member, Pacific Education Centre Advisory roles:  
  Tongan Community Suicide Prevention Project (MoH)  
  Tala Pasifika (NZ Heart Foundation Pacific Tobacco Control)  
  Member Pacific People’s Advisory Panel, Auckland Council  
  Consultant:  
  Government of Tonga: Manage RSE scheme in NZ  
  NZ Translation Centre: Translates government and health provider documents.  
  Promotus GSL on Rheumatic Fever campaign (HPA)  
  Taulanga U Society Rheumatic Fever Innovation project (MoH).  
  Member, Ministerial Advisory Council for Pacific Island Affairs. |
<table>
<thead>
<tr>
<th>Name</th>
<th>Positions and Activities</th>
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<tbody>
<tr>
<td>Wendy Bremner</td>
<td>• CEO Age Concern Counties Manukau Inc&lt;br&gt;• Member of Health Promotion Advisory Group (7 Age Concerns funded by MOH)&lt;br&gt;• Member Interagency Suicide Prevention Group</td>
</tr>
<tr>
<td>Ezekiel Robson</td>
<td>• Department of Internal Affairs Community Organisation Grants Scheme Papakura/Franklin Local Distribution Committee&lt;br&gt;• Be.Institute/Be.Accessible ‘Be.Leadership 2011’ Alumni&lt;br&gt;• Member, CM Health Patient &amp; Whaanau Centred Care Consumer Council</td>
</tr>
<tr>
<td>John Wong</td>
<td>• Director, Asian Family Services at The Problem Gambling Foundation of New Zealand (PGF), also part of the PGF national management team&lt;br&gt;• Member, National Minimising Gambling Harm Advisory Group&lt;br&gt;• Chairman and Trustee, Chinese Positive Ageing Charitable&lt;br&gt;• Chairman, Chinese Social Workers Interest Group of the Aotearoa New Zealand Association of Social Workers&lt;br&gt;• Chairman, Eastern Locality Asian Health Group&lt;br&gt;• Founding member and council member, Asian Network Incorporation (TANI)&lt;br&gt;• Board member, Auckland District Police Asian Advisory Board&lt;br&gt;• Member, Auckland and Waitemata DHBs Suicide Prevention Advisory Group&lt;br&gt;• Board member, Manukau Institute of Technology (MIT) Chinese Community Advisory Group&lt;br&gt;• Member, CADS Asian Counselling Service Reference Group&lt;br&gt;• Member, Waitemata DHB Asian Mental Health &amp; Addiction Governance Group&lt;br&gt;• Member, Older People Advisory Group (ACC)&lt;br&gt;• Member, University of Auckland Social Work Advisory Group&lt;br&gt;• Member, Community Advisory Group of Health Care New Zealand&lt;br&gt;• Member, Auckland Regional Public Health Service – Asian Public Health External Reference Group&lt;br&gt;• Member of the Advisory Committee for the School of Social Sciences &amp;Public Policy at AUT University</td>
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<tr>
<td>Director having interest</td>
<td>Interest in</td>
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<tr>
<td>Mr George Ngatai</td>
<td>CMH Quit Bus</td>
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<tr>
<td>Ms Colleen Brown</td>
<td>Emerge Aotearoa (formerly Richmond NZ Trust Ltd)</td>
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<tr>
<td>Ms Dianne Glenn</td>
<td>Liquor Licensing</td>
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<tr>
<td>Ms Margie Apa</td>
<td>Integrated Home &amp; Community Support Services Redesign</td>
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<tr>
<td>Mr Sefita Hao’uli</td>
<td>Suicide Prevention</td>
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Minutes of Counties Manukau District Health Board
Community & Public Health Advisory Committee

Held on Wednesday, 2 March 2016 at 1.30 – 4.30pm, Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau

Present: Dr Lee Mathias (Board Chair), Ms Sandra Alofivae (Committee Chair), Ms Colleen Brown, Ms Dianne Glenn, Mr George Ngatai, Mr David Collings, Mr Ezekiel Robson, Ms Wendy Bremner, Mr John Wong.

In attendance: Mr Geraint Martin (Chief Executive), Mr Benedict Hefford (Director, Primary Health & Community Services), Ms Karyn Sangster (Chief Nurse Advisor, Primary Care), Dr Campbell Brebner (Chief Medical Advisor, Primary Care) and Ms Dinah Nicholas (Minute Taker). Ms Charlie Saunders (Franklin Family Support Services) also attended the public session of this meeting.

Apologies: Mr Sefita Hao’uli, Apulu Reece Autagavaia and Ms Margie Apa.

1. Welcome
   Mr Ngatai opened the meeting with the following proverb (Sir James Henare, 1989):
   
   “You have come too far not to go further, you have done too much not to do more”.

2. Governance
   2.1 Attendance & Apologies
   
   Noted.

   2.2 Disclosure of Interest/Specific Interests
   
   Ms Dianne Glenn advised the Committee that she is now President of Friends of Auckland Botanic Gardens and Chair of the Friends Trust.

   Ms Glenn also disclosed a Specific Interest in relation to Item 7.2 on this agenda which was noted.

   2.3 Confirmation of Public Minutes (20 January 2016)
   
   Resolution
   That the Public Minutes of the Counties Manukau District Health Board Community & Public Health Advisory Committee meeting held on Wednesday 20 January 2016 were taken as read and confirmed as a true and accurate record.

   Moved: Dr Lee Mathias  Seconded: Mr George Ngatai  Carried: Unanimously
2.4  **Action Item Register Public**

Noted.

3.  **Presentation**

3.1  **Child Health Deep Dive**

Ms Carmel Ellis and Dr Pip Anderson took the Committee through their presentation highlighting the following:

- **SUDI** – SUDI is the leading cause of preventable post-neonatal deaths in infancy and CM Health has the highest SUDI rate in New Zealand. Maori infants are 5 times more likely to experience SUDI than non-Maori with around 40 SUDI deaths among Maori per year. Strategies implemented to date include:
  - Northern regional alliance 2012 5 year SUDI plan
  - CM Health SUDI action plan
  - Safe Sleep intervention programme (informed by CM Health research) and a Safe Sleep Coordinator was appointed to facilitate this programme.

We have seen a reduction in SUDI rates:

<table>
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<tr>
<th>SUDI rates per 1,000 births</th>
<th>2005-2009</th>
<th>2010-2014</th>
<th>Reduction</th>
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<tr>
<td>Total population</td>
<td>1.44</td>
<td>0.96</td>
<td>0.48</td>
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<td>Maori</td>
<td>3.26</td>
<td>2.13</td>
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- **Breastfeeding** – we have low breastfeeding rates with minimal progress being made over the past 24 months – complex whanau life realities and health provider barriers are some issues impacting on mothers’ breastfeeding. Our ongoing challenges are:
  - A lack of information antenatally and support provided postnatally to mothers
  - A fractured health system and lack of integration
  - Not all maternity and child health professionals have the belief, knowledge, education and commitment to support breastfeeding
  - Mind-set and approach of health professionals engaging with whanau
  - A slow uptake and referrals from LMC and primary care to Te Rito Ora services

Strategies to mitigate these challenges include:
  - Ensure whanau have access to evidence-based breastfeeding education antenatally to inform them of the benefits of breastfeeding
  - Support breastfeeding services that are coordinated and delivered with a community development focus
  - Improve health professionals knowledge in this area
  - Promote Te Rito Ora services to LMCs, Well Child providers and child health professionals

- **Oral Health** – we have low enrolment and engagement of pre-schoolers within community oral health services in particular for Maori, Pacific and Asian. Only half of 5 year old children make it to school caries free in our district, this is less for Maori, Pacific and Asian children. 85% of 2-4 year olds do not meet tooth brushing guidelines.

Some strategies to address some of these issues include:
  - Enrolment by 5 months into oral health services by Well Child Tamariki Ora providers
  - Preschool examinations using a flexible model for better access, engagement & attendance
  - Increased access hours for hub dental clinics through a Saturday – currently under trial at Browns Road Hub Clinic for pre-schoolers
o Incentive welcome packs for children aged 1 year for their first examination (toothbrush, toothpaste etc)
o Follow up persistent DNAs in preschool patients through Well Child Tamariki Ora
o Review the preschool tooth brushing programme to expand from 150 high needs/high Maaori & Pacific preschools to an additional 80 identified preschools
o Look at funding under 5’s and different ways of delivering the service

The Chair thanked the presenters for their deep dive into children’s issues.

(Dr Mathias departed at 2.33pm)

4. Resolution to Exclude the Public
   Individual reasons to exclude the public were noted.

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

   Moved: Ms Dianne Glenn  Seconded: Mr David Collings  Carried: Unanimously

2.35pm Public Excluded session.

3.23pm Open meeting resumed.

6. Director of Primary Health & Community Services Report
   Mr Hefford took the Committee through some highlights of the Report.

   6.1 Executive Summary

   The Community Health Integration is on track to have supported discharges operating across all areas of the hospital by May 2016 supported by Community Central.

   Winter planning is well underway in all localities.

   A diabetes collaborative has been established to improve diabetes control in 50% of patients with poorly controlled HbA1c by 1 December 2016. The focus will be to ensure knowledge transfer and for general practice staff to become more confident in diabetes care so enhanced clinical care will trickle down to the care of all people with diabetes.

   6.2 National Health & IPIF Targets

   Preliminary results for Q2 for national health targets are now available with CM Health being ranked between second and fifth out of all district health boards nationally with CVD and Immunisations showing excellent results locally.

   Smoking cessation support has recently become a focus of the MoH and we are working on improving performance in this area. Currently in CM Health, 22.1% of smokers have received cessation support which is below the national average of 28.3%. Actions being taken to increase smoking cessation with PHOs include increasing availability of group based therapy, initiating text messaging to smokers who have recently turned 15 and analysing practise data
(ie) prescribing information, to identify suitable patients. Mr Hefford agreed to bring the PHO Smokefree Plans to next CPHAC for discussion.

6.3 Primary Health

Palliative Care – there has been $20m additional funding nationally with some of this flowing into hospice services already but there is another piece of funding that we can bid for locally in relation to Innovations Funding. Over January/February, the CM Health Palliative Care Clinical Working Group has been working closely with Totara and Franklin Hospices to develop proposals which will include building palliative care capability for the community and regional after hours palliative care services. A final proposal is due to be submitted to MoH shortly where a national panel will review and make a final decision on the proposals received. Mr Hefford agreed to provide an update on this in his report at the next meeting.

6.4 Mental Health & Addictions

Refugees as Survivors – Following the crisis in Syria, the NZ Government have increased the annual quota of refugees being accepted into New Zealand over the next 2.5 years by 500. CM Health and the MoH have been working with Refugees as Survivors NZ to identify the additional service provision and associated funding needed in order to support this increased volume of refugees who will be accessing the service. The current funding is administered on behalf of the MoH by CM Health as the national refugee reception centre is based in our district.

6.5 Child Youth & Maternity Services
The report was taken as read.

6.6 Adult Rehabilitation & Health of Older People

Community teams and NASC have come together under an MDT model and are now focussing on scaling up that approach before winter and having a focus on what needs to be in place by June in order to meet that demand and keep the system safe and effective (early discharge and reablement).

Aged residential care rates are dropping which means we have got this working right.

MyCare – the MyCare website has been set up for individuals and families managing care arrangements and gives people the tools to find and manage the care they need for themselves or a loved one. If you are looking for more help, MyCare is where you can find carers who live in your community and are seeking clients. Link to MyCare below: https://www.mycare.co.nz/

6.7 Intersectoral Initiatives
The report was taken as read.

6.8 Progress with Systems Integration
The report was taken as read.

6.9 Locality Reports
The reports were taken as read.

6.10 Finance Report
The report was taken as read.
Resolution
That the Community and Public Health Advisory Committee receive the report of the Director of Primary Health & Community Services.

Moved: Mr David Collings          Seconded: Ms Dianne Glenn          Carried: Unanimously

7. Reports

7.1 Pacific Health Progress Trend Report/Summary Progress Report
Ms Tania Wolfgramm, Senior Programme Manager, Pacific Health Development and Losa Mo’atane took the Committee through their report highlighting the following:

- There has been progress in achieving many national health targets for Pacific people particularly immunisations at 8 months (97% v target of 95%), cardiovascular risk assessments (92% v target of 90%) and smoking advice provided in hospital.
- The broader priorities for Pacific people in the Pacific Health Plan suggest that the following areas for improvement warrant a deeper dive if we are to see improvement as part of the health equity campaign:
  - Breastfeeding, oral health & well child in the context of childhood obesity prevalence amongst Pacific children & young people
  - Newborn enrolment in primary care and ASH in the context of overall acute presentations among Pacific people including hospital admissions in the first year of life
  - Workforce development – broader initiatives that will increase Pacific health professionals within the CM Health workforce.

Deep dives into these areas will be presented at future CPHAC meetings.

7.2 Auckland Region Public Health Service Update
Ms Jane McEntee, General Manager & Ms Julia Peters, Clinical Director, Auckland Region Public Health Service took the Committee through their report containing updates on:

- Auckland Council’s 1080 aerial operation in the Hunua Ranges
- ARPHs involvement in the proposed Auckland Unitary Plan hearing process
- The release of ARPHs Pacific Demographic Profile
- Legionella risk associated with industrial cooling towers
- Healthy Auckland Together

The Chair thanked Ms McEntee & Ms Peters for attending the meeting and for continuing to advocate for our issues in the public arena and pushing the boundaries and asked them to come back with a further update in another six months.

Mr Ngatai closed the meeting reiterating his opening proverb:

“You have come too far not to go further, you have done too much not to do more”.

The meeting closed at 4.20pm. The next meeting of the Community & Public Health Advisory Committee will be held on Wednesday, 13 April 2016 in the Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau.
The Minutes of the meeting of the Counties Manukau District Health Board Community & Public Health Advisory Committee held on Wednesday, 2 March 2016 are approved.

Signed as a true and correct record on Wednesday, 13 April 2016.

(Moved: /Seconded: )

Chair 13 April 2016
Ms Sandra Alofivae Date
Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

### Community & Public Health Advisory Committee Meeting – Action Items/Resolution Register – 13 April 2016

<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
<th>COMPLETE</th>
</tr>
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<tbody>
<tr>
<td>8.7.2015</td>
<td>4.0</td>
<td>Update from Auckland Regional Public Health Service every 6 months on current issues.</td>
<td>17 August</td>
<td>Mr Hefford</td>
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<td>27.5.2015</td>
<td>3.2</td>
<td>Update on Rapid Response from the Franklin Primary Care Practices.</td>
<td>13 April</td>
<td>Ms Sangster</td>
<td>Refer Item 3.1 on this agenda.</td>
<td>✓</td>
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| 19.8.2015| 5.10 | Localities  
- Update on how the Southern Initiative is working from a DHB perspective (ie) issues/hurdles.  
-Presentations:  
- East  
- West  
- South  
- Lynda Irvine  
- Date TBC  
- Dates TBC | Date TBC  
- Mr Hefford | | | |
| 30.9.2015| 5.6  | Mental Health – deep dive into Mental Health & Addictions (incl. alcohol & smoking) looking at the breadth and scope and how well we are placed overall to address the needs of our population.  
-Key Worker Review Implementation – full briefing on this review. | 13 April     | Ms Ahern           | Refer Item 3.2 on this agenda.     | ✓        |
| 16.12.2015| 3.0  | DCIP Changes – report back on progress. | 13 April     | Dr Brebner         | Refer Item 3.4 on this agenda.     | ✓        |
| 16.12.2015| 7.2  | General Business – schedule a CPHAC meeting in the community in 2016. | 28 September - TBC | Mr Hefford       |                                    |          |
| 20.1.2016 | 2.3  | Deep dive into the Plunket Society. | Date TBC     | Mr Hefford/Ms Sangster |                                    |          |
| 20.1.2016 | 2.4  | Clinical Pathways update and demonstration of pathway tool. | 13 April     | Mr Hefford/Dr Brebner | Refer Item 3.3 on this agenda.     | ✓        |
| 20.1.2016 | 2.4  | Asian Health update - quarterly. | 25 May       | Ms Apa             |                                    |          |
Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
<th>COMPLETE</th>
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<tbody>
<tr>
<td>20.1.2016</td>
<td>3.5</td>
<td>ARHOP – national Health of Older People Strategy draft.</td>
<td>25 May</td>
<td>Mr Hefford/Ms Ralph-Smith</td>
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<tr>
<td>20.1.2016</td>
<td>3.8</td>
<td>Systems Integration – take the Committee through some recent integration changes – when, why, what did the change lead to, where is it now, have we tracked it in terms of milestones; did it work.</td>
<td>13 April</td>
<td>Mr Hefford</td>
<td>Refer Item 3.2 on this agenda.</td>
<td>✓</td>
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<tr>
<td>20.1.2016</td>
<td>2.3</td>
<td><strong>Resolution</strong>&lt;br&gt;That the Board request of Ministry of Health that all Well Child providers are required to meet defined breastfeeding targets as indicated by Government policy which is underpinned by the Innocenti Declaration. <strong>Moved</strong> Dr Lee Mathias/<strong>Seconded</strong> Ms Sandra Alofitave/<strong>Carried</strong> Unanimously</td>
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<td></td>
<td>Passed to Board Secretary 27.1.2016</td>
<td>✓</td>
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<tr>
<td>2.3.2016</td>
<td>6.2</td>
<td>National Health Targets – PHO Smokefree Plans for discussion.</td>
<td>13 April</td>
<td>Mr Hefford</td>
<td>Refer Item 4.3 on this agenda.</td>
<td>✓</td>
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<tr>
<td>2.3.2016</td>
<td>6.3</td>
<td>Primary Health – update on the Palliative Care Innovations Funding proposal.</td>
<td>13 April</td>
<td>Mr Hefford</td>
<td>Refer Item 4.3 on this agenda.</td>
<td>✓</td>
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<td>23.3.2016</td>
<td>-</td>
<td>Women’s Health – Ms Knetsch to provide some objective analysis on the 4 major programmes (HT, SIB, CT, Papakura) as to which will provide the DHB with the best spend and how quickly we can evaluate the outcomes.</td>
<td>Date TBC</td>
<td>Ms Carmel Ellis</td>
<td>This item was transferred from HAC 23.3.2016 for reporting back purposes through CPHAC.</td>
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Rapid Response

Franklin Locality
Franklin Locality
Aim Statement

• To develop a coordinated network that links primary and secondary services within the Franklin Locality in a timely manner to reduce avoidable hospital admissions

• *In, out and sort them out* ......
The Concept

“If only there was a service that could respond quickly to wrap around supports to prevent me from calling an ambulance ”

Locality GP Principal
2011
In the beginning...

• Origins from Beyond 20,000 campaign

• The development of the Franklin Locality

• Rapid Response was co-designed from a core group of Interagency, Interdisciplinary and transdisciplinary people.
What did they want?

- Responsiveness
- Joining the dots
- Reduce duplication
- Neutral space
- Smooth patient journey
- Supportive discharge
- Keeping it within the community
Challenges

- Hard sell when it was a temporary role.
- Sustainability, lack of permanent funding
- Patch protection – needing to clarify purpose
- Dissemination of information to Primary Care esp. GP
- Shared documentation
- Monitoring and measuring – soft data
Successes

• Permanent funding
• Increase in hours and FTE 1.5
• GP Champion
• Winter Road-Show to all General Practices
• 2015 Innovations award
Coordinator Profile

• Advanced Assessment skills – are they in a crisis?
• Ability to deal with a crisis appropriately
• Excellent communication, innovative thinkers, (broad shoulders)
• Belief in concept (vision)
• Leadership and support
• Advanced Skills – IV, palliative care, wound care, continence, stomal
• Change Agent – can do attitude
• Relationships and Networks – Primary Care, St John Ambulance,
  ACC, NASC, POAC, Allied Health, Reablement, mental health
Who is using the service?

Franklin Rapid Response Service - Source of Referral to August 2015

- GP/PN: 133
- HHC: 96
- APAC: 108
- Dlist: 111
- IP55: 48
- MoW: 6
- St John: 47
- Family: 70
- Pharm: 20
- Other: 46
Franklin Rapid Response Services - Ages of Referrals From July 14 to August 15

- Ages: <=59, 60-64, 65-69, 70-74, 75-79, 80-84, 85-89, =>90

- Age Profile:
  - <=59: 56
  - 60-64: 26
  - 65-69: 30
  - 70-74: 70
  - 75-79: 103
  - 80-84: 108
  - 85-89: 103
  - =>90: 81
Reasons for referrals

Reasons for Referral to Franklin Rapid Response Service From July 2014 to August 2015

- Incident - Falls: 35
- Not coping at home: 42
- Sudden Medical Decline: 44
- Change in Mental State: 16
- Change in Social Circumstances: 56
- Change in Physical State: 84
- Medication Support: 24
- Support Discharge Home: 182
- Confirm Patient Safety: 92
What did we do?

Rapid Response Primary Interventions July to August 2015

- Equipment Provision: 19
- Intervention Declined: 1
- Advice to Patient/Carer: 84
- Support Inpatient Discharge: 21
- Referral on: 62
- Service Coordination: 125
- Nursing Assessment: 145
- Medication Support: 25
- Multi-Service Coordination: 65
- Correct Unsuccessful Discharge: 2
- Nursing Treatment: 26
Response times

Franklin Rapid Response Service - Time From Receipt of Referral to First Contact to August 2015

<table>
<thead>
<tr>
<th>Hours to 1st Contact</th>
<th>No. of Referrals</th>
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<tbody>
<tr>
<td>0 to 1</td>
<td>487</td>
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<tr>
<td>1 to 2</td>
<td>69</td>
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<tr>
<td>2 to 5</td>
<td>57</td>
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<td>5 to 12</td>
<td>7</td>
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<td>13 to 24</td>
<td>55</td>
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<td>24 to 48</td>
<td>6</td>
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<tr>
<td>&gt;48</td>
<td>9</td>
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Correlation of Rapid Response and Acute Admissions – 75yrs +

Franklin Resident Acute Admissions aged 75 Years + and Rapid Response Referrals
Post discharge follow-up

- Post discharge follow ups can be requested from APAC or Charge Nurses or other health professional.
- Pull referrals – identifying people at risk for readmission
The Nursing Assessment

- Assess people within their own home that cannot make it to their GP and decide what needs to be done next.
- Do they need to go to hospital?
- Do they need transport to GP?
- Do they need an ambulance?
- Do they need supports in the home?
The Fall

- Why did they fall?
- Do they need equipment?
- Do they need OT or PT input?
- Are they safe to be left at home?
- Do they need supports within the home?
- Do they need Reablement?
The Medication Supports

- Confusion over multiple medication changes when being discharged from hospital.
- Adjusting to blister packs
- Polypharmacy
Coordination of services

• What services will be required to keep this person out of hospital?
• Who is the most appropriate person to go in first?
• Links to both Primary and Secondary Care – who do I contact?
• Referral makers
• The “Go-to-girls”
• Handing back to GP.
Working together within the Franklin Locality to keep people safe, supported and out of hospital
Mental Health and Addictions Integration Transformation Agenda

Tess Ahern, General Manager, Mental Health and Addictions and Pete Watson, Clinical Director, Mental Health and Addictions

Purpose

This paper provides an update for stakeholders on the ‘whole of system’ integration agenda for mental health and addictions.

Change is needed to improve the health outcomes of our communities and to improve people’s experiences of using services. To achieve this, a commitment has been made to transform the mental health and addictions system with effective integration across primary care, specialist mental health and addictions, and NGO provision. Through a process of co-design engagement and the input of a sector-wide mental health and addictions leadership group, we have identified the proposed approach outlined in this paper to support the following vision:

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. To achieve this, mental health and addictions 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 and addictions workforce working as an integrated team with other parts of the health system.

We have taken our broad proposals to each of the four locality leadership groups for discussion and endorsement. In addition, the Integrated Mental Health and Addictions Leadership Group hosted a joint session with key collaborative groups to share thinking and gauge support for the direction of travel. These key stakeholders were supportive of the direction of travel and in agreement that a transformative approach to the mental health and addictions system is a key component towards gains across the wider health system.

We have presented our high level thinking – about why change is needed and what we think the areas of focus will be - to the CM Health Executive Leadership Team (ELT) to seek endorsement and a mandate to proceed with the development of detailed proposals and implementation plan. There is
still significant work to be done to design a comprehensive ‘whole of system’ approach and to ensure that what people have told us through the co-design process is recognised and incorporated into our future model of care. The proposals in this paper provide only the initial framework and we have committed to providing ELT with a detailed proposal for the design and implementation process.

Executive Summary

The current mental health and addictions system in Counties Manukau needs to be transformed if we are to better meet the needs of our population. Good progress has been made – increased service access, enhanced workforce capability, expanded scope, and development of a wide range of community-based services - but much more needs to be achieved. Historically our focus has been on supporting the small percentage of the population (3%) with the most severe and enduring mental health needs; whilst retaining our focus on supporting those with the most complex needs, we want to be able to intervene earlier (in the life course and in the course of a condition), providing deliberate, systematic, joined-up support across primary care, specialist mental health and addictions, and NGO providers. Traditionally mental health and addictions has been viewed, and has functioned, as a speciality distinctly separate from the wider health system. This needs to change, with mental health and addictions embedded within, and working as part of, the wider health system.

These changes to our mental health and addictions system need to be bold if we are to effectively meet local need – and begin to address the significant, and unacceptable, health disparities that exist for people with mental health and addiction needs. These disparities not only directly affect the life expectancy and wellbeing of individuals, but also affect their family/whaanau and our wider community – an individual’s ability to work, attend education or be involved in everyday activities. We know that life expectancy for those with serious and enduring mental illness is up to 25 years less than the population average. The World Health Organisation now cites depression as one of the ten leading causes of disability-adjusted life years lost, and current WHO predictions indicate that by 2030 it will be within the top three leading causes of disease burden. With a clear strategic goal for CM Health to achieve health equity for our community, including addressing the issue of alcohol related harm, it is imperative that we take significant steps to challenge the status quo for people with mental health and addiction needs. Alongside addressing the disparities in health outcomes experienced by all people with mental health and addiction needs, we also need to ensure that this agenda addresses the mental health and addiction inequities experienced by our Māori and Pacific communities including reduced access to early treatment and disproportionately high prevalence rates of serious mental health disorders.

In taking forward this agenda, we need to consider how it fits within the wider strategic direction of CM Health. An integrated approach to meeting the needs of our communities is a core component of CM Health’s Healthy Together strategy, with a commitment to provide more care closer to home within primary and community settings. The focus is on creating capacity and improving the way we all work to enable integration across the health system and with broader inter-sectorial partners. Aligning with this approach, what we are seeking to achieve is a continuum of care with mental health and addictions integrated with the wider health system, ensuring access to a comprehensive range of services provided collaboratively by primary care, NGOs and specialist services.

We have initiated a process of co-design engagement with stakeholders - service users, family/whaanau, primary care, NGOs, specialist mental health and addictions, and wider stakeholders with an interest in mental health and addictions - to inform our thinking about the transformation of the mental health and addiction system and will seek to continue this engagement
as the agenda progresses. In the initial discussions, people spoke both positively and negatively about their experiences, with notable issues around the challenges of the soloed approach to service delivery and a desire for a system that supports people’s needs ranging from mild to moderate, to severe and enduring. People spoke many times of the need for ‘any door is the right door’ to be a reality and were eager for a system that worked in a seamless way, responsive to and reflective of local need, whether that be responding to demographics or recognising the challenges of geographical location. Participants were unanimous that change is needed to better meet the needs of our population. The feedback from the co-design process has helped to inform our direction and the breadth of contributions will also contribute to the next stage of detailed design.

Co-design engagement – service user story (addictions and mental health):

During the co-design engagement process, we heard a number of stories of the frustrations and challenges people experienced when needing support for both their mental health and addiction. An example of this was a woman who spoke of being known to both a CMHC and CADS and who had been well for an extended period of time, effectively managing her wellbeing. Unfortunately unexpected life events impacted significantly on her ability to manage, with her behavior and excessive drinking leading to her being detained by the police. Specialist mental health services were called by the police but when they arrived at the hub, they advised her that they were unable to help her because she was intoxicated and needed to engage with CADS to address her drinking first, before turning to leave. At the co-design session, she spoke of her “utter devastation” as they walked away, having left her alone to work out the next steps for herself.

(This is one example of the type of stories we have heard through our recent co-design process and an example of the type of service breakdown that has resulted in significant failings and serious incidents.)

Reflecting on our experiences of the system, the views of our cross-sector Integrated Mental Health and Addictions Leadership Group, and the input from the co-design process, our focus for leading change includes:

- Sector reconfiguration – our focus will be on developing an integrated ‘team’ by taking a ‘whole of system’ approach that considers the role of each part of the mental health and addiction system and how it will effectively contribute to a model of care that best meets our population’s needs. The intention with such an approach is to share knowledge and expertise, intervene earlier and move away from the current system of formal referrals, establishing a dynamic and responsive working relationship.

This will include:
  o developing new teams that include specialist services and NGO providers working in collaboration with primary care, with access to a suite of services provided by NGOs;
  o an alignment with the localities approach, designing and developing the new teams to function alongside the proposed locality hubs and general practice clusters. The integrated community teams will be connected to, and supported by, highly
specialised district-wide services such as maternal mental health, EPIT (Early Psychosis Intervention Team) and ICT (Intensive Community Team);
  o developing our commissioning and contracting approaches to ensure responsive, locally-focussed, outcomes-orientated services;
  o integration between specialist mental health services and specialist addiction services, with a focus on locally delivered services.

• Workforce development –
  o developing our workforce capability (within specialist mental health and addictions and NGO provision) to better align and work more effectively with a primary care/community focus, ensuring that people are working at the top of their scope;
  o on-going mental health and addictions education and skill-sharing with primary care.

• System infrastructure –
  o shared information systems and alignment of IT, working towards one shared-care plan that reflects what matters to the individual and their family/whaanau.

• Community development and education –
  o developing our communities’ abilities to better self-manage their mental wellbeing, instilling resilience and a focus on keeping well;
  o developing and establishing broader inter-sectorial links to ensure a focus on wider determinants of wellbeing.

Key differences in our new model of care would be:
  • access to a comprehensive range of mental health and addiction services within each CM Health locality;
  • a mental health and addictions workforce embedded in Enhanced Primary Care as part of a comprehensive and responsive health team, reducing the need for formal referrals;
  • co-existing addiction and mental health needs treated holistically by the same specialist team at a locality level.

Background
Overview
While good progress has been made in the areas of mental health and addictions in Counties Manukau, significant transformation is required if we are to best meet the needs of our population – improving their health outcomes and experience of using our services – within the existing financial envelope. Current service provision is spread across provider arm services (inpatient and community), NGO provision, and services contracted through inter-district flows (IDFs) which includes CADS (Community Alcohol and Drug Service) and other regional services. For the purposes of our integration agenda, the focus for change will be broadly on the community (non-acute) aspects of provider arm services, NGO provision and the addiction services (CADS) contracted through Waitemata DHB. Alongside determining how these may function differently within an integrated model, the focus on the continuum of care will seek to integrate mental health and addictions alongside primary care and ensure continuity of care across acute and non-acute services.

Taking a ‘whole of system’ approach will involve changing the way our specialist community teams are configured and function to better align and integrate with primary and community partners, together with a level of reconfiguration across our NGO and CADS provision to support a more integrated approach.
Over time the different components of NGO provision have been procured in response to identified need, without an opportunity to step back and take an overarching view of the range of contracts and consider how we can work as effectively as possible with the NGO sector to best meet population need. We currently hold 50 contracts with 27 NGOs covering a range of services including residential housing and recovery, respite, community support workers, community living services, peer support, cultural services, and support for skills in relation to employment, parenting and tenancy management. Residential services for housing and recovery, and respite, are primarily clustered around Mangere, Otara and Manukau, with little or no provision located in Franklin and Eastern localities.

Specialist addiction services are provided by Waitemata DHB’s Community Alcohol and Drugs Service with community-based teams, including specific youth and cultural teams, and access to an inpatient detoxification service based in Pt Chevalier. With specialist addictions services contracted and provided separately to specialist mental health services, the two components have developed their own silos and do not operate in an integrated way. The arrangement with CADS has been in place for approximately 20 years and while the services are broadly meeting the addiction needs of our population, we believe that as part of our MH&A integration agenda, there is an opportunity to explore the best way to meet our population’s addiction needs.

Alongside developing a change model for greater primary/community integration focus for our specialist community mental health teams and an integrated approach to addiction services, we want to ensure that the suite of services provided within each locality is flexible and responsive to local need. To achieve this, we want to review our current contracting arrangements with NGOs. This may lead to contracting in a different way and/or NGOs working more collaboratively in a consortium model to provide the necessary suite of services. As part of the suite of locally delivered services, we want to include specialist addictions to ensure a fully integrated system that aligns effectively with locality hubs.

Local leadership
To spearhead our integration agenda, we have formed the Integrated Mental Health and Addictions Leadership Group, with members invited to join the group based on their professional and personal experience and expertise, rather than for the organisations or sectors that they represent. The group includes a balanced mix across specialist mental health and addictions, primary care, NGO providers and Maori and Pacific health. The group is a key leadership and advisory group and its purpose is to provide oversight of the strategic direction of the CM Health mental health and addictions integration agenda, and to guide and actively support joined-up, whole of system transformational change. The group brings a wealth of experience across the mental health and addictions system and the broader health sector, and is committed to driving transformational change that reflects the needs of our communities, ensuring that mental health is everyone’s business.

The key elements of the Leadership Group’s vision for mental health and addictions are:

- support when needed, quickly and easily, in local communities;
- the promotion of positive mental health as part of the community psyche;
- a clear focus on early intervention;
- deliberate, systematic and proactive approach to identifying, assessing and treating MH&A;
- a highly capable, mobile, fully IT-enabled mental health and addictions workforce working as an integrated team with other parts of the health system.

The key principles of such a system would be:
• service users and family/whaanau at the centre;
• the aim of fundamentally improving people’s wellbeing and experience of services;
• supporting resilience, recovery and positive mental health enablement and empowerment;
• working as one integrated system, with every door being the right door - providing a seamless experience for individuals;
• assessing and treating needs holistically; working with other sectors towards shared goals – owned and determined by the individual/family/whaanau.

The Leadership Group’s thinking has been informed by a combination of their own experiences of the health system, the significant number of contributions we had through a process of co-design and the wider local and national contexts.

Context and population need
The direction of travel for mental health and addictions sits within the strategic focus for CM Health – care closer to home within localities; a focus on Enhanced Primary Care; effective integration; and keeping people well.

It also needs to ensure that it reflects what we know of population need and the impact that mental health and addiction needs can have on wider wellbeing and the demands on the health system. From recent analysis of the mental health and addiction needs of our population, we know that:

• almost 1 in 10 adults received care for a mental health disorder, with two-thirds of these seen only in primary care. (This does not include those receiving non-pharmacological assistance in primary care)¹;
• nearly seven percent of the population received care for depression and/or anxiety²;
• there are substantial differences in the proportion of the population receiving care for mental health disorders between ethnic groups, with Pacific and Asian communities having significantly lower access rates than other groups;
• although Maori have high rates of access to services, Maori in Counties Manukau have much higher rates of serious mental illness, compulsory treatment and suicide rates than non-Maori;
• mental health disorders and long-term physical health conditions often occur together, with 4,000 people receiving care for diabetes and a mental health disorder, and 2,000 for CVD and a mental health disorder³;

¹ Populations who have received care for mental health disorders, CM Health MH Service and Population Health Team, 2013
² Populations who have received care for mental health disorders, CM Health MH Service and Population Health Team, 2013
³ Populations who have received care for mental health disorders, CM Health MH Service and Population Health Team, 2013
potentially avoidable hospital admissions were two to three times more likely for people who had received care for a mental health disorder⁴;  
in terms of AOD (alcohol and other drug), figures based on the NZ Drug and Alcohol Survey give an estimated figure of over 10,000 people in Counties experiencing harmful effects from AOD use⁵.

The key driver for the mental health and addictions transformation agenda is to improve our ability to better meet the needs of our local communities – retaining a focus on those with the most severe and enduring needs but extending our reach with early intervention in the life course and in the course of a condition. Historically people’s mental wellbeing has been assessed and treated in isolation from their physical health, but as noted from the figures above, a significant cohort of our population is presenting with both physical and mental health needs, and people with mental health conditions have poorer health outcomes than the population as a whole. A large number of people are presenting to primary care for their mental health needs and, with a focus on early intervention, we need to improve our ability to support primary care mental health capacity and capability

The focus for the mental health and addictions integration agenda will be in alignment with the current CM Health direction of locality hubs with care closer to home in primary and community settings. The development of this broader integrated care agenda is being taken forward through a number of strands of work, including:

- **Enhanced Primary Care** – a collaboration between the DHB, PHOs and a number of early adopter practices to transform the primary care model of care to operate in a more integrated and inter-disciplinary way;
- **Community Health Services Integration** – transforming the way community health services work to provide an integrated service that moves away from specialist teams. These teams will operate within general practice and adopt an interdisciplinary approach with a focus on reablement, supported discharge, rapid response and rehabilitation;
- **Development of Community Hubs** – the establishment of six Community Health Hubs within the four localities. The hubs will offer a core suite of services that are beyond the typical scope of general practice.

While we will be seeking to design a model of care that aligns effectively with the CM Health localities model, we will also ensure that the range of services across Counties, and access to them, meets the needs of our Māori, Pacific and Asian communities.

When considering the direction of travel for the mental health and addictions system within Counties Manukau, it is important to reflect on the national focus and how we in Counties can ensure that local system development is in line with the national approach. The direction of travel for the mental health and addictions system set out in *Rising to the Challenge* and *Blueprint II* identified a number of factors relevant to the transformation of the system within Counties Manukau:

- the need to make effective use of current resources;
- the need for integration between primary and specialist services;
- the importance of building resilience in our populations;
- the need for workforce development.

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⁴ Populations who have received care for mental health disorders, CM Health MH Service and Population Health Team, 2013  
⁵ Community Alcohol and Drug Services (CADS) Annual Report, 2014
Blueprint II emphasised the need to continue to make changes in order to meet future need. Focussing on a life course approach, underpinned by an emphasis on recovery, wellness and building resilience, key themes are:

- earlier and more effective responses;
- improved equity of outcomes;
- increased access;
- increased system performance;
- effective use of resources;
- improved partnerships.

More recently the New Zealand Health Strategy consultation has identified five strategic themes which align with the direction of travel across Counties, including our vision for mental health and addictions:

- people powered;
- closer to home;
- value and high performance;

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6 Figure 2: Life course approach, Blueprint II: Improving mental health and wellbeing for all New Zealanders, p9
• one team;
• smart system.

The Strategy consultation recognises the importance of health in a wider context, the determinants of wellbeing, and its impact on our society and communities. This resonates strongly with what we have heard through our process of co-design; that our community’s mental wellbeing cannot be viewed or supported in isolation to all the other factors in people’s lives. Our service provision currently includes a focus on issues such as housing and employment and areas such as this will be a key component as we develop a more integrated and inter-sectorial focus across our services. We have been encouraged by the range of organisations/sectors that engaged with us through our co-design process and expressed an interest in working collaboratively for our community’s wellbeing. We will look to pursue and strengthen these connections as an important component of our transformation agenda.

Co-design engagement
Forty co-design sessions were held with a range of stakeholders, totaling over 500 participants. Dedicated sessions were held to hear the views of service users and family/whaanau, as well as specialist services, NGO providers and primary care. In addition, participation extended to a much wider range of community and inter-sectorial partners including education (guidance counsellors, school principals, school nurses), Ministry of Social Development, Child, Youth & Family, police, pharmacists, midwives, aged-care and youth organisations, disability organisations and other members of our communities.

While there was some variation across the four localities in terms of feedback, the reoccurring themes across localities and stakeholder groups were very similar. Common themes were around:

• the importance of good relationships
  ▪ between service users, family/whaanau and service providers
  ▪ between the different service providers;
• the challenges of understanding and navigating the current system – for those using the system and for professionals within and outside the health sector. These discussions reflected concerns about the current number of NGO providers and the existing separation between specialist mental health and specialist addiction services;
• the importance of information sharing
  ▪ quality information that doesn’t need to be repeated multiple times
  ▪ on-going information sharing, keeping people informed and updated;

7 Ministry of Health, Consultation draft – Update of the New Zealand Health Strategy, October 2015
• the need to have confidence in a workforce that is skilled and capable in relation to mental health and addictions;
• the need to continue to tackle stigma, ensuring that the mental wellbeing of our communities is everyone’s business;
• the need to be person-centred, empowering individuals in their own wellbeing;
• the importance of being inclusive of family/whaanau and recognising their significant contribution;
• to not look at mental health and addictions in isolation, but to assess and support it as part of a holistic approach that includes physical health and the wider determinants of wellbeing such as housing, employment and education;
• the need for collective responsibility – everyone playing their part and being accountable;
• the need to recognise the challenges around accessing services, bringing services out to communities – making the system fit the person’s needs and not the other way around.

People spoke of good experiences and good individual relationships, but they also spoke of poor experiences and a system that is disjointed and operating in silos. The need for consistency was a key theme running throughout all the co-design discussions.

From a specific locality perspective, both the Eastern and Franklin localities spoke to the geographical challenges of accessing services and the need to ensure that those communities had access to a range of services that did not necessitate travelling to other parts of Counties Manukau.

From a cultural perspective, in addition to the themes outlined above, key messages included:

• the importance of being able to engage with services in your own language – to hear your language spoken as soon as you engage;
• the importance of cultural understanding and recognition, ensuring it underpins the whole system;
• the importance of family/whaanau and including them in the recovery journey.

In addition to the co-design workshops, we decided to take the discussions a step further and invite a number of core mental health and addiction collaborative groups to participate in ‘greenfield’ thinking discussions. The rationale behind the greenfield session was that to achieve real and significant improvements in outcomes and experience, consideration needed to be given to truly transforming the system from its current model. Participants were encouraged to discuss ideas unconstrained by consideration of existing organisational structures and funding streams. For the greenfield sessions, key themes were around:

• taking a whole family/whaanau approach;
• not discharging – or making the system more responsive when people need to re-engage;
• taking services into the community – and connecting with a range of partners to provide wrap around support;
• an integrated service providing a life course approach for Maaori whaiora and whaanau;
• community hubs and mobile services;
• a single point of contact through a navigator;
• a workforce with a diverse range of skills, including utilising people’s lived experience of mental illness and addiction;
• a flexible system that can be responsive to individual need;
• a system that is focused on empowerment.
It is impossible to do justice here to the full range of contributions, experiences and ideas that people shared through the co-design process. We will be working to reflect what we have heard in the detailed design and planning process and will continue to engage with stakeholders as the work progresses.

**A new model of care**

In a new model of care, we envisage a mental health and addictions ‘team’ (covering all age groups) functioning as part of a primary care-based MDT, able to provide advice, input and specialist treatment without the need for a formal referral process.

Teams will have on-site presence in locality hubs/clusters, while continuing to provide the existing mobile component that takes specialist mental health and addictions out into the community. Working alongside general practice and specialist mental health and addictions clinicians, will also be NGO partners, providing seamless access to appropriate recovery and support services. Our expectation is that these teams will have significant links and established relationships with other sectors/agencies such as housing, education and employment, ensuring a wrap-around approach that includes the broader determinants of wellbeing.

It is important to recognise that not all members of our communities choose to engage with general practice and we will ensure that the development of our model of care, and the range of services provided by specialist and NGOs partners, is accessible to our communities through whichever means they choose to engage.

While continuing to support those with the most severe and enduring needs, the intention is that by sharing skills, knowledge and capacity, we will develop and strengthen capability across the whole system, identifying and treating mental health and addiction needs earlier, supporting primary care to manage demand and hopefully impacting on health outcomes and the number of people requiring longer term, more specialist support.
Annex A provides a simple example of the difference that we are aiming to achieve in service user experience.

Next steps

We will be working to develop detailed proposals and an implementation plan that underpins the approach set out in this paper. Key areas of focus will be:

- a detailed design of a generic hub model that clearly articulates and demonstrates how mental health and addictions will function within a locality hub;
- overlaying what we know about population need, inequalities, and what’s important to our Māori, Pacific and Asian communities to identify what's required within each locality and/or across Counties Manukau and the range of functions/services to best meet those needs;
- developing a people strategy that supports our organisations and workforce to start thinking and acting in ways that fosters integration across the system;
- developing a comprehensive business case for how this change process will be delivered and managed.

The co-design engagement that has informed the discussions and thinking has been invaluable and we will continue to involve stakeholders, seeking their views and contributions as this agenda develops.
Annex A: MODEL OF CARE - SERVICE USER EXPERIENCE

Grace* is a 38 year old Samoan woman with a history of mental illness and addiction. She has been significantly overweight for a number of years and has type 2 diabetes. Grace also has a history of high blood pressure and is at risk of developing CVD. Grace lives in a two-bedroom Housing NZ house with her partner, three children and her parents. Grace's partner is employed but supporting a household of four adults and three children is extremely difficult and places a lot of pressure on the whole family. The school that Grace's children attend have met with Grace and her partner to discuss concerns regarding their behaviour. Grace's parents are getting older and both have a range of physical health needs.

(*Grace is a fictional person. Her experiences of the mental health and addictions system reflect the experiences that service users and other partners have shared with us.)

CURRENT STATE

- Grace visits her GP to get WINZ form signed
- Grace tells her story. Her GP identifies that she is experiencing anxiety/depression and is drinking.
- Grace's GP refers her to a psychologist and Grace waits to be seen. Her GP also refers Grace to the alcohol and drug service for counselling. Grace retells her story to both services.
- Grace's counselling sessions end. She returns to her GP, is still struggling with her mental health and is prescribed anti-depressants.
- Grace doesn't respond to the anti-depressants and her GP refers her to secondary mental health. Grace retells her story.
- Grace's GP loses track of her while she is under secondary mental health and does not know what is happening with her. Her mental health team would like her to be connected to her GP to ensure follow-up for her physical health but they aren't sure how to engage with her GP. Grace's family have an array of agencies and services in their lives. Information is rarely shared.
- Grace's mental health improves and she is discharged back to her GP. Grace's GP isn't clear about what is happening in terms of follow-up. Grace still feels overwhelmed by all the different people involved in her family's life.

FUTURE STATE

- Grace visits her GP and tells her story once. Her GP identifies that in addition to her physical health needs, she is experiencing anxiety/depression and is drinking.
- Together with Grace, the GP agrees a plan with the named mental health & addictions professionals connected with the general practice. They are part of the wider practice ‘team’ and include representation from specialist and NGO mental health and addiction services.
- Grace receives support for her depression, anxiety, drinking, diabetes and weight management.
- Grace continues to struggle with her mental health but feels supported by a team of health professionals (GP, practice nurse, psychiatrist, MH&A clinicians, community support and peer workers) who work to one shared plan, connecting with other services and agencies who are also involved with Grace and her family.
- Grace's physical and mental wellbeing is maintained. She remains well connected to her GP, mental health & addictions clinicians, support workers and other health professionals.
- Grace's team liaise with the education and health professionals connected to her children and to her father. The family feels supported with everyone working together.
- Grace's MH&A support worker helps her to reconnect with her church. Her support worker also helps with other issues such as money management and housing. Grace is much better and more able to cope. She knows her GP will support her mental wellbeing. She can easily reconnect with additional MH&A support if needed.
Mental Health & Addictions

Deep Dive

CPHAC April 2016
Deep Dive Overview

• Mental health and addictions transformation agenda
• Models of care – reviews and development
• Moving forward
Setting the scene

- commitment to transform the MH&A system
- part of the wider CM Health focus on transformation through integration across the whole system, with a focus on a locality approach
- making best use of current funding – to continue to support complex needs but to also intervene earlier and keep people well
- want to deliver a holistic approach to people’s health and well-being – across the life course
Why do we need to transform the MH&A system?

We want people in our communities with mental health and addiction needs to live longer, healthier lives.

We believe that by working together, we can:

• improve access to a range of services and supports;
• be better able to care for people when they are unwell;
• help them maintain their wellbeing when they are well.
Process to date

- Co-design engagement
- Cross-sector leadership group
- Engagement with collaborative partners
- ELT and Board endorsement
COUNTRIES MANUKAU
HEALTH

MENTAL HEALTH & ADDICTIONS UPDATE

30 NOV 2015

- Quick
- Easy
- Local

Support

When needed

Vision

Promotion of positive mental health

Early intervention

Integrated team

Workforce
- Mobile
- IT enabled
- Capable

Identify
- Access
- Treat

Deliberate
- Systematic
- Proactive

Service users & family/whānau
at the centre

Holistic health & wellbeing across the life course

What are the things that keep people well?

How do we bring services closest to people's homes?

Seamless experience

Navigation/facilitation
- As needed
- Encourage individuals/family

Significant-mobile workforce

Referrals
- Easy in/out
- Ability to re-engage/reconnect

Shared information/IT

6 Hubs

Manukau

Mangere

Takanini Papakura

Franklin

Eastern

Healthy together

Whole system integration

Significant transformation to get us to a new place

With specialist services across

Working together

Inter-sectoral engagement

Focus on:
- Self management
- Education
- Coaching
- Family support

Every door the right door
## MH&A Transformational Change Model

### 1. Shift to the left services and focus

- **Community located person and whanau centric model**

### 2. Expand our frame of ‘integrated care’ services

### 3. The leadership task to activate networks and relationships

### 4. Using different change approaches

### 5. Supported by streamlined decision making and aligned enabling strategies

### Table: Population Health

<table>
<thead>
<tr>
<th>Population Health</th>
<th>Primary and Integrated Care</th>
<th>Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health promotion including harm reduction (e.g. alcohol)</td>
<td>NGO, primary and community based care, with specialist clinical support for whole of system</td>
<td>1. Acute care including inpatient care 2. Highly specialised or intensive community care</td>
</tr>
</tbody>
</table>

### Table: Multi-sectoral, with communities

<table>
<thead>
<tr>
<th>Multi-sectoral, with communities</th>
<th>Localities, Networks and Community Hubs</th>
<th>Highly specialised teams Locality or regional wide</th>
</tr>
</thead>
</table>

### Table: Collaborate, test and spread

| Collaborate, test and spread | Design, build, scale up and embed | Efficient delivery, consistency and improvement |
Who’s in control - when?

Graph showing the relationship between Acuity and Control. The graph has two curves:
- Consumers: The curve starts at 100% control at low acuity and decreases as acuity increases, approaching 0% control at high acuity.
- System: The curve starts at 0% control at low acuity and increases as acuity increases, reaching 100% control at high acuity.

The graph illustrates that as acuity increases, consumers lose control and the system gains control.
Progressing our model of care

Single point of entry
Includes
0800 line, e-referral, GP line

Intake and assessment
Acute and hospital care

Specialist needs

Episodic and integrated primary care

Long term conditions

Maori & Pacific across the spectrum

PHO

NGO

CMDHB Mental Health Services
model of care 2012
Integrating MH&A with the wider health system

- Centralised District Specialist Services
- Specialist Services Supporting GP Clusters
- Locality-based Community Health Services
- Enhanced General Practice
- ACTIVATED PATIENTS & WHAANAU

Mental Health and Addictions
Developing a suite of locality services

Locality hubs and GP clusters

Inter-sectorial partners

- Specialist MH/AOD
- Parenting support
- Residential
- Respite
- Peer support
- CLS / CSW
- Employment support
- Cultural
- Whaanau
- Building community resilience
- Self management
Model of care reviews

EPIT

ICT

LIAISON & PSYCHOLOGY

MATERNAL
Whole of System projects

ACUTE PATHWAYS
- Adult I&A
- Kotahi RA
- HBT
- Awake overnight nurse

INTEGRATED CARE
- RCRC
- Co-design
- Non-urgent referrals
- Primary care liaison pilots
Refocusing Clinical Roles in the Community – the key worker review

Whole of Systems – enabler for integrated care

- Variation in clinical roles and activities
- Duplication of roles and tasks e.g. coordination, care plans
- Aim to clarify roles & responsibilities of keyworker, primary care liaison and primary care co-ordinator roles
- Enabler for integration between MH&A services, primary care and NGO
Next steps

- On-going service development through WoS projects and MoC reviews
- Detailed business case and implementation plan for transformation agenda covering:
  - sector reconfiguration
  - workforce development
  - system infrastructure
  - community development
Northern Region Clinical Pathways in Primary Care

Dr Kathryn de Luc, Sponsor
Dr Campbell Brebner, Clinical Sponsor
Dr Charlotte Harris, Clinical Lead
April 2016
About the Programme

Auckland Regional HealthPathways
- STATIC website - live since 24th August 2015
- Metro Auckland DHBs (3), PHOs (7) and general practices (300+)
- Canterbury HealthPathways content
- Vendor: Streamliners
- Clinical lead, Development manager, Clinical editors
- 560 + clinical pages; 95+ localised
- Funded 50:50 PHOs & DHBs

Nexxt
- DYNAMIC platform
- Electronic clinical decision support
- Integrated with PMS
- Northern region DHBs (4), PHOs (9) and general practices (400+)
- Vendor: Pathway Navigator
- Clinical lead, Implementation manager
- 92 practices; 10 pathways
- Funded by DHBs only
Clinical Pathway Objectives

- Standardise primary care management of common conditions
- Enable primary care to work at the top of its scope
- Improve quality of referrals received into secondary care and integration with secondary care
- Reduce variation of care and inequities in outcome
- Promote safety in practice
- Ability to monitor variations (dynamic)
- Support system wide model of care change
2011/12: GAIHN started development of 54 STATIC (algorithm) pathways

2012: GAIHN commenced DYNAMIC pathway project. RFP by healthAlliance. NEXXT™ Dynamic Tool selected


2016: Funding ($3.5M) approval process for NEXXT™ ongoing. Continued localisation (200+). Deep Dive commenced.
Evaluation report on Nexxt™ dynamic pathways in preparation for funding stage gate November 2015

“Nexxt™ enables a new ‘way of doing things’.

Of the systems we have seen, Nexxt™ has the best potential to reduce inappropriate variation within a system of care, to support integrated care over time, place and provider within general practice, within primary care and between primary and secondary care, and it is a platform to expand the role of nurses in primary care.

To realise this potential will require forward-thinking investment.”

Timothy Kenealy and Nicolette Sheridan (Sept. 2015)
Enabler of system-wide integration initiatives

“Clinical pathways need to be seen in the context of the wider integration strategy being pursued by the DHBs and Alliances in the Northern Region. The pathways can only realise their potential benefit if they become an integral component of other system-wide programmes of work, especially those seeking to establish more integrated and collaborative models of care”
Decision support at point of care

‘Static pathway’ it refers to a pathway represented in a fixed format such as an algorithm on paper or in non-interactive form on a computer.

‘Dynamic pathway’ it refers to a pathway represented in an interactive form on a computer interface that changes in response to data input.
Foreign Bodies Ingested by Children

Pathway shared - same for Canterbury and West Coast

This pathway discusses urgent and routine care, and provides links to the emergency treatment of foreign bodies (FB) ingested by children.

See also Foreign Bodies Inhaled by Children.

About ingested foreign bodies in children

Red Flags

- Disc battery ingestion e.g., from hearing aid or camera.
- Any object > 5 cm long, sharp objects, and multiple magnets

Assessment

1. Take a history:
   - Type and size of item seen ingested.
   - Any symptoms, including swallowing difficulty, drooling or dribbling, that may indicate oesophageal obstruction.
   - If battery ingestion, find out the exact type and refer immediately.

2. Look for neck swelling, crepitus, focal wheeze, or decreased breath sounds.
Nexxt™

Bob Bobson | Iron Deficiency

Initial presentation

Prerequisites

☑ Patient is confirmed to be iron deficient
Low serum ferritin, red cell microcytosis or hypochromia in the absence of chronic disease or haemoglobinopathy

☑ Patient is safely managed

Exclude and manage other causes of blood loss

Date of initial presentation: 28/07/2014

☑ Non-GI cause
Consider dietary iron loss (e.g. heavy menstrual bleeding, donation, severe dietary deficiency)

☑ Aspirin or NSAID use

☑ Full clinical examination (including rectal examination) raises suspicion of cancer

☑ Urinalysis - haematuria

☑ Coeliac antibodies

Investigations

Based on

- Patient is confirmed to be iron deficient
- Patient is safely managed

Waiting for

- Full clinical examination (including rectal examination) raises suspicion of cancer
- Coeliac antibodies
- Aspirin or NSAID use
- Urinalysis - haematuria
- Non-GI causes of iron deficiency

Reinforce dietary gluten free advice, consider referral to dietitian

Sufficient Data

Recommended

Full history and examination

Insufficient Data

Referral for assessment/diagnostic examination

Referral for gastroscopy/colonoscopy and commence iron replacement while awaiting investigation

Consider renal malignancy and commence iron replacement while awaiting investigation

Reinforce dietary gluten free advice, consider referral to dietitian
The Benefits

- **Patients perspective** - consistent care, increased engagement with decision-making

- **Provider perspective** - easy access agreed standards of care, efficiency referral processes. Culture change

- **System perspective** - more care right place, right time, working at top of scope

- **Population perspective** - ability to audit activity and monitor quality and consistency of decision making, set standards, improve health outcomes and reduce inequity

- **Integration perspective** - benefits realised earlier with larger cohort of patients

- **Future costs** avoided with breakeven FY 20/21.
Auckland Regional HealthPathways - Live since 24th August 2015

Progress to Feb 2016

Most Frequently Viewed Pathways
1. Antenatal First Consult
2. Deep Vein Thrombosis
3. Giant Cell Arteritis (GCA) or Temporal Arteritis
4. Cellulitis in Adults
5. Gout
6. Breast Pain (Mastalgia)
7. Breast Symptoms
8. Faster Cancer Treatment Programme
9. Amenorrhoea
10. Testosterone Undecanoate (Reandron) Injections

Participation in Clinical Working Groups

6850 Sessions
2098 Registered Users
169 Live localised pages
Nexxt™ dynamic clinical pathways

Uptake by clinicians participating in the proof of concept and pilot phase

Nexxt™ Pathways Started up to 18th of February 2016

- Dyspepsia: Proof of Concept 68, Pilot 30
- Iron def: Proof of Concept 76, Pilot 6
- Gout: Proof of Concept 205, Pilot 46
- Cognitive impairment: Proof of Concept 75, Pilot 71
- COPD: Proof of Concept 127, Pilot 54
- Cellulitis: Proof of Concept 118, Pilot 12
- AF: Proof of Concept 190, Pilot 9
- DVT: Proof of Concept 137, Pilot 59
- Type 2 diabetes: Proof of Concept 183, Pilot 59
- Sore throat: Proof of Concept 70, Pilot 0
The Deep Dive

- Survey, focus groups, interviews
- High and low users
- Understand utilisation pattern
  - Which pathways and why
  - Who uses and why
- Understanding training and change management requirements
- Identify and prioritise integration interfaces e.g. PMS, E-referrals, Concerto, POAC, E-shared care, ACC, WINZ, E-Rx
- Benefits realisation: undertake baseline measures and identify benefit owners.
Innovation challenges...

- Multiple stakeholders and agendas. The programme requires an “all Auckland and Northland approach” “horizontal balanced with vertical integration”
- Risk of implementing an IT tool rather than enabling integration
- Developing the tool with the vendor - developmental/ partnership approach required not suited to current contractual/transactional environment
- Agile approach needed when innovating but with strong clinical and programme governance
- Very new tool (dynamic) - need to understand what we have and what is it’s potential both technologically and in model of care changes/patient benefits
- Need long-term financial security for vendor. Risk misalignment of vendor business model and customer requirements
- Linking primary with hospital based pathways
- Creating the right incentives for users
- Technology situation changing e.g. EHR. Need to justify why this is not potentially wasted investment
- Lack of standards for easy integration with other systems
Are we getting it right?

- How do we develop an agile partnership approach for innovation?
- Need benefits framework to measure all the integration enablers.
- How to ensure strong links with the other integration enablers - At Risk Individuals, Enhanced Primary Care, Cognitive Impairment initiative...
- Are we getting the right patients on the pathways & linking to our risk stratification tools?
- Developing patient experience measures and access measures
- Is it assisting us develop more responsive services to our increasingly diverse population?
- Is it contributing to reduction of inequities?
- Monitoring whether improved outcomes for our priority populations
- How do we capitalise on the international community?
More Information?

URL  www.aucklandregion.healthpathways.org.nz

Username: connected
Password: healthcare

Contact: Dr Charlotte Harris
charlotte@aucklandpho.co.nz

Contact: Dr Kathryn de Luc
Kathryn.deluc@middlemore.co.nz
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

<table>
<thead>
<tr>
<th>Acronyms</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;D / AOD</td>
<td>Alcohol and Drug</td>
</tr>
<tr>
<td>ARI</td>
<td>At Risk Individuals</td>
</tr>
<tr>
<td>CHSI</td>
<td>Community Health Services Integration</td>
</tr>
<tr>
<td>DCIP</td>
<td>Diabetes Care Improvement Package</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HOP</td>
<td>Health of Older People</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-government organisation</td>
</tr>
<tr>
<td>NHC</td>
<td>National Hauora Coalition</td>
</tr>
<tr>
<td>NZQA</td>
<td>New Zealand Qualification Authority</td>
</tr>
<tr>
<td>PATHS</td>
<td>Providing Access to Health Solutions Programme</td>
</tr>
<tr>
<td>PHO</td>
<td>Primary Health Organisation</td>
</tr>
<tr>
<td>POAC</td>
<td>Primary Options to Acute Care</td>
</tr>
<tr>
<td>VHIU</td>
<td>Very High Intensive User</td>
</tr>
</tbody>
</table>

Executive Summary

- The Counties Manukau Children’s Team was launched on 22 March and is the country’s largest Children’s Team supporting about 1400 vulnerable children and their families over the next two years. The official opening was undertaken by Honourable Minister Anne Tolley at Clendon Park School.

- We continue to be on track to achieve all National Health targets for 15/16. The main focus to 30 June is on additional actions to achieve the smoking brief advice target. The Minister of Health has announced new health system performance measures for 16/17 including - acute hospital bed days per capita; - ambulatory sensitive hospitalisation rates for 0-4 year olds; - patient experience of care; - amenable mortality; - youth access to and utilisation of youth appropriate health services; - number of babies in smoke-free households at six weeks post-natal.

- In February The Ministry of Health released Sudden Unexplained Death of Infant data showing a 30% decrease over five years of Sudden Unexplained Deaths of Infants in Counties Manukau. Referrals for newborn baby beds have increased following the release of this data. Subsequent media
coverage has highlighted initiatives like the Counties Manukau pepi-pod and maternal smoking programme.

- Community Central has commenced with centralised triage for clinical referrals and tablets being used by clinical champions in the Eastern and Franklin localities. The staff are testing and using their tablets in the field and participating in a co-design process to improve the functionality and system for the next roll out phase. Consultation with staff and unions is underway on team configuration and hours of operation to support the model of care change.
### 4.2 National Health and Integrated Performance & Incentives Framework Targets

<table>
<thead>
<tr>
<th>Target</th>
<th>15/16 Target</th>
<th>14/15 Q4</th>
<th>15/16 Q1</th>
<th>15/16 Q2</th>
<th>February 2016</th>
<th>On Track</th>
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<tbody>
<tr>
<td>More Heart and Diabetes Checks</td>
<td>90%</td>
<td>92.3%</td>
<td>92.1%</td>
<td>92.1%</td>
<td>91.3%</td>
<td>Yes</td>
</tr>
<tr>
<td>Better Help for Smokers to Quit</td>
<td>90%</td>
<td>96.1%</td>
<td>86.9%</td>
<td>87.6%</td>
<td>86.7%</td>
<td>Improvement required</td>
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<tr>
<td>Increased immunisations - 8 months</td>
<td>95%</td>
<td>95.2%</td>
<td>93.6%</td>
<td>94.7%</td>
<td>95.1%</td>
<td>Yes</td>
</tr>
<tr>
<td>Increased immunisations - 24 months</td>
<td>95%</td>
<td>95.3%</td>
<td>95.2%</td>
<td>96.0%</td>
<td>96.5%</td>
<td>Yes</td>
</tr>
<tr>
<td>Cervical screening coverage (Enrolled population: Connex/DHBSS)</td>
<td>80%</td>
<td>76.0%</td>
<td>76.1%</td>
<td>N/A</td>
<td>N/A</td>
<td>Improvement required</td>
</tr>
</tbody>
</table>

*Note: February results are provisional only, based on calculation from PHO data. Monthly cervical screening data is not yet available. Better Help for Smokers to Quit reporting on unadjusted numbers from 1 July 2015. Connex/DHBSS data is no longer providing Cervical Screening coverage, this will be provided by the MoH IPIF team shortly for Quarter two.*

Counties Manukau Health continues to meet the target for ‘More heart and diabetes checks’, with a slight drop in performance between Quarter Two (December 2015) and February 2016. Performance for the eight month and 24 month immunisations targets is tracking well with the expectation that both targets will be met by June 2016.

We are maintaining a strong focus on meeting the cervical screening target, with resource and activity directed at priority group women and PHOs with lower than expected performance. Newly available data showing women who are overdue for their cervical smear at a practice level will help to progress this work.

There has been a slight drop in performance for ‘Better Help for Smokers to Quit’ since Quarter Two, however there has been an improvement in comparison to the January result. Primary Health Organisations and practices are working together on strategies to improve performance including proactively calling patients and offering brief advice and cessation support options.

The Minister of Health has announced new Integrated Performance and Incentives framework Measures. These include:
- acute hospital bed days per capita;
- ambulatory sensitive hospitalisation rates for 0-4 year olds;
- patient experience of care;
- amenable mortality;
- youth access to and utilisation of youth appropriate health services;
- number of babies in smoke-free households at six weeks post-natal.

Three of these new measures - acute hospital bed days, preventable hospitalisation rates and patient experience of care - will be financially incentivised in 2016/17, along with the two existing primary care national health targets (better help for smokers to quit and increased immunisation).
**More Heart and Diabetes Checks**

<table>
<thead>
<tr>
<th></th>
<th>Historical Quarters</th>
<th>Current Month</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>2015-Q4</td>
<td>2016-Q1</td>
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<tr>
<td>PHO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alliance Health Plus</td>
<td>93.9</td>
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</tr>
<tr>
<td>East Health</td>
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<tr>
<td>NHC</td>
<td>89.8</td>
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<td>ProCare</td>
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<tr>
<td>Total Healthcare</td>
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<td>CMDHB</td>
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<td>National</td>
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</tr>
<tr>
<td>Target</td>
<td>90.0</td>
<td>90.0</td>
</tr>
</tbody>
</table>

February 2016 results are provisional only, based on calculations from PHO data. Quarterly data for PHOs is MOH published.

Most Primary Health Organisations have continued to reach the target over a sustained period. However, coverage for Māori (particularly Māori men) has not improved recently. Strategies to engage with this population group continue, including focusing on practices specifically with large numbers of Māori men enrolled.

Other innovative approaches to increase coverage are being shared between Primary Health Organisations, for example some East Health practices now ask all new eligible patients to have a blood test so that Cardiovascular disease screening is a routine part of a new patient appointment.
Better Help For Smokers To Quit

<table>
<thead>
<tr>
<th></th>
<th>Historical Quarters</th>
<th>Current Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2015-Q4</td>
<td>2016-Q1</td>
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<tr>
<td>Alliance Health Plus</td>
<td>98.6</td>
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<td>East Health</td>
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<td>NHC</td>
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<td>ProCare</td>
<td>100.2</td>
<td>88.5</td>
</tr>
<tr>
<td>Total Healthcare</td>
<td>89.2</td>
<td>86.3</td>
</tr>
<tr>
<td>CM Health</td>
<td>96.1</td>
<td>86.9</td>
</tr>
<tr>
<td>National</td>
<td>90.5</td>
<td>83.2</td>
</tr>
<tr>
<td>Target</td>
<td>90.0</td>
<td>90.0</td>
</tr>
</tbody>
</table>

February 2016 results are provisional only, based on calculations from PHO data. Quarterly data for PHOs is MOH published results.

Note: Reporting is for unadjusted numbers from 1 July.

Ongoing work is occurring with Primary Health Organisations to sustain momentum and meet the Better Help for Smokers to Quit target. Primary Health Organisations are working closely with their low performing practices and providing additional resources to support these practices (such as improved coding and call centre activity). Some Primary Health Organisations have also been encouraging well-performing practices to reach 100% rather than the 90% target (to improve the overall average).

Other actions include increasing availability of group based therapy and encouraging practices to refer to Counties Manukau Health cessation support services. The Counties Manukau Health Quit Bus continues to attend regional events to engage with the community.

Immunisations

The Immunisation target for June 2016 requires 95% of all eligible children aged eight months, twenty-four months and five years of age to have completed their scheduled course of immunisations. Progress is discussed monthly with Primary Health Organisations and the Immunisations Working Group. Where immunisation is delayed by families they are referred to the Outreach Immunisation Service team and where needed to the Well Child Tamariki Ora provider.

We are well positioned to achieve the target for eight months and twenty-four months immunisation, however the five years immunisation is still lagging at 78% for February 2016 and 73% at 12 months data.

Action to improve the achievement of 95% of all five year immunisations includes faster turnaround of the overdue reports to practices and actioning of the Immunisations Response Plan. In addition the Outreach Immunisation Service team are encouraging the parents of four year olds referred to Outreach to attend Manukau SuperClinic Before School outreach clinic on a Saturday and combine their visit with the Before School check if it hasn’t been done. If they don’t attend they will be followed up at home.
Eight months Immunisations coverage

Current data for eight months immunisation for February shows 95% achievement for three months coverage, and by ethnicity shows Maori at 91%, Pacific at 97% and Asian at 96%. Improved coverage for Maori may be attributed to focus on outreach immunisations. Coverage of high deprivation Quintile four and five is 94%.

<table>
<thead>
<tr>
<th>PHO</th>
<th>Historical Quarters</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2015-Q4</td>
<td>2016-Q1</td>
</tr>
<tr>
<td>Alliance Health</td>
<td>92.5</td>
<td>93.7</td>
</tr>
<tr>
<td>East Health Trust</td>
<td>95.0</td>
<td>94.3</td>
</tr>
<tr>
<td>NHC</td>
<td>87.4</td>
<td>96.7</td>
</tr>
<tr>
<td>ProCare</td>
<td>95.3</td>
<td>95.2</td>
</tr>
<tr>
<td>THO</td>
<td>94.9</td>
<td>96.5</td>
</tr>
<tr>
<td>CMDHB</td>
<td>95.2</td>
<td>93.6</td>
</tr>
<tr>
<td>National</td>
<td>92.9</td>
<td>93.1</td>
</tr>
<tr>
<td>Target</td>
<td>95.0</td>
<td>95.0</td>
</tr>
</tbody>
</table>

Counties Manukau Health PHO Eight Month Immunisations Performance Total Population to February 2016
Three month data lag on National Performance due to national data assurance requirements
Twenty-four months Immunisations coverage

Current data for twenty-four months immunisation for February shows three months coverage at 96%, and by ethnicity shows coverage improved for Maaori at 95%, Pacific at 98%, Asian at 98%. There are very pleasing results in high deprivation Quintile five of 97%.

Graph Three: CM Health 24 Month Immunisations Performance: Total Population to Feb 2016

Performance by Ethnicity

<table>
<thead>
<tr>
<th>Historical Quarters</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHO</strong></td>
<td></td>
</tr>
<tr>
<td>Alliance</td>
<td>95.7</td>
</tr>
<tr>
<td>East Health Trust</td>
<td>95.4</td>
</tr>
<tr>
<td>NHC</td>
<td>85.4</td>
</tr>
<tr>
<td>ProCare</td>
<td>94.8</td>
</tr>
<tr>
<td>THO</td>
<td>97.2</td>
</tr>
<tr>
<td>CMDHB</td>
<td>95.3</td>
</tr>
<tr>
<td>National</td>
<td>93.2</td>
</tr>
<tr>
<td>Target</td>
<td>95.0</td>
</tr>
</tbody>
</table>

CM Health PHO 24 Month Immunisations Performance Total Population to February 2016

3 month data lag on National Performance due to national data assurance requirements
Quarterly trend shows improvement overall for twenty-four month immunisations.
### Cervical Screening – Total Population 3 year Coverage

<table>
<thead>
<tr>
<th></th>
<th>Q4 June 15</th>
<th>Q1 Sept 15</th>
<th>Q2 Dec 15</th>
<th>Maaori at Jan 16</th>
<th>Pacific at Jan 16</th>
<th>Asian at Jan 16</th>
<th>European/Other at Jan 16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CMDHB PHO ‘enrolled’ population</strong></td>
<td>76.0%</td>
<td>76.1%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>CMDHB ‘resident’ population</strong></td>
<td>72.5%</td>
<td>72.6%</td>
<td>73.2%</td>
<td>63.5%</td>
<td>76.7%</td>
<td>65.1%</td>
<td>80.2%</td>
</tr>
<tr>
<td><strong>National Performance</strong></td>
<td>76.5%</td>
<td>76.6%</td>
<td>76.7%</td>
<td>63.7%</td>
<td>74.6%</td>
<td>64.3%</td>
<td>81.8%</td>
</tr>
</tbody>
</table>

**Source:**
Connex (DHB Shared Services for PHO enrolled population) DHBSS is no longer providing Cervical Screening coverage. This will be provided by the MoH IPIF team shortly for Quarter two.
National Cervical Screening Programme Register – women aged 25-69 years for CMDHB resident population

**Note:** Monthly reporting on cervical screening coverage at DHB level (including ethnicity breakdown) will shortly be available from NCSP.

We have continued to support Total Healthcare (the Primary Health Organisation with the lowest cervical screening uptake) to improve their cervical screening systems and processes. Work is also ongoing with the Ministry of Health/National Screening Unit to improve data quality and availability.

The Maaori Health Advisory Committee recently endorsed the following recommendations:
- Commit funding to continue the employment of the cervical screening coordinator to 30 June 2017;
- Refresh the activities/focus areas for the cervical screening coordinator for the 16/17 year to support the implementation of the Maaori Health Plan actions;
- Work with Primary Health Organisations and other stakeholders to refresh the Counties Manukau Health Cervical Screening Action Plan to reflect priorities and agreed actions from the Maaori Health Plan for the 16/17 year;
- Provide increased outreach and after-hours services for Maaori and other high needs women in Counties Manukau Health, including trialling outreach home visits, and
- Trial (and resource) the call centre approach (used in achieving the Primary Care Smokefree Health Target) for women to be called and offered a smear and Well Women’s check.
4.3 Primary Health

To deliver comprehensive in and out of hours primary health care which is ‘Better, Sooner, and More Convenient’.

**Progress**

**After hours services update**

Primary Health Organisations and District Health Boards continue to advance two options for after hours services that are currently being developed. Broadly, the two options being considered are:

- Value based contracts model where after hours service contracts would be available to any service providers that meet the eligibility criteria and are willing to provide after-hours services according to specified service and funding requirements.
- A locality-based model which would include a procurement process to determine a network of locality based providers. The number of providers required across the region would be informed by analysis of service utilisation volumes and population demographics. The service would aim to address over and underutilisation.

District Health Boards and Primary Health Organisations are currently working through a benefits and risks process to identify a preferred model which will be prepared for presentation to Boards in April.

**Palliative Care – Innovations Fund**

The Minister of Health announced $7m nationally per annum of new resourcing (split across New Zealand based on Population Based Funding) for hospices to develop hospice-led innovation and collaboration for new community-focused services. Totara and Franklin hospices engaged with Counties Manukau Health and other stakeholders including primary care and the Age Related Residential Care sector to identify service developments considered to bring the greatest benefit for the Counties Manukau district.

The proposals (summarised in Table 1) have been submitted to a national panel for review and we expect to be notified of the outcome of the review in April.

**Overview of Palliative Care Innovations Funding Proposals Endorsed by CMDHB**

<table>
<thead>
<tr>
<th>Proposal Name &amp; lead hospice</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palliative Care Partnerships (Totara Hospice)</td>
<td>The proposed approach includes training of GPs with a special interest in palliative care, Nurse Practitioners supporting Age Related Residential Care, primary and community care and improved palliative care training and support for primary and community providers. The aim is to build capability in Age Related Residential Care, primary and community settings.</td>
</tr>
<tr>
<td>Mauri Mate Service Development Proposal (Totara Hospice)</td>
<td>Development of a model to improve equity of access and service experience for Maori. It is expected that this model will be beneficial for a broad range of palliative care service providers and would be available nationally for services to adopt.</td>
</tr>
<tr>
<td>Improvement in After Hours Care, Auckland Region</td>
<td>The metro Auckland District Health Boards support improved access to after hours palliative care services. The proposal contains a number of potential initiatives such as an after hours palliative care specialist telephone support line, a regionally</td>
</tr>
<tr>
<td>Proposal</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Consistent approach to out of hours planning and pharmacy support. Initiatives will require further input from stakeholders along with prioritisation within available resources.</td>
<td></td>
</tr>
<tr>
<td>Improving Delivery of Culturally Responsive End of Life Care (Mercy Hospice)</td>
<td>This proposal focuses on development of information resources, training packages and best practice standards to support more culturally responsive palliative care service delivery for Culturally and Linguistically Diverse communities.</td>
</tr>
<tr>
<td>Caregiver Support in the Community (Hibiscus Hospice)</td>
<td>The proposal includes training for formal and informal carers (Home-based Support Workers, Health Care Assistants, Volunteers and family members providing care and support). Counties Manukau District Health Board has provided endorsement for this proposal at a regional level, however any resource requirements and implementation planning relevant to the Counties Manukau Health district will require further consultation with stakeholders.</td>
</tr>
</tbody>
</table>

**Modified Diabetes Care Improvement Package**

Up to 19 general practices, each with over 100 people with poor diabetes control have been invited to participate in a Modified Diabetes Care Improvement Package Programme for 12 months. The aim of the modified programme is to improve the management of people with poor diabetes control through specialist clinician support of general practice and collaborative learning and improvement processes with practices.

District Health Board and general practice clinicians will share expertise and discuss the management of difficult cases. A care bundle approach will be used with the practices as a mechanism to improve practice processes so that patients receive interventions that are evidence based. Practices will be funded on the number of enrolled people with poorly controlled diabetes. Patients can also be part of the At Risk Individuals programme and access services such as extended nurse consultations. This approach enables broader multidisciplinary team participation, addresses comorbidities, and is person centred. The Modified Diabetes Care Improvement Package Programme will be supported by clinical indicator information that will be received for the whole population. This enables a comparison of the indicators between different practices, localities, ethnicity and programmes.

Practices not participating in the 12 month programme will continue on the existing Diabetes Care Improvement Package programme.

**Regional Clinical Pathways Programme**

**Static pathways**

The Auckland Region community membership of the HealthPathways (Canterbury model) was completed in December 2014. Progress to date includes:

- Alignment of the 54 pathway developed through GAIHN (2011-2014) to the new site
- Localisation of an additional 76 pathways from the HealthPathways content
- Localisation of an additional 101 pages of information including referrals to secondary services, regional programs i.e. Healthy Homes.
Utilisation

- 2126 clinicians registered for access since go live on 24th August 2015
- 47,254 pages viewed over this time
- returning visitor rate of 71%

Dynamic pathways

The pilot in 92 practices has been completed and includes the following outputs:

- 1847 patients were enrolled on a pathway
- 442 clinicians utilised the pathways across the target of 92 practices.

The Business Case for further development of pathways over the next three years has been presented and endorsed by various stakeholder groups. The static element of the business case has been approved and the dynamic element will be presented to Boards in April/May.

CM Health PHO Smokefree Plans

As part of reaching the National Health Target “90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months”, all Primary Health Organisations in the district were asked to develop and submit a Smokefree Plan for the 2015/16 year. The plans were required in the ‘Working Together to Achieve National Smokefree Targets’ contract between Counties Manukau District Health Board and each Primary Health Organisation.

Each plan outlines key activities to reach the target and support clients to quit smoking, with a particular focus on Maaori, Pacific, Asian and pregnant smokers. An overview of the actions and measures across the five Primary Health Organisation plans is included in Table one below.
## Summary of CM Health PHO Smokefree Plans 2015/16

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Actions</th>
<th>Outcome measures</th>
</tr>
</thead>
</table>
| **Leadership**  | • GPs and nurses to identify Smokefree champions to help drive practice activity.  
• Meet on a regular basis with clinical team, District Health Board and Counties Manukau Health Integrated Performance and Incentives Framework meetings with other Primary Health Organisations. | • All practices have a recorded champion.  
• Attend meetings.                                                                                                                                 |
| **Reporting**   | • Accurate collation of performance data for dissemination to Ministry and Counties Manukau Health.  
• Disseminate practice level results on both brief advice and cessation support to all practices.  
• Follow up practices who have not achieved providing advice/support for patients to be smokefree.  
• Use new and innovative tools to record and capture smoking data.  
• Break smoking data down by ethnicity.                                                                                                                                 | • Accurate monitoring of performance targets and clear visibility of overall trends.  
• Improved/enhanced practice level monitoring of smoke free targets.  
• Practices engaged and activated to deliver improved outcomes.  
• Primary Health Organisation to focus on improving equity in terms of smoking status being recorded, brief advice and cessation support including development of specific actions targeted at ethnic groups. |
| **Quality systems** | • Use of audit tools to provide weekly data to practices.  
• Use TXT2Remind to contact patients and provide current and ex-smokers with brief intervention. This includes training and support for usage of TXT2Remind, and has simplified programme plans for practices to use it effectively. | • Continued use of audit tool.  
• All practices using and funded for TXT2Remind.                                                                                                                                                                                                 |
| **Education/training** | • Develop practice training to promote ABC and Quit Card provider support to ensure 90% of GPs and nurses have undertaken training.  
• Promote use of existing e-learning platforms, Ministry of Health and Heart foundation.  
• Standardise/recommend conversation openers e.g. How do you feel about your smoking?  
• Nurse Leader and Health Promotion Coordinator to undertake a NZQA Stop Smoking Practitioner qualification and NZQA assessor qualification.  
• Smokefree training provided to staff that require it on a regular basis as well as other training opportunities such as monthly sessions, annual education evening etc. | • PHO monitoring staff training to ensure 90% of GPs and nurses are current ABC Quit Card providers.  
• Number of Primary Health Organisations and District Health Board Smoking Cessation Coordinators provided with What Smokers Really Want education resource.  
• Enhanced support to patients and health care teams using tools, skills and current evidence based practice  
• Annual education evening/Continuing Medical Education sessions hosted.                                                                                                                                                         |
<table>
<thead>
<tr>
<th>Objectives</th>
<th>Actions</th>
<th>Outcome measures</th>
</tr>
</thead>
</table>
| **Group-based therapy**          | • Provide smoking cessation support to remote practices.  
• Increase education access via current Primary Health Organisation Smoking Cessation Practitioners.  
• Referral to existing stop smoking group based treatment via med tech, advanced forms to ensure ease of referral to stop smoking services.  
• Referral to Quitline and Counties Smoking Cessation Services.  
• Increase access to Māori/Pacific Stop Smoking Services and Counties incentives programme for pregnant clients.  
• Primary Health Organisation to deliver four or more seven-week group based treatment programmes per year.  
• Advocacy with Smokefree coordinators and Primary Health Organisation health promoters for group-based treatment training for primary health care nurses.  
• Increase awareness within practices of motivational interviewing. | • Primary Health Organisations to continue to collate numbers of staff attending CNE/CME smoking cessation education sessions.  
• Increased uptake of referrals to culturally appropriate Stop Smoking Services, in particular through Māori/Pacific and Asian services.  
• Increased volume and improved opportunities for smokers to quit using group based treatment methodology.  
• GPs and nurses engagement with 75% of Smokefree coordinators and Primary Health Organisation health promoters throughout New Zealand to promote group based training.  
• Motivational interviewing session hosted. |
| **Increasing primary care Smokefree capability** | • Active engagement with local networks and community groups to grow support and increase stop smoking opportunities for patients to include the quit bus at Community events.  
• Primary Health Organisation Nurse Leader and Health Promotion Coordinator actively engaged with the Smoke Free Community Provider network meetings with Counties Stop Smoking Practitioners. | • Primary Health Organisation monitoring staff training to ensure 90% of GPs and nurses are current ABC quit card providers.  
• Number of Primary Health Organisation s and District Health Board Smoking Cessation Coordinators provided with What Smokers Really Want education resource.  
• Enhanced support to patients and health care teams using tools, skills and current evidence based practice. |
| **Planning/ sustainability**      | • Ensure all practices have a Smokefree plan.  
• Recruit and train additional project team members. | • Development of plan and meeting of actions.  
• Achievement of Integrated Performance and Incentives Framework Better Help for Smokers to Quit target each Quarter. |
<p>| <strong>Funding</strong>                      | • Some Primary Health Organisations use an incentivised payment system for practices. |                                                                                                                                                                                                                                                                                             |</p>
<table>
<thead>
<tr>
<th>Objectives</th>
<th>Actions</th>
<th>Outcome measures</th>
</tr>
</thead>
</table>
| Promotion  | • Practices asked to display Smokefree posters on walls that encourage patients to talk to the physicians, and have hand-outs available for patients in consultation rooms.  
• Receptionists encouraged to ask for smoking status opportunistically if not recorded. If Smoking Brief Advice and/or Cessation is recorded and overdue, receptionists are to alert clinical staff members to discuss. Receptionists are expected to be trained with smoking cessation support, and can phone/text patients for ABC.  
• Promotion and engagement with Stoptober campaign and World Smokefree Day.  
• A Smokefree pregnancy health promotion campaign.  
• Promotion of Smokefree Aotearoa 2025.  
• Provide smoking cessation support to tie in with other activities e.g. physical and nutrition courses. | • Stoptober campaign agreed and communicated, regional events attended.  
• Smokefree pregnancy health promotion pack campaign distributed.  
• Culture change in increasing health promotion.  
• Increased number of quit attempts across the network.  
• Reduction in number of smokers per practice. |
4.4 Progress with Systems Integration

Quality and Safety – Safety in Practice

88 people from across the metro Auckland region attended the 3rd Learning Session for Safety in Practice at Ko Awatea on the evening of 31st March, to learn from each other around the four bundles of care and their experience using the trigger tool and safety climate survey. The majority of participants reported that they had gained at least two ideas as a result of the evening.

April sees the start of Roadshows across the Primary Health Organisation’s for year three of the programme. Numbers are expected to increase and two new care bundles will be introduced.

Community Health Service Integration

The first key milestone for the Community Health Service Integration programme is to have an early supported discharge response operating for all areas of the hospital by May 2016.

Formal consultation has now commenced with Locality Community Health Teams and the Very High Intensive Users Team to seek their individual views on the proposed model of care changes and the impact on their current roles and team configuration. While staff support the model of care changes, they have raised concerns about the proposal to gradually extend the hours of operation for the teams, capacity issues that prevent their ability to adopt changes to the way they work, and community safety during home visiting. We continue to work through these issues with staff and unions. Processes are underway to involve staff in Health and Safety reviews of current risk assessment processes and implementation of supporting strategies to ensure patient and staff safety in the community.

Reablement Workstream

Engagement with hospital teams continue to review the process for identifying appropriate patients for Reablement/Early Supported Discharge. For medical wards, the Acute and Post Acute nursing team will be the key contact for Reablement and we will trial using e-Shared Care to admit the patient directly and bypass traditional referral processes which will enable a faster route onto the pathway and minimise delays.

A draft clinical guideline is under development to ensure hospital clinicians have good information as to the patient cohorts who are most likely to benefit from a Reablement approach and Early Supported Discharge. This will ensure clinical safety when discharging. The Acute Rehabilitation and Health of Older People team have worked to complete the first draft and this will be reviewed by other stakeholders to ensure the younger adults with long term conditions needs are defined as part of the guideline.

Community Central

The centralised intake process commenced with a team at the Orakau Rd base on the 14th March 2016. This involves a consistent team of clinicians (Nursing, Needs Assessment/Service Co-ordination and Allied Health) to undertake the triage of referrals for Community Health Services in all localities, applying the principle of ‘first best response’ and ceasing the practice of putting patients onto multiple wait lists. A feedback process is in place for staff receiving the referrals and for referrers to enable review of triage outcomes. A team of clinicians have developed working drafts of discipline specific triage criteria and core competencies needed for each discipline. This process is informing
where there is overlap in skills and roles and is informing the triage process as we establish a more combined way of triaging centrally.

Appropriate tablet based assessment forms, tools and workflow have been created for testing with locality staff before wider roll-out to enable better technology enabled mobile working. The co-design process has been constrained by the capacity of staff due to current clinical workloads, which has limited their ability to test and use the tablets in their busy clinical schedule however we are still broadly on track with the roll-out plan.
Reablement Service Dashboard

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

Dashboard # 4: March 2016

Reablement Approach Snapshot

192 Patients Enrolled
155 Transitioned From Reablement

Reablement Enrolments by Locality
Manukau 56%
Eastern 24%
Franklin 20%

Reablement Referrals & Enrolments by Age

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

Number of Reablement Referrals & Enrolments by Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Referrals</th>
<th>Enrolments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pacific</td>
<td>28</td>
<td>21</td>
</tr>
<tr>
<td>Maori</td>
<td>24</td>
<td>17</td>
</tr>
<tr>
<td>Asian</td>
<td>26</td>
<td>20</td>
</tr>
<tr>
<td>European</td>
<td>134</td>
<td>195</td>
</tr>
</tbody>
</table>

Reablement Enrolments by Gender
Female 64%
Male 36%

Reablement Enrolments by Locality

Reablement Referrals & Enrolments by Age

Referrals to Reablement by Locality

For further information www.countiesmanukau.health.nz/integrated-care
Reablement Referral Origin
Social workers 55%
APAC team 15%
OT/PT 16%
Nurses 7%
Other 7%

Reablement Referrals by Referral Location
Other
Wards 1, 2, 6 (Other Medical)
Wards 8, 9, 10, 11, 34E, 34N, 35N (Surgical)
Wards 4, 5, 23, 24 (HOP)
EC/MAU
Endocrine
Gastro
Respiratory

Number of Weeks on Reablement - Transitioned patients

EuroQol - Score at Start of Reablement vs. Score at End of Reablement
An improvement is indicated by a decrease in the EuroQol score

NEADL - Score at Start of Reablement vs. Score at End of Reablement
An improvement is indicated by an increase in the NEADL score – a high score equals a high level of independence

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

Readmissions
Readmitted within 7 Days: 7
Readmitted within 28 Days: 22
Readmitted within 90 Days: 36

Readmission criteria:
Acute casemix funded admissions only to the same health specialty as initial admission. Transfers are excluded. EC admissions with LOS <1 day are excluded.
At Risk Individual (ARI) dashboard

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

At Risk Current Snapshot
Key numbers & stats about our current programme:

18,164

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

PERCENTAGE OF ENROLLED POPULATION

<table>
<thead>
<tr>
<th>Population</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin</td>
<td>5.1</td>
</tr>
<tr>
<td>Mangere/Otara</td>
<td>4.1</td>
</tr>
<tr>
<td>Eastern</td>
<td>3.3</td>
</tr>
<tr>
<td>Manukau</td>
<td>3.9</td>
</tr>
</tbody>
</table>

ARI ETHNICITY

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>12.0</td>
</tr>
<tr>
<td>European</td>
<td>38.4</td>
</tr>
<tr>
<td>Maori</td>
<td>18.1</td>
</tr>
<tr>
<td>Pacific</td>
<td>28.7</td>
</tr>
<tr>
<td>Other</td>
<td>3.9</td>
</tr>
</tbody>
</table>

What does success look like

MORE THAN 60,000 PATIENTS WITH A LONG TERM CONDITION IN COUNTIES MANUKAU

18,462 SHARED CARE PLANS
Patients with a goal based care plan that is electronically shared with the care team members.

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

Patients per year enrolled in ARI programme

BY JULY 2016

18,462

30,000

MDTs are occurring within general practice cluster networks to support care planning for complex patients.

BY DECEMBER 2016

18,164

50,000

General practice clusters have broad networks of healthcare professionals supporting them.

BY JULY 2017

18,164

30,000

Improved self-management means patients feel more in control and understand their health condition.

For further information [www.countiesmanukau.health.nz/integrated-care](http://www.countiesmanukau.health.nz/integrated-care)
4.5 Eastern Locality Reports

1. Acute Locality

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Unplanned readmissions (28 days)</td>
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<td>6.4%</td>
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<td>0.8</td>
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<td>1.2</td>
<td>0.9</td>
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<td>1.3 Average bed day usage in last 6 months of life</td>
<td>11.9</td>
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<td>11.1</td>
<td>6.3</td>
<td>10.8</td>
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2. Quality

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<td>2.3 Middlemore Radiology &lt; 6 week wait time for GP Referrals</td>
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<td>86.6%</td>
<td>94.9%</td>
<td>89.9%</td>
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3. Shared Accountability Services

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<td>3.1 ED presentations not admitted</td>
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<td>228</td>
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<td>4.1 E-referrals as % of all referrals</td>
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<td>4.1%</td>
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<td>4.3%</td>
<td>3.6%</td>
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Performance

The Eastern Locality as a whole continues to have a total of 3,587 patients enrolled on the At Risk Individual programme with a shared care plan. This is across all three Primary Health Organisations who have practices in the locality. A review of how At Risk Individuals is working within the locality took place in February 2016. Areas where patients who would benefit from the At Risk Individuals programme were identified with the Primary Health Organisation’s with an aim to increase the numbers of enrolled patients in the locality benefitting from the At Risk Individuals programme.

The Eastern Community Health Team (not including the Needs Assessment Service) provided 1860 face to face patient contacts, with a combined caseload of 1,441 patients across the team.

Centralised Interdisciplinary triage is now in its third week of working ensuring all referrals are centralised triage before being forwarded to each base as part of the Community Central roll out. All referrals are reviewed, triaged, prioritised and then sent to each base with a suggestion of who should be the best first responder.

There continues to be a number of patients who are awaiting an assessment from a member of the team from an allied health background or for a continence assessment. A review of the allied health services provided across Counties Manukau Health and East Health Primary Health Organisation is being completed, to ensure unnecessary lengthy waits are eliminated particularly for physiotherapy and occupational therapy.
The provision of non-complex wound care management by Primary Care via the Primary Options for Acute Care schedule’s continues to be used as a key pathway development which is being reviewed and promoted via the centralised triage function.

Work with the short term home care provider who is supporting the reablement model in the Eastern Locality is underway to review current and proposed ways of working to ensure that workforce and systems are in place for increased activity to support early supported discharge/ reablement from May 2016.

**Strategic**

Accident & Medical service provision: East Care and the allocated Senior Medical Officer from Middlemore Emergency Department are developing a model of care where there is a greater level of appropriate, safe observation and treatment facilities available in the locality as an alternative to presenting at Middlemore Hospital Emergency Department.

**Falls Prevention**

We continue to make progress with Active Plus (the Ministry of Health funded rehabilitation provider) and with ACC on a comprehensive, community based falls prevention approach for older people.
Otara/Mangere Locality

1. Acute Demand

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<tbody>
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<td>8.2%</td>
<td>7.7%</td>
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<td>7.4%</td>
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<tr>
<td>1.2 ASH rate (per 1,000 enrolled patients)</td>
<td>3.0</td>
<td>2.5</td>
<td>2.3</td>
<td>2.4</td>
<td>2.5</td>
<td>2.7</td>
<td>2.9</td>
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<tr>
<td>1.3 Average bed day usage in last 6 months of life</td>
<td>6.6</td>
<td>10.4</td>
<td>9.7</td>
<td>11.7</td>
<td>15.2</td>
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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.

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<td>95.4%</td>
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<tr>
<td>2.3 Middlemore Radiology &lt; 6 week wait time for GP Referrals</td>
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<td>92.6%</td>
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<td>93.0%</td>
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3. Shared Accountability Services

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<td>24.1%</td>
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<td>4.2 Medical Outpatient DNA rate</td>
<td>16.6%</td>
<td>19.2%</td>
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<td>17.1%</td>
<td>18.2%</td>
<td>15.2%</td>
<td>9.4%</td>
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Community Integrated Self Management Support Initiative

The project steering group continue to work through the year one implementation plan. Mapping local stakeholders who have credentials in nutritional health is the current focus. A Self Management Support stakeholder meeting is being planned for May for the purpose of networking and feeding back on progress made to date on the implementation plan.

Health & Social Service Integration

Local health and social service providers participated in an all-localities workshop with social service providers working in Counties Manukau Health secondary services and primary care, to start a conversation about how to work together across the sector, better.

Integrated Foot Care

Mangere Community Services Trust and Counties Manukau Health renal services are working together with Locality Leadership Team members to design a model of foot care for people with high risk foot disease who come to Toto Ora for haemodialysis.

Locality Hub Planning

The Mangere Shared Service Hub facility planning continues. Premises for the Hub in Otara are being scoped. There is active interest in clinic space from a number of Counties Manukau Health clinical service providers.
Diabetes Care Improvement Package

There has been a good response from General Practices in Otara and Mangere to the opportunity to participate in the Collaborative to improve diabetes care of people with high HbA1c and other risk factors.

Multidisciplinary Team Meetings

A survey of general practice and wider stakeholders participating in General Practice specific and Cluster Multi-Disciplinary Team meetings found strong support for continuing the service. Areas for improvement were identified.
Franklin Locality

1. Acute Demand

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<td>6.2%</td>
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<td>6.9%</td>
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<tr>
<td>1.2 ASH rate (per 1,000 enrolled patients)</td>
<td>1.5</td>
<td>1.7</td>
<td>1.3</td>
<td>1.4</td>
<td>1.3</td>
<td>1.6</td>
<td>1.9</td>
</tr>
<tr>
<td>1.3 Average bed day usage in last 6 months of life</td>
<td>12.3</td>
<td>7.7</td>
<td>8.3</td>
<td>13.1</td>
<td>17.9</td>
<td>25.9</td>
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<tr>
<td>2.1 Children fully immunised at 8 months (Target = 90%)</td>
<td>92.2%</td>
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<td>92.6%</td>
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<td>92.7%</td>
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<td>94.7%</td>
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<td>94.6%</td>
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<tr>
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<td>82.0%</td>
<td>94.8%</td>
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3. Shared Accountability Services

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<td>3.1 ED presentations not admitted</td>
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<td>115</td>
<td>111</td>
<td>145</td>
<td>145</td>
<td>114</td>
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<tr>
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<td>6.0%</td>
<td>4.7%</td>
<td>6.4%</td>
<td>5.4%</td>
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Reducing Unplanned Admissions/ Self-Management

Winter Planning

Preparations are mostly on track with a few elements waiting for completion or sign off. The National Flu Campaign commences April 6th and it is anticipated that we should be close to this for the distribution of the Winter Wellness message packs.

A small pilot project is planned for using local community pharmacies to deliver flu vaccinations. This is being discussed with local GPs.

The Social Service workshop outlining the Winter Plan for Franklin resulted in a number of enthusiastic Franklin agencies wanting to be involved with some of the elements around a blanket and curtain bank. A follow up session is planned.

Services Closer to Home

Dementia Pathway Outreach Pilot - Waiuku Health Centre

Twenty six patients have now been enrolled on the dynamic pathway at the pilot Practice. Another education session has been received with enthusiasm by the Waiuku Practice discussing the delivery of a dementia diagnosis and the removal of driving licenses. The practice has agreed to pilot the education programme. The next milestone is to develop the pilot into a “bundle” format to be able to share with other Practices.
Integration

Wound Care

Non-Complex management of wounds in primary care went live 30th November to release capacity for the District Nursing to engage in the Community Health Services Integration initiatives. To date the number handed over to primary care (via Primary Options for Acute Care) is fewer than anticipated. It is anticipated centralised triage will assist in streamlining and setting up a consistent process for passing appropriate referrals to Primary Options for Acute Care.

Mobility Devices

Tablets are currently being trialled at Franklin and Eastern Locality, and as of the middle of March two clinicians in each area are testing their functionality and usability. Clinical safety is of prime importance in this development and patients will be added incrementally as testing progresses.

Locality Hub Planning

The business case for phase one of Franklin Community Health Hub development has been completed and submitted for Infrastructure and Capital and Asset approval. This concentrates on providing accommodation to accommodate a Mental Health Team, Health Care assistants for the Reablement programme, additional parking and funding towards a 20-year site plan to direct phase two.

A meeting of all the Locality GP Principals is planned for 24th March when the main topic of discussion will be the possible development of an Accident and Medical facility with a small observation unit at Pukekohe Hospital. Local GPs are discussing the idea of forming an entity to run the unit collaboratively.

Review of Locality Group Roles

Terms of reference for the new groups – Locality Leadership Group and the Clinical Operation Group have been drafted and circulated for feedback and sign off next month.
Manukau Locality

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<td>662</td>
<td>676</td>
<td>767</td>
<td>838</td>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 E-referrals as % of all referrals</td>
<td>28.9%</td>
<td>29.1%</td>
<td>30.2%</td>
<td>28.2%</td>
<td>30.8%</td>
<td>29.6%</td>
<td>25.9%</td>
</tr>
<tr>
<td>4.2 Medical Outpatient DNA rate</td>
<td>8.4%</td>
<td>9.7%</td>
<td>8.5%</td>
<td>10.6%</td>
<td>10.3%</td>
<td>8.8%</td>
<td>9.4%</td>
</tr>
</tbody>
</table>

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

Community Collaboration in the Manukau Locality Winter Wellness campaign for 2016

The Winter Wellness Campaign in Manukau Locality focuses on Manurewa due to the high use of the Emergency Centre and will support two key messages of:
- Seek advice early
- Phone first to know your best option for healthcare

These messages will be shared through the five Community Networks the Locality is now very actively engaged with. Interest in the campaign is strong and from both Government Departments and Health and Social services Non-Government Organisations based in the Manukau Locality. These networks will assist with delivery of the message to their local communities.

Engagement with Auckland City Council Strategic Brokers for Local Boards in Manukau Locality

On 22nd March representatives from the Manukau Locality met with the three recently appointed Auckland City Council Strategic Brokers, for Papatoetoe, Manurewa and Papakura Local boards. The mandate for these brokers is to support community empowerment by supporting communities to make things happen for themselves. It has been identified that working with these Strategic brokers will be another avenue to supporting successful community health service integration in the Manukau locality.

Clinical Priorities

The Diabetes project continues to progress well. Patients who have had a repeated HbA1c level at three months are showing good improvement at this early stage and will continue to be monitored three monthly to ensure this improvement is sustained.
4.6 Child Youth & Maternity

Maternity

This month will see the launch of a coordination service with Primary Options for Acute Care to enable pregnant women in Counties Manukau timely access to urgent ultrasound scans when required. This service has arisen from the need to address the demand for urgent ultrasound scan services and to support with the administration of a service to support funded co-payments for women and whanau experiencing financial hardship.

Sudden Unexplained Death of Infant

The February announcement of a 30% decrease in Counties Manukau Health Sudden Unexplained Deaths of Infants over 5 years has increased the impetus within the Safe Sleep intervention programme. Referrals for newborn baby beds have increased with whaanau being given the choice between pepi-pods (plastic) and wahakura (woven flax). Approximately 30 baby beds are being distributed each month.

Safe Sleep Strategy

The Safe Sleep policy implementation continues to make progress in Counties Manukau with Safe Sleep audits being monitored weekly in all primary birthing units, maternity wards, Neonatal care and Kidz First Medical wards. Feedback is provided to all units monthly where there are issues in documentation of education to Mothers or, an unsafe sleeping position is noted.

Well Child Tamariki Ora

A number of initiatives are being implemented to improve Counties Manukau Health achievement of Well Child Tamariki Ora provider targets. The initiatives focus on achievement of enrolment, service utilisation in high deprivation areas and the quality of the service being delivered.

One of the key focus areas includes the development of an engagement model to facilitate shared visits with Well Child Tamariki Ora and Midwives to assist with a more targeted coordinated service to those whaanau most in need. This will allow for a more collaborate approach and the provision of well-coordinated suite of services.

Te Rito Ora – Community Breastfeeding Support

The Te Rito Ora community pilot is fully operational providing breastfeeding and baby feeding support to Mums and whaanau in Manurewa and Papakura through a peer support programme, drop-in baby feeding clinics, and community based lactation consultant service. The Ministry of Health have indicated that the funding for the service will be extended for a further one to two years, enabling the service to be extended into the full Manukau locality and Mangere/Otara locality. Discussions regarding the service delivery model for the expanded service are currently being undertaken.

Before School Checks

Before School checks are conducted in Counties Manukau by Plunket and Well Child Tamariki Ora Providers. Plunket also provide clinical leadership and training to the Well Child Tamariki Ora providers. The 2015/16 Ministry of Health targets for the year are for 8,025 Before School checks to be completed overall, with 3,565 of these from quintile five (high deprivation).
At the end of February Counties Manukau Health were at: 68% overall, 64% for Quintile five (high deprivation). Year to date a total of 5497 checks have been completed and 2281 of these are Quintile five. We are well on track to achieve targets by 1 July 2016.

Saturday Before School check outreach clinics at the Manukau Super clinics commenced for the year on the 13th of February and are still proving to be very popular with our hard to reach community. These clinics are booked for nine Saturdays per school term excluding public holidays and invites are sent out every week targeting hard-to-reach children who have not attended prior appointments for Well Child or Immunisations.

**Children’s Team**

The Counties Manukau Children’s Team was launched on 22 March with the official opening being undertaken by Hon Minister Anne Tolley. The event was hosted by Clendon Park School with a number of performances undertaken by the tamariki and rangitahi from the local area.

The Counties Manukau team is the country’s largest and will support about 1400 vulnerable children and their families over the next two years.

**Mana Kidz**

The Mana Kidz programme is currently being delivered in a third of Primary and Intermediate schools in Counties Manukau. Approximately 25,000 children (>95% of whom are Maaori and Pacific) aged five to 12 years have access to the Mana Kidz programme which includes a throat swabbing service to identify and treat Group A streptococcal throat infections in order to prevent rheumatic fever. The programme is currently targeted at schools with students at greatest risk of developing Rheumatic Fever. Mana Kidz resulted in 14,380 Group A streptococcal positive swabs being treated last year in students attending Mana Kidz schools and their household contacts. In addition 16,279 skin conditions were identified and managed. The Ministry of Health has reported a 53% reduction in Rheumatic Fever rates in Counties Manukau since the beginning of the rheumatic fever prevention programme.
Cumulative Acute Rheumatic Fever Initial Attack Notifications by Admission Month in 5-12 year olds, CMH

Oral Health

We are working with the Auckland Regional Dental Service to implement action plans to ensure all service metrics and targets such as enrolments and examination of preschool children zero to four years, and arrears will be achieved.

Due to vacancies and our growing patient group in the Counties Manukau area the arrears (volume of children not seen on time for their annual check-up) increased to 15 percent of enrolled children. The Clinical teams are implementing a number of strategies to stabilise and reduce arrears. These include the recruitment and mentoring of new graduates and evening/weekend clinics at hub locations.

Youth Health

The comprehensive and integrated school-based health service at Papakura High School will commence on 1st July 2016. New service components include an onsite GP clinic, youth worker and extended nursing services to be provided during the school holidays.

The quality improvement initiative for primary care is underway and involves an audit and improvement programme for general practices to improve their ‘youth friendly’ capability. The project is aligned with existing quality improvement initiatives in primary care such as At Risk Individuals and Safety in Practice, and the newly appointed Youth Health Quality Improvement Advisor will start on 4th April. We are also undertaking a joint review of health services delivered in Child, Youth and Family Care and Protection and Youth Justice residences. Once completed a Request for Proposals will be released, with the chosen provider starting on the 1st July 2016. All work streams are on track, with no known risks.
4.7 Mental Health and Addictions

Service Access Rates and Waiting Times

**Total clients seen by DHB of Domicile, Ethnicity - All**

- 0-19 Yrs
- 20-64 Yrs
- 65+ Yrs
- Target 0-19 Yrs
- Target 20-64 Yrs
- Target 65+ Yrs

Annual unique Counties Manukau Health resident access rates to Programme for Integrated Mental Health Data reporting mental health services from January 2015 to December 2015 (NGO & DHB services).

Note that there is a three month report lag due to national data assurance requirements.

This Ministry of Health performance measure provides a view on the whole of population access to specialist mental health and addiction services.

**Clients seen by Organisation Type, Ethnicity - All**

Total number of unique Counties Manukau Health residents seen by Programme for Integrated Mental Health Data reporting Mental Health and Addiction Services by Service type from January 2015 to December 2015.
Wait times for new clients referred to AOD services from January 2015 to December 2015 (NGO & DHB services).

There has been an increase in the Alcohol and Drug wait times in the last quarter, this is currently under investigation. We are also working with the Ministry of Health with regards to data to assist us to work with our providers to ensure better data integrity.

**Intensive Care Team – Supporting Women with High and Complex Needs**

The Intensive Care Team and one of the residential rehabilitation facilities have developed a pilot initiative to support women with high and complex needs in the community. Currently in Counties Manukau there is only support for males with multiple and complex needs at Tamaki Oranga, a minimally secure regional recovery unit. There is no such similar support for females.

The Intensive Care Team staff have been able to work with and train Emerge Non Government Organisation staff to put individual plans in place to support six women to remain in the community. One of the women has been in Tiaho Mai, the mental health inpatient unit for nearly a year due to her mental illness, substance misuse and the inability to source an appropriate place for her to live in the community.

The team are reviewing the progress weekly and there are measurements in place to monitor any progress or issues along the way. Each woman has a personalised wrap-around care package and early indications have already seen an improvement in the quality of life and overall wellbeing for these clients, as well as a reduction of critical incidents and reduced acute hospital stay.
A paper setting out the direction and areas of focus for the whole of system integration agenda for mental health and addictions was considered by the Board on 23 March. Endorsement was given to proceed with further work to develop our thinking and underpin the proposals with detailed analysis and assessment and a detailed business case implementation plan.

CPHAC has requested a deep dive for mental health and addictions, including a focus on the review of our keyworker role. In addition to an update on the keyworker review, the deep dive presentation will provide an opportunity to discuss the wider ‘whole of system’ transformation agenda for mental health and addictions. A separate paper provides additional context for this deep dive discussion.
4.8 Adult Rehabilitation and Health of Older People

Percentage of Home and Community Support Services client interRAI assessments complete by locality

(Reported Quarterly in arrears) – Number and percentage of clients who have received home and community support services during the last quarter, and have had an interRAI assessment at some point. Between November 2015 and January 2016 93.9% of patients receiving home based support services have had an InterRAI assessment.

<table>
<thead>
<tr>
<th>Locality</th>
<th>Clients</th>
<th>w/InterRAI</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>1054</td>
<td>905</td>
<td>85.9%</td>
</tr>
<tr>
<td>Franklin</td>
<td>666</td>
<td>659</td>
<td>98.9%</td>
</tr>
<tr>
<td>Mangere/Otara</td>
<td>587</td>
<td>567</td>
<td>96.6%</td>
</tr>
<tr>
<td>Manukau</td>
<td>1484</td>
<td>1430</td>
<td>96.4%</td>
</tr>
<tr>
<td>CM Health</td>
<td>3791</td>
<td>3561</td>
<td>93.9%</td>
</tr>
</tbody>
</table>

Needs Assessment Service Co-ordination by locality referral to complex assessments within 5 days:

<table>
<thead>
<tr>
<th>Locality</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>31.6%</td>
</tr>
<tr>
<td>Franklin</td>
<td>33.8%</td>
</tr>
<tr>
<td>Mangere/Otara</td>
<td>38.5%</td>
</tr>
<tr>
<td>Manukau</td>
<td>31.3%</td>
</tr>
<tr>
<td>CM Health</td>
<td>28.5%</td>
</tr>
</tbody>
</table>

Needs Assessment Service Co-ordination by locality referral to non-complex assessments within 15 days:

<table>
<thead>
<tr>
<th>Locality</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>22.4%</td>
</tr>
<tr>
<td>Franklin</td>
<td>28.5%</td>
</tr>
<tr>
<td>Mangere/Otara</td>
<td>28.5%</td>
</tr>
<tr>
<td>Manukau</td>
<td>28.5%</td>
</tr>
<tr>
<td>Other</td>
<td>27.0%</td>
</tr>
<tr>
<td>CM Health</td>
<td>27.0%</td>
</tr>
</tbody>
</table>

Percentage of patients entering Aged Residential Care who had a Home Care Assessment in the six months prior to admission:

<table>
<thead>
<tr>
<th>Locality</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>22.2%</td>
</tr>
<tr>
<td>Franklin</td>
<td>22.2%</td>
</tr>
<tr>
<td>Mangere/Otara</td>
<td>26.7%</td>
</tr>
<tr>
<td>Manukau</td>
<td>26.7%</td>
</tr>
<tr>
<td>CM Health</td>
<td>26.7%</td>
</tr>
</tbody>
</table>

Community Health Service Integration - Reablement

Further work with Community Health teams has identified that key roles are required to improve the identification of reablement patients in the hospital. Clear clinical criteria are being refined to be used by hospital liaison roles to ensure clear handover to the Reablement team and Community Central.

Community Specialists Health of Older People Teams (reported quarterly)

During the month of February the Community Geriatric Service team continued to provide support to multiple Primary Care practices and residential care providers. 18 aged residential care facility staff attended the February education forum; which was focused on sexuality and intimacy for the older adult.

Community Geriatric Services

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

February 2016 saw 68 Aged Related Residential Care Clients present to Emergency Care. Of these, 11 presentations were falls related and 11 were potentially avoidable admissions.
Memory Team (Dementia Care Pathway)

The Pilot Pathway was developed with a view to further spread to other Practices both within Franklin and to the other Localities. All education sessions have been recorded for future use. Support from the Memory Team and the project team for the champions and the wider Practice has been appreciated and has created a valuable link with the specialist service.

The Memory Team have been involved in the development and facilitation of the Capacity Assessment workshop with the aim of developing a certification process for appropriate registered Health Professionals.

Memory Team (Dementia Care Pathway) Activity:

<table>
<thead>
<tr>
<th>February 2016</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals (all for cognitive assessment this month)</td>
<td>58</td>
<td>927 cumulative accepted referrals (June 2013)</td>
</tr>
<tr>
<td>Number declined (due to out of Memory team catchment area)</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Referrals managed by Memory Team</td>
<td>35</td>
<td>66% (target 30%)</td>
</tr>
<tr>
<td>Referrals from General Practice</td>
<td>20</td>
<td>34%</td>
</tr>
<tr>
<td>Contacts</td>
<td>459</td>
<td>From 52 GP Practices</td>
</tr>
<tr>
<td>Caseload – open cases</td>
<td>209</td>
<td>Cases deemed appropriate to keep open for future action. MT monitor and close as appropriate</td>
</tr>
<tr>
<td>Caseload – active cases</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>Cases under Alzheimer’s Auckland</td>
<td>118</td>
<td></td>
</tr>
<tr>
<td>Number of clinicians</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Diagnosis made</td>
<td>427 – total dementia, 211 - total non-dementia diagnosis</td>
<td>638</td>
</tr>
</tbody>
</table>
4.9 Intersectoral Initiatives

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, Autex Industries Limited, Installed (formerly known as 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 2015-29 February 2016)

<table>
<thead>
<tr>
<th>Month</th>
<th>Total Number of Referrals</th>
<th>Total Number of Homes Insulated</th>
<th>Total Number of Home Visits completed post install</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2015</td>
<td>217</td>
<td>39</td>
<td>28</td>
</tr>
<tr>
<td>August 2015</td>
<td>172</td>
<td>55</td>
<td>36</td>
</tr>
<tr>
<td>September 2015</td>
<td>121</td>
<td>68</td>
<td>28</td>
</tr>
<tr>
<td>October 2015</td>
<td>115</td>
<td>61</td>
<td>32</td>
</tr>
<tr>
<td>November 2015</td>
<td>162</td>
<td>104</td>
<td>31</td>
</tr>
<tr>
<td>December 2015</td>
<td>77</td>
<td>77</td>
<td>13</td>
</tr>
<tr>
<td>January 2016</td>
<td>67</td>
<td>77</td>
<td>0</td>
</tr>
<tr>
<td>February 2016</td>
<td>58</td>
<td>88</td>
<td>34</td>
</tr>
<tr>
<td><strong>Total number of referrals generated to date</strong></td>
<td><strong>989</strong></td>
<td><strong>569</strong></td>
<td><strong>202</strong></td>
</tr>
</tbody>
</table>

Please note: There is a time delay between referrals being received by the provider and the completion of the insulation install.
Self-identified ethnicity by household for the current financial year (total referrals received 1 February 2016 – 29 February 2016):

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Number of referrals</th>
<th>Percentage of total referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>5</td>
<td>5%</td>
</tr>
<tr>
<td>European</td>
<td>24</td>
<td>26%</td>
</tr>
<tr>
<td>Indian</td>
<td>7</td>
<td>7%</td>
</tr>
<tr>
<td>Maori</td>
<td>34</td>
<td>37%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Pacific</td>
<td>22</td>
<td>24%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>93</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

The Providing Access to Health Solutions Programme

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

Total Number of Voluntary Participant Enrolled onto the Providing Access to Health Solutions Programme

<table>
<thead>
<tr>
<th>Month</th>
<th>Total Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2015</td>
<td>18</td>
</tr>
<tr>
<td>August 2015</td>
<td>15</td>
</tr>
<tr>
<td>September 2015</td>
<td>16</td>
</tr>
<tr>
<td>October 2015</td>
<td>17</td>
</tr>
<tr>
<td>November 2015</td>
<td>16</td>
</tr>
<tr>
<td>December 2015</td>
<td>11</td>
</tr>
<tr>
<td>January 2016</td>
<td>6</td>
</tr>
<tr>
<td>February 2016</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total Number</strong></td>
<td><strong>111</strong></td>
</tr>
</tbody>
</table>

Emergency Housing Update

The Auckland Council has funded Community Housing Aotearoa to improve the effectiveness of local responses to the growing demand for emergency housing in Auckland.

Boarding House Review

Auckland Council has continued with their review of boarding houses and is currently undertaking inspections in the Otahuhu area.
4.10 Primary and Community Finance Report

Summary

Primary and Community Services had a small favourable variance to budget for February of $59k and favourable $619k year to date. Most expenditure budget variances in the table below have matching contra revenue variances with highlighted exceptions noted below.

15/16 financial reporting now includes the Home Healthcare and Needs Assessment Service Coordination budgets in the Locality structure and also includes Public Health Nurses within Child, Youth and Maternity portfolio. All were previously included within Hospital reporting in 14/15.

Localities (YTD $137k favourable variance)

In total, the Locality budget shows a relatively small favourable variance but there are concerning trends in the Home Healthcare budgets in each locality with a year to date unfavourable variance total of $238k. When this is annualised it amounts to full year forecast of $322k greater than budget. These variances are largely driven by what has been a busy winter with higher acuity from supported hospital discharge, high staff illness, higher use of casual nursing staff and budgets that have little allowance for vacancy backfill. Supported discharge also has a high cost impact on clinical supplies. Fortunately these have largely been offset by underspends elsewhere within the Locality area of responsibility.

Community Pharmaceuticals (YTD $553k unfavourable variance)

This variance is offset by additional funding on the revenue line for under 13s of $353k. The spend year to date is currently greater than budget by $200k. A new Pharmac forecast is due, and will hopefully resolve this overspend issue.

Health of Older People (YTD $668k favourable variance)

The 14/15 trend of flat growth against an over 65 population growth of over 4% continues albeit at a slower rate. When the next surge in demand will start is unknown but the budget savings here will fund the investment now underway in the Community Health Services Integration implementation.

Primary & Community – Management (YTD $293k unfavourable)

Increased activity relating, in particular to the Community Health Services Integration implementation, has meant spend above budget. This was anticipated and conditional on the continued budget underspend from over 65s Home based and aged residential care costs. See Health of Older People comment above.

Mental Health ($5,247k favourable variance)

Typical slow start in procuring mental health services to ensure our ring fence requirement is maintained. The below budget spend is matched by a corresponding deferral on the revenue line.
## CPHAC Financial Report

**As at 29 February 2016**

<table>
<thead>
<tr>
<th></th>
<th>Mth</th>
<th>Mth</th>
<th>Mth</th>
<th>YTD</th>
<th>YTD</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual $000</td>
<td>Budget $000</td>
<td>Var. $000</td>
<td>Actual $000</td>
<td>Budget $000</td>
<td>Var. $000</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>33,710</td>
<td>34,000</td>
<td>(290)</td>
<td>268,219</td>
<td>272,002</td>
<td>(3,783)</td>
</tr>
<tr>
<td><strong>Expenditure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Demand Driven Costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmaceuticals</td>
<td>8,776</td>
<td>8,523</td>
<td>(253)</td>
<td>68,737</td>
<td>68,184</td>
<td>(553)</td>
</tr>
<tr>
<td>PHO/GMS/Rural Retention</td>
<td>7,090</td>
<td>6,954</td>
<td>(136)</td>
<td>57,651</td>
<td>55,635</td>
<td>(2,016)</td>
</tr>
<tr>
<td>Other PC Demand Driven costs</td>
<td>759</td>
<td>754</td>
<td>(5)</td>
<td>6,028</td>
<td>6,028</td>
<td>0</td>
</tr>
<tr>
<td>ARI / DCIP / Depression / VHIU Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Targets</td>
<td>939</td>
<td>1,036</td>
<td>96</td>
<td>8,113</td>
<td>8,286</td>
<td>173</td>
</tr>
<tr>
<td>POAC</td>
<td>181</td>
<td>181</td>
<td>0</td>
<td>1,415</td>
<td>1,452</td>
<td>37</td>
</tr>
<tr>
<td>Regional After Hours</td>
<td>647</td>
<td>607</td>
<td>(40)</td>
<td>5,118</td>
<td>4,856</td>
<td>(262)</td>
</tr>
<tr>
<td>Access to Diagnostics</td>
<td>93</td>
<td>100</td>
<td>7</td>
<td>898</td>
<td>800</td>
<td>(98)</td>
</tr>
<tr>
<td>Primary Care NGOs</td>
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<td>(111)</td>
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<td>73</td>
<td>74</td>
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<td>585</td>
<td>73</td>
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<td>176</td>
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<td>Locality - Mangere/Otara</td>
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<td>437</td>
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<td>212</td>
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<td>1,653</td>
<td>1,710</td>
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<td>Locality - Manukau</td>
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<td>322</td>
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<td>2,604</td>
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<td>88</td>
<td>11</td>
<td>626</td>
<td>710</td>
<td>84</td>
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<td>69</td>
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<td>530</td>
<td>553</td>
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<td>Child, Youth &amp; Mortality - Management</td>
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<td>251</td>
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<td>Mana Kidz</td>
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<td>0</td>
<td>(110)</td>
<td>1,397</td>
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<td>(725)</td>
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<td>100</td>
<td>12</td>
<td>754</td>
<td>798</td>
<td>44</td>
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<td>Child, Youth &amp; Mortality - Other Services</td>
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<td>244</td>
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<td>2,081</td>
<td>1,955</td>
<td>(126)</td>
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<td>(21)</td>
<td>1,955</td>
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<td>(118)</td>
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<td>554</td>
<td>(29)</td>
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<td>4,436</td>
<td>1,123</td>
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<td>190</td>
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<td>1,809</td>
<td>1,517</td>
<td>(293)</td>
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<td>27</td>
<td>0</td>
<td>(27)</td>
<td>313</td>
<td>0</td>
<td>(313)</td>
</tr>
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<td>20k bed day Initiatives</td>
<td>(105)</td>
<td>102</td>
<td>207</td>
<td>(1,678)</td>
<td>819</td>
<td>2,497</td>
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<tr>
<td>Savings Initiatives</td>
<td>(805)</td>
<td>(1,053)</td>
<td>(248)</td>
<td>(6,060)</td>
<td>(8,421)</td>
<td>(2,361)</td>
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<td>HOP - LTS CHC</td>
<td>275</td>
<td>345</td>
<td>70</td>
<td>2,787</td>
<td>2,764</td>
<td>(23)</td>
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<tr>
<td>HOP - Home Based Support Services</td>
<td>1,621</td>
<td>1,651</td>
<td>(30)</td>
<td>12,732</td>
<td>13,207</td>
<td>(474)</td>
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<td>HOP - Rest Home</td>
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<td>1,784</td>
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<td>14,187</td>
<td>14,271</td>
<td>(84)</td>
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<td>34,210</td>
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<td>HOP - Other Services</td>
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<td>380</td>
<td>49</td>
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<td>3,041</td>
<td>1,141</td>
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<td>HOP - Management</td>
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<td>59</td>
<td>9</td>
<td>415</td>
<td>472</td>
<td>57</td>
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<td>Mental Health NGOs</td>
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<td>757</td>
<td>30,591</td>
<td>35,919</td>
<td>5,328</td>
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<td>Mental Health - Management</td>
<td>32</td>
<td>29</td>
<td>(3)</td>
<td>317</td>
<td>236</td>
<td>(81)</td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td>34,279</td>
<td>34,627</td>
<td>348</td>
<td>273,405</td>
<td>277,806</td>
<td>4,402</td>
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<tr>
<td><strong>Net contribution</strong></td>
<td>(569)</td>
<td>(627)</td>
<td>59</td>
<td>(5,186)</td>
<td>(5,805)</td>
<td>619</td>
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</tbody>
</table>
COUNTIES MANUKAU DISTRICT HEALTH BOARD

5.0 Resolution to Exclude the Public

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

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

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Minutes of CPHAC meeting 2 March 2016 with public excluded</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Confirmation of Minutes For the reasons given in the previous meeting. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
</tr>
<tr>
<td>6.2 Action Items Register Confidential</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Confirmation of Action Items Register For the reasons given in the previous meeting. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
</tr>
</tbody>
</table>