# Northland District Health Board

Community & Public Health
and
Disability Support
Advisory Committee

## AGENDA

**DATE:** Monday 25 September 2017

**TIME:** 10.45 am

**VENUE:** Waipoua Meeting Room
Tohora House
Whangarei Hospital

NORTHLAND DISTRICT HEALTH BOARD
*Te Poari Hauora Ā Rohe O Te Tai Tokerau*

**AGENDA**

CPHAC/DiSAC MEETING
MONDAY 25 SEPTEMBER 2017

| | | | |
|---|---|---|---|
| 10.45am | | Karakia | |
| | | Apologies | |
| | | Register of Interests | 3 |
| | | • Does any member have an interest they have not previously disclosed?<br>• Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda? | |
| | | Attendance Register | 5 |
| 10.45am | 1.0 | Committee Minutes | 6 |
| | | 1.1 Confirmation of Minutes 26 June 2017 | 7 |
| | | 1.2 Matters/Actions Arising | 12 |
| | | 1.2.1 Update on Saturday immunisation clinics | |
| | | 1.2.2 Copy of the new NZ Disability Strategy | 13 |
| | | 1.2.3 Early draft of implementation framework for NZ Disability Strategy | |
| 10.55am | 2.0 | Chair's Report | 65 |
| 11.05am | 3.0 | System Performance | 66 |
| | | 3.1 Northland Health Services Plan Update | 67 |
| | | 3.2 NDHB Statement of Performance Update | 69 |
| | | 3.3 Northern Region Health Plan Update | 74 |
| 11.25am | 4.0 | Information Papers | 115 |
| | | 4.1 Public and Population Health Services Update | 116 |
| 11.35am | 5.0 | General Business | 120 |
| | | 5.1 Government Planning Priority - Healthy Ageing<br>• Implementation of Healthy Ageing Strategy<br>• Health of Older People Model of Care<br>• Dementia Model of Care | 121 |
| | | Presentation: Lyn Rostern, Population Health Strategist, Health of Older People DSS & Palliative Care | |
| 12.15pm | 6.0 | Next Meeting Details | 208 |
| 12.15pm | | Closure | |

**CPHAC/DiSAC INTERESTS REGISTER**

| Name | Nature of Interest | Date Updated |
|---|---|---|
| Libby Jones (Chair) | • Councillor – Kaipara District Council<br>• Deputy Chair – Otamatea High School<br>• Deputy Chair - Rural Support Northland<br>• Trustee - Sport Northland<br>• Deputy Chair - Paparoa Medical Society<br>• Member - Rural Health Alliance Aotearoa New Zealand (RHAANZ)<br>• Clinical Supervisor - of staff member Manaia PHO<br>• It's Not Ok Family Violence Awareness Champion - Rodney/Otamatea<br>• Manager Jigsaw North Family Services | 29/1/17 |
| Craig Brown | • Director - Serene Developments<br>• Trustee - Serene Trust<br><br>Helen Macrae Brown (Wife)<br>• Employee - Northland DHB | 5/12/16 |
| Sue Brown | • Owner and Executive Director – Papatoetoe Residential Care<br>• Chair – Auckland Northland Regional Bridge Committee<br>• Treasurer – Kerikeri RSA<br>• Business Advisor – Andra Healthcare Ltd<br>• Trustee, Waimate North Landcare Trust | 25/5/17 |
| Beth Cooper | • Employee, Massey University School of Nursing<br>• Volunteer, Achieve 2B<br>• Volunteer, Civil Defence, Northland Regional Council<br>• Contractor for Big Tree Studio (Pilates) | 26/6/17 |
| Colin Kitchen | • Councillor – Far North District Council (Te Hiku Ward)<br>• Member – FNDC Community Development and Services Committee, Member – FNDC Audit and Finance Committee<br>• Employee – NZ Fire Service (Volunteer Support Officer)<br>• Chairman – Northland Civil Defence Emergency Management<br>• Board member – Northern Rural Fire Authority<br>• FNDC representative on Volunteering Northland<br><br>Raina Kitchen (Wife)<br>• Employee – Whakawhiti Ora Pai Community Health Service | 5/12/16 |
| Sally Macauley | • Representative - Northern Regional DHB Executive<br>• Councillor – Far North District Council<br>• FNDC Committee member: Corporate, Strategy and Operations<br>• Chairman – FNDC Creative Communities – Creative NZ<br>• Chairman – Northland Community Response Forum (MSD)<br>• Chairman – Bay of Islands Arts Festival Trust<br>• Director/Trustee – Kerikeri International Piano Competition Trust<br>• Director – Kaikohe Education Trust<br>• Director- Kaikohe Community and Youth Centre Trust | 23/1/17 |

| Name | Nature of Interest | Date Updated |
|---|---|---|
| | • Judicial and Ministerial Justice of the Peace – Far North Justice of the Peace Association Inc.<br>• Latterly visiting Justice Northern Regional Corrections Facility<br>• Northern Regional Representative – Benefits Review Committee (WINZ)<br><br>Peter Macauley (Husband)<br>• Partner Palmer Macauley Lawyers<br>• Member of Priority Chapter NZ St John | |
| SHEA Sharon | • Principal - Shea Pita Associates Ltd<br>• Board member – Auckland DHB<br>• Contract with Manaia PHO to deliver workforce development training<br>• ADHB/WDHB – Maori Integrated contracts<br>• Te Runanga o Te Rarawa – outcomes project.<br>• Plunket – Outcomes implementation framework<br>• Te Putahitanga o Te Waipounamu Whanau Ora Commissioning Agency – multiple management consulting projects<br>• Consultant - Auckland and Waitemata DHB Maori Workforce Development project<br>Iwi Affiliations: Ngati Ranginui, Ngati Hine, Ngati Hako and Ngati Haua<br><br>Morris Pita (Husband)<br>• Part owner Turuki Pharmacy Ltd, Auckland<br>• Board member - Waitemata DHB<br>• Shareholder and Director - Healthcare Applications Ltd | 10/7/17 |
| Beryl Wilkinson | • President, Executive Chair - Age Concern, Whangarei<br>• Member - Health Quality & Safety Commission Falls Prevention and Medication Expert Advisory Groups | 15/2/17 |
| Jonny Wilkinson | • CEO – Tiaho Trust<br>• Member – Disability Advisory Group, Whangarei District Council<br>• Member – Expert Panel for NZ Disability Strategy, MSD<br>• Trustee – Achieve 2B<br>• Trustee – Sailability Northland | 14/2/17 |

**MEMBER ATTENDANCE - 1 JULY 2016 - 30 JUNE 2017**

| | 2016 | | | | | | 2017 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **CPHAC** | **Jul** | **Aug** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **June** |
| Libby Jones (Chair) | | | | | | | | | ✓ | | | ✓ |
| Craig Brown | | | × | | | | | | × | | | ✓ |
| Beth Cooper | | | | | | | | | ✓ | | | ✓ |
| Sue Brown | | | | | | | | | ✓ | | | ✓ |
| Colin Kitchen | | | ✓ | | | | | | ✓ | | | × |
| Jonny Wilkinson | | | | | | | | | ✓ | | | ✓ |
| Sharon Shea | | | ✓ | | | | | | ✓ | | | ✓ |
| Beryl Wilkinson | | | ✓ | | | | | | ✓ | | | ✓ |
| Sally Macauley | | | ✓ | | | | | | ✓ | | | ✓ |
| Mark Sears | | | × | | | | | | | | | |
| Peter Jensen | | | ✓ | | | | | | | | | |
| Debbie Evans | | | ✓ | | | | | | | | | |
| Tony Norman | | | ✓ | | | | | | | | | |

**MEMBER ATTENDANCE - 1 JANUARY 2017 - 31 DECEMBER 2017**

| | 2017 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **CPHAC** | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **June** | **July** | **Aug** | **Sept** | **Oct** | **Nov** | **Dec** |
| Libby Jones (Chair) | | | ✓ | | | ✓ | | | | | | |
| Craig Brown | | | × | | | ✓ | | | | | | |
| Sally Macauley | | | ✓ | | | ✓ | | | | | | |
| Sue Brown | | | ✓ | | | ✓ | | | | | | |
| Colin Kitchen | | | ✓ | | | × | | | | | | |
| Sharon Shea | | | ✓ | | | ✓ | | | | | | |
| Beth Cooper | | | ✓ | | | ✓ | | | | | | |
| Jonny Wilkinson | | | ✓ | | | ✓ | | | | | | |
| Beryl Wilkinson | | | ✓ | | | ✓ | | | | | | |

**No meeting held**
**Term commenced 5.12.16**
**Term of office concluded**

## 1.0 COMMITTEE MINUTES

1.1 Confirmation of Minutes 26 June 2017

1.2 Matters/Actions Arising

- 1.2.1 Update on Saturday immunisation clinics
- 1.2.2 Copy of the new NZ Disability Strategy
- 1.2.3 Early draft of implementation framework for NZ Disability Strategy

**DRAFT MINUTES OF THE MEETING OF THE NORTHLAND DISTRICT HEALTH BOARD COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE**

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**HELD ON MONDAY 26 JUNE 2017**
**IN THE WAIPOUA ROOM, TOHORĀ HOUSE, WHANGAREI HOSPITAL**

**COMMENCING AT 11.00AM**

**CPHAC/ DiSAC**

Libby Jones (Chair)
Craig Brown
Sue Brown
Beth Cooper
Sally Macauley
Beryl Wilkinson
Jonny Wilkinson

**IN ATTENDANCE**
Nick Chamberlain, John Wansbone, Lyn Rostern, Kathryn Leydon, Sarah Hunt (minutes)

**APOLOGIES** Colin Kitchen, Libby Jones (early departure), Sharon Shea

**MOVED Craig Brown: SECONDED Beryl Wilkinson** **CARRIED**

**CONFLICTS OF INTEREST –** The Chair reminded Committee members that in keeping with agreed protocol, conflicts of interest should be declared on a meeting-by-meeting basis as issues arise.

Beth Cooper advised the following: Employee, Massey University School of Nursing; Volunteer, Achieve 2B; Volunteer, Civil Defence Northland Regional Council; Contractor for Big Tree Studio (pilates).

**1. COMMITTEE MINUTES**

1.1 That the minutes of the CPHAC/DiSAC meeting held on 27 March 2017 be approved.

**MOVED Beth Cooper : SECONDED Beryl Wilkinson** **CARRIED**

**1.2 Matters/Actions Arising**

Beryl Wilkinson wanted to note for the minutes that she was interested in looking at the models of care for older people & older people living alone. Would like this addressed as part of the work plan the Committee are looking at later in the meeting.

**1.2.1 Pregnancy Hapu Wananga Project**

- Progressing well. Funding secured for the programme, will identify RBA outcomes.
- Currently recruiting for new clinical role.
- It is known that Maori women attend ante natal sessions at a very low rate, results in adverse outcomes for Maori babies. Hopeful this approach will get more engagement and clear focus on outcomes, through RBA.
- Teenage pregnant women, large number are Maori. Highest risk in terms of adverse outcomes.

**1.2.2 District Council Disability Support Activity**

- Paper was taken as read.
- Slight differences, but relative to council capacity and their needs, jurisdiction.
- Often have workshops to further educate staff on hearing and visual impairments.
- On-going relationship between DHB and councils in this space. To meet Annual Planning obligations for 17/18 NDHB has put together a cross sector working group. Someone from the council is part of that group which will be in place form 1 July.

**1.2.3 Draft Work Plan**

- Great to have a plan, request for more emphasis around primary health care services/

determinants of health.

- Would like to see much more community focus. Large number of initiatives currently occurring in primary care.
- Oversight of Northland Health Services Plan is part of committee requirements.
- Look to include updates on the Neighbourhood Healthcare Homes programme together with Primary Options programme as part of the work plan.

**It was moved that the Committee endorse the draft 2017 work plan**

**MOVED Craig Brown: SECONDED Beth Cooper CARRIED**

**1.2.4 Volunteer System and Hands Up Website**

- Online platform, partnership model, that looked to connect people who needed volunteers with volunteers.
- Website established, coordinated through Bush Road Medical Centre. Has not been well utilised.
- Believe this is due to a variety of reasons: Bush Rd Medical Centre doctors finding it difficult to sit down with patients to take them through the tool; many people who need assistance don't have access to website; some competition with other providers (Volunteering Northland).
- Discussed the options for the future of the website.
- Volunteering Northland has a good website which is being well utilised. Missing link is between GP (who can often identify the patient) and the patient connecting to the site.
- Noted some concerns about use of volunteers. Need to ensure that those who live alone are not discriminated against and have exactly the same services available as those living in a partnership.
- Volunteering role was intended to partner with someone i.e. going for walks.
- Consider healthcare assistants in practices to do this. Would like to see a coming together with Volunteering Northland.
- Noted new Health & Safety regulations and extra requirement that entails.

## 2. CHAIR'S REPORT

- Nothing to report.

Libby Jones left meeting at 11.25am. Sally Macauley took over as Chair of meeting.

## 3. SYSTEM PERFORMANCE

**3.1 Northland Health Services Plan Update**

- Successful symposium occurred recently for Neighbourhood Healthcare Homes.
- Currently undertaking EOI process for second tranche. Confirming practices moving forward this week. Have 4 change plans approved, with 2, from the 1st tranche.
- By end of 2nd tranche process will have 85,000 population in Northland covered. Still one more tranche to go. Very intensive and does require a lot of resource.
- All feedback from practices that have embarked on the Neighbourhood Healthcare Home journey has been very positive. GP triage has been a dramatic change – 1/3 of urgent appointments can be avoided with appropriate advice. Fantastic initiative.
- Whanau Tahi going well. Gone through data conversion and bulk uploads. Now have 1400 shared care plans. Looking to develop rules for engagement between primary and secondary care and pharmacy. **Request for patient feedback outcome measures/ measures of success when available.**
- Nurse navigator role – enabling use of shared care plan approach. Led by Manaia PHO and Whangarei based. Care coordination project role will be around Mid and Far North.

**3.2 Northern Region Health Plan Update**

- Taken as read.
- **Committee would like to see a 1 page summary of key items related to Northland in future reporting**. **Where statistics are given, would also like to see the breakdown for**

**Northland**, rather than combined figures for Northern region.

- Bullet points requested for Health of Older People Models of Care, how they are to be implemented, when they are to start, how it is to evolve. Presentation requested on implementation of Health of Older People Model of Care.
- Key element for focus is equality. The NHSP includes disability in equality element. Feed back to report writers that don't see much focus on disability, whether it's inequity or somewhere else. To include in the 17/18 plan.
- Some of the reporting details are to do with assessment. Queried what happens after assessment, what about implementation and outcomes for the benefit of the patient.
- Assessments for older people – queried whether there are delays in putting systems in place after assessments have occurred (Number 3 in the NRHP Top 10 commitments).
- Child health group – done well around safe sleep programme, reducing SUDI deaths.
- Challenges with colonoscopy. Have now recruited gastroenterologist to allow provision of colonoscopies.
- Northland DHB does very well with cardiac patients.
- Diabetes is influenced by demographics so poorer than other DHBs on that due to high Maori population.
- Doing well with MHAS services, stroke unit.
- Teen pregnancy has improved somewhat.
- Inequity is not an area where doing things regionally will have as much of an effect as doing locally.

## 4. INFORMATION PAPERS

4.1 Public and Population Health Services Update

- The paper was taken as read.
- Queried success of extra Saturday clinics for immunisations. Ministry are pleased with us doing it. Biggest hurdle in Northland is the decline rate. Vaxxed movie discussed.
- **Update on Saturday immunisation clinics requested.**

## 5. GENERAL BUSINESS

5.1 Government Planning Priority for Disability Support – Presentation: Lyn Rostern, Population Health Strategist, Health of Older People, DSS & Palliative Care; Jonny Wilkinson, CEO Tiaho Trust

**Presentation – Responding to Disability in 2017/18**

- Statutory Obligations of a DiSAC - The functions of the disability support advisory committee of the board of a DHB are to give the board advice on
  - The disability support needs of the resident population of the DHB; and
  - Priorities for use of the disability support funding provided
- The aim of a disability support advisory committee's advice must be to ensure that the following promote the inclusion and participation in society, and maximise the independence, of the people with disabilities within the DHBs resident population:
  - The kinds of disability support services the DHB has provided or funded or could provide or fund for those people;
  - All policies the DHB has adopted or could adopt for those people
  - A disability support advisory committee's advice may not be inconsistent with the New Zealand Disability Strategy.
- New Zealand Disability Strategy is based on the social model.
  - Disability is not something individuals have. What individuals have are impairments. Disability is a process which happens when one group of people create barriers by designing a world only for their way of living, taking no account of impairments other people have.
  - Physical barriers in the built environment
  - Attitudinal barriers within an organisational culture
- If we understand that, we then understand the concept of creating the DHB environment to be a non-disabling environment.
- Different to the medical model which focuses on individual. Social model focusses on not creating a disabling environment in society. About removing barriers – two categories: built

environment, have a universal design that is accessible to everyone; attitudinal variance, attitudes of people interfacing with disabled people.

- NZ Disability Strategy 2016-2018
    - We have the highest attainable standards of health and wellbeing
    - Healthcare professionals treat us with dignity and respect. We are seen as individuals and receive appropriate and timely support for all of our health needs, not just those related to our impairment. We do not face barriers accessing mainstream health services because of our impairments.
- New document has 12 outcomes. One of these is around health & wellbeing – a function of DiSAC. What this means:
    - Disabled people are consulted on and actively involved in the development and implementation of legislation and policies concerning health and wellbeing
    - Access to mainstream health services is barrier-free and inclusive
    - Services that are specific to disabled people, including mental health and aged care services, are high quality, available and accessible.
    - All health and well-being professionals treat disabled people with dignity and respect.
    - Decision-making on issues regarding the health and well-being of disabled people is informed by robust data and evidence.
- Cabinet paper on implementation framework and measurements to record progress. Should be out August/ September.
- How Tiaho Trust contributes to this – developed training package called "Customer Services Disability Awareness Training".
- Short video viewed and discussed.

**Government Planning Priority for Disability Support Services**

Outlined the four outcomes that were agreed as priority responses in 2017/18 Annual Plan:

- Accessibility (outcome 5)
- Attitudes (outcome 6)
- Health and Wellbeing (outcome 3)
- Leadership (outcome 8)

- Functionality – enabling components of the plan.
- Consumer council involved in developing design principles for site master plan. Have been approached for additional training around disability services. Opportunity to further support that, add to that mix.
- Do have trained accessibility auditor. Do have people with experience and training for staff.

- Attitudes – raising staff and volunteer awareness. Mandatory moodle traiing module, also link that to promoting use of health passport.
- Social workers have been instrumental in continuing to promote passport.

- Health & Wellbeing - Intellectual and sensory impairment attending breast screening. After instances of anxiety or difficulty attending meaning people didn't' attend. Visual story as an effective way to communicate.
- Health Passport being reviewed by HDC. Have been involved with that, will be live shortly.

- Active consumer leadership – engaged consumer in decision making. A number of initiatives in this area.
- Continue to deliver actions to support wrap around services to older people.

**Way forward as a committee**

- **Committee requested a copy of the new NZ Disability Strategy**. Agreed to include it in the next papers for this meeting.
- Needs to be prominently reflected in the next health services plan, starting next year.
- Vital part of planning for site master plan. Interpreting building plans in the concept of functionality.
- Signal to the 3 district councils the new strategy to allow them to include in their plans as well.
- The Strategy articulates things DHBs need to do, when the implementation framework comes out there will be more detail. Extensive consultation has occurred. Try and **get an early draft of the implementation framework for CPHAC/DiSAC to consider.**

**6. NEXT MEETING DETAILS**

The date of the next meeting is: Monday 25 September 2017 at 10.45am in the Waipoua Room, Tohorā House, Whangarei Hospital.

There being no further business the meeting closed at 12.25pm

**Confirmed that these minutes constitute a true and correct record of the proceedings of the meeting**

| | |
|---|---|
| CHAIR | DATE |

**ACTIONS ARISING FROM THE NORTHLAND DHB**
**COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING**

| | ACTION | BY | WHEN |
|---|---|---|---|
| 1 | Request for patient feedback outcome measures/ measures of success for Neighbourhood Healthcare Homes projects when available. | GM Planning, Integration, People & Performance | When available |
| 2 | 1 page summary of key items related to Northland from the Northern Region Health Plan Update. Where statistics are given, provide the breakdown for Northland where available.<br><br>*See NRHP Update (Agenda Item 3.2)* | GM Planning, Integration, People & Performance | On-going |
| 3 | Whether there are delays in putting systems in place after long term HBSS clients have an interRai clinical assessments have occurred for (Number 3 in the NRHP Top 10 commitments).<br><br>*Verbal report to meeting* | GM Medicine, Health of Older People, Emergency & Clinical Support | September 2017 |
| 4 | Update on Saturday immunisation clinics to be provided.<br><br>*Verbal report to meeting* | GM Child, Youth, Maternal, Oral, Public Health & District Hospitals | September 2017 |
| 5 | Copy of the new NZ Disability Strategy to be Included in next agenda papers<br><br>*Strategy attached* | GM Planning, Integration, People & Performance | September 2017 |
| 6 | Early draft of implementation framework for NZ Disability Strategy to be considered at the next CPHAC/ DiSAC meeting | GM Planning, Integration, People & Performance/Population Health Strategist, Health of Older People, DSS & Palliative Care | December 2017 |

# New Zealand Disability Strategy

2016–2026

Office for Disability Issues
Te Tarī Mō Ngā Take Hauātanga
Administered by the Ministry of Social Development

Published November 2016
Ministry of Social Development
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New Zealand

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# Contents


| | |
|---|---|
| Foreword – Minister for Disability Issues | 5 |
| Executive Summary | 6 |
| Our journey – an introduction | 9 |
| Our vision – where to from here | 11 |
| Who we are – our community | 12 |
| Principles and approaches | 16 |
| Our outcomes – priorities for change | 22 |
| Outcome 1: education | 24 |
| Outcome 2: employment and economic security | 26 |
| Outcome 3: health and wellbeing | 28 |
| Outcome 4: rights protection and justice | 30 |
| Outcome 5: accessibility | 32 |
| Outcome 6: attitudes | 34 |
| Outcome 7: choice and control | 36 |
| Outcome 8: leadership | 38 |
| Making it work | 40 |
| Getting it going – who is involved | 48 |
| Glossary | 49 |
| Appendix 1 – The Reference Group | 50 |

# Foreword – Minister for Disability Issues

We have come a long way since the first New Zealand Disability Strategy was agreed in 2001. The aim of the strategy was to eliminate barriers to enable disabled people to reach their potential and participate fully in the community.

The progress that we have made in partnership with disabled people is something that we can all be proud of.

Our journey since 2001 has seen the development of initiatives that will oversee the transformation of the disability support system, an increased focus on supporting disabled people into employment, improvements in inclusive education opportunities for disabled children, and New Zealand Sign Language becoming one of our official languages.

There is much to celebrate.

Together, this work has helped New Zealand take a lead role in the negotiation on the United Nations Convention on the Rights of Persons with Disabilities.

Since ratifying the Convention in 2008, we have established a unique mechanism for independent monitoring, actively considered and responded to recommendations from the Committee on the Rights of Persons with Disabilities, and supported Robert Martin in his successful candidacy for the Committee.

We have reaffirmed our lead role internationally on the rights of disabled people.

The development of the New Zealand Disability Strategy 2016–2026 has given us an opportunity to reflect not just on our progress, but also what we are still learning as a country about disability and how we can keep improving the lives of disabled people.

We must continue to acknowledge and respect the diversity within the disability community and recognise the value it adds to the community.

People can experience disability in different ways depending upon age, gender, ethnicity, impairment and many other factors.

For example, during the consultation to develop this Strategy, disabled adults shared the importance of having a meaningful job and being able to support their families. Disabled children talked about wanting to fit in at school and get out and about with their friends.

Despite what we have learnt and the progress that has been made since 2001, many disabled children and adults still face some barriers that prevent them from reaching their full potential.

If these barriers are not dismantled and removed, then all of us miss out. We will not prosper if disabled people are not able to participate in and contribute to our communities on an equal basis with others.

The United Nations Convention on the Rights of Persons with Disabilities has reinforced that disabled people have the same rights as others. It is about making sure everyone is treated with dignity and respect at all times, and that no one is left behind.

Our government is committed to continuing to improve the lives of disabled people and the New Zealand Disability Strategy will guide the government to achieve this over the next 10 years.

The direction and priorities outlined in the Strategy are based on what disabled people have said is most important to them.

During the two-stage consultation process, more than 1130 people attended the workshops we held throughout the country. We also received around 770 submissions from individuals and organisations via our 'Join the Conversation' website.

It is this strong foundation that gives us confidence in this Strategy guiding the work of government agencies for the next 10 years. After all, disabled people are experts in their own lives.

The Strategy will be critical in ensuring we are all working together towards achieving the same vision. There is much to be done and it is vital that we have a consistent framework from which to make decisions on where to focus our efforts.

We would like to acknowledge and thank members of the New Zealand Disability Strategy Revision Reference Group. Their expertise and advice proved invaluable in shaping this Strategy into something we are very proud of.

We want to thank the disabled people who participated in and supported the consultation to develop the New Zealand Disability Strategy.

You shared your hopes and dreams through this process with honesty and integrity. Your experience matters and your voices have been heard; it has become the foundation upon which this new Strategy has been built.

Finally, thank you to all the families, whānau and others who were involved in this process, particularly when disabled children or adults were not able to speak up for themselves.

We all have roles and responsibilities for achieving the vision of a non-disabling society. The Government will lead by example and we encourage others to join us too.

**Hon Nicky Wagner**
Minister for Disability Issues

# Executive Summary

## The New Zealand Disability Strategy (the Strategy) will guide the work of government agencies on disability issues from 2016 to 2026.

### The vision of this Strategy is:

- New Zealand is a non-disabling society – a place where disabled people have an equal opportunity to achieve their goals and aspirations, and all of New Zealand works together to make this happen.

### Three sets of principles and two approaches will help implement the Strategy

The principles and approaches will help make sure the disabled community is visible, acknowledged and respected on an equal basis with others, and that disabled people can live a life with dignity and feel valued.

The three principles are: Te Tiriti o Waitangi, the Convention on the Rights of Persons with Disabilities, and ensuring disabled people are involved in decision-making that impacts them.
The two approaches are: Investing in our whole lives – a long-term approach, and Specific and mainstream services – a twin-track approach.

## The Strategy identifies eight outcome areas

The outcome areas that will contribute to achieving the vision of the Strategy are:

**Outcome 1 – education**
We get an excellent education and achieve our potential throughout our lives

**Outcome 2 – employment and economic security**
We have security in our economic situation and can achieve our full potential

**Outcome 3 – health and wellbeing**
We have the highest attainable standards of health and wellbeing

**Outcome 4 – rights protection and justice**
Our rights are protected, we feel safe, understood and are treated fairly and equitably by the justice system

**Outcome 5 – accessibility**
We access all places, services and information with ease and dignity

**Outcome 6 – attitudes**
We are treated with dignity and respect

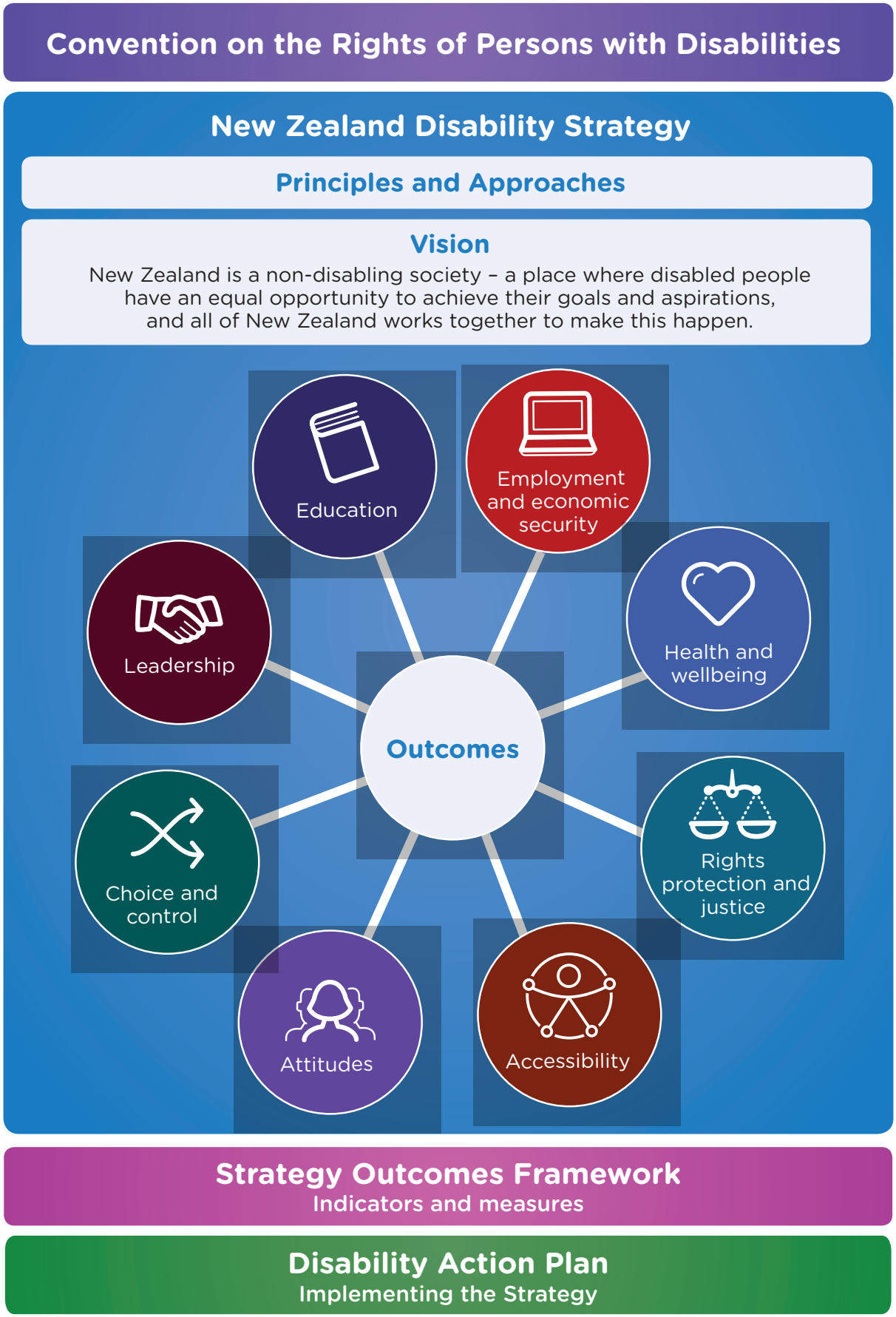
**Outcome 7 – choice and control**
We have choice and control over our lives

**Outcome 8 – leadership**
We have great opportunities to demonstrate our leadership.

## Targets will be developed, measures will be in place, and actions will be undertaken to implement the Strategy

An Outcomes Framework will be developed in 2017 which will set targets and measures for the Strategy. Annual reporting against the Outcomes Framework will be published on the Office for Disability Issues website. The Disability Action Plan will be the primary vehicle for implementing the Strategy. Figure 1 on the following page outlines the Strategy's framework.

## Figure 1 | Disability Strategy Framework



# Our journey – an introduction

## He aha te mea nui o te ao?
## He tangata! He tangata! He tangata!

## What is the most important thing in the world?
## It is people! It is people! It is people!

### The New Zealand Disability Strategy – A map to guide our way

The New Zealand Disability Strategy (the Strategy) will guide the work of government agencies on disability issues from 2016 to 2026.

It can also be used by any individual or organisation who wants to learn more about, and make the best decisions on, things that are important to disabled people.

The Strategy realises the rights of disabled people and supports implementation of the United Nations Convention on the Rights of Persons with Disabilities (the Convention) in New Zealand.

### The way we look at disability in New Zealand has changed

Since the first New Zealand Disability Strategy was developed in 2001 there has been real progress in the lives of many disabled people and their families and whānau. A significant milestone was the development of the Convention, which New Zealand ratified in 2008.

Disabled children are growing up wanting the same things as non-disabled children and the expectations of disabled adults have changed and grown. There is also a growing recognition that disabled people are experts in their own lives, and ensuring their right to be involved in the decisions that impact on them will lead to better outcomes.

### There is still more work to be done

Even though there has been progress since 2001, this revised Strategy is needed because disabled people remain worse off than non-disabled people across all social and economic outcomes.[1] This persistent gap has a flow-on effect. When disabled people are not able to participate in society, the entire country misses out on their contribution.

1 Statistics New Zealand (2014) Disability Survey: 2013

## Written from the perspective of disabled people

The development of this Strategy was supported by the New Zealand Disability Strategy Revision Reference Group, of whom the majority of members identify as disabled people.[2] It is also based on what disabled people said was most important to them during public consultation in 2016.

In order to remain true to the vision and priorities of the people at the centre of this Strategy, the Who we are, Principles and Approaches and Outcomes sections have been written from the perspective of disabled people.

Some words and terms can be understood by different people in different ways. Wherever possible, an explanation of how a word or term has been used in this Strategy has been included. A Glossary is available on page 49.

2 The New Zealand Disability Strategy Revision Reference Group members are listed in Appendix 1 on page 50.

# Our vision – where to from here

## New Zealand is a non-disabling society – a place where disabled people have an equal opportunity to achieve their goals and aspirations, and all of New Zealand works together to make this happen.

*The Strategy's Vision*

**A note on terms:**

Non-disabling is about removing the barriers in society that disable people with impairments. We consider this to be stronger and more meaningful than 'enabling', which will only help disabled people get around barriers rather than remove them completely.

# Who we are – our community

## We are children, young people and adults, we are parents and grandparents. We are also friends, family and whānau. What we want is no different to anyone else in New Zealand; we want to belong, contribute to our families and whānau and participate in our communities.

We are 1.1 million New Zealanders and we represent almost a quarter (24 percent) of New Zealand's population.

### What disability means to us

Disability is something that happens when people with impairments face barriers in society; it is society that disables us, not our impairments, this is the thing all disabled people have in common. It is something that happens when the world we live in has been designed by people who assume that everyone is the same. That is why a non-disabling society is core to the vision of this Strategy.

Every human being is a unique individual. Even if we have the same impairment as someone else, we will experience different opportunities and barriers because of where we live and how we are treated by those around us. The time and context in our lives when we may acquire our impairment(s) also informs what barriers or opportunities we may experience.

This is the social model of disability and it is how we understood disability in the first Strategy in 2001. It still holds true today. It is also the same understanding of disability that is embodied in the Convention. The Convention says that disabled people include:

> *"...those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others..." (Article 1).*

## The language about disability is really important

There are many words and terms that are used to identify disability. The way these are understood differs and this was apparent during consultation to support the development of this Strategy. For some of us, the term 'disabled people' is a source of pride, identity and recognition that disabling barriers exist within society and not with us as individuals.

For others, the term 'people with disability' has the same meaning and is important to those who want to be recognised as a person before their disability.

This Strategy uses the term 'disabled people'. This is based on advice from the New Zealand Disability Strategy Revision Reference Group and in recognition of the history of the term in the 2001 Strategy. In future, it is possible that our community reaches a consensus on a different way to describe us. If this happens, the language in this Strategy can be changed to reflect this.

Not all members of our community identify with disability-focused language. For example, older people and their families and whānau sometimes think that disability is a normal part of the ageing process. People with invisible impairments such as mental health issues can sometimes identify as part of the mental health community, and not the disability community. Deaf people identify as part of the Deaf community with its own unique language and culture, and do not always identify as being disabled. Most Māori disabled people identify as Māori first. The importance of their cultural identity, which encompasses language, whānau, cultural principles, practices and linkages to the land through genealogy, is paramount to how they live their day to day lives in both Te Ao Māori and Te Ao Pakeha.

It is also important to recognise that Te Reo Māori and New Zealand Sign Language are both official languages of New Zealand. Their place in our society needs to be acknowledged, respected and supported in the implementation of this Strategy.

We know that non-disabled people are sometimes not sure which words or terms to use in order to be respectful. Our advice is to listen to how we refer to ourselves and use the same language. If you are still not sure, then just ask us what language we prefer.

## We are part of diversity and we are diverse ourselves

Disabled people are part of the vast and diverse human experience. Just as we accept and respect differences like gender, ethnicity, language or belief, the difference and diversity of disabled people need to be understood, acknowledged and celebrated.

Just like other communities, the disability community has different groups of people who experience life in different ways. We think it is important to acknowledge the diversity of our community, both because we are proud of it and also because we want to make sure that no one is left behind. The Strategy is for all of us.

The points below describe some of the rich diversity within our community:

- Māori are the tangata whenua of New Zealand and as the indigenous people they have a special relationship with the Crown. This relationship is recorded in the founding document of Aotearoa New Zealand, Te Tiriti o Waitangi.
- Addressing the inequality that Māori disabled people face is important; 26 percent of Māori identified as disabled in 2013. When adjusted for age, the Māori disability rate is 32 percent.[3] A Māori world view needs to be woven into the implementation of this Strategy. This includes the cultural importance of whānau and a whānau-centred approach which differs from Western concepts of family and disability.
- New Zealand Sign Language (NZSL) is an official language of New Zealand used by some 20,000 New Zealanders[4], approximately 4,000 of whom are Deaf people who use NZSL as their first or preferred language[5].
- The demography of our country is changing, and we are increasingly becoming a multicultural society. This is important to the disability community, as people from different ethnic and cultural backgrounds can sometimes understand and experience disability in different ways to others.
- Pacific peoples make up a growing proportion of our country and of the disability community (19 percent of Pacific people identified as disabled in 2013), as do people from Asian backgrounds (13 percent in 2013). Twenty-eight percent of people from Middle Eastern, Latin American and African backgrounds identified as disabled in 2013. Over the coming decades, we will see more cultural and ethnic diversity in the disability community.
- New Zealand has an ageing population which will result over time in an increasing proportion of people experiencing disability. In 2013, 59 percent of people over the age of 65 identified as disabled[6]. Disabled people are also living longer, and there will be an increasing number of people with age-related impairments. This is a global trend and one that is drawing greater attention to disability. Meeting the needs and challenges of our ageing population is a significant issue now, and will continue to be over coming decades.
- Gender norming plays out in the disability community, just like it does in society more generally. Disabled women and girls face different barriers to disabled men and boys.

3 Statistics New Zealand (2015). He hauā Māori: Findings from the 2013 Disability Survey
4 Statistics New Zealand Disability Survey: 2013
5 From Deaf Aotearoa's Deaf Way Report, page 5: http://deaf.org.nz/resources/deaf-way-report
6 Statistics New Zealand (2014) Disability Survey: 2013

- Disability and sexuality is also important for our community. Some of our members do not identify as part of the gender binary (male or female) or have a predominant sexual orientation. There can also be an incorrect perception that disabled people do not have sexual needs or desires.
- The international catch-cry of disabled people is 'nothing about us, without us'. For our disability community in New Zealand, this also includes those of us who find it hard to, or are not able to, speak for ourselves. We are amongst the most vulnerable and marginalised members of our disability community. While there may be different terms used for our group, such as people with 'intensive support', or 'special' needs, the thing we have in common is that we often rely on other people to support us to make decisions and to communicate.

## Our community will change

This is just a snapshot of the rich diversity of the disability community. Because disability is about the way other people treat us, it is a dynamic concept that will continue to evolve as our society changes over time.

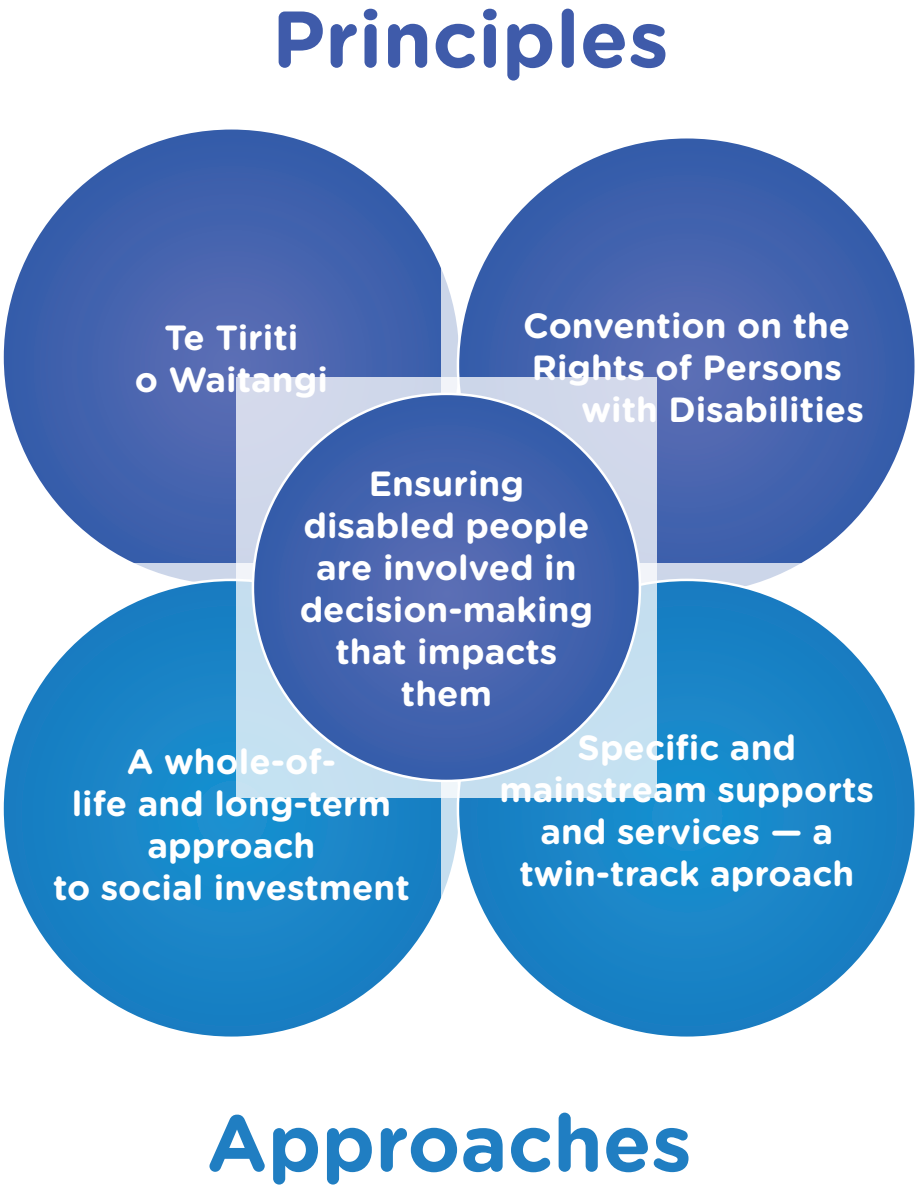
Future economic growth of the country has the potential to be constrained by skill and labour shortages. The low employment rates of disabled people represent a significant loss of potential contribution to New Zealand's economy.

## Disability impacts on many non-disabled people too

Our families, whānau, friends, carers and supporters are an important part of our community. In this way, disability is something that impacts on people without impairments. The disabling society we experience affects them too.

# Principles and approaches

**Figure 2 | Principles and approaches**



# The principles and approaches that will be used to implement the Strategy are outlined in this section; they are the 'how' to complement the outcomes (which are the 'what').

The principles and approaches will help make sure all of our community is visible, acknowledged and respected on an equal basis with others, and that we can live a life with dignity and feel valued.

This section has three sets of principles:

1. Principles of Te Tiriti o Waitangi
2. Principles of the Convention on the Rights of Persons with Disabilities
3. Ensuring disabled people are involved in decision-making that impacts them.

It also has two approaches:

1. Investing in our whole lives – a long-term approach
2. Specific and mainstream services – a twin-track approach.

Figure 2 on the previous page illustrates the connection between the principles and approaches.

## Principles

The principles of both Te Tiriti o Waitangi and the Convention will be reflected in the way this Strategy is implemented; they are for everyone and apply to Māori and non-Māori, disabled people and non-disabled people. The principles are a framework for building a positive relationship between disabled people and the Government.

### 1. Principles of Te Tiriti o Waitangi

The Strategy will be guided by the principles of Te Tiriti o Waitangi as the founding document of our country.

The principles of the Treaty are:

- **Partnership:** Māori and the Crown have a relationship of good faith, mutual respect and understanding, and shared decision-making.
- **Participation:** the Crown and Māori will work together to ensure Māori (including whānau, hapū, iwi and communities) participate at all levels of decision-making. This includes the right to seek opportunities for self-determination and self-management.
- **Protection:** the Crown actively contributes to improving the wellbeing of Māori, including support for independent living and the protection of Māori property and identity, in accordance with Māori values. Māori have the same rights and privileges as other citizens.

**2. Principles of the Convention on the Rights of Persons with Disabilities**

The principles of the Convention are:

- Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons
- Non-discrimination
- Full and effective participation and inclusion in society
- Respect for difference and acceptance of disabled people as part of human diversity and humanity
- Equality of opportunity
- Accessibility
- Equality between men and women
- Respect for the evolving capacities of disabled children and respect for the right of disabled children to preserve their identities.

**3. Ensuring disabled people are involved in decision-making that impacts them**

We are experts in our own lives and making sure we are involved in decision-making on issues that impact us leads to better quality results. The Convention also has a specific obligation on this (Article 4.3):

> *"In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States Parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organisations".*

## Approaches

### 1. A whole-of-life and long-term approach to social investment

It is important that both whole-of-life and long-term approaches are considered when social investment decisions are being made by the Government on things that impact on us. This will help ensure that we are more independent, are able to participate as much as we choose to, and that we are able to contribute to our communities and reach our potential.

Such an approach will help ensure that:

- the silos between different supports and services are removed to provide a coordinated approach to enable us to achieve our potential
- we receive the right supports and services throughout our lives. Early and proactive support, particularly after an impairment has been diagnosed or it changes, will help set us up for a better future
- the contribution we make to our families, whānau and communities is recognised across a broad range of areas including economic, community and social participation
- our families, whānau and carers are also able to access the right supports and services in order to help us reach our potential.

Making sure there is the right evidence at the right time to inform investment decisions is critical. All too often we have been invisible because disability has not been counted, recognised or understood, and therefore our needs have not been considered.

Evidence is both quantitative (data) and qualitative (lived experience, or stories, directly from us and those who care for us). We know that both are equally important and need to be valued alike to ensure there is a good understanding of the problem (before deciding on solutions); what interventions work best for us; and to be able to measure results against the outcomes we are seeking.

**2. Specific and mainstream supports and services – a twin-track approach**

A twin-track approach is about making sure mainstream services and supports are inclusive of, and accessible to, us and that services and supports that are specific to us as disabled people are also available. This approach is not about having to choose between the specific or mainstream option; rather it is about having the right access to the right high quality support or service, at the right time and in the right place.

Some of us do not need any specialised supports or services, whereas some of us do so that we can access mainstream opportunities. Our needs for either or both can change over time too.

Ensuring that mainstream services and supports are inclusive of us requires the provision of reasonable accommodation and incorporation of universal design.

- Reasonable accommodation is defined in the Convention as:
  - "…necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms" (Article 2).
  - Reasonable accommodation can often cost very little or nothing at all. Because it is specific to a situation, what it looks like in practice can vary significantly.
- Universal design is good design that works for everyone.
  - It is about making sure everything is accessible to, understood by and used to the greatest extent possible by everyone, without adaptation or requiring little adaptation. Incorporating universal design early on is cost-effective.
  - Universal design is often referred to in relation to the built environment, but it applies to services, supports, the curriculum and technologies as well.
  - Universal design is distinct from accessible design. Accessible design represents the minimum accessibility requirements in built design, whereas universal design seeks accessible design outcomes that work for everyone.

**A note on terms:**

Mainstream refers to services or supports that are not designed to be specific to or only for disabled people. It includes things that are open for everyone to use or participate in (such as public transport) and also things that may still be targeted towards a particular group (such as maternal health services).

# Our outcomes – priorities for change

**Figure 3 | Interconnections of outcomes**

# The eight outcomes that will contribute towards achieving the vision of the Strategy are outlined in this section.

Each outcome has two parts to it:

1. A description of what our future looks like – this is an aspirational description of what things should look like for disabled people in the future. This will help make sure that everyone has the same understanding about what the future should look like and that all actions are consistent with this.
2. What this means – this describes at a high level what needs to happen to achieve the aspirational description. It also gives direction to what needs to happen in implementation.
   - For each outcome, the first bullet point states that disabled people are consulted on and actively involved in the development and implementation of legislation and policies concerning the outcome area.
   - This language is taken directly from the Convention.

Specific actions to implement the outcomes will be determined through the Disability Action Plan. You can read more about this in the Making it work section from page 40.

All outcomes are interconnected and should not be read in isolation. For example, achieving the employment outcome is dependent upon the education outcome. The outcome on attitudes is also relevant to all other outcomes. Figure 3 on the previous page shows this interconnection.

# Outcome 1: education

## We get an excellent education and achieve our potential throughout our lives

### What our future looks like

Our learning pathway supports us to develop friendships and social skills, as well as resilience, determination and confidence. It gives us a sense of belonging, builds our identity and language skills and prepares us for life beyond compulsory education.

All local schools and education services (including early childhood, primary secondary, tertiary, kohanga reo and kura kaupapa Māori) are welcoming and provide a great inclusive education for us. We have trained teachers and educators who support and believe in our progress and achievement, and value our contribution to the learning environment.

Education is provided in a way that supports our personal, academic and social development, both in and out of the formal schooling system. This includes making sure that those of us who use different languages (in particular New Zealand Sign Language), and other modes or means of communication, have ready access to them to achieve and progress. Information will be made available at the right time to those who support us, both when we are young or for those of us who need on-going support. This will help us succeed – whatever our individual education pathway may look like.

We are treated with respect and dignity by those around us in the education system, including our peers and those who teach and support us. The love and expertise of our families and whānau and their wish to see us succeed in education will be honoured without question.

As we move on to tertiary and life-long learning, the transition periods are smooth, with the right information and supports available at the right time – particularly when our needs or situations change.

## What this means:

- Disabled people are consulted on and actively involved in the development and implementation of legislation and policies concerning education, including early childhood, primary, secondary and tertiary education.
- Access to mainstream education is inclusive (including policy, practice and pedagogy).
- Services that are specific to disabled people are high quality, available and accessible.
- Inclusive education is a core competency for all teachers and educators.
- Decision-making on issues regarding education of disabled people is informed by robust data and evidence.

# Outcome 2: employment and economic security

## We have security in our economic situation and can achieve our potential

### What our future looks like

We take pride in the meaningful paid and voluntary work we do, knowing that we are contributing to our families and whānau, communities and the country as a whole.

We are proportionately represented at all levels of employment, we are self-employed, we own businesses, and we are employers, managers and employees. Career progression is an important part of our working life.

Employers are confident and willing to employ us in meaningful jobs that utilise our strengths and make the best use of what we have to offer. They also have access to on-going support, guidance and tools to help support them in their role as a fair and equitable employer. When we apply for jobs, we do not face any barriers in the application process.

We are treated with respect and dignity by our non-disabled peers and we feel that the work we do is meaningful, valued and real.

Those of us who need specialised supports and services have ready access to them to secure and sustain employment. Reasonable accommodation is understood and provided by our employers. We will have the same opportunities to progress our careers as our non-disabled peers. The additional costs of disability are met, so that we are able to enjoy the same standard of living as other workers.

We have an adequate standard of living that enables us to fully participate in society, where necessary through the provision of income support which takes into account the additional cost of disability. This applies to everyone, including those of us who are not able to work, are retired, are unable to work full-time, or work full-time yet are still unable to afford and maintain an adequate standard of living.

## What this means:

- Disabled people are consulted on and actively involved in the development and implementation of legislation and policies concerning employment and income support.
- Access to mainstream employment and income support services is barrier-free and inclusive.
- Services that are specific to disabled people are high quality, available and accessible.
- All frontline workers, including case managers and employers, treat disabled people with dignity and respect.
- Decision-making on issues regarding employment and income support of disabled people is informed by robust data and evidence.

# Outcome 3: health and wellbeing

## We have the highest attainable standards of health and wellbeing

### What our future looks like

Healthcare professionals treat us with dignity and respect. We are seen as individuals and receive appropriate and timely support for all of our health needs, not just those related to our impairment. We do not face barriers accessing mainstream health services because of our impairments, in particular sexual and reproductive health services for disabled women and girls. When we need to, we can access services specific to our impairment (including habilitation, rehabilitation and recovery) in a way that provides early diagnosis and ensures our needs as individuals are taken into consideration.

We have choice and control over all the supports and services we receive, and information about these services is available in formats that are accessible to us. We also have access to information about us. Those of us who need support to communicate or make decisions receive it in an appropriate way at the right time, and those decisions are recognised and respected. We are not secluded within services, and not segregated from or isolated within our communities.

Issues of bio-ethics and bodily integrity are treated with sensitivity, with due regard for our rights and informed consent. This includes making sure our families, whānau and those who support us have the right access to the right information when they are involved in supporting us to make decisions. In the rare circumstances when decisions need to be made on our behalf, these are based on the best interpretation of our will and preference, as opposed to just thinking about what is in our best interests.

Access to high quality peer support enables us to recover from periods of being unwell, and flourish with the confidence that we are not alone.

Our identity as members of other communities, such as Māori or Pacific, will be respected and we will have access to services that are culturally appropriate.

The importance of belonging to and participating in our community to reduce social isolation, and increase our overall wellbeing, is recognised and supported. We get involved in sport, recreation and arts activities, and are recognised and valued for this. Those of us who identify as members of other communities do not face barriers participating in and contributing to cultural activities because of our impairments. We are supported to be healthy and well, and can participate in community activities on an equal basis with others.

## What this means:

- Disabled people are consulted on and actively involved in the development and implementation of legislation and policies concerning health and wellbeing, including sport, recreation, arts and culture.
- Access to mainstream health services is barrier-free and inclusive.
- Services that are specific to disabled people, including mental health and aged care services, are high quality, available and accessible.
- All health and well-being professionals treat disabled people with dignity and respect.
- Participation in community activities if we choose (for example, sport, recreation, arts and culture), or just being present and belonging to our community is supported and valued.
- Decision-making on issues regarding the health and well-being of disabled people is informed by robust data and evidence.

# Outcome 4: rights protection and justice

## Our rights are protected; we feel safe, understood and are treated fairly and equitably by the justice system

### What our future looks like

We will continue to be treated with fairness and respect at all stages of our journey through the justice system, regardless of whether we are victims, perpetrators, witnesses, or fulfilling a civic duty such as jury service.

Those of us who need services or supports specific to our impairment will receive them, wherever possible, the first time we interact with the justice system. We will continue to receive these supports in a way that does not require us to keep telling our story or risk missing out on something we need, unless our needs change. The people we interact with have a good understanding of any impact our impairment may have on our journey, and take this into account as appropriate.

Those of us who need support to communicate or make decisions receive it in an appropriate way at the right time, and those decisions are recognised and respected. We will continue to be recognised as a person before the law. We feel secure exercising our rights as there are appropriate safeguards in place, even if we need support to make decisions and understand what's happening.

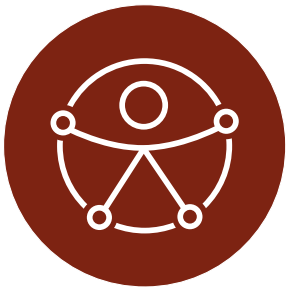
For those of us who end up in the youth or adult justice system, the transition out of it is accompanied by rehabilitation services that recognise and understand our impairment, and help us to find a positive place in society.

If we feel unsafe, vulnerable to or affected by violence and abuse, we will continue to have access to support that recognises our needs and responds effectively and with sensitivity. We also feel confident in speaking up or complaining if we have been discriminated against or hurt, because we are listened to and our concerns are addressed.

Our needs and rights continue to be taken into account in any prevention and response initiatives. This includes making sure there continue to be safeguards in place for those of us who may be at risk of violence and abuse (for example, caring relationships, community awareness).

## What this means:

- Disabled people are consulted on and actively involved in the development and implementation of legislation and policies concerning justice, violence and abuse prevention and human rights.
- The justice sector is barrier-free and inclusive of disabled people with supports and services specific to a person's impairment provided readily when required.
- All justice sector professionals treat disabled people with dignity and respect.
- Supported decision-making will increasingly be recognised and disabled people can use it in practice.
- Decision-making on issues regarding justice, violence and abuse prevention and human rights is informed by robust data and evidence.



# Outcome 5: accessibility

## We access all places, services and information with ease and dignity

### What our future looks like

We have access to warm, safe and affordable housing that meets our needs and enables us to make choices about where we go to school or work and to fully participate as members of our families, whānau and communities.

We can get from one place to another easily and safely, for example from home to school, work or to a friend's house. We can also access all public buildings, spaces and facilities with dignity and on an equal basis with others.

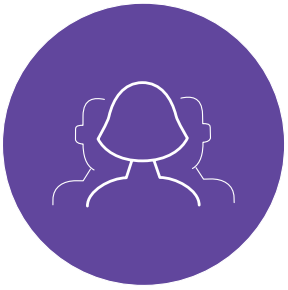
We feel safe taking public transport to get around and are treated well when we do so. Our needs are also appropriately considered when planning for new transport services. Private transport services are responsive to and inclusive of us. For those of us who need it, there is access to specific transport options that are affordable, readily available and easy to use.

Information and communications are easy for us to access in formats and languages that are right for us, including in our country's official languages of Te Reo Māori and New Zealand Sign Language. This helps us to be independent because we do not have to rely on other people. We use technology on the same basis as everyone else; those of us who need specific technology solutions will have access to these in a way that is innovative, progressive and helps to eliminate barriers. The evolving opportunities presented by new technology helps us to achieve our goals.

Our accessible communities are free of barriers (for example, access to shops, banks, entertainment, churches, parks, and so on), which enables us to participate and contribute on an equal basis with non-disabled people.

## What this means:

- Disabled people are consulted on and actively involved in the development and implementation of legislation and policies concerning housing (home ownership, social housing and private rentals), transport (public and private), public buildings and spaces and information, communication and technology.
- Universal design is understood, recognised and widely used.
- All professionals involved in accessibility have a good understanding of the principles of universal design and the needs of disabled people and take these into account in their work.
- We enjoy and are fully included in artistic, cultural, sporting and recreation events whether as spectators or as performers.
- Decision-making on issues regarding housing, transport, public buildings and spaces and information, communication and technology are informed by robust data and evidence.



# Outcome 6: attitudes

## We are treated with dignity and respect

### What our future looks like

Disability is understood and accepted as a part of the diversity of the human experience and we are treated with dignity and respect by those around us and society more broadly.

There is a willingness to explore attitudes towards disability, in particular those that negatively stereotype, stigmatise and discriminate. There is an appetite for seeking out ways to change attitudes and ensure that basic human rights are upheld for all people. These changes are made in a way that is safe and that upholds our views and diverse voices.

We are able to choose how we want to be identified and this is acknowledged and respected by society. This is particularly important for those of us who identify first within, for example, our ethnicity or culture and not with disability.

We will be encouraged to speak out in whatever language we use, and our views will be listened to. This includes those of us who may communicate differently, use technology to communicate, and/or have support to communicate or express our preferences. As a result, we are confident demonstrating the value we bring to our families, whānau, community and the country as a whole.

Our views, either as an individual or as part of a group, will be listened to without being diminished, and society will not seek to take this away, either by accident or design.

## What this means:

- Disabled people are consulted on and actively involved in the development and implementation of legislation and policies concerning attitude change, stigma and discrimination, in particular where they are specific to disabled people.
- The rich diversity of the disability community will be included and represented in initiatives to change attitudes and behaviours, which will also ensure that disabled people are seen as part of other communities or groups.
- There is a particular focus on making sure all frontline service providers and professionals treat disabled people with dignity and respect.
- Decision-making on issues regarding attitude change, stigma and discrimination, is informed by robust data and evidence.

# Outcome 7: choice and control

## We have choice and control over our lives

### What our future looks like

When we are young, our families, whānau and carers will be supported to help us grow up. Our views as children and those of our families, whānau and carers will be considered when choices are made about what supports and services we receive and what things work best for us. There will also be respect for the evolving capacities of disabled children, and ensuring their input into decisions that affect them.

As we get older we will make our own choices and decisions on things that affect how we live our lives, including where we live. Some of us may need support some of the time or all of the time. Plans or decisions that affect, or have implications for us, will not be developed without our involvement or consent. We have access to information in ways that help us understand what is happening so that we give consent in an informed way.

Those of us who need support to communicate or make decisions receive it in an appropriate way at the right time and those decisions are recognised and respected. The way this support is provided will be empowering and will help build our confidence. In the rare circumstances when decisions need to be made on our behalf, they are based on the best interpretation of our will and preferences, as opposed to just thinking about what is in our best interests. Needing support does not diminish our independence or our ability to have choice and control over our lives.

We will make informed choices based on what is available, rather than settling for a less desirable option because that is all that is offered to us. We are able to change our mind about our decisions.

Sometimes the decisions we take may expose us to risk. Taking risks is part of the human experience, and it is our right to take risks, learn from our mistakes and live our lives as we see fit. If we need support to understand risks and make decisions, this will be provided in a way that helps us understand all the options and consequences. The times when we are prevented from taking risks will be the exception rather than the rule.

## What this means:

- Disabled people are consulted on and actively involved in the development and implementation of legislation and policies concerning supports and services that are both specific to them and for the mainstream.
- Those who support disabled people to make choices or decisions will have a good understanding of their role and access to information and support to help them do this in an informed way.
- Decision-making on issues regarding choice and control over supports and services, in particular those specific to disabled people, is informed by robust data and evidence.

# Outcome 8: leadership

## We have great opportunities to demonstrate our leadership

### What our future looks like

We have opportunities and are supported to be leaders or role models in whatever field or level we may choose. Leadership for us includes doing great things on behalf of our country or at a national level, and also doing everyday ordinary things for ourselves, our families, whānau or communities. For example, we can be leaders in employment, through voluntary work or at a political level, both locally and nationally.

We are on a level playing field with others and are recognised for our skills, talents and leadership potential. We are supported to develop our leadership potential, and take responsibility for the pursuit and achievement of our goals. When we are young or have an emerging leadership role, we are supported and mentored.

When there are discussions and decisions on things that are important to disabled people, we have strong leaders who represent our views around the table. Our experience of disability is recognised as expertise, and we are acknowledged as experts in our own lives. This representation includes the diversity of the disability community, including the groups within our community who often have not had a voice.

When there are non-disabled people in leadership roles that are important to our community, in the public, private and not-for-profit sectors, they will act as our allies and work closely with us. In this way they can use their influence to help break down the barriers that we experience and that disable us.

## What this means:

- Disabled people are consulted on and actively involved in the development and implementation of legislation and policies concerning leadership, in particular where this is specific to them.
- Disabled people are recognised as experts in their own lives.
- People in leadership roles in the public, private and not-for-profit sectors will be supported to see themselves as allies to the disability community. They will work in partnership with disabled people on things that are important to them.
- Decision-making on issues regarding leadership, in particular those specific to disabled people, is informed by robust data and evidence.

# Making it work

## Figure 4 Governance and Monitoring

# This section outlines how the Strategy will be implemented.

It has two parts:

1. Keeping on track with progress
2. Achieving practical action
   - Disability Action Plan
   - Governance
   - Monitoring implementation
   - Convention on the Rights of Persons with Disabilities – making rights a reality
   - Making sure the priorities are right – how consultation will work.

An area of strength for the disability community and sector is that it is diverse, with a range of perspectives. This includes different experiences, areas of expertise and representation (either being representative of a particular group or more formally representing an organisation/group) and advocacy. This is sometimes referred to as wearing many different 'hats'. We are also recognised as experts in our own lives and making sure we are involved in decision-making on issues that impact on us leads to better quality results.

All of these perspectives are important in different ways for the governance and independent monitoring mechanisms, as well as the consultation processes that will support the effective implementation of this Strategy. These mechanisms and processes should aim to reflect the diversity and the changing nature of the disability community.

Figure 4 on the previous page reflects the governance and monitoring of the Strategy.

## Keeping on track with progress

It is a priority for the Government that progress toward implementing the Strategy remains on track. To monitor this, an Outcomes Framework will be developed with public consultation in 2017. The Outcomes Framework will outline how we will monitor progress against the Strategy. The framework will specify:

- the targets and indicators (including for each outcome and the principles and approaches where appropriate)
- where the information comes from
- how often it will be collected
- who is responsible for collecting it
- where proxies are needed and how information gaps will be addressed. (Note: 'proxy' or 'proxies' means 'something similar'. Proxy indicators are used when the required data is not available, so a similar indicator is used instead.)

The Outcomes Framework will also help make sure there is continuous learning and improvement prior to a final evaluation of the Strategy in 2026.

Every year, the Minister for Disability Issues will report publicly to Parliament on the progress made to implement the Strategy against the Outcomes Framework. This will meet the requirement for the Minister to report under the New Zealand Public Health and Disability Act 2000. The reports will also be submitted to Cabinet to ensure they inform the development and update of Disability Action Plans.

## Achieving practical action

### Disability Action Plan

The Disability Action Plan (the Plan) will be the primary vehicle for implementation of this Strategy. Future plans will:

- focus on high priority and significant actions for one or more government agencies (this will help make sure the Plan is manageable and easy to understand)
- present a complete picture of the priorities in implementing the Strategy
- support effective learning across government agencies, particularly in the application of the principles and approaches that are applied throughout the Strategy.

Future Plans will continue to cover a four-year period and they will be updated at the mid-point to ensure priorities remain relevant (that is after two years). Issues like funding or legislation need to be considered in the context of actions in the Plans rather than in this Strategy.

There are other strategies and plans that are also relevant to the Disability Strategy. A description of some of these links can be found on the Office for Disability Issues website.

### Governance

As a Government Strategy, decisions on implementation will be made by Cabinet.

These will be informed by the existing governance mechanisms for the Disability Action Plan: the Chief Executives' Group on Disability Issues (and associated Senior Officials Group) and Disabled People's Organisations.

## Monitoring implementation

The Independent Monitoring Mechanism (IMM) will help provide an independent perspective on progress toward achieving the outcomes and goals of the Disability Strategy.

The IMM was established by the Government in 2011. It fulfils an obligation for the Government under the Convention to have an independent mechanism to promote, protect and monitor implementation under Article 33 of the Convention. It is made up of the Human Rights Commission, Office of the Ombudsman and the Convention Coalition Monitoring Group (a group of Disabled People's Organisations).

The Strategy is the primary vehicle for progressive realisation of the Convention. Therefore it is appropriate for the IMM to provide an independent perspective on implementation of the Strategy. This will not however, be seen to limit in any way, the IMM's mandate to monitor the Convention.

**Convention on the Rights of Persons with Disabilities – making rights a reality**

Every four years, the Government reports to and receives Concluding Observations from the United Nations Committee on the Rights of Persons with Disabilities. Concluding Observations recognise areas of good progress but also include recommendations on things that need to be improved.

The Concluding Observations will be included as part of the public consultation process to develop and update the Disability Action Plans. Recommendations from the IMM will also be considered as part of this consultation alongside those from the Committee.

Making the Concluding Observations and recommendations an integral part of implementation of the Disability Strategy will help make the rights of disabled people a reality.

**Consultation**

Every two years there will be public consultation to inform the development or update of the Disability Action Plans. There is a lot that needs to be done to make this Strategy work, and it is important that priorities for action are informed by what disabled people and the community says is most important to them.

The process for public consultation will reflect the diversity of the disability community as well as the principles of Te Tiriti o Waitangi and the Convention (including Articles 4.3).

## Making it work – a schedule of implementation

| Year | What happens |
|---|---|
| **2016** | • New Disability Strategy 2016–2026 agreed by Cabinet |
| **2017** | • Public consultation process to develop the Outcomes Framework for the Strategy<br>• Outcomes Framework for the Strategy agreed by Cabinet<br>• Update of the Disability Action Plan – to align with the new Strategy<br>• Annual report from Minister for Disability Issues, including baseline information against the Outcomes Framework where possible |
| **2018** | • Government reports to and receives Concluding Observations from the United Nations Committee on the Rights of Persons with Disabilities<br>• Government receives recommendations from the Independent Monitoring Mechanism<br>• Annual report from Minister for Disability Issues against Outcomes Framework |
| **2019** | • Public consultation process to develop new Disability Action Plan (to include recommendations from the United Nations Committee/Independent Monitoring Mechanism)<br>• New Disability Action Plan (2019–2022) agreed by Cabinet<br>• Annual report from Minister for Disability Issues against Outcomes Framework |
| **2020** | • Annual report from Minister for Disability Issues against Outcomes Framework |
| **2021** | • Public consultation process for mid-point update of Disability Action Plan<br>• Updated Disability Action Plan to be agreed by Cabinet<br>• Annual report from Minister for Disability Issues against Outcomes Framework |

| Year | What happens |
|---|---|
| **2022** | • Government reports to and receives recommendations from the United Nations Committee<br>• Government receives report from the Independent Monitoring Mechanism<br>• Annual report from Minister for Disability Issues against Outcomes Framework |
| **2023** | • Public consultation process to develop new Disability Action Plan (to include recommendations from the United Nations Committee/Independent Monitoring Mechanism)<br>• New Disability Action Plan (2023–2026) agreed by Cabinet<br>• Annual update report from Minister for Disability Issues against Outcomes Framework |
| **2024** | • Annual report from Minister for Disability Issues against Disability Outcomes Framework |
| **2025** | • Public consultation process for mid-point update of Disability Action Plan<br>• Annual report from Minister for Disability Issues against Outcomes Framework |
| **2026** | • Government reports to and receives recommendations from the United Nations Committee<br>• Government receives report from the Independent Monitoring Mechanism<br>• Evaluation of the Strategy (and Disability Action Plans)<br>• Annual report from Minister for Disability Issues against Outcomes Framework<br>• End of current Disability Strategy 2016–2026. Next steps to be confirmed |

# Getting it going – who is involved

Achieving the vision and outcomes of the Strategy will take all New Zealanders working together. With rights there also come responsibilities, for everyone. There are also some key groups who have particular responsibilities under the Strategy. They are:

- **Disabled people, families, whānau, allies and the disability community and sector** – providing input through governance, independent perspectives and public consultation.
- **Cabinet** – responsible for considering regular reports and making decisions on implementation of the Strategy through the Disability Action Plan.
- **Ministerial Committee on Disability Issues** – supports co-ordination of implementation across government.
- **Independent Monitoring Mechanism** – responsible for providing an independent perspective on implementation of the Strategy.
- **Chief Executives' Group on Disability Issues (and Senior Officials Group) and Disabled People's Organisations** – responsible for governance and coordination of the Disability Action Plans.
- **Government agencies** – responsible for implementing the Strategy according to the priorities agreed in the Disability Action Plan.
- **All New Zealanders** – breaking down the barriers of a disabling society and supporting implementation of the Strategy.
- **Local Territorial Authorities (City, District and Regional Councils)** – consider their responsibility for disabled people in the space they oversee, in line with the Strategy and the Convention.
- **Private sector, businesses and Non-Governmental Organisations** – ensure their business as usual is inclusive and responsive to disabled people on an equal basis with others.

# Glossary

**Barrier** is something that makes it difficult or impossible for people to do something

**Demography** is statistics about people, such as age and ethnicity

**Disability** is something that happens when people with impairments face barriers in society that limit their movements, senses or activities

**Disabled people** are people who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. This is the understanding of disability in the Convention

**Enabling** is to provide with the ability or means to do something

**Equality** means that everyone gets the same opportunities

**Equity** is recognising that sometimes people need different things in order to be equal

**Impairment** is a problem with the functioning of, or the structure of someone's body

**Investing** is about spending time, energy or money on something

**Mainstream** means things including activities, services, supports, attitudes or ideas, that are open to everyone to use or participate in (for more detail of the disability context, see page 21)

**Non-disabling** is about removing the barriers in society that disable people with impairments

**Pedagogy** is the theory of teaching

**Proxy** means something similar.

**Reasonable Accommodation** is making necessary and appropriate modifications and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms

**Twin-track approach** is making sure that mainstream activities and opportunities are inclusive of, and accessible to, all people and that specific activities and opportunities that are required by some people are also made available to those people (for more detail of the disability context, see page 21)

**Universal design** is good design that works for everyone (for more detail of the disability context, see page 21)

# Appendix 1 – The Reference Group

Members of the New Zealand Disability Strategy Revision Reference Group (for further details on each member of the group please refer to the Office for Disability Issues website): www.odi.govt.nz

**Colleen Brown** MNZM, from Auckland, brings a families perspective.

**Robbie Francis**, from Hamilton, brings the perspective of young people and lived experience of disability.

**Lance Girling-Butcher** QSM, from New Plymouth is a nominated Disabled People's Organisations (DPOs) representative. Lance became blind as an adult.

**Peggy Koopman-Boyden** CNZM, from Hamilton brings an older person's perspective from research and personal experience.

**Clive Lansink**, from Auckland, is a nominated DPOs representative. Clive is blind and is a strong advocate for disabled people speaking for themselves.

**Victoria Manning (Co-Chair)** MNZM, from Wellington is also the Chair of the NZSL Board. Victoria is Deaf and also brings 20 years' experience in disability policy.

**David Matthews**, from Christchurch and Wellington, brings a service provider's perspective.

**Papaalii Seiuli Johnny Siaosi**, from Auckland, brings a perspective from mental health and addictions consumers, their families and Pasefika communities.

**Dr Martin Sullivan** QSO, from Palmerston North, brings his perspective as a disabled person.

**Hamish Taverner**, from Palmerston North, speaks up for the rights of people with learning disabilities. He brings the perspective of lived experience of this disability.

**Jonny Wilkinson**, from Whangarei, brings the perspective of a person with lived experience of disability.

**Gary Williams** MNZM, from Christchurch, is a self-employed disability consultant bringing over 40 years of expertise in the disability sector. Gary also brings a perspective of a Māori disabled person.

Government agencies had two representatives on the group. During the development of the Strategy, these representatives were Brian Coffey (Ministry of Education), Kathy Brightwell (Ministry of Health) and Sacha O'Dea (Ministry of Social Development).

Paul Brown from the Office of the Ombudsman was an observer.

Megan McCoy, Director of the Office for Disability Issues, Co-Chaired the reference group meetings.

New Zealand Government

## 2.0 CHAIR'S REPORT

## 3.0 SYSTEM PERFORMANCE

3.1 Northland Health Services Plan Update
3.2 NDHB Statement of Performance Update
3.3 Northern Region Health Plan Update

# Northland District Health Board
# Briefing Paper to CPHAC/DiSAC

**SUBJECT: NORTHLAND HEALTH SERVICES PLAN (NHSP) UPDATE**

**RECOMMENDATION**

The content of this paper is noted.

This briefing advises you about:

- Progress with
  - Neighbourhood Healthcare Homes (NHH) Implementation Programme including the following workstreams:
    - In Practice Change Facilitation
    - GP Information Reports
    - Whanau Tahi e-shared care
    - Care Coordination Project

**BACKGROUND**

The NHSP was adopted by Northland DHB in April 2012 and responsibility for implementation was delegated to the Chief Executive. Northland DHB strategic governance oversight is delegated to the Community and Public Health/Disability Support Advisory Committee (CPHAC/DiSAC).

Northland DHB employs a Portfolio Manager and Project Managers to coordinate the implementation of the NHSP. Project work implementing the strategic work programme is delivered through the NHSP Office and other Directorates and Services spread across the Northland DHB.

Five major projects were established in the 2014/15 year and reported through the NHSP Office.

Four of the five major projects have transitioned to business as usual managed outside of the NHSP Office. The NHH Project has transitioned to a Programme of work with multiple workstreams managed by the NHSP Office and governed by the NHH Steering Group.

**Neighbourhood Healthcare Home Programme (NHH)**

The second call for expressions of interest from General Practices wanting to adopt the NHH model of care resulted in the selection of four practices: Dargaville Medical Centre; Te Whare Ora o Tikipunga; Broadway Medical Centre; Raumanga Medical Centre. Broadway Medical Centre includes three practices in Kaikohe, Waipapa and Kaitaia.

The population coverage for NHH practices is over 82,000 enrolled patients, which is a total reach of more than 50% of the Northland population.

All tranche one practices have completed the establishment phase and are now implementing the NHH model of care. This means many patients will be experiencing differences. One example is when they call for a same day appointment with their GP they may be offered a telephone call back by their GP who will give them an appointment on the day if required, or may resolve the issue over the phone.

***In Practice Change Facilitation***

Dargaville Medical Centre and Te Whare Ora o Tikipunga are commencing the NHH establishment phase this quarter.

Tranche one practices are reporting benefits including released capacity, improved continuity of care, reduced waste and increased value as well as improved patient satisfaction.

***GP Information Report***

The primary care reporting database (PrimaryDW) was moved from the test environment to a live server this month. This allows for better ability to back up the database and queries on the data perform better. Management Information Services provide data base management support.

A data sharing agreement has been signed by the two PHOs and Northland DHB in the form of a Memorandum of Understanding. This outlines what data we will share, how we will share it and protocols and processes for accessing and reporting the shared data.

Dr Gary Jackson, Ernst & Young, presented the 2016 GP Information Data Package and Narrative Report to Dargaville Medical Centre. DHB and PHO team members also attended. This report and presentation establish a baseline for population health information as the Practice moves into the establishment phase of the Neighbourhood Healthcare Home model of care.

June quarter risk stratification reports were provided to all general practices, with improvements based on practice feedback. These risk reports are intended to assist general practices in identifying patients with long term conditions or high ED utilisation, who could benefit from proactive planned care to live well with their condition, avoid acute exacerbation and future hospitalisation. The improvements include a sheet about how to use the Excel spreadsheets and updates to the definitions sheet. There was also a change to the way High Intensity Users (HIU) of inpatient services are reported. Acute transfers between hospitals are now counted as 1 admission to hospital.

Northland DHB MIS analysts have commenced work on running the Sapere predictive risk model for Northland. We are aiming to include a predictive risk score in the December quarter risk reports. This score provides a percentage risk of hospitalisation in the next 6 months for individual patients.

***Whānau Tahi e-Shared Care***
**160,000 patients are on Whanau Tahi enabling 2250 shared care plans to be developed.**

The implementation of the Whanau Tahi Connected Care software platform is enabling the sharing of patient information in a number of ways. For all Northlanders registered with general practice a snapshot shared care record of key clinical data derived from the general practice PMS (Practice Management System) is able to be viewed by other healthcare teams with access to Whanau Tahi. For example, clinical staff at the DHB can access the shared care record directly from the patient front page in Concerto. Community pharmacists are now able to access the shared care record via their PMS.

Before this key functionality is more widely promoted, further work is underway to develop the Whanau Tahi product and embed the associated workflow actions required in general practice to ensure the information held in the shared care record is available and kept up-to-date when new patients enrol and when patients transfer between practices in Northland. The aim is to automate as much of this process as possible.

General practice are also in the process of identifying patients with long term conditions and complex needs (Kia Ora Vision) who would benefit from having a shared care plan. These plans are being created using the Whanau Tahi Personalised Care Plan template which is then able to be viewed and contributed to by other healthcare teams as they engage with the patient about 'what matters to them' and their goals. NDHB and NGO cardiac rehabilitation nurses are also developing shared care plans for patients. To date over 2250 Personalised Care Plans have been initiated.

The NHSP Project Manager role supporting this project has recently become vacant and the project is currently undertaking a review of the status of completion of the 'Whanau Tahi initial implementation phase' ahead of scoping the next phase of the rollout in collaboration with key stakeholders.

***Care Coordination***
At this stage the project will be governed by the NHH Steering Group. GM Medicine, Health of Older People, ED & Clinical Support and Director Scientific, Technical, Allied Health have joined the NHH Steering Group as executive leads of the Care Coordination project.

Following feedback and new learnings the project brief has been updated to focus less specifically on general practice. The project team and working group have engaged with ADHB to understand work they have recently completed to move to a locality model (with nursing and allied health staff working in multidisciplinary teams) and implement a central referral centre to allow better coordination of support and best use of resources closer to home. Some new Northland DHB projects have been identified that potentially cross over or complement this work, these are being probed further and links established to better understand the Northland work already underway to improve co-ordination, so that we do not duplicate effort.

# Northland District Health Board
# Briefing Paper to CPHAC/DiSAC

**SUBJECT: STATEMENT OF PERFORMANCE SIX-MONTHLY UPDATE**

**Prepared by:** John Wansbone, General Manager Planning, Integration, People and Performance

**Endorsed by:** Dr Nick Chamberlain, Chief Executive

**RECOMMENDATION**

That CPHAC/DiSAC note the information on Northland's performance against the Statement of Performance 2016/17.

**BACKGROUND**

Until 2016, CPHAC/DiSAC received six-monthly reports on achievement of the actions in the Annual Plan. The intention was to monitor progress on improvement of health services and health status, but these reports did not help realise this. The reports were pitched at operational level, they described details of activities rather than 'raising the gaze', and the reports' exception-based focus meant they did not provide a comprehensive picture.

Late in 2016 the GM POID agreed to trial a new approach by using the Statement of Performance (SP) as the basis for the reports. The SP is prepared at the end of each business year for inclusion in the Annual Report. It reports achievement in relation to the baselines and targets published in the Statement of Performance Expectations that appeared in the Annual Plan for the year just gone. The SP is produced according to requirements laid down by the Crown Entities Act 2004. It is overseen by Audit NZ, operating as agents for the Office of the Auditor General.

The remainder of this report is extracted from the Statement of Performance that is in the final stages of preparation for the 2017 Annual Report. Another report will be prepared early in March 2018.

## Statement of Performance

The Statement of Performance is a selective snapshot of how the services provided for the Northland population are performing. The four output classes cover the spectrum of services from those promoting health in the population through to complex hospital services and later-in-life care.

The Statement of Performance assesses how well we are doing in 2016/17 compared with the targets set during the previous year's planning cycle. The measures selected are a combination of national priorities (including all the Health Targets) and local priorities. Collectively they contribute to the high level outcomes described in the previous section. We have tried to keep the number of measures small by choosing a representative sample of key ones, while still covering the breadth of services.

The measures do not cover just Northland DHB's services. DHBs are legislatively responsible for the health of their populations, so as well as providing services ourselves we also contract with, monitor and evaluate other service providers in the health sector. Many of the measures, especially those in the first two output classes, describe performance in the wider health sector.

The Statement of Performance includes both impact measures (labelled **I,** that assess direct effects on people's health over a one to five year timeframe) and output measures (labelled **O**, that measure service activity and have a one-year timeframe). The longer-term focus of impact measures means they feature more prominently in the earlier output classes, while output measures appear more in the later classes.

### Achievement ratings

| Achieved | Substantially achieved | Not achieved but progress made | Not achieved | No conclusion can be drawn |
|---|---|---|---|---|
| ● | ● | ● | ● | ● |
| *Target met or bettered* | *Within 5%[1] of target* | *More than 5% from target, but progress made* | *Not achieved* | *Problems with data availability, changing definitions etc* |

### Output Class 1: Prevention

This Output Class includes publicly funded services that protect and promote health across the *whole population* or particular subgroups of it. These services improve the health status of population groups, as distinct from treatment services (the other three Output Classes) which deal with illnesses and injuries of individuals. It includes:

- health promotion to prevent illness
- statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases
- population health protection services (immunisation, screening etc)
- well-child services.

[1] For most measures "within 5%" means within 5% absolute of the target. When targets are a small percentage (as in the mental health measure) or a small number (the oral health measure, some of the quality ones) a different sort of 'close to target' assessment is required. How that is addressed is described in footnotes.

| Output measure | Ethnicity | 2015/16 result | 2016/17 target | 2016/17 result | Achieve -ment |
|---|---|---|---|---|---|
| % of Year 10 students who have never smoked ▮ | Total<br>Māori<br>Non-Māori | 65.2%<br>57.2%<br>76.2% | 65.0% | 67.5<br>50.7<br>85.2 | ●<br>●<br>● |
| % of Northland adult population who are current smokers ▮ | Total<br>Māori<br>Non-Māori | n/a[2] | 21.4%<br>34.6%<br>16.0% | n/a | ● |
| Full and exclusive breastfeeding at 6 weeks ▮ | Total<br>Māori<br>Non-Māori | 77%<br>69% | 75% | 79.3%<br>76.5%<br>83.7% | ●<br>●<br>● |
| % of 8-month-olds who are fully immunised ▮ **National Health Target** | Total<br>Māori<br>Non-Māori | 89%<br>90%<br>88% | 95% | 88.8%<br>89.9%<br>87.3% | ●<br>●<br>● |
| Breast cancer screening in eligible populations ▮ | Total<br>Māori<br>Non-Māori | 71.0%<br>69.3%<br>71.5%[3] | 70.0% | 71.8%<br>70.5%<br>72.2% | ●<br>●<br>● |
| Cervical cancer screening in eligible populations ▮ | Total<br>Māori<br>Non-Māori | 74.1%<br>64.8%<br>76.3% | 75.0% | 75.2%<br>68.3%<br>78.2% | ●<br>●<br>● |

## Output Class 2: Early Detection and Management

Commonly referred to as 'primary' or 'community' services, these are accessible directly by individuals (as distinct from secondary services for which a referral is needed). They are delivered by a range of agencies and are typically *generalist* (non-specialist) in nature. Similar types of services are usually delivered in numerous locations across the community. It includes:

- primary health care
- oral health
- primary community care programmes
- pharmacy services
- community referred testing and diagnostics (laboratory and imaging services)
- primary mental health services.

| Output measure | Ethnicity | 2015/16 result | 2016/17 target | 2016/17 result | Achieve -ment |
|---|---|---|---|---|---|
| Good blood sugar management in diabetics (equal to or less than 64 mmol/mol) ▮ | Total<br>Māori<br>Non-Māori | 61.5%<br>53.3%<br>67.7% | 80.0% | 39.5%<br>37.8%<br>40.8%[4] | ●<br>●<br>● |
| Ambulatory sensitive | Total | *0-4:* | No target | | |

[2] Baseline data is drawn from the Miinistry's NZ Health Survey. Its latest data covers only up to 2011 to 2014, so there is no result for 2015/16. Data was combined over 2011-2014 to increase the sample size and therefore validity, but it means it is not possible to monitor trends over that time. Updates of the NZHS are sporadic and the periods of time they cover are unpredictable, so the survey has proved of little use for monitoring. Up-to-date data is now being drawn from our PHOs, which shows a smoking rate for 2016/17 of 19.3% for the total population, 34.7% Māori and 12.5% non-Māori. This cannot be compared with NZHS data because the questions asked and the collection methods are different. The PHO data will be used in the 2016/17 SPE.

[3] Breast screening is recorded over a calendar year. These results are for 2016.

[4] The 2015/16 data reports those with good blood sugar control as a proportion of everyone on the general practice count of patients with diabetes. The 2016/17 figure is those with good blood sugar control who had had a Diabetes Annual Review during the year as a proportion of all those on the Virtual Diabetes Register, MoH's estimate of the total number of people with diabetes in Northland. If we used the 2015/16 methodology this year the results would be Māori 47% non-Māori 61%, overall 55%, still under target but not by as much. The frequent changes MoH has made to the counting and analysis of this data and the inconsistent templates they have provided, have been detrimental to monitoring performance.

| Output measure | Ethnicity | 2015/16 result | 2016/17 target | 2016/17 result | Achieve -ment |
|---|---|---|---|---|---|
| hospitalisation rate, ages 0-4, 45-64[5] | Māori<br>Non-Māori | Total 67.3<br>Maori 84.1<br>Non-M 46.0<br>*45-64:*<br>Total 32.8<br>Maori 57.7<br>Non-M 24.2 | set | 65.2<br>76.6<br>50.5<br><br>36.4<br>63.1<br>27.1 | ●<br>●<br>●<br><br>●<br>●<br>● |
| Average number of decayed, missing or filled teeth in Y8 students | Total<br>Māori<br>Non-Māori | 1.23<br>1.61<br>0.76 | 1.00 | 0.89<br>1.43<br>0.61 | ●<br>●<br>● |
| Eligible people receiving cardiovascular (CVD) risk assessment in the last 5 years | Total<br>Māori<br>Non-Māori | 91.3%<br>87.4%<br>93.0% | 90.0% | 90.8%<br>87.1%<br>91.9% | ●<br>●<br>● |

## Output Class 3: Intensive Assessment and Treatment

These are *specialist* services that deal with complex or multiple problems, commonly referred to as 'secondary' or 'hospital' services. They are accessible only by referral from a primary practitioner. They are available in only a few locations, either on hospital sites or they use hospitals as the base from which to provide services in the community. The Output Class includes:

- inpatient services, both acute (treatment is needed now) and elective (treatment can be scheduled at a later date), (includes diagnostic, therapeutic and rehabilitative services)
- ambulatory services for people treated by a hospital but not admitted as an inpatient (includes outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
- emergency department services including triage, diagnostic and therapeutic services
- secondary mental health services
- secondary maternity services
- assessment treatment and rehabilitation.

| Output measure | Ethnicity | 2015/16 result | 2016/17 target | 2016/17 result | Achieve -ment |
|---|---|---|---|---|---|
| % of patients who receive their first cancer treatment (or other management) within 62 days referred urgently with a high suspicion of cancer and a need to be seen within two weeks **National Health Target** | Total<br>Māori<br>Non-Māori | 73.9%<br>65.4%<br>75.6% | 85.0% | 81.3%<br>75.0%<br>83.2% | ●<br>●<br>● |
| % of people with enduring mental illness aged 20-64 who are seen over a year[6] | Total<br>Māori<br>Non-Maori | 5.68%<br>8.98%<br>4.15% | 5.70%<br>9.24% | 5.76%<br>9.02% | ●<br>● |
| Increase in elective service discharges **National Health Target** | Total<br>Māori | 10,123<br>3,462<br>6,661 | 8,575[7]<br>2,924<br>5,626 | 10,570<br>2,867[8]<br>7,703 | ●<br>●<br>● |

[5] In the SPE actuals data was mistakenly presented for 2014/15, not 2015/16. It was also by major condition groups (cardiovascular, dental, respiratory, gastrointestinal, diabetes), not as all conditions combined. No targets were set for 2015/16. For 2017/18 the ASH measure will change to the ages 0-4 one used in System Level Measure reporting and these issues will not the arise again. For indicative purposes a retrospective analysis was performed on ASH data for the top four conditions combined for ages 45-64. This showed a rate per 100,000 of 33.1 in 2015/16 and 36.4 in 2016/17.

[6] No data or target was included for non-Māori in the SPE because it is not part of MoH's reporting requirements.

[7] The correct total is 8,575, but the target in the SPE was incorrectly recorded as 8,550. The 2,924 and 5,626 for Maori and non-Maori respectively were based on the 8,550 total.

[8] The 2015/16 target figure for Māori was mistakenly set too high. Typically Māori have comprised 25% to 27% of all electives, whereas the 3,462 Māori in 2015/16 represents 34%.

| Output measure | Ethnicity | 2015/16 result | 2016/17 target | 2016/17 result | Achieve -ment |
|---|---|---|---|---|---|
| | Non-Māori | | | | |
| Patients with an emergency department length of stay of less than 6 hours **National Health Target** | Total<br>Māori<br>Non-Māori | 92.0%<br>93.0%<br>91.3% | 95.0% | 92.7%<br>93.8%<br>92.1% | ●<br>●<br>● |
| Number of falls causing harm in NDHB facilities[9] | Total | 103 | 0 | 76 | ●[10] |
| Number of pressure injuries in NDHB facilities | Total | 64 | 0 | 56 | ● |
| % compliance with surgical checklist | Total | n/a | 90.0% | n/a[11] | ● |
| % hand hygiene compliance | Total | 84% | 90% | 85% | ● |
| % patients with medicines reconciled[12] | Total | 60% | None set | 67% | ● |

## Output Class 4: Rehabilitation and Support

This Output Class covers services for older people and palliative care services:

- needs assessment and service coordination
- home based support
- age related residential care beds
- respite care
- day services
- rehabilitation
- palliative care
- life-long disability services.

| Output measure | Ethnicity | 2015/16 result | 2016/17 target | 2016/17 result | Achieve -ment |
|---|---|---|---|---|---|
| % Home and Community Support Services (HCSS) clients assessed using interRai tool | Total | 81% | 95% | 89% | ● |
| % of HCSS providers certified | Total | 100% | 100% | 100% | ● |
| % of ARRC providers with at least 3-year certification | Total | 83% | 87% | 79%[13] | ● |

[9] For the five quality measures (this one and the next four) there is no data by ethnicity, though there are plans to provide this in future.

[10] Although the result of 76 sounds a long way from the zero target, it forms a very small proportion (0.2%) of the combined 39,268 inpatients and daypatients in Northland DHB's hospitals in 2016/17. Because the numbers are so small for both this and pressure injuries (where they are even lower), performance has been assessed as equivalent to being within 5% of target.

[11] From 2016/17 Q1 the Health Quality and Safety Commission changed the way this was reported by splitting it into three separate measures: sign in, time out and sign out. Not only does this make it difficult to compare with previous years, but the data is incomplete. HQSC does not accept data if it is drawn from fewer than 50 audits each quarter, which has been the case for six of the nine quarters to date in 2016/17 (Q4 data is not yet available).

[12] 'Reconciled' refers to monitoring consistency between medications prescribed by a patient's GP and those prescribed while they are in hospital.

[13] The apparent lower performance is mainly an artefact of rules around change of ownership. Of our 24 facilities, four automatically received one-year certification during the year because they acquired new owners. Of the remaining 20, 3- or 4-year certification was received by 19, or 95%.

# Northland District Health Board
# Briefing Paper to CPHAC/DiSAC

**SUBJECT: NORTHERN REGION HEALTH PLAN 2016/17, QUARTER 4 UPDATE**

**Prepared by:** John Wansbone, General Manager Planning, Integration, People and Performance

**Endorsed by:** Dr Nick Chamberlain, Chief Executive

## RECOMMENDATION

That CPHAC/DiSAC note the Northern Region Health Plan 2016/17 update, a summary of what is supplied to the Ministry by the Northern Regional Alliance (NRA) as part of quarterly reporting.

## BACKGROUND

At the June CPHAC/DiSAC meeting the Committee requested that a one-page summary be prepared of key items relating to Northland in the Northern Regional Alliance's quarterly reports to the Ministry on the Northern Region Health Plan.

Preparing a one-page summary has proved to be difficult to achieve. Capturing the references in a table would require explaining the context in which each was made, including which section of the report it occurred in, what topic was being addressed and perhaps why Northland had been highlighted. Each explanation would probably occupy more space than the original reference, and with 32 references in the Q4 report it was difficult to keep the table to one page.

Instead of a series of discrete references in tabular format, it is proposed that it is clearer and simpler if all references to Northland are highlighted in the report itself, so that they are quickly identified.

The full report is attached. All references in the report to Northland or Northland DHB have been highlighted with yellow. References to "the Northern Region" or "all DHBs" have not been highlighted.

### 1 Key achievements this quarter include:

**Child Health**

The Skin Infection Prevention Primary Care Pathway has been published, key messages agreed and resources tested in primary care sites with evaluation.

**Health of Older People**

The Northern Region led the development and production of a suite of national dementia education and training resources for primary health care professionals (in partnership with the other three regions). The Dementia E-Learning Toolkit is the first of its kind in New Zealand and provides clinical education points for Doctors and Nurses. Officially launched in March 2017, the toolkit has been well received with a total of 393 users during Q4 April to June including 141 Doctors, 187 Nurses and 65 Other health workforce.

**CVD**

Regional Catheter Lab planning continues to progress with interim plans to manage service requirements at both NDHB and CMDHB being developed, whilst long term plan options are reviewed.

The implementation of the GoodSAM app is progressing along with national initiatives to increase awareness and training for CPR across the country

**Diabetes**

A mental health pilot project, undertaken in conjunction with the MoH, supporting people with poorly controlled diabetes to access mental health services is delivering positive results in Northland. A full evaluation will be published in September.

Two healthy lifestyle manuals, 'Tackle Diabetes' and 'Tackle Pre-Diabetes', written by Dr Catherine McNamara have recently been published. These manuals, providing a six part action plan for managing Type 2 Diabetes and Pre-Diabetes, have been well received by the network. The primary care liaison members are particularly keen to see these made widely available to GP practices across the region.

**Mental Health and Addictions**

Proposed Substance Abuse (Compulsory Assessment & Treatment) SACAT Model of Care for the Northern Region completed and forwarded to Ministry as requested.

120 people attended a clinical network day for Perinatal and Infant Mental Health (PIMH) Services.

Stocktake completed of Mental Health and Addiction uptake of e-referrals and workplan identified for 2017/18 to progress web-based referrals and intra-referrals.

**Stroke**

Implementation of the Centralised Stroke Hyperacute After-Hours Model of Care is on track to commence 24 July 2017, commencing with the West Auckland population.

Stroke services in the Northern Region continues to exceed the KPI target of 80% patients admitted to a dedicated stroke bed which is now over four consecutive quarters, indicating a sustainable trend

**Youth**

The surveys which are part of the Regional Standards for Quality Care for Adolescents and Young Adults in Secondary or Tertiary Care tool kit are now available electronically. Engagement continues with the DHBs, the renal service at CMDHB has picked up the standards along with the sexual health service at ADHB. The standards have also been added to the Centre for Youth Health Point page.

**Hepatitis C**

From January to June 2017, 281 patients were diagnosed as being Hepatitis C positive through RNA/PCR testing from a total of 824 tests performed; this represents a positive rate of 34.1%. This gives confidence that the vulnerable populations are being targeted as the positive rate for the general population is only 1.1%.

New cases scanned from January to June 2017 has increased to 283 from 94 cases in the previous six months

**Health Equity**

Work is progressing with Dementia Auckland, the Maori Health teams and Researchers at the University of Auckland to work to develop a Northern Regional Maori Dementia Plan. This will support the development of the national Dementia resources for Maori and the delivery of culturally appropriate dementia training at local marae. The Region intends to extend this joint project to Pacific carers and families in the 2017-2018 year.

**Health Quality & Safety**

HQSC led a regional workshop for the medication safety leads in May which provided opportunities for DHBs to share and learn from each other and to understand what priorities were being worked on at each DHB.

**Workforce**

The regional psychiatry registrar project "Improving Recruitment of New Zealand Trainees to the Psychiatry Registrar Training Programme - Auckland Metro Region" is now completed. The report and findings have been accepted and focus has now shifted to implementing the recommendations.

CMDHB was the principal sponsor for Te Kahu Korako: Maori Health Leadership Summit which was hosted by Te Rau Matatini, over three days in May. Around 1,000 Maori leaders attended the event which focused on; growing and sustaining Maori Health Leadership, Rangatahi Leadership and Practice Development Addictions Sector. Around 1000 Maori leaders attended the event.

**Information Systems**

The Executive Overview of ISSP" has been completed with the Regional Governance Group approving the contents on 1 June. The Programme has subsequently refocused upon updating and finalising the ISSP and ISSP Annex.

The Northern Region continues to increase use of the eReferrals solution. Across the metro DHBs over 1,100,000 eReferrals have now been received since go live. 100% of GP practices are eligible to send eReferrals using the regional solution.

**Capital**

Continuation of the Northern Region Long Term Investment Plan: The region has agreed a high level 'regional network' model to inform a proposed future state. This model is being used to develop counterfactuals and financial models to inform decisions about a preferred regional investment path.

## 2 Progress on the top 10 commitments

| | | |
|---|---|---|
| ● On track | ▲ Some concerns regarding progress to target | ◆ Not achieved or declining performance |

| | Commitment | Status | Notes |
|---|---|---|---|
| 1 | Achieve and maintain the National Health Targets | | National targets were achieved with regard to 'Improved access to elective surgery'; and 'Raising healthy kids' and 'Better help for smokers to quit – maternity'.<br>National targets substantially achieved with regard to:<br>• 'Shorter stays in ED' (94% on target of 95%)<br>• 'Better help for smokers to quit - primary' (achieved 87.7% against a target of 90%)<br>• 'Increased Immunisation' (achieved 92.8% against a target of 95%)<br>• 'Faster Cancer Treatment' (achieved 84.8% against a target of 85%). |
| 2 | Child Health continue to reduce SUDI deaths to ≤ 0.4 SUDI Deaths per 1,000 Maori live births | ● | The Primary Care Pathway has been published and the Safe Sleep Calculator is being tested in primary care sites with evaluation |
| 3 | 75% of clients receiving long term Home Based Support Services have an interRAI clinical assessment within the previous 24 months | ● | 83% of LT HBSS clients have received an interRAI clinical assessment within the previous 24 months (as of Mar 2017) |
| 4 | 85% of patients receive their first cancer treatment or other management within 31 days from decision to treat | ● | Note: 1 quarter data lag<br><br>Achieved 88.7% |
| 5 | Lift proportion such that 30% of bowel investigations are CTC; consistent with the Regional Colonoscopy Plan and Bowel investigations Programme Business Case | ▲ | Note: 1 quarter data lag<br><br>In the Jan to Mar quarter, CTC rates remained at or around 20% for the region. |
| 6 | 80% of patients presenting with ST elevation myocardial infarction (STEMI) referred for percutaneous coronary intervention (PCI) will be treated within 120 minutes[1] | ▲ | The Northern Region is slightly below the target this quarter at 76.4%.<br>This is largely due to NDHB and WDHB results for this quarter. |

[1] There may be some variation for patients from NDHB due to geographical isolation and dependence on emergency helicopter transport.

| | Commitment | Status | Notes |
|---|---|---|---|
| 7 | 80% of diabetes patients to have good or acceptable glycaemic control (HbA1c≤64) | ▲ | Reports from Jan 2017 indicated 71% of patients have good or acceptable glycaemic control, which is similar to the previous 6 months.<br>The latest report, due end of July; will confirm any improvement in this target. |
| 8 | 90% of discharges from adult mental health services receive post discharge community care (within 7 days) | ▲ | 68.2% for last 3 months: 69.2% YTD<br>National average 65% YTD |
| 9 | 80% of patients who have a stroke are treated in a stroke unit | ● | The Northern Region achieved 79% for stroke patients treated in a dedicated stroke unit for the period Jan-Mar 2017. |
| 10 | Reduce unintended teen pregnancies | ● | There is evidence of an ongoing reduction in termination rates and a reduction in the number of teen pregnancies. |
| **Equity Priority** | | | |
| EP | Equity (which will be an emphasis across each clinical network area of work) involving identification of equity issues in the areas of priority regional focus, and developing plans to address the gaps identified. | ● | The Region has identified equity issues in all clinical network groups and has developed actions that aim to address these issues in the 2017/28 Regional Plan |

**Northern Region Health Plan**

**Implementation Progress Report**

**Quarter 4**

**April to June 2017**

# Contents

1. Summary of Key Achievements

2. Progress for top 10 Commitments

3. Progress Summary for the Workstreams

4. Risks Management

**Appendices**

A: National Health Targets

B: Workforce and Training Hub Report

C: IS Report

D: Regional Information Systems Updated Implementation Plan

E: Regional KPI summary

This report has been compiled by the Northern Regional Alliance on behalf of the four Northern Region District Health Boards. For further information relating to the information contained within this report please contact:

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## 1. Summary of Key Achievements

- **Child Health** - The Skin Infection Prevention Primary Care Pathway has been published, key messages agreed and resources tested in primary care sites with evaluation.
- **Health of Older People** –The Northern Region led the development and production of a suite of national dementia education and training resources for primary health care professionals (in partnership with the other three regions). The Dementia E-Learning Toolkit is the first of its kind in New Zealand and provides clinical education points for Doctors and Nurses. Officially Launched in March 2017 the toolkit has been well received with a total of 393 users during Q4 April to June including 141 Doctors, 187 Nurses and 65 Other health workforce.
- **Cancer -** Local delivery of Herceptin volumes at CMH have now reached expected volumes and planning for local delivery of Herceptin at WDHB is well advanced, with a mid-July commencement planned
- **CVD**
    - Regional Catheter Lab planning continues to progress with interim plans to manage service requirements at both NDHB and CMH being developed, whilst long term plan options are reviewed.
    - The implementation of the GoodSAM app is progressing along with national initiatives to increase awareness and training for CPR across the country and increase access to AEDs
- **Diabetes**
    - The West Auckland QI co-ordinator role and initiative presented by Janine Strickland was awarded a Prize for Innovation at the recent New Zealand Society for the Study of Diabetes meeting (NZSSD). This project was initially undertaken by the Diabetes network.
    - A mental health pilot project, undertaken in conjunction with the MOH, supporting people with poorly controlled diabetes to access mental health services is delivering positive results in Northland. A full evaluation will be published in September.
    - Two healthy lifestyle manuals, 'Tackle Diabetes' and 'Tackle Pre-Diabetes', written by Dr Catherine McNamara have recently been published. These manuals, providing a six part action plan for managing Type 2 Diabetes and Pre-Diabetes, have been well received by the network. The primary care liaison members are particularly keen to see these made widely available to GP practices across the region.
- **Mental Health and Addictions**
    - Proposed SACAT Model of Care for the Northern Region completed and forwarded to Ministry as requested.
    - 120 people attended a Clinical network day for PIMH Services.
    - Stocktake completed of Mental Health and Addiction uptake of e-referrals and workplan identified for 2017/18 to progress web-based referrals and intra-referrals.
- **Stroke**
    - Implementation of the Centralised Stroke Hyperacute After Hours Model of Care, is on track to commence 24 July 2017, commencing with the West Auckland population.
    - Stroke services in the Northern Region continues to exceed the KPI target of 80% patients admitted to a dedicated stroke bed which is now over four consecutive quarters, indicating a sustainable trend
- **Youth -** The surveys which are part of the Regional Standards for Quality Care for Adolescents and Young Adults in Secondary or Tertiary Care tool kit are now available electronically. Engagement continues with the DHBs, the renal service at CMDHB has picked up the standards along with the sexual health service at ADHB. The standards have also been added to the Centre for Youth Health Point page.
- **Hepatitis C** –
    - From Jan to June 2017, 281 patients were diagnosed as being Hep C positive through RNA/PCR testing from a total of 824 tests performed and represent a positive rate of 34.1%. This gives confidence that the vulnerable populations are being targeted as the positive rate for the general population is only 1.1%.
    - New cases scanned from January to June 2017 has increased to 283 from 94 cases in the previous six months
- **Health Equity -** Work is progressing with Dementia Auckland, the Maori Health teams and Researchers at the University of Auckland to work to develop a Northern Regional Maori Dementia Plan. This will support the development of the national Dementia resources for Maori and the delivery of culturally appropriate dementia training at local marae. The Region intends to extend this joint project to Pacific carers and families in the 2017-2018 year.
- **Health Quality & Safety** - HQSC led a regional workshop for the medication safety leads in May which provided opportunities for DHBs to share and learn from each other and to understand what priorities were being worked on at each DHB.

- **Workforce**
  - The regional psychiatry registrar project "Improving Recruitment of New Zealand Trainees to the Psychiatry Registrar Training Programme - Auckland Metro Region" is now completed. The report and findings have been accepted and focus has now shifted to implementing the recommendations.
  - CMH was the principle sponsor for Te Kahu Korako: Maori Health Leadership Summit which was hosted by Te Rau Matatini, over three days in May. Around 1,000 Maaori leaders attended the event which focused on; growing and sustaining Maori Health Leadership, Rangatahi Leadership and Practice Development Addictions Sector. Around 1000 Maaori leaders attended the event.
- **Information Systems**
  - The Executive Overview of ISSP" has been completed with the RGG approving the contents on the 1 June. The Programme has subsequently refocused upon updating and finalising the ISSP and ISSP Annex.
  - The Northern Region continues to increase use of the eReferrals solution. Across the metro DHBs over 1,100,000 eReferrals have now been received since go live. 100% of GP practices are eligible to send eReferrals using the regional solution.
- **Capital** - Continuation of the Northern Region Long Term Investment Plan. The region has agreed a high level 'regional network' model to inform a proposed future state. This model is being used to develop counterfactuals and financial models to inform decisions about a preferred regional investment path.

| NZ Health Strategy – Regional highlights for the quarter | | | | |
|---|---|---|---|---|
| **People - powered** | **Closer to home** | **Value and high performance** | **One team** | **Smart system** |
| The Region has begun work with Dementia Auckland, the Maori Health teams and Researchers at the University of Auckland to develop a Northern Region Maori Dementia Plan, supporting the development of the national Dementia resources for Maori and the delivery of culturally appropriate dementia training at local marae. The Region intends to extend this joint project to Pacific carers and families in the 2017-2018 year. | Service redesign work continues with the aim of ensuring Primary Care and Retinal Screening/Podiatry Services have the capability and capacity to provide quality services to people living with diabetes, especially high risk and vulnerable populations. | There has been a significant change in the mix of patients that Auckland DHB's Liver Transplant Unit manages. This is a direct result the increasing role of primary care in the treatment and ongoing management of patients with Hepatitis C. This has been mirrored in the utilisation of liver elastography scanning which continues to increase in referrals from primary care directly. The unnecessary burden on First Specialist Appointments for the non-complex liver cases is reducing freeing capacity to deal with complex patients. | The primary care pathway for the identification and management of children following head injury (not requiring hospital admission) has been piloted with ACC funding attached to the primary care SCAT 3 assessment. ACC is determining whether it will provide funding for the SCAT3/5 assessment to be implemented nationally, alongside the pathway | Shared electronic records, data repository and central diabetes register are all being worked towards as part of the Diabetes SLAT activity occurring in the three metro Auckland DHBs |

## 2. Progress for the Top 10 Commitments

The table below shows progress against the top 10 commitments

| | | |
|---|---|---|
| On track | Some concerns regarding progress to target | Not achieved or declining performance |

| | Commitment | Status | Notes |
|---|---|---|---|
| 1 | Achieve and maintain the National Health Targets | | National targets were achieved with regard to 'Improved access to elective surgery'; and 'Raising healthy kids' and 'Better help for smokers to quit – maternity'.<br>National targets substantially achieved with regard to:<br>• 'Shorter stays in ED' (94% on target of 95%)<br>• 'Better help for smokers to quit - primary' (achieved 87.7% against a target of 90%)<br>• 'Increased Immunisation' (achieved 92.8% against a target of 95%)<br>• 'Faster Cancer Treatment' (achieved 84.8% against a target of 85%). |
| 2 | Child Health continue to reduce SUDI deaths to ≤ 0.4 SUDI Deaths per 1,000 Maori live births | | The Primary Care Pathway has been published and the Safe Sleep Calculator is being tested in primary care sites with evaluation |
| 3 | 75% of clients receiving long term Home Based Support Services have an interRAI clinical assessment within the previous 24 months | | 83% of LT HBSS clients have received an interRAI clinical assessment within the previous 24 months (as of Mar 2017) |
| 4 | 85% of patients receive their first cancer treatment or other management within 31 days from decision to treat | | Note: 1 quarter data lag<br><br>Achieved 88.7% |
| 5 | Lift proportion such that 30% of bowel investigations are CTC; consistent with the Regional Colonoscopy Plan and Bowel investigations Programme Business Case | | Note: 1 quarter data lag<br><br>In the Jan to Mar quarter, CTC rates remained at or around 20% for the region. |
| 6 | 80% of patients presenting with ST elevation myocardial infarction (STEMI) referred for percutaneous coronary intervention (PCI) will be treated within 120 minutes[1] | | The Northern Region is slightly below the target this quarter at 76.4%.<br>This is largely due to NDHB and WDHB results for this quarter. |
| 7 | 80% of diabetes patients to have good or acceptable glycaemic control (HbA1c≤64) | | Reports from Jan 2017 indicated 71% of patients have good or acceptable glycaemic control, which is similar to the previous 6 months.<br>The latest report, due end of July; will confirm any improvement in this target. |
| 8 | 90% of discharges from adult mental health services receive post discharge community care (within 7 days) | | 68.2% for last 3 months: 69.2% YTD<br>National average 65% YTD |
| 9 | 80% of patients who have a stroke are treated in a stroke unit | | The Northern Region achieved 79% for stroke patients treated in a dedicated stroke unit for the period Jan-Mar 2017. |
| 10 | Reduce unintended teen pregnancies | | There is evidence of an ongoing reduction in termination rates and a reduction in the number of teen pregnancies. |
| **Equity Priority** | | | |

[1] There may be some variation for patients from NDHB due to geographical isolation and dependence on emergency helicopter transport.

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| EP | Equity (which will be an emphasis across each clinical network area of work) involving identification of equity issues in the areas of priority regional focus, and developing plans to address the gaps identified. | | The Region has identified equity issues in all clinical network groups and has developed actions that aim to address these issues in the 2017/28 Regional Plan |

## 3. Progress Summary for the Workstreams

### Our Priority Goals

| Work Stream status | Achievements | Challenges |
|---|---|---|
| **Child Health** | • The evaluation of the skin infection prevention resources is positive. Regional discussion is occurring with primary care and DHBs to consider models of care and funding options to implement in Early Childhood Education Centres, WCTO and in primary care practices.<br>• The primary care pathway for the identification and management of children following a head injury (not requiring hospital admission) has been piloted with ACC funding attached to the primary care SCAT 3 assessment. ACC is determining whether it will provide funding for the SCAT3/5 assessment to be implemented nationally, alongside the pathway.<br>• All projects have been endorsed by the Child Health Steering Group | • Developing sustainable funding mechanisms to implement regional projects<br>• Projects that require IT system support are complex to navigate and progress<br>• DHBs have varying workforce capacity to engage and access Early Childhood Education Centres. |
| **Health of Older People** | **Dementia Pathways**<br>• **Pathways -** The pathways have been well received by GPs and uptake continues to increase. In particular the Cognitive Impairment pathway which as of Q4 Apr to Jun had 251 users 18 of whom were new users and had 368 hits during Q4<br>• **Primary Care Education Resource -** The Dementia E-Learning Toolkit was officially launched in March 2017. It provides clinical education points for Doctors and Nurses and has been well received with a total of 393 users during Q4 April to June including 141 Doctors, 187 Nurses and 65 Other health workforce.<br><br>**interRAI**<br>• 83% of clients receiving long term Home Based Support Services have had an interRAI clinical assessment within the previous 24 months.<br>• 2,204 interRAI Home Care assessments were completed:<br>  ○ 24% have cognitive difficulties with everyday decisions<br>  ○ 47% have no enduring power of attorney<br>  ○ 24% of informal carers express feelings of distress, anger or depression<br>• The Regional Health of Older People Clinical Network Group and Regional HOP Planning and Funding managers forum met regularly with national interRAI representatives to discuss interRAI quality improvement, implementation and training needs.<br>• The Northern Region is leading a project to work together with national interRAI to identify where ethnicity data reporting could be strengthened, this is on-going and is scheduled to be completed in 2017/18<br>**Quality and Safety**<br>• 100% of data is now regularly input into the Hip Fracture Registry this will help to inform service improvement long term. | • Difficulty in finding a suitable replacement for the Regional HOP Clinical Lead.<br><br>• A lack of interRAI training in ARRC. In particular the largest provider BUPA has expressed concerns that they cannot keep up with training demands. We are currently discussing these issues with national interRAI.<br><br>• A lack of robust ethnicity data reporting from National interRAI. We are currently discussing these issues with national interRAI. |

| Work Stream status | Achievements | Challenges |
|---|---|---|
| | **Health Equity**<br>• In Q3 and Q4 the Region has been working with Dementia Auckland, the Maori Health teams and Researchers at the University of Auckland to develop a Northern Regional Maori Dementia Plan. This will support the development of the national Dementia resources for Maori and the delivery of culturally appropriate dementia training at local marae. The Region intends to extend this joint project to Pacific carers and families in 2017/18 | • Maori have a higher rate of risk factors for dementia when conditions such as depression, head trauma, and substance abuse disorders are included. |
| **Cancer** ▲ | **Faster Cancer Treatment**<br>• As a whole, the region is close to 85% achievement – 83.6% for Jan-Mar 17.<br><br>**Local Delivery of Oncology**<br>• Local delivery of Herceptin volumes at CMH have now reached expected volumes<br>• Planning for local delivery of Herceptin at WDHB is well advanced, with a mid-July commencement planned.<br><br>**Oncology Psycho-Social Initiative**<br>• Recruitment of an additional 2 psychologists at ADHB and 1 social worker at WDHB. Preliminary results from the service evaluation undertaken by Sapere are starting to be disseminated.<br><br>**Lung Tumour Stream**<br>• A regional audit and review of the up-front ordering of PET-CT under SPOAC has been completed with no extraneous increase in uptake.<br>• ALK testing of negative EGFR specimens is now routinely undertaken at LabPLUS.<br><br>**Information Systems**<br>• The region maintains strong links with the CHIS Programme National Director and Chair of the Steering Committee and work is referenced at Cancer Board and ROOG. | • FCT: sustaining long run performance improvements and the ability to consistently meet an increased target of 90% is expected to be challenging and resource intensive but the change in technical requirements and inclusion of delay codes may make it possible.<br>• Oncology Psycho-Social Initiative: interim measure at NDHB has seen a second social appointed to 0.5 FTE while recruitment continues for a psychologist in this role. |
| **CVD** ● | • Regional Cath Lab planning has identified a requirement for additional capacity. Work is progressing to assess options to meet this need and is assessing the financial and clinical impact of a range of potential changes<br>• The region is working closely with Northland DHB in support of it reaching the ACS targets. | |
| **Diabetes** ● | • Work is being progressed regionally to ensure consistency of retinal screening services and to ensure that we improve performance against screening targets. A performance improvement plan will support delivery of 17/18 targets and a higher target for 18/19<br>• A metro group for sharing procurement processes and considering joint RFP processes is being convened. Northland has expressed interest in joining this group, which is an opportunity to share learnings. | • Retinal screening targets continue to be underachieved across the region. Recent calculations of the retinal screening numbers show that the likely number screened regionally in 2016/17 will be 31,949<br>• The network has recalculated the 17/18 retinal screening targets based on earlier projected 16/17 screening volumes, to be |

| Work Stream status | Achievements | Challenges |
|---|---|---|
| | | completed by June 2017 (32,328), plus 3%, to allow for diabetic population increase. |
| **Major Trauma** | • Regional clinical guidelines work is underway<br>• A Trauma Website is under development<br>• An education symposium was held in Northland<br>• Case reviews continue to be undertaken where issues potentially have regional impacts | • No trauma nurse appointed to North Shore Hospital yet |
| **Mental Health** | **Eating Disorders Services**<br>All aspects of the service are operational. The lease on the current residential and day programme facility has been further extended until February 2019.<br>The Model of care will be reviewed and refined once negotiations have concluded with Midland.<br><br>**Services for people with high and/or complex needs.**<br>ADHB and WDHB have been progressing a review of clients to confirm the need for contained rehabilitation beds including projected numbers. The review is also determining whether the development of these beds will reduce the demand for open rehabilitation beds. It is likely the review will be completed by the end of August, 2018, and will inform decisions re whether to progress to a full business case for a contained rehabilitation facility.<br><br>**Youth Forensic Services**<br>• Workplan achieved for 2016/17. Model of care finalised in in 2016.<br>• A regional Youth Forensic Clinical Governance Group has been established.<br>• Workplan has been developed for 17/18, this includes alignment of MOC in Northern region with MOC for Nga Taiohi and a cross-sector initiative to minimise the restrictive practice for this client group.<br><br>**Perinatal and Infant Mental Health**<br>• Workplan achieved for 2016/17.<br>• Review completed and forwarded to Ministry in December 2016.<br>• A regional PIMH clinical governance group is operational and is progressing priorities identified in the December 2016 review.<br>• Positive feedback from a Clinical Network day held on the 3 April that 120 people attended<br>• RFP has been developed to tender for a workforce development package.<br><br>Indicatively it appears that service volume is being maintained; however, based on review of historical data (inclusive of seasonal impacts) and feedback from services, it appears that not all records have been processed into PRIMHD for Q3. It is hoped that the next PRIMHD data update will remedy this. | The Midland DHBs have not given a five year commitment to the residential component of the service, which will impact on the viability of maintaining a standalone facility. |

| Work Stream status | Achievements | Challenges |
|---|---|---|

| MMH Data | | | | | | |
|---|---|---|---|---|---|---|
| DHB of Service | | 15/16 | Q1 | Q2 | Q3 | YTD |
| | | Total | 16/17 | 16/17 | 16/17 | Total |
| NDHB | SU Contacts | 970 | 465 | 250 | 177 | 892 |
| | Discharges | 114 | 36 | 48 | 9 | 93 |
| WDHB | SU Contacts | 3106 | 1006 | 1999 | 1340 | 4345 |
| | Discharges | 185 | 56 | 68 | 75 | 199 |
| ADHB | SU Contacts | 3024 | 1451 | 1394 | 426 | 3271 |
| | Discharges | 552 | 165 | 133 | 62 | 360 |
| CMDHB | SU Contacts | 2292 | 757 | 1190 | 821 | 2768 |
| | Discharges | 202 | 105 | 124 | 74 | 303 |
| Total SU contacts | | 9392 | 3679 | 4833 | 2764 | 11276 |
| Total Discharges | | 1053 | 362 | 373 | 220 | 955 |

PRIMHD reporting has a 3 monthly time lag, SU Contacts include all SU present and SU phone contacts.

MBU has shown an increase in services over the 15/16 FY.

| MBU Data | | |
|---|---|---|
| | Total | Total |
| | 15/16 | 16/17 |
| Service Users | 42 | 52 |
| Bed nights | 660 | 771 |
| Utilisation Rate | 60% | 70% |

MBU data provided by ADHB, direct from HCC

**Improve physical health for people with low prevalence.**

- A decision was made in 2016 to progress Equally Well initiatives at a DHB level
- Key focus regionally has been selection of Predict as the metabolic screening tool across the 3 metro DHB's. Progressing detailed service design.
- Physical health of Mental Health service users has been identified as a pathway for development by the Regional Health Pathways. The Mental Health and Addictions network has given commitment to both support development and to provide forum for endorsement of pathways once finalised.

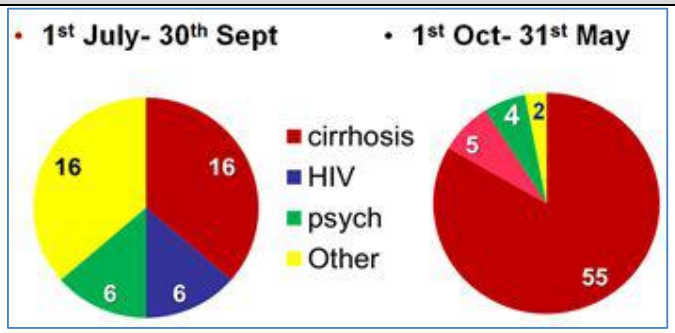
**Workforce**

- Regional suicide prevention training framework to inform training priorities across the sector has been developed, along with stocktake of training options currently being utilised. Forwarded to Regional Suicide Prevention Group to inform decision-making.
- Youth Forensics Training framework was delayed whilst MOC finalised and Regional Clinical Governance Group operationalised. Minimising restrictive practice is likely to be the focus in focus in 2017/18.
- Focus has been on contribution to the National training standards working with Aspire, rather than a regional framework. Smokefree co-ordinators have continued to provide inservice across the sector. Currently piloting a Blended Group based/ Motivational Interviewing treatment model of Smoking Cessation for Mental Health service users.

**Information systems**

- A stocktake has been undertaken in relation to current status of e-referrals. Over 88% of GP referrals are electronic. A working group is being established to progress intra-referrals and web-based referrals from other key referral agencies. Predict is the

| Work Stream status | Achievements | Challenges |
|---|---|---|
| | metabolic screening tool that will be implemented across Auckland in 17/18 year.<br>• Plans are underway to upgrade HCC to incorporate NZULM. | |
| **Stroke** | • The final proposal for the Northern Region Hyperacute Stroke & Thrombectomy Model of Care was endorsed by the Regional Governance Group (RGG) in April 2017 and is now progressing through DHB Board approval processes.<br>• The Phase 1 roll-out is on track to commence 24 July, with West Auckland domiciled patients (who will divert directly to ACH - full metro Auckland roll out scheduled July 2018). Phase 1 KPIs and baselines are currently being collected to evaluate the first stage of implementation.<br>• The region continues to excel, with another increase in the number of patients thrombolysed, achieving a new high of 10% (from 9.2% previously in Q3.<br>• Admission of patients to a dedicated stroke bed KPI target, was 79% - just short of the 80% target (Oct-Dec = 84%).<br>• The "Proportion of all people with acute stroke transferred to inpatient rehabilitation services" remained the same at 26.9% for the quarter (Oct-Dec = 27.0%). Stroke patients transferring to rehab within 7 days increased to a regional high of 54.1% (Oct-Dec = 50.8%).<br>• The % of cases coded as "unspecified" was 4.0% (Oct-Dec = 5.4%).<br>• A recent workshop, attended by key stakeholders (incl MOH & NZ Stroke Foundation) in May, determined work plans for further stages of the regional stroke clinical pathway which includes; inpatient acute, rehabilitation & community components of the pathway. | • The steadily improving thrombolysis rate is encouraging; however other centres/regions are continuing to exceed the Northern Region. There is strong commitment by all four DHBs to improve their rate each quarter.<br>• The Northern Region is unlikely to attain an 80% target for patients transferred to inpatient rehabilitation services within 7 days of acute admission. It has been signalled to the MOH, availability of rehabilitation beds are a major issue for two of the four DHBs – interim improvements and future solutions are being progressed. |
| **Youth Health** | • The surveys which are part of the Regional Standards for Quality Care for Adolescents and Young Adults in Secondary or Tertiary Care tool kit are now available electronically. Engagement continues with the DHBs, the renal service at CMH has picked up the standards along with the sexual health service at ADHB. The standards have also been added to the Centre for Youth Health Point page.<br>• KPI reports continue to be developed and refined.<br>• Inclusion of initially the Metro Auckland suicide data in the KPIs to take place. NDHB is not in a position to share their data at this time but anticipate that this will be regional in the future | |
| **Hepatitis C** | **Service Delivery**<br>• Service delivery through Community Alcohol and Drug Services, Needle Exchange, and Corrections Department facilities continues to be strengthened as the services bed in and awareness and education of core staff develops.<br>• The Auckland Central Liver Clinic (ACLC), run out of the Central Needle Exchange service has initiated a local initiative involving the New Zealand prostitutes collective and local GP's working collaboratively within their community to optimise patient engagement.<br>• There has been significant change in the mix of patients managed by Auckland City Hospital secondary care following the uptake by primary care treating patients with Viekira Pak.<br><br>**Patient –mix at ACH pre and post community treatment options** | |

| Work Stream status | Achievements | Challenges |
|---|---|---|
| |  <br>**Diagnostics**<br>• From Jan to June 2017, 281 patients were diagnosed as being Hep C positive through RNA/PCR testing from a total of 824 tests performed and represent a positive rate of 34.1%. This gives confidence that the vulnerable populations are being targeted as the positive rate for the general population is only 1.1%.<br>• Waitemata has received its portable Fibroscan© machines and initiated clinics at the Waitemata and North Shore Hospitals in late May.<br>• New cases scanned from January to June 2017 has increased to 283 (67% increase) from 94 cases in the previous six months. The total volume of Fibroscan cases has also declined slightly over the second half of the year primarily due to better rationalising and education of referrers of the need for a fibroscan once every 3 years. Bringing the portable Fibroscan's out into the community has also meant that some of the most vulnerable cases have been reached that would not otherwise have been seen.<br><br>**Fibroscans** / **New scans** / **Total scans**<br>**1 July – 31 Dec 2016** / **94** / **489**<br>**1 Jan – 30 June 2017** / **283** / **472** | • Many in this patient population have poor venous access. A finger prick point of care test is required to support these patients for diagnosis. |
| **Health Equity** | Key achievements in Q4 are set out below.<br>**Growing the Maori and Pacific workforce with a series of intentional actions.**<br>• The Auckland metro DHBs are progressing work to enter into the Youth Employment Partnership Pledge with the Auckland Council. The Pledge is a key initiative in the Auckland Council to address the rising rates of unemployed Youth within the Auckland region.<br>• Korako: Maori Health Leadership Summit hosted by Te Rau Matatini, over three days in May. The event's focus included; growing and sustaining Maaori Health Leadership, Rangatahi Leadership and Practice Development Addictions Sector. Around 1,000 Maaori leaders attended the event.<br><br>**Child Health**<br>• The evaluation of the skin infection prevention resources confirms acceptability and utility. Strategies are being considered for regional implementation for children 0-5 years across low decile Early Childhood Education Centres with high Pacific and Maori enrolments<br><br>**Cancer Services**<br>• The equity gap for Maori and Pacific Island patients against FCT target is being discussed with organisation leads for Maori and PI, and engagement with the Regional Migrant Health Project Manager.<br><br>**Health of Older People** | • Maori and Pacific people are underrepresented in many areas of the Regional Health Workforce |

| Work Stream status | Achievements | Challenges |
|---|---|---|
| | • Work is progressing with Dementia Auckland, the Maori Health teams and Researchers at the University of Auckland to work to develop a Northern Regional Maori Dementia Plan. This will support the development of the national Dementia resources for Maori and the delivery of culturally appropriate dementia training at local marae. The Region intends to extend this joint project to Pacific carers and families in the 2017-2018 year.<br>• Better Ethnicity data reporting for National interRAI indicators will help to achieve Health Equity for Maori, Pacific and Asian Older people<br>• The Northern Region is leading a national project to identify where interRAI ethnicity data reporting could be strengthened, this is on-going and is scheduled to be completed in 2017-2018.<br><br>**Hepatitis C**<br>• Ngawha Prison, which has a high Maori population, has implemented a consent form for treatment initiation to facilitate buy in and a commitment to treatment completion.<br>• Wiri Men's Prison is screening all new prisoners on entry to their facility for HCV with the intention being to provide the full complement of service including treatment in conjunction with the prison medical teams. | • Maori have a higher incidence of Hepatitis C than other Ethnic groups. Challenges include early diagnosis and access to services |
| **Health Quality & Safety** | *Medication Safety*<br>• HQSC led a regional workshop for the medication safety leads in May which provided opportunities for DHBs to share and learn from each other and to understand what priorities were being worked on at each DHB.<br><br>*Regional SAC 3 & 4 review*<br>• The regional SAC 3 & 4 review work is on hold as the region considers the national reportable events policy changes<br><br>**Northern Region Deteriorating Patient Programme**<br>• ADHB shared lessons learnt from their Workstream 1 test with the DPP group in June. Issues noted included:<br>  ○ Stakeholder engagement and communications<br>  ○ Balancing observation policy versus what is realistic/feasible<br>  ○ Recording of modifications<br>• Non-test site DHBs are looking at what they need to prepare for roll-out, noting the HQSC advice that DHBs should be ready for implementation by the end of this year.<br>• Challenges with resourcing have been highlighted by DHBs. DHBs noted the mis-alignment between MoH funding and the expectations of the Commission, and noted it would be helpful if the Commission explicitly stated that clinical and admin resources should be directed to this as a priority. | |

**Clinical Services**

| Work Stream status | Achievements | Challenges |
|---|---|---|
| **Elective Services** | Models of care and Service:<br>• The Northern Region DHBs have prioritised efforts to meet ESPI targets. However, despite these efforts the | • Continued production stresses for Electives surgery placed all services under pressure to continually meet the ESPI |

| | | |
|---|---|---|
| | region has experienced ESPI target breaches during Q4.<br>• ADHB has completed its external service review and is in the process of implementing targeted improvement strategies<br>• Northern Region cancer services continue to develop tumour stream pathways and protocols through close engagement with the regional cancer networks<br>• Northland and Waitemata DHBs continue to consolidate their collaborative approach to improving access to bariatric surgery for the Northland community<br>• Access to Ophthalmology services for the Counties Manukau population has been addressed through a number of local initiatives<br>• The region's DHBs have implemented a number of clinical prioritisation tools, as they have been agreed by clinical services, in the following areas :<br>  • Ophthalmology<br>  • Cataract surgery<br>  • Orthopaedics<br>  • General surgery<br>  • Plastics<br><br>Information Systems:<br><br>• Progress continues, albeit delayed, on the e-Referrals Phase Two (2.3/2.4 – Intra and Inter Hospital referrals) programme. The implementation team continues to :<br>  ○ Work towards system go-live. This has been delayed due to interdependencies with development of an Eclaire service pack and its contribution to a regional eOrders function<br>  ○ Schedule a benefits realisation evaluation 6 months following go-live with an estimated due date under negotiation<br><br>The Northern Region maintains its engagement with the progression of the national patient flow concepts | targets. Auckland and Northland DHBs particularly have worked to address the causes of previous breaches with some ongoing challenges, particularly in the areas of ENT and Orthopaedics<br><br>• Regional ESPI compliance depends on *all* four of the region's DHBs successfully meeting the ESPI targets. Despite heavy DHB investment in managing electives service scheduling and delivery processes a small percentage of cases cause intermittent breaches for individual DHBs. The collective sum of intermittent individual DHB breaches results in the region routinely being in breach |

**Enablers**

| Work Stream status | Achievements | Challenges |
|---|---|---|
| **Workforce** | CMH was the principle sponsor for Te Kahu Korako: Maori Health Leadership Summit hosted by Te Rau Matatini, over three days in May. The event focus included: growing and sustaining Maaori Health Leadership, Rangatahi Leadership and Practice Development Addictions Sector. Around 1000 Maaori leaders attended the event.<br><br>Over the past year the region's DHBs have all increased opportunities for their support workforces to gain Level 2 and 3 national certificate qualifications. Substantial numbers of orderlies, cleaners, dental assistants, therapy assistants and health care assistants have completed or are currently undertaking these qualifications.<br><br>Increased support for the lower paid workforces has also been evident through step up literacy and numeracy courses, scholarships, 'earn & learn' initiatives, free gyms memberships and improving access to a range of subsidized services through normal DHB 'work perks' initiatives. | Securing budget for trainee positions – AP technicians, management trainees and CBAs remains a significant challenge for all DHBs. |
| **Information Systems** | Please refer to<br>• Appendix C for the Northern Region Q4 IS/IT report<br>• Appendix D for the updated IS/IT implementation plan 'Northern Region Priority Programmes/Projects FY2016/2017 – Key Deliverables' as required for the Northern Region Health Plan 2016-17. | |
| **Capital and Assets** | Northern Region work during Q4 included:<br>• Progression of regional investment management improvement initiatives in response to areas identified during the 2016 Investor Confidence Rating assessment<br>• Work continued on Phases 2 and 3 of the Northern Region Long Term Investment Plan<br>• Meeting the Treasury and Ministry's investment and capital planning requirements as outlined in the IMAP framework and associated guidance<br>• DHB engagement with the Treasury and Ministry on the ongoing ICR implications<br>• Continued regional oversight of the DHBs capital development plans by the Regional Capital Group.<br><br>Business Cases and other documents reviewed by the Group during this quarter include:<br><br>**NDHB**<br>• NDHB Strategic Assessment Business Case for Transforming Health Services in Northland: Whangarei Hospital Service and Campus | • Development of the region's capital investment programme as part of the Northern Region Long Term Investment Plan (NRLTIP) has required significant resource and commitment from all four DHBs during Q4. Approvals for significant investment programmes to address emerging DHB capacity challenges have been delayed during development of this Plan.<br>• Managing the complexity of the region's IS/IT Capital programme continues to be focus. A refreshed regional implementation and monitoring process has been implemented and an investment programme for 2017/18 negotiated between healthAlliance and the DHBs. The region's Information Services' Strategic Plan (ISSP), which is linked closely with the NRLTIP, will continue to inform the future IS investment pathway. |

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|---|---|---|
| | Redesign<br><br>**WDHB**<br>• National Child Health Information Platform (NCHIP) business case (on behalf of WDHB / ADHB / NDHB)<br>• Surgical Pathology Level One Office Conversion business case<br>• Elective Capacity Inpatient Bed project business case<br>**ADHB**<br>• Facilities Remediation Strategic Assessment<br>• Defibrillator fleet replacement<br>• Mobile Image Intensifier replacement<br><br>**CMDHB**<br>• Scott Building Re-cladding<br><br>**hA**<br>no cases<br><br>**NRA**<br>• Northern Region Long Term Investment Plan (NRLTIP) updates, including:<br>  ○ Interim governance approach for cases presented during development of the NRLTIP<br>  ○ NRLTIP shaping future options for investment<br>  ○ NRLTIP Investment Assessment and Prioritisation Framework<br>  ○ NRLTIP Financial / Investment model | |

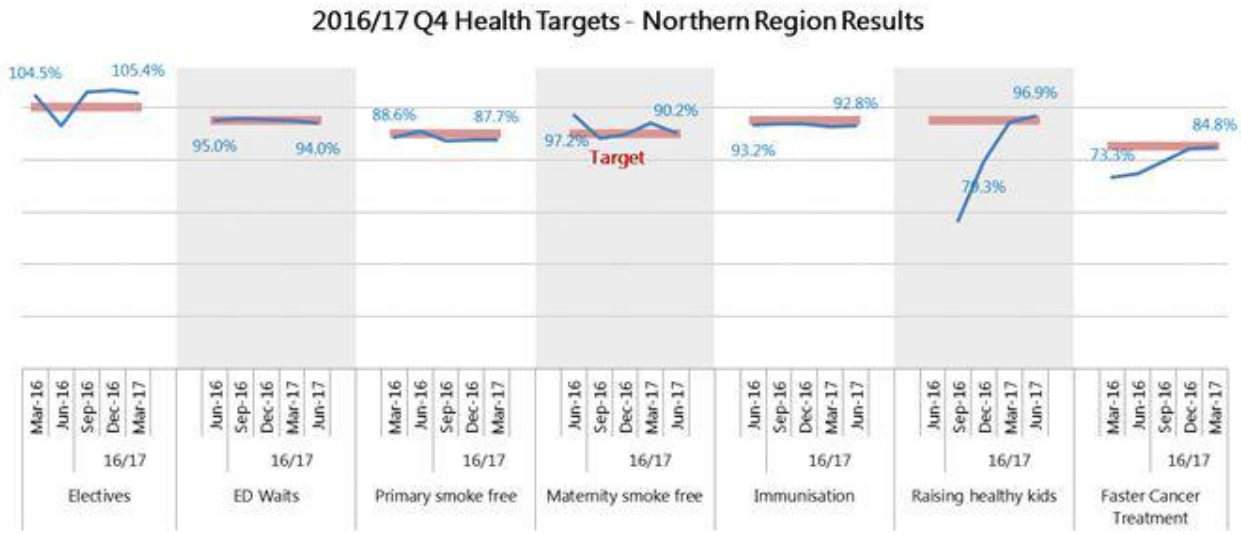
## 4. Risk Management

The key NRHP risks are summarised below.

| Risk ID | Description | Business Unit | Inherent Classific-ation<br>Baseline risk | Residual Classific-ation<br>Risk left after controls in place | Controls |
|---|---|---|---|---|---|
| 1. | **Information systems**<br>*Critical to support many of the proposed changes in models of care* | hA IS | High | Medium | hA has processes in place to:<br>• mitigate operational risks<br>• agree regional requirements and priorities and respective hA and DHB responsibilities |
| | **Actions:** No action required. Controls under healthAlliance management and Regional Governance structure. NRHP to be kept informed. | | | | |
| 2. | **DHB commitment**<br>*DHB leadership must commit and participate in monitoring and decision making processes.* | DHBs Executive Management | medium | Low | Senior clinical and executive Management are strongly supportive of the plan.<br>Budgets approved. |
| | **Actions**: No action required | | | | |

## Appendix A: National Health Targets

Following are the national target results available for Q4:



## Appendix B: Workforce and Training Hub Report

**Year:** 2016/2017
**Quarter:** Q4
**Report compiled by:** Cecilia Lynch and Jenny Wong

**Detailed progress against initiatives**

| Item | Process/ Action | 2016/17 Quarter completed by | Quarter Status Update |
|---|---|---|---|
| | **Strengthen clinical leadership and management capability throughout the workforce** | | |
| 1 | Harness our regional resources to raise the visibility and value of leadership in health and build the capability of our leaders and the wider management workforce.<br><br>- Participate in and align our leadership development activities with the national leadership development programme.<br><br>- Strengthen cultural competency across all our senior leaders.<br><br>- Continue the development and implementation of a regional Health Management Development Pathway | Q1 – Q4 | The strategy for the regional integration of the SSC Framework is underway. Additional activities to note include:<br>• CMH is represented on the SSC Development Framework Working Group and have a completed a Tiers 1 and 2 Talent mapping exercise. They are now in the process of developing an implementation plan to roll out the Leadership Success Profile.<br>• The NDHB 2017 Leadership Pathway Programme continues. The DHB is considering whether to offer the Programme again in 2018.<br><br>In addition to achievements in Q1 -3:<br>• NDHB continues to offer the 'Engaging with Maori' course and 56% of staff have now completed the course (a 12 % increase from Q3). The target is for 100% staff completion by August 2018.<br>• CMH also continues to offer the 'Engaging with Maori' course and up to 370 employees have completed the course since February 2017. The Executive Leadership Team is scheduled to complete this course in September 2017 and will be asked to champion this course to other senior leaders.<br><br>Graduate Management Development (GMD) Programme (Pilot):<br>• There are seven trainees across the metro-Auckland DHBs; four in their second year and three in their first year<br>• Performance development processes have been reviewed and improved so that trainee projects/ pieces of work and performance capabilities sit together to enhance and measure success<br>• Identifying permanent employment opportunities for second year trainees is a focus; they will finish the two year programme in eight months (March 2018)<br>• A formal evaluation process will commence shortly and continue until completion of the pilot<br>Regional Management Development:<br>• The organisational development teams from the metro-Auckland DHBs are now meeting quarterly to share progress and identify collaboration opportunities<br>• Principles for collaboration have been drafted<br>• Teams agree that a new or relatively new initiative |

| | | | |
|---|---|---|---|
| | | | will make a better test case for collaboration rather than something that is very well established in one or more DHBs e.g. Foundations of Management |

| | **Grow the capacity and capability of our Maori and Pacific Workforce** | | |
|---|---|---|---|
| 2 | We will increase the size of our Maori and Pacific workforces to reflect the communities we serve by 2025.<br><br>To achieve this we will:<br>Agree differential targets for our clinical and non-clinical workforces and develop related strategies to achieve these. | Q1 | The ADHB/WDHB Maori Alliance Leadership Team (MALT) is reporting regularly to the CEOs on the progress towards the targets. Additional activities in this space include:<br>• Leaders from Maori Health, Organisational Development and Recruitment are developing a collaborative approach to implement the Maori Workforce Plan 2017/18.<br>• ADHB has shared its approach, learning and findings from 2016/17 with WDHB. Going forward, the two DHBs will be discuss and agree on the structure of the collaborative group including membership, objectives, expectations and reporting in a Terms of Reference document.<br>NDHB and CMH continue activities to set differential targets for the different occupational groups in a staged approach. Of note:<br>• NDHB has set a target for nursing – at least 30% Maori nurses per new graduate nurse intake.<br>• CMH has set specific targets for the nursing, junior doctors, midwifery, dietitians', occupational therapists and physiotherapists. |
| | Increase the profile of our Maori and Pacific workforce and develop a more robust and consistent narrative about the importance of developing and recruiting the future Maori and Pacific health workforce. | Q1 | ADHB has developed a presentation on importance of diversity in the workforce (particularly Maori and Pacific) in relation to patient population and health outcomes and illustrated activities to increase workforce participation.<br>NDHB – via the Nga Manukura o Apopo programme and in partnership with the National Maori Hauora Coalition, the 'Karangahia Te Ata' video has been developed to call for more Māori new graduate nurses to work in primary health care. The video is designed to promote career opportunities within primary health care for Māori nurses, and the importance of this workforce to improve health outcomes for Maori. |
| | Improve our data quality and intelligence by:<br>- Standardising our ethnicity data to align with the Ministry of Health and Census ethnicity data protocols/ guidelines;<br>- Improving the completeness of our ethnicity data; and<br>- Generating intelligence to understand who our Maori and Pacific applicants are and their success rates for employment within the DHBs at the department/ professional group level (including retention rates and length of service); and to inform our efforts to support population health need and human resources strategy. | Q2 - Q4 | In addition to achievements in Q 1-3, the DHBs are continuing to:<br>• Amend their local systems to collect and record ethnicity data as per MoH ethnicity data protocol requirements.<br>• Improve ethnicity data completeness for their employees. The ethnicity data completeness rate for the metro DHBs is over 93% and for Northland improved to 86%.<br>ADHB/WDHB has initiated a data remedial programme' to audit, improve process and outputs for more accurate ethnicity data recording and reporting. WDHB expects a 30% increase on the Maori workforce data for the last quarter as a result of remedial programme – a high proportion of those were nursing staff.<br>To achieve regional ethnicity reporting consistency, CMH has liaised with the Taleo Administrator to generate a similar ethnicity workforce report format as to ADHB/WDHB.<br>The DHBs are continuing a staged approach in setting hiring KPIs for the different occupational groups. Of note, ADHB Nursing Workforce Directorates have set targets for Maori and Pacific nurses. In the last round |

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| | Focus on increasing the numbers Maori and Pacific in our workforce by:<br>- Setting KPIs for hiring managers around the recruitment of new graduates.<br>- Working with our hiring managers and recruitment managers to align recruitment criteria to ensure the unique strengths of the Maori and pacific workforce bring to health care delivery are valued and recognised.<br>- Providing proactive support to all Maori and Pacific applicants for employment.<br>- Commission and implementing initiatives to reduce unconscious and conscious bias in recruitment systems.<br><br>Increase mentoring and support to future workforce candidates to assist completion of their study and prepare them for employment in health workforce.<br>- Undertake a regional Diversity Hui with tertiary partners focusing on allied health professions. Identify key transition points up to graduation and on to employment and implement targeted strategies to support students into employment. | Q1 - Q4<br><br>Q2 -Q4 | of NETP, ADHB and WDHB each had 26 Maori nursing applicants and recruitment will be finalised in July.<br><br>Recruitment leaders are included in the ADHB/WDHB MALT to ensure there are transparency in discussions and decisions relating to recruitment strategies and processes for the Maori and Pacific workforce.<br><br>CMH has offered 'value-based recruitment sessions' to their recruitment managers – up to 220 managers have attended over the last 12 months.<br>The Northland Maori nursing and midwifery group facilitated an evening session with unit 6 nursing students focusing on interview techniques. This was well attended (12 Maori students), with scenario based discussions and interview tips provided.<br>NDHB also reported a positive impact on their recent NETP recruitment where up to 58% of the nursing intake was Maori – this is the highest record since the inception of the programme.<br><br>WDHB Allied Health continues to work with W&AT (Working & Achieving Together) Programme to support Maori and Pacific student with soft skills required for the recruitment process i.e. CV writing, skills identification, discussing the skill set at the interview.<br><br>The Auckland metro DHBs will be entering a Youth Employment Partnership Pledge with Auckland Council. The Pledge is a key initiative in Auckland Council to address the increasing rates of unemployed youth within the Auckland region. The Pledge will be signed on 26 July 2017 at the Youth Employment Summit – with a 'futuristic' theme.<br><br>Also, a number of events and activities have taken place via Kia Ora Haurora including:<br><br>Rangatahi Health Symposium, 19-21 April. Forty-five students from Y11 to Y13 across the northern region DHBs attended. The event was designed to support NCEA achievement, tertiary preparedness and retaining Maori in health pathways. Also, promoting Northland as a great place to live and work.<br>Regional Reference Group – quarterly hui, 25th May. Attendance from tertiary providers-AUT and Otago, Iwi provider-Ngati Whatua ki Orakei, DHBs-CMDHB, Waitemata & Auckland. The meeting allowed sharing of information-new Maori grads, update on Programme information and entry requirements, engagement Programmes for KOH secondary students<br>NorthCATE Expo, 15 June. Provider expo for all Northland Secondary School Careers advisors/gateway coordinators to connect with providers/organisations and tertiary institutions who offer programmes to schools and students. New contacts established and maintenance of current school leads<br>KOH National Operations Hui 30th June. Regional Coordinators with NCC leading this hui. Agenda to include-Transition to work and transition to tertiary data for the regions, KOH Database – track and trace/ cleansing/effective tools, Website development, Business case for future KOH funding<br>Tertiary Support Grant Four Maori Student bodies supported with $2K grant. Intention is to support Maori retention rates at tertiary level. This includes Manukau Institute of Technology-Maori Nurses, Midwifery. |

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| | | | Auckland University of Technology-Te Ao Marama, Maori Nurses. North Tec-Maori Nurse<br><br>Carrier roadshow – Far North Promote the KOH Programme & attain registrations in Far North secondary schools. Engagement with and registrations attained from – Kaitaia College, Abundant Life, Broadwood AS, TKKMO Pukemiro, Kerikeri High, Whangaroa, Okaihau Coll, Opononi AS, Northland Coll, TKKMO Kaikohe, Bay of Islands Coll, TKKMO Taumarere. 43 new KOH registrations attained. 3 new schools engaged in the KOH programme<br>**Intern-KOH Admin** Contract for tertiary student to support and deliver KOH admin and social media plan. Intern position to be completed Dec 17<br>**E-Putaiao,** KOH Online tutorial for NCEA level 2 & 3 Maths and Science. Thirteen Maori students registered to "See the Solutions" |
| | Widen the pipeline to grow our workforce by partnering with the Ministry of Social Development to advance specific and target innovations to increase Maori and Pacific applicants for employment. | Q1 – Q4 | Under the Equity campaign WFD systems project LEAP (Local Entry Access Programme) has Pacific Health Development & MSD amongst its collaborative. The project is tracking well and proving an effective mechanism to connect and recruit from local community into entry level jobs. Weekly sessions are held at the Mangere library to promote employment opportunities. As of 2017, CMH has presented 10 roles to these events and MSD, with two successfully gaining employment. Work will continue with MSD to propose they consider funding options to confirm LEAP a community to career pathway. |
| | Review and strengthen our human resources strategy to support intentional and targeted approaches to achieve more equitable employment outcomes for Maori and Pacific | Q2 | In addition to Q2, WDHB have drafted a People and Capability strategy which has four goals. One of the goals is for the workplace to support the employees and their contributions, and one of the outcomes for this work is to have a workplace that better reflects our patient population.<br>NDHB local Maori Midwifery network, Te Kahui Wahine are working with Maori Wifery students to support them through the programme as part of their strategy to improve employment outcomes for Maori midwifery students. |
| 3 | Identify and prioritise potential Maori and Pacific for leadership development and accelerated pathway opportunities to targeted senior level leadership roles. | Q1- Q4 | CMH was the principle sponsor for Te Kahu Korako: Maori Health Leadership Summit hosted by Te Rau Matatini, over three days in May. The event focus included: growing and sustaining Maaori Health Leadership, Rangatahi Leadership and Practice Development Addictions Sector. About 1000 Maaori leaders attended the event. |
| | **Increase the flexibility and affordability of the workforce to manage rising demand** | | |
| 4 | Monitor the first cohort's progress through the nursing endoscopy training and identify candidates for the second cohort. | Q1 - Q4 | Two ADHB endoscopy trainees are progressing well. There is discussion with NRA for the ADHB Chief Nursing Officer to join the Endoscopy Governance Group NZ to strengthen the discussion on Nurse Endoscopy. |
| | Establish a regional view in regard to the local development of advanced practice roles, particularly those which increase flexibility to work across hospital and community settings.<br>- Advance the role of allied health in Emergency Care and FSAs such as | Q2 – Q3 | NDHB now has two RN Designated Prescribers (in addition to the previous two diabetes prescribers). Northland has developed a DHB/PHO process for credentialing prescribers, however is now working regionally with the Auckland DHBs to ensure an agreed regional approach to nurse prescribing.<br>WDHB is reviewing and aligning its allied health career |

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| | for orthopaedics, audiology and others. | | structure/pathway, where it makes sense, for Senior Advance Clinician and Advanced Practitioner roles to ADHBs model.<br>CMH is developing a career structure pathway for specialist clinicians, advanced clinicians and advanced practitioner roles. Job descriptions for these roles are under development too. |
| | Support nurses to provide chemotherapy through a hub and spoke model supported by the e-learning delivery of the Australasian chemotherapy standards. | Q1 – Q4 | Discussions are underway between ADHB and WDHB to commence local delivery of Herceptin. WDHB has progressed learning for nurses undertaking monoclonal/ biological infusion.<br>NDHB Blood and Cancer Services has opened a new oncology unit in Kaitaia Hospital. The 'Tatau kit e Waka Oranga' is a hub and spoke model that will provide a more locally based treatment centre of patients in far north. The service educator is supporting the team to complete the ADAC competencies and access to eVIQ resources.<br>CMH nurses have completed all learning modules. |
| | **Build and align the capability of the workforce to deliver new models of care** | | |
| 5 | Identify opportunities to better utilise and support the non-regulated workforce:<br>- Create a common understanding on the assistant role. | Q1 | WDHB has a common understanding that all assistant roles should be performing top of scope and attain NZQA Level 3 qualification offered via Careerforce.<br>CMH has developed a skill mix document outlining the expectations and scope of practice for allied health assistants working in the community. |
| | - Enable career progression opportunities for the assistant workforce using the Careerforce qualification pathways. | Q1 – Q4 | WDHB – 15 Therapy Assistants and Dental Assistants graduated with their Certificate in Health and Wellbeing (Level 3) Health Assistance strand and Dental Assistance strand at a ceremony held in June 2017. This is the second cohort of graduates WDHB has supported through the programme.<br>ADHB plans to utilise the Careerforce pathway for our new Community Health Assistant staff once they have completed the service specification orientation and basic competencies. |
| | Provide opportunities to better support our low paid workforce through:<br>- Targeted access to educated and training pathways to support merit based steps to increase income. | Q1 - Q4 | The DHBs continues to provide training opportunities to their low paid workforces. Of note:<br>WDHB<br>• NZQA Level 3 in cleaning qualification – offered to cleaning staff within six-months into their employment<br>• NZQA Level 3 in Health and Wellbeing (Orderly Services) offered to orderlies within six-months into their employment<br>• NZQA Level 3, Certificate in Health Assistance – is offered to healthcare assistants, up to 25 healthcare assistants per year.<br>• 14 dental assistants recently completed their NZQA diplomas and graduated in June<br>NDHB<br>• The two cohorts (20 per cohort) are continuing the NZQA Level 3 in Health and Wellbeing<br>• Have a scholarship opportunity for a low paid workforce employee to undertake a NZQA qualification.<br>CMH:<br>• Is working toward supporting healthcare assistants (HCAs) to attain the appropriate NZQA qualifications i.e. level 4 for HCAs working within a |

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| | | | hospital setting and level 3 for HCAs working within the communities<br>• Has provided tailored coaching and training for groups of team leaders in Central Sterile Support Division and non-Clinical Services.<br>• Commenced the Step up literacy and numeracy courses in May 2017 with four cohorts. They are on target to deliver the 50 places by September. |
| | - Develop Primary care/ community based positions for PGY 2s in line with the MCNZ requirements for General Registration. | Q1 - Q4 | The Northern region has 11 CBA positions in place providing for 35 CBA attachments per year.<br>A further 10 positions are under consideration with implementation decisions dependent on funding availability. |
| | **Optimise the pipeline and improve the sustainability of priority Workforces** | | |
| 6 | Develop a sustainable sonographer trainee pathway including options for an alternative training and supervision model that safeguards trainee places and ensures a stead trainee supply to meet future demand.<br>Identify vulnerable workforces such as those which are small and highly technical and develop strategies to improve sustainability. | Q2 – Q4<br>Q1 –Q4 | The trainee pathway for the Auckland metro DHBs has been drafted and in principle is endorsed by the Steering Group for the DHBs to adopt into their local training plans when finalised.<br>The regional psychiatry registrar project "*Improving Recruitment of New Zealand Trainees to the Psychiatry Registrar Training Programme - Auckland Metro Region"* is now completed. The focus has now shifted to implementing the recommendations. |

## Appendix C:

# Information Systems Quarterly Report

**Year:** 2016/17
**Quarter:** Q4
**Report compiled by:** Sarah Tibby

**Detailed Project Report**

| Regional Patient Administration System / Northern Electronic Health Record Implementation Planning Study & Business Case Development | |
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| **Summary and achievements** | **Green**<br>**NEHR**<br>• The Regional Governance Group appointed an Independent Advisor to review the NEHR IPS and Business Case work undertaken to date with the aim of identifying an affordable, workable approach that provides utility/benefits and supports the region to move towards an aligned EHR. This advice is being incorporated into the ISSP which will set the future direction for IS in the Northern Region. |
| **Issues and mitigation** | • RGG has appointed an Independent Advisor to assist them to determine the actions that will be taken to progress the completion of work and ensure alignment with the Regional ISSP and national EHR project. |

| Manawa Tahi – Regional ISSP | |
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| **Summary and achievements** | **Overall Status Amber**<br>Programme was directed to develop "Executive Overview of ISSP" for CE / Chair review and endorsement. This has been completed with the RGG approving the contents on the 1st of June. The Programme has subsequently refocused upon updating and finalising the ISSP and ISSP Annex. Dates for these deliverables moved from May to June These documents are now available in draft. They are currently being socialised with the Programme Working Group. Further socialisation activities are planned with Drop In sessions at the DHBs, PHO, hA and NRA. Working with LTIP to align with a view to ultimately creating V2.0 of ISSP.<br><br><u>Business Vision</u><br>**Green.** Work complete.<br><br><u>Technology Vision and Domain Strategies</u><br>**Green**. Working completed. Artefact approved by Programme Working Group.<br><br><u>Portfolio and Financial</u><br>**Green.** Draft portfolio plan has been developed and is being circulated with stakeholders for review and feedback. Financial model in draft. Focus upon FY17/18 with demand details passed to DHB CFOs for consideration.<br><br><u>ISSP Document & Annex</u>**.**<br>**Green.** Draft documents provided to Programme Working Group for review and feedback. Annex includes 10 year portfolio plan. Supporting Financial model has been developed in draft.<br><br><u>Application Portfolio Management (APM)</u><br>**Amber.** Requirements complete, RFP documentation partly complete. Key decision on whether DIA default tool (Planview) can be used for APM and EA tools needs. If so will not need to complete full RFP process. Indicative implementation date October 2017. Specific date dependent upon outcome of |

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| | solution decisioning. |
| **Issues and mitigation** | The need to produce ISSP Executive Summary has driven changes to some dates and deliverables. ISSP, Tech Vision, Portfolio have been refactored to take account of changes. Programme back on track with draft V1.0 of ISSP and Annex (including portfolio plan) being reviewed by PWG.<br><br>LTIP Dependencies. ISSP is dependent upon LTIP to define, validate and refine overarching business imperatives and objectives. V2.0 of ISSP will be produced to ensure that any changes to "Business Vision" driven by LTIP as well as implications around choices on of different investment mixes reflected in ISSP.<br><br>Interdependence with FY17/18 capital planning process. Manawa Tahi has reviewed ICT and CABA plans and provided details of additional ISSP demand (priority FY17/18 work packages). Associated funding discussions and decisions being driven by hA CFO in conjunction with DHB CFOs. |

| **CareConnect** | |
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| **Summary and achievements** | |
| ● | eReferrals<br>**Green.** The Northern Region continues to increase use of the eReferrals solution. Across the metro DHBs over 1,100,000 eReferrals have now been received since go live. 100% of GP practices are eligible to send eReferrals using the regional solution. The top 5 specialties in the region for receipt of eReferrals are: Radiology, Gynaecology, Orthopaedics, ORL and Cardiology. The highest volume of eReferrals received on any day has been 2,116 eReferrals. |
| ⌛ | eReferrals - eTriage (RMS2) Completed<br>**Completed:** There are now 101 services grading online with around 20,400 eReferrals per month being graded online. |
| ⌛ | eReferrals - Web Portal<br>**Completed** Web Portal has gone live in the region. Uptake has been high resulting in an unexpected influx of requests to the MOH for digital certificates. Across the metro DHBs, the number of received web referrals over the reporting period is increasing growing from 5 to around 80 referrals per month. |
| ▲ | eReferrals - Intra and Inter Hospital Referrals<br>**Amber.** Some environmental issues have been identified as part of user acceptance testing. These are currently being resolved and the solution is due to go live in July 2017 with inter/intra outpatient referrals for Metro Auckland DHBs. |
| ● | Clinical Pathways<br>**Green**. Dynamic Pathway Enabler activities completed.<br><br>Static pathway development is continuing with over a 50% of pages localized. Steady increase in usage is occurring amongst clinicians. |
| ▲ | Shared Care Integration<br>**Amber.** NDHB have commenced implementation activities for Shared Care, and have currently uploaded 98% of the population. Metro Auckland DHBs are interested in undertaking a whole population upload if this is successful for NDHB. |

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| ◆ | Patient Portal Integration Strategy<br>**ON HOLD:** Patient Portal strategy activities are on hold as funding not available in 16/17. |
| **Issues and mitigation** | Shared Care Integration<br>Lack of Integration between Whanau Tahi and MedTech continues to reduce system usability and uptake of the product. With the increased use in NDHB expected as a result of the whole population upload the need for integration increases.<br><br>Subject to funding availability in FY17/18 the integration between Whanau Tahi and MedTech will be enhanced. |

| **National Patient Flow** | |
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| **Summary and achievements**<br>●<br>●<br>▲ | Phase 1: **Green**. All DHBs achieved full compliance in Phase 1. Information on prioritisation outcome of referrals by specialty at a national level has been released. The MoH will release an update which will show prioritisation outcome for all FSA referrals received over the 9 month period between July 2015 to March 2016.<br><br>Phase 2**: Green.** The Phase 2 reporting environment closed at the end of July. All NR DHBs were submitting Phase 2 production data prior to it closing. ADHB, CMH and WDHB are not able to submit all mandatory data items, and have implemented the remediation plans agreed with the MOH. All are submitting the data items they can.<br><br>Phase 3**: Amber.**<br><br>NDHB: Ministry of Health awarded NDHB 4 star compliance for NPF phase 3. NDHB is one of only 4 DHBs in NZ with 4 star compliance. RMS Lite (e-Referrals) upgrade project initiated. A change is required for 5 star compliance; to allow coding of the presenting problem using SNOMED. No production extract files have been sent since WebPAS go live. NDHB Management Information Services (MIS) need to complete work to link active referrals from Alpha with activity from WebPAS before a production file can be extracted. Goal is to submit extract file containing WebPAS data by 31st July 2017.Once compliance is achieved for WebPAS data, all production files will be submitted to date.<br><br>WDHB: Radiology data is being submitted to Production, currently resolving HL7 issue. Upgrade to PAS will see the implementation of a rules engine which will address some of the data quality issues. WDHB has achieved 4 Stars.<br><br>CMDHB iPM upgrade is planned for July 2017, this date is at risk with some key tasks still outstanding at the time of writing this report. The iPM upgrade will allow staff to collect additional information to support NPF. There is a risk if this information is not available discharge will be delayed. Staff training is looking to minimize the risk.<br><br>ADHB: Production data is being submitted and 2-Star compliance has been confirmed. Focus is now on resolving data errors to enable achievement of 3-star compliance |
| **Issues and mitigation** | Phase 2-3 data errors are subject to ongoing review and resolution for ADHB, CMH, WDHB and NDHB.<br><br>ADHB, CMH and WDHB are not able to submit all Phase 3 mandatory data items. Phase 2 remediation plans have been implemented if they were agreed and may need to be extended to Phase 3. |

| **ePrescribing and Administration (ePA)** | |
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| **Summary and achievements**<br>● | WDHB: The ePA Stage 2 rollout is complete. Versions 8.3.2 is being tested but there are performance issues which the Vendor is working on.<br><br>ADHB: Implementation into in the remaining two Older People's Health wards is now complete and planning has commenced for an all of hospital rollout. Capital funding has not been prioritized for this project in 17/18. However |

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| | incremental ward rollouts will continue during 17/18 if funding becomes available.<br><br>CMH: eMedications: ePharmacy progressing well to go live in Q2 FY17/18. ePA has been slow to progress contracting phase with DXC and hA, looking at implementation to initial wards Q3/Q4 FY17/18. |
| **Issues and mitigation** | DXC do not offer multi-tenanted or a fully integrated eMedicines solution, therefore DHBs are required to implement separated instances of both Medchart and ePharmacy to gain the benefits of electronic prescribing and drug administration. Nationally it would be good to work through with DXC their product and integration roadmap if the solution is to be considered longer term |

| **eOrders for Laboratory & Radiology** | |
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| **Summary and achievements** | **Green**. Radiology eOrders ADHB/ WDHB implementation is now complete. The CMH project is underway with the first implementation schedule for May 2017.<br><br>Laboratory eOrders:<br><br>CMH has already implemented a local solution and is working with Sysmex and hA to finalise implementation activities to upgrade to the regional solution. Priority has been given to the relocation of laboratory services, implementation of robotics and amalgamation of their Delphic laboratory system configuration to be nationally consistent.<br><br>WDHB - Older Adults live since 9th May, refined solution rolled out to Cardiology on 20th June & on-track for DHB-wide inpatient phlebotomy collection as of 11th July.<br><br>ADHB Capital funding has not been prioritized for this project in 17/18. However business case approval and implementation will commence in 17/18 if funding becomes available.<br><br>NDHB's plan for eOrders is under review and a revised timeline for business case development is yet to be agreed. |
| **Issues and mitigation** | ROERS and LOERS users experience issues with result escalation due to issues with identifying the responsible clinician. This is a difficult issue to resolve in a non-integrated systems environment<br><br>Sysmex NZ workload exceeding capacity impacting initiatives across the Northern Region |

| **Radiology/PACS** | |
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| **Summary and achievements** | **Green.** The Regional Radiology PACS Upgrade Programme has delivered a Metro PACS solution. All 3 Metro DHBs are using a single, highly available PACS system, located across the regional data centres with a single enterprise radiology image viewer. The creation of a single regional radiology image archive is in progress.<br><br>The Business Continuity System went live as planned on 6th April, 2017. The issues were resolved with the Agfa Xero Enterprise and it continues to meet user expectations.<br><br>The project remains open, and will be closed when IMPAX 6.6 performance can be tested with the Network Attached Storage; as this is the creation of the single regional image archive. |
| **Issues and mitigation** | |

| **National Maternity Clinical Information System** | |
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| **Summary and achievements** | **Amber.** CM Health is expressing its concerns formally to Jill Lane, DDG about the lack of a clearly defined roadmap, ongoing funding for development, and reasonable timeframes for improvement. While still supportive of an electronic clinical information system there is too much variability in the way that information can be accessed from MCIS due to its complex design. CM Health is looking to minimise clinical risk by reducing variability in the way clinicians |

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| | use MCIS through greater standardisation of workflow/processes and targeted training/coaching. Recent 'laboratory environments' to test the addition of additional paper (hybrid) to the process have uncovered additional patient safety risks due to fragmented information. A full evaluation of the testing is being completed. |
| **Issues and mitigation** | Spend to date exceeds budget, and CM Health are required to continue to fund additional resources (both CAPEX and Operational costs) until the system becomes fit for purpose in the inpatient setting. CM Health advised the DDG of ongoing concerns about the lack of a fit for purpose system. |

**Appendix D:**

## Regional Information Systems Updated Implementation Plan

## Regional Information Systems Implementation Plan (updated Q4 2016-17)

## Northern Region Priority Programmes/Projects FY2016/2017 – Key Deliverables

| Projects | Deliverables 2016/17 | | | | | | | | Deliverable 2017-2018 | Deliverable 2018-2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Q1 July – Sep | | Q2 Oct - Dec | | Q3 Jan – Mar | | Q4 April - June | | | |
| **CareConnect Programme** | | | | | | | | | | |
| **eReferrals Phase Two (2.3/2.4) (Intra and Inter Hospital eReferrals)**<br>**Implementation** | | | Development complete and system testing commenced | G | System integration testing and completed | G | System go-live delayed until mid July | A | Regional implementation ongoing - 50% completed by December 2017 for intra-DHB and inter-DHB eReferrals<br>Regional implementation completed for intra-DHB and inter-DHB eReferrals completed June 2018 | |
| | | | NDHB: Gap analysis completed | G | NDHB: Preferred option selected | A | NDHB: Planning complete | A | NDHB: Solution in place for Intra and Inter hospital eReferrals | |
| **Patient Portal Strategy (on hold as funding not available in 16/17)** | | | | | Patient Portal strategy commenced | R | Patient Portal strategy and approach confirmed | R | | |
| **Shared Care Development & Integration** | CareConnect Technical integration commenced | G | | | CareConnect Technical integration completed, subject to funding availability | A | On hold due to funding constraints | A | | |
| **Clinical Pathways Implementation** | | | Exit activities aligned to contract completed | G | | | | | | |

| Projects | Deliverables 2016/17 | | | | | | | | Deliverable 2017-2018 | Deliverable 2018-2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Q1 July - Sep | | Q2 Oct - Dec | | Q3 Jan – Mar | | Q4 April - June | | | |
| **eMedicines Programme** | | | | | | | | | | |
| **Hospital ePharmacy** | | | | | CMH: Development completed system testing commenced | G | | | WDHB: regional implementation completed<br>CMH: regional implementation completed | |
| **ePrescribing and Admin'n (ePA)** | | | WDHB: ePA implementation completed | G | | | | | | |
| | ADHB: ePA Phase 1 Implementation completed | G | | | ADHB: Further roll out to 2 wards commenced | G | ADHB: Further roll out to 2 wards completed and incremental rollouts completed as funding becomes available | G | ADHB: business case for ongoing rollout approved and all of hospital rollout commenced (subject to prioritisation and capital funding availability) | ADHB: all of hospital rollout completed (subject to prioritisation and capital funding availability) |
| | | | | | | | CMH: Development completed system testing commenced | G | CMH: ePA Early Adopter implementation commenced | |
| | | | | | | | NDHB: Business case for ePA Implementation initiated | G | NDHB: ePA Implementation commenced | NDHB: ePA Implementation ongoing |

| Projects | Deliverables 2016/17 | | | | | | | | Deliverable 2017-2018 | Deliverable 2018-2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Q1 July - Sep | | Q2 Oct - Dec | | Q3 Jan – Mar | | Q4 April - June | | | |
| **NZ Formulary (NZF)** | | | | | | | | | WDHB: implementation of ePharmacy and Reference viewer upgrade completed<br>CMH: implementation of ePharmacy and Reference viewer upgrade completed | |

| Projects | Deliverables 2016/17 | | | | | | | | Deliverable 2017-2018 | Deliverable 2018-2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Q1 July – Sep | | Q2 Oct - Dec | | Q3 Jan - Mar | | Q4 April - June | | | |
| **National Solutions** | | | | | | | | | | |
| **National Patient Flow** | Phase 3 functionality delivered | G | Remediation of Phase 3 data errors and initial compliance for submission of production data | G | Progressive increase in compliance levels for all DHBs and continued data error remediation | G | Progressive increase in compliance levels for all DHBs and continued data error remediation | G | Progressive increase in compliance levels for all DHB and continued data error remediation | |
| **National Maternity** | | | | | CMH: Hybrid model implementation.<br>Further DHB implementation on hold until National direction confirmed | A | | | | |

| Projects | Deliverables 2016/17 | | | | | | | | Deliverable 2017-2018 | Deliverable 2018-2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Q1 July - Sep | | Q2 Oct - Dec | | Q3 Jan – Mar | | Q4 April - June | | | |
| **Patient Management and Clinical Workstation** | | | | | | | | | | |
| **Clinical Workstation Upgrade** | CMH/WDHB: Clinical Workstation upgrade Commenced | G | | | | | | | CMH/WDHB: Clinical Workstation upgrade Completed | |
| | | | | | | | | A | NDHB: Clinical Workstation business case approval | NDHB: Clinical Workstation Upgrade completed |
| | | | | | | | ADHB: Clinical workstation upgrade initiation to commence | G | ADHB: Clinical Workstation Business Case approval | ADHB: Clinical Workstation Upgrade completed |
| **Patient Management System Upgrade** | CMH/WDHB: Patient Management System upgrade commenced | G | | | | | | | CMH/WDHB: Patient Management System upgrade completed | |
| | | | | | | | ADHB: Decision on PAS replacement pending outcome of Deloitte IT Risk Assessment and Regional ISSP | G | Requirements definition and business case development for PAS Replacement | Implementation of PAS replacement (subject to prioritisation and capital funding availability) |
| | | | | | NDHB: WebPAS implementation completed | G | | | | |

| Projects | Deliverables 2016/17 | | | | | | | | Deliverable 2017-2018 | Deliverable 2018-2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Q1 July – Sep | | Q2 Oct - Dec | | Q3 Jan – Mar | | Q4 April - June | | | |
| **eOrders Programme** | | | | | | | | | | |
| **Laboratory eOrders** | WDHB: Laboratory eOrders implementation commenced | G | | | | G | WDHB: Laboratory eOrders implementation completed | G | | |
| | | | | | CMDHB upgrade: Project commencement | G | | G | CMDHB: Laboratory eOrders upgrade completed | |
| | | | | | | | | | ADHB: Business Case Commenced (subject to capital funding availability) | ADHB: Implementation |
| **Radiology eOrders** | WDHB: Radiology eOrders implementation completed | G | | | | | | | | |
| | CMDHB: Radiology eOrders implementation commenced | G | CMDHB: development completed | G | CMDHB Radiology eOrders pilot | A | CMDHB: Rollout underway | A | CMDHB: Radiology eOrders implementation completed | |
| | | | | | | | | | NDHB: Radiology eOrders implementation commenced | |
| **Clinical Documentation** | | | | | | | | | | |
| **Nursing Notes** | WDHB: eVitals implementation commenced | G | | | CMDHB: eVitals implementation commenced<br>WDHB:eVitals implementation completed | G | | | CMDHB: eVitals implementation completed | |

**Appendix E:**

**Regional Key Performance Indicators Summary**

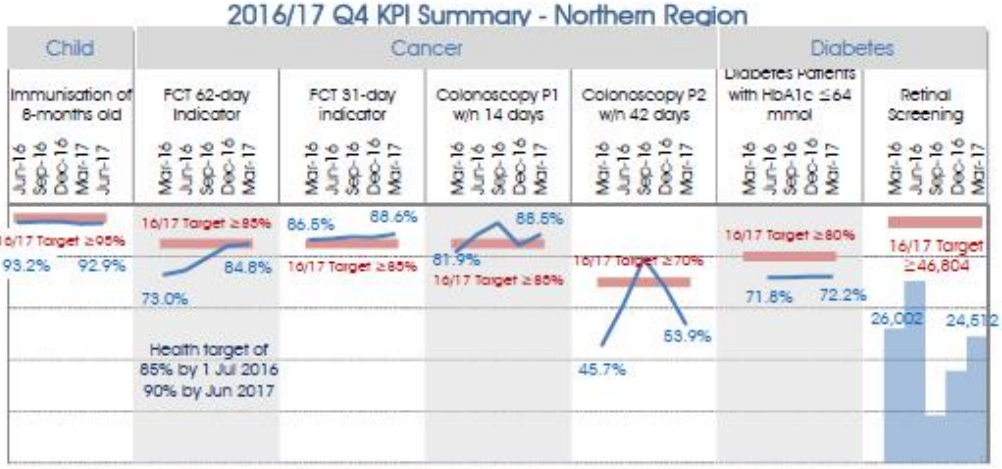
## 2016/17 Q4 KPI Summary - Northern Region

Achieved
- On Target or better

Substantially Achieved
- 0.01-9% away from target

Partly Achieved
- 9-20% away from target

Not Achieved
- >20% away from target




| Target | Substantially Achieved | Substantially Achieved | Achieved | Achieved | Not Achieved | Partly Achieved | Not Achieved YTD (Region) |
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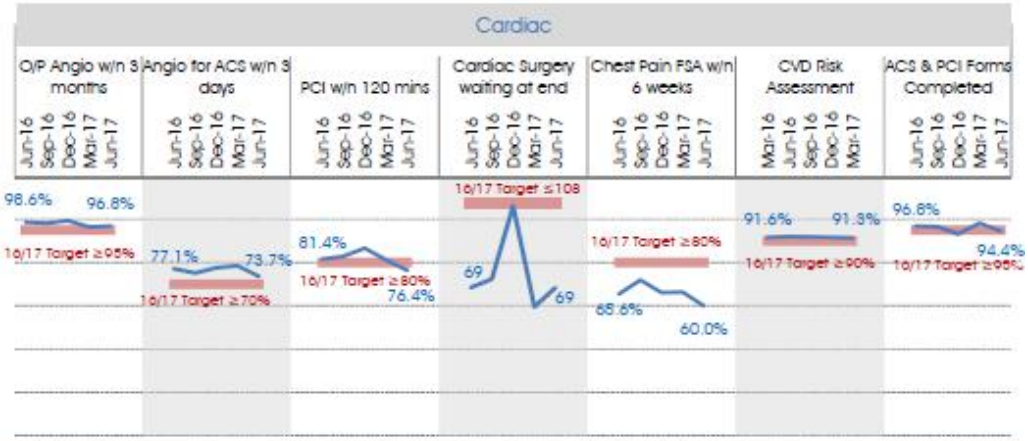


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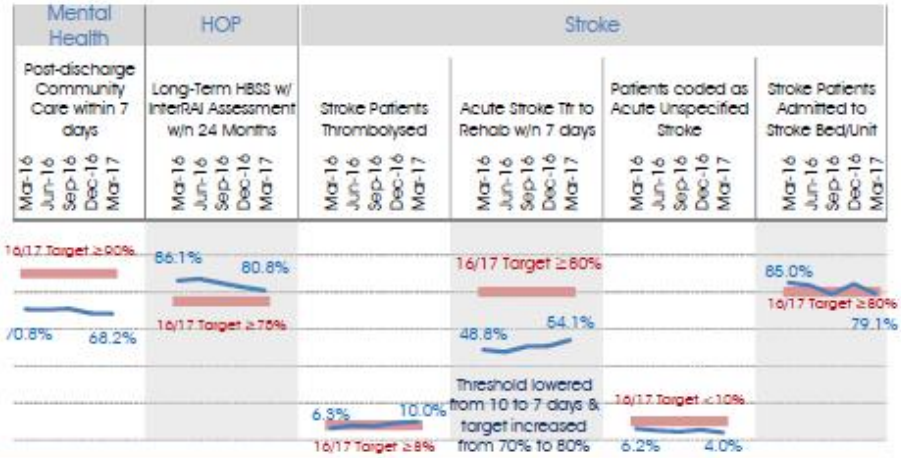


| Target | Not Achieved | Achieved | Achieved | Not Achieved | Achieved | Substantially Achieved |
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## 4.0 INFORMATION PAPERS

4.1 Public and Population Health Services Update

**NORTHLAND DISTRICT HEALTH BOARD**
**BRIEFING PAPER TO CPHAC/DISAC**

**SUBJECT:** Public & Population Health Services (Northland PHU)

**UPDATE AND KEY POINTS:**

## 1. Public and Population Health Services contracts/planning

### *1.1. Northland PHU Strategic Plan*

Performance measures and indicators (based on Results-Based Accountability) are being identified for the Northland PHU's strategic plan to monitor progress and performance of the PHU against the goals identified in the strategic plan.

### *1.2. Health in All Policies (HiAP)*

Northland PHU is considering looking at initiating/implementing 'Health in All Policies' (HiAP) as a follow-up of a workshop attended by the Medical Officer of Health in Dunedin recently.

### *1.3. Northland Sexual Health Strategic Plan*

Northland PHU is involved in providing input for Northland DHB's sexual health strategic planning especially in regards a collaborative health promotion plan for Northland.

### *1.4. Kainga Ora o Otangarei*

Northland PHU is part of the Healthy Lifestyles work group under the lead of the General Manager that is part of a place based initiative in Otangarei. The objective of the work stream is '*people participating in healthy and active lifestyles, providing facilities, activities and services aimed to empower tamariki and their whanau to live healthy, happy lives'.* Planning is underway to reinstate a basketball court along with discussions around a fitness circuit for the community.

## 2. Building healthy public policy/submissions *(June 2017 – August 2017)*

### 2.1. Energy Labelling of Alcoholic Beverages - Targeted Consultation

We did not support the implementation of energy labelling or the inclusion of Nutrition Information Panels on any alcoholic beverages. This initiative could unintentionally increase inequality in terms of obesity. The population most vulnerable to alcohol-related harm may not pay any attention to the labels while already health conscious individuals make a more informed choice.

### 2.2. Government's Inquiry into Havelock North Drinking Water – Stage 2 Issues

Supported a multiple barrier approach, with residual disinfection such as chlorination for all water sources as the appropriate treatment for drinking water. Highlighted the challenges of maintaining effective relationships with the Regional Council, District Councils, and DWAs in the provision of safe drinking water. Supported the retention of DWAs within the DHB structures.

### 2.3. Far North District Council's Proposed Trade Waste Bylaw 2017

The PHU broadly supported the proposed Trade Waste Bylaw. However, we recommended that the Council could strengthen the bylaw by including a separate section on 'Access', similar to the proposed 'Waste Water Drainage Bylaw 2017', so that it has better ability to monitor and test any non-complying trade waste discharges into the wastewater treatment system within the district before these systems are adversely affected.

### 2.4. Far North District Council's proposed Reserve Management Plan For Kerikeri Domain

PHU submission recommended that council should maintain the current loop track around the Domain ensuring that it is accessible to the young, the elderly, and people with disabilities. Council can increase the utilisation of the loop track by ensuring safe access and providing a walkable link to community facilities such as the Turner Centre, and town centre. Council should consider adequate access to toilet facilities in planning all outdoor active spaces in the future. Council should upgrade the existing public water fountain and install further public water

fountains along the loop track to promote the "Water is the Best Drink" message. The Domain should be an alcohol free area, including during events. We also recommend the Domain be kept as a Smoke Free environment. Council should develop and adopt a broader Far North District plan for its parks and domains similar to the Blue Green Network Strategy for Whangarei City.

**2.5. Whangarei District Council's Proposed Camping In Public Places Bylaw 2017**
Supported the proposed Camping In Public Places Bylaw 2017. The submission suggested that the Council should strengthen the bylaw by using consistent terminology for "freedom camp". PHU supported the proposed list of prohibited and restricted areas for freedom camping across Whangarei District. Appendix should enlist all rubbish disposal transfer stations across the district to reduce illegal dumping of rubbish by freedom campers.

**2.6. Feedback to develop Whangarei District Council's (WDC) Draft Long Term Plan (LTP) 2018 – 2028**
Supported the proposed activities in the LTP with key suggestions around transportation, drinking water and to have dedicated funding attached to the Blue Green Strategy so that it can be implemented effectively.

**2.7. GBC Winstone Quarry submission to Whangarei District Council**
Northland PHU made a submission opposing the grant of a consent for an application by GBC Winstone Quarry for a Resource Consent regarding the extension of Otaika quarry. The proposal requires consent as a Discretionary Activity. The opposition is based on potential adverse health and amenity effects due to the proposal's close proximity (adjacent) to residential area(s), and the adequacy of any proposed conditions of consent in the event that consent is to be granted. The PHU has been offered the opportunity of a pre-meeting (before the hearing) with the applicants and Council representatives to discuss the PHUs submission. Expert advice has been requested from the Ministry of Health (dust and noise experts).

## 3. Communicable diseases

With the changes in the Health (Infectious and Notifiable Diseases) Regulations 1966 in January (regarding Infectious diseases and graduated powers of MOH, in managing high risk public health cases), there is a change in the role of the Medical Officer of Health and Health Protection Officers that would bring in a few changes in the PHU's functions related to Infectious and notifiable diseases.

Mumps notifications continue (linkage within some families, in general unimmunised families). There is an increase in mumps notifications throughout NZ. An alert was sent out to Medical Practitioners on 3 August and schools were also advised.

*Meningococcal Disease* - Two cases of meningococcal infection were notified at the end of June (from the same family – a rare occurrence). Public Health contact tracing has been undertaken as per protocols. There have been a few media queries regarding the same (in July).

## 4. Rheumatic Fever

One case of acute Rheumatic Fever was notified (aged 7 years) in June, this brings the total to 5 cases notified this calendar year. Root cause analysis was undertaken to identify contributing factors. PHU was visited by a Ministry of Health senior adviser to discuss Rheumatic Fever – we were advised that the NDHB were the only DHB to meet the target.

## 5. Health Protection and Health Promotion activities (key highlights)

***5.1. Prevention of alcohol-related harm – regulatory work***
Two Controlled Purchase Operations (CPOs)[1] were undertaken during June at off licenced premises. In the Far North, 11 premises were tested across Russell and Paihia that resulted in

[1]Controlled Purchase Operations (CPO's) are planned operations designed to monitor and enforce the provisions relating to the sale of liquor to minors in the Sale and Supply of Alcohol Act 2012 (SSAA). They involve supervised volunteers aged under 18 years attempting to buy alcohol from licensed premises. If a volunteer's purchase proves successful, the premise's operator, manager or licensee is liable to prosecution or other sanction via the Alcohol Regulatory and Licensing Authority (ARLA) or the District Court. CPO's are also used as an educative tool for licensees, their staff and the wider community.

four sales. In Whangarei, 23 premises were tested across Maunu, CBD, Regent, Kamo, Tikipunga, Onerahi, Okara, Otaika resulting in four sales too. A media statement to this effect was released and picked up by the NZ Herald/Northern Advocate, and Northern Age.

Far North District Council (FNDC) - Medical Officer of Health attended the Alcohol Regulatory and Licensing Authority (ARLA) hearing in Kaikohe, in relation to FNDC's Provisional Local Alcohol Policy (PLAP) under Section 83(2) – where FNDC was seeking ARLA to direct them to reconsider elements of the PLAP (rather than proceed to a full hearing). The outcome is that ARLA has directed FNDC to reconsider certain elements of the PLAP, and has directed that element 4.5 in relation to off-licence hours should proceed to a full hearing. This means that the restriction in hours for off-licences e.g. supermarkets, bottle stores (9am – 10pm *vs* the default hours of 7am – 11pm) can now properly be heard. Northland DHB's position is hours of 9am – 10pm.

Whangarei District Council (WDC) – Northland PHU have been advised by the Ministry of Health that the WDC lawyer is taking the results of the recent Auckland PLAP hearing back to WDC for discussion. He has asked that the MOH provide expert witness briefs (by 15 September) to inform deliberations – this is currently being addressed.

### *5.2. Drinking water*

As reported in June, a Health Protection Officer participated in a small video clip arranged by Northland Regional Council, to deliver a public health message about clean water at the Whangarei Falls (Otuihau).

Northland Public Health Unit's (PHU) Waiora Coordinator undertook surveillance sampling throughout Northland, offering public health advice where necessary, particularly following failed water sample results are received. One of PHU trainee Drinking Water Assessors (DWA) successfully undertook the on-site field assessment by visiting OPUS trainers. The next step in the road to designation as a DWA is to be successfully assessed by International Accreditation New Zealand (IANZ).

The Annual Drinking Water survey was been completed by Northland PHU during August.

### *5.3. Sewage and waste collection and disposal*

PHU has started conducting routine surveillance and evaluation of the local council's management of public health aspects of sewage and waste collection and disposal. The waste sites work involves liaising with the Councils/Council contractors to visit and evaluate the sites according to our public health checklists. The site visit itself involves discussing with the operator their practices and if there are any active resource consents for the site, if there are sensitive waterways nearby that may be at risk of leachate (if appropriate), the nature of the operation including; types of, if any, recycling undertaken, depth of workface, whether e-waste and hazardous substances are collected and the methods of nuisance control if at all appropriate (dust, vectors etc). Note is taken also of the general condition and tidiness of the station and to ensure that no such nuisances are being created by the operation.

### *5.4. Hazardous Substances*

The Environmental Protection Authority (EPA) audit of our Hazardous Substance work processes has resulted in our review of the internal mechanisms relating to the issuing of Vertebrate Toxic Agent (VTA) permissions. This work has been further developed into more of developing a desk-file incorporating risk matrixes to be used when assessing the application for a VTA. The result will make specific public health risks more obvious and highlight the idiosyncrasies of particular VTA areas. Northland PHU's VTA work may be seen as driven by the seasons and with spring around the corner, we are expecting (and have seen) an increase in VTA activity, i.e. applications for Public Health permissions to apply a VTA to an area.

### *5.5. Sexual health promotion*

The Sexual Health and Healthy Relationships Pilot Project started delivery with 7 schools in the mid and Far North taking part. Delivery includes engaging with students through internet based resources and is receiving strong positive feedback from students and schools. An evaluation will

be conducted at the end of 2017. The Public health registrar provided a joint presentation on Syphilis at Grand Round (with Dr Ayogi, ID Physician and Dr Anson, MO Sexual Health).

**6. Other highlights**

The Ministry of Health's Physical Environments issue-leads (Sally Gilbert & Peter Burt) visited PHU. The outcome of their visit - more integrated approach of service delivery was established and the challenges faced in Northland were noted/acknowledged by the Ministry.

## 5.0 GENERAL BUSINESS

5.1 Government Planning Priority - Healthy Ageing

- Implementation of Healthy Ageing Strategy
- Health of Older People Model of Care
- Dementia Model of Care

Presentation: Lyn Rostern, Population Health Strategist, Health of Older People DSS & Palliative Care

# Northland District Health Board
# Briefing Paper

## SUBJECT: GOVERNMENT PLANNING PRIORITY FOR HEALTHY AGEING

**Prepared by:** Lyn Rostern, Population Health Strategist, (Health of Older People, DSS, Palliative Care)

**Endorsed by:** Dr Nick Chamberlain, Chief Executive

## RECOMMENDATION

It is recommended that CPHAC/DiSAC notes the contents of this briefing

## BACKGROUND

The focus of the approved CPHAC/DiSAC work plan for the committee's September 2017 meeting includes the following reporting:

### Government Planning Priority - Healthy Ageing

- Implementation of Healthy Ageing Strategy
- Health of Older People Model of Care
- Dementia Model of Care

The Northern Region and Northland DHB is committed to supporting the vision of the NZ Healthy Ageing Strategy (2016) which is to see that older people live well, age well and have a respectful end of life in age-friendly communities, and that health equity is achieved especially for Maori and Pacific communities.

In 2014 Northland DHB's Health of Older People Service adopted a Health of Older People (HOP) Model of Care which was aligned to the Northland Health Services Plan (NHSP) Outcomes Framework. The HOP Model of Care has provided the platform for the delivery and monitoring of HOP Services, service improvement and the investment strategy for the period to 30 June 2017.

During 2017 the Health of Older People Management Team completed a Health of Older People Service Plan (2017-2020), and this documents the key issues for Northland's health of older people related to the themes of the NZ Healthy Ageing Strategy (2016).

Consumer co-design and adopting a whole-of-sector approach underpin the proposed Health of Older People service improvement goals and objectives 2017-2020.

Growth predictions for Northland's over 65 years population indicate a higher percentage of older people living in the community compared to most of the country, and we are experiencing significant growth in the number of those over 75 years. Both the number of older people and rate of increase are increasing.

Studies estimate that 20% of 80+ year olds have dementia with prevalence increasing to 30% of 90+ year olds.[1] The prevalence formulae applied to Northland's ageing population do not include pertinent differences related to ethnicity and risk factors such as alcohol and drug dependency, prison population and vascular and diabetes risk factors. Northland's projections therefore are likely to be under-estimated.

In keeping with the government's planning priority for continuing to improve the patient journey for those experiencing mild cognitive impairment and dementia, both the 2017/18 Northern Region Health Plan and Northland DHB Annual Plan continue to prioritise this work.

In August 2017 Northland DHB's HOP Service adopted the *Living Well with Dementia Model of Care.*

[1] Brodaty, H et al. *Alzheimers & Dementia.* 2013; 9(3):310-317

The purpose for Northland DHB developing a Dementia Model of Care is:

- To continue to shift the dementia care paradigm and pathway from secondary care to primary and community care, supporting general practice and primary health care teams to adopt integrated long term conditions (LTC) care coordination.
- To adopt the principles of the National Dementia Framework (2013) and Northern Regional Service Guide (2013) to provide earlier diagnosis and continuity of care for people with dementia and their families.
- To provide a framework for prioritising the allocation of resources across the dementia care continuum and,
- To meet Northland DHB's continuing obligations under the 2017/18 Annual Plan and Northern Region Health Plan and future years.

MINISTRY OF HEALTH
MANATŪ HAUORA

New Zealand Government

# Healthy Ageing Strategy

2016

**Released 2016** **health.govt.nz**

**E noho ora ana te hunga pakeke, e noho pai ana i ngā tau o te kaumātuatanga tae noa atu ki ngā tau whakamutunga o te rangatira i roto i nga ringa manaaki, ringa atawhai o te hā pori.**

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

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MINISTRY OF HEALTH
MANATŪ HAUORA

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# Foreword
## Associate Minister of Health

Older New Zealanders are a large and growing proportion of our population – by 2036, one in four of us will be aged 65 years or older. We all deserve our best support to age well, live healthy, independent lives and to have a respectful end of life.

I commissioned this revision of the Health of Older People Strategy to help ensure that the resources of our health system remain focused on providing that support and empowering people. It sets the direction for the health sector and outlines the actions needed to improve the health outcomes and independence of older people in a sustainable way.

I have rebranded it the Healthy Ageing Strategy for several reasons. We are all ageing, in different ways, and don't necessarily become 'old' when we reach the age of 65. Healthy ageing recognises the diversity of older people, and ultimately seeks to maximise health and wellbeing into and throughout people's older years.

The Healthy Ageing Strategy is aligned with the wider New Zealand Health Strategy. It also has strong links the Positive Ageing Strategy. Older people make a significant contribution to and have an integral role in our society. The Government is committed to the goals of positive ageing, where older people age well and are healthy, connected, independent and respected.

At its heart, the Healthy Ageing Strategy is about people. Its priority is adding life to years not just years to life. People age in different ways, and our population is diverse. We must recognise the range of ways older people access and interact with services.

We need a multi-faceted and coordinated approach to improve the health and wellbeing of our older people, particularly those living with long-term conditions, with high and complex needs or in population groups that are experiencing poorer outcomes from our health system. Our health system also needs to meet the health and support needs of an increasingly ethnically diverse population.

This will require the health and social sectors to work collaboratively and for everyone in New Zealand to recognise the important role that family and whānau carers play in supporting our older people in their homes and communities.

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

Many people and organisations have been involved in developing this Strategy. This reflects the wide variety of those who care about and influence older people's health and wellbeing. I would like to thank everyone who has contributed.

I would especially like to acknowledge the input of older people and their family and whānau carers. Your contribution has been particularly important in helping shape the Strategy and the services it provides.

Hon Peseta Sam Lotu-Iiga
**Associate Minister of Health**

# Foreword
## Director-General of Health

With the release of the New Zealand Health Strategy, now is the right time to set out a refreshed strategy for the health of older New Zealanders – the Healthy Ageing Strategy.

Its predecessor, the Health of Older People Strategy, was launched in 2002. The 2002 strategy delivered many successes, including greater choice in long-term health care services. We can all be proud of that.

However, the social and demographic picture in our country has changed over the past 14 years. In 2002, when the current strategy was published, those aged over 65 made up 11.5 percent of the New Zealand population. That amount has now climbed to 15 percent and is set to climb further. This has significant implications for policy, planning, service design and delivery.

We must ensure our health system provides the care, support and treatment that older New Zealanders need and that level of care is sustainable. We want a health system that works for every older New Zealander.

Achieving this means taking into account all the factors that impact on peoples' health and wellbeing in later life.

The Healthy Ageing Strategy has been written with this goal in mind. It has a strong focus on prevention, wellness and support for independence. It also recognises the importance of family, whānau and community in older people's lives. It gives greater priority to equity and supporting the most vulnerable, including those with high and complex needs and in the final stages of life. In addition, it signals the need for government agencies, health care providers and all who seek to make a positive difference to health and wellbeing to work together. Better integrating health and social responses will help us to be more responsive to New Zealanders' needs and choices.

The five New Zealand Health Strategy themes support the Healthy Ageing Strategy actions. These themes – people powered, closer to home, value and high performance, one team and smart system – articulate the wider system in which the goals of the Healthy Ageing Strategy can be achieved.

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

Leadership in this context is not about being in charge or having all the answers. Many people and organisations were involved in creating this strategy: from individuals to families and whānau, carers, health professionals, service providers, government and non- governmental organisations. We all have an ongoing role to play in helping every older New Zealander live well, get well and stay well.

I'd like to thank everyone who has contributed to the Healthy Ageing Strategy. I look forward to working with you as we deliver it.

Chai Chuah
**Director-General of Health**

# Acknowledgements

The Ministry of Health has received valuable input from over 200 written submissions on the draft Health of Older People Strategy (now Healthy Ageing Strategy) by the closing date of 7 September 2016. Five regional workshops also collected input from hundreds of participants around the country, including researchers, district health boards, clinicians, primary health and other non-governmental organisations, older people, carers, and aged-care, Māori and Pacific providers.

Earlier rounds of engagement workshops had provided a high degree of confidence around the overall approach and themes of the draft Strategy. The public consultation process on the draft focussed largely on identifying whether the right actions had been developed and given priority. Over 2000 people were involved in those Strategy development workshops.

The Ministry would like to particularly acknowledge the contribution of the expert advisory group:

- Dr Janice Wilson, Chief Executive, Health, Quality and Safety Commission (Chair)
- Dr Michal Boyd, Senior Lecturer, School of Nursing and Department of Geriatric Medicine, University of Auckland
- Stephanie Clare, Chief Executive, Age Concern New Zealand
- John Collyns, Executive Director, Retirement Villages Association
- Hamish Crooks, Chief Executive, Pacific Homecare
- Dr Ken Greer, Clinical Advisor, Primary and Integrated Care, Capital and Coast District Health Board
- Vui Mark Goshe, Chief Executive, Vaka Tautua
- Julie Haggie, Chief Executive, Home and Community Health Association
- Sir Matiu Rei, Director, Ora Toa
- Robyn Scott, immediate past Chief Executive, Age Concern New Zealand
- Simon Wallace, Chief Executive, New Zealand Aged Care Association
- Sarah Clark, Director, Office for Seniors (ex-officio member)
- Blair McCarthy, Acting Director, Office for Seniors (ex-officio member).

# Contents

**Foreword Associate Minister of Health** iii

**Foreword Director-General of Health** v

**Acknowledgements** vii

**Why a Healthy Ageing Strategy** 1

**Strategic context** 3
- New Zealand Disability Strategy 3
- Positive Ageing Strategy 4
- Treaty of Waitangi and He Korowai Oranga 4
- A'la Mo'ui – Pathways to Pacific Health and Wellbeing 2014–2018 5
- Other national plans and initiatives 5
- Global Strategy on Ageing and Health 5

**Taking a life-course approach** 6

**Challenges and opportunities** 7
- Health inequities 8
- Staying healthy and independent in older age 9
- New investment approaches 9
- Workforce development 10
- Families and communities 10
- Integration across the health and social sectors 11
- Smart system 11

**Vision and priorities for action** 12
- Ageing well – Te pai o ngātau o te kaumātuatanga 13
- Acute and restorative care – Ngātuāhuatanga manaaki, whakaora i te hunga māuiui 18
- Living well with long-term conditions – E noho ora ana i roto i ngā mauiuitanga o te tinana 23
- Support for people with high and complex needs – He tautoko i te hunga pakeke he uaua, he maha hoki o rātau taumahatanga 26
- Respectful end of life – Te mate rangatira i ngā tau whakamutunga o te hunga pakeke 30

**Turning the Strategy into action** 33
- Implementing the action plan 33
- A system of continuous improvement 34

**Action plan** **35**
Ageing well goals 35
Acute and restorative care goals 38
Living well with long-term conditions goals 40
Support for people with high and complex needs goals 44
Respectful end of life goals 48
Implementation, measurement and review 49

**References** **51**

**List of Figures**

Figure 1: A life-course framework for healthy ageing 6
Figure 2: Population projections by age group with 10 year percent change 7
Figure 3: Māori and non-Māori life expectancy at age 65 8
Figure 4: New Zealand Triple Aim Framework 9
Figure 5: Strategic framework for healthy ageing 12

# Why a Healthy Ageing Strategy

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

Remaining in good health, ageing well and being able and supported to live well with long-term conditions, however complex, is critical to enable older people to continue participating and feeling valued (two important factors for health and wellbeing).

We have a good base to build on, with many significant improvements to the health and disability support system for older people since the release of the 2002 Health of Older People Strategy. For example, we are supporting more people than ever with long-term health conditions and disabilities to remain in their homes for longer. We also provide more consistent and comprehensive needs assessments, greater choice and improvements in the quality of home and community services and aged residential care. Moreover, access to elective surgery has improved, as have discharge practices.

We want to maintain the positive changes we've seen over the last 14 years and improve on them in the current context. Our operating environment and the strategic context in which we work have changed. We need a new strategy that expands on the strengths of the past and sets the direction for improved performance and outcomes across the board.

The Healthy Ageing Strategy (the Strategy) is for older people, their families and their communities. Older people are by no means a homogenous population group. We don't become 'old' at any particular age or in the same way. Ageing is only partially associated with chronological ageing and it does not 'start' at 65. Some older people remain independent and competent, both physically and mentally, throughout their older years. Some enter their older years with long-term or chronic health conditions or disabilities, and their needs become more complex as they age. Others develop disabilities and become dependent as they age, due to cognitive and physical decline, and conditions such as dementia.

We need to ensure our system is truly people-centred and appropriate to New Zealand's growing ethnic diversity.

Our system and services must aim to keep people in good health for longer, recognising that older people have different needs at different times.

People with the highest needs may be those who have the fewest resources and the least capacity to address those needs.

This document sets out a strategy for the health and wellbeing of older people for the next 10 years.

It is the result of extensive engagement with older people, their families, whānau and carers, aged-care providers, health care professionals, professional bodies, researchers, Māori and Pacific peoples and their service providers, government agencies, district health boards (DHBs), primary health organisations (PHOs) and other non-governmental organisations (NGOs) that represent and support older people.

Hearing the voice of older people was especially important in developing this strategy, and many older people provided feedback and were involved in forming the Strategy's actions. They came from a wide variety of backgrounds and offered many different perspectives, aspirations and ideas about ageing.

While it is important not to generalise, their feedback covered some notable, consistent themes, including:

- the desire to be connected and respected
- a need to reduce barriers to participation in society, to keep active physically, mentally and socially
- enthusiasm for age-friendly communities
- a keenness to be empowered to take responsibility for their health, and to develop the skills to do so
- the importance of good communication and empathy in health care, and for providers to help older people articulate and listen to what is important to those people in their care
- a call for more flexible services that respond to people's individual needs and diversity, but where people
- can expect to have the same level of access wherever they are in the country
- a clear appreciation of the quality of health care
- an expectation for a highly integrated, well-coordinated, responsive health system
- acknowledgement of the tangible benefits of technology, provided no one is excluded or left behind.

There are three parts to this document. The first part introduces the strategy and the context in which it exists. The second section presents the overarching direction for the health system for the next ten years with respect to the health and wellbeing of older people. The third section is the action plan: specific actions we intend to take to address the health and wellbeing requirements for older people and achieve the desired outcomes.

# Strategic context

The New Zealand Health Strategy provides the overarching framework and directions for our country's health system.

The New Zealand Health Strategy describes the future we want, identifies the cultures and values that underpin this future and sets out five strategic themes for changes we can make that will take us toward its vision.

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

The New Zealand Health Strategy provides the building blocks for this Healthy Ageing Strategy. Together they define how we will maintain and improve healthy ageing and independence, regardless of people's health status, and provide better support for older people with high and complex needs and at the end of their lives.

## New Zealand Disability Strategy

The New Zealand Disability Strategy also informs the Healthy Ageing Strategy. It presents a long-term plan for:

> A **society** that **highly values** the lives of people with disabilities and continually enhances their **full participation**.
>
> New Zealand Disability Strategy vision

The Disability Strategy was informed by the United Nations Convention on the Rights of Persons with Disabilities, ratified in 2008. The Healthy Ageing Strategy is consistent with the articles of the Convention.

# Positive Ageing Strategy

Government has a long-standing commitment to the vision and principles of the cross-government New Zealand Positive Ageing Strategy 2001, as reiterated in 2013 in *Older New Zealanders – Healthy, Independent, Connected and Respected*.

> Older New Zealanders: **healthy**, **independent**, **connected** and **respected**.
>
> Cross-government New Zealand Positive Ageing Strategy 2001

Government agencies are working with local government, towards a 'vision of a society where people can age positively and where older people are highly valued and recognised as an integral part of families and communities'.

# Treaty of Waitangi and He Korowai Oranga

The health of older Māori is a priority for this strategy. We recognise and respect the special relationship between Māori and the Crown through the Treaty of Waitangi. In the health and disability sector, this involves working to the principles of:

- **partnership:** working with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services
- **participation**: involving Māori at all levels of the health and disability sector, including in decision-making, planning, development and delivery of health and disability services
- **protection**: working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.

**Pae ora**: Healthy Futures for Māori
**wai ora**, **whānau ora**, **mauri ora**.

Our approach to improving Māori health is guided by He Korowai Oranga, Māori Health Strategy. He Korowai Oranga has an overarching goal of pae ora, which translates to healthy futures for Māori. Pae ora comprises wai ora (healthy environments), whānau ora (healthy families) and mauri ora (healthy individuals). Pae ora encourages everyone in the health and disability sector to work collaboratively, and to work across sectors to achieve a wider vision of good health for everybody. Implementation of He Korowai Oranga across the health system recognises and respects the principles of the Treaty.

# A'la Mo'ui – Pathways to Pacific Health and Wellbeing 2014–2018

A'la Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018 is the Government's national plan for improving health outcomes for Pacific peoples, families and communities. A'la Mo'ui has four priority outcome areas:

- systems and services meet the needs of Pacific peoples
- more services are delivered locally in the community and in primary care
- Pacific peoples are better supported to be healthy
- Pacific peoples experience improved broader determinants of health.

# Other national plans and initiatives

Other specific national strategies, action plans and work programmes influence the health of older people and guide programmes and services on ways to meet their needs. These include:

- New Zealand Framework for Dementia Care
- Improving the Lives of People with Dementia
- Primary Health Care Strategy
- Living Well with Diabetes: A plan for people at high risk of or living with diabetes 2015–2020
- The New Zealand Carers' Strategy and Action Plan 2014–2018
- Pharmacy Action Plan 2016–2020
- Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017
- Review of Adult Palliative Care Services.

The Healthy Ageing Strategy incorporates several aspects of these population, service improvement and condition-related strategies and work programmes.

# Global Strategy on Ageing and Health

Internationally, New Zealand is a signatory to the World Health Organization (WHO) Global Strategy on Ageing and Health 2016–2020, a five-year strategy for action to maximise functional ability for all, and build the evidence and partnerships for a Decade of Healthy Ageing from 2020 to 2030. The Global Strategy's five strategic objectives are:

- commitment to action on healthy ageing in every country
- developing age-friendly environments
- aligning health systems to the needs of older populations
- developing sustainable and equitable systems for providing long-term care (home, communities, institutions)
- improving measurement, monitoring and research on healthy ageing.

# Taking a life-course approach

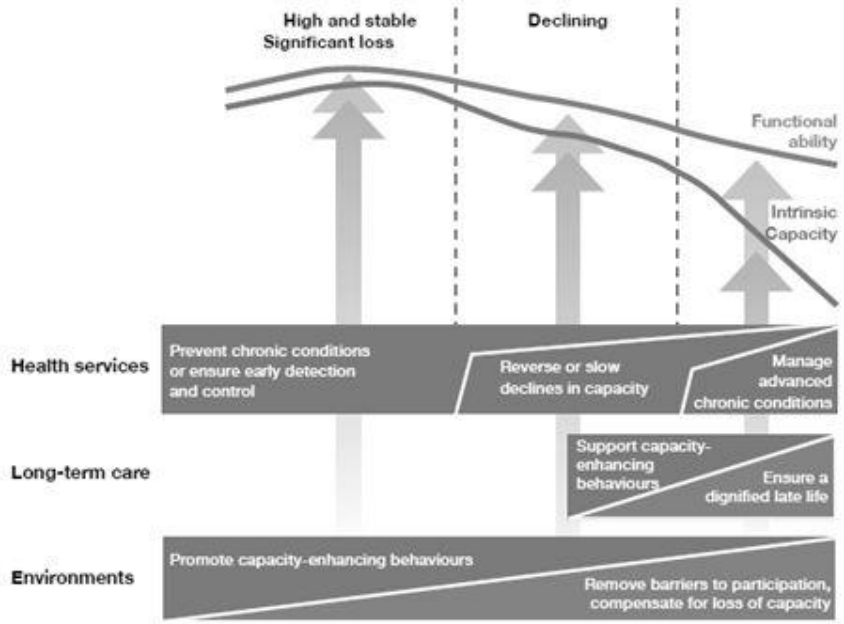
How well we age is influenced by our genetics, our upbringing, how healthily we live in our younger years and throughout our adult life and our exposure to health risks including poor housing, workplace discrimination and family violence.

Also highly influential are our physical and mental capabilities; our access to resources and opportunities; our resilience including in the face of adversity; our relationships; our personal circumstances, including our occupation, level of wealth, educational attainment and gender; our potential for personal growth; and our cultures and sense of identity, security, value and wellbeing.

This strategy applies a life-course approach to achieving the aim of healthy ageing. It recognises that we age in different ways and have different needs at different times, and that our health is affected by our environment. The approach involves enhancing growth and development, preventing disease and ensuring every person functions to the highest capacity possible throughout their life. 'Healthy ageing' does not refer to the absence of disease or physical or mental ill health. WHO defines healthy ageing as 'the process of developing and maintaining the functional ability that enables wellbeing in older age.'

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

**Figure 1: A life-course framework for healthy ageing**




Source: WHO 2015

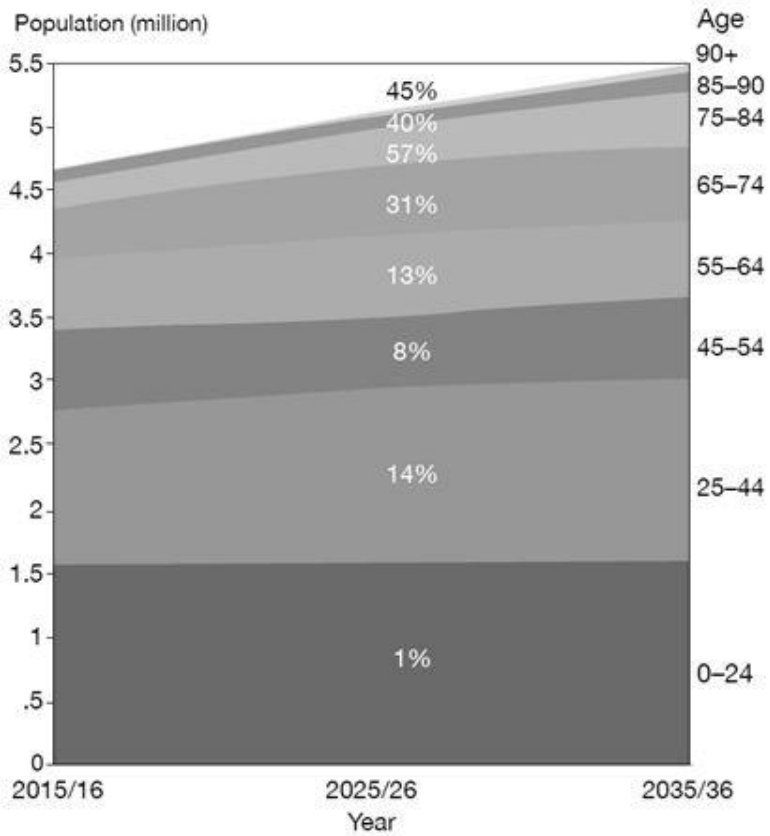
# Challenges and opportunities

New Zealand's population is ageing. There will be a substantial increase in the number of older people over the next decade.

This older population, and our communities, will also become more ethnically diverse. The Māori population of people aged 65 and older is projected to increase by 79 percent in the 10 years to 2026. The older Pacific population is expected to increase by 63 percent, and older Asian population by 125 percent in this same period.

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

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




Source: Statistics New Zealand, 2016

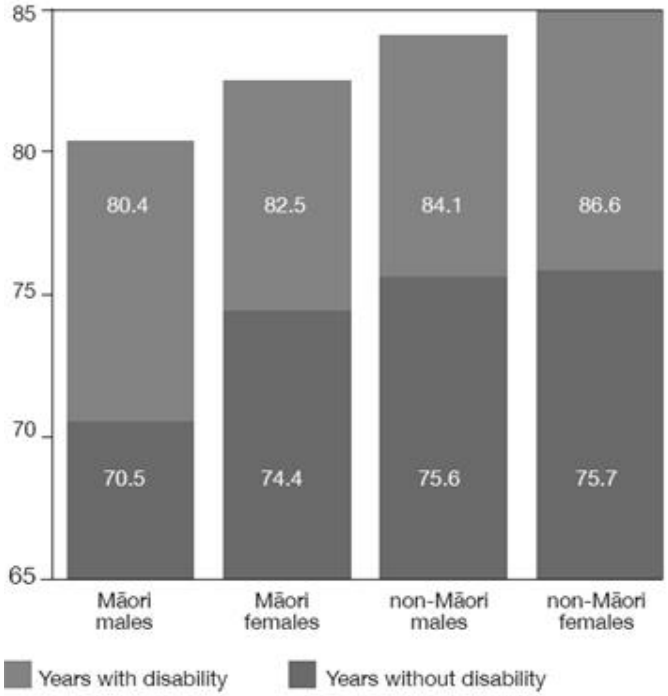
Currently, over one in six older people are living with three or more long-term conditions. Based on existing trends, an increasingly older population will mean steadily increasing health care needs. As a population group, older people have much higher rates of long- term chronic health conditions, and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

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

This is not the same for all population groups. In a comparison of Māori and non-Māori males and females, Māori males aged 65 can expect the shortest remaining time of living without disability or long-term illness (5.5 years on average) and the highest proportion of remaining time lived with disability requiring support (64 percent).

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

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




Source: Ministry of Health, 2013

# Health inequities

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

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

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

**Figure 4: New Zealand Triple Aim Framework**

We need to better understand how well our services are working for different population groups, and why problems arise. This has implications for the way that the health sector conducts research, collects data and evaluates the effectiveness of services.

# Staying healthy and independent in older age

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

# New investment approaches

If we continue to fund health services in the way we currently do, care of older people will account for 50 percent of DHB expenditure by 2025/26, up from 42 percent in 2015/16. It is vital that we ensure we are getting the best value from the investments and resources across the health and social sectors.

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

# Workforce development

The health system faces some significant workforce challenges. The health of older people workforce is itself ageing and some key workforce groups have experienced recruitment difficulties. For example, forecasts show that we will have trouble maintaining the necessary number of geriatricians and some other medical specialties, as well as registered and enrolled nurses, in aged care.

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

We need to make a priority of attracting, retaining and making the best use of the skills in the health workforce to meet the needs of an older population. We need to ensure workforce training keeps pace with technological change, and retraining is easily accessible for staff, and is efficient and effective.

We also need to ensure that our health workforce appropriately reflects our growing ethnic diversity and ensure that it appropriately reflects and caters to a diverse older population.

# Families and communities

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

We are starting to see the development of age-friendly communities in New Zealand. This term refers to communities that commit to physically accessible and inclusive social living environments that promote healthy and active ageing and a good quality of life, particularly for those in their later years.

Many are led by older people, together with local councils and a variety of organisations, who work towards local solutions to optimise older people’s opportunities for healthy ageing, participation, security and quality of life. Age-friendly communities provide new opportunities for developing knowledge and skills for healthy ageing, and for the health sector to partner with older people in developing health and resilience.

# Integration across the health and social sectors

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

More collaborative approaches will enable us to be efficient and innovative in the way we utilise specialist roles, such as nurse practitioners, clinical nurse specialists and all health professionals including allied health professionals, such as dental hygienists, dieticians, occupational therapists and radiographers; pharmacists and paramedics, to improve outcomes and enable innovative models to develop in home care, primary health care and residential care.

# Smart system

Today's health system is data-rich, with a tremendous volume of information that can be harvested to create a much smarter system.

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

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

# Vision and priorities for action

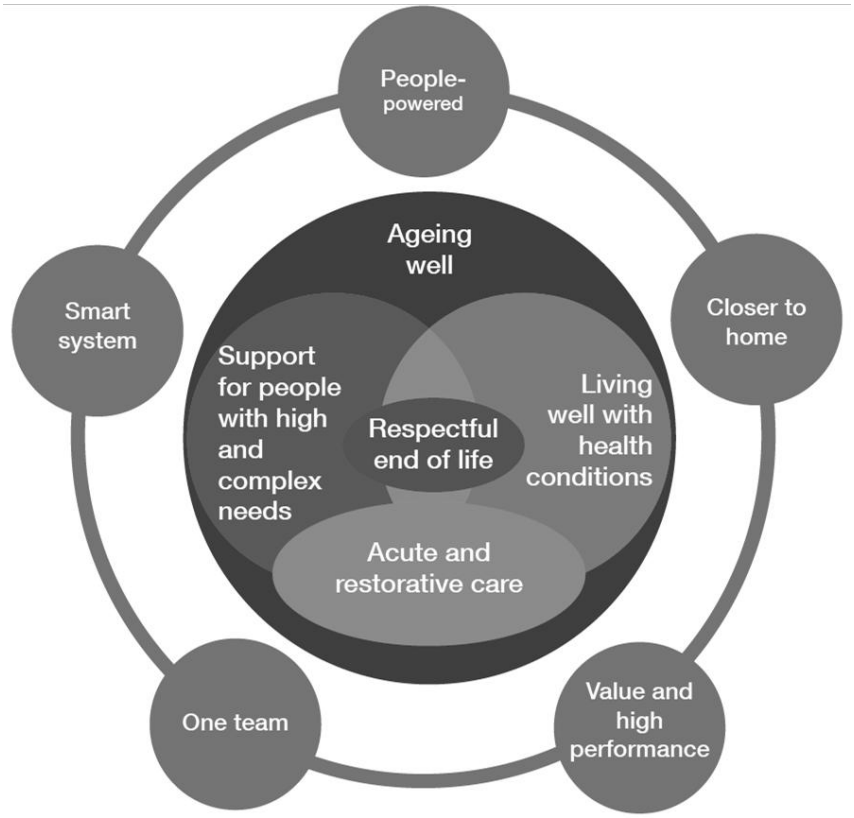
The vision for this Strategy is that: Older people live well, age well and have a respectful end of life in age-friendly communities.

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

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

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

**Figure 5: Strategic framework for healthy ageing**



# Ageing well
## Te pai o ngātau o te kaumātuatanga

This outcome area is about:

- maximising people's physical and mental health and wellbeing throughout their lives
- developing health-smart and resilient older people, families and communities to help older people age positively
- achieving equity for Māori and other population groups with poorer health outcomes
- taking actions to improve the physical, social and environmental factors of healthy ageing
- supporting the development and sustainability of age-friendly communities that enable older people to age positively.

### Why this is important

Health is fundamental to being able to live well, age well and continue to participate in family and community life. Older people make a significant contribution to our society, economically, socially and intellectually as mentors, leaders and skilled workers and volunteers. A healthy ageing approach seeks to enable older people to continue to be active, engaged and enjoying life.

While people may experience some loss of strength and mobility over time, many of the conditions associated with ageing (such as frailty) are not inevitable. The WHO estimates that more than half of the health conditions older people experience are potentially avoidable through lifestyle changes. There is increasingly clear evidence that healthy lifestyles and physical and mental resilience are determinants of health in older age. There are also many opportunities to benefit longer term from investing in social and environmental factors that influence health.

Ageing well is not just about preventing ill health and disability. It is also about maximising physical and mental health and wellbeing, independence and social connectedness as people age. Healthy ageing relates to all older people, including people with life-long disabilities or long-term conditions, those recovering from injuries or poor health, those with high and complex needs and those in their final stages of life. Subsequent chapters build on this chapter.

Investing in healthy ageing has the potential to increase the proportion of healthy, active and independent older people, prevent long-term conditions and their impacts on people's lives and result in long-term savings to the heath system.

A healthily ageing and robust population would help enable individuals to continue participating in their communities and contributing economically, socially and intellectually to a greater extent. Fewer people would require acute health interventions and would be able to stably maintain themselves if they developed chronic health conditions.

To ensure people age well, we need to focus on:

- building physical and mental resilience
- achieving equity in health across all population groups
- developing a health smart population through health literacy and helping people to plan for their future health and health-related needs
- a health system that supports healthy ageing closer to home
- supporting people to plan for future health and health-related needs
- improving social, physical and environmental determinants of health
- promoting and supporting the development of age-friendly communities.

## Resilience

Resilient people are more likely to age well and avoid cognitive decline or loss of function until very late in life. Resilient people can overcome stressful obstacles and recover from events that might tip a less resilient person into a state of poor health.

Resilience develops through physical activity, healthy behaviours, mental wellbeing and social connectedness. Our focus is therefore on increasing physical activity and other healthy behaviours among older people – for example, encourage good nutrition, not drinking alcohol or only drinking at low- risk levels, not smoking tobacco, taking part in mentally stimulating activities and relationships that build people's strengths and resilience.

People staying active and connected as they grow older is critical. There is strong evidence that social isolation or loneliness is linked to poor mental and physical health outcomes. We need to increase awareness of this fact across the health system, and join with social sector agencies, as well as community and voluntary organisations to reduce this risk factor and increase social interaction and connectedness.

We must also improve mental wellbeing among older people. Social connectedness, nutrition, physical health and activity all contribute to mental health, as does an environment that promotes older people's sense of self-worth and value to others. We need to continue to reduce the stigma of depression and anxiety among older populations, and promote the factors and supports for greater mental wellbeing. We need to foster approaches that build people's strengths and capabilities, increase optimism and hope and reduce the potential and impact of depression, anxiety and cognitive decline.

## Equity

Reducing health inequities is a core component of a healthy ageing approach and a priority for government. Equity is defined by the WHO as 'the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically.' Health equity approaches aim to improve fairness and reduce the incidence of avoidable, undesirable differences in health status.

People differ in their ability to attain or maintain good health, for many reasons. Some population groups have markedly poorer health outcomes: Māori, Pacific peoples, people with intellectual disabilities, and people in socioeconomically deprived areas. Other groups, such as ethnic communities and rural communities, are also vulnerable to poorer health outcomes.

Our focus on health equity aims to increase the age which these groups can expect to remain in good health and independence and includes:

- ensuring equity of access to health services, including through innovative and effective services provided closer to home, and catering to people's cultural preferences
- enabling equal opportunities to raise the capacity, functional ability and wellbeing, by directing resources at those with greatest need
- removing physical, financial, institutional and other barriers to high-quality health services and equitable health outcomes
- working across government and in communities on the social determinants of health, including housing, elder abuse and neglect, negative attitudes and discrimination, social isolation and inclusive, age-friendly communities
- minimising the impact of disability and illness on people's lives.

## Being health smart

### Health literacy

People are empowered in their everyday lives when they can make decisions that positively affect their health and care. Health literacy is the capacity to make good decisions, act on health information and navigate the health system. It is an essential component of resilience and a priority of this Strategy.

Empowering and supporting older people to be 'health smart' in their later years requires the health system to have a strong understanding of what it takes to age well and takes part in achieving healthy ageing. We will support older people in a way that is meaningful for them, and that is fully inclusive, where people are at the centre of the process. We will make health information available and shared in a way that overcomes cultural and communication barriers.

## Planning for the future

People's needs change as they age, and there may become a time when a person is no longer able to make decisions or advocate for themselves. Advance care plans and enduring powers of attorney allow an individual to retain a degree of autonomy in relation to their health care and treatment, minimise the potential for conflict or harm, and reduce stress on family members and others. There is some evidence that advance care plans can improve the experience of end-of-life care and their use across clinical disciplines is an integral part of a dying person's coordination of care.

Advance care plans and the discussions around them create an opportunity for people to think and talk about their values, preferences and beliefs. These conversations are easier when they begin well before the end of life. However, as people's preferences often change over time, it is also important that they be reviewed and updated at key points and when circumstances change.

The New Zealand Health Strategy commits to supporting people and their clinicians to develop advance care plans by building on existing national and international resources and networks. We can also promote advance care planning through, for example, community organisations, to help reduce stigma around talking about death and dying, and to increase the likelihood that people receive quality health care according to their wishes. The quality of care is further discussed in the 'Respectful end of life' section.

We know that financial security is also important for mental wellbeing and healthy ageing. The Commission for Financial Capability is carrying out a national strategy and leading work across government and together with communities to grow New Zealanders' financial capability. Better financial capability will improve family and community wellbeing, reduce hardship, increase investment and grow the economy, contributing to everyone's resilience.

## High-quality care closer to home

Primary health care services are generally people's first interaction with the health system when they are unwell. They are where people receive most of their professional medical advice.

A strong, well organised primary health care system that is provided close to where people live and work will empower individuals, enabling them to make informed choices and supporting them as they navigate their way through the health system. They also reduce health inequities and improve population resilience.

## Improving the social and environmental factors influencing health

Together with other government sectors and communities, the health system will work to improve the social, economic and physical factors for healthy ageing and achieve equity, removing barriers to participation.

We need a coordinated, system-wide approach to preventing, identifying and reducing elder abuse and neglect that includes providing accessible, well- tailored, effective services. As part of the Ministerial Group on Family Violence and Sexual Violence work programme, the health, social and justice sectors are working together to develop an integrated system for preventing and responding to family violence and sexual violence, including elder abuse and neglect, and reducing the impacts of such violence on wellbeing. The work is built around people-centred service design and delivery, in the four areas of primary prevention, identification, incident response and follow-up responses.

We will work with housing providers to improve the quality and range of age-friendly housing for older people. This will include a focus on rental housing stock, which older people are increasingly likely to live in, and supported living housing options. We will work with social housing providers to ensure that social housing is warm, safe and dry, and with others to promote options for housing that meet the needs of an ageing population. We will also look for opportunities with the housing development sectors to understand the future housing needs of an ageing population.

Transport solutions are needed to reduce social isolation and improve older people's ability to participate in their communities and access health and other social services. Government agencies will work with transport providers to increase access to alternative means of transport for older people, to help prevent isolation. They will work to increase the flexibility of social services in areas where transport options are most limited.

Whānau ora service approaches are examples of how agencies can work well together to reduce the social, physical and environmental barriers some people face to achieving good health and wellbeing.

## Age-friendly communities and workforce

Age-friendly communities are accessible and inclusive. They value people of all ages, and optimise opportunities for healthy ageing, including in the areas of participation, dignity, security, and quality of life. Age-friendly communities ensure older people have a voice, including those with disabilities and dementia, and marginalised older people. They recognise older people's wide range of skills and resources, and ensure that communities protect those who are most vulnerable. They anticipate and respond flexibly to the changing physical, mental and social needs and preferences of older people and ageing populations.

The 'age-friendly' concept and its implementation have significant momentum internationally and is starting to gain pace in New Zealand. The Office for Seniors will lead the development, through a co-design process, of a New Zealand-centric approach, and further develop the resources and networks to guide communities through the process of becoming age-friendly.

Across central and local government agencies, and in partnership with communities, we will support older people and promote age-friendly communities throughout New Zealand. We will support older people and others leading age-friendly communities locally. Together we will work to improve policies, services, structures and environments, particularly outdoor spaces and buildings, transport, housing, social participation, respect and social inclusion, civic participation and employment, communication, and health and social services. Our collaboration will enable collective impact at the national, regional and local levels.

An integrated health workforce with knowledge of social determinants of health, culturally competent and with a focus on wellness and upstream early intervention in supporting healthy lifestyles is an important contributor to age-friendly communities.

## Goals for healthy ageing

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

# Acute and restorative care
## Ngātuāhuatanga manaaki, whakaora i te hunga māuiui

This outcome area is about:

- ensuring appropriate admissions to hospital for older people with acute or urgent clinical/care needs
- coordinating care across specialities and between ACC and the health sector
- ensuring hospital stays are safe for older people who are frail, vulnerable or have dementia
- helping older people to regain, maintain or adapt to changed levels of function after an acute event
- looking for ways to weave family or whānau and wider community support into an older person's recovery and ongoing functioning.

### Why this is important

Older people benefit from access to a wide range of hospital services, including emergency or acute services. But unnecessary emergency visits, and inappropriate admissions are stressful for the individuals and use valuable resources.

Ambulance services and emergency departments are generally the first services to deal with acute and potentially life-threatening situations. But they may not be the best places for older people whose conditions could be managed at home or by their local primary health care clinics or aged residential care homes.

Once in hospital, older people can be especially vulnerable to rapid deterioration putting them at risk of further harm, (eg, by acquiring an infection).

When older people stay in hospital too long, they face the risk of further decline in their health associated with reduced physical activity (leading to loss of muscle tone and the chance of bed injuries), stress leading to increased confusion, and inappropriate medication.

These factors can lead to loss of confidence and social contact and are strong predictors of increased length of stay, long-term cognitive impairment, complications or death, as well as higher costs for care. They can also mean a slower recovery for the individual and increased distress for family, whānau and carers.

However, at the other end, premature discharge may result in loss of functioning or condition in the older person or even readmission. Premature discharge can also cause significant stress for family, whānau and carers who feel unprepared and unsupported.

When an older person returns home after a stay in hospital, they may need to make adjustments to their daily routines, and they may require temporary or ongoing support. Re-integration to family, whānau and community life is a key goal at this stage.

Successful treatment of an acute event and effective follow-up care are reliant on proactive and integrated planning, timely treatment and a team approach. Planning needs to involve the individual and their family and whānau and should address physical, mental and spiritual aspects.

Service providers and staff need to understand cultural and other preferences, and be committed to working with Māori, Pacific and other organisations, families, whānau and community leaders to get the best outcomes possible for individuals.

Older people told us that they want their:

- urgent care needs managed at the right level (that is, don't take them to hospital if they don't need to go there)
- assessment and other important information to be available to all who need it (that is, not to have to repeat their information several times over)
- families, whānau and carers involved in their rehabilitation and planning for their return home
- discharge, ongoing rehabilitation, home support and equipment organised in a timely way.

Therefore we will focus on improving the three main parts of the journey for older people – managing acute presentations, providing safe, quality treatments in hospital stay, and ensuring supported discharges and rehabilitation into the community.

## Managing acute presentations

To reduce unnecessary admissions, we need a system-wide response, including prevention, timely primary health care responses for older people with acute needs, better communication between providers and systems, coordinated clinical and social care, links between regular hours and after-hours services, and engagement with community providers.

The first stage of the journey is prevention. A range of people can have a role in this stage, including general practitioners, pharmacists, physiotherapists and home support workers. All these primary care givers should be able to recognise a deteriorating or acute situation and know where to go for further advice before calling on emergency care services.

Family and carers could be the 'eyes and ears' of an older person's care team and initiate timely interventions.

Some DHBs have developed 'pathways of care', that is, guidelines for assessing and managing particular conditions (eg, strokes or heart disease) to improve the coordination and documentation of care. Such pathways can reduce unplanned referrals to hospital.

We need to spread innovations that reduce the need for unnecessary intensive services.

Ambulance services in the Kāpiti Coast region, out of Wellington, are using an 'urgent community care model' and Healthline, as well as frontline triaging in emergency departments. Gerontology nurse specialists in the Waitemata DHB provide assessments and care coordination across primary health care and hospital services for complex wound care to be managed in the home or aged residential care setting, thus reducing the risk of an older person's health deteriorating and the need for acute care.

We will encourage and support such innovations, evaluate their outcomes and spread good practice.

## Safe, quality treatment in hospital

Hospitals can be frightening and bewildering places. Hospital staff need to be acutely aware of the vulnerability of older people, especially those who are frail, experience dementia, have complex conditions or disabilities or could become delirious.

Many older people have multiple conditions, which can lead to transfers between specialists or hospital departments and lack of overall coordination. We need geriatric specialists to assist with assessments and care planning. Equally important, a range of health professionals need to be trained to deal with the common conditions and complications associated with caring for older people.

A comprehensive collection of clinical and personal information will already exist for some older people, for example through an interRAI assessment or gathered by their primary or community health care team. There is scope for these providers to share information to improve care planning and reduce duplication. Such information needs to be accurate, accessible, easy to interpret and up to date.

Joint initiatives between ACC, the Ministry and the Health Quality and Safety Commission New Zealand are underway to reduce patient harm and improve analysis and data sharing on patient safety and treatment injury.

This work aims to enable continuous quality improvements and help reduce disparities in care between injury and non-injury patients.

Space and time are often short in hospital, especially in emergency settings. Nevertheless, respecting cultural preferences and practices, for example, by creating enough space to accommodate extended family and whānau, can help improve the patient and family experience of care.

Around one-third of deaths among older people occur in hospital, including in acute settings. Links with palliative care services are therefore critical. Advance care plans (ie, documentation around the goals and limits or 'ceilings of care') and enduring powers of attorney need to be readily accessible.

## Supported discharges, rehabilitation and restorative care

'Rehabilitation' refers to the process by which health providers assist a person to recover from a procedure or event and regain, maintain or attain as much functioning as possible. The term 'restorative care' is also commonly used to refer to the building up of a person's capacity and resilience to maximise their autonomy.

Preparation for being discharged home needs to begin as early as possible, and it is critical to engage the family or whānau and carers who will be involved in providing ongoing support in the home and community as well as the various members of the clinical care team. This is commonly referred to as 'early supported discharge'.

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

Some DHBs have dedicated teams to plan and manage 'early supported discharge', for example START and CREST Team in Waikato and Canterbury DHBs respectively.[1] Such teams have been shown to be effective in reducing a person's time in hospital, preventing readmissions and lower costs overall.

In other areas, district nursing services provide clinical care and oversight of rehabilitation – sometimes home based, sometimes in a community clinic.

[1] Supported Transfer and Accelerated Rehabilitation Team and the Community Rehabilitation Enablement and Support.

Some people need longer periods of time to recover and a different setting and benefit from a 'step-down' or 'intermediate care' provided after discharge from hospital, but before it is possible for them to return home.

For example, in some parts of the country, aged-residential care facilities provide a safe place for ongoing rehabilitation, which also includes training for family, whānau and carers.

Wherever rehabilitation occurs we are looking for a shift in philosophy from simply doing things for people, to working with people to help them regain or maintain their ability to manage their day-to-day needs.

For some people, this will mean finding a new balance – adapting to changed or reduced levels of functioning, including addressing the psychological and social effects of this change, for example after a stroke.

Clarifying an individual's goals and motivations is a key part of developing a personalised care plan, and provides a way to recognise and respect cultural preferences.

Family and whānau involvement is critical to supporting the older person through their rehabilitation, and it is important to identify any help the carer needs to be able to provide that care in a safe and sustainable way.

Volunteer groups can also play a valuable role (eg, stroke support or cardiac companion groups).

## Integration in the health sector and across agencies

Funding for rehabilitation and recovery services is currently spread across different parts of the health system, including health, disability and ACC (and occasionally New Zealand Veterans' Affairs). This can lead to duplication of services, or gaps and delays in coordinating care (eg, a person needing home care, district nursing, nutrition advice and equipment may face four different assessments).

Streamlining assessments, standardising the use of shared care plans and routinely using multi-disciplinary teams might make any funding differences invisible to the person needing services.

## Workforce

A variety of different workforces with complementary skills support the health and wellbeing of older people. In all settings, staff need an understanding of common conditions for older people such as frailty, confusion, falls, or risk factors such as incontinence pressure injuries or polypharmacy.

Ideally, there should be multi-disciplinary teams involved in care planning and delivery. This ensures comprehensive coverage, and coordinated care. Integrated technology and tools (such as shared electronic records) can provide greater flexibility by supporting 'virtual' teams'

We need a skilled generalist workforce and a specialist workforce that provides both clinical services to individuals, and training and support to allow other staff to work to the top of their scope.

Allied health staff (such as occupational and speech language therapists, dieticians and physiotherapists) have key skills for rehabilitation, recovery and restoration, but access to them can be limited. Greater integration will rely on more flexible access to such staff.

Kaiāwhina and family or whānau need to be involved in rehabilitation. Information sharing, training and other means of support could enhance the range of support activities they undertake, and improve their confidence and ability to provide ongoing care throughout the rehabilitation period.

The health and disability workforce needs to be able to respond to our ethnically diverse population and to deliver services and supports in culturally competent ways.

## Quality

Quality measures in this area need to include individual experiences and outcomes; for example, can the person now dress themselves? Was the person satisfied with their recovery? Did their family or whānau feel supported to help with their rehabilitation?

Quality measures can also include 'system' measures, such as the number of acute bed-days, and contributory measures, such as whether discharge was timely and support services were in place, and whether the person was readmitted to hospital within a short time.

Quality is an ongoing process that needs to be supported by the provision of up-to-date evidence to inform and spread best practice.

## Technology

Arrangements are in place in most areas of the country to ensure that primary health care practices are advised whenever a person uses an ambulance or emergency department service. This needs to be available across the country, and potentially extended to other areas such as aged residential care.

An increasing array of electronic reminders and measurement and monitoring tools are available to assist rehabilitation. We want to see both health professionals and older people supported to use such tools effectively.

Shared patient records that include assessment information and care plans and that indicate how people want to be treated at their end of life, are critical to support care coordination.

## Goals for acute and restorative care

- Innovations and research support best practice triage, assessment, integrated care, discharge planning, rehabilitation strategies, and follow-up support.
- Older people are supported through recovery by specialists and general staff who are competent to deal with common conditions, including frailty, delirium or dementia. Hospital staff and processes respect cultural preferences and differences.
- Family, whānau and carers are included in discharge planning and receive training and support to provide ongoing rehabilitation in home and community settings.
- Quality measures include patient experiences as well as clinical outcomes.

# Living well with long-term conditions
## E noho ora ana i roto i ngā mauiuitanga o te tinana

This outcome area is about:

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

### Why this is important

The WHO has referred to long-term health conditions as 'the health care challenge of this century'. Long-term conditions include diabetes, obesity, cardiovascular and chronic obstructive pulmonary disease (COPD), cancer, asthma and other respiratory conditions, arthritis and musculoskeletal diseases, stroke, chronic pain, dementia, mental illness and addiction. Long-term conditions also include physical, sensory and intellectual disabilities.

With an ageing population, the numbers of people living with long-term conditions are expected to increase. Long-term conditions can occur at any age, but become more prevalent and are more common among older people. Currently one in six older New Zealanders are living with three or more long-term conditions. For example, the numbers of New Zealanders with dementia is expected to rise to 78,000 by 2026, from an estimated 50,000 currently. Some population groups, such as people with intellectual disabilities, and Māori and Pacific peoples tend to have higher rates of long-term and age-related conditions at earlier ages.

Long-term conditions are often complex, with multiple causes. They can lead to a gradual deterioration of health and mobility but can also become acute suddenly, resulting in hospitalisation and sometimes dependence on long-term support services or family and whānau.

Higher rates and greater complexity of long-term conditions will increase demand for health services in general, and home and community support services in particular. This will also mean that increasing numbers of people will be caring for and supporting family and whānau members.

The New Zealand Health Strategy's overarching goal is to see all New Zealanders live well, stay well and get well, and therefore spend more of their lives in good health. As part of a healthy ageing approach, for those with long-term conditions, our focus is on reversing or slowing declines in health and function, and promoting and supporting the behaviours and other factors that enhance people's capacity. We want to ensure that older people with long-term conditions retain the highest level of mental and physical function possible; they enjoy life, and their communities respect them.

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

## Prevention and detection

A major theme of the New Zealand Health Strategy is to have New Zealanders become more health smart. To create a health smart population, we need to provide individuals, as well as family and whānau and carers, with information about preventing long-term conditions.

For those living with long-term conditions, we need to provide information about specific conditions, symptoms, medication and management, as well as the importance of healthy lifestyles. We also need to enable people to connect with groups and organisations that can help them to manage their conditions.

We need to improve our ability to prevent and manage long-term conditions that lead to the development of frailty.

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

## Priority populations

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

We need to ensure that older people of all ethnicities are health literate and can access culturally appropriate services including home and respite care, long term residential care, mental health and dementia services. The health workforce should also reflect our growing ethnic diversity. We will do this in partnership with these population groups and their families and whānau, and the providers and NGOs that represent these population groups.

Dementia is particularly prevalent long-term condition in older ages, and an important priority. We will implement the New Zealand Framework for Dementia Care (see Ministry of Health 2013) to give people who are living with dementia the best possible independence and wellbeing.

Living well with long-term conditions requires identification, interventions, information and advice relevant to specific conditions. We will investigate and, where appropriate, deliver relevant approaches for people living with stroke, musculoskeletal conditions, dental conditions, low vision and diabetes.

## Enabling technology

Technological tools such as smartphones, apps and wearable devices have many valuable applications in the area of health. They will become increasingly important as a way of allowing older people to maintain autonomy, dignity and a better quality of life, including through the ability to remain living in their own homes for as long as they wish.

The pace at which older people adopt such tools will vary. We need to ensure that late adopters continue to have equal access to the services they require.

## Health workforce and service delivery

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

Primary health care, pharmacists and home and community support services are well placed to take a greater role in the care and support of people who need assistance to remain living at home for example through medicine optimisation services.

We need to accelerate improvements in the models of primary health care to ensure that it is able to respond to the challenges of a diverse older populations with higher rates of co-morbidities.

In the case of home care, we could better align service models, funding methods and levels of training, to allow a greater level of involvement with other parts of the health system. At present, the home and community workforce is fragile. Jobs in this sector are generally characterised by low pay, irregular working hours and variable access to training, which contributes to high staff turnover.

We will invest in the home and community support workforce and develop service and funding models. Models will take a sustainable, culturally appropriate, equitable and person-centred approach to supporting older people with long-term conditions. This will include consideration of the role of individualised funding and retirement villages.

## Family and whānau

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

## Goals for living well with long-term conditions

- Improved methods of early detection and prevention result in fewer older people being affected by long-term conditions or frailty.
- Older people with long-term conditions retain the highest level of mental and physical function possible; they enjoy life and their communities respect them.
- Older people with long-term conditions are ‘health smart’, are actively self-managing their conditions to a practical and comfortable level and are supported to do so closer to home.
- The workforces that support older people with long-term conditions, including the health workforce, home and community support services and family and whānau carers, collaborate and have appropriate resources, structures and training and work in an integrated manner.
- Home and community support services are equitable and appropriate to older people’s needs and preferences and maximise their wellbeing.
- Health outcomes for vulnerable older populations with long-term conditions are equitable, with good outcomes for the population as a whole.

# Support for people with high and complex needs

## He tautoko i te hunga pakeke he uaua, he maha hoki o rātau taumahatanga

This outcome area is about:

- building on the vision and actions of previous outcome areas to consider issues particularly relevant for older people with high and complex needs
- ensuring people are in the right place to receive the care and support that most appropriately meets their needs
- individuals maintaining choice and control when they need significant support
- helping families and whānau to provide the best support they can while maintaining their own wellbeing
- coordinating, integrating and simplifying health and social services for older people with high and complex needs
- providing flexible home and aged residential care services that suit the needs of the increasingly diverse older population
- reducing avoidable visits to emergency departments and acute care among a group of potentially high users
- enabling all older people with high and complex needs to easily access care and support, irrespective of their financial position
- promoting innovative models of complex care that better support older people, their family and whānau and carers
- ensuring value and high performance for services that use a large proportion of the health budget.

### Why this is important

Older people with high and complex needs are one of the most vulnerable groups in society. They are more likely to become 'frail'; that is, to deteriorate markedly after an event that would commonly have a minor effect on other older people's health. The number and complexity of conditions in older people with high and complex needs makes treatment and care more difficult, as conditions and treatments affect each other.

For some people with high and complex needs, moving into aged residential care improves the quality of their lives in their remaining years.

This part of the Strategy expands on the goals and actions relating to long-term conditions. Doing more to support older people with high and complex needs is particularly relevant for the population of Māori and Pacific older people with high and complex needs, given the higher rates of Māori and Pacific people in this category. There are good examples of health practitioners, purchasers and providers partnering with Māori and Pacific providers to develop services that meet the needs and aspirations of Māori and Pacific people in culturally appropriate ways for individuals and their families and whānau.

## Knowledge and communication

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

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

Older people with high and complex conditions have to navigate their way through more parts of the health and support system than other older people. These services need to communicate and work well together to ensure such people are well supported with their health care.

## Technology

Technological tools such as smartphones, apps and wearable devices are making it increasingly easier to monitor a person's health and communicate health information. Health service providers will pay particular attention to each individual's ability to use such devices and accommodate a range of technical literacy levels.

## Services closer to home

Older people value their independence highly. They do not want to be seen as a burden on spouses, family or social services. They want to stay in their communities, and access services closer to home. High performing primary care and home care service models referred to in the long-term conditions chapter are particularly important for people with high and complex needs. We will also strengthen health and social sector coordination, workforce and support family and community in their roles are carers.

## Health and social sector coordination

Older people who are developing higher and more complex needs generally receive better care when their primary health care service is close to their home. It is easier for the health professional caring for them to have more regular contact with them and know more about their situation and their lives.

Older people who need to see a variety of health professionals want their individual health information to be available to all the clinicians they see so they don't have to retell their story repeatedly. We will develop systems so that clinicians are informed about patients' other conditions and treatments.

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

To achieve best value and high performance, DHBs will commission services that provide older people with quality care in the right setting at a sustainable cost. This can involve identifying potential health issues and instituting preventive care plans in response.

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

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

## Workforce

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

The workforce needs to ensure that the services are culturally appropriate to meet the needs of a wide range of ethnic communities. Support workers make up a large part of the workforce for people with high and complex needs. We will pay, train and value these workers as part of the integrated 'one team'.

## Family and community

Beyond the formal workforce, we will support families and whānau and others in their roles as carers of older people with high and complex needs. This support could involve health literacy education, and training specific to the carer role, and having regard for the carers' own health needs, particularly in relation to mental health.

Older people with high and complex needs often have comprehensive clinical assessments of their needs electronically recorded in the interRAI database. Care providers use this information to develop care plans. The information will be a rich resource for the range of health professionals dealing with each person and for PHOs and DHBs learning about the outcomes of older people receiving support services in a location or population group.

## Goals for supporting people with high and complex needs

Older people with high and complex needs:

- are able to live as independently and actively as possible
- have the information and freedom to make good choices about the care and support they receive
- know that health care workers understand their wishes and support their needs
- are assured that information about their circumstances and needs flows easily between health care workers who work in an integrated manner
- have care plans that reduce the likelihood they will deteriorate markedly after a health event
- are able to access care and support irrespective of their financial position
- experience equitable access to services and equitable outcomes regardless of ethnicity or rural location
- move easily to and through care settings that best meet their needs
- have reduced need for acute care.

Families and whānau and carers have the support, information and training they need to assist older family members, and the stress of caring does not affect their own health.

District health boards bring together data from various sources, know the value and quality of the care they provide for older people in their district, and can easily learn from other DHBs.

# Respectful end of life
# Te mate rangatira i ngā tau whakamutunga o te hunga pakeke

This outcome area is about:

- respecting the goals and preferences of people in their last stages of life
- tailoring care to the physical, emotional, social and spiritual needs of the individual and their family and whānau
- continuing to provide high-quality palliative care and preparing the health system for future palliative care needs
- providing coordinated care that meets all individuals' needs, wherever they are
- supporting family and whānau and friends to support dying older people.

## Why this is important

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

This outcome area builds on the four others. At the end of life we continue to manage conditions, often in complex combinations requiring good coordination. A person in the last stages of their life can still be subject to episodes of acute illness and recovery, just as those in acute care can unexpectedly take a turn for the worse and require end of life care. The ultimate goal for the end of life is to achieve optimal wellbeing, physically, socially, emotionally and spiritually.

In the last stages of life, what commonly matters to people are: to feel accompanied by their family and whānau and friends, to be confident that their symptoms and pain are controlled well, attention to spiritual and cultural needs, and to receive good information, communication and well-coordinated care. We should expect, and take steps to ensure a person at the end of their life will receive high-quality palliative care that respects their wishes.

High-quality palliative care involves relieving the distressing symptoms and physical pain of a person with a life-threatening or terminal condition. It regards dying as a normal part of life, provides support for the person and their family and whānau and friends helps them all come to terms with the dying process. It aims to be a positive influence on the course of illness, and to enable the person to live their regular day-to-day life as much as possible until their death. It seeks to give the person space to be themselves, achieve their goals and to interact with their family and whānau and friends as much or as little as they need.

We need to ensure that people at the last stages of their life are in control of their care as much as they are able, and that their preferences are well understood and adhered to as much as practical by those involved in their care.

New Zealanders hold many different world views; they have different cultural and spiritual needs and different expectations about the end of life as well as ideas about family, community and life in general. As a health system we should acknowledge and respect the diversity of our older population, and the profound emotional and spiritual significance of the end of life process.

Achieving a respectful end of life for Māori, Pacific and other ethnic communities requires all health practitioners and services and personnel to be particularly aware of the physical, mental, social and spiritual needs of individuals, their families and whānau. A good understanding of tikanga is also essential.

## Increasing the emphasis on primary palliative care

As our population ages, more people will die each year. Many will have uncomplicated deaths, but as we live longer, we can expect increasing numbers of people with more complex conditions and comorbidities, including dementia, requiring more specialised care. As a health system, we will need to make sure we can consistently provide end of life care to a high standard and that we have the capacity to meet future demand. We need to embed palliative care as a core element of practice across the broader health workforce and ensure this workforce is adequately supported by a highly trained specialist workforce.

There are opportunities to use a range of professions better, including in pharmacy and allied health, to improve the quality of palliative care, for example, through medicine optimisation services. Pharmacists, physiotherapists, occupational therapists, speech and language therapists, dieticians, social workers and psychologists, practice nurses and others can be involved in ensuring wellbeing in the last stages of life.

If our primary health care workforce is trained in core palliative care practices, we should be able to continue to meet people's palliative care needs. However, it will require an adequate specialist palliative care workforce to provide specialist clinical care as well as support, advice and education. Shared clinical records, patient portals and other technologies will support this integrated service delivery.

## Improving quality in all settings

Palliative care takes place in a variety of settings, including in hospitals, aged residential care, hospices and individuals' homes. Ideally, it takes place where a person wants to be and where they feel safe, comfortable and supported. It is coordinated by a qualified individual or a multi-disciplinary of the person's choosing.

Sometimes the onset of the last stages of life is quicker than expected, and a person can spend their last hours dying somewhere unanticipated. To ensure seamless care, we need to support, up-skill and use the existing skills and experience of staff across all health care settings to ensure they are adequately prepared to provide palliative care as needed.

As part of the work towards improving the quality of end-of-life care in all settings, we need to understand and measure the key indicators of good palliative care, including from an individual and whānau perspective. There needs to be national agreement on what constitutes quality end-of-life care, and we need to enforce quality standards that apply to all areas of the health system to ensure we provide consistently good palliative care.

## Growing the capability of carers and communities

Families and whānau and carers can be intimately involved in the dying process and can make an invaluable contribution to the experience of the dying person. We need to support these carers well and recognise the importance of their role and the impact of caring for a dying person.

We can improve the support we provide informal carers, by providing respite, information, guidance, and training to lift their skills and confidence. We need to work with employers to ensure informal carers are respected in the workplace and to reduce any work-related barriers to their caregiving.

## Responding to the voices of people with palliative care needs and their families and whānau

Clear communication is an essential factor to good quality end-of-life care. The health system must strive to ensure that a dying person's goals and wishes have been well articulated, understood and respected by all involved in their care at every levels.

Information on people's experiences, including bereaved people, is an invaluable tool for ensuring palliative care is person-centred, and identifying areas for improvement.

We will take steps to accommodate people's wishes the best we can, and respond to what people, and their friends and family have told us in order to continually improve palliative care.

## Goals for enabling a respectful end of life

- The health system responds to older people's goals and care needs at the end stages of life, and the experience of their family, whānau, caregivers and friends involved in their end-of-life care.
- All health care teams are responsive to the cultural needs of different groups.
- Health service providers coordinate palliative care to ensure all providers in the health system are used to their fullest. All of those who support people dying in old age are aware of the dying person's plans and know their own role in achieving those plans.
- People die feeling as comfortable and safe as possible.
- Expert advice and support is available to families and whānau, other carers and the health workforce involved in end-of-life care.

# Turning the Strategy into action

Achieving the vision and goals set out in this strategy requires the commitment of many people across and throughout the health and social system, working in partnership with NGOs, communities, older people and their families and whānau.

It also requires us to have the right set of actions, and the right leadership and systems in place to implement those actions and keep us on course.

A package of actions is set out over the following pages to implement this strategy over a 10-year period. The actions were developed in discussion with older people and their representatives as well as other stakeholders from the health and social system across New Zealand.

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

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

Equity and workforce are considered across all the actions.

Implementing the actions will involve a variety of stakeholders from across the health and social sectors, as well as older people and their families and whānau. Many of these partners are listed alongside each action. However, each action is given a specific lead who takes on accountability for achieving that action.

## Implementing the action plan

The action plan will be implemented in several phases. Actions that will be implemented over the first two years are shown with an asterisk (*). However, it is recognised that some of these actions will require longer than two years to fully implement.

The Ministry will develop an implementation plan with major partners, setting out the finer details of the actions, including the mechanism, timing, sequencing, responsibilities and resourcing required for each one.

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

# A system of continuous improvement

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

We recognise this Strategy is a living document. The Ministry will review the action plan after two years. The review will look at how well the actions are being delivered and how effective they are. We may need to adjust some actions, replace them or combine them with other initiatives to strengthen their chance of success. Implementation will always need to fit to the available resources, and we will need to prioritise the initiatives.

While the Ministry is responsible for putting together the Strategy and reporting on its progress, continuous improvements to health services and health outcomes for older people will require all relevant parties to remain involved and committed. This includes a wide variety of service providers, the communities in which older people live and older people themselves.

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

Ultimately, we will ensure that information and our investment in, and the outcomes of, research inform policy development and service improvement.

# Action plan

## Ageing well goals

- Older people are physically, mentally and socially active; have healthy lifestyles and display greater resilience throughout their lives, meaning that they spend more of their lives in good health and living independently.
- Older people are health smart, able to make informed decisions about their health and know when and how to get help early.
- Everyone in the health system and in the wider social sector understands what contributes to healthy ageing and actively works to achieve it.
- All older populations in New Zealand are supported to age well in ways appropriate to their needs and cultures.
- Communities are age-friendly, with initiatives to keep people healthy, well-connected, independent, respected and able to participate fully in their communities and with family and whānau.

| Actions | | Lead<br>Partners |
|---|---|---|
| **1. Develop and support the growth of age-friendly communities.** | | |
| a. Promote the concept of age-friendly communities nationally and in communities and workforces.*<br>b. Provide advice and tools to support older people, local government and others leading the establishment and development of age-friendly communities and builds the knowledge base for an age-friendly New Zealand.*<br>c. Build strong partnerships between DHBs, Healthy Families New Zealand, public health units, PHOs and age-friendly communities for effective healthy ageing initiatives in communities.*<br>d. Develop, through a co-design process, a New Zealand- centric approach to age-friendly communities that:*<br>– draws from the WHO framework for age-friendly cities<br>– builds on local experience<br>– includes a networked infrastructure at national, regional and local levels. | ● ● ● | **Office for Seniors**<br>National, regional and local government agencies and NGOs, older people other community members |

* Implemented in the first two years.

● People powered ● Closer to home ● Value and high performance ● One team ● Smart system

| Actions | | Lead<br>Partners |
|---|---|---|
| **2. Increase physical and mental resilience.** | | |
| a. Increase the availability of strength and balance programmes in people's homes and community settings.* | ● ● | **ACC**<br>Health Quality & Safety Commission New Zealand, Ministry of Health, DHBs |
| b. Expand the provision of targeted health literacy initiatives, and services to increase resilience among Māori, Pacific and other priority older populations who have poorer health status. | ● | **DHBs**<br>Government agencies |
| c. Review the Green Prescription programme, including the potential for other health professionals to prescribe and improve its utilisation by older people. | ● | **Ministry of Health**<br>DHBs, primary health care |
| d. Increase understanding and explore partnerships in promoting mental health for older people at an individual, organisational and community level. | ● | **Ministry of Health** |
| e. Encourage services and providers to promote healthy eating, physical activity and healthy lifestyles.* | ● ● | **DHBs**<br>health organisations, NGOs, New Zealand Nutritional Foundation |
| f. Encourage services and providers to promote the reduction of alcohol-related harm.* | | **Health Promotion Agency** |
| **3. Work across government on the socioeconomic determinants of health to prevent harm, illness and disability and improve people's safety and independence.** | | |
| a. Work across government and social sector agencies to improve access, and coordinate assistance to socially isolated and other vulnerable older people and develop initiatives that better address the physical and social determinants of health. | ● ● | **Ministry of Social Development**<br>DHBs, other government agencies, PHOs, other NGOs |
| b. Participate in the cross-government Ministerial Group on Family Violence and Sexual Violence Work Programme.* | ● ● ● | **Ministry of Social Development**<br>Ministry of Justice |
| c. Update the *2007 Family Violence Intervention Guidelines: Elder Abuse and Neglect*, and promote their uptake by a wider range of health professionals. | ● | **Ministry of Health** |
| d. Establish a cross-government working group to identify and progress opportunities to improve housing options for older people and better enable older people to live in age- and disability-friendly homes. | ● | **Ministry of Social Development**<br>Ministry of Business, Innovation & Employment Ministry of Health, Local Government New Zealand, Housing New Zealand |
| e. Support initiatives that maximise healthy ageing through supported housing and age-friendly communities where this will also contribute to regional economic and social development.* | ● | **Ministry of Business, Innovation & Employment**<br>Te Puni Kōkiri, Ministry of Health |
| f. Promote volunteering, networking and paid work among older people, as a means to support their sense of wellbeing and social connection. | ● | **Ministry of Social Development**<br>NGOs, health providers |
| g. Increase the accessibility for older people of the built environment and transport services through the implementation of Priority 10(a) of the Disability Action Plan. | ● | **Ministry of Transport**<br>New Zealand Transport Agency |

* Implemented in the first two years.

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| Actions | | Lead<br>Partners |
|---|---|---|
| **4. Improve health literacy.** | | |
| a. Strengthen the capability of the workforce in provider organisations to understand the range of health literacy needs of older people, and improve the accessibility and responsiveness of services. | ● ● | **DHBs** |
| b. Enhance health promotion and service information to Māori, Pacific peoples and other ethnic communities and priority groups to enable greater accessibility and engagement. | ● | **DHBs**<br>Primary health care |
| c. Improve the effectiveness of health literacy information distributed by health and social sector agencies. | ● | **Ministry of Health**<br>Health Promotion Agency |
| d. Support older people's uptake of technologies for communication with health providers and their family and whānau.* | ● | **DHBs**<br>Primary health care |
| e. Increase the accessibility of information on healthy ageing and health and social services through govt.nz, Your Health, SuperSeniors and links to other websites, so that people can be more 'health smart'.* | ● | **Ministry of Health**<br>Government agencies |
| f. Increase public and workforce awareness about and use of advance care planning and enduring powers of attorney across the health sector, government and community agencies and amongst older people and their carers.* | ● | **Ministry of Health**<br>Office for Seniors, Ministry of Social Development, community organisations |

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# Acute and restorative care goals

- Innovations and research support best practice triage, assessment, integrated care, discharge planning, rehabilitation strategies, and follow-up support
- Older people are supported through recovery by specialists and general staff who are competent to deal with common conditions, including frailty, delirium or dementia. Hospital staff and processes respect cultural preferences and differences
- Family, whānau and carers are included in discharge planning and receive training and support to provide ongoing rehabilitation in home and community settings
- Quality measures include patient experiences as well as clinical outcomes.

| Actions | | Lead<br>Partners |
|---|---|---|
| **5. Reduce inappropriate acute admissions and improve assessment processes.**<br>a. Support initiatives to reduce unnecessary acute admissions, for example by extending paramedic roles, improving after-hours clinical support for aged residential care facilities, using intensive home-based support, developing acute geriatric care pathways and applying proven technological solutions.*<br>b. Work with the health sector to streamline acute assessment tools and processes and spread best practice options.* | ● ● | **DHBs**<br>Primary health care providers, emergency response services, aged residential care providers, needs assessment service providers, home and community support providers |
| **6. Improve treatment and outcomes for older people in hospital due to acute ill-health or injuries.** | | |
| a. Promote and implement evidence-based models of care to:*<br>– improve the patient journey and experience, including for those with delirium, dementia, and common frailty symptoms<br>– improve the quality of care for those admitted for falls and fractures, including hip fractures<br>– enhance early supported discharge planning<br>– ensure patient experience and cultural responsiveness are reflected in quality measures. | ● | **ACC**<br>Ministry of Health, Health Quality & Safety Commission New Zealand, DHBs |
| b. Make use of data to identify older people at risk of falls and fractures, to target and coordinate investments and interventions.* | ● | **ACC**<br>Ministry of Health, Health Quality & Safety Commission New Zealand, DHBs |

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| Actions | | Lead<br>Partners |
|---|---|---|
| **7. Support effective rehabilitation closer to home by working across the whole system.**<br>a. Work with the sector (including service users) to identify and promote best practice in:*<br>– rehabilitation partnerships with primary health care, allied health, community nurses, pharmacists, aged care providers, home support providers, family and whānau<br>– home-based and community-based models that support ongoing rehabilitation and restoration of older people<br>– facilitating staff working in rehabilitation to collaborate across workforce groups and work to the top of their scope. | ● | **Ministry of Health**<br>DHBs, primary care providers, aged-residential care, home support providers, older people, and carers |

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# Living well with long-term conditions goals

- Improved methods of early detection and prevention result in fewer older people being affected by long-term conditions or frailty.
- Older people with long-term conditions retain the highest level of mental and physical function possible; they enjoy life, and their communities respect them.
- Older people with long-term conditions are 'health smart', are actively self-managing their conditions to a practical and comfortable level and are supported to do so closer to home.
- The workforces that support older people with long-term conditions, including the health workforce, home and community support services and family and whānau carers, have appropriate resources, structures and training.
- Home and community support services are equitable and appropriate to older people's needs and preferences and maximise their wellbeing.
- Health outcomes for vulnerable older populations with long-term conditions are equitable, with good outcomes for the population as a whole.

| Actions | | Lead<br>Partners |
|---|---|---|
| **8. Improve models of care for home and community support services.**<br>a. Identify and implement models of care that are person-centred, needs-based and equitable, and deliver high-value, high-quality and better outcomes through home and community support services across New Zealand. As part of this work:*<br>– involve service users and their family and whānau<br>– review the role of needs assessment and service coordination<br>– ensure needs assessment and care planning are culturally appropriate and meet the needs of Māori and other priority population groups. | ● ● | **Ministry of Health**<br>DHBs, aged-care providers |
| b. Use interRAI assessment data to identify quality indicators and service development opportunities including with health providers.* | ● | **Ministry of Health**<br>DHBs, aged care providers |

* Implemented in the first two years.

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| Actions | | Lead<br>Partners |
|---|---|---|
| **9. Ensure that those working with older people with long- term conditions have the training and support they require to deliver high-quality, person-centred care in line with a healthy ageing approach.** | | |
| a. Regularise and improve training of the kaiāwhina workforce in home and community support services.* | ● | **Ministry of Health**<br>DHBs, aged care providers |
| b. Ensure undergraduate and graduate curricula support an integrated model of care that:<br>– enables all health professionals to work as one team<br>– works in partnership with older people and their family (including cultural understanding of older Māori)<br>– promotes healthy ageing and restoration<br>– addresses risk factors for social isolation and mental health and problematic alcohol use. | ● ● ● | **Health Workforce New Zealand**<br>Tertiary training providers |
| c. Progress training packages to enhance the capacity and capability of kaiāwhina to support people with long-term conditions and their families and whānau, as part of the *Kaiāwahina Action Plan*.* | ● ● | **Careerforce** |
| d. Develop a range of strategies to improve recruitment and retention of those working in aged care, beginning with an update of the 2011 report *Workforce for the care of older people* and development of a whole of workforce action plan.* | ● | **Ministry of Health**<br>DHBs, aged care providers |
| e. Better utilise the allied health workforce to enhance care for older people in primary health care, home care and aged residential care. | ● | **DHBs**<br>Primary health care, aged care providers |
| f. Enhance workforce capability and training pathways to encourage more entry and retention of the workforce among Māori and Pacific peoples and other ethnic groups.* | ● ● | **Ministry of Health** |
| g. Improve training and information for family carers that helps them to safely and competently carry out their caring role and keep well themselves. | ● | **Ministry of Health** |
| **10. Enhance cross-sector, whole-of-system ways of working.** | | |
| a. Make better use of common points of contact across the health and social sectors to identify and support older people with mental health and alcohol and other drug problems earlier. | ● ● | **Ministry of Health**<br>Ministry of Social Development, DHBs, housing agencies |
| b. Share educational resources and good practice on effective ways to increase physical activity levels among older people with debilitating health conditions to support service improvement. | ● ● | **Providers** |
| c. As part of implementing the *Pharmacy Action Plan 2016 to 2020* (Ministry of Health 2016), improve medicines management and encourage better liaison between pharmacists and other health professionals including through: | | **DHBs** |
| – increasing use of brief interventions, screening, assessment and referral in primary health care, including by pharmacists | ● | |
| – sharing examples of innovative models of care that can be adopted to support pharmacist and pharmacist prescribers' delivery of medicines management. | ● | |

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| Actions | | Lead<br>Partners |
|---|---|---|
| **11. Expand and strengthen the delivery of services to tackle long-term conditions.** | | |
| a. Strengthen the implementation of the New Zealand Dementia Framework, and the actions specified in *Improving the Lives of People with Dementia* (Ministry of Health 2014).* | ● | **DHBs** |
| b. Work with health and social services and communities to become more dementia-friendly.* | ● | **Ministry of Health**<br>Office for Seniors, DHBs, Alzheimers New Zealand, Dementia Cooperative and other dementia organisations |
| c. Reduce the instances of complications from diabetes, particularly for people in aged residential care in line with *Living Well with Diabetes: A plan for people at high risk of or living with diabetes 2015–2020* (Ministry of Health 2015a), by providing tools, resources and quality standards.* | ● | **DHBs**<br>Primary health care, aged care providers |
| d. Better coordinate and integrate rehabilitation for people recovering from a stroke by identifying improvements to business models, the workforce and models of care.* | ● | **DHBs**<br>Ministry of Health, aged care providers |
| e. Provide community-based, early intervention programmes for people with musculoskeletal health conditions, including through the Mobility Action Programme.* | ● ● | **DHBs**<br>Ministry of Health, primary health care |
| f. Improve the early identification of mental illness and other conditions and addictions, such as problematic alcohol use, that can mask or contribute to other long- term conditions. | ● | **Primary health care**<br>DHBs |
| g. Ensure that older people with mild to moderate mental health conditions are able to access mental health services in their communities. | | **Primary health care**<br>DHBs |
| **12. Better enable individuals and communities to understand and live well with long-term conditions and get the help they need to stay well.** | | |
| a. Promote community support for older people with mental illness and substance misuse issues, to both reduce the stigma among older people and help them seek treatment.* | ● ● | **Primary health care**<br>DHBs |
| b. Ensure home and community support models of care cover advice to and support for older people to remain physically and mentally active, and strengthen skills they may have lost. | ● ● | **DHBs** |
| c. Investigate options for rehabilitation services to support older people with low vision.* | ● ● | **Ministry of Health** |
| **13. Use new technologies to assist older people to live well with long-term conditions.** | | |
| a. Include health apps targeting older people with long- term conditions in the health app library that is currently being developed.* | ● ● ● | **Ministry of Health** |
| b. Promote use of technology options to monitor conditions and alleviate social isolation, especially among rural and remote locations.* | ● ● ● | **DHBs**<br>Primary health care |
| c. Promote the use of assistive technologies to support home-care workers to achieve good outcomes. | ● ● | **DHBs** |

* Implemented in the first two years.

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| Actions | | Lead<br>Partners |
|---|---|---|
| **14. Improve oral health in all community and service settings.** | | |
| a. Develop clinical pathways for optimal dental care throughout ageing and into the end of life, to maintain independence and minimise pain. | ● | **Ministry of Health**<br>DHBs, PHOs, oral health service providers |
| b. Identify and promote innovative care arrangements for the oral health care of older people receiving home and community support services and living in aged residential care. | ● ● | **Ministry of Health**<br>DHBs, PHOs, oral health service providers, aged care providers |
| c. Disseminate updated information and advice on dental care to older people's families and carers, and aged- care providers.* | ● ● | **Ministry of Health**<br>DHBs, PHOs, oral health service providers, aged care providers |

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# Support for people with high and complex needs goals

- Older people with high and complex needs:
  - are able to live as independently and actively as possible
  - have the information and freedom to make good choices about the care and support they receive
  - know that health care workers understand their wishes and support their needs
  - are assured that information about their circumstances and needs flows easily between health care workers, in an integrated manner
  - have care plans that reduce the likelihood they will deteriorate markedly after a health event
  - are able to access care and support irrespective of their financial position
  - experience equitable access to services and equitable outcomes regardless of ethnicity or location
  - move easily to and through care settings that best meet their needs
  - have reduced need for acute care.
- Families, and whānau and carers have the support, information and training they need to help the older people they care for, and the stress of caring does not affect their own health.
- District health boards bring together data from various sources, know the value and quality of the care they provide for older people in their district and can easily learn from other DHBs.

| Actions | | Lead<br>Partners |
|---|---|---|
| **15. Focused care of frailty in the community.** | | |
| a. Explore the possibilities for a frailty identification tool to enable primary and other health professionals to identify frail older people earlier.* | ● ● | **Primary health care**<br>DHBs |
| b. Build responsiveness to frailty in primary health care settings and improve links to all necessary supports, treatment and rehabilitation services. | ● | **Primary health care**<br>DHBs |

* Implemented in the first two years.

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| Actions | | Lead<br>Partners |
|---|---|---|
| **16. With service users, their families and whānau, review the quality of home and community support services and aged residential care in supporting people with high and complex needs and involving family and other caregivers.** | | |
| a. Review the quality of home and community support and aged residential care in supporting older people with high and complex needs with service users and promote service commissioning models that enable such people to receive the care most suited to their needs, without unnecessary barriers to moving between care settings or deciding funding sources. | ● ● | **DHBs**<br>Ministry of Health, ACC, NZ Aged Care Association, aged care providers |
| **17. Integrate funding and service delivery around the needs and aspirations of older people to improve the health outcomes for priority population groups.** | | |
| a. In specific locations, trial commissioning one organisation to coordinate the health and support services for frail elderly people that:<br>– are strongly person centred and take account of family and whānau carer needs<br>– assist older people to meet their individual objectives<br>– minimise the need for the most expensive health and support services<br>– could include primary health care, pharmacy, ambulance, home and community support, aged residential care and acute care services. | ● | **DHBs**<br>Ministry of Health, service providers |
| b. Ensure that some trials focus on population groups that currently have poorer health and social outcomes or are not well catered for in current approaches. | ● | **DHBs**<br>Ministry of Health, service providers |
| c. Develop referral systems for older people at risk of or experiencing social and economic isolation through their contact with primary care, aged-care needs assessors, social housing, the ACC and other government agencies. | ● ● | **DHBs**<br>Government agencies, NGOs |
| d. Improve the coordination of health and social services to vulnerable older people within health and across the social sector. | ● | **DHBs**<br>Government agencies |
| **18. Improve the physical and mental health outcomes of older people with long-term mental illness and addiction.** | | |
| a. Improve access to physical health services among people with high mental health and addiction needs, and improve integration of these services with residential care or home care services. | ● ● | **DHBs**<br>Specialist AOD and Mental Health Services, primary health care, Ministry of Health, NZ Aged Care Association, aged care providers |

* Implemented in the first two years.

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| Actions | | Lead<br>Partners |
|---|---|---|
| **19. Better integrate services for people living in aged residential care.** | | |
| a. Develop standard referral and discharge protocols between aged residential care facilities, pharmacists, primary care (including providers of after-hours services and medicines advice), ambulance and hospital services.* | ● | **DHBs**<br>NZ Aged Care Association and aged residential care providers, pharmacists, primary care, ambulance |
| b. Explore technology options for providing advice and triage for aged residential care facilities, especially after hours. | ● | **Ministry of Health** |
| c. Ensure systems, resources and training are in place that allow aged residential care facilities to communicate with and involve family and whānau at the point of discharge from hospital or where urgent care is needed. | ● | **Aged residential care providers**<br>DHBs, Ministry of Health |
| d. Explore options for aged residential care facilities to become providers of a wider range of services for older people such as post-acute restorative care, including non-residents. | ● ● | **DHBs**<br>NZ Aged Care Association, Ministry of Health |
| **20. Improve integration of information from assessment and care planning with acute care services, and with those responsible for advance care planning.** | | |
| a. Develop systems that collate relevant information and make it readily available at the point of care, as well as for planning at all levels. | ● | **Ministry of Health**<br>DHBs, primary health care, pharmacists, aged residential care providers, home and community support providers |
| b. Develop tools and resources for health professionals and providers to support the integration of long-term care management, acute care services and advance care planning. | ● ● | **DHBs**<br>Service providers |
| c. Ensure home and community support staff and, where appropriate, social workers and a range of health professionals, are able to contribute to shared care plans and interdisciplinary teams. | ● | **Primary health care**<br>DHBs, Ministry of Health, home and community support providers |
| **21. Improve medicines management.** | | |
| a. Develop education partnerships between pharmacists and other health professionals to increase medication adherence and make better use of pharmacists' expertise. | ● | **DHBs**<br>Pharmacists, primary health care, home and community support providers, aged residential care providers |
| b. Implement pharmacist-led medicines reviews for older people with high needs receiving home and community support services and those in aged residential care. | ● ● ● | **Primary health care**<br>Pharmacists, Home Support providers, aged residential care providers, DHBs |
| c. Ensure models of care and contractual arrangements provide equitable access to medicines management services targeting people receiving high-risk medicines and/or polypharmacy, people in aged residential care and older people with complex health needs living in their own homes.* | ● | **DHBs**<br>Pharmacists, primary health care, home and community support providers, aged residential care providers |

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| Actions | | Lead<br>Partners |
|---|---|---|
| **22. Build the resilience and capability of family and whānau, volunteer groups and other community groups that support older people with high and complex needs and those with end-of-life care needs.** | | |
| a. Improve the support for informal carers in alignment with the *Caring for Carers: New Zealand Carers' Strategy Action Plan for 2014–2018*, including for various types of respite care, guidance and information, and training. | ● | **Ministry of Social Development**<br>Ministry of Health, Ministry of Business, Innovation & Employment, ACC |

* Implemented in the first two years.

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# Respectful end of life goals

- The health system responds to older people's goals and care needs at the end stages of life and to the needs of their families, whānau, caregivers and friends involved in their end-of-life care.
- All health care teams are responsive to the cultural needs of different groups.
- Health service providers coordinate palliative care to ensure all providers in the health system are used to their fullest. All of those who support people dying in old age are aware of the dying person's plans and know their own role in achieving those plans.
- People die feeling as comfortable and safe as possible.
- Expert advice and support is available to families and whānau, other carers and the health workforce involved in end-of-life care.

| Actions | | Lead<br>Partners |
|---|---|---|
| **23. Build a greater palliative care workforce closer to home.** | | |
| a. Ensure that core elements of end-of-life care (such as aligning treatment with a patient's goals, basic symptom management and psychosocial support) are an integral part of standard practice for all relevant health professionals and health care workers. | ● | **Ministry of Health**<br>Tertiary education providers, aged care providers, other health providers |
| b. Revise national referral guidance for specialist palliative care to better support sector understanding of the interface between specialist and primary palliative care. | ● | **Ministry of Health**<br>DHBs |
| c. Better utilise pharmacists, allied health and advanced nursing roles, and specialist palliative care nurses as members of integrated palliative care teams. | ● | **Ministry of Health,**<br>DHBs, PHOs |
| d. Encourage the use of new technologies to both support people at the ends of their lives to remain in their homes and enable easy access to shared clinical records and specialised support and advice, such as telecare, e-monitoring and assistance technologies in the home. | ● | **Ministry of Health,**<br>DHBs |
| **24. Improve the quality and effectiveness of palliative care.** | | |
| a. Work with the Palliative Care Advisory Panel to implement the actions from the 2016 Review of Adult Palliative Care Services.* | ● | **Ministry of Health** |
| b. Develop and agree national service expectations and an outcomes framework for palliative care. | ● | **Ministry of Health**<br>DHBs |
| c. Support the implementation of Te Ara Whakapiri: Principles and guidance for the last days of life (Ministry of Health 2015b).* | ● | **Ministry of Health**<br>DHBs |
| d. Progress options for a national survey of patient and family and whānau carers' experiences of the care provided at the end of life to ensure person centred care.* | ● ● | **Ministry of Health**<br>Health, Quality & Safety Commission New Zealand |

* Implemented in the first two years.

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# Implementation, measurement and review

| Actions | | Lead<br>Partners |
|---|---|---|
| **25. Implement the Healthy Ageing Strategy.**<br>a. With health and social sector partners, complete a Healthy Ageing Strategy Implementation Plan within the first four months of the Strategy's release.* | ● ● ● | **Ministry of Health**<br>Wide range of partners |
| **26. Include older people in service design, development and review and other decision-making processes.** | | |
| a. Work with older people to identify outcomes they wish to achieve from the services they receive and indicators of these desired outcomes when services are being designed or reviewed. | ● ● | **DHBs** |
| b. Ensure there are feedback loops through which PHOs, DHBs and the wider health system can learn from outcomes, including patient experience, and plan for service and workforce improvement. | ● | **DHBs**<br>Primary health care, ACC |
| c. Improve the knowledge of user's experience in home and community support and in aged residential care for service commissioning and monitoring outcomes.* | ● | **Health Quality & Safety Commission New Zealand**<br>Ministry of Health DHBs |
| d. Include representatives of older people in DHB forums.* | ● | **DHBs** |
| e. As part of implementing the *Pharmacy Action Plan 2016 to 2020* (Ministry of Health 2016), co-design a service model with consumers to support the development and implementation of a minor ailments and referral service.* | ● | **Ministry of Health**<br>Pharmacists DHBs |
| **27. Establish an outcomes and measurement framework, commissioning and review processes.** | | |
| a. Develop a system to evaluate progress against the goals of the Healthy Ageing Strategy and support the health system to be person centred and focused on maximising healthy ageing and independence. | ● | **Ministry of Health** |
| b. As part of the measurement and evaluation system, include an outcomes framework and indicators to assess, support and improve the health outcomes for older people (including where possible relevant measures that are already being produced for other purposes, such as for the Whānau Ora Outcomes Framework). These indicators will form contributory measures that district alliances can monitor to help them improve on the overall health system level measures. | ● | **Ministry of Health**<br>DHBs, health providers, organisations representing older people |
| c. Regularly review the Healthy Ageing Strategy implementation progress and the prioritisation of actions.* | ● | **Ministry of Health**<br>DHBs |
| d. Publish indicators for each DHB on a regular basis.* | ● | **Ministry of Health**<br>DHBs |
| e. Develop strategies for lifting performance on indicators including researching the reasons for trends and the reasons for differences from better performing DHBs. | ● | **DHBs**<br>researchers, Ministry of Health |
| f. As part of implementing Health Strategy 2016 action 17(c)(iii), improve commissioning models for older people's services to enable streamlined and flexible contracting that supports providers to be sustainable. | ● | **Ministry of Health**<br>NGOs |

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| Actions | Lead<br>Partners |
|---|---|
| **28. Improve the knowledge base.** | |
| a. Implement a system to collect a minimum dataset on kaiāwhina workforce. | **Health Workforce New Zealand** |
| b. Encourage National Science Challenges to appropriately communicate research relating to older people to a broad audience and encourage stakeholders to use the research to inform policy development and service design.* | **Ministry of Business, Innovation & Employment** |
| c. Ensure alignment between the New Zealand Health Research Strategy, key research initiatives and centres with the identified needs of the ageing population, and that the research informs policy and service and workforce development.* | **Ministry of Health** |

* Implemented in the first two years.

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# Living Well With Dementia Model of Care

5 JULY 2017

**Medicine, Health of Older People, Emergency & Clinical Support Services**

A Healthier Northland
He Hauora Mo Te Tai Tokerau

NORTHLAND DISTRICT HEALTH BOARD
Te Poari Hauora Ā Rohe O Te Tai Tokerau

1. EXECUTIVE SUMMARY ..... 1

Introduction ..... 1
The Problem ..... 2
Recommendations ..... 2

2. BACKGROUND AND STRATEGIC CONTEXT ..... 3

3. CURRENT STATE ..... 4

Overview ..... 4

Addressing inequities - Consumer Co-design ..... 5

Drivers for Change ..... 7
Ageing Population and Dementia Prevalence ..... 7
Shifting the Paradigm from specialist to primary and community care ..... 8
Increasing cost of Specialist Dementia Services ..... 9

4. FUTURE MODEL OF CARE ..... 9
Approach ..... 9
Vision ..... 9
Living with dementia model of care ..... 10
Funding Plan ..... 11

The model of care: ..... 12
How will we measure success? ..... 12

Outcome Measures: ..... 12

Process Measures: ..... 13

5. RISK MANAGEMENT FOR AN AGEING POPULATION ..... 13

# 1. EXECUTIVE SUMMARY

## *INTRODUCTION*

'Dementia is one of the main causes of dependence and disability at older ages[1]'. There is no known cure and death normally occurs within 8-10 years from the onset of obvious dementia symptoms. It is a condition of the ageing brain, and estimated that 20 percent of over 80 year olds have dementia with prevalence increasing to 30 percent of over 90 year olds.[2] Census 2013 has identified that Northland DHB's population of over 80 year olds will double between 2013 and 2028 increasing from 6,550 to 12,700.

The Dementia Economic Report 2016[3] shows that new models of care are urgently needed to reduce the significant and increasing human and financial cost of dementia.

Health system expenditure is currently dominated by the rising cost of aged care in a traditional health system focused on late and specialist dementia diagnosis, responding to acute needs and institutionalisation.

Additional costs relate to:

- A myriad of co-morbidities that are exacerbated by dementia and, injuries and illnesses attributable to the functional and cognitive decline that accompanies dementia, eg repetitive wound care.
- Hi-end utilisation of personal care products, eg incontinence support
- The financial and social impact of disconnected health and social services

Emergency Departments are often the portal of admission for people with dementia and represent a last chance to prevent unnecessary hospitalisation.

Developing a *Living Well With Dementia Model of Care* focuses on the care of people with long term conditions living well throughout their dementia journey. The model includes support that will enable people to stay well and live independently for longer in their own homes, rather than unnecessary hospitalisation or entering residential care sooner than they otherwise might.

*The Living Well with Dementia Model of Care* was piloted by Waitemata DHB and its two Primary Health Organisations (PHOs) and evaluated by The University of Auckland, Department of Geriatric Medicine. The evaluation provided evidence that the *'living well with dementia model of care'* is low cost, provides high quality care, is

[1] World Alzheimer's Report, 2014. *Dementia and Risk Reduction an analysis of protective and modifiable factors.* www.alz.co.uk/worldreport2014
[2] Brodaty, H et al. *Alzheimers & Dementia.* 2013; 9(3):310-317
[3] New Zealand Alzheimer Society/Deloitte, *Dementia Impact Report(March 2017)*

clinically safe, and improves quality of life for those with dementia and their family and whanau carer who carries the burden of care.

The purpose for Northland DHB developing a Dementia Model of Care is:

- To continue to shift the dementia care paradigm and pathway from secondary to primary and community care, supporting general practice and primary health care teams to adopt integrated long term conditions (LTC) care coordination.
- To adopt the principles of the National Dementia Framework (2013) and Northern Regional Service Guide (2013) to provide earlier diagnosis and continuity of care for people with dementia and their families.
- To provide a framework for prioritising the allocation of resources across the dementia care continuum, *and*
- To meet Northland DHB's continuing obligations under the 2017/18 Annual Plan and Northern Region Service Plan and future years.

### *The Problem*

Already 20 percent of Northland people are 65 years and over and this will approach 25 percent in 10 years' time. At that time there will be more older people living in Northland than were in the Auckland DHB catchment at the 2013 census.

The challenge is how Northland DHB will increase the relatively low levels of coverage for diagnostic, treatment and continuing care services while maintaining quality, managing demand and cost of care predominately delivered through a specialist model of care by a limited number of gerontology specialists and practitioners and Psychiatric Services for Older People (POPs) resource.

### *Recommendations*

i. That primary care, diagnose and manage mild cognitive impairment (MCI) and typical dementia.
ii. That resource is allocated to support primary care to adopt integrated long term condition (LTC) care coordination targeted to support the person with dementia rather than the condition, and towards practices over-represented in the over 80 years population.
iii. Engage with Neighbourhood Healthcare Homes (NHH) practices to ensure alignment with current service improvement initiatives.
iv. That equitable funding allocation be applied to future workforce and service improvement to meet the needs of people from diagnosis to end of life care, regardless of where they live.
v. That addressing the needs of people experiencing cognitive and physical frailty is inclusive across all Northland DHB planning and funding and facility and site-planning activity.

## 2. BACKGROUND AND STRATEGIC CONTEXT

Improvement in dementia care is a Ministry of Health priority, as described in the 'New Zealand Framework for Dementia Care' (2013)[4]. The framework was developed to guide District Health Boards (DHBs) to develop dementia pathways that integrate health and social services at local levels to provide people with dementia services they need, from diagnosis to the end of life. It encourages diagnosis and management of mild cognitive impairment and typical dementia in primary care. The National Framework stresses the impact of dementia on those whose lives are most affected by the journey of this disease, in particular the family and whanau carer who carries the burden of the 24/7 care. Stress and uncertainty are commonly caused by a diagnostic process which often takes more than twelve months.

The New Zealand Healthy Ageing Strategy (2016)[5] recognises the diversity of older people, and ultimately seeks to maximise health and wellbeing into and throughout people's older years.

To achieve the strategic vision and framework for healthy ageing the focus is on:

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

The focus of the District Health Board Annual and Northern Region Service Plan for 2017/18 is on implementing the Healthy Ageing Strategy and continuing to strengthen dementia pathways to ensure that they are used consistently, supported by education and support people living with dementia and their family, whanau and carers.

Northland DHB has continued to have robust engagement with people and whanau experiencing dementia, and a range of stakeholders and communities of interest. Following a consumer co-design process with 37 consumers and carers in 2015 a dementia care coordination pilot was implemented in two general practice settings in the mid-North, between 1 February 2016 and 31 December 2016.

Two pathways were tested:

- *The Northern Region Clinical Pathway for the Management of Cognitive Impairment* which is designed to enable primary health care teams (PHTs) to make timely diagnoses for cognitive impairment enabling the earlier provision of support and services for patients and whanau/family; *and*

[4] New Zealand Framework for Dementia Care, November 2013. www.health.govt.nz
[5] NZ Ministry of Health, Healthy Ageing Strategy (13 December,2016).

- *The Northland Community-Based Dementia Care Coordination Pathway* which is the basis for care coordination engagement and the support for patients, carers, family and whanau through the phases of dementia care.

The findings of the two pilot programmes found benefits and lessons for shifting care delivered in specialist services to primary and community care, trained and supported by specialists in dementia care:

- 27 patients participated in the pilot, including 17 previously undiagnosed.
- There was good matching of case finding with prevalence estimates.
- There was very positive feedback from the two participating practices regarding the benefit of having a structured care coordination pathway.
- The additional time for care coordination across the five phases of dementia care was consistent with the Waitemata DHB Pilot Programme.
- There was very high Maori participation and access for Maori whanau.
- Only 5/27 people were referred onto secondary services for diagnostic support over the period of the pilot.

However:

- There was one referral to the Northland Alzheimer's Society for information, education and advisory support particularly for carers. For Maori there was a preference for mobilizing whanau networks and access to wrap-around Whanau Ora Services where a general practice was attached to a Maori health provider.
- Data collection solutions are needed for any future roll-out and increases in patient numbers.

# 3. CURRENT STATE

## *OVERVIEW*

The introduction of the Northern Regional Dementia Care Pathways into Northland general practices with education and training support initiated a process of building primary care confidence for diagnosing and managing mild cognitive impairment and typical dementia. General practitioners not utilising a dementia care pathway or are reluctant to make a diagnosis commonly results in GPs referring a person to secondary care at a late stage of the condition, for a definitive diagnosis of dementia and care planning guidance. By this stage the person with dementia is commonly exhibiting challenging behaviours, the carer is heavily stressed and family and whanau coping capacity is frequently at breaking point. The evidence[6] now exists that earlier diagnosis combined with regular specific psychosocial interventions won't stop progression of the underlying dementia disease, but can slow down the cognitive and functional decline in significant numbers of people with dementia which

[6] World Alzheimer's Report, 2014. *Dementia and Risk Reduction: an analysis of protective and modifiable factors.* www.alz.co.uk/worldreport2014

directly improves the quality of life and health outcomes for the person and their family and whanau carer(s).

Uncoordinated responses across the whole continuum of dementia care remain and there are certain points along the journey where support is crucial from the individual and carer perspective. Northland consumers consistently raise the need for assistance to negotiate uncertain and fragmented health and social services, and having access to someone able to assist them "where and who to go next".

### *ADDRESSING INEQUITIES - CONSUMER CO-DESIGN*

**Addressing Inequities**

1. **What inequities exist in relation to dementia care, what are the determinants or factors behind the inequities?**
2. **How will the Living Well with Dementia Model of Care reduce or eliminate the inequities?**
3. **How will reduction in inequities be measured?**
   - **Increase in the number of people with earlier diagnosis in primary care**
   - **Time from diagnosis to ARRC admission**
   - **Carer wellbeing (InterRAI)**
   - **Timely access to appropriate services such as; early diagnosis in primary care, care coordination, information and health literacy support, comprehensive geriatric assessment and interdisciplinary team management.**

Models of care or prescriptive pathways can create barriers to practicing good "supportive care" as when someone has a model of care in mind it is easy to fit a person's symptoms or situation to the model, forms or their own perceptions around a diagnosis. Listening to the goals and aspirations of the person and fully understanding their symptoms and situation and then drawing on various functional and psychosocial choices may help to improve their participation in care planning and continuity of care.

*"Assessments – "start with the story not the forms", what does this really look like in a whanau setting? Timing can result in a poorer assessment (a good day vs a bad day), people may not want or be ready to tell "others". Helping people to "say-it." Forms are a barrier for some".*

For the person with dementia and their carers a good deal of guidance is required through the progressive stages of dementia and uncertainty in order for them to be able to benefit from the possibilities of good quality supported care.

*"Having coping mechanisms for whanau is important. The whanau left behind have to make the decisions, and you can't make decisions without knowledge, resources and support".*

*"There is significant benefit in sharing practical tips and means of coping in a group and exploring ideas that fit our own circumstances".*

*" This needs to be at the beginning when things start to go wrong"*

Maori maybe more likely to experience dementia due to the significant impact of long-term conditions. Workforce development in primary, community and secondary care must include training that supports staff and volunteers to competently support Maori whanau.

*"Maintaining the integrity of cultural aspirations and practices, and familiar connections of those experiencing cognitive impairment is important".*

For people with dementia to be genuinely at the centre of their own care, there will need to be a shift to person-centered or self-directed funding options that may see the unbundling of current NASC service coordination processes in order for the person with dementia or their primary carer to drive the process.

*"Whanau hold a strong commitment and aroha for those they are caring for and the strength for mobilising support and "whanau network" is important for carers' well-being and their ability to maintain their caring role".*

The treatment gap research shows that there are many currently living with cognitive impairment and dementia who have not received a formal diagnosis either recognised or documented in primary care. They and family carers do not therefore have access to treatment, care and organised support that getting a formal diagnosis can provide. Patient stories indicate experiences of a diagnosis being withheld from those with cognitive impairment or dementia, carers or both.

*Whanau struggle to know where or who to go to for help - "the hardest part is having no support", "trying to get information"," knowing how to get care".*

*"Not understanding what to expect or what was happening and why I was a stranger to what my father was going through", managing "the annoyance, not the memory, all the other stuff", "burn-out" "if we had had knowledge or information it might not be so difficult".*

Dementia is not commonly recognised as a terminal progressive illness often resulting in the exclusion of primary palliative care. There is a planning and funding gap regarding palliation and end of life care for people with dementia and their primary carers beyond death.

People with dementia should be encouraged and enabled to exercise their autonomy in options for future care planning (ACP) consistent with their values and preferences and reviewed and revised over time. Improving function and achieving comfort (palliation) may be required during various phases of dementia and at different degrees. Carers should not be excluded from *Caring for Carers* innovation occurring in primary care.

*"The importance of understanding the story and expectations"*

*"Whanau would go back to their GP or general practice when they need information or help". "They have more knowledge of the person and whanau*

*than Whangarei." (Describing an unnecessary hospital admission).*

People with dementia are particularly vulnerable to harm and poor health outcomes during a hospital admission from a range of risks such as hospital acquired infections, agitation and falls, delirium with reduced capacity for informed consent and adherence to investigations, treatment, procedures and rehabilitation from which they can be deemed ineligible.

Rapid risk screening at the "front door" will positively screen people with dementia for frailty triggering an immediate referral to a gerontology resourced team initiating a comprehensive geriatric assessment and care planning. Implementing an **A**cute **C**are For the **E**lderly Model of Care is proposed to better support vulnerable older people throughout their entire inpatient journey and safe transition back to the community.

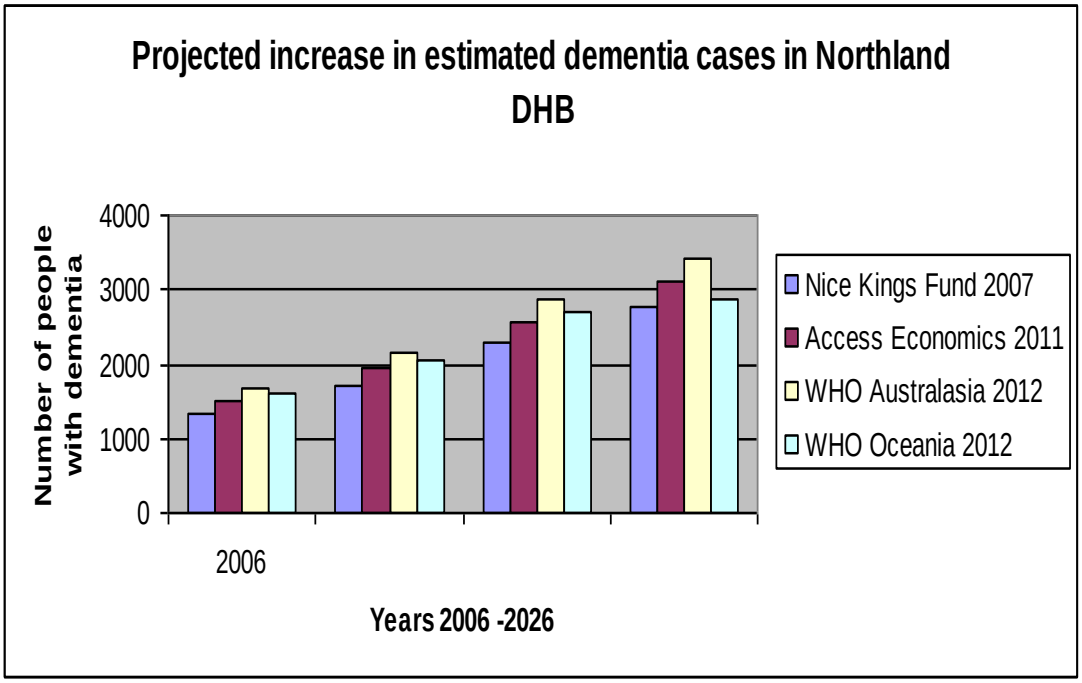
## DRIVERS FOR CHANGE

### AGEING POPULATION AND DEMENTIA PREVALENCE

Northland has a higher percentage of older people living in the community compared to most of the country, and we are experiencing significant growth in those over 75 years. Projected figures from the 2013 census indicate that the 65 and over population will exceed 20 percent of Northland's total population in 2018 and by 2028 will exceed the total current 65 and over population of Auckland DHB. By 2043, there will be almost 60,000 people 65 and over with the greatest growth in the 75 and over age group.

Estimates of the number of people with dementia are made by applying a prevalence estimate (the proportion of people affected by dementia) to the numbers of people in any given population. The graph below presents a range of increasing prevalence estimates for Northland and uses the New Zealand all DHB's Estimated Resident Population 2006-2026 for population data[7].

[7] Thomson. S, *Prevalence and Incidence in Northland* (31 July 2013),NRA




The formulas applied do not include differences related to ethnicity and risk factors pertinent to Northland's ageing population such as alcohol and drug dependency, prison population and vascular and diabetes risk factors. Northland's projections therefore are likely to be under-estimated.

### *Shifting the Paradigm from specialist to primary and community care*

Half of all referrals to a Geriatrician have primary cognitive impairment with late diagnosis in secondary services.

Mild cognitive impairment and dementia remains undetected, under-diagnosed or disclosed and therefore under treated or managed in the primary care environment where individual GPs may only have small numbers of enrolled "patients" experiencing cognitive impairment and therefore a lack of dedicated resource to guide people with mild cognitive impairment or dementia and carers through a coordinated process.

The specialist model of dementia care does not facilitate holistic management or care coordination for multi-level morbidities. These are core functions of primary care.

Primary care is the natural first point of call and therefore plays an important role in the identification of likely cases, diagnosis of "typical" MCI, continuing care and referral for "atypical" presentations.

### *Increasing cost of Specialist Dementia Services*

Northland's ageing population will have a significant impact on the capacity and capability of all funded services.

Dementia will be a significant contributor to the projected HOP cumulative investment plan (2015-2021). In 2017 a cumulative investment of $5,250,981 is projected rising to $13,582,383 by 2021.

Based on 2017/18 funding submissions and service improvement proposals the following expenditure is applied to specialist dementia services (**excluding pay equity**).

| **Specialist Dementia Service** | **Cost** |
|---|---|
| ARRC Dementia (158 beds) | $4,228,778 |
| Psychogeriatric Hospital Level Care (20 beds) | $910,005 |
| Residential Respite (two secure dementia respite beds) | $126,003 |
| Alzheimer's Society - Information and Advice | $211,921 |
| Dementia Day Care Services | $479,836 |
| Dementia Care Pathway Development | $150,000 |
| **Total Annual Funding** | **$6,106,543** |

## 4. Future Model of Care

### *Approach*

Developing a new model of care recognises Northland DHB's projected population growth for those over 80 years and the potential for DHB services and contracted services being overwhelmed with the needs of people with cognitive impairment and their family and whanau carer.

The *"living well with dementia model of care"* enables the problems of dementia to be anticipated and managed as they arise, rather than responding to crises.

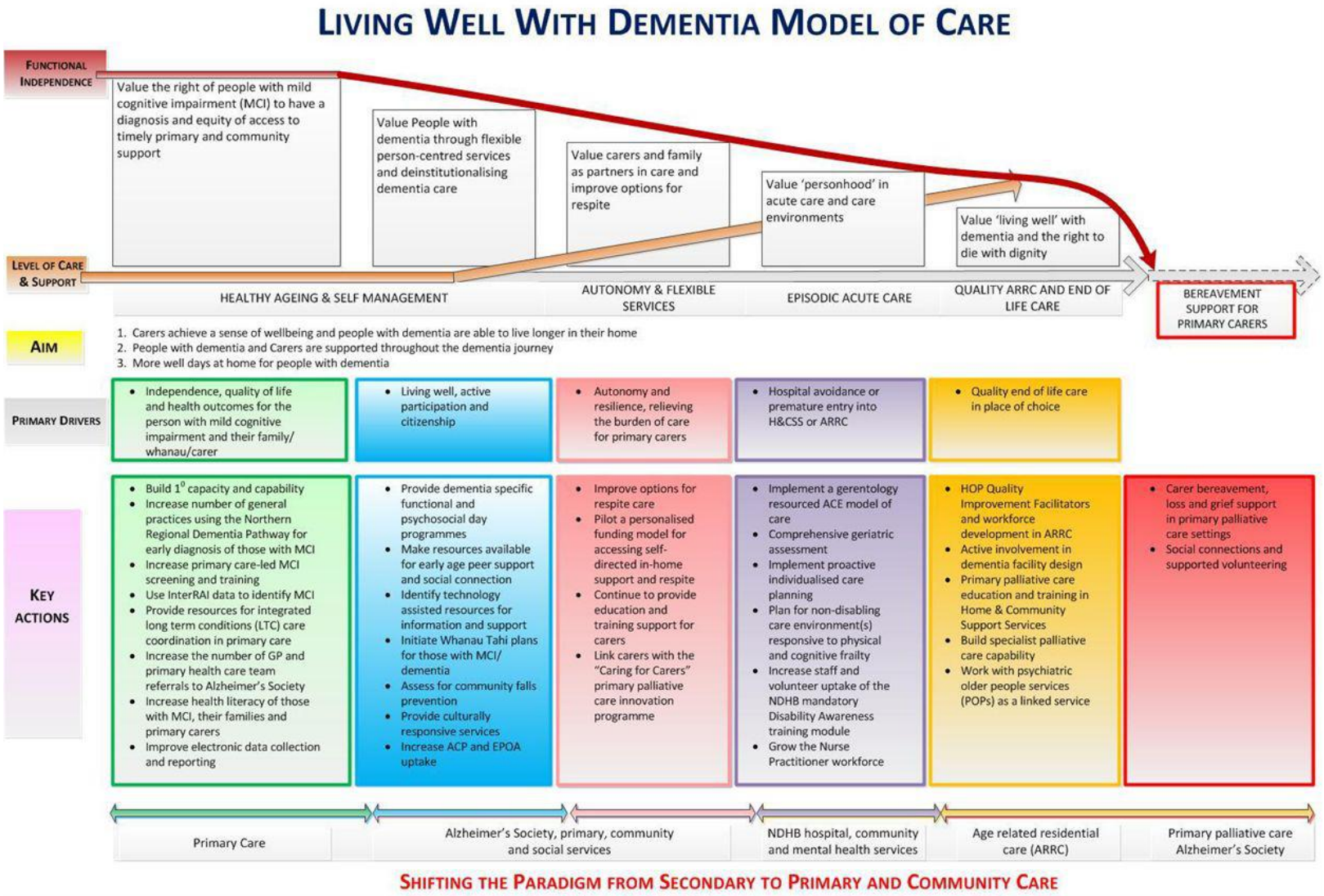
### *Vision*[8]

A society in which people with dementia and their families and whanau remain accepted members of the community. This acceptance encourages people with dementia and their families and whanau to engage early with an integrated health system which recognises them as valued partners and supports them to achieve optimal well-being and quality of life throughout their journey with dementia from diagnosis until death, and for families and close carers, beyond.

[8] Northern Region Dementia Services Guide (2013).

### *Living with Dementia Model of Care*

The following diagram illustrates a person-centred model of care aimed at achieving the vision and following model of care description.



# FUNDING PLAN

| | | | | | |
|---|---|---|---|---|---|
| **GAP ANALYSIS** | • Diagnosis not known or made available to patients with dementia (PWD)/family carers<br>• Lack of information and knowledge of support options<br>• Late diagnosis in secondary care – PWD and family already in crisis<br>• Uncoordinated responses across the continuum of care<br>• No proactive advanced care planning (ACP) | • Significant number of years between "early" symptoms/mild cognitive impairment (MCI) and access to functional, psycho-social and peer support<br>• Increased burden of 24/7 care for family carers<br>• Prescriptive packages of home and community support services not meeting the needs of PWD/family carers<br>• Inequitable access to appropriate dementia care and support services | • Historical focus on unsustainable formal services and institutionalisation<br>• Inpatient and community services becoming overwhelmed with PWD/ cognitive impairment<br>• Lack of sustainable workforce with dementia training<br>• Lack of comprehensive geriatric assessment and individualised care planning<br>• Increasing risk of harm and poorer health outcomes | • Dementia not recognised as a terminal, progressive illness<br>• Limited access to specialist dementia care closer to home | • Prolonged 24/7 burden of care impacting on the wellbeing of carers<br>• Social disconnection, loss and grief experienced by family carers |
| **FUNDING** | • **Dementia Care Pathway Development**<br>- GP/PHCT Mocca Screening and diagnosis in primary health care<br>- PWD and family carers know their diagnosis<br><br>- Care coordination:<br>* from diagnosis to end-of-life care<br>* Whanau Tahi plan<br>* ACP conversation(s) | • **Alzheimer's Society:**<br>- Information and advice<br>- Specialist dementia day programmes<br>- Care coordination and education<br>- Peer support PWD and family carers<br><br>• Flexible self directed carer support and respite care<br>• Access to Falls & Fracture Prevention programme(s)<br>*(No exclusions if PWD able to participate or family carer able to prompt exercises) ACC funded* | • Comprehensive geriatric care programme (ACE)<br>- hospital<br>- community<br>• Workforce development within current budget(s) and FTE<br>• Need for increase in Aged Residential Care bed capacity (ARRC demand calculations)<br>- Psychogeriatric $<br>- Dementia rest home $<br>- Residential respite $ | • ARRC quality improvement and educational support<br>- End of life care<br>- Primary palliative care | • Access to Alzheimer's Society volunteer programme and peer support network<br>• Care coordination → primary/community services |

**NB: Red entries are new or enhanced services**

### *THE MODEL OF CARE:*

- Is empowering to the person with dementia, carer, family and whanau enabling them to "live well" with dementia
- Addresses inequalities
- Supports the capacity and capability of the primary and community workforce
- Includes training to competently support Maori whanau and people with increasing disability
- Is community-orientated
- Focuses on early detection, independence, health maintenance and quality of life
- Continues to build primary care confidence, competence and consistency of diagnosis and management of mild cognitive impairment (MCI) and typical dementia
- Provides access to timely care coordination in primary care by a qualified health professional with a current practicing certificate and additional learning in assessment and management of dementia, which remains in place until the person with dementia dies or is admitted to Age Related Residential Care (ARRC) and beyond for primary carers
- Does the right thing, at the right time, in the right place and with the right competencies
- Supports access to functional and psychosocial day programmes and services
- Is part of an integrated continuum of care, and strengthens an intra-disciplinary approach and shared care planning
- Supports early referral to a specialist dementia education and support programme provider
- Continues to support earlier recognition and referral to secondary care of atypical dementia
- Enables specialist services to focus on complex presentations of cognitive decline, and significant behavioural or psychological symptoms
- Addresses the drivers for change
- Is value for money within an integrated system.

### *HOW WILL WE MEASURE SUCCESS?*

The following measures are required or proposed for 2017/2018:

### *OUTCOME MEASURES:*

- Utilisation trends for dementia care in ARRC
- Time from diagnosis to ARRC admission
- Improvement in primary carer wellbeing (InterRAI).

### *Process Measures:*

- Pathway utilisation in primary care (number of hits)
- Number of GP/PHCT referrals to Northland Alzheimer's Society/number of participating practices
- Uptake of GP/PHCT use of education resources designed by the Goodfellow Unit
- Uptake of care coordination/diagnosed/newly diagnosed
- Number/percentage changes in primary care referrals for secondary care diagnoses
- Equitable access to information and training resources/locality/ethnicity
- /people with dementia /carers
- Uptake of respite care options.

## 5. Risk Management For An Ageing Population

While the current strategic focus is on living well with dementia this does not mean less attention to the complex, medical, social and ethical impact of physical and cognitive decline that leads to death.

At the time of the 2013 Census ADHB had (and still has) >100 beds dedicated to HOP services. We currently use approximately 15. We need to understand what this massive discrepancy means given the pace of Northland's population projections. Either we start devoting more facility to the needs of the most vulnerable older people including those with cognitive impairment and delirium or we plan to make our entire facility and care model appropriate for their needs. Frailty will be the commonest condition we treat in the adult environment. It doesn't feature in any diagnosis coding. This has to be a major focus of our models of care.

Currently 47 percent of New Zealanders over 65 years of age have Age Related Residential Care as their last place of death and the number of deaths for those over 65 years is going to double. Deaths for those under 65 years will decrease.

Northland's utilisation of the twenty psychogeriatric hospital level beds in ARRC is fluctuating between 80 and 95 percent with rest home dementia utilisation around 90.5 percent. Future ARRC capacity and capability has to be a focus for Northland DHB's HOP Service Planning as our population of over 80 year olds will be double by 2028.

Increases in capacity will need to consider such things as equity of access for both residents and older carers, providers' financial sustainability and continuity of services, limitations of existing facility modification and design, and facility and workforce restraints that may adversely affect those with moderate to severe cognitive impairment

**Health of Older People Service Plan (2017-2020).**

**Final Draft, 4/9/17**

| | | |
|---|---|---|
| **1.** | **Accountability** | Health of Older People Management Team |
| **2.** | **Service Description** | The Health of Older People Service is designed to assess the needs of people, provide service coordination, specialist geriatrician and GNS assessment and appropriate referral to NDHB or community services (such as community falls prevention) for those aged 65 and over, or those "like in interest and age", i.e. under 65 but whose health or disability support needs have been assessed as if they were 65 years or older. People accepted for HOP Services will be known to the Needs Assessment and Service Coordination Service, or will be under the care of a geriatrician or psycho-geriatrician.<br><br>The Northern Region and Northland DHB is committed to supporting the vision of the NZ Healthy Ageing Strategy (2016) which is to see that older people live well, age well and have a respectful end of life in age-friendly communities, and that health equity is achieved especially for Maori and Pacific communities.<br><br>The aim of the Northland DHB Health of Older People Model of Care is that:<br><br>• Older people living in Northland will be able to access a range of primary health care community and specialist services across the region that will optimise their abilities, reduce likelihood of loss of function and support identified needs in a way that is convenient and acceptable to them and their families.<br><br>• Community based services will be locality based, aligned or integrated with primary health care and specialist service teams across Northland. Care will be flexible, to meet clients' needs and focused on improving people's ability to manage their own lives. Clients' and their whanau will be partners in this process.<br><br>• The 1200+ Northland people living in age related residential care facilities will continue to maintain their quality of life through supported quality activities such as falls and pressure injury reduction, access to Geriatrician and enhanced GNS first response support, quality end of life care and collaborative workforce development.<br><br>• There is a foundation for longer-term clinical, financial and workforce sustainability. |

| | | |
|---|---|---|
| **3.** | **Measures** | The following measures, targets and outcomes are required by the 2017/18 Annual Plan (AP) and Northern Regional Health Plan, and the NDHB/ACC Injury Prevention Partnering Agreement 2017-2020.<br><br>**Northern Regional Health Plan 2017/18:**<br>• Regional Cognitive Impairment Pathway utilisation in primary care (number of hits recorded-NRA).<br>• Uptake of Goodfellow Unit dementia education resources by GPs and Practice Nurses.<br><br>**2017/18 Annual Plan (AP)**<br><br>• An exception report where the percentage of older people who have received long term home and community support services in the last three months who have had an interRAI Home Care or a Contact assessment and completed care plan is less than 95 percent.<br>• Number of older people referred for an interRAI assessment to access publicly funded services undergo the assessment and have a service allocated/declined in a timely manner. NDHB timeliness targets set.<br>• Older people seen by a Fracture Liaison Service (target 653).<br>• Number of people prescribed bisphosphonates. Using pharmacy data source<br>• Older people seen by an in-home Strength and Balance Service (target 392).<br>• identified action(s) to improve equity and reported any related activity to improve its level of performance as per AP commitment.( *Increase the number of NASC/GP referrals to Alzheimers Society education and carer support programmes for Maori whanau carers). [Links with NRHP] [EOA]*<br>• Workforce – regularisation: Actions to implement the kaiāwhina workforce action plan and regularise the home and community workforce including guaranteed hours, paid training and wages linked to training *(action included under 'workforce priority' in Annual Plan* |
| **4.** | **Growth predictions** | Northland has a higher percentage of older people living in the community compared to most of the country, and we are experiencing significant growth in those over 75 years. Both the number of older people and rate of increase are increasing.<br>In 2018, there will be 20% (34,335) of northland people 65years and over and this will increase to 22 % to 2020, approaching 26.6 % by 2028, compared with 20.2% nationally.<br><br>Service utilisation increases for those over 80 years of age and Census update 2015 identified that Northland DHB's population of 80+ year olds will continue to increase between 2015 and 2020 from 6965 to 8,220.This age group will have doubled between Census 2013 and 2028 increasing from 6,550 to 12,700. |

| | | |
|---|---|---|
| | | Studies estimate that 20% of 80+ year olds have dementia with prevalence increasing to 30% of 90+ year olds.[1] The prevalence formulae applied to Northland's ageing population do not include pertinent differences related to ethnicity and risk factors such as alcohol and drug dependency, prison population and vascular and diabetes risk factors. Northland's projections therefore are likely to be under- estimated. |
| **5.** | **Key issues related to the 5 themes of the NZ Healthy Ageing Strategy (2016).** | **Service Planning Issues related to the 5 Themes of the Healthy Ageing Strategy (2016).**<br><br>**1. Ageing Well**<br>As the Northland population continues to age, responsive and timely home and community support services are needed to enable people to remain *safely* in their homes and neighbourhood home communities. Home and Community Support Services are becoming an increasingly important part of the health workforce responsive to meeting the increasing acuity and needs of frail older people in the community.<br><br>Family and whanau carers are key partners in care enabling people to remain living at home, often carrying the burden of 24/7 care. Carers need flexible, accessible support and information to be able to appropriately and safely care for an older person while maintaining their own health, self- direction and social connections. Having access to flexible respite care is important for carers being able to sustain their caring role or being able to mobilise other family or supportive community networks over time.<br><br>Contracted Home and Community Support Services (H&CS) are currently funded to provide a historical prescriptive disability support model of care limiting choice and opportunity for more preferred, functional and psychosocial choices for community dwelling older people and their carers.<br><br>InterRAI assessments are completed for older people as part of contact screening and Home Care Assessment for needs assessment and care planning. InterRAI assessments are initiated by the NASC Service. Assessments can be completed by qualified health practitioners trained and competent in using applicable InterRAI assessment tools. There is the opportunity to<br>increase the use and timeliness of InterRAI screening or assessment at the first points of contact with older people or for reassessment when new or changing care needs arise.eg primary care, H&CS, Aged Related Residential. This would continue to inform our understanding of the needs of our ageing population and proactive use of interRAI data including ethnicity data to drive service improvement for healthy ageing.<br><br>1,324 Northland clients received a Home Care InterRAI Assessment by NASC in 2016-17: (northern region: 8,271)<br><br>A higher proportion of Northland DHB assessed clients are Maori, and overall, clients are younger than the northern region average. |

[1] Brodaty,H et al. *Alzheimers & Dementia.* 2013; 9(3):310-317

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| | | 18% are Maori (northern region: 7%)<br>37% aged over 85 years (northern region: 42%)<br><br>Falls are the most common and costly cause of injury for older people. Most falls are a result of a fall in the community so effective integrated approaches to reducing falls, improving bone health so that there are less fractures from falling and improved recovery after falls and fractures will enable older people to stay well and independent at home.<br><br>**2. Acute and Restorative Care**<br>Whangarei hospital has hit its capacity ceiling with increasing pressure on beds and incidence of access block.<br><br>Older people now represent a significant and increasing proportion of Emergency Department and hospital patients. Frailty will be the commonest condition we treat in the adult environment. It doesn't feature in any diagnosis coding.<br><br>The 76+ population make up about 13% of all ED presentations with a high risk of admission at 60%for the over 80 years patient population.<br><br>Forty percent of all admissions to the Whangarei Hospital medical services are over 75 years of age. Medical admissions are rapidly progressing towards geriatric medicine. The 75+ year age group accounted for 90% of the growth of medical admissions over the last 15 years.<br><br>Over the next three years Health of Older People Services need to be actively engaged in Northland DHB's current planning and integration, and site master planning processes. Either we start devoting more facility to the needs of the older population or we plan to make our entire facility and care model appropriate for their needs.<br><br>**3. Living Well With Long Term Conditions**<br>'Dementia is one of the main causes of dependence and disability at older ages[2,]. It is a condition of the ageing brain with no known cure and death normally occurs within 8 - 10 years from the onset of obvious dementia symptoms. Those with dementia experience a myriad of injuries and illnesses attributable to their functional and cognitive decline.<br><br>Studies estimate that 20% of 80+ year olds have dementia with prevalence increasing to 30% of 90+ year olds.[3] Northland DHB's projected population growth for those over 80 years has the potential for DHB and contracted services becoming progressively overwhelmed with the needs of people with cognitive impairment and their family and whanau carer. |

[2] World Alzheimers Report, 2014 *Dementia and Risk Reduction an analysis of protective and modifiable factors.* www.alz.co.uk/worldreport2014
[3] Brodaty,H et al. *Alzheimers & Dementia.* 2013; 9(3):310-317

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| | | Health System expenditure is currently dominated by the rising cost of aged care in a traditional health system focused on late and specialist dementia diagnosis, responding to acute care needs and institutionalisation.<br><br>When a person is referred from primary health care to specialist services at a late stage of the condition for a definitive diagnosis of dementia and care planning guidance, the person with dementia is commonly exhibiting challenging behaviours, the carer is heavily stressed and family and whanau coping capacity is frequently at breaking point. The evidence[4] now exists that earlier diagnosis combined with regular specific psychosocial interventions won't stop progression of the underlying dementia disease, but can slow down the cognitive and functional decline in significant numbers of people with dementia which directly improves the quality of life and health outcomes for the person and their family and whanau carer(s).<br><br>The challenge is how Northland DHB will progressively increase the relatively low levels of coverage for diagnostic, treatment and continuing care services while maintaining quality, managing demand and cost of care predominately delivered through a specialist model of care by a limited number of gerontology specialists and practitioners and Psychiatric Services for Older People (POP) resource.<br><br>**4. Support for People with High and Complex Needs.**<br>Older patients often present with complex health issues or illnesses that underlay chronic diseases. Early access to co-ordinated services can decrease the need for admission and supports earlier discharges.<br><br>Northland DHB clients have higher level of interRAI assessed clinical risk than northern region average:<br>• 27% reported feeling lonely (northern region: 19%)<br>• 17% report they live with severe or excruciating pain each day (northern region: 11%)<br>• 57% have the potential to do more things for themselves like showering, eating, walking (northern region: 69%)<br>• 27% have cognitive difficulties with everyday decisions (northern region: 24%)<br>• 23% at risk of entering ARRC (northern region 20%).<br><br>Mechanisms for sharing both clinical information and patients' goals, preferences and aspirations are required to ensure seamless transition(s) of care, positive patient and whanau experiences and health outcomes.<br><br>While there has been some effort to look at who is coming into hospital, a 1.5% admission rate from primary care and ARRC is not an unreasonable level and with the right "tools" and with the development of GNS led first response community ACE support in the future, some would not need to come to hospital.<br><br>In hospital older patients have higher rates of adverse events and are more likely to become deconditioned. |

[4] World Alzheimer's Report, 2014. *Dementia and Risk Reduction: an analysis of protective and modifiable factors.* www.alz.co.uk/worldreport2014

A significant paradigm shift is required moving from:

- Rapid disposition to continuity of care
- Single problem or trigger to addressing multifactorial problems
- Reducing falls(deconditioning) to safe mobility

To improve the entire patient journey for older people, models of care that avoids deconditioning and promotes functioning need to be systematically established. As older patients recover medically before they recover functionally acute care of older people requires a change of emphasis in care. The emphasis is on maintaining a patients' level of independent functioning, and muscle strength while in hospital to support returning home quickly.

**5. Respectful End of Life**

The National draft *Adult Palliative Care Services Review* (2016) proposes five priority areas for supporting primary and community palliative care approaches across a range of settings, supported by Specialist Palliative Care Services.

The proposed priority areas are:

1. Increased emphasis on palliative care as an integral part of good patient care.
2. Growing the capability of communities and informal carers
3. Responding to the voices of people with palliative care needs and their families/whanau
4. Improving quality in all settings
5. Ensuring strong strategic connections and links to actions under the New Zealand Health Strategy: Roadmap of actions 2016.
6. Workforce Development opportunities for ARRC staff for ACP and end of life conversations. Utilisation of the new Palliative Care Tool: http://www.health.govt.nz/publication/te-ara-whakapiri-principles-and-guidance-last-days-life .

Advanced care plans are a tool for identifying and implementing the wishes of the person with palliative care needs; along with the monitoring of patient experiences. Current InterRAI data for those over 65 years assessed in Northland shows 97% have no documented Advanced Care Plan (ACP).

Due to demographic ageing and the steady rise in numbers of deaths 47 % of New Zealanders total population over 65 years of age have age related residential care as their last place of death and the number of deaths for those over 65 years is going to double. Deaths for those under 65 years will decrease[5].

Fifty-one percent of those entering ARRC for the first time are over 85 years of age, 34% are aged between 75-84 years and 15 % are aged between 65 and 74 years. Those entering ARRC have higher

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| | | complex needs and shorter lengths of stay.<br><br>The occupancy of Northland's 1299 contracted ARRC beds is fluctuating between 69%(psycho-geriatric hospital level secure dementia care) and 109 %(Rest home level secure dementia care) with 70% occupancy of the remaining subsidised hospital and rest home beds. Future ARRC capacity has to be a focus for Northland DHBs HOP Service Planning as our population of 80+ year olds continues to grow. We already have periods of high occupancy in our contracted dementia care beds with limited access to dementia services closer to home outside of Whangarei. |
| **6.** | **5 Priority SMART Goals 2017-2020**<br>Goal = Future condition or performance levels that your service intends or desires to attain, with a measure (how will you know you have made a change) | **Goal1**<br>Older People eligible for HOP Services will have their longer term care and support needs met in the community through reliable and accessible Home and Community Support Services.<br><br>**Objectives:**<br>• Northland DHB NASC will consistently meet its targets in delivering timely InterRAI AI assessments service coordination to acute and non-acute clients.<br>• Flexible packages of care options will be responsive to older peoples' complex care needs, goals, self-determination and preferences for their supported wellbeing and independence at home.<br>• Continue formal engagement processes with Northland's contracted Home and Community Support Service providers around the outcomes for IBT Settlement Agreement, pay parity and regularised workforce and; sustainability of the workforce, person centred service delivery and funding models.<br><br>**Goal 2**<br>All acute medical admissions for those over 80 years will be screened for frailty and managed through an in-patient comprehensive geriatric care programme.<br><br>**Objectives:**<br>• Recruit the Gerontology MDT (Medical, GNS, and Allied Health) staff required to increase the workforce and gerontology focus required to provide appropriated, effective and equitable care for older adults over 80 years of age admitted to hospital.<br>• Improve acute care for the complex older adult, to increase the number of well days at home for the over 80 year olds by 25% by 30 June 2018(1660 more days).This equates to 4.6 beds per day.<br>• Decrease the number of ED LOS breaches for those over 80 years.<br>• Initiate early ACP conversations, increasing the number of older people with a documented Advanced Care Plan. |

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| | | **Goal 3**<br>The diagnosis and management of mild cognitive impairment (MCI) and typical dementia will occur earlier in primary care.<br><br>**Objectives:**<br>• Adopt Northland DHB's *Living Well with Dementia Model of Care* (2017).<br>• Support more primary care general practices to utilise the Northern Regional Cognitive Impairment Pathway and Dementia E Learning Toolkit, achieving earlier diagnosis and management of mild cognitive impairment. Earlier diagnosis and management shall occur at the first point of concern, not at the point the person with dementia and their family or carers are in crisis.<br>• Allocate targeted resources for care coordination in primary health and community care providing continuity of care and flexible support options for people with dementia and their families across the whole dementia care pathway.<br>• Engage with Neighbourhood Healthcare Homes (NHH) practices to ensure alignment with current primary health care initiatives.<br>• Continue to work in partnership with Maori whanau to develop culturally accessible dementia resources and support (NRHP).<br><br>**Goal 4**<br>There will be an improvement in the experiences of people living in Age Residential Care.<br><br>**Objectives:**<br>• Develop dedicated GNS/NP first response support for ARC Services across Northland<br>• Increase confidence and skills of the staff in ARRC to use end of life care plans using the Te Ara Whakapiri Toolkit.<br>• Implement planned discharge processes for all Whangarei Hospital discharges to ARRC facilities across Northland.<br><br>**Goal 5.**<br>There will be a reduction in the incidence of harm for community dwelling frail older people over 75 years at risk of a fall or fragility fracture and polypharmacy.<br><br>**Objectives:**<br>• Implement Northland's Local Falls Pathway and phased 3 year actions including single point of entry falls assessment and triage and in-home strength and balance programmes for older people with complex needs, unable to attend community based programmes. |

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| | | • Achieve the success indicators and target incidence outcomes for falls and related fractures under the NDHB and ACC three year *Falls Partnering Agreement, 2017-2020.* |
| **7.** | **Objectives (as above)**<br><br>Objective = the aims or responses that your service articulates to address the change or improvement. | |
| **8.** | **Milestones and Monitoring** | Key deliverable actions that contribute to meeting the objectives over the 3 years will be confirmed under an HOP RBA Framework and monitored monthly and quarterly by the Health of Older People Management Group. |

## 5.0 NEXT MEETING DETAILS

The next meeting will be held on **Monday 4 December 2017** in the **Waipoua Meeting Room, Tohora House, Whangarei Hospital** starting at **9.00 am**.

Please note new meeting time.

***NORTHLAND DISTRICT HEALTH BOARD***

***GLOSSARY OF ACRONYMS*** ***July 2017***

| Acronym | Meaning |
|---|---|
| A&D | Alcohol and Drug |
| A&E | Accident and Emergency Department |
| A&M | Accident & Medical Centre |
| AAU | Acute Assessment Unit *(part of child health services)* |
| ACMO | Associate CMO |
| ACP | Advanced Care Planning |
| A&C | Audit & Compliance |
| ACA | Access Criteria for First Assessment |
| ACC | Accident Compensation Corporation |
| ADON | Assistant Director of Nursing |
| ADHD | Attention Deficit and Hyperactivity Disorder |
| ALOS | Average Length Of Stay |
| AMI | Acute Myocardial Infarction |
| AOD | Alcohol and Other Drugs |
| AP | Annual Plan |
| AR | Active Review |
| ARRC | Age Related Residential Care |
| ARC | Aged Residential Care |
| ASH Rates | Ambulatory Sensitive Hospitalisation Rates |
| ASMS | Association of Salaried Medical Specialists |
| BAU | Business As Usual |
| BOI | Bay of Islands |
| BSC | Balanced Scorecard |
| BSI | Blood Stream Infections |
| CABG | Coronary Artery Bypass Graft |
| CAPD | Chronic Ambulatory Peritoneal Dialysis |
| CATT | Crisis Assessment Treatment Team |
| CBA | Cost Benefit Analysis |
| CCP | Contribution to Cost Pressures |
| CCU | Coronary Care Unit |
| CEA | Collective Employment Agreement |
| CEO | Chief Executive Officer |
| CFA | Crown Funding Agreement |
| CGB | Clinical Governance Board |
| CHC | Child Health Centre |
| CHS | Community Health Services |
| CIPP | Community Injury Prevention Programme |
| CMO | Chief Medical Officer |
| CME | Continuing Medical Education |
| COPD | Chronic Obstructive Pulmonary Disease |
| CPAC | Clinical Priority Assessment Criteria |
| CPSOG | Clinical Pharmacy Services Operational Group |
| CPHAC | Community and Public Health Advisory Committee |
| CPR | Cardio pulmonary resuscitation |
| CSC | Community Services Card |
| CSU | Central Sterilising Unit |
| CT | Computerised Tomography |
| CVD | Cardiovascular Disease |
| CWD | Caseweighted Discharge |
| DAO | Duly Authorised Officer |

| Acronym | Meaning |
|---|---|
| DHB | District Health Board |
| DHBSS | District Health Board Shared Services |
| DIAS | Disability Information Advisory Service |
| DiSAC | Disability Support Advisory Committee |
| DN | District Nurse |
| DNA | Did not attend |
| DONM | Director of Nursing and Midwifery |
| DRG | Diagnostic Related Group |
| DSAC | Doctors for Sexual Abuse Care |
| DSS | Disability Support Services |
| EAP | Employee Assistance Programme |
| ECG | Electrocardiogram |
| ED | Emergency Department |
| EENT | Eyes, Ears, Nose and Throat |
| EEO | Equal Employment Opportunity |
| ELT | Executive Leadership Team |
| ENT | Ear Nose and Throat |
| EOI | Expressions of Interest |
| ERA | Employment Relations Act |
| ESS | Elective Services Statistics |
| ESPI | Elective Services Performance Indicators |
| FAQ | Frequently Asked Questions |
| FBT | Fringe Benefit Tax |
| FFT | Future Funding Track |
| FRS | Financial Reporting Standard |
| FSA | First Specialist Assessment |
| FST | Financial Sustainable Threshold |
| FTE | Full time equivalent |
| GETS | Government Electronic Tender Service |
| GDB | General Dental Benefit |
| GM | General Manager |
| GMS | General Medical Services Benefit |
| GSE | Government Special Education |
| hA | healthAlliance |
| HAC | Hospital Advisory Committee |
| HBSS | Home Based Support Services |
| HDC | Health and Disability Commissioner |
| HRT | Health Round Table |
| HHC | Home Health Care |
| HIN | Health Information Network |
| HNA | Health Needs Analysis |
| HOD | Head of Department |
| HOP | Health of Older People |
| HPO | Health Protection Officer |
| HPV | Human Papillomavirus |
| HQSC | Health Quality & Safety Commission |
| HWNZ | Health Workforce New Zealand |
| IANZ | International Accreditation New Zealand |
| IAT | Income and Asset Testing |
| ICU | Intensive Care Unit |
| ICT | Intensive Care Team (Mental Health) |
| IDF | Inter District Flows |
| IEA | Individual Employment Agreement |
| IFHC | Integrated Family Health Centre |
| IIA | Income in Advance |
| InterRAI | International Research and Assessment Instruments |

| Acronym | Meaning |
|---|---|
| IR | Industrial Relations |
| IS | Information Systems / Information Services |
| ISSP | Information Systems Strategic Planning |
| IT | Information Technology |
| JV | Joint Venture |
| KPI | Key Performance Indicator |
| LMC | Lead Maternity Carer |
| LOS | Length of stay |
| LTC | Long Term Conditions |
| MDO | Maori Development Organisations |
| MECA | Multi Employer Collective Agreement |
| MERAS | Midwifery Employee Representation & Advisory Services |
| MF (score) | Missing Filled (score) *(dental services)* |
| MHGC | Maori Health Gains Council |
| MHIPU | Mental Health Inpatient Unit |
| MI | Myocardial infarction |
| MIF | Monitoring and Intervention Framework |
| MMR | Measles-mumps-rubella |
| MoH | Ministry of Health |
| MOH | Medical Officer of Health |
| MOSS | Medical Officer Special Scale |
| MOU | Memorandum of Understanding |
| MPDS | Maori Provider Development Scheme |
| MRI | Magnetic Resonance Imaging |
| MRT | Medical Radiation Technologist |
| MSD | Ministry of Social Development |
| MVS | Meningococcal Vaccine Strategy |
| NASC | Needs Assessment and Service Co-ordination |
| NDHB | Northland District Health Board |
| NEST | Northland Emergency Services Trust |
| NGO | Non-Government Organisation |
| NHB | National Health Board |
| NHI | National Health Index |
| NHSP | Northland Health Services Plan |
| NHSS | National Health Supply Service |
| NIF | Northland Intersectoral Forum |
| NIR | National Immunisation Register |
| NRA | Northern Region Alliance (formerly NDSA Northern DHB Support Agency) |
| NRHP | Northern Region Health Plan |
| NRTH | Northern Regional Training Hub |
| NTA | National Travel Assistance |
| NZBS | New Zealand Blood Service |
| NZCOM | New Zealand College of Midwives |
| NZHS | New Zealand Health Strategy |
| NZHPL | New Zealand Health Partnerships Ltd |
| NZMC | New Zealand Medical Council |
| NZNO | New Zealand Nurses' Organisation |
| O&G | Obstetrics and Gynaecology |
| OIA | Official Information Act |
| OMG | Operational Management Group |
| OP | Outpatient |
| ORL | Otorhinolaryngology (=ENT) |
| OSH | Occupational Safety and Health |
| OT | Occupational Therapy *(sometimes also* Operating Theatre*)* |
| PACU | Post Anaesthetic Care Unit |

| Acronym | Meaning |
|---|---|
| PBFF | Population Based Funding Formula |
| PCO | Primary Care Organisation |
| PDRP | Professional Development Recognition Programme |
| PGY | Post Graduate Year |
| PHO | Primary Health Organisation |
| PHN | Public Health Nurse |
| PHU | Public Health Unit |
| PIPP | Planning, Integration, People & Performance |
| PN | Practice Nurse |
| POPN | Primary Options Programme Northland |
| PQ | Parliamentary Questions |
| PSA | Public Service Association |
| PSAAP | PHO Service Agreement Amendment Protocol |
| PS&QID | Patient Safety & Quality Improvement Directorate |
| PUC | Purchase Unit Cost |
| RBA | Results Based Accountability |
| RDA | Resident Doctors' Association |
| RFF | Regional Funding Forum |
| RFP | Request for Proposal |
| RG | Referral Guidelines |
| RICF | Reducing Inequalities Contingency Funding |
| RMO | Resident Medical Officer |
| RWL | Residual Waiting List |
| SAT | Self Assessment Tool |
| SAU | Surgical Admission Unit |
| SBL | Surgical Booking List |
| SCBU | Special Care Baby Unit |
| SCOPE | Service Coordination – Primary Care Navigation for Older People in their Environment |
| SDS | School Dental Service |
| SHO | Senior House Officer |
| SIA | Service to Improve Access |
| SLT | Speech Language Therapy |
| SMO | Senior Medical Officer |
| SOI | Statement of Intent |
| SPNIA | Service Planning and New Intervention Assessment |
| SSSG | Shared Support Services Group |
| STAH | Scientific Technical & Allied Health |
| STV | Single Transferable Voting |
| SUDI | Sudden Unexplained Death in Infancy |
| TAS | Technical Advisory Services |
| TLA | Territorial Local Authorities |
| TOR | Terms of Reference |
| TOW | Treaty of Waitangi |
| TPK | Te Puni Kokiri |
| TPOT | The Productive Operating Theatre |
| TROTR | Te Runanga O Te Rarawa |
| WERO | Whanau End smoking Regional whanau Ora Challenge |
| WHO | World Health Organisation |
| WIIE | Whanau Integration Innovation & Engagement Fund |
| WOC | Whanau Ora Collective |
| YTD | Year-to-date |

**Any additions/amendments, please contact Kathryn Leydon, kathryn.leydon@northlanddhb.org.nz**