



Public

Wairarapa, Hutt Valley and Capital & Coast District Health Boards Community & Public Health and Disability Support Advisory Committees

17 November 2017

COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEES

Agenda



17 November 2017, 10.00am to 1.00pm

CSSB Lecture Room, Ground Floor Clinical & Support Services Building, Blair Street, Masterton

	ITEM	ACTION	PRESENTER	MIN	TIME	PG
1 PROCEDURAL BUSINESS				15	10am	1
1.1	Karakia					
1.2	Apologies	RECORD				
1.3	Continuous Disclosure - Conflict of Interest	ACCEPT				3
1.4	Confirmation of Minutes 1 September 2017	APPROVE				7
1.5	Matters Arising	NOTE				
1.6	Action List	NOTE				13
1.7	Dissolution of 3DHB CPHAC/DSAC	APPROVE				15
1.8	DSAC Meeting schedule 2018	APPROVE				17
2 DISCUSSION						
2.1	Regional Child Oral Health		Nicky Smith Kathy Fuge			19
2.1 (a)	Wairarapa Child Oral Health		Lynette Field			25
2.2	Regional Public Health Update		Peter Gush			32
2.3	Regional Screening Update		Lindsay Wilde			61
3 INFORMATION						
3.1	Bowel Cancer Screening Update		H Carbonatto			71
3.2	Disability Strategy Implementation First Quarter Report		Pauline Boyles			74
3.3	Masterton Hospital Accessible Journey Review		Pauline Boyles			80
ADJOURN						
	LUNCH				12.30PM	
4 APPENDICES						
4.1	BEE Healthy Equity Data					90
4.2	Caries Free Data – CCDHB					93
4.3	Healthy Ageing Strategy (Ministry of Health)					94
4.4	Strategic Disability Plan Evaluation Framework					170



COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEES

Conflicts & Declarations of Interest Register

UPDATED AS AT AUGUST 2017

Name	Interest
Dame Fran Wilde <i>Chairperson</i>	<ul style="list-style-type: none"> Deputy Chair, Capital & Coast District Health Board (includes HAC) Chair, Remuneration Authority Deputy Chair NZ Transport Agency Chair Wellington Lifelines Group Director Museum of NZ Te Papa Tongarewa Member Whitireia-Weltec Council Director Business Mentors NZ Ltd Director Frequency Projects Ltd Chief Crown Negotiator Ngati Mutunga and Moriori Treaty of Waitangi Claims Chair Wellington Culinary Events Trust Chair National Military Heritage Trust
Mr Andrew Blair <i>Member</i>	<ul style="list-style-type: none"> Chair, Southern Partnership Group (appointed jointly by Ministers of Finance and Health to provide governance for the redevelopment of Dunedin Hospital) Member of the Board of Trustees of the Gillies McIndoe Research Institute Member, Hutt Valley District Health Board Finance, Risk and Audit Committee Chair, Hutt Valley District Health Board (from 5 December 2016) Former Member of the Hawkes Bay District Health Board (2013-2016) Former Chair, Cancer Control (2014-2015) Former CEO Acurity Health Group Limited Director, Safer Sleep Ltd Director, Safer Sleep LLC Ltd Advisor to the Board, Forte Health Limited, Christchurch Owner and Director of Andrew Blair Consulting Limited, a Company which from time to time provides governance and advisory services to various businesses and organisations, include those in the health sector Chair, Capital & Coast District Health Board (from 5 December 2016) (includes HAC) Chair, Hutt Valley District Health Board Hospital Advisory Committee Member, 3DHB combined Community and Public Health and Disability Support Advisory Committees
Ms Eileen Brown	<ul style="list-style-type: none"> Member of Capital & Coast District Health Board

Wairarapa, Hutt Valley and Capital & Coast District Health Boards

Name	Interest
<i>Member</i>	<ul style="list-style-type: none"> • Board member (until Feb. 2017), Newtown Union Health Service Board • Employee of New Zealand Council of Trade Unions • Senior Policy Analyst at the Council of Trade Unions (CTU). CTU affiliated members include NZNO, PSA, E tū, ASMS, MERAS and First Union. • God daughter/family friend employed as a solicitor at specialist health law firm, Claro.
Ms Sue Kedgley <i>Member</i>	<ul style="list-style-type: none"> • Member, Capital & Coast District Health Board (includes HAC) • Member, Greater Wellington Regional Council • Member, Consumer New Zealand Board • Shareholder in Green Cross Health • Step son works in middle management of Fletcher Steel • Deputy Chair, Consumer New Zealand • Environment spokesperson and Chair of Environment committee, Wellington Regional Council
Mr Alan Shirley <i>Member</i>	<ul style="list-style-type: none"> • Member, Wairarapa District Health Board (includes HAC) • Member, Wairarapa, Hutt Valley and CCDHB CPHAC DSAC Committee • General surgeon at Wairarapa Hospital • Wairarapa Community Health Board Member • Wairarapa Community Health Trust Trustee (15 September 2016)
Jane Hopkirk <i>Member</i>	<ul style="list-style-type: none"> • Member, Wairarapa District Health Board • Member, Wairarapa, Hutt Valley and CCDHB CPHAC DSAC Committee • Member, Wairarapa Te Iwi Kainga Committee • Kaiarahi, Takiri Mai Te Ata, Kokiri Hauora • Member, Occupational Therapy Board of New Zealand (23 February 2016)
Kim Smith <i>Member</i>	<ul style="list-style-type: none"> • Employee of Te Puni Kokiri • Trustee for Te Hauora Runanga o Wairarapa • Brother is Chair for Te Hauora Runanga o Wairarapa • Chair, Te Oranga o Te Iwi Kainga • Sister, Member of Parliament
Lisa Bridson <i>Member</i>	<ul style="list-style-type: none"> • Member, Hutt Valley District Health Board (Includes HAC) • Member, 3DHB Combined CPHAC DSAC Committee • Hutt City Councillor • Chair, Kete Foodshare
Yvette Grace <i>Member</i>	<ul style="list-style-type: none"> • Member, Hutt Valley District Health Board (includes HAC) • Deputy Chair, 3DHB combined Community and Public Health and Disability Support Advisory Committees • Chair, Te Oranga O Te Iwi Kainga Māori Relationship Board to Wairarapa DHB • Trustee, Rangitane Tu Mai Ra Treaty Settlement Trust • Manager, Compass Health Wairarapa • Member, 3DHB Youth SLA (Service Level Alliance) • Member, Te Whiti Ki Te Uru Central Regions Māori Relationship Board

Name	Interest
	<ul style="list-style-type: none"> • Husband, Family Violence Intervention Coordinator and Child Protection Officer Wairarapa DHB • Husband, Community Council, Compass Health • Husband, Community member of Tihei Wairarapa Alliance Leadership Team • Sister in law, Nurse at Hutt Hospital • Sister in Law, Private Physiotherapist in Upper Hutt • Niece, Nurse at Hutt Hospital
Prue Lamason <i>Member</i>	<ul style="list-style-type: none"> • Member, Hutt Valley District Health Board (Includes HAC) • Member, 3DHB combined Community and Public Health and Disability Support Advisory Committees • Deputy Chair, Hutt Mana Charitable Trust • Deputy Chair, Britannia House – residence for the Elderly • Councillor, Greater Wellington Regional Council • Deputy Chair, Greater Wellington Regional Council Holdings Company • Trustee, She Trust • Daughter is a Lead Maternity Carer in the Hutt
John Terris <i>Member</i>	<ul style="list-style-type: none"> • Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Hospital Advisory Committee • Member, 3DHB combined Community and Public Health and Disability Support Advisory Committees
Mr Derek Milne <i>Member</i>	<ul style="list-style-type: none"> • Member, Wairarapa District Health Board • Member, WrDHB CPHAC/DSAC (30 March 2016) • Brother-in-law is on the Board of Health Care Ltd • Daughter, GP in Manurewa, Auckland
Fa’amatuanu Tino Pereira <i>Member</i>	<ul style="list-style-type: none"> • Managing Director Niu Vision Group Ltd (NVG) • Chair 3DHB Sub-Regional Pacific Strategic Health Group (SPSHG) • Chair Pacific Business Trust • Chair Pacific Advisory Group (PAG) MSD • Chair Central Pacific Group (CPC) • Chair, Pasefika Healthy Home Trust • Establishment Chair Council of Pacific Collectives • Chair, Pacific Panel for Vulnerable Children • Member, 3DHB CPHAC/DSAC
Dr Tristram Ingham <i>Member</i>	<ul style="list-style-type: none"> • Senior Research Fellow, University of Otago Wellington • Member, Capital & Coast DHB Māori Partnership Board • Clinical Scientific Advisor & Chair Scientific Advisory Board – Asthma Foundation of NZ • Trustee, Wellhealth Trust PHO • Councillor at Large – National Council of the Muscular Dystrophy Association • Trustee, Neuromuscular Research Foundation Trust • Member, Wellington City Council Accessibility Advisory Group • Member, 3DHB Sub-Regional Disability Advisory Group

Name	Interest
	<ul style="list-style-type: none"> • Professional Member – Royal Society of New Zealand • Member, Institute of Directors • Member, Health Research Council College of Experts • Member, European Respiratory Society • Member, Te Ohu Rata o Aotearoa (Māori Medical Practitioners Association) • Director, Miramar Enterprises Limited (Property Investment Company) • Daughter, Employee of Hutt Valley based Māori provider (Tu Kotahi Māori Asthma Trust) • Wife, Research Fellow, University of Otago Wellington
Sue Driver <i>Member</i>	<ul style="list-style-type: none"> • Member of Capital & Coast District Health Board (Including HAC) • Member, 3DHB combined Community and Public Health and Disability Support Advisory Committees • Community representative, Australian and NZ College of Anaesthetists • Board Member of Kaibosh • Daughter, Policy Advisor, College of Physicians • Former Chair, Robinson Seismic (base isolators, Wgtn Hospital) • Advisor to various NGOs
'Ana Coffey <i>Member</i>	<ul style="list-style-type: none"> • Member of Capital & Coast District Health Board (Including HAC) • Member, 3DHB combined Community and Public Health and Disability Support Advisory Committees • Councillor, Porirua City Council • Director, Dunstan Lake District Limited • Trustee, Whitireia Foundation



3DHB CPHAC/DSAC Meeting

DATE:	1 September 2017	TIME:	9am - Midday
VENUE:	Boardroom, Pilmuir House, Hutt Valley District Health Board		
PRESENT:	Dame Fran Wilde (Chair), Bob Francis, Derek Milne, Dr Tristram Ingram, Lisa Bridson, Prue Lamason, Ana Coffey, Yvette Grace, Sue Kedgley, Andrew Blair (from 11.30am),		
APOLOGIES:	Alan Shirley, Tino Pereira, John Terris, Jane Hopkirk, Kim Smith, Sue Driver,		
IN ATTENDANCE:	Debbie Chin, Ashley Bloomfield, Adri Isbister, Rachel Haggerty, Helene Carbonatto, Nigel Broom, Pauline Boyles, Jenny Langton (minutes)		
PUBLIC	No members of public present		
PRESENTERS	<p>Advance Care Planning: Catherine Epps, Director Allied Health, CCDHB Helen Rigby, Project Manager, Strategy Innovation and Performance, CCDHB</p> <p>Aged Care Services update: Jan Marment, Senior System Development Manager – Older People, CCDHB Kate Calvert, Portfolio Manager – Older People, HVHDHB Joanne Edwards, Portfolio Manager – Older People, Wairarapa DHB</p>		

	Agenda Item	Discussion	Action Required And by Whom
1	PROCEDURAL BUSINESS		



1.1	KARAKIA	Tristram Ingram led Karakia, Committee Chair, Dame Fran Wilde, welcomed members and DHB staff	
1.2	APOLOGIES	Received from Jane Hopkirk, Eileen Brown, Sue Driver	
1.3	INTEREST REGISTER	No new conflicts	
1.4	Confirmation of previous minutes	<p>Correction noted – both Ana and Yvette were present at the last meeting.</p> <p>Derek noted the previous request for a short overview of mental health system hasn't been minuted. Staff noted that the request was picked up as an action and is included on the action list to provide in 2018.</p> <p>Otherwise, minutes were accepted as true and correct.</p> <p>Derek Milne</p>	
1.5	Matters arising	No matters arising	
1.6	Action points	Note action point 2.1 – Mental Health and Wellbeing is linked to the minuted request for short overview of the health system (see 1.4 above)	
1.7	Final CPHAC/DSAC Terms of Reference	The combined terms of reference were noted.	
2	DISCUSSION		
2.1	Palliative Care Strategy paper	<p>The difference in approaches across the three DHBs was NOTED. This is partly due to different hospice settings in each of the DHBs.</p> <p>The Gold Standards Framework for Palliative Care was identified as a tool that the DHB should have regard to.</p>	



		<p>A consumer voice in palliative care discussions was NOTED as important. Consumer Council probably needs older person's representation.</p> <p>The Committee ENDORSED the progress of the 3 DHBs against the sub-regional Palliative Care Strategy</p>	
2.2	<p>Advance Care Planning presentation</p> <p>Helen Rigby</p> <p>Catherine Epps</p>	<p>Presentation outlining progress with implementing Advance Care Planning (ACP) across the sub-region in all settings.</p> <p>Stimulated broad discussion about the importance of these conversations and what is needed to enable this to happen. ACP represents a social movement and we need to ensure there are no system or workforce barriers to the conversation happening.</p> <p>Concern was raised that we don't create unintended consequences (eg, is there a risk of bias to conversations being had with people deemed 'less worthy' of being kept alive).</p> <p>Members NOTED generally Māori do not find it difficult to talk about death and observed a more likely explanation for not reaching Māori is clinician discomfort. The key is the way you have the conversation and that different approaches are needed for Māori whānau (it is less about the document/piece of paper).</p> <p>Staff are starting the conversation about ACP with Pasifika communities also. Pamphlets in six pacific languages have been developed. The Committee RECOMMENDED the ACP presentation be given to the Pacific Sub-Regional group.</p> <p>Staff described the Northland DHB "waka" model for ACP that they would be bringing Northland down to present to the sub-region.</p> <p>Derek MOVED that the Pacific sub-regional group be invited to attend when Northland come to present the Waka model.</p>	



2.3	Aged Care Services Update Jan Marment Kate Calvert Joanne Edwards	<p>Presentation followed by discussion on Aged Care Services and quality assurance of ARC providers.</p> <p>Discussed the need for a life-course approach in planning and commissioning services. A comment that the current hard lower age-limit (65) is restrictive – ideally there would be a softer age limit for access to aged care services. Staff noted current funding models limit flexibility in this area.</p> <p>Noted there are national and local roles and responsibilities across the whole social system and the action plan to implement the new Health Ageing strategy is important.</p> <p>ACTION: Distribute the Healthy Ageing action plan with the minutes.</p> <p>Discussed the role of DHB Boards in monitoring quality standards in ARC and the associated challenges given Boards don't directly commission or deliver the services. Boards would like to see some form of regular dashboard looking at ARC provider performance.</p> <p>ACTION: The three GMs will look at what information we have ready access to that could sensibly be reported to Boards on a regular basis.</p>	
3	DISCUSSION		
3.1	Sub-regional Disability Update Bob Francis Pauline Boyles	<p>Updated on implementation of the 3DHB Disability Strategy</p> <p>Good progress being made working with Ministry of Health, Health and Disability Commissioner and 3DHB ICT on developing an electronic Health Passport. We are looking at a platform that is owned by the person, easy to operate and interoperable with other health IT systems.</p> <p>Working to develop a reporting Dashboard by the end of this Year.</p>	



		<p>Discussed the current complexities in NASC services particularly the challenges transitioning to different services (eg child transitioning to adult etc). Members consider we need to work towards a single NASC locally irrespective of national progress.</p> <p>Staff noted a project is underway to move towards a single whole of life NASC for the sub-region and would be happy to provide an update of this work, which is proving more complex than it sounds.</p> <p>The Committee suggested there should be regular reports on this issue to DSAC.</p> <p>Recommendations in the paper were accepted.</p>	
4.0	OTHER		
4.1	Structure of CPHAC-DSAC across the sub-region	<p>Paper recommended maintaining a sub-regional DSAC for services that are delivered within a 3DHB model – ie, disability support services and mental health.</p> <p>Paper recommended respective Boards manage CPHAC locally within individual DHBs to allow stronger focus on local population health needs including health equity for local prioritisation of health strategies and investment.</p> <p>Wide ranging discussion about the challenges with servicing a 3DHB Committee since SIDU was disestablished and the limited ability for the Committee to influence the direction and outcomes of initiatives across three DHBs.</p> <p>However, there was concern about losing 3DHB forum to guide opportunities for collaboration, collective activity and strengthened integration where appropriate. There was widespread agreement that there needs to be an on-going focus on sub-regional approaches and integration where possible.</p>	



		<p>Staff noted the three DHBs are working collectively across a range of initiatives outside of the CPHAC-DSAC process and considered there are a range of formal and informal opportunities for collaboration.</p> <p>The Committee ENDORSED the recommendations</p> <p>Fran Wilde/Derek Milne</p> <p>The Committee also RECOMMENDED the three Chief Executives consider how strategic integration across the sub-region can be advanced at a governance level should the respective Boards agree to move to local CPHAC structures.</p>	
NEXT MEETING 17 November 2017			



SCHEDULE OF ACTION POINTS - PUBLIC CPHAC-DSAC COMMITTEES

AP No:	Topic:	Action:	Responsible:	How Dealt With:	Delivery Date:
Ex CPHAC-DSAC Public Meeting 20 November 2015					
1.3	Confirmation of Minutes	Equity indicators will be reviewed annually.	Director, SIP	On June 2017 agenda.	Closed
Ex CPHAC-DSAC Public Meeting 20 May 2016					
2.3	Equity Monitoring Indicators	Requested management to bring back to the Committee in the next Equity Report an outline of the specific actions in the Annual Plan and the Maori Health Plan and advice to the Committee so it could advise the Boards on an equity action plan over a longer time period.	Director, SIP	Replaced by development of Equity Approach presented at March 2017 meeting. Recommendations to come back to November 2017 meeting	November, 2017
2.5	Regional Public Health Update Report	Report back on DHBs role in working with the homeless as they often have high health needs and find access to services difficult.	HVDHB	On work programme for November 2017.	November, 2017
Ex CPHAC-DSAC Public Meeting 6 June 2017					
2.1	Mental Health and Wellbeing	Equity and co-design needs to be explicitly stated in recommendations:	Director, SIP	Regular updates provided to CPHAC/DSAC meetings. Whole System Investment Plan early 2018.	First 2018 meeting.
Ex CPHAC-DSAC Public Meeting 1 September 2017					
2.1	Advanced Care Planning	Requested that the Pacific sub-regional group be invited to attend when Northland come to present the Waka model.	Director, SIP		
2.3	Aged Care Services Update	ACTION: The three GMs will look at what information we have ready access to that could sensibly be reported to Boards on a regular basis.			

4.1	Structure of CPHAC-DSAC across the sub-region	Recommended the three Chief Executives consider how strategic integration across the sub-region can be advanced at a governance level should the respective Boards agree to move to local CPHAC structures.			
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ITEMS CLOSED SINCE LAST MEETING – 1 September 2017

AP No:	Topic:	Action:	Responsible:	How Dealt With:	Delivery Date:
Ex CPHAC-DSAC Public Meeting 6 June 2017					
1.7	Final CPHAC/DSAC Terms of Reference	Amend and correct grammatical errors. Reflect 3DHB representation and clarify if there is a process for proxies in the absence of members particularly from sub regional group and Maori Partnership Board	Secretariat	Secretariat to make changes, clarify query and send out to members.	Closed
3.2	Quality Assurance – Health of Older People	Ensure the appropriate discussion on quality assurance in Health of Older People.	Director, SIP	Discussion at September 2017, CPHAC/DSAC.	Closed
3.3	Update	Bowel screening rolling out at Hutt Valley and Wairarapa DHB.	CE, HVDHB	Update on bowel screening to CPHAC/DSAC. These services are implementing in short timeframes. The update for CPHAC DSAC has been delayed till September 2017 .	September, 2017
Ex CPHAC-DSAC Public Meeting 1 September 2017					
2.3	Aged Care Services Update	ACTION: Distribute the Healthy Ageing action plan with the minutes.	Director, SIP	Distributed with Agenda	Closed

PUBLIC

  		DISCUSSION PAPER
		13 November 2017
Author	Rachel Haggerty, Director, Strategy, Innovation and Performance	
From:	Rachel Haggerty, Director Strategy Innovation and Performance	
Endorsed By	Debbie Chin: Chief Executive Capital and Coast DHB Ashley Bloomfield, Chief Executive, Hutt Valley DHB Adri Isbister: Chief Executive, Wairarapa DHB	
Subject	3DHB Disability Services Advisory Committee	
	It is recommended that CPHAC DSAC members: <ul style="list-style-type: none">▪ note the DSAC meeting schedule for 2018▪ note the proposed membership remains as current, to be confirmed by each Board▪ note the Terms of Reference for the DSAC will be presented to the first meeting in March 2018	

1. PURPOSE

At the 3DHB CPHAC DSAC it was agreed that:

- a. DSAC is maintained at a sub-regional level, meeting quarterly, and focus on those areas managed and delivered across the sub-region being mental health and disability support services.
- b. CPHAC is managed locally at an individual DHB level enabling a focus on the needs of local populations including equity, enabling prioritisation of localised health strategies and investment requirements.

This paper briefly outlines the approach for 2018, the membership and the meeting schedule.

2. DISCUSSION

In summary the purpose of DSAC is to consider the needs of the population, the services provided and the plans and opportunities to improve outcomes as they relate to supporting those with disability and those with mental illness and addiction. These two service areas are planned and led across the 3DHBs. The Terms of Reference will be presented to the March meeting.

Mental health and disability are, of course, connected to community, public health, primary care and specialty services planning and funding. By having a 3DHB focus it provides greater time to consider the issues and opportunities and develop stronger Board understanding in these important areas. This will strengthen the leadership opportunities for change.

These inter-connections between the areas of focus will be managed through the relationship between DSAC and the Boards and CPHACs of each DHB.

3. MEMBERSHIP

The initial membership from CPHAC DSAC has been transferred to DSAC. This membership is:

CCDHB	HVDHB	WDHB	Invited
Fran Wilde Chair Andrew Blair (CCDHB & HVDHB) Eileen Brown Ana Coffey Sue Driver Sue Kedgley	Lisa Bridson Yvette Grace Deputy Chair Prue Lamason John Terris	Jane Hopkirk Derek Milne Alan Shirley Kim Smith	Bob Francis (SRDAG) Dr Tristram Ingham (MPB) Tino Pereira (SRSHAG)

4. MEETING SCHEDULES

In planning the meeting schedules quarterly meetings have been identified as needed particularly considering the focus of the new Government on Mental Health and Addictions. The proposed dates are below.

- Monday 19 March
- Monday 18 June
- Monday September 10
- Monday December 3

CAPITAL & COAST DISTRICT HEALTH BOARD

3District Health Board – Disability Services Advisory Committee

Meeting duration 10.00am–12.30pm

Time	Date	Location	Members
10am	Monday 19 March		Fran Wilde (CCDHB) Chair Andrew Blair (HVDHB) Lisa Bridson (HVDHB)
10am	Monday 27 August		Eileen Brown (CCDHB) Yvette Grace (HVDHB) Deputy Chair Sue Kedgley (CCDHB) Prue Lamason (HVDHB) Derek Milne (WDHB) Jane Hopkirk (WDHB) Alan Shirley (WDHB) Kim Smith (WDHB) John Terris (HVDHB) Sue Driver (CCDHB) 'Ana Coffey (CCDHB) Bob Francis (SRDAG) Tino Pereira (SRSHAG) Dr Tristram Ingham (MPB)

Capital & Coast District Health Board – Community and Public Health Advisory Committee

Meeting duration 9.30am–12.00pm

Time	Date	Location	Members
9.30am	Monday 12 February		Fran Wilde (CCDHB) Chair Eileen Brown (CCDHB) Sue Kedgley (CCDHB) Sue Driver (CCDHB) 'Ana Coffey (CCDHB) Bob Francis (SRDAG) Tino Pereira (SRSHAG) Dr Tristram Ingham (MPB)
9.30am	Monday 16 April		
9.30am	Monday 11 June		
9.30am	Monday 24 September		
9.30am	Monday 19 November		

PUBLIC

		CPHAC/ DSAC INFORMATION PAPER
		Date: 27 October 2017
Author	Nicky Smith, Service Manager, Regional Child Oral Health Service Kathy Fuge, Clinical Director, Regional Child Oral Health Service	
Endorsed By	Dale Oliff, Chief Operating Officer, HVDHB	
Subject	Regional Child Oral Health Service Update	
RECOMMENDATION It is recommended that CPHAC/DSAC: <ul style="list-style-type: none">a. NOTE that all Regional Dental Hubs are fully operational, with over 73,000 children enrolled in the service (Hutt Valley DHB and CCDHB);b. NOTE that mobile vans access most schools in the region to provide on-site dental examinations for primary and intermediate school aged children;c. NOTE that the Service accommodates the needs of children with disabilities and works closely with secondary dental services to ensure wrap-around provision of care for these children;d. NOTE there is a number of equity initiatives underway, including clinical best practice initiatives, to improve service responsiveness to Maori and Pacific children in order to reduce arrears and increase attendance at follow-up treatment appointments;e. NOTE that the service is being reviewed this year now that the new model of care is fully implemented to ensure it is sustainable and able to deliver to the needs of the population in future.		
ADDENDUMS: SERVICE BALANCED SCORECARDS SEPTEMBER 2017 HVDHB AND CCDHB DMFT 2016		

1 PURPOSE

This paper updates CPHAC/ DSAC on the work of the Regional Child Oral Health Service.

2 WELLINGTON REGIONAL CHILD ORAL HEALTH SERVICE (RCOHS)

2.1 Background

Hutt Valley DHB is the current Ministry of Health (MoH) contract holder for the Regional Child Oral Health Service, which encompasses the CCDHB and the Hutt Valley DHB regions. Service delivery is via 13 fixed dental hub clinics and 11 examination mobile vans.

2.2 Enrolment

Children born in the region are enrolled at birth (since 2015), with a first examination scheduled at two years of age. We have currently over 73,000 children enrolled in the RCOHS, aged 0-13.

2.3.1 Current Model

The Service provides free dental care for children up to the age of 18 (under MoH service specifications). Care for children from birth to school-year-8 is provided directly by clinicians employed by the service. During Year 8, children are transferred to a private dentist of their choosing, which is funded until they are 18 via the Combined Dental Agreement (CDA). The service is responsible for transferring children at year 8 to a nominated private provider with a contract.

The Service operates under a shared care model in which all children in the region are allocated to a dental hub, which is then responsible for ensuring that the children are recalled for examination annually and that treatment identified is undertaken promptly. Pre-school aged children are routinely called for their first examination to one of the thirteen regional dental hubs at the age of two. Pre-school-aged children are then offered routine annual examinations in a hub setting. Complementary approaches are used to reach Maori and Pacific children, particularly targeting low decile Te Kohanga Reo and Early Childhood Centres (ECC) and to provide 'knee-to-knee' dental examinations for enrolled children.

When enrolled in a primary school, these children are then identified on the school rolls and examined on an annual basis. Mobile dental vans parked in school grounds provide examinations, preventive treatment and x-rays (if required). This model supports high levels of equitable participation for children enrolled in these schools, with every child receiving a dental examination and preventative treatment in school hours. The region has 29 'no access' schools (due to topography and space) and children attending a no-access school are seen by appointment in their assigned dental hub with their parent/caregiver. All dental treatments are undertaken at a dental hub.

2.3.2 Children with Disabilities

Children with disabilities are seen wherever best suits their particular needs. Some children prefer to attend the mobile with their class mates. Some caregivers prefer to bring children in by appointment. All hubs except Paraparaumu, Petone, and upstairs at Selby House have wheelchair access. Children with complex medical or management needs are referred to the hospital dental departments where they receive one complete treatment then return to the RCOHS or have on going regular care in the hospital department. For example; children undergoing active treatment for cancer receive all care in the hospital department until 12 months after the completion of their active cancer treatment. Children who require extensive treatment may receive this care in the hospital, then return to the community oral health service for routine examinations and prevention. We have an ongoing relationship with CCDHB where a Registered Nurse and one of our therapists visit Mahinawa Specialist School (in Porirua) and its satellite classes for yearly examinations and care (when required) is provided at most appropriate location for child.

2.4 Workforce

The RCOHS currently employs 34.78FTE Registered Dental Therapists and 34.81FTE Dental Assistants to provide dental care to enrolled children. The Dental Hub teams are supported by a Service Manager, 3 Team Leaders, a Clinical Director (0.7 FTE), 2 Community Dentists (0.8 FTE), an Early Intervention Prevention Team and an administrative team. RCOHS has approval to recruit eight new Graduates for 2018 and is currently planning this with Otago University and AUT.

Workforce succession planning and growing the workforce has commenced with Career and Allied Health Salary Progression Framework being supported. Dental Therapists will have the opportunity to undertake CASP Step 7 during 2018, supported by RCOHS Leadership Team and the HVDHB Director of Allied Health. In addition, the leadership team is currently drafting a CASP Maintenance Programme for staff who have achieved CASP (step 7), to ensure that they are supported and challenged to innovate and grow the Service appropriately.

2.5 Early Intervention and Prevention Team

The RCOHS Early Intervention and Prevention Team work alongside clinical staff to provide health promotion support and facilitate pre-school examinations in 61 Kohanga Reo and Early Childhood Centres in the Region. This team is also responsible for the year 8 adolescent transfer process (to private dentists with a combined dental agreement contract).

3 SERVICE DELIVERY MEASURES

The service publishes a monthly scorecard with key service delivery indicators for staff and some external stakeholders to follow progress throughout the year. The October scorecard is appended.

The service reports four data sets annually (20 April) to the Ministry of Health for the previous calendar year; these reports are provided in the appendix:

- PP10 is the number of decayed missing and filled permanent teeth (DMFT) and % caries free for enrolled year 8 children
- PP11 is the decayed, missing and filled deciduous (baby) teeth (dmft) and % caries free for enrolled 5 year olds. % Caries free is a measure of caries prevalence (i.e. how much is out there in the population); a higher value is good. DMFT/dmft is a measure of caries severity (i.e. how severe is that experience for individuals and populations); a lower value is good.
- PP12 is a measure of adolescent utilisation of publicly funded services that is populated by the MoH from pro-claim data. Extra volumes can be added by each DHB.
- PP13a is the % of preschool children enrolled in the service based on a population denominator from Statistics NZ. PP13b is the % of enrolled children who did not receive their annual examination (arrears). Both these are influenced by a combination of families not attending an examination booked (Did not attend) and children not being offered an appointment due to service constraints; there are specific initiatives in train to address both of these factors.

The level of caries in a population is largely influenced by socio-demographic determinants, water fluoridation, oral health practices and diet including beverage choices so are likely to fluctuate slightly year-on-year but remain reasonably constant until population-based and targeted upstream changes are instigated that reduce poverty, sustain equity and enable and effect healthy lifestyle choices.

4 UPDATE OF CURRENT WORK PLAN AND PLANNING FOR 2018

4.1 Equity of Service Initiatives

4.1.1 Hub Administration Roles

A number of initiatives have recently been instigated to target children who are either in arrears or have not attended appointments, the highest being Maori and Pacific children. These include the introduction of Hub Administration Support Roles to exclusively target these children. The three roles

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are placed in each of the three large hubs of Naenae (Hutt Team), Brandon (Kapi-Mana team) and Selby House (Wellington Team) and are responsible for administration support for the hubs that come under each team.

4.1.2 Holiday Programme

RCOHS has been working in conjunction with Ora Toa and Porirua City Council for the funding and installation of mobile van plugs in areas where there can be targeted school holiday programmes for provision of dental examinations. To date, the team has provided mobile dental examinations during the Easter and July school holidays at Ora Toa (Cannons Creek) and have just completed a successful week at Te Rauparaha Arena in which 71 children were examined in 4 days, a large percentage of which were local pre-school aged children. The RCOHS is currently in discussion with Wellington City Council for funding mobile sites and has plans to increase the number of plugs in targeted areas in Upper and Lower Hutt through working with the respective Councils during 2018.

4.1.3 Increasing scope for Early Intervention and Prevention Team (EIP)

The EIP Team is currently working in conjunction with Maori and Pacific providers for the 2018 programme to be present for health promotion events in our communities, e.g. Creekfest and PolyFest.

In addition, the team is widening its scope for Te Kohanga Reo ECC and Kindergarten visits for 2018, which has shown to be successful at providing dental examinations for pre-school aged children, through knee-to-knee checks. Planning is currently in progress for this initiative.

The EIP are also working with Regional Public Health (RPH) and Healthy Families to provide support for the 'Water in Schools' initiative. From 2018, the RCOHS will provide each school (post dental van visit) with data on children seen and the percentage of caries identified in those children with the option for the school to be contacted by RPH for further discussion in this initiative.

4.1.4 Late Night Appointment Trials

The Service has been trialling late night appointments at Naenae Dental hub from Term 3, in order to provide increased flexibility of dental appointments for children. To support this initiative, processes have been developed to support staff treating children at these appointments. Evaluation and feedback is due January 2018, with potential to roll this out across the Service in targeted areas.

4.1.5 Consumer Feedback

In order to better understand and be more responsive to the needs of our children and their caregivers, the RCOHS is currently trialling an electronic consumer feedback survey in Term 3 and Term 4 in all dental hubs. The effectiveness of this survey including feedback is closely monitored and will be evaluated in January 2018 to assess its effectiveness.

5 CLINICAL BEST PRACTICE

Clinical best practice for the individual child is dependant upon a comprehensive caries risk assessment at the outset of their care. This may change at each subsequent examination. Clinical care is tailored to the needs and abilities of the individual child to cope. If a child has care that is out of the scope of a therapist or has extensive needs making care difficult in the clinic setting, they are referred to a contracted private dentist or to a DHB hospital department for a first specialist assessment (FSA) to consider sedation or general anaesthetic to help manage their care.

5.1 Radiographs

Diagnostic posterior bitewing x-rays should be taken on children as soon as the spaces between teeth have closed and surfaces can not be seen visually any more (around 4-5 years) and then according to risk (high risk: 6-12 monthly; low risk: 2 yearly). Our therapists have undertaken this since 2012 across the service and are audited yearly.

5.2 Preventative Treatment (Fluoride varnish)

Fluoride Varnish is a high fluoride treatment that is applied to children's teeth according to risk. It provides further decay prevention even in the presence of good tooth brushing practices and water fluoridation. Children at high risk of caries need twice yearly application, while low risk children in a fluoridated area required it once a year or not at all. The therapists are audited regularly on the use of this preventive tool.

5.3 Stainless steel crowns (SSC)

SSC are a silver metal cover that is placed over a tooth rather than using a white or silver filling. They have a better success rate and are more likely to last the lifetime of a baby tooth meaning a child will only need to have a filling done once and not replaced. They are the gold standard for back baby teeth with medium to large sized cavities. Conventional SSCs involved the removal of the decayed tooth tissue. A novel method called the Hall Technique is now being introduced to the service that has strong national and international evidence for its longevity, safety and child acceptability where the decay is not removed but the crown simply cemented over the tooth. The decay stops growing and the tooth lasts in-situ until it exfoliates naturally between 10-12 years of age. Introduction of this technique to our service is exciting as it adds another tool to the therapist armamentarium which may mean the child has a quick treatment with no need for injection or drilling. Often this means that a child unable to cope with conventional treatment can receive this as an alternative and not need a referral to hospital for treatment under GA. The main reason a caregiver or child would decline this option is the silver colour but this is becoming more widely accepted.

Approximately half our therapists have the scope to provide SSC and pulpotomy (a deciduous root canal treatment). We have recently gained accreditation to provide training for therapists to add this to their scope of practice. Our first four therapists without the scope will receive this training early November 2017 with a plan to train the remaining therapists both here and in the Wairarapa in the next 12 months so that all therapists can offer the same treatment options consistently according to evidence based best practice.

6 ADDITIONAL PLANNING FOR 2018-2020

This year has largely been centred on fully establishing the new model of care and allowing the new full time service manager to clarify and consolidate and allocate budget and service delivery. This has put us in a better position to plan for a strong future. Our future vision is based on having the child at the centre, and consistently delivering evidence-based changes that allow children to live play and learn free of pain and decay from their teeth. We are working towards a service team that are supported to provide high quality targeted care and prevention in a timely manner.

6.1 Digital Radiography

The RCOHS is developing a project plan for the implementation of digital radiography, which allows diagnosis at point of examination, with immediate formulation of treatment plan (this is unavailable to RCOHS currently).

PUBLIC**6.2 Mobile Van Resources**

A business case for an additional mobile dental van is being developed as the current mobile vans are at full capacity, which this prohibits the Service from increasing the number of children who are able to have onsite dental examinations whilst at school. An additional mobile dental van would allow a greater number of children to be examined at school and would also allow coverage for periods when existing mobile dental vans are off the road for maintenance and repair.

  		CPHAC-DSAC PAPER	INFORMATION
		Date: 7 November 2017	
Author	Lynnette Field, Clinical team leader, Wairarapa Oral Health Service		
Endorsed by	Nigel Broom, Wairarapa DHB		
Subject	Oral Health Service update		
RECOMMENDATION			
It is recommended that CPHAC-DSAC:			
<div>1. NOTE that both mobiles and the community Dental Clinic are fully operational.</div> <div>2. NOTE that Wairarapa have an annual rotation of 15 locations with the mobiles and that Wairarapa DHB ensures that each town has at multiple visits per year aside from Tinui, Martinborough and Kahutara who only have one.</div> <div>3. NOTE that Lakeview which has been identified as having the most ‘at risk’ children receives 4 visits per year (one each term)</div> <div>4. NOTE that we work closely with the mobile surgical bus service to provide GA services to the children in the Wairarapa.</div> <div>5. NOTE that we work closely with HVH and CCH to ensure those with special needs have access to tertiary services.</div> <div>6. NOTE that we are awaiting the outcome of the ministry of health information technology review when a national oral health computer programme will be settled on. This will act as a catalyst for the introduction of this programme to the Wairarapa oral health service.</div>			
Appendices:			
<div>1. Wairarapa DMFT 2016</div> <div>2. Achievements against workplan</div>			

1. PURPOSE

The purpose of this report is to update CPHAC/DSAC on the work of the Wairarapa Oral Health Service.

2. BACKGROUND

Wairarapa District Health Board is the current Ministry of Health (MoH) contract holder for the Oral Health service that encompasses the Wairarapa. The service is delivered from the Community Dental Clinic and two, 2 chair mobiles which travel around the Wairarapa providing the same full service as the Community Dental Clinic.

2.1 Enrolments

Children in the region are enrolled at birth and the family is first seen when the baby is around 10 weeks old. At the end of 2016 we had a roll of 7152 children from birth till the end of year 8.

2.1.1 Current Model

The service provides free dental care for children up to the age of 18 (under MoH service specifications). As previously stated care is provided up until the end of year 8 by the personnel of the Wairarapa oral health service and after that the students are transferred to a private dentist. All dentists within the Wairarapa are party to the

Combined Dental Agreement so parents can choose whichever dentist best meets their needs. The service employs an adolescent oral health coordinator who works with the staff of the oral health service to ensure all students are transferred to a private practitioner.

The service operates as a team and all children within the Wairarapa District Health Board are able to be seen at either the community dental clinic or the mobiles when in their area. Pre-school children are seen at 10 weeks (approximately) and then annually thereafter. Schools notify us when children enroll and they are added to the roll of that school. An annual check is done to ensure all children in educational settings are on our books.

Mobiles parked within schools provide the same care for the children of the school as the community dental clinic. This includes prevention, radiographs and treatment.

2.1.2 Children with special needs

Children with disabilities or special needs are seen wherever best suits the family. This can include home visits for those who are acutely ill and where the family is asking for advice.

Children with complex management needs can be seen on either the mobile surgical bus or if there is medical issues as well they may be referred to either Hutt or Capital Coast hospitals according to their needs.

2.2 Workforce

We currently employ 6FTE registered Dental Therapists and 3FTE dental assistants.

We have .9 Administration support and .5 Clinical team leader to provide dental care for 7152 children.

We have had approved an increase of .4 FTE Dental Therapist and we will be appointing a new graduate who will use this FTE along with .6 from a retiring Dental Therapist. We are currently interviewing Otago university 2018 graduates.

We have an aging workforce but with the retirement of one therapist and the imminent retirement of yet another we are working at ensuring a healthier age spread amongst staff.

2.3 Service Delivery measures.

The service reports annually (20th April) to the ministry. These reports are attached in the appendices.

The level of caries in a population is largely influenced by socio-demographic determinants, water fluoridation, oral health practices and diet including beverage choices so the level of caries fluctuates annually.

The Wairarapa has a particular issue in that our highest needs groups are within our fluoridated areas.

3. UPDATE ON CURRENT WORK PLAN AND PLANNING FOR 2018

3.1 Increase in scope of practice for dental therapists

We are currently working towards adding stainless steel crowns to the scope of every dental therapist within the Wairarapa DHB along with pulpotomies.

3.2 New Graduate

2018 will see us with a new graduate. A great deal of mentoring and support will be offered to this person. We will only have 5 FTE therapists to do this so one person will be taken out of the operating equation for the first term. This will cause a stress to the service in the short term but the long term gain is a fully functional therapist to add to our team.

3.3 iMoko

The Wairarapa DHB has a trial introduction of a programme called iMoko. This programme provides immediate medical care for an enrolled group of children. Oral health will be an integral part of this service providing training on oral health issues to the adults referring the children and assisting when necessary.

3.4 Wahi Pai Wahi Ora

The two Maori health providers within the Wairarapa are running a programme to assist Maori with various oral health needs to access services. The oral health service provides professional advice and is part of the steering committee as well as providing training in the needs for a healthy mouth for the participants.

4. CLINICAL BEST PRACTICE

Clinical best practice for the individual child is dependent upon a comprehensive caries risk assessment at the outset of their care. This may change at each subsequent examination. Clinical care is tailored to the needs and abilities of the individual child to cope. If a child has care that is out of the scope of a therapist or has extensive needs making care difficult in the clinic setting, they are referred to a contracted private dentist or to the outpatients dept. for a first specialist assessment (FSA) with the dentist who operates on the Mobile Surgical Bus to consider general anesthetic to help manage their care.

4.1 Radiographs

Diagnostic posterior bitewing x-rays should be taken on children as soon as the spaces between teeth have closed and surfaces can not be seen visually any more (around 4-5 years) and then according to risk (high risk: 6-12 monthly; low risk: 2 yearly). Our therapists have engaged this best practice since 2012

4.2 Preventative Treatment (Fluoride varnish)

Fluoride Varnish is a high fluoride treatment that is applied to children's teeth according to risk. It provides further decay prevention even in the presence of good tooth brushing practices and water fluoridation. Children at high risk of caries need twice yearly application. Low risk in a fluoridated area once a year or not at all.

4.3 Stainless steel crowns (SSC)

SSC are a silver metal cover that is placed over a tooth rather than using a white or silver filling. They have a better success rate and are more likely to last the lifetime of a baby tooth meaning a child will only need to have a filling done once and not replaced. They are the gold standard for back baby teeth with medium to large sized cavities. Conventional SSCs involve the removal of the decayed tooth tissue. A novel method called the Hall Technique is now being introduced to the service that has strong national and international evidence for its longevity, safety and child acceptability where the decay is not removed but the crown simply cemented over the tooth. The decay stops growing and the tooth lasts in-situ until it exfoliates naturally between 10-12 years of age. Introduction of this technique to our service is exciting as it adds another tool to the therapist armamentarium which may mean the child has a quick treatment with no need for injection or drilling. Often this means that a child unable to cope with conventional treatment can receive this as an alternative and not need a referral to the mobile surgical bus for treatment under GA. The main reason a caregiver or child would decline this option is the silver colour but this is becoming more widely accepted.

We are still undergoing training in this scope and expect to introduce this next year. (2018)

Pulpotomy (a deciduous root canal treatment) is also a scope we will introduce in 2018. Hutt Valley DHB has gained accreditation to train in these two scopes and they plan to train the therapists both there and in the Wairarapa in the next 12 months so that all therapists can offer the same treatment options consistently according to evidence based best practice.

APPENDIX 1:

Wairarapa DMFT Scores for 2016 – Year 8 Children

Calendar year 2016

Dental Health Status	Number of Children Examined	Number of Children Caries-Free	Number of Decayed Teeth	Number of Teeth Missing due to Caries	Number of Filled Teeth	Number of Decayed, Missing due to caries and Filled Teeth	% Caries Free	Mean D	Mean M	Mean F	Mean DMFT	Mean DMFT for children with caries			
												Mean D	Mean M	Mean F	Mean DMFT
All Year 8 Children	378	243	8	0	278	286	64%	0.02	0.00	0.74	0.76	0.06	0.00	2.06	2.12
All Maori Year 8 Children	83	46	8	0	84	92	55%	0.10	0.00	1.01	1.11	0.22	0.00	2.27	2.49
All Pacific Year 8 Children	11	7	0	0	8	8	64%	0.00	0.00	0.73	0.73	0.00	0.00	2.00	2.00
All "Other" Year 8 Children	284	190	0	0	186	186	67%	0.00	0.00	0.65	0.65	0.00	0.00	1.98	1.98
All Fluoridated Year 8 Children	154	94	1	0	137	138	61%	0.01	0.00	0.89	0.90	0.02	0.00	2.28	2.30
All Non-Fluoridated Year 8 Children	224	149	7	0	141	148	67%	0.03	0.00	0.63	0.66	0.09	0.00	1.88	1.97
Maori Fluoridated Year 8 Children	43	21	1	0	51	52	49%	0.02	0.00	1.19	1.21	0.05	0.00	2.32	2.36
Maori Non-fluoridated Year 8 Children	40	25	7	0	33	40	63%	0.18	0.00	0.83	1.00	0.47	0.00	2.20	2.67
Pacific Fluoridated Year 8 Children	8	5	0	0	4	4	63%	0.00	0.00	0.50	0.50	0.00	0.00	1.33	1.33
Pacific Non-fluoridated Year 8 Children	3	2	0	0	4	4	67%	0.00	0.00	1.33	1.33	0.00	0.00	4.00	4.00
Other Fluoridated Year 8 Children	103	68	0	0	82	82	66%	0.00	0.00	0.80	0.80	0.00	0.00	2.34	2.34
Other Non-fluoridated Year 8 Children	181	122	0	0	104	104	67%	0.00	0.00	0.57	0.57	0.00	0.00	1.76	1.76

Other comments

Enter any other comments here that may help explain the figures provided.

If any of these results did not meet your DHB's targets, you must provide an explanation here that includes a description of what your DHB is doing to rectify the problem.

Our most deprived families live in the Masterton area which correlates with the higher decay rates in the fluoridated areas. Of interest however is the higher DMFT of the Maori yr 8's in the non fluoridated areas. i.e. if your going to get decay you get more in the non fluoride areas if you are Maori or Pacifica. Any year 8 children due in the last few months of 2016 were not seen in 2016 as our PP see all year 9's in the first couple of months of the school year. We are working with the 2 local iwi providers targeting high risk Maori.

Wairarapa DMFT Scores for 2016 – 5 Year Old Children

Five-year-old children, 2016 calendar year

Dental Health Status	Number of Children Examined	Number of Children Caries-Free	Number of Decayed Teeth	Number of Teeth Missing due to Caries	Number of Filled Teeth	Number of Decayed, Missing due to caries and Filled Teeth	% Caries Free	Mean d	Mean m	Mean f	Mean dmft	Mean DMFT for children with caries			
												Mean d	Mean m	Mean f	Mean dmft
All 5-year old Children	477	314	96	45	480	621	66%	0.20	0.09	1.01	1.30	0.59	0.28	2.94	3.81
All Maori 5-year old Children	138	73	68	25	214	307	53%	0.49	0.18	1.55	2.22	1.05	0.38	3.29	4.72
All Pacific 5-year old Children	20	8	15	1	23	39	40%	0.75	0.05	1.15	1.95	1.25	0.08	1.92	3.25
All "Other" 5-year old Children	319	233	13	19	243	275	73%	0.04	0.06	0.76	0.86	0.15	0.22	2.83	3.20
All Fluoridated 5-year old Children	233	139	32	32	282	346	60%	0.14	0.14	1.21	1.48	0.34	0.34	3.00	3.68
All Non-Fluoridated 5-year old Children	244	175	64	13	198	275	72%	0.26	0.05	0.81	1.13	0.93	0.19	2.87	3.99
Maori Fluoridated 5-year old Children	82	42	19	20	133	172	51%	0.23	0.24	1.62	2.10	0.48	0.50	3.33	4.30
Maori Non-fluoridated 5-year old Children	56	31	49	5	81	135	55%	0.88	0.09	1.45	2.41	1.96	0.20	3.24	5.40
Pacific Fluoridated 5-year old Children	12	3	4	1	22	27	25%	0.33	0.08	1.83	2.25	0.44	0.11	2.44	3.00
Pacific Non-fluoridated 5-year old Children	8	5	11	0	1	12	63%	1.38	0.00	0.13	1.50	3.67	0.00	0.33	4.00
Other Fluoridated 5-year old Children	139	94	9	11	127	147	68%	0.06	0.08	0.91	1.06	0.20	0.24	2.82	3.27
Other Non-fluoridated 5-year old Children	180	139	4	8	116	128	77%	0.02	0.04	0.64	0.71	0.10	0.20	2.83	3.12

Other comments

Enter any other comments here that may help explain the figures provided.





If any of these results did not meet your DHB's targets, you **must** provide an explanation here that includes a description of what your DHB is doing to rectify the problem.

The vast majority of our low decile patients are in the fluoridated areas. Masterton has 'higher' than the national average of deprivation. Masterton is our only Fluoridated area.
Please note the Maori children in the non Fluoridated area have higher decay than thier fluoridated colleagues even though on average they will have a lesser deprivation scale.
We are working with our Maori providers at targeting all Maori 0-4 years of age and giving targeted Oral Health information to these families. We are also working at DNA rates with the Maori womans welfare league.
We are currently providingoral health information group sessions for all 8-12 week old babies we anticipate this will lower the decay rates further. The Pacific children are such a small cohort that they are not statistically viable.




APPENDIX 2:

ACHIEVEMENT AGAINST WORK PLAN




Service design and development

Action Areas (description)	Traffic Light	Deliverables	Quarterly Milestone(s)	Identified Risk/Narrative
All children over 4 years of age are offered radiographs. Every child has had a radiograph by the age of 6.		Consent sent to caregivers. Children at 6 years of age have received at least one radiograph	Achieved	
All new born babies and their caregivers are offered dental health education sessions.		All parents of new born babies receive invitations to attend sessions.	Achieved	
Mobiles fully staffed.			Staff Roster for mobiles full	
Increase pre-school enrolments.		Provide information re oral health enrolment to at risk groups	Pacific Island church information day. Whaiora and Plunket engagement	


Improve service culture and workforce development.

Action Areas (description)	Traffic Light	Deliverables	Quarterly Milestone(s)	Identified Risk/Narrative
Take on one dental student over year.		Otago student organised	Student in term 3	
One social event offered per term for staff.		Drinks after work once a term.	Achieved	
Provide on-going appropriate training		CPD provided with local PP's and HVH.		


Stakeholder relationships.

Action Areas (description)	Traffic Light	Deliverables	Quarterly Milestone(s)	Identified Risk/Narrative
Engage with Tamariki Ora providers.		Lift the lip training	Achieved	
Establish relationships with pacific groups		Training session at church meeting		attend church groups.
Engage with local P.P's		Provide social and information evenings for local PP's	Social and CPD nights held	

Quality

Action Areas (description)	Traffic Light	Deliverables	Quarterly Milestone(s)	Identified Risk/Narrative
Quality fully embedded in staff meetings.		Staff meeting minutes reflect value placed on quality by staff.	Achieved each staff meeting.	

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  		CPHAC/DSAC DISCUSSION PAPER
		Date: 1 November 2017
Author	Clare Munro, Senior Business Support Analyst, Regional Public Health Shane Bradbrook, Senior Public Health Advisor, Regional Public Health	
Endorsed By	Peter Gush, Service Manager, Regional Public Health Dr Stephen Palmer, Clinical Head of Dept., Regional Public Health	
Reviewed/approved by	Nigel Broom, Executive Leader, Planning & Performance, Wairarapa DHB Helene Carbonatto, General Manager, Strategy, Planning and Outcomes, Hutt Valley DHB Rachel Haggerty, Director, Strategy, Innovation and Performance, Capital & Coast DHB Chief Executives, Wairarapa DHB, Hutt Valley DHB, and Capital & Coast DHB	
Subject	Regional Public Health Update	
RECOMMENDATION It is recommended that CPHAC/DSAC: a) NOTE issues, strategies and future focus in regard to <i>environmental health</i> – in housing, climate change, emergency management and preparedness and water quality. b) NOTE issues, strategies and future focus in regard to <i>preventing long term conditions</i> – in tobacco, alcohol, obesity, and other drugs (methamphetamine and synthetic cannabis).		

1. PURPOSE

To provide an update of Regional Public Health (RPH) activities and to identify future activities.

2. BACKGROUND

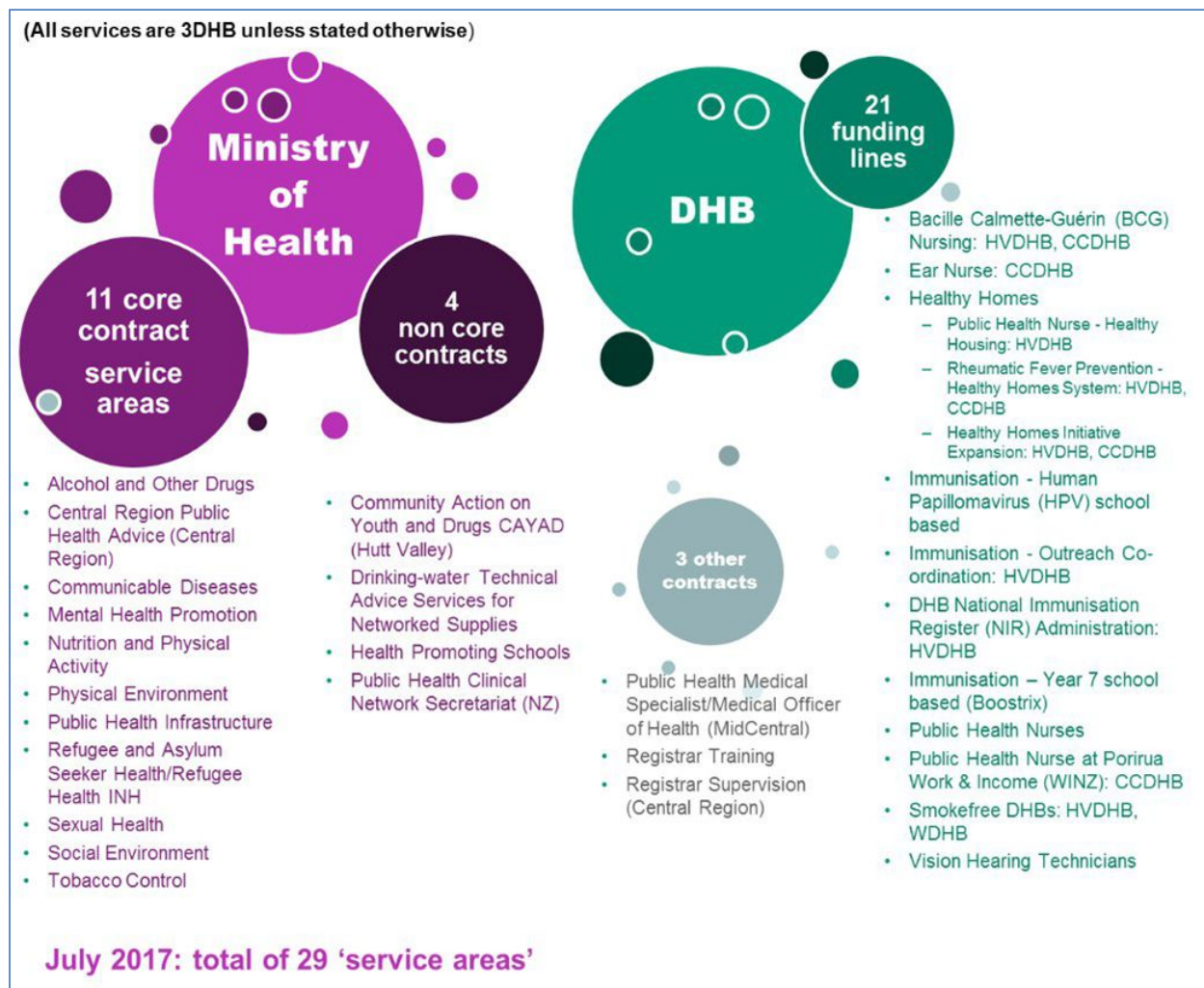
Regional Public Health (RPH) is a sub-regional service with a range of contracts and funding lines. Its core contract with the Ministry of Health (MOH) is based on delivering five core public health functions for the populations of Wairarapa District Health Board (WDHB), Hutt Valley District Health Board (HVDHB), and Capital & Coast District Health Board (CCDHB).

- **Health promotion:** is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions.
- **Health protection:** is a term used to encompass a set of activities within the public health function. It involves: Ensuring the safety and quality of food, water, air and the general environment. It also includes preventing the transmission of communicable diseases.
- **Preventive interventions:** includes a wide range of activities — known as ‘interventions’ — aimed at reducing risks or threats to health. Disease prevention and health promotion share many goals, and there is considerable overlap between functions.

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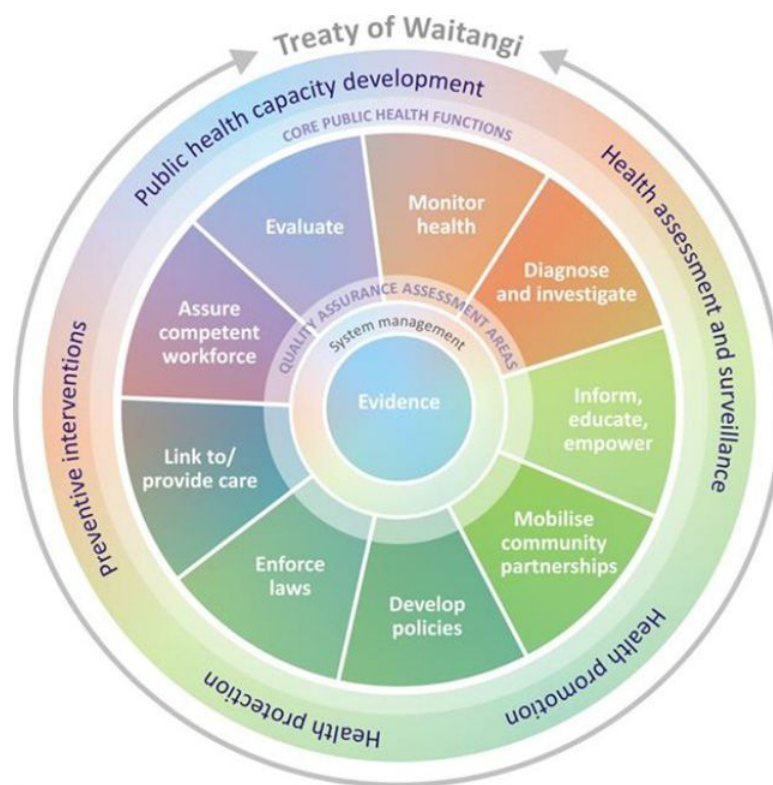
- **Health assessment and surveillance:** Public health surveillance is the continuous, systematic collection, analysis and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice.
- **Public health capacity development:** enhancing our public health systems' capacity to improve population health e.g. developing partnerships with Iwi, hapū, whānau and Māori to improve Māori health.

RPH also provides a range of other public health services. All services agreed with funders are summarised in the diagram below:



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As a Public Health Unit, RPH carries out unique, essential public health services every day. The following 'wheel'¹ shows a snapshot of the wide range of public health approaches undertaken.



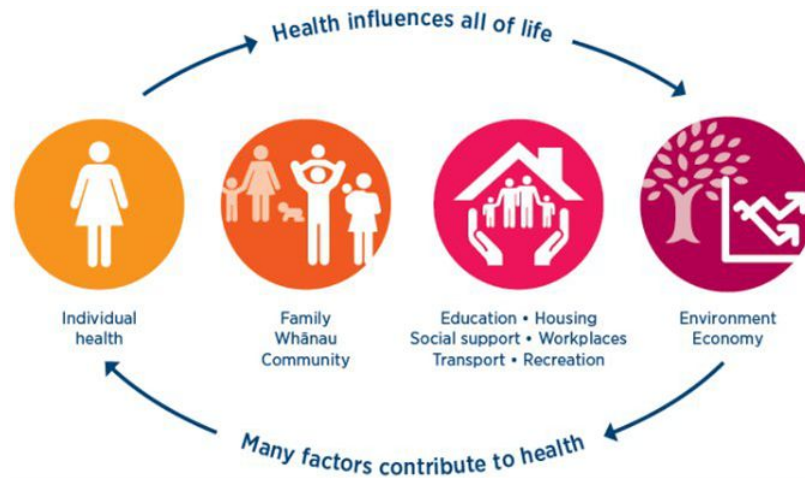
3. CONTEXT

3.1 People and Place – a longer term perspective

The opportunity for health begins long before the need for medical care - in families, neighbourhoods, schools and jobs. To support optimal health and wellbeing, for *all* people in our rohe, RPH centres services on a holistic framing of health and wellbeing, people who face significant barriers to better health, and contributing to a long term impact. This means a focus on people (from beginning to end of life), their whānau, their communities, and their environments. It includes having on-going working relationships with many sectors, agencies and community groups that are actively seeking to make a difference with, and for, people who don't have the same opportunity to be as healthy as others.

¹ RPH quality assurance wheel

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The following extract is from the Royal Australasian College of Physicians (RACP), who recently released a health equity position statement 'Make it the Norm.'² It helps explain why a 'whole of health and wellbeing' (holistic) lens is vital for a district health board and their public health unit.

"... The RACP³ recognises health as multidimensional, encompassing more than just the treatment of illness and disease...

"As physicians and paediatricians we are treating patients who are struggling with preventable illnesses every day," Dr Christiansen, the RACP President, explained. "We need more holistic approaches to addressing the social determinants of good health, including healthy housing, 'good' work and whānau wellbeing."

Paediatrician and RACP New Zealand President-Elect Dr Jeff Brown agreed.

"I'm seeing an increase in repeat hospital admissions of kids with respiratory illnesses, including pneumonia, caused by living in cold, mouldy homes," he said. "We treat them, and send them right back to the same unhealthy environment."

Dr Christiansen said the evidence overwhelmingly supports action on the social determinants of health and requires a whole-of-society response. Central and local government, communities, non-government organisations and industry need to work together to support the health and well-being of all New Zealanders.

"Health and well-being must become the norm," Dr Christiansen said. "Where people live, how they spend their time, and who they live with, all have a major impact on human health. The best way to enable health equity is to look at the conditions in which people grow, live, work and age, and how these can support positive health outcomes.... Ensuring whānau are supported to lead healthy lives by addressing the causes of poor health will lead to reduced costs for the health system and greater health equity."

3.1.1 Key strategies



Bridging between communities and agencies

In every day work with, and for, communities and agencies, RPH often is 'the bridge.' - working alongside community leaders and other agencies to agree how to collectively make a difference. For example, in housing related work, RPH regularly brings together *Housing NZ*, the *Ministry of Social Development* and locally based providers such as the *Sustainability Trust* and *Tū Kotahi Māori Asthma Trust*.

Influence decision-making

Collaborating with a range of organisations and planning forums. Some of the key areas include local and central government, the health system, urban planning, housing, water, transport, emergency management and preparedness.

² Available from <https://www.racp.edu.au/docs/default-source/default-document-library/make-it-the-norm-pres-letter.pdf?sfvrsn=6>

³ The Royal Australasian College of Physicians (RACP) is a professional medical College of over 15,000 physicians and 7,500 trainee physicians, in Australia and New Zealand.

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Supporting the voices of people who are more vulnerable

Community led action in neighbourhoods. For example, Wainuiomata youth led action on smokefree cars and sports grounds.

Providing public health information and advice

Examples of providing information to support action include:

- The RPH website (www.rph.org.nz)
- The *Public Health Post*, a quarterly newsletter to primary health practitioners
- Public Health Alerts detailing current health concerns e.g. mumps, measles and the Zika virus.
- Analysed public health data to a variety of stakeholders e.g. about the water quality of coastal, streams, rivers and drinking water supplies.

3.1.2 Future focus

More focus on actively empowering people with the greater need, to be involved alongside agencies and decision-makers.

3.2 ENVIRONMENTAL HEALTH**3.2.1 Housing****Key messages**

- Poorly maintained, damp, mouldy, and cold housing is hazardous to health
- Overcrowding increases the spread of infectious diseases
- Since starting in April 2015, *Well Homes* (HVDHB and CCDHB) has received over 2,000 referrals.

The inability to access decent, affordable housing is one of the most significant barriers to an adequate standard of living. At a family level, housing represents the most significant single budget item for many New Zealanders. Additionally, the quality of housing directly affects people's health, particularly in the case of children and old people. For children, security and adequacy of housing have far-reaching effects on their health, achievements in education and their general development.

In New Zealand, many houses are old, cold, damp, mouldy, poorly built with inadequate insulation and heating. Living in poor quality or inadequate housing is linked with specific conditions including: asthma and depression, rheumatic fever, meningococcal disease, and skin infections.

An ultimate aim is that all people have choices about being well-housed across the housing continuum:⁴

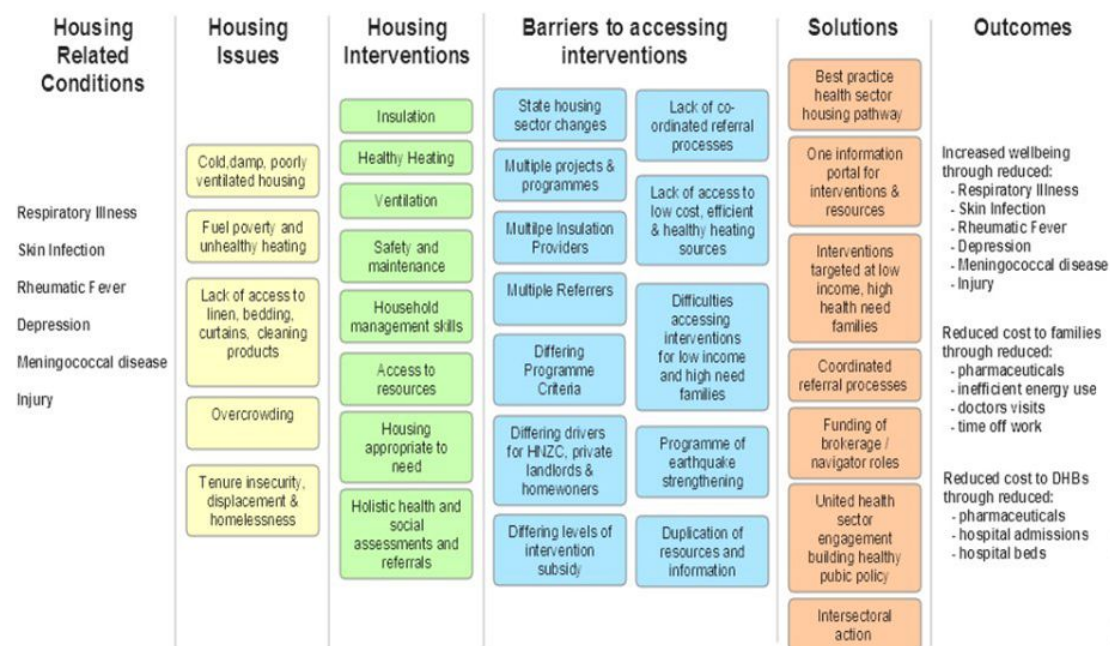


⁴ Source: <http://www.makinghomeshappen.co.nz/the-housing-continuum/>

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RPH provided the following diagram to CPHAC in 2012 papers about housing and health. It shows the relationship between housing related conditions, housing issues and interventions, intersectoral barriers, as well as their possible solutions. From this the Well Homes service has evolved as the main current housing programme delivered by RPH (see key strategies below),

Figure 1: Housing and Health - Addressing Sub-regional Integration
CPHAC 15 October 2012



Key strategies

Well Homes partnership.

Well Homes is a partnership formed between RPH, *Tū Kotahi Māori Asthma Trust*, *Sustainability Trust* and *He Kāinga Oranga (University of Otago)* to deliver housing assessments to a range of whānau, usually referred by health professionals but also by social services and community groups. Currently the partnership is contracted for delivery in the HVDHB and CCDHB districts.

Since its inception as an integrated housing programme in April 2015, *Well Homes* has received over 2,000 referrals; these are focussed around Māori and Pacific households and areas of social deprivation. From early 2017, an automated referral process agreed between *Well Homes*, HVDHB and CCDHB has resulted in an increase in referrals.

The *Well Homes* programme operates from a hub located at RPH and uses an in-house customised database to input data of consenting whānau who meet the criteria for the MOH's Rheumatic Fever and Healthy Housing Initiative Expansion contracts. Public Health Nurses triage the referrals and whānau are visited by either a nurse or qualified housing assessor. Child health is a key focus and whānau are provided information to reduce overcrowding, mould, draughts and dampness and are offered interventions including insulation, heating, curtains, blankets, bedding and beds as appropriate. Whānau outside the eligibility criteria are offered alternative housing solutions.

The following graph, showing recent analysis of nine years of housing sensitive hospitalisation (HSHR children 0 – 14) by area unit across the region has confirmed the focus on Maori, Pacific and areas of socioeconomic deprivation.

Wairarapa Healthy Homes

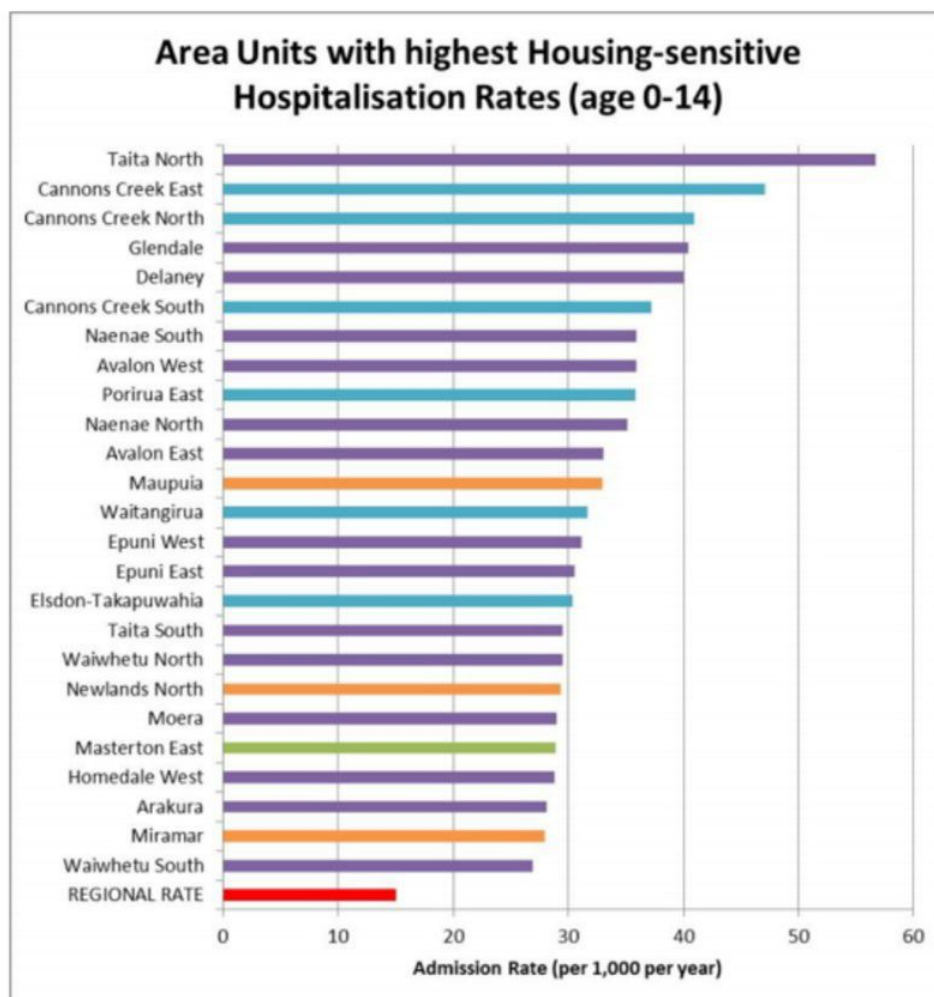
Wairarapa DHB contributes annually, along with several other funders, to the Wairarapa Healthy Homes (WHH) project run out of Masterton District Council. The WHH project has been running since 2004 and

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involves the installation of energy efficient retrofit measures into targeted Wairarapa homes. The community funding has been leveraged with the Energy Efficiency and Conservation Authority (EECA's) various schemes to deliver the retrofit measures.

Comparing the sub regional rate of 15 hospitalisations per 1,000 HSHR, the top three area units in:

- HVDHB rohe are: Taita North (58), Glendale (>40), and Delaney (40);
- CCDHB rohe are: Canons Creek East (48); Canon's Creek North (41); Cannons Creek South (37);
- WDHB rohe (only one in the top 25): Masterton East (28)



Funding for housing 'interventions' such as heaters and children's beds, is sourced from philanthropic entities, most recently the *Hutt-Mana Energy Trust*. Well Homes has also set up a partnership with the *Department of Corrections* Rimutaka Prison using donated funds to purchase high quality children's bedding sets, blankets, door snakes and fire bricks for whānau made by prison inmates. Over 59% of prisoners participate in industry training to reduce recidivism, and some whānau receiving these products are among the prison community.

Collaboration

The affordability, quantity and quality of housing are topical in the news, and a key driver of health outcomes. There are many players in addition to the health sector. Well Homes is engaged across Ministry of Business, Innovation and Enterprise (MBIE), Ministry of Social Development (MSD), Housing New Zealand (HNZ), Energy Efficiency and Conservation Agency (EECA), Treasury, Councils etc. with the

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purpose of collaborating around regulatory, compliance and policy matters, funding interventions and sharing learning from *Well Homes*’ data.

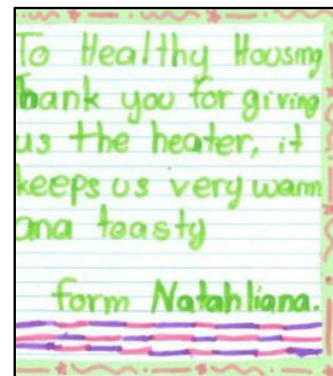
Future focus*Maintain current services*

Maintain an integrated housing programme, including the *Well Homes* partnership.

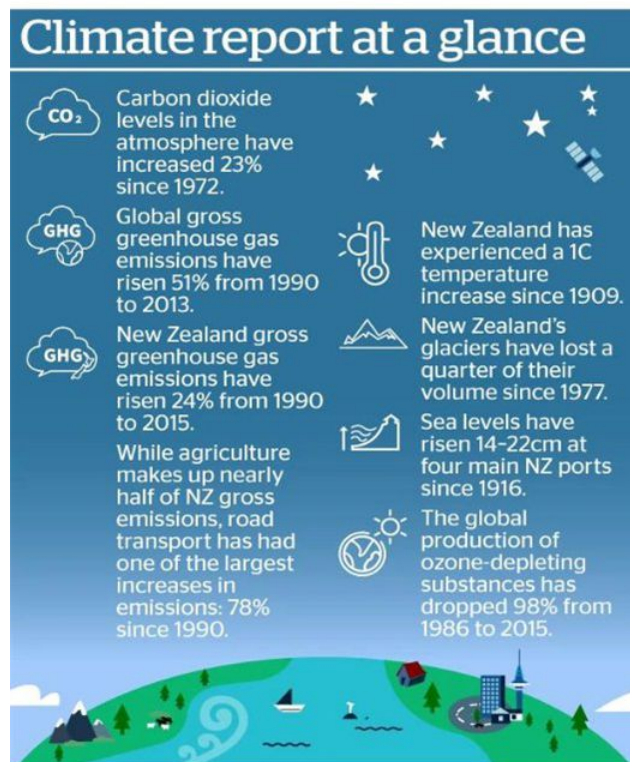
Influence decision-makers

Influence decision-makers in health, housing and urban planning with a focus on improving the living environments of those at risk of housing related illnesses (respiratory and rheumatic fever), vulnerable infants/children/new mothers and priority populations affected by housing and social disparities. This includes working with local and central government to influence good urban design and planning. For example, at the end of July 2017, *Greater Wellington Regional Council* held a meeting with representatives from the above agencies with the purpose of coordinating a regional approach to housing. *Well Homes* experience was presented; there were at least two potential collaboration projects resulting from the meeting as well as a commitment from the agencies present to work together.

Client quote: *Thank you sooo much for the wonderful heater that was given to our whānau home. One of the first comments my daughter made was ‘mum it’s not cold’. - Single mother of 3 young children.*

**3.2.2 Climate change**

Climate change is affecting New Zealand and the health of New Zealanders as many factors that contribute to our health and well-being are threatened by climate change. The effects of climate change will not be spread evenly across the population, exacerbating existing socioeconomic and ethnic health inequities. Well-designed policies to reduce global greenhouse gas emissions will not only limit climate change and reduce the associated risks to human health, but have the potential to improve population health and reduce health inequalities.



Source: Ministry for the Environment / Stats NZ ⁵

⁵ Graphic source: NZ Herald http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11934626

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An expert report recently released by New Zealand's leading body for science, Royal Society - Te Apārangi⁶, includes the following info-graphic and summary showing how climate change will disrupt the 'building blocks' of our health.

**Community**

Strong social ties support our health but communities may be disrupted if neighbourhoods are abandoned or relocated.

Well-being

Mental outlook is important for health but repeated stresses from extreme weather and other impacts of climate change may take a toll on our well-being.

Water

Clean water is essential for our health but droughts, floods and increased temperatures may lead to water contamination and toxic algal blooms.

⁶ The Royal Society of New Zealand is an independent, national academy of sciences, and a federation of scientific and technological societies.

PUBLIC**Food**

We need healthy food but droughts, floods and changes in weather patterns increase risk of crop disease, food spoilage, shortages and contamination.

Air

Clean air is vital for our health but changes in temperature and rainfall can increase air pollution and pollen allergens, which will increase the prevalence of respiratory problems.

Temperature

Moderate temperatures make life and work comfortable but more hot days will increase heat stroke, aggression and heart disease, especially for outdoor workers.

Shelter

We need adequate shelter for our health but some homes may become uninhabitable due to floods, erosion or fire.

Disease

Avoiding disease is vital for our health but rates of infection are likely to increase. Tropical diseases like malaria or West Nile virus may establish in New Zealand.⁷

New information commissioned from the National Institute of Water and Atmospheric Research (NIWA) in 2017, projects that there will be significant impacts to the Wellington region by 2090 if global emissions are not significantly reduced:

- Annual regional temperatures will increase by 3°C
- Wellington and Wairarapa will experience significant increase in hot days
- Frosts in the high elevations of the Tararua Ranges is likely to disappear
- Spring rainfall will reduce by up to 15% in eastern areas
- Up to 15% more winter rainfall could be experienced along the west coast
- The risk of drought will increase in the Wairarapa
- More extreme rainfall events⁸

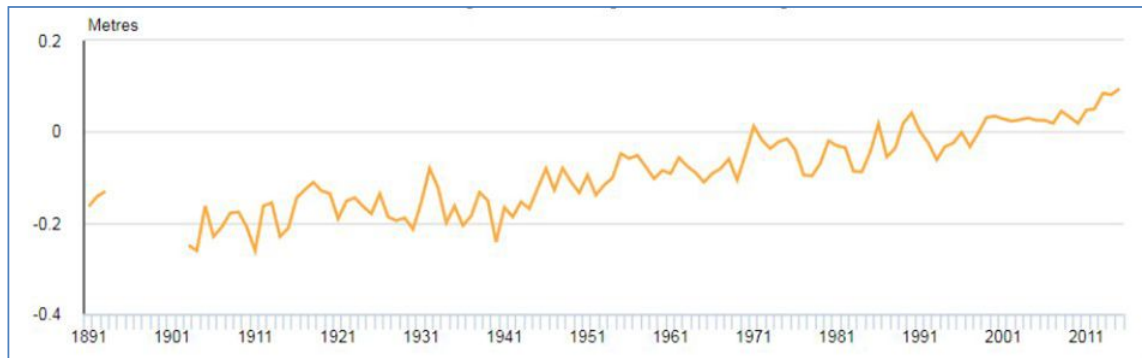
Of the four ports monitored across New Zealand, the Wellington tide gauge showed the most marked trend with a rate of increase of 2.23 (±0.16) mm/year for 1891 to 1893 and 1901 to 2015.

Figure2: Change in annual mean sea level for Wellington (relative to 1986-2005 baseline average)

⁷ Source: Human Health Impacts of Climate Change for New Zealand Evidence Summary, Royal Society, 2017

⁸ Source: Climate change and variability - Wellington Region, NIWA, 2017. Available at <http://www.govt.nz/climate-change/>

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⁹ Source: http://www.stats.govt.nz/browse_for_stats/environment/environmental-reporting-series/environmental-indicators/Home/Marine/coastal-sea-level-rise.aspx

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Following are two examples of RPH service areas particularly relevant to climate change - emergency management and water quality. Services such as these contribute to the region's resilience and preparedness for a changing climate.

3.2.3 Emergency management and preparedness

Effective emergency management ensures that we have the capability to respond appropriately to emergency events where there are potential threats to public health. These include significant disease outbreaks, pandemics and physical events such as an earthquake or flood, or from a disease vector or an ill traveller coming across our border. Prompt and effective measures are required to protect the health of the public against injury, disease or illness arising from such emergencies.

RPH has a legislative and contractual relationship with the MoH and DHBs to provide public health services during all phases of an incident or emergency (reduction, readiness, response and recovery). Experience in New Zealand and overseas overwhelmingly confirms that the impact of emergency events on vulnerable communities is more significant than those communities who have greater resources and resilience. Many emergency management activities reflect RPH's commitment to working collaboratively with other agencies and communities on preparedness and resilience building.

Local context*Emergency Management*

The greater Wellington region has experienced a number of emergencies caused by hazards, including earthquakes, floods, landslides, drought and pandemics. It is likely that the region would face multiple hazards in any type of event, for example, an earthquake could result in transport disruption, landslides, tsunami etc, similarly, a high rainfall event may cause flooding, landslides and transport accidents. The region has some unique geological and geographic features and combined with human activity present a number of hazards.

Border Health

The Wellington region contains two international points of entry. *Wellington International Airport Limited (WIAL)* and *CentrePort Wellington Limited (CPWL)*. Both are designated points of entry under the *International Health Regulations 2005 (IHR)*.

WIAL previously only operated Trans-Tasman international flights, however, the airport continues to expand and now operates twice weekly flights to and from Fiji and has recently introduced flights to Singapore via Canberra. CPWL is a cruise, log and container port with moderate shipping traffic. Approximately 60-70 cruise ships are expected to visit the port during the 2017/18 holiday season. The numbers of vessels first porting Wellington is fairly low compared to other large ports like Auckland and Tauranga, however, although delayed by recent earthquake damage, there are plans to further expand the operation in order to receive larger ships.

Effective border health planning, surveillance and response protocols ensure that RPH is able to minimise the risk posed to public health from diseases that may otherwise cross New Zealand's borders, for example, Ebola Virus Disease, Zika Virus, MERS-Cov, Wild Polio and Non Seasonal Influenza. Although services aim to protect the whole population, particular focus is given to protecting the most vulnerable groups. RPH continues to further develop excellent working relationships with our fellow border health agencies and stakeholders, e.g., NZ Police, NZ Fire Service, Wellington Free Ambulance, Customs, and the Ministry for Primary Industries.

In 2013 and again in November 2016, the Wellington region experienced earthquakes (centred in Seddon and Kaikoura), significant storm events and the threat of potable water shortages. The effects of technological failures affecting lifelines (water, electricity, infrastructure) and the impact on vulnerable communities (for example Māori, Pacific, Refugees, Housing New Zealand tenants, children, elderly) were highlighted in these events. RPH worked hard during the lengthy electricity outages caused by the June 2015 storm to ensure that the welfare needs of the vulnerable were being met.

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In May 2015, Emergency Operations Centres were activated in Kāpiti, Hutt and Porirua. Heavy rains caused a small landslide on State Highway 1 that blocked the route between Kāpiti and Porirua and caused a number of rivers and streams in the region to rise which combined with surface flooding caused damage to homes and businesses around the region. We provided advice during this event particularly with regards to drinking and recreational water matters and clean up information for those affected with flooded properties. These events highlighted the regions risks to the strong possibility that areas may be cut off in emergencies due to Wellington's main transport corridors, both road and rail, being in a Y shape, with few links between the main arterial routes.

In October 2015 flooding in the Upper Hutt area caused the Birchville Bridge to collapse resulting in a 10 hour shutdown of the city water supply to 70 properties and a temporary water supply (via fire hoses) for a further 5-6 days.

The above responses were an opportunity for RPH to demonstrate the role of public health in an emergency, in particular ensuring that the welfare needs of vulnerable groups were met.

Key strategies

RPH continues to undertake weekly mosquito surveillance in and around our two main points of entry (fortnightly in winter) and maintain the ability to respond to interceptions/incursions as and when required. Although the climate and frequent high winds in Wellington are not favourable to exotic species at present, the continued progress of global warming and the expansion of international travel mean that the threat of exotic species becoming established in Wellington cannot be underestimated (Zika Virus, Chikungunya and Dengue Fever are present in the Pacific Islands).

Current work aims to strengthen and enhance emergency preparedness, response and recovery. This includes providing support to local marae to enhance resilience of the marae following an emergency event.

RPH gives high priority to maintaining strong links with DHB emergency planners and the regional Emergency Services Co-ordinating Committee (ESCC). RPH was instrumental in ensuring that the Wellington ESCC re-started in 2015 and are proactively seeking the Hutt Valley ESCC to restart. We will continue to foster relationships with Wellington Region Emergency Management Office (WREMO) and other emergency services, including participating in regional exercises. RPH is represented on the Regional Welfare Advisory Group and continues to actively be involved in welfare planning.

Future focus

RPH will continue to focus on engagement with key health providers, emergency response agencies, welfare agencies and communities across the sub-region to enhance health sector emergency preparedness.

RPH is committed to supporting resilience for vulnerable groups and will continue to work to strengthen and enhance resilience following an emergency event.

3.2.4 Water Quality

RPH activities actively encourage healthy water supplies and safe recreational water management practices that promote good health for our communities. RPH works at a high level (influencing regional and national policy) as well as through targeted local activities, such as involvement in the Porirua Harbour Project. RPH is committed to strengthening relationships with Iwi and hapū in the region to support their active engagement in maintaining healthy environments. This includes working directly and indirectly with tāngata whenua to maintain the integrity of recreational water bodies and traditional food sources. A healthy water body will sustain healthy ecosystems, support a range of cultural uses and reinforce the cultural identity of Māori.

PUBLIC**Drinking Water**

A safe and adequate supply of drinking water is a prerequisite for good health. Many small rural New Zealand communities, including marae, do not have access to drinking-water that is known to be safe. These communities are specifically targeted through the Drinking-Water Assistance Programme which provides technical assistance to help improve their water supplies. Larger water supplies are audited to ensure their risk identification and mitigation plans are adequate and being implemented, and that their operators are competent in the use of drinking water quality monitoring tools. An important aspect of this work is working with drinking water suppliers when monitoring shows microbial contamination. A good understanding of how the drinking water supply has become contaminated is essential to clearing the contamination and preventing a reoccurrence.

Recreational Water

Recreational water activity seeks to prevent the risk of disease associated with the public use of recreational waters and also optimise the social and physical health effects of this part of the environment. In addition, many discharges to fresh and marine waters pose a threat to health through contamination of food sources. Many of these food sources (e.g. shellfish, watercress) are collected as a traditional food source by many ethnic groups who are therefore at greater risk of illness.

Local Context

Greater Wellington Regional Council manages 320 kilometres of river channels and 280 kilometres of stopbanks and is responsible for one of the largest flood protection schemes in New Zealand.

While the Wairarapa has a smaller population, there are increasing challenges in minimising public health impacts in relation to drinking water supplies and land use.

About 155 million litres of high quality drinking water is treated and delivered by Wellington Water each day, on average, to the Wellington, Hutt, Upper Hutt and Porirua City Councils. There are a number of smaller council run supplies on the Kāpiti Coast and in the Wairarapa as well as community and individual supplies.

Key Strategies

Protection of water catchments such as Kaitoke and Wainuiomata is vital to ensure that the drinking water for our major communities continues to meet the Drinking-Water Standards of New Zealand requirements.

Fluoridation of public water supplies. This is a topical issue nationally and regionally. RPH works with territorial local authorities and DHBs to promote the fluoridation of drinking water supplies and ensure they have accurate scientific information about the risks and benefits of water fluoridation.

Ensuring adequate controls are placed on wastewater discharges to fresh and marine waters and that the public health risks of contamination of recreational waters are mitigated.

Future focus

Following the investigation into the recent contamination of the drinking water supply in Havelock North, the Inquiry Panel is due to provide the Stage Two Report by early December 2017. As at 30 June 2017, of the twenty two water supplies in the region, fifteen did not fully comply with the New Zealand Drinking Water Standards. Many of these are in the Wairarapa area. We are working with these suppliers to help them become fully compliant.

3.3 PREVENTING LONG TERM CONDITIONS**Strategic and operational plan for the prevention of long term conditions**

Long Term Conditions (LTCs) are:

- the leading cause of health loss in New Zealand
- associated with high healthcare costs and
- contributing to ethnic inequalities in health.

As the population grows and ages, the increasing burden of LTCs on society and the healthcare system will become unsustainable.

Potentially, one third of health loss can be prevented by minimising exposure to four shared risk factors: tobacco, diet, alcohol and physical inactivity. However, these risk factors do not exist in isolation, and are strongly influenced by the environment and societal conditions such as income, housing, poverty and education. In order to prevent LTCs the wider determinants of health need to be considered and addressed.

The proposed *Framework for Prevention of Long Term Conditions* (see below) draws on international, national and regional tools, plans and frameworks, including:

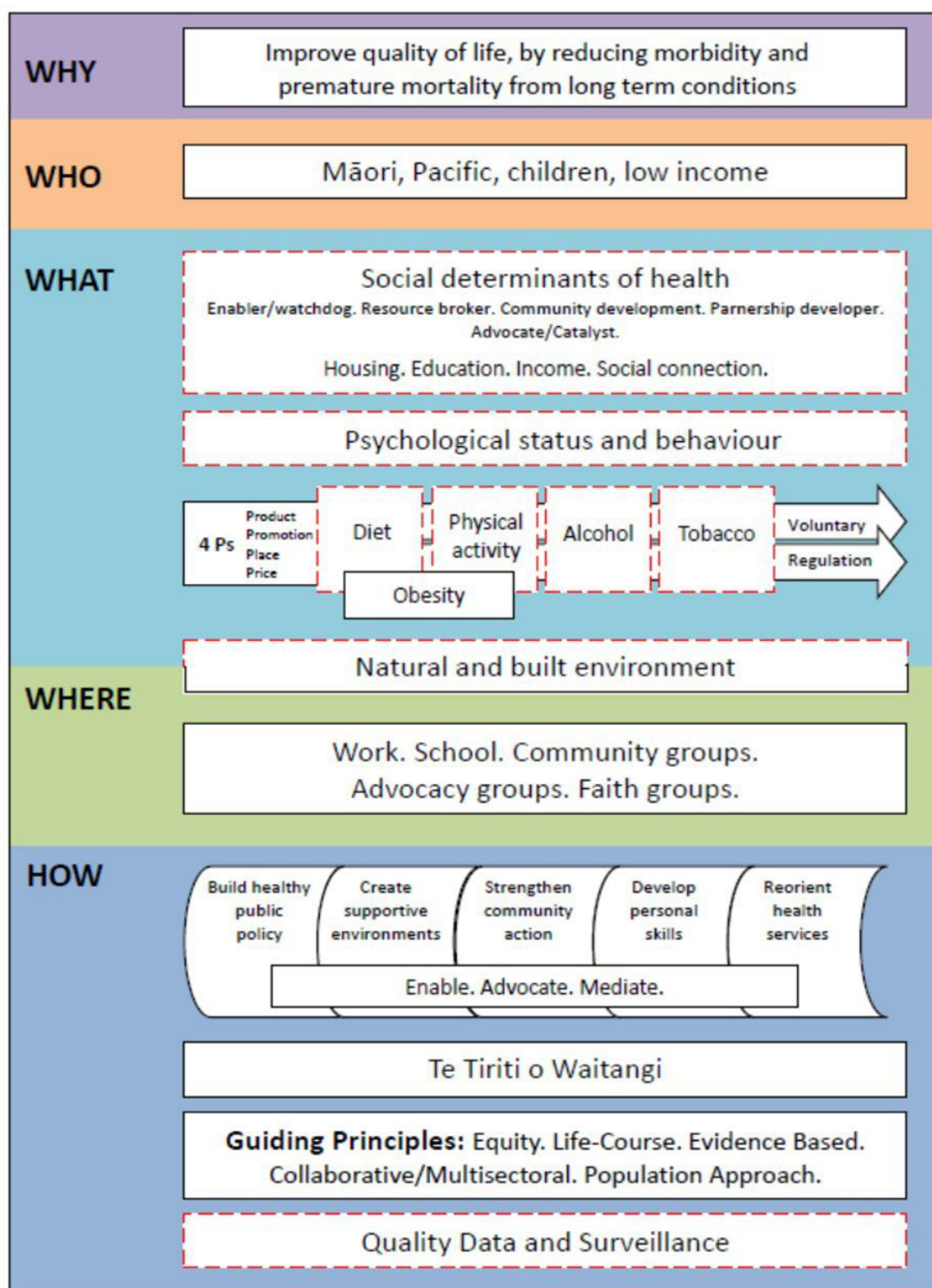
- the WHO Global Action Plan for the Prevention and Control of Non-Communicable Disease;
- the Ottawa Charter for Health Promotion;
- Dahlgren and Whitehead model for Social Determinants of Health;
- Canadian Tool for Chronic Disease Prevention;
- the New Zealand Health Strategy;
- the MoH Outcomes Framework for LTCs and
- Māori models of health.

The Framework outlines: why, who, what, where and how for the prevention of LTCs. It also sets out eight proposed key intervention domains:

1. Social determinants of health
2. Psychological status and behaviours
3. Diet
4. Physical activity
5. Alcohol
6. Tobacco
7. Quality data and surveillance
8. Natural and built environment

These intervention domains are supported by key guiding principles:

- Equity life-course
- Evidence-based
- Multisectorial/collaborative practice
- Population based

Framework for Prevention of Long Term Conditions**3.3.1 Tobacco****Key messages**

- Support and contributes to the advancement of the *Smokefree Nation 2025* goal.
- Reduce daily smoking prevalence rates to <5% by 2025.
- Increase public support for the overall goal of a *Smokefree Aotearoa* by 2025.

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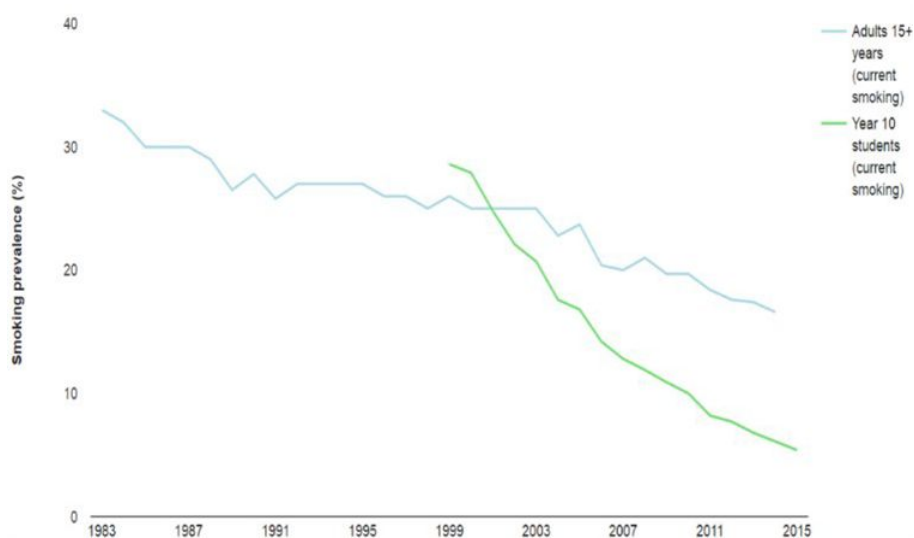
- Increase compliance and awareness of the *Smokefree Environments Act 1990*.
- Increasing successful smoking cessation quit rates.
- Support the '*Better Health for Smokers to Quit*' target within primary and secondary care settings.
- Tobacco use is a major contributor to health inequities for Māori, Pacific peoples, and lower socio-economic groups.

In March 2011 the government adopted the *Smokefree Nation 2025* goal. This was in response to the recommendations of the landmark parliamentary inquiry into the tobacco industry by the Māori Affairs Select Committee. All RPH's tobacco control efforts are making a contribution to this goal.

Tobacco smoking is a major public health problem in New Zealand. It is estimated that smoking annually kills around 4500-5000 people, of which over 600 are Māori. Smoking is the main cause of lung cancer and is a prominent risk factor for chronic obstructive pulmonary disease (COPD), cardiovascular disease (CVD), upper aero digestive cancers (includes cancers of the mouth, oesophagus, pharynx and larynx), and many other cancers and chronic diseases.

Tobacco use is recognised as a major contributor to health inequities. Māori, Pacific peoples and those in lower socioeconomic groups have much higher rates of smoking and higher rates of ill-health and death from both smoking and passive smoking. The health burden attributable to tobacco smoking prevalence is higher amongst those within low socio-economic position where Māori are over-represented.

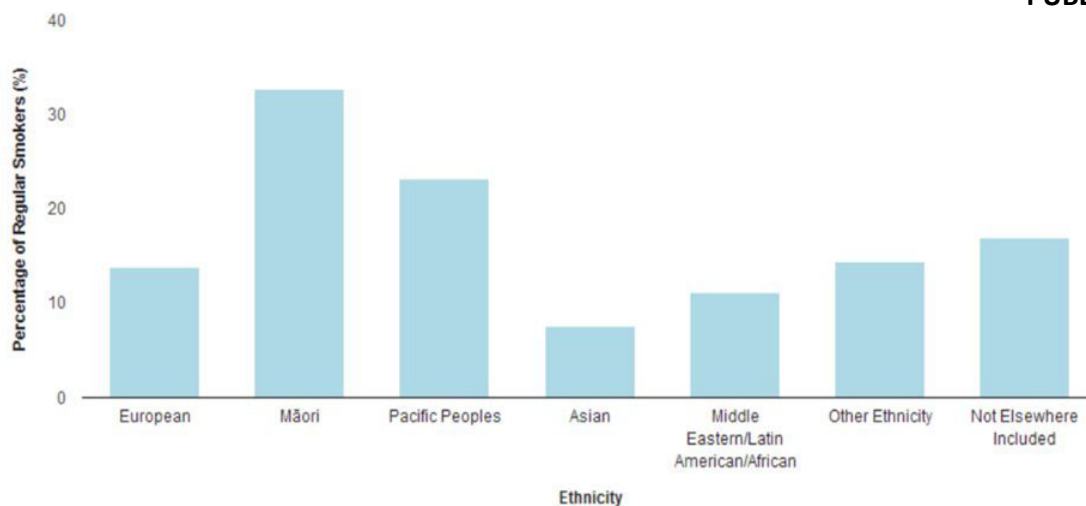
National context



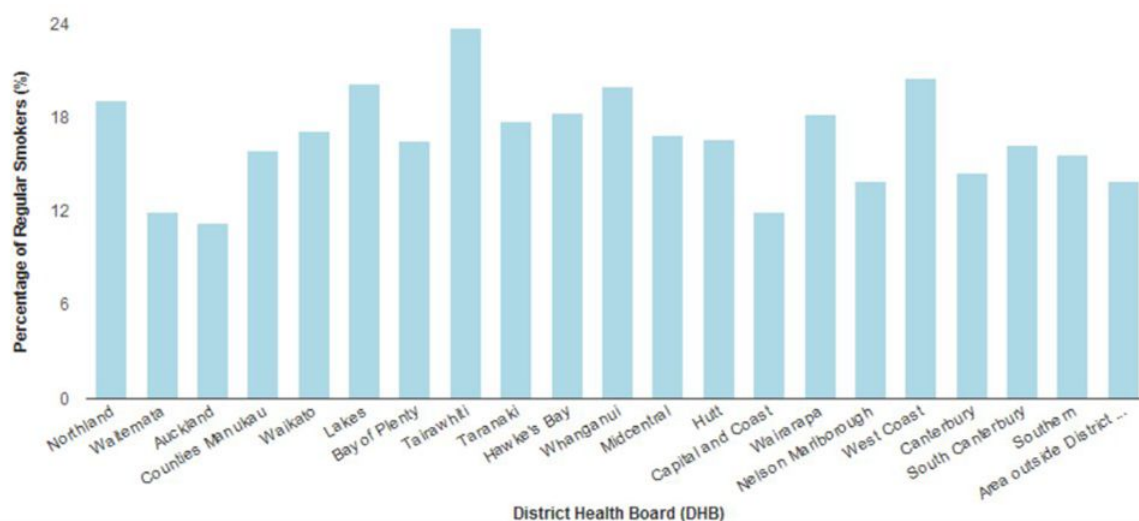
Smoking prevalence rates in New Zealand from 1983 to 2015

(Sources: Tobacco Trends 2008: A brief update of tobacco use in New Zealand, Ministry of Health, 2008; New Zealand Health Survey, Ministry of Health, 2012; Year 10 Snapshot Survey, Action on Smoking and Health)

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Smoking prevalence rates by ethnicity
(Source: New Zealand Census 2013, Statistics New Zealand)



Smoking prevalence rates by DHB
(Source: New Zealand Census 2013, Statistics New Zealand)

Regional context

Primarily the intention is to work within geographical areas that meet criteria that reflect communities with a higher proportion of Māori, Pacific peoples and low income earners. This intent will be inclusive of sub-groups such as pregnant women and children and youth.

There are approximately 550 tobacco retailers across greater Wellington. Locally RPH knows that 4974 Māori in the Capital & Coast region, 4587 in the Hutt Valley and 410 in the Wairarapa are regular smokers. The Hutt Valley at 34.4% and Wairarapa at 36% are above the national average of 32.7%. Capital & Coast smoking prevalence rate is at 26.2%.

Key strategies

- Supporting smoking cessation quit programmes
- Achieve set government targets
- Establishing and improving referral pathways for smokers to quit with support
- Enforcement of sales to minors
- Promote *Smokefree Nation 2025*
- Events: attend and/or support targeted events with health promotion messaging on banners, tents

Future focus*Tobacco-free retailers*

Investigate working with retailers to remove tobacco products for sale.

Smokefree enforcement

This activity builds on ongoing compliance with the Smokefree Environments Act legislation. Work has focused on providing educational sessions with retailers prior to conducting enforcement operations. Targeting areas on both geographical basis and communities with high numbers of Māori, Pacific peoples and low income populations will occur.

Strengthening alliances

The Smokefree/Tobacco-free Network will expressly coordinate, and provide secretariat support, activities that contribute to *Smokefree Nation 2025*.

Smokefree settings

RPH will continue to support and provide advice on extending smokefree environments e.g. outdoor spaces, streets etc with the regions Councils.

Better help for smokers to quit

RPH will focus on supporting highly vulnerable Māori and Pacific communities in quit attempts. RPH will work alongside external providers to optimise quit rates.

3.3.2 Alcohol**Key messages**

- Reduced number of alcohol outlets in communities of high Māori, Pacific peoples and/or low socio-economic populations
- No alcohol sales to minors within communities of high Māori, Pacific peoples and/or low socio-economic populations
- Communities are supported to prevent alcohol related harm

Alcohol related harm is suffered disproportionately by certain groups in the New Zealand population, including those with low socio-economic status, Māori, Pacific peoples and young people. RPH aims to reduce the higher levels of hazardous alcohol consumption exhibited by these groups. Hazardous drinking rates have risen back to 2006/07 rates.

Geographic areas that have high Māori, Pacific peoples, young persons and/or low socio-economic populations will be prioritised. To reduce alcohol related harm we need to address the New Zealand drinking culture. This requires multiple strategies at national, regional and local levels. Activities will include:

- both health protection and health promotion strategies
- be responsive to local needs
- look to maximise any gains occurring at a national level.

National context

The Ministry of Health 2014/15 New Zealand Health Survey [Hazardous drinking in New Zealand] found that:

- 25% of men were hazardous drinkers compared with 11% of women
- Hazardous drinking rates peaked among young adults (43% of men and 24% of women aged 18–24 years), and decreased thereafter. By the age of 75 years and over, hazardous rates decreased to 5.4% of men and 0.8% of women. Young adults (aged 18–24 years) also had the highest rate of drinking six or more drinks on one occasion (binge drinking) at least weekly (19%)
- About one in three Māori adults (32%) had a hazardous drinking pattern, as did 23% of Pacific adults. Despite relatively low rates of Pacific adults drinking alcohol in the past year, Pacific adults were more likely to have a hazardous drinking pattern than non-Pacific adults, after adjusting for age and sex differences. Over half of male Pacific drinkers (52%) were hazardous drinkers. Asian adults (5%) were much less likely to be hazardous drinkers than non-Asians, after adjusting for age and sex differences
- Adults in the most socio-economically deprived areas were more likely to be hazardous drinkers (23%) than those in the least deprived areas (14%).

Regional context

There are over 1,500 individual license holders in eight territorial authorities across greater Wellington. Each of these areas is unique and has its own characteristics relating to demography, supply and harm issues. RPH staff work with a range of networks to address identified issues, provide advice and give guidance on harm reduction practice.

Alcohol harm is greatest in areas of high outlet density. Density issues are primarily of two different types, those in central city areas catering for entertainment and those in residential areas with high numbers of off licenses. Both are of concern for RPH.

Work priority for this activity plan focuses on high license density in the Wellington entertainment district and residential areas of high social deprivation and/or high health impact (i.e. Eastern Porirua, Newtown, Naenae, and Wainuiomata). RPH will work directly with these communities and support existing networks in those communities.

Alcohol harm reduction uses a widespread approach that includes intervention to change both physical and social environments. The approach empowers local communities to take ownership and promote change.

RPH is one of only a few agencies that has staff working in the area of harm reduction that have responsibility for service delivery throughout the region rather than working in smaller geographical settings. RPH is constantly gathering public health intelligence to improve harm reduction techniques.

Key strategies

A region free from the harm of alcohol is the ultimate goal. Significant change in hazardous drinking levels in our priority populations is not expected in the short-term. Goals that alter the environment are achievable in the short-term and should sit alongside strategies that in the longer term will infiltrate the public's perceptions of that culture.

RPH will respond to the needs of the populations most at risk of harm from alcohol misuse. This means finding ways to improve RPH engagement with Māori and Pacific communities as well as youth. Where possible, efforts will be made to support improved sector integration across alcohol, tobacco and other drugs work.

Future focus*Harm reduction*

There is ongoing work towards reducing alcohol and other drug related harm in the greater Wellington region. This work builds on our legislative requirements under the Sale and Supply of Alcohol Act 2012 and partnering with health promotion initiatives to maximise positive outcomes for our communities.

Wellington Regional Hospital Emergency Department data

Work is ongoing to develop a process to receive and analyse data collected from Wellington Hospital Emergency Department. As of the 1st July 2017 all Emergency Departments are required to collect this data. Over time this will provide clarity regarding alcohol related harm occurring across our region and help support RPH interventions.

Strategic planning

RPH is reviewing its strategic direction with a view to formalising a three to five year plan.

Submissions

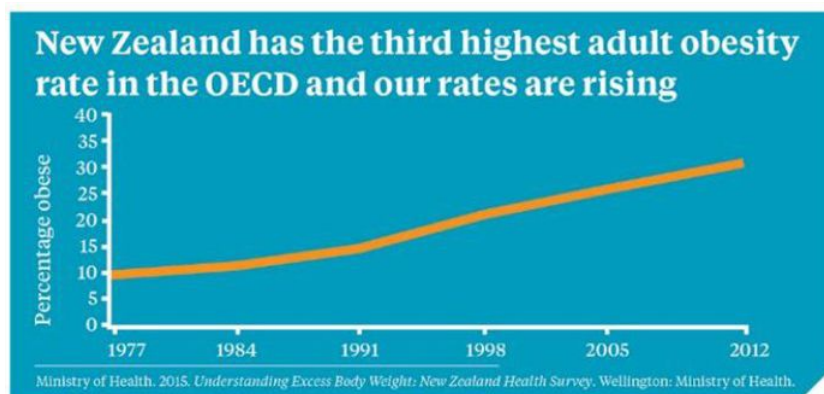
Provide evidential support for community initiated calls for challenging alcohol licensing applications in areas of high Māori and Pacific populations.

3.3.3 Obesity (Nutrition/Physical activity)**Key messages**

- Environments influence individuals to make the healthier choice the easier choice to make
- Poor diet has overtaken tobacco smoking as the greatest risk to health loss (Ministry of Health, Health loss in New Zealand 1990-2013, a report from the New Zealand Burden of Disease, Injuries and Risk Factors Study - 2016)
- Empower people in the Wellington region by focusing on communities where the potential for health gains are the greatest, to make healthier food choices as recommended by the Ministry of Health [Food and Nutrition Guidelines](#)
- Māori and Pacific adults and children alike (and those living in the most deprived areas) have disproportionately higher rates of obesity and non-communicable diseases than the general population.

The increasing prevalence of low nutritional value diets and sedentary lifestyles are major contributing factors of the growing obesity epidemic and rising rates of non-communicable diseases such as type two diabetes, cardio-vascular disease, osteoarthritis and some cancers.

Obesity rates in New Zealand are among the highest in the OECD, with the 2012/13 *New Zealand Health Survey* finding almost one in three adults aged 15 years and over (31%) to be obese and a further 34% overweight. The survey also found one in nine children aged 2-14 years (11%) to be obese and one in five (22%) to be overweight.



(Source: Ministry of Health, 2015)

Unequal experience of obesity

The 2012/13 New Zealand Health Survey shows 48% of Māori adults, 19% of Māori children, 68% Pacific adults and 27% Pacific children are obese. It also identified that children living in the most deprived areas were three times as likely to be obese than children in least deprived areas. This finding is not explained by differences in the sex, age or ethnic composition of the child population across areas of high and low deprivation and suggests some direct correlation with the experience of deprivation.

RPH seeks to address these inequalities in a number of ways including focussing on:

- the broader food/physical activity environment, especially low socio-economic communities e.g. East Porirua and Wainuiomata to increase the opportunities for healthy behaviour choices for residents of these communities
- relationships/partnerships with groups and organisations which are kaupapa Māori led or Māori/Pacific based e.g. Wesley Community Action; Pacific Health Services; Wainuiomata Valley Church Samoan congregation; Wellington Early Childhood Pacific Collective
- resources meeting the needs of the Māori/Pacific communities, e.g. translation of Fruit and Vegetable Cooperatives information into Samoan (and where relevant other languages)
- involving mainly Māori and Pacific participants in a cooking lesson pilot.

Issues with accessing healthy food

Food security (the state of having reliable access to a sufficient quantity of affordable, nutritious food), is increasingly an issue with growing numbers of children, adolescents and adults regularly experiencing the inability to access adequate, safe, affordable and acceptable foods. Findings from the 2008/09 New Zealand Adult Nutrition Survey found that since 1997 food insecurity has increased for males by 1.6-5.6% and for females by 3.8-8.8%. The total proportion of households experiencing low food security is 7.3% and there is a 25% decrease in those living in food secure households. The results showed that the levels of food insecurity were significantly higher for Māori and Pacific, with Māori adults being over two times, Pacific males four times and Pacific females three times more likely to live in a household with low food security, than those who are not Māori or Pacific.

The influence of the food environment

The causes of obesity and its associated preventable chronic diseases are multifaceted and complex. A recent analysis (Vandevijvere and Swinburn 2014) considered different scenarios for decreasing prevalence of childhood (2-14 years) obesity of 25% by 2025 in New Zealand. It will be an enormous challenge to reach this target by 2025 (Australia is now at this level) and reduce, or at least not increase, inequities across ethnic groups at the same time. This suggests two broad approaches are needed:

- community-based interventions which prioritise at risk populations and
- broader policy/regulatory approaches.

RPH has prioritised working in this area through the development and co-delivery of Fruit and Vegetable Cooperatives across the Wellington sub-region and the development and testing of implementation methodology for healthy food and beverage policies for large influential organisations. Growth in these work areas will be a key future focus.

Low physical activity levels

Only 54% of adults in New Zealand meet the minimum recommended level of physical activity (with physical inactivity levels being higher for women) while Pacific and Asian adults have lower levels of physical activity than other groups, along with those living in the most deprived areas. According to the Youth 2007 report sedentary activities are common among secondary school students. The proportion of students watching more than one hour of television each day increased from 55% in 2001 to 73% in 2007, with levels of television watching being higher for Māori children than non-Māori children.

Government initiatives

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The key initiative for addressing the causes of obesity at the systems level is through the pilot contracts of Healthy Families NZ in 10 key communities around New Zealand; Hutt City Council leads Healthy Families Lower Hutt. Through RPH's sector networks and relevant programmes we are working in collaboration to assist in the delivery of each other's goals while being cognisant that the remaining communities in our area of responsibility do not have access to this extra resourcing.

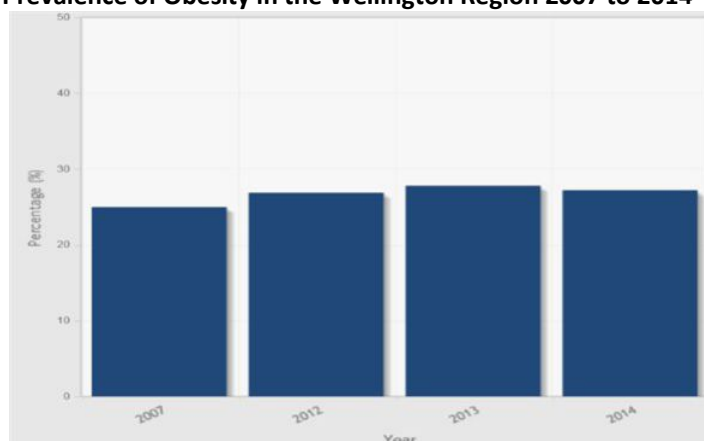
National context

- Good nutrition, regular physical activity, and a healthy body size are important in maintaining health and wellbeing and for preventing serious health conditions such as cardiovascular disease, diabetes and some cancers.
- Obesity rates in New Zealand are rising with two in three New Zealand adults overweight or obese. Māori are almost twice as likely to be obese as non-Māori while Pacific adults are 2.5 times as likely to be obese as non-Pacific adults (Ministry of Health, 2013).
- Obesity prevalence of New Zealand children continues to increase.
- From conception to childhood, parents/caregivers, families and communities directly shape a child's physical and social environment and indirectly influence behaviours, habits, preferences and attitudes.

(Source: www.hpa.org.nz/what-we-do/nutrition-and-physical-activity)

Regional context

Prevalence of Obesity in the Wellington Region 2007 to 2014



(Source: Greater Wellington Regional Council Wellington Region Genuine Progress Index
<http://www.gpiwellingtonregion.govt.nz/outcomes/social/healthy-community/obesity/>)

Findings of the Greater Wellington Regional Council Wellington Region Genuine Progress Index:

- In 2014, 27.2% of the Wellington region adult population were classified as obese.
- The percentage of adults in the Wellington region who were obese increased from 25.0% in 2007 to 27.2% in 2014.

Key strategies*Fruit and Vegetable Cooperatives*

Following a successful pilot in Porirua East (May to December 2014) RPH has worked in partnership with *Wesley Community Action* to co-deliver the expansion of the 'FoodTogether' model, using a community led process, across the Wellington region. Efforts have focussed on working with groups in communities with affordability and accessibility issues to fruit and vegetables. There are hubs running in 10 locations (East Porirua, Titahi Bay-Tawa, Miramar-Strathmore, Waiwhetū-Petone, Wainuiomata, Naenae-Pomare-Taita-Stokes Valley, Upper Hutt-Timberlea, Kāpiti-Paraparaumu, *Victoria University of Wellington*) providing over five tonnes of locally sourced fresh fruit and vegetables weekly.

National DHB Food and Drink Policy

RPH has supported the development and implementation of this policy developed by the DHB Healthy Food and Drink Environments Network and/or public health representatives from all DHBs, along with the MOH, with the intent that it would be able to be implemented over a two-year period by most DHBs. This national collaboration resulted in a robust policy that provides national consistency for food vendors and food suppliers throughout the country, streamlining the work food companies would need to do to align with product composition and size. The MOH has adopted the policy and it is available for all individual DHBs to consider. A similar policy appropriate for adoption by other organisations and workplaces has also been developed.

Nutrition policy in other organisations

RPH is working with *Victoria University of Wellington*, to develop a Food and Drink Policy for the campus endorsed by the Board. Support was provided with writing and presenting a proposal to the *VUW* Wellbeing Steering Group. Preliminary discussions with other organisations, such as local councils, have been held to further expand this work in the food environment in the 2017/18 working year.

3DHB Food and Beverage Environment Guideline

Implementation of the 3DHB "Healthy Food and Beverage Environment Guideline" has been completed at WDHB, HVDHB, and CCDHB. An implementation group including representatives from the three DHBs guided and supported the implementation process. With the *National Food and Drink Policy* document also completed, there is consideration regarding how the three DHBs align, or partly align, with the National DHB Policy. A 'working group' from the Implementation Group has been evaluating the current *Guideline* to determine what challenges and successes the food providers are having. The findings will inform the decision whether to align more closely with the national policy.

RPH has specifically provided support to the Hutt Hospital Food Services to change menus, recipes and be involved in successful implementation of the 3DHB guideline in the cafeteria, as the service did not have a dietitian or nutritionist.

Water-Only Schools Policy

RPH undertook a survey of all 201 schools in the sub-region with primary aged children. This has led to the development of the 'Water-only in Schools' toolkit and webpage, hosted by RPH.

The survey received a 39% response rate (78 schools). Most supported 'water-only': 22 (28%) had implemented a policy; 10 (13%) were in the process of doing so; 22 (28%) were considering it; and 12 (15%) were 'water-only', but did not have a policy. Only 12 (15%) were not considering a 'water-only' policy.

This project could not have been achieved without the collaborative efforts of:

- Healthy Families (HVDHB)
- Healthy Futures (CCDHB)
- The Heart Foundation
- Ministry of Education, and
- Regional Dental Service

Community and voluntary food sector

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A scoping paper has been developed to explore the challenges and opportunities of the local charitable food sector to support optimal nutrition and well being of people who are food insecure. This paper is to be shared more widely to engage the sector in identifying and gaining a greater understanding of ways to optimise this vital nutrition lifeline.

Stakeholder relationships

RPH continue with regular contact with physical activity and nutrition providers, including public health dietitians, Childhood Prevention of Obesity, the Regional Nutrition and Physical Activity Network and type two diabetes groups to support improved physical activity and nutrition in the greater Wellington region. Regular contact and collaboration has continued with local councils.

Physical activity opportunities

RPH provides support for other physical activity initiatives such as North-East Pathways Project and leading the establishment of the Porirua Sport-fest in partnership with *Sport Wellington* and *Sport NZ*. RPH can optimise its working relationships with education groups, councils (e.g. *Hutt City Council* sports and recreation team) and community based groups to maximise the inclusion of physical activities.

Active transport

RPH continued to work with the transport sector to increase physical activity opportunities, in particular in our targeted communities. RPH also supports various active transport initiatives including Active a2b, Walk to Work Day and Bike to Work Day.

Future focus*Fruit and Vegetable Cooperatives*

Maintaining and expanding Fruit and Vegetable Cooperatives.

Water in schools

Supporting and guiding 'Water in Schools' programme.

Policy

Garnering support for the adoption of the National Food and Beverage Policy within DHBs and local councils. Influencing educational settings such schools, Te Kohanga Reo, Kura, Early Childhood Centres etc will be advanced.

Position paper

Develop position paper on Sugary Drinks Tax.

Innovative initiatives

Investigate new approaches and initiatives that could be adopted into our region e.g. *Whānau Pakari*: http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11935210

3.3.4 Other drugs – Methamphetamine**Key messages**

- Harm minimisation approach for users of methamphetamine
- Focus on treatment and support

Methamphetamine is a potent and addictive stimulant drug which can be smoked, snorted, injected or ingested orally or anally. Smoking as a powder is common in New Zealand; however researchers have noted indications that injecting methamphetamine is becoming more popular. The changing patterns of methamphetamine use have been referred to as 'waves', and New Zealand has been described as experiencing the 'second wave' of methamphetamine use currently. Methamphetamine induces a state of euphoria, increased wakefulness, energy and sex drive, and decreased appetite. The effect of

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methamphetamine can last up to 12 hours, which is significantly longer than other stimulant drugs, for example cocaine's effects last around 30 minutes (Source: National Institute on Drug Abuse, 2009).

The most recent government statistics show that overall numbers of methamphetamine users in New Zealand have been dropping. 0.9% (26,400 people) used the drug once or more in 2014/15, down from 2.2% in 2009. Around one fifth of those took the drug monthly or more, according to 2013/14 data. There is limited data collection regarding methamphetamine prevalence rates within the regional context.

Key strategies

Based on research, an approach addressing methamphetamine harm needs to:

- Focus on non-stigmatising treatment and support
- Build protective factors and community resilience, that prevent methamphetamine harm in vulnerable communities; as per the Methamphetamine Action Plan, 2015
- Ensure medical and social support for methamphetamine rehabilitation is accessible, and supports are in place up to two years after quitting

Focus on harm minimisation such as:

- Provide current methamphetamine users with appropriate sexual health services and contraception
- Preventative messages to methamphetamine users to not inject
- Provide access to clean needles and equipment for methamphetamine users who inject.

Future focus*Community focus*

Support community initiatives to support methamphetamine users and recovering users, in a non-judgmental environment. This may be support groups of methamphetamine users and ex-users, or a 'walk-in' system. RPH will continue working with the Hutt Valley community (note comments below in 3.3.5 re the CAYAD contract) to strengthen protective factors.

De-stigmatisation

Contribute to de-stigmatising methamphetamine users, with the aim of focusing the message on seeking help.

Mapping

Mapping of addiction services for CCDHB and HVDHB needs to be undertaken with a specific focus on:

- The service's ability to respond to referrals within appropriate timeframes
- Levels of treatment services available for low to high needs methamphetamine addiction
- Investigate access to services such as needle exchange and sexual health services for methamphetamine users.

3.3.5 Other drugs – Synthetic cannabis**Key messages**

- Synthetic cannabis is a dangerous and unpredictable drug
- Harm minimisation approach for users of synthetic cannabis

Synthetics are a class of drug which are synthesised synthetically. There are two common 'synthetic' drugs used in New Zealand. 'Synthetic cannabis' is a drug which resembles cannabis, but is plant matter sprayed with synthetic cannabis and/or other chemicals. Synthetic cannabis is usually smoked, but the effects of the drugs and the harm varies depending on which psychoactive or poisonous substances have been used.

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Synthetic cannabis products were legal until the Psychoactive Substances Act 2013. The ban has resulted in a black market supply of the product. These substances are manufactured overseas with no safety standards, and shipped to New Zealand. These substances contain untested and often toxic compounds.

Synthetic cannabis is a dangerous and unpredictable drug. The recent deaths in Auckland and subsequent media attention focused on the dangers of synthetic cannabis may change public perception. If the public are aware of the dangers of the drug, education might not be an effective measure to take to reduce harm. In addition to these reports, there have been reports of increased hospital admission for psychosis.

(Link: http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11897763)

There is no data collected regarding synthetic cannabis prevalence rates within the national and regional context.

Key strategies

- Community/youth education about synthetic cannabis
- Encourage community discourse about synthetic cannabis
- Harm minimisation for users of synthetic cannabis

Future focus

RPH works primarily with our Hutt Valley focused *Community Action on Youth and Drugs (CAYAD)* team that sits within RPH, in providing regional and national oversight. RPH supports the following recommended national CAYAD approach to synthetic cannabis:

Community engagement

Engage with and support organisations/community groups to plan and deliver community action initiatives to reduce alcohol and other drug related harm affecting young people.


Health promotion

Design, deliver and support awareness-raising activities that provide opportunity for informed discussion and debate, increase knowledge and/or create behaviour change around the use of alcohol and other drugs.

Submissions

Provide position papers/submissions to cannabis reform debate and to the *Psychoactive Substances Act 2013* review in 2018-19.

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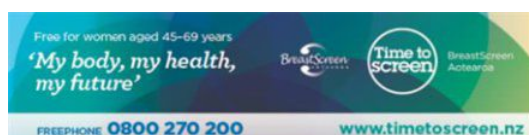
		CPHAC/DSAC INFORMATION PAPER
		Date: November 2017
Author	Lindsay Wilde – Service Manager, Regional Screening	
Endorsed by	Dale Oliff – Chief Operating Officer Dr Ashley Bloomfield – Chief Executive	
Reviewed/approved by	Madeleine Wall, Clinical Director Regional Screening	
Subject	Regional Screening Services Update	
RECOMMENDATION It is recommended that CPHAC/DSAC: a) NOTE the contents of this paper		
APPENDICES -		

1. PURPOSE

This report informs CPHAC/DSAC about Regional Breast and Cervical Screening Services and provides an overview of the work underway to address equity issues for our priority women.

2. BACKGROUND

2.1 Breast Screening



New look Breast Screening rebrand

The objective of the national breast screening programme is to find breast cancers early and therefore reduce the morbidity and mortality for women. To achieve this we aim to screen all eligible women every two years and this is free of charge.

HVDHB operating as BreastScreen Central (BSC) holds a Breast Screen Aotearoa (BSA) contract for screening women in the Wellington subregion. This contract covers Hutt Valley, Wairarapa and Capital and Coast DHB regions and is one of eight breast screen providers across the country. The contract is worth around \$5.550 million per annum, the bulk of which is for the delivery of the mammography services and the rest for regional coordination and some fixed funding. We have been working on the renewal of our contract with BSA which will change to a results based accountability contract (RBA) in January 2018; we are currently in an interim rolled-over contract until then.

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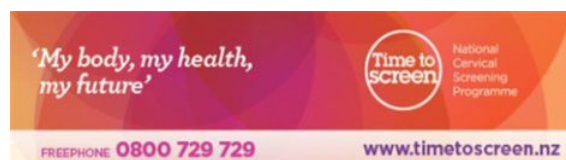
Breast screening services in NZ started screening eligible women aged 50 – 64 years in December 1998. The service was extended to include women aged 45-49 in 2004. BSA (as per Ministry request) is currently investigating the potential for extending the age range to 74 years.

BSC has a number of fixed screening sites (Hutt base and Kenepuru Hospitals), two subcontracted sites with Pacific Radiology (PRL) at Wakefield Hospital and on Lambton Quay and a mobile screening unit that mainly services outlying areas such as Wairarapa and Kapiti but also supports other areas within the region as required.

Our goal is to provide and maintain a coverage target of 70% of the eligible population. A key focus for breast screening is targeting the unscreened or under-screened priority women and ensuring that there is not a duplication of effort with other providers. Māori and Pacific women are our key priority groups and the hardest to reach, engage, educate and screen and thus achieve target rates and health equity.

To achieve equity for high needs populations, the service undertakes data matching with PHOs to identify women who are under-screened or not screened. The Team has developed programmes to encourage these women to attend screening including targeted Saturdays, working in collaboration with Primary Health Organisations, General Practices, Māori and Pacific Providers (Mana Wahine Alliance and the Central Pacific Collective), providing support and transport to bring women in to screen, education and attendance at health promotion events, proactive follow-up of women who “do not attend” (DNA), liaising with community groups and other providers, and using all links available to see and screen women.

2.2 Cervical Screening



New look Cervical Screening rebranding

HVDHB also has a contract with the National Cervical Screening Programme (NCSP) to provide regional coordination, liaison, registration, management and operation of the NCSP-Register, invitation and recall, smear taking (capped volumes) and colposcopy (capped volumes related to the cervical screening programme), again across the 3 sub-regional DHBs. The National Screening Unit (NSU) in conjunction with regional screening services and working closely with providers and DHBs aims to reduce the incidence and mortality of cervical cancer.

The NCSP Priority Group women are Māori, Pacific, Asian and under-screened eligible women over the age of 30 who have not had a cervical smear for five years or un-screened women, eligible women over the age of 30 who have never had a cervical smear. The service also works closely with our migrant women populations to increase participation in the cervical screening programme.

Cervical Screening is for eligible women 20-69 years every three years. The coverage target is 80% for all ethnicities and this measure is proving difficult to achieve. We are working closely with PHOs, General Practices, Māori, Pacific, Asian and Migrant Services by providing support and transport to bring women into cervical and colposcopy appointments, undertake education and raise awareness through health promotion events, follow-up women who DNA. We have funded a smear taker so that we can provide smears for women at more convenient locations and at priority screening days. More emphasis has been placed on Māori, Pacific and Asian women over the last year. As with Breast Screening we work with Primary Health Organisations, General Practices, Māori and Pacific Providers (Mana Wahine Alliance and the Central Pacific Collective). We have subcontracts with Maraeroa Marae Health Clinic and Te Runanganui o Te Atiawa ki te Upoko o te ika a Maui to support smear taking and support to screening.

In 2018, the National Cervical Screening Programme (NCSP) is planning to change the first step in the screening pathway from liquid-based cytology screening to primary human papillomavirus (HPV) screening. Primary HPV screening means that a cervical screen sample is first tested for the presence of an HPV infection because almost all cervical cancer is caused by infection with HPV. High-risk types of HPV can cause cell changes in the cervix which, if not treated, can lead to cervical cancer. This will also decrease the screening interval from three to five years.

Also in 2018 we will also see an increase in the screening age from 20 years old currently to 25 years old (as well as self-sampling, which is currently being trialled in Northland and Auckland). The primary reason for the age increase is because HPV, which causes more than 90 per cent of cervical cancers, is common in younger age groups and typically clears up on its own.

2.3 Symptomatic Breast Services

Regional Screening Services also include the Hutt Symptomatic Breast Clinic and a Wairarapa Symptomatic Breast Clinic (contracted). Women who have a positive result from a screening mammogram are referred to a breast clinic as the final part of the screening process. Women with breast symptoms are also referred directly to this service. The symptomatic clinics are DHB hospital services and are a separate stream of both activities and funding. The symptomatic services were joined with screening around 10 years ago (they utilise the same process and staffing much of the time) to ensure that women had a seamless journey through their breast cancer pathway.

The symptomatic service involves assessment and diagnosis, surgical clinics and referral for surgery (via surgical services), follow up and surveillance and then referral back to the screening programme. High risk women are also monitored through the symptomatic service. The growth in this service over the last few years has been significant and as such is straining the clinical staff resources (radiologists, radiographers, surgeons and nurses).

3. WHERE ARE WE AT WITH BREAST AND CERVICAL SCREENING?

Breast Screen Central exceeded the 70% screening target for all women overall in 2016/17. While we did not meet these targets for the Pacific and Māori women in all geographical areas we continue to focus on these priority women to ensure their rate improve. We did continue to make incremental gains against this target for Māori and Pacific women in all three geographical areas (see Table 1).

BSC screened 29,396 women across the sub region in 16/17m which was 1,400 above the budgeted target of 28,000.

Saturday priority clinics for combined breast and cervical screening have proved very popular and successful in improving access for high-priority women. We hold these regularly over the year at Hutt hospital and Kenepuru hospital, and are hoping to be able to facilitate a Wellington-based one later this year.

The National Screening Unit has changed their screening websites with a new “Time to Screen” logo with different colours for cervical (orange red- see below) and breast (blue). The new website and resources along with a new ‘Facebook’ launch will allow women easier access to information.

DHB coverage comparison trends by ethnicity

Table 1: BSA coverage (%) of women aged 50–69 years in the two years ending 31 March, 2015, 2016, 2017, by ethnicity and District Health Board

DHB	Māori			Pacific			Other		
	Mar 2015	Mar 2016	Mar 2017	Mar 2015	Mar 2016	Mar 2017	Mar 2015	Mar 2016	Mar 2017
Northland	69.2%	69.1%	70.3%	70.3%	64.1%	68.3%	71.5%	70.9%	72.7%
Waitemata	64.7%	64.1%	63.6%	76.2%	75.2%	74.1%	67.6%	67.5%	66.3%
Auckland	63.4%	60.2%	57.6%	76.1%	75.1%	72.7%	65.3%	63.6%	63.2%
Counties Manukau	67.8%	65.2%	62.8%	79.5%	77.8%	75.1%	68.5%	67.9%	67.1%
Waikato	58.1%	59.8%	57.8%	63.4%	62.9%	58.5%	69.4%	69.1%	68.5%
Lakes	65.0%	61.6%	62.0%	47.8%	51.5%	64.4%	71.3%	69.1%	70.5%
Bay of Plenty	59.1%	59.9%	59.7%	77.3%	70.8%	65.3%	71.0%	72.2%	70.0%
Tairāwhiti	65.2%	66.2%	69.3%	54.9%	56.2%	64.4%	70.8%	71.7%	72.6%
Taranaki	62.2%	61.3%	61.1%	58.1%	62.7%	62.4%	75.2%	75.3%	75.5%
Hawke's Bay	64.6%	67.4%	66.2%	67.3%	65.9%	66.1%	73.6%	74.2%	74.9%
Whanganui	70.2%	71.8%	71.4%	71.1%	75.0%	70.5%	76.5%	78.5%	79.1%
MidCentral	62.2%	64.4%	65.2%	68.7%	66.0%	66.3%	76.1%	77.0%	77.6%
Hutt Valley	66.1%	65.7%	67.5%	66.3%	64.7%	68.8%	75.3%	74.1%	76.4%
Capital and Coast	61.7%	65.5%	66.9%	62.7%	67.2%	69.2%	71.2%	72.8%	73.3%
Wairarapa	65.1%	70.3%	69.1%	79.6%	81.4%	71.9%	73.2%	75.0%	76.3%
Nelson Marlborough	75.2%	72.9%	77.3%	61.0%	64.8%	68.1%	78.7%	79.2%	80.5%
West Coast	76.3%	70.5%	67.7%	36.8%	35.0%	30.0%	76.4%	77.7%	76.6%
Canterbury	74.9%	71.5%	69.2%	65.0%	62.9%	64.0%	79.9%	78.6%	76.0%
South Canterbury	73.7%	73.1%	70.9%	50.0%	56.7%	52.9%	79.2%	79.2%	78.0%
Southern	66.2%	62.5%	64.8%	61.0%	56.5%	62.3%	74.3%	72.3%	75.0%
Total	65.2%	64.8%	64.5%	74.2%	73.2%	71.9%	72.6%	72.1%	71.9%

Table 2: Wairarapa BSC coverage in the two years until June 2017 by ethnicity.

Ethnicity	Population	Women screened in last 2 years	2-year coverage	Additional screens to reach target*
Māori	670	461	68.80%	8
Pacific	65	45	69.20%	
Other	5,580	4,245	76.10%	
Unspecified		3		
Total	6,315	4,754	75.30%	

*For the total population the number of additional screens is the number required to move from the total population coverage to 70%. This may not be the same as the sum of additional screens required for each ethnic group to reach 70%.

Table 3: Capital and Coast BSC coverage in the two years until June 2017 by ethnicity.

Ethnicity	Population	Women screened in last 2 years	2-year coverage	Additional screens to reach target*
Māori	2,660	1,797	67.60%	65
Pacific	1,870	1,302	69.60%	7
Other	30,160	22,224	73.70%	
Unspecified		53		
Total	34,690	25,376	73.20%	

*For the total population the number of additional screens is the number required to move from the total population coverage to 70%. This may not be the same as the sum of additional screens required for each ethnic group to reach 70%.

Table 4: Hutt Valley BSC coverage in the two years until June 2017 by ethnicity.

Ethnicity	Population	Women screened in last 2 years	2-year coverage	Additional screens to reach target*
Māori	2,030	1,404	69.20%	17
Pacific	940	652	69.40%	6
Other	14,830	11,278	76.00%	
Unspecified		19		
Total	17,800	13,353	75.00%	

*For the total population the number of additional screens is the number required to move from the total population coverage to 70%. This may not be the same as the sum of additional screens required for each ethnic group to reach 70%.

4. NATIONAL CERVICAL SCREENING PROGRAMME DATA

The Cervical screening graphs show that while we achieved the 80% target for European/other women for C&CDHB (Table 2) we did not reach coverage for Māori and Asian women across all 3 DHBs. Pacific coverage was achieved for WDHB. For cervical screening, the Asian population are also proving more difficult to recruit to the programme with the exception of HVDHB which continues to improve. We continue to work with the PHOs and GP practices to identify, recruit and screen the hard to reach priority women. Targeted data matching with high-needs practices using PHO/Data Matching Reports to assist follow-up of DNA women, phoning overdue women on behalf of the Practice (day/evening), booking clinic appointments, arranging transport and support, referral to support to services and re-engagement to

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priority Saturday Smear Clinics are a key contributor to increasing coverage and reducing inequalities for cervical screening.

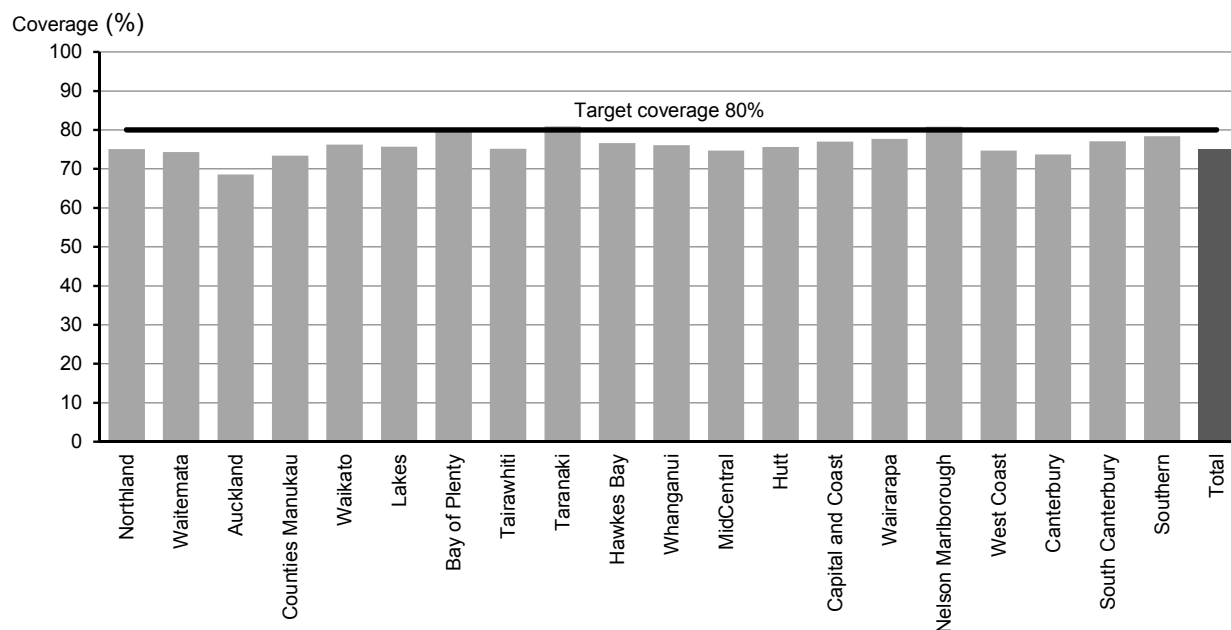
Recently the National Cervical Screening Programme Support to Services Providers was given access to the NCSP Register for screening histories. This will be particularly useful for after hour's clinics and to answer queries from women preventing delays to screening.

4.1 NCSP coverage comparison trends by ethnicity

Table 5: NCSP coverage (%) of women aged 25–69 years in the three years ending 30 June, 2015, 2016, 2017, by ethnicity and District Health Board

DHB	Māori			Pacific			Asian			Other		
	June 2015	June 2016	June 2017	June 2015	June 2016	June 2017	June 2015	June 2016	June 2017	June 2015	June 2016	June 2017
Northland	69.6%	69.3%	68.3%	63.7%	65.8%	66.7%	62.0%	59.5%	62.4%	83.1%	81.7%	79.6%
Waitemata	60.4%	60.5%	59.3%	75.9%	75.7%	72.6%	70.0%	69.7%	68.6%	80.6%	80.3%	78.7%
Auckland	55.0%	56.0%	55.3%	71.0%	73.0%	71.4%	58.7%	57.4%	56.0%	77.9%	78.4%	78.5%
Counties Manukau	63.5%	66.3%	65.3%	79.6%	83.7%	81.2%	67.6%	68.2%	67.6%	77.9%	77.8%	76.9%
Waikato	65.7%	67.2%	66.7%	78.7%	79.1%	77.2%	63.2%	63.5%	65.4%	82.0%	81.1%	80.5%
Lakes	70.6%	71.2%	70.7%	74.5%	79.5%	80.7%	56.9%	59.9%	60.5%	82.1%	81.5%	80.1%
Bay of Plenty	70.5%	70.4%	69.1%	75.9%	73.0%	73.8%	60.6%	58.4%	57.6%	88.7%	87.6%	85.4%
Tairāwhiti	68.4%	68.6%	69.8%	59.8%	62.7%	65.8%	60.8%	58.2%	62.2%	80.2%	81.8%	81.6%
Taranaki	73.9%	73.3%	73.2%	75.5%	73.2%	79.7%	62.2%	61.1%	61.7%	84.9%	84.7%	83.7%
Hawkes Bay	74.5%	74.4%	72.4%	70.4%	75.0%	74.4%	65.0%	64.3%	66.2%	81.2%	80.7%	78.9%
Whanganui	69.7%	71.2%	70.3%	66.8%	63.8%	66.7%	66.0%	69.7%	67.7%	80.9%	81.5%	78.8%
MidCentral	63.3%	63.4%	61.3%	68.6%	71.5%	69.7%	61.2%	60.8%	62.6%	80.9%	79.9%	79.4%
Hutt	67.4%	68.6%	66.8%	72.1%	73.2%	71.2%	75.6%	77.0%	77.2%	79.4%	78.7%	77.7%
Capital and Coast	62.3%	63.1%	61.5%	67.7%	67.8%	67.0%	63.6%	64.2%	63.1%	82.5%	83.1%	83.2%
Wairarapa	71.1%	71.4%	72.4%	81.9%	82.8%	93.0%	68.6%	65.9%	67.5%	82.4%	80.9%	78.8%
Nelson Marlborough	68.2%	68.7%	68.1%	66.4%	69.8%	71.8%	63.0%	64.4%	66.2%	85.1%	84.7%	83.1%
West Coast	62.3%	64.7%	63.4%	52.9%	58.2%	58.7%	45.7%	48.9%	50.5%	78.2%	79.0%	77.7%
Canterbury	61.4%	59.5%	58.1%	72.3%	72.3%	73.5%	56.2%	57.8%	60.2%	78.5%	78.1%	76.9%
South Canterbury	61.7%	60.9%	59.6%	79.2%	87.8%	91.5%	56.7%	55.0%	60.3%	79.5%	80.1%	79.2%
Southern	63.1%	63.4%	62.6%	78.6%	78.2%	81.3%	53.8%	54.4%	55.7%	82.0%	81.3%	81.6%
Total	65.7%	66.3%	65.3%	75.1%	77.2%	75.5%	63.7%	63.6%	63.2%	81.1%	80.7%	79.8%

Figure 1: Overall NCSP coverage (%) of women aged 25–69 years in the three years ending 30 June 2017 by District Health Board



**For the total population the number of additional screens is the number required to move from the total population coverage to 80%. This may not be the same as the sum of additional screens required for each ethnic group to reach 80%.*

Figure 1: NCSP coverage (%) of women aged 25–69 years in the three years ending 30 June 2017 by ethnicity, Total Coverage

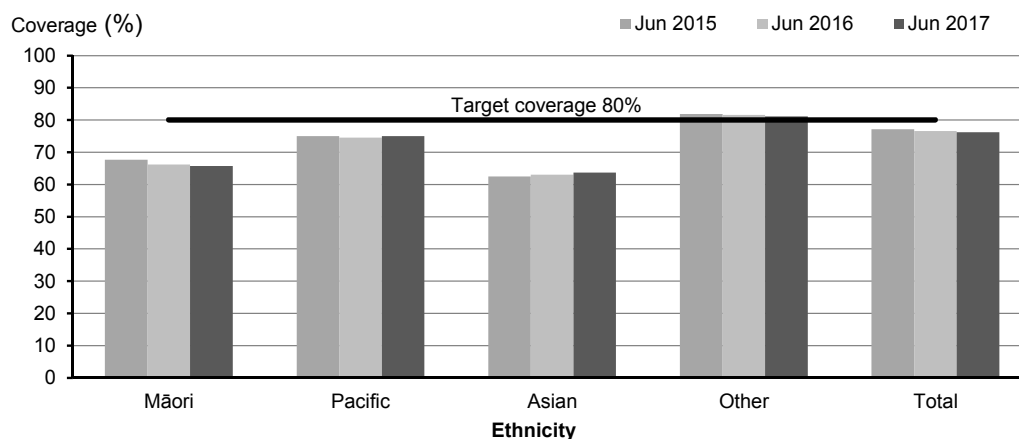


Figure 3: NCSP coverage (%) of Māori women aged 25–69 years in the three years ending 30 June 2017 by District Health Board

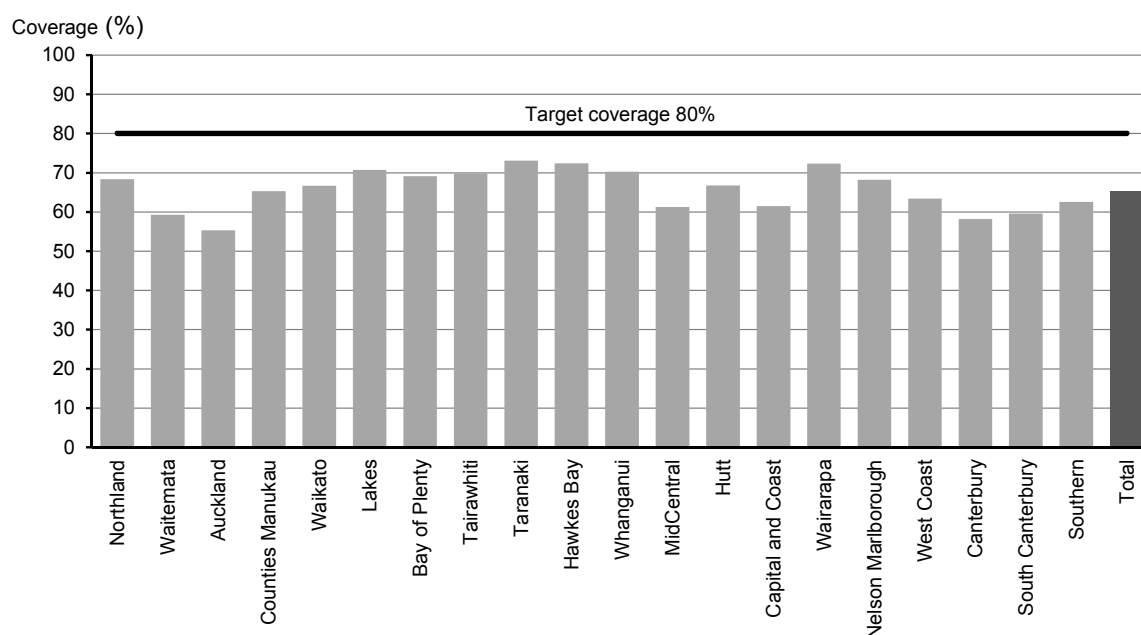


Figure 4: NCSP coverage (%) of Pacific women aged 25–69 years in the three years ending 30 June 2017 by District Health Board

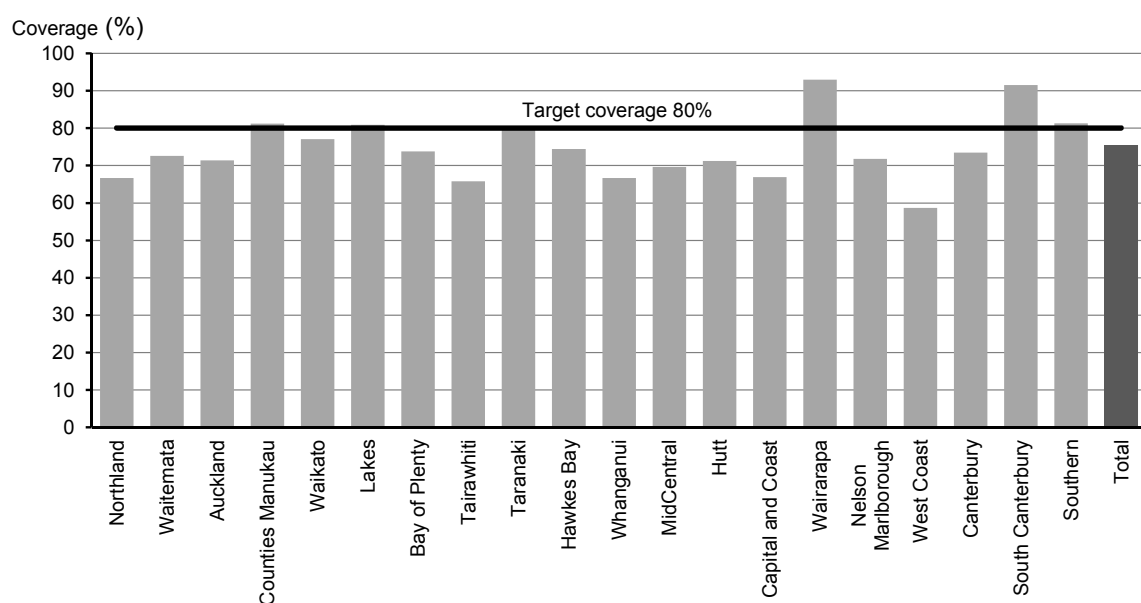
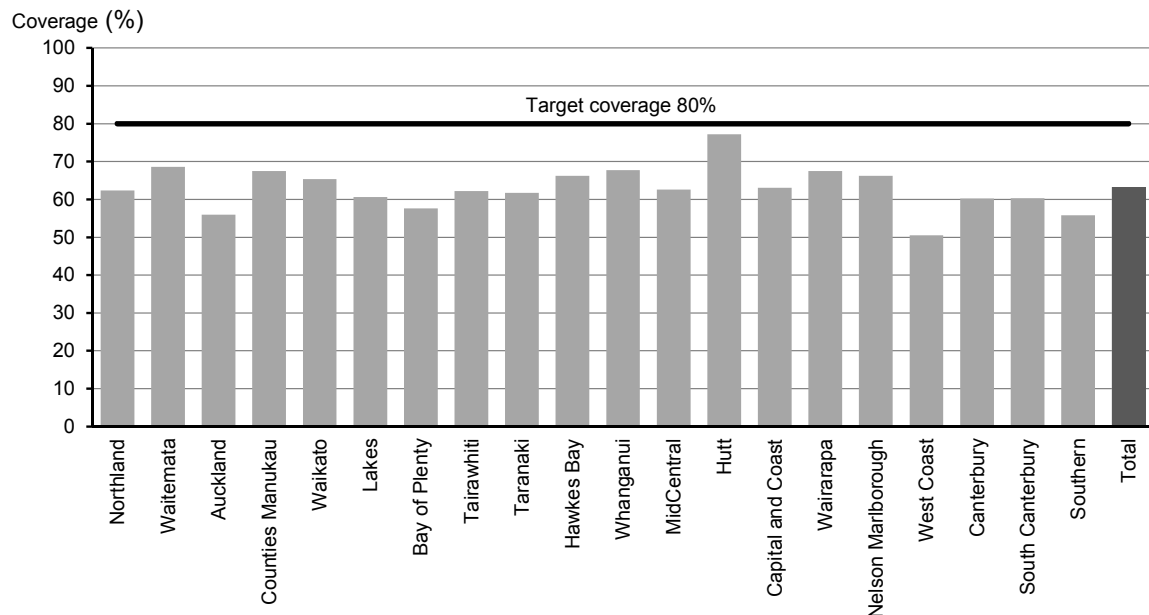


Figure 5: NCSP coverage (%) of Asian women aged 25–69 years in the three years ending 30 June 2017 by District Health Board



5. WHAT ARE WE DOING TO ADDRESS EQUITY ISSUES?




Addressing equity is a significant part of the work that both the cervical and the breast screening Recruitment and Retention (R&R, also known as ‘health promotion’ or ‘invitation and recall’) teams do. A higher proportion of priority women (Māori and Pacific) than non-Māori/non-Pacific are not enrolled with their GP or do not have a GP. Evidence shows that some Māori and Pacific women respond positively to direct approaches by phone or face-to-face rather than mail and that it is important for us to provide appointments at places and times convenient to people in lower paid jobs, who have less flexibility in their work and may be using public transport as well.

The service and the R&R teams have to find, engage and get these women to screening. There are a number of ways they do this:

- Data matching with primary care practices identifies women who are not registered and provides permission for BSC, on behalf of the practice, to contact the women to enrol them in the programme.
- We are trialling a new approach to primary engagement with priority women by phoning directly rather than sending out invitation letters and waiting for a response. This avoids inevitable waiting to discover that a woman has moved or does not respond to invitation or official looking letters, and allows immediate engagement and opportunity to address any concerns the women may have.
- We are training staff to have a better understanding of what equality and equity so they can get a better perspective on what they need to do to support priority women.
- We hold Saturday priority combined screening clinics at both Hutt and Kenepuru base sites. Our R&R team and our primary care partners can transport these women if required.
- We are planning Hutt and CCDHB staff combined cervical and breast priority days.
- We are reviewing how and where we deliver breast screening (fixed sites versus mobile) to ensure that we provide the best opportunity for priority women to access screening.

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- When we contact priority women we are asking them what the issues are that prevent them from accessing our services.
- Engaging with Māori and Pacifica through DHB Māori and Pacific Units, Mana Wahine, and Central Pacific Collective
- We have subcontracts with Maraeroa Marae Health Clinic and Te Runanganui o Te Atiawa ki te Upoko o te ika a Maui (via Puketapu Kokiri Centre) to run cervical screening clinics. These are not associated with the women's GPs so there is no charge and no stigma about attending when there are unpaid bills owing.

  		CPHAC-DSAC INFORMATION PAPER
		Date: 3 November 2017
Author	Helene Carbonatto, GM Strategy, Planning & Outcomes, Hutt Valley DHB Nigel Broom, Executive Leader, Planning & Performance, Wairarapa DHB	
Endorsed by	Ashley Bloomfield, CE Hutt Valley DHB Adri Isbister, CE Wairarapa DHB	
Subject	Update on the bowel cancer screening programme	
RECOMMENDATION It is recommended that the CPHAC-DSAC Committee: <ol style="list-style-type: none">Notes the approach to implementation of the bowel cancer screening programme in the Hutt Valley and Wairarapa districts;Notes the equity approach that is in place across Hutt and Wairarapa DHBs.		

1. Introduction

Bowel Cancer is the most frequently diagnosed cancer and the second highest cause of cancer death in New Zealand. More than 3000 people are diagnosed with bowel cancer every year and more than 1200 die from the disease. (MOH)

The incidence of bowel cancer among Māori is lower than for other ethnic groups, however the mortality rate is relatively high.

In 2010, the Ministry of Health ('the Ministry') awarded the Waitemata DHB a contract to plan and implement a four-year bowel screening pilot. The main aim of the pilot was to establish if a national bowel screening programme was feasible in New Zealand.

Launched in October 2011, the pilot has been operating at full capacity since January 2012. Following the Pilot, Ministry announced the roll out of a National Bowel Screening Programme (NBSP), with Hutt Valley and Wairarapa being the first DHBs to commence in July 2017.

2. Implementing the bowel screening programme

Hutt Valley

Since the 'Go live' date in July 2017, there have been just under 2800 invitations sent to Hutt residents to participate. Of the returned kits, there have been approximately 900 negative tests, 45 tests that have not been able to be analysed, and 53 tests returned positive for blood. Of the 53 positive results, we have a number of referrals at different stages of the patient pathway, with some opting for private care. The endoscopy services has now completed several procedure lists with one patient found to have cancer, and one patient undergoing further investigations for suspected cancer.

All systems and processes for patient care are embedded and all 'teething' issues have been. We continue to develop the range of reports and plans required by the Ministry and there is ongoing community and stakeholder engagement to raise awareness of the Programme.

Wairarapa

In Wairarapa, approximately 90 – 95 kits are sent weekly to eligible participants, with a total of 1,300 sent up until the end of October with 493 returned. It is too early to interpret the data, however early indications of August's data show good participation rates. There have been 38 spoilt kits returned, and these are monitored to determine if any change in education or local messaging needs to occur. All patients with positive results have either undergone or are booked for colonoscopy.

We are currently embedding the systems and processes developed to meet the programme requirements and for stakeholders in the pathway.

Quarterly reporting and review by the MOH will be undertaken during the initial rollout phase.

An increase in symptomatic referrals is currently being experienced, and this is being monitored to determine if it is a short term consequence of increasing community awareness or is an ongoing trend.

2.1. Equity Approach

Ensuring equitable participation has been a key focus of the programme to date. The key tasks were to identify our populations, establish priority groups, outline activities already in the pathway, and undertake engagement and consultation. As there were no previous participation data for Hutt Valley and Wairarapa DHBs, and it had been identified in the Pilot there were lower participation rates for Pacific and Māori, we have focused our approach on these populations. This is also consistent with the nationally identified priority groups of Māori and Pacific peoples.

2.2. Participant information/Resources

Written information for participants is available in multiple formats and languages, including videos, posters, website, and leaflets. There is a 0800 number for participant queries about the Programme, with people who speak a range of languages available to speak with callers. There has been a collaborative approach between Waitemata, Hutt Valley and Wairarapa DHBs and the Ministry to review existing resources as we moved from the pilot to a national programme.

2.3. Active Follow Up

Waitemata provides an Active Follow Up process for people who do not respond at the invitation phase or return a test kit with a focus on the national priority populations of Māori, Pacific and Deprivation Quintile 9 and 10.

2.4. Providing followup

When there is a positive FIT (result), and subsequent referral/notification from Primary Care, DHBs have systems and processes to manage the care for the person. These range from nurse contact, interpreters, travel assistance, appointment reminders, DNA processes and contacts, and referral to Pacific or Māori Health teams as appropriate.

2.5. Primary Health Care

Engagement occurred early with PHOs and primary care was involved from the outset. The PHOs in Hutt and Wairarapa have also participated in a series of equity forums alongside Māori and Pacific health providers and services.

Four CME sessions have been held within the wider region covering Hutt, Wairarapa and Wellington GPs. These sessions are also open across the region, so can be attended any health professional or worked at a practice – GPs, Nurses, Health Workers, practice managers, receptionists, etc – in order to increase knowledge about the Bowel Screening Programme.

2.6. Pacific People's Health

Tofa Suafole-Gush has been a driving force in providing leadership and direction for the programme team. There has been a strategic approach at both DHBs to focus on engagement by Pacific groups. Work has also commenced engaging with Pacific Health workers to identify opportunities to reach Pacific communities and with Church Leaders on what bowel cancer is and why screening is important in the early detection of cancer. These presentations have been fronted by the Programme Clinical Lead, or Lead GP, across a range of

community sites, supported from the Pacific nurses and health workers and translated to the specific audiences.

Pacific Health Nurses are championing the programme at any opportunity and have been provided tools such as the Powerpoint presentation and flyers to enable this. Development of Pacific specific tools is essential to remaining engagement and we are looking forward to receiving translations of resources from the Ministry.

Pacific radio interviews are also being planned, translated into five Pacific languages, as well as 'quick snippet' sections on a daily basis, e.g. don't forget to return your BSP kit if you received one; don't forget your hospital appointment, etc.

As the eligible Pacific population is relatively small in the Wairarapa region individual participant approaches are possible.

At each engagement opportunity we are reviewing feedback and developing the approaches as we learn.

2.7. Māori Health

Engagement and consultation with the Māori Health Teams at both sites has been initiated. The Hutt Māori Health team manager and a lead staff member have facilitated links with community-based Māori Health Services and supported attendance and engagement by the programme staff, which has now led to further engagement opportunities. Alongside individual engagement, we recently held a forum at Hutt DHB focused on ensuring equitable participation in the programme.. This included representatives from Te Awakairangi PHO, Pacific People's Health (HVDHB), Pacific Health Services, Compass Health PHO, MOH, Māori Health Unit (HVDHB), Kokiri-Hauora services, and Te Runanganui. Actions and outcomes from the meeting are being followed up.

The Wairarapa Maori Health Directorate is very involved in the Wairarapa Bowel Screening Programme. From early on in the programme an Equity Advisory Group was established with representation from Primary Health, PHO, Maori Health, Pacific, Disability and the BSP Clinical Lead and Nurse Co-ordinator. This group meets regularly and lead equity planning. This has also provided the opportunity to meet with different teams and establish contacts within services. The Kaumatua Council have agreed to champion the campaign on behalf of the wider Maori community. The Maori Health Co-ordinator and BSP Clinical Nurse Co-ordinator have been presenting to a number of community groups on bowel screening.




3. Bowel Screening Regional Centre (BSRC)

Hutt Valley DHB hosts the BSRC for the Central Region. A regional forum was held for stakeholders from the six DHBs, the Central Cancer Network, Primary care, Screening and MOH, with excellent attendance and feedback. There was presentation from Hutt Valley and Wairarapa DHBs and the Ministry, starting the processes of shared learnings and knowledge. Key topics of discussion were equity, financial information, volumes and what information would be provided to help DHBs plan.

Hawke's Bay DHB has been given a go-live date of October 2018. The remaining Central Region DHBs (Whanganui, MidCentral and Capital & Coast) have not yet been told when bowel screening will commence in their areas although all DHBs will be signing a two-phase contract within the next month. Phase one asks DHBs to provide information for the Ministry's 2018/2019 business case, with the second phase covering planning and implementation of bowel screening.

The Central Region BSRC has also successfully bid to host the National Pacific Bowel Screening Network. Negotiations are now in place regarding what services will be provided under this umbrella and the Network's first Fono will be held on 4 December.

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  		DISCUSSION PAPER
		13 November 2017
Author	Dr Pauline Boyles, Director of Disability	
From:	Rachel Haggerty: Director Strategy Innovation and Performance Helene Carbonatto: Director Strategy planning and outcomes Nigel Broom: Director Planning and Performance	
Endorsed By	Debbie Chin: Chief Executive Capital and Coast DHB Ashley Bloomfield, Chief Executive, Hutt Valley DHB Adri Isbister: Chief Executive, Wairarapa DHB	
Subject	Disability Strategy Implementation First Quarter Report	
	<p>RECOMMENDATIONS</p> <p>It is recommended that Board members</p> <p>Note</p> <p>1. Sub Regional Report key areas</p> <ul style="list-style-type: none">▪ Dashboard of highlights (first quarter) against the sub regional Disability Strategy and 17/18 commitments (including annual plan)▪ Formal agreement and Co- production of electronic health passport 17th October to 27th) currently occurring: (Ministry of Health, Health and Disability Commissioner and Sub Regional District Health Boards)▪ New Zealand Medical Journal has accepted article for publication (experiences of deaf people within health services). <p>2. Local Area Highlights</p> <ul style="list-style-type: none">• Wairarapa DHB• Hutt Valley DHB• Capital and Coast DHB <p>3. SRDAG Engagement and activities</p> <p>4 Special tribute to Debbie Chin</p>	
<p>APPENDIX ONE: DISABILITY STRATEGY HIGHLIGHTS DASHBOARD FIRST QUARTER AND 17/18 TARGETS</p> <p>APPENDIX TWO: ACCESS MAP WAIRARAPA DHB</p>		

1. PURPOSE

- 1.1 To present the Disability Strategy implementation monitoring framework against Sub Regional Disability Strategy (2017-22)
- 1.2 To present first quarter highlights of progress and achievements against sub regional strategic framework
- 1.3 To present recent progress updates on improving clinical and service responsiveness Wairarapa Hutt Valley and Capital and Coast DHBs

1.4 To report Sub Regional Disability Advisory Group activity

2. PERFORMANCE FRAMEWORK: SUB REGIONAL DISABILITY STRATEGY (2017-22)

The Sub Regional Disability Strategy was endorsed by the three District Health Boards in April 2017 and publically launched June 9 2017. The performance framework presented shows how this ambitious plan will begin and gradually unfold with annual developmental targets. The following summary will target two key strategic areas: the monitoring framework and the development of electronic resources.

2.1 Performance Framework and Structural Measures

Progress under the following two focus areas are described as progress highlights

Focus Area 1: Leadership:

The sub-regional DHBs, in partnership with disabled people, their families, Whanau and communities; plus, other relevant stakeholders, will provide leadership to achieve equity in health and wellbeing on an equal basis to others.

1.4 Ensure better accountability by creating a monitoring framework

The strategic framework was produced after significant intersectoral consultation by a sub committee of SRDAG with the Disability Strategy team. The 72 actions underpinning the main areas are documented and tracked within the wider framework. The front page highlights dashboard measures activity and early progress against each key focus area.

This framework represents the most rigorous form of monitoring available nationally available within District Health Boards. It identifies progress and quality indicators yielding some contributory measures to overall service improvement.

The monitoring of improvement on disability access using structural/system measures remains problematic in health services. The lack of a consistent national and international data set that is agreed across all services is demonstrated by the lack of disability population analysis in each published health needs assessment report. Therefore a key deliverable of this strategy of interest nationally is the overall methodology including data collection using disability alerts. In total 9000 people now have registered disability alerts across CCDHB and Hutt valley

SIP analyst team, two consumer/clinical members of SRDAG and Disability Strategy and Performance have formed an expert monitoring group to meet the requirements of strategic area 1.4.

Focus Area 2: Inclusion and Support

The sub-regional DHBs will improve and promote the full inclusion of disabled people and will ensure the best service for disabled people and their families is available on an equitable basis

2.2 Co- production of electronic health passport Ministry of Health, Health and Disability Commissioner and Sub Regional DHBs (Appendix Two)

This project relates to the following strategic areas:

1.1 Encourage intersectoral leadership on disability issues across government organisations and community and public Health Services to Partner Work with local communities

1.2 Practice positive partnerships to enhance collaboration and co-design

2.2 Ensure IT platforms accommodate disability responsiveness tools

See Appendix one for highlight dashboard.

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The sustained commitment by all sub regional DHBs to the health passport since 2011 has resulted finally in a significant milestone agreement with the Health and Disability Commissioner and the Ministry of Health to refresh and develop an electronic version of the health passport. The leadership of Bob Francis is recognized in this report as pivotal to gaining funding from the Ministry of Health for the first stage development. This piece of work has been led by the members of the Sub Regional Disability Advisory Group alongside local area allies. Members led by Bob Francis have been generous with their time and expertise despite other significant commitments.

Considerable work has been done with the group and the Disability Strategy team to achieve alliances with consumers and clinicians and identify testing environments and opportunities. At least 50 people from a variety of skill areas and experiences are engaged in the workshops and work place interviews.

Co Design and Sprint workshops**Educating each other: People with disability expertise collaborate with IT experts and clinicians**



Key outputs:

Four concepts which informed the proposition design:

- Modularity of information and the idea of tiers of information
- The possibility of integration with doctors systems
- The idea of visual triggers.
- The potential for Manage my Health to be used as one of the platforms

A proposition for experience design has been presented and has been critiqued. Negotiation with the Ministry of Health and the Director General for further funding for the next stage will occur within the next few weeks supported by the Health and Disability Commissioner

2.3 New Zealand Sign Language Plan

Focus Area 3: Access

Services are more accessible and meet the health, wellbeing and social needs of disabled people, their families and Whanau.

3.4 Improve access to New Zealand Sign Language interpreters and quality of care for Deaf community

Progress on electronic resource development (MSD funded) is on track developed with support and advice from a sub regional deaf task force group. It is expected the resources will be launched early 2018.

An article documenting research which took place in 2015 on the experiences of deaf people within health services has been accepted for publication by the New Zealand Medical Journal. It is expected to be released by the end of the year.

Co- writers are Jo Witko, Dr Pauline Boyles, Dr Kirsten Smiler (Post doctoral fellow) and Rachel McKee (Victoria University post doctoral fellow). This work is unique in New Zealand and is expected to attract considerable attention from media. An important outcome is the commitment that has now been made by Strategy Innovation and Performance and the Disability Strategy Team to a long term plan to improve access for deaf NZSL users. The plan also aims to benefit people who are also hard of hearing.

3. LOCAL AREA INITIATIVES

3.1 Wairarapa DHB

Highlights

- International day of persons with disability planning underway – hospital display, afternoon tea, awaiting 3DHB plan and materials for implementation
- Executive Leadership Team agreed establishment of a strategic Disability Action Group staff. This group comprises of staff from hospital and community in collaboration with consumer

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advisory groups. It is led by The Chief Medical Officer and the Director of Disability Strategy and Performance and the first meeting will be held in February 2018

- The Executive Leadership Team agreed that e learning would be mandatory from 2018 for patient facing staff. This is a first step to more comprehensive work force development
- ELearning rollout in Wairarapa is underway – communications, education of lead staff in clinical areas concurrently and two competitions to start this week with prizes to be presented at Staff Xmas party.
- Accessible route (CCS) managed assessment done last week. Identified some actions required **Appendix Two** both in hospital grounds and outside. This has been a useful exercise to engage younger volunteers who have experience of disability and improve access for all.

3.2 Hutt Valley DHB Highlights

- Work force Development: a number of training sessions have occurred with allied health, nurses and Year one doctors over the last month. These have been well received and follow up
- Work force development: Primary Care disability responsiveness training is developed and run with SRDAG members and staff of the DHB and PHO
- Improved on site access to information and support for staff and people using services. Extended use of main corridor help desk. Volunteer support (associate member of SRDAG) has led to a fully operational help desk three days per week. This facility will be developed for a range of information and navigation tools as they are developed
- Healthy Ageing Expo attracts significant engagement from community on use of health passport and alerts registration. 47 people registered for alerts and will be followed up by staff to ensure their support needs are accurately documented within the clinical record through the disability alert
- Final co design Hui for the child to adult transition pathway within primary care has lead to a proposal for an electronic version of the family developed toolkit. This will be tested by families with primary care Hutt Valley (Hutt Valley demonstration for sub regional use). **See Appendix One 2.2**

3.3 CAPITAL AND COAST DHB HIGHLIGHTS

Highlights

- Work force Development: a review of work force needs with regard to disability competence as per the sub regional plan is big undertaken. Education sessions are being co led by consumers and staff across a range of disciplines with excellent evaluations.
- Interim Clinical Governance (ICG)¹ is leading to timely decisions between and by needs assessment services. Seven patients were referred via the Disability Strategy team during September. Each referral was accepted but also referred on to the relevant agency which created immediate transparent and timely responses prior to the date of the panel indicating improved communications and responsiveness.
- Engagement in Health Consumer Council's Annual Meeting.
- Whole of Life Strategic project on development of an integrated approach to needs assessment service delivery is progressing well with excellent cross systems engagement from community and hospital services.
- SRDAG involvement in Citizen's Health Council development has been endorsed and supported by the group
- Citizen's Health Council follow up workshop with all partners 27 October

¹ ICG was established to address the needs of complex patients for whom clinicians struggled to discharge and/or place in the community due to the funding silos between age groups and diagnoses

4. SUB REGIONAL DISABILITY ADVISORY GROUP UPDATE

KEY ACTIVITIES

The group has been actively engaged in the co production of the health passport design as well as a range of local and national development areas.

The following areas of activity were reported at the last meeting 29th September 2017:

- People First member input and presentations on Health Passport to regional members
- Wairarapa and Hutt Valley Healthy Ageing Expos successful Staff and community driven
- MOH Health and Disability Workforce Strategy, Consumer Working Group, 11 August.
- Engagement with Ministry of Health on Electronic record
- Nursing Workforce Taskforce, meeting 25 August. Consumer representation from sub regional members
- IHC Public Meeting on Enabling Good Lives (EGL), 29 August, St Joseph's Church: report on Enabling Good Lives and Disability Support System Transformation demonstration (Mid Central)
- MOH NZ Health Strategy road show, half day 6 Sept, Pipitea Marae
- IHC/ DPA Election Forum, 7 Sept, ASB Arena, Kilbirnie.

Significant work is being done by each member in their local area as well as in raising the profile of disability and health within a range of other forums. This includes election forums, health forums and multiple workshops on Disability Support System transformation. Their ownership of and engagement with the work within each DHB and the Disability Strategy team is invaluable and much appreciated. Special thanks to Bob Francis for his leadership and determination particularly in the achievement of funding for the important project to review and re develop the national health passport

5. TRIBUTE TO DEBBIE CHIN

The disability community wish to pay tribute to the work and tenacity of Debbie Chin Chief Executive CCDHB. She has not only supported the work of CPHAC DSAC, the Sub Regional Group and the teams involved, she has recognized and valued the leading and cutting edge nature of the work being undertaken. Without this leadership from the CEO the work would not have flourished.

SRDAG and the Disability Strategy Team are unanimous in their appreciation and admiration for Debbie Chin. We wish her well in her future endeavours

Review of the Footpath Accessible Journey

Masterton Hospital

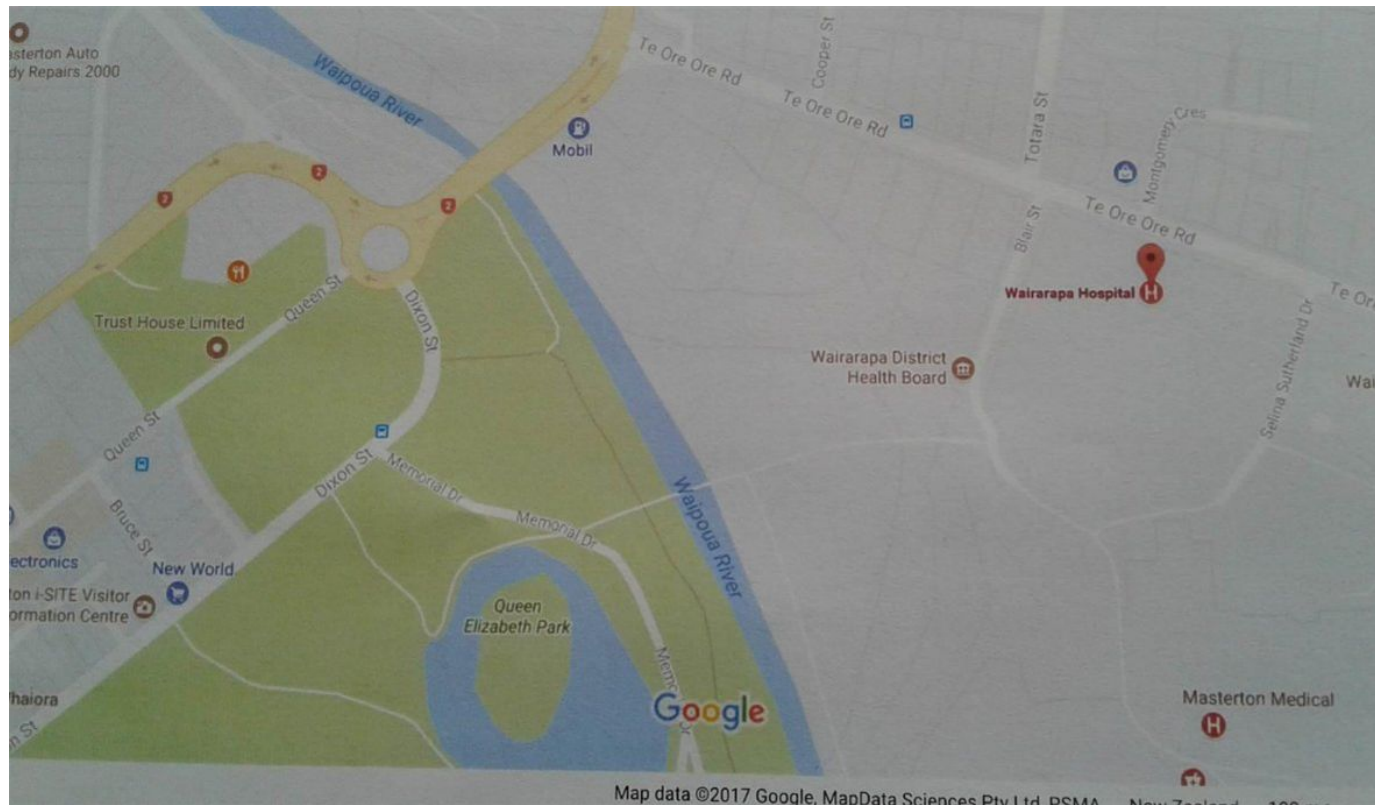
Te Ore Ore Rd, Lansdowne, Masterton 5810



Assessment of accessibility and usability for people with impairments

October 2017

Description of the Journey



Te Ore Ore Road exiting from the entrance to the Hospital, turning right to nearest pedestrian crossing and returning to nearest pedestrian crossing to the left of the Hospital. Through Blair St, across the swing bridge into Queen Elizabeth Park and return. The review was completed during daylight hours on a fine day. No comment has been recorded on shelter or lighting.

Participants.

Bridget McLaren

Matt Wills

Hemi Veale


Heather Atkinson, Disability Responsiveness Advisor WRDHB


Overview.


Generally the footpaths adjacent to the main roads were in good repair and of excellent width. Foliage from trees and gardens did not impact on the journey which was in the main manageable by all participants.




Blair Street, however lacked footpaths and the journey was completed in the road access.




Feature	Description / Issues	
Car Park outside main entrance	<p>A total of 4 mobility car parks, with worn paint and no signage.</p> <p>No kerb cut to footpath, access via road.</p> <p>Refer to Building Code 4121:2001 Section 5 Car Parks.</p> <p>Recommendation:</p> <p>Directory board less than 1000mm from kerb raked 6° from vertical and max height 1750mm.</p> <p>Accessible park is visible from vehicle entrance to car park.</p> <p>If not, directional signage is provided to indicate location of car park.</p> <p>Identified by ISA on ground, wall or post.</p> <ul style="list-style-type: none"> To increase visibility and help reduce the level of abuse by non-disabled drivers, place the ISA painted yellow within a blue square located at the 	

	<p>entry end of the mobility park.</p> <ul style="list-style-type: none"> • Posts displaying the ISA also help identify the location of car parks. NB. Their position can impede exit from rear mounted hoist vehicles if they are backed into the car park for safety. Placing the ISA on a convenient wall, or placing posts further back from the car park helps overcome this problem. <p>Note: There is no time limit on parking in Hospital grounds.</p>	
Hospital Dairy.	<p>The footpath has advertising boards along the footpath close to the dairy car park and on the kerb. This restricts a clear vision or tapping line for people with vision impairments.</p> <p>Recommendation: Owner of the dairy be requested to keep all signs on one edge of the footpath.</p> <p>Masterton Council By Law 4.2b states you shall not: <i>“Place or leave any material, good, or thing, including signage, on a public place that could obstruct the public right of passage, without the permission of an authorised officer and then only in accordance with such conditions as may be imposed”</i></p>	
Montgomery Crescent	<p>Kerb cut on eastern side has potential for wheelchairs to get stuck. Road has been resurfaced leaving a ditch rather than a smooth transition and no variation of slope from side to side. Any lip slows down the ability of users</p>	

	of mobility equipment to quickly exit the road and hence reduce possible interaction with vehicles. The participant using a power chair was able to increase speed to negotiate the uneven surface, with the risk of tipping the chair.	
Lake view crossing	The South side has an uneven transition causing the manual wheel chair user to hit the foot plates on the road surface.	
Entrance to Hospital car park.	<p>Signage for the entrance to the hospital has very limited visibility from either direction along Te Ore Ore Road. It is unclear where pedestrians should enter the Hospital grounds.</p> <p>Recommendation: Directional road signage to the Hospital be considered at major intersections along the accessible journey and at entry points to Hospital grounds.</p> <p>See table on signs at end of report.</p>	

<p>Blair Street</p>	<p>The crossing has tactile tiles installed. One panel is not aligned correctly to the direction of travel and would lead people to the raised island in the centre of the crossing. Tactile ground surface indicators (TGSIs) provide pedestrians with visual and sensory information. The two types of TGSIs are warning indicators and directional indicators. Warning indicators alert pedestrians to hazards in the continuous accessible path of travel, indicating that they should stop to determine the nature of the hazard before proceeding further. They do not indicate what the hazard will be. Directional indicators give directional orientation to people who are blind or have low vision and designate the continuous accessible path of travel when other tactile or environmental cues are insufficient.</p> <p>For further information see RTS 14 – Guidelines for facilities for blind and vision impaired pedestrians</p> <p>The bus stop, visible from Blair Street, in the hospital grounds is not accessible, although it does provide shelter.</p>	 
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	<p>There are no footpaths on either side of Blair Street. Pedestrians have access only along the road. There are many barriers through to the medical centre. These include 2 speed bumps, cones blocking access to the flat roadside, vehicles parked on yellow painted, no stopping lines and broken glass on roadside.</p> <p>One mobility car park outside the CSISB required repainting and appropriate signage</p>	  
--	--	--

	<p>DHB mobility car parks close by the Selina Hospital were all occupied but no vehicles were displaying mobility parking permits.</p> <p>Signage of mobility car parks outside of the Medical Centre is appropriate but outdated.</p> <p>Note. The emergency assembly area is not accessible. Recommended: A review of assembly points be undertaken to ensure they are accessible and the Emergency Response Plan be amended if appropriate.</p>	  
<p>Access to Queen Elizabeth Park.</p>	<p>The walk over the swing bridge into Queen Elizabeth Park was completed with one of the group pushing the manual wheelchair. The route was not accessible but could be a feature to be developed by Council in future. This would require the ramp leading up to the bridge to be longer and have a stable, firm, slip resistant flat surface under all environmental conditions.</p>	

	Once across the bridge access to Dixon Street was on the road.	
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SIGNS

(NZBC D1.1[c], D1.3.6[c], F8.1[c], F8.2[d], F8.3.4, G5.3.6; D1/AS1 1.1.1, F8/AS1 5.0; NZS 4121 4.8 and Appendix E)

<p>The Building Act 2004, the Building Code and NZS 4121:2001 all require the erection and maintenance of appropriate signs both inside and outside a building to be :</p> <ul style="list-style-type: none"> • Informative - advising about availability of facility or service • Directional - directing to a specific facility • Locational - identifying the place where the facility is provided <p>The two signs required to be displayed are the :</p> <ul style="list-style-type: none"> • International Symbol of Access (ISA) • International Symbol of Deafness (ISD) <p>For additional detail on signs refer to 'Accessible signage guidelines', Blind Foundation 2013. https://bf-website-uploads-production.s3.amazonaws.com/uploads/2015/09/Accessible-Signage-Guidelines.pdf</p>	
General:	Are both the ISA and the ISD displayed with the correct proportional layout, lettering and colour contrast?
	Are signs fixed 1400 - 1700mm above floor or ground level to bottom of sign plate?
Car parking:	Is the ISA marked on the surface finish of the accessible car parking space(s) provided?
	If necessary, is ISA also displayed on wall or post?
	If necessary, is the ISA displayed to indicate direction to accessible entrance?
Entrance:	If necessary, is the ISA displayed to indicate an alternative accessible entrance?
Accessible routes:	If necessary are ISA signs displayed to indicate direction to lifts and accessible toilets?
	On main information board in entry foyer, is the ISA displayed to indicate location of accessible toilets?
	On main information board in entry foyer, is the ISD displayed to indicate location of any listening systems installed? Also refer to 'Listening Systems'
Doors:	Is the ISA displayed on the entry door(s) to all accessible toilets?
	Is the ISA displayed on the entry door(s) to all accessible showers?
	Is the ISD displayed on the entry door to any room which has a listening system installed? Also refer to Listening systems" earlier in the checklist

Raewyn Hailes

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Te hunga hauā mauri mō ngā tāngata katoa

Bee Healthy Dental Service - **WHOLE SERVICE**

Monthly Balanced Scorecard September 2017

KEY PERFORMANCE INDICATORS 2016/2017

PATIENT EXPERIENCE

	Sep-17		Period	
	Target	Month	Target	YTD
Number of preschool children enrolled			27178	24193
Total % Preschool children enrolled			95%	89%
Total number of preschool 2-4 yr olds enrolled				16172
	Target	Month	Target	YTD
Total number of primary school children enrolled				47691
Number of Primary school examinations	4883	4551	34187	32844
Primary school examinations %		93%		96%
Number of Fluoride Varnish Applications		3889		27642
Fluoride Varnish %		85%		84%
Number of Preschool examinations	1897	905	13191	7889
Preschool examinations %		48%		60%
Number of Fluoride Varnish		443		3527
Fluoride Varnish %		49%		45%

PROCESS & EFFICIENCY

	Sep-17		Period	
	Target	Month	Target	YTD
Did not attend rate (excludes:Mobile)	15%	15%	15%	16%
DNA rate Primary	15%	15%	15%	15%
DNA rate Maori Primary	15%	26%	15%	25%
DNA rate Pacific Primary	15%	27%	15%	28%
DNA rate Other Primary	15%	9%	15%	10%
DNA rate Pre School	15%	17%	15%	18%
DNA rate Maori Pre School	15%	28%	15%	30%
DNA rate Pacific Pre School	15%	35%	15%	34%
DNA rate Other Pre School	15%	10%	15%	13%
Bitewings %				42%

Enrollment Traffic Lights

Traffic Light Rules	Colour Code
90%-100%	
70%-89%	
0-69%	

Examinations & Completions Traffic Lights

Traffic Light Rules	Colour Code
95%-100%	
80%-94%	
0-79%	

DNA Traffic Lights

Traffic Light Rules	Colour Code
>=15%	
16%-24%	
<=25%	

Bee Healthy Dental Service - HVDHB

Monthly Balanced Scorecard September 2017

KEY PERFORMANCE INDICATORS 2016/2017

PATIENT EXPERIENCE

	Sep-17		Period	
	Target	Month	Target	YTD
Number of preschool children enrolled			9428	8491
Total % Preschool children enrolled			95%	90%
Total number of preschool 2-4 yr olds enrolled				5675
	Target	Month	Target	YTD
Total number of primary school children enrolled				17057
Number of Primary school examinations	1764	1557	12351	11971
Primary school examinations %		88%		97%
Number of Fluoride Varnish		1530		11447
Fluoride Varnish %		98%		96%
Number of Preschool examinations	672	375	4619	3008
Preschool examinations %		56%		65%
Number of Fluoride Varnish		240		1689
Fluoride Varnish %		64%		56%

PROCESS & EFFICIENCY

	Sep-17		Period	
	Target	Month	Target	YTD
Did not attend rate (excludes:Mobile)	15%	16%	15%	18%
DNA rate Primary	15%	15%	15%	17%
DNA rate Maori Primary	15%	24%	15%	26%
DNA rate Pacific Primary	15%	24%	15%	26%
DNA rate Other Primary	15%	9%	15%	11%
DNA rate Pre School	15%	20%	15%	19%
DNA rate Maori Pre School	15%	31%	15%	30%
DNA rate Pacific Pre School	15%	39%	15%	33%
DNA rate Other Pre School	15%	11%	15%	12%
Bitewings %				47%

Enrollment Traffic Lights	
Traffic Light Rules	Colour Code
90%-100%	
70%-89%	
0-69%	

Examinations & Completions Traffic Lights	
Traffic Light Rules	Colour Code
95%-100%	
80%-94%	
0-79%	

DNA Traffic Lights	
Traffic Light Rules	Colour Code
>=15%	
16%-24%	
<=25%	

Bee Healthy Dental Service - CCDHB

Monthly Balanced Scorecard September 2017

KEY PERFORMANCE INDICATORS 2016/2017

PATIENT EXPERIENCE

	Sep-17		Period	
	Target	Month	Target	YTD
Number of preschool children enrolled			17749	15703
Total % Preschool children enrolled			95%	88%
Total number of preschool 2-4 yr olds enrolled				10497
	Target	Month	Target	YTD
Total number of primary school children enrolled				30634
Number of Primary school examinations	3119	2994	21836	20873
Primary school examinations %		96%		96%
Number of Fluoride Varnish		2359		16194
Fluoride Varnish %		79%		78%

Number of Preschool examinations	1225	530	8572	4881
Preschool examinations %		43%		57%
Number of Fluoride Varnish		203		1837
Fluoride Varnish %		38%		38%

PROCESS & EFFICIENCY

	Sep-17		Period	
	Target	Month	Target	YTD
Did not attend rate (excludes:Mobile)	15%	14%	15%	15%
DNA rate Primary	15%	15%	15%	14%
DNA rate Maori Primary	15%	28%	15%	25%
DNA rate Pacific Primary	15%	29%	15%	29%
DNA rate Other Primary	15%	9%	15%	9%
DNA rate Pre School	15%	14%	15%	18%
DNA rate Maori Pre School	15%	24%	15%	31%
DNA rate Pacific Pre School	15%	30%	15%	35%
DNA rate Other Pre School	15%	10%	15%	13%

Bitewings %		38%
-------------	--	-----

Enrollment Traffic Lights	
Traffic Light Rules	Colour Code
90%-100%	Green
70%-89%	Yellow
0-69%	Red

Examinations & Completions Traffic Lights	
Traffic Light Rules	Colour Code
95%-100%	Green
80%-94%	Yellow
0-79%	Red

DNA Traffic Lights	
Traffic Light Rules	Colour Code
>=15%	Green
16%-24%	Yellow
<=25%	Red



Capital & Coast

Select your DHB from the list in this cell

#VALUE!

Dental Health Status	Number of Children Examined	Number of Children Caries-Free	Number of Decayed Teeth	Number of Teeth Missing due to Caries	Number of Filled Teeth	Number of Decayed, Missing due to caries and Filled Teeth	% Caries Free	Mean d	Mean m	Mean f	Mean dmft	Mean DMFT for children with caries			
												Mean d	Mean m	Mean f	Mean dmft
All 5-year old Children	3,179	2,114	2,322	507	1,363	4,192	66%	0.73	0.16	0.43	1.32	2.18	0.48	1.28	3.94
All Maori 5-year old Children	429	216	487	119	272	878	50%	1.14	0.28	0.63	2.05	2.29	0.56	1.28	4.12
All Pacific 5-year old Children	348	137	565	180	307	1,052	39%	1.62	0.52	0.88	3.02	2.68	0.85	1.45	4.99
All "Other" 5-year old Children	2,402	1,761	1,270	208	784	2,262	73%	0.53	0.09	0.33	0.94	1.98	0.32	1.22	3.53
All Fluoridated 5-year old Children	3,131	2,081	2,294	505	1,345	4,144	66%	0.73	0.16	0.43	1.32	2.18	0.48	1.28	3.95
All Non-Fluoridated 5-year old Children	46	33	17	2	18	37	72%	0.37	0.04	0.39	0.80	1.31	0.15	1.38	2.85
Maori Fluoridated 5-year old Children	427	216	480	119	272	871	51%	1.12	0.28	0.64	2.04	2.27	0.56	1.29	4.13
Maori Non-fluoridated 5-year old Children	1	0	2	0	0	2	0%	2.00	0.00	0.00	2.00	2.00	0.00	0.00	2.00
Pacific Fluoridated 5-year old Children	347	137	564	180	303	1,047	39%	1.63	0.52	0.87	3.02	2.69	0.86	1.44	4.99
Pacific Non-fluoridated 5-year old Children	1	0	1	0	4	5	0%	1.00	0.00	4.00	5.00	1.00	0.00	4.00	5.00
Other Fluoridated 5-year old Children	2,357	1,728	1,250	206	770	2,226	73%	0.53	0.09	0.33	0.94	1.99	0.33	1.22	3.54
Other Non-fluoridated 5-year old Children	44	33	14	2	14	30	75%	0.32	0.05	0.32	0.68	1.27	0.18	1.27	2.73

Other comments

Enter any other comments here that may help explain the figures provided.

If any of these results did not meet your DHB's targets, you **must** provide an explanation here that includes a description of what your DHB is doing to rectify the problem.

dmft not recorded

Children Examined = 2 Caries Free = 0

dt=11 mt=0 ft=0 dmft=11

From 2013 the % examinations on children 6 years and under associated with a set of PBW xrays has increased year on year from 19% in 2013 to 53% in 2016. It would be expected that this would result in the detection of more dentine caries in this age group which may explain the 2-4% reduction in caries free.

Healthy Ageing Strategy

E noho ora ana te hunga pakeke, e noho pai ana i ngā tau o te kaumātua tanga tae noa atu ki ngā tau whakamutunga o te rangatira i roto i nga ringa manaaki, ringa atawhai o te hāpori.

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

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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-liga
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.

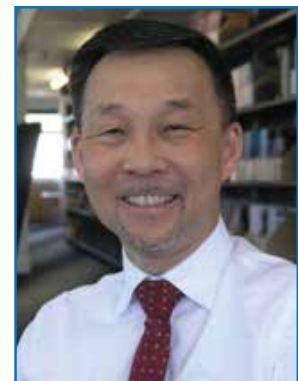
Its predecessor, the Health of Older People Strategy, was launched in 2002. The 2002 strategy delivered many successes, including greater choice in long-term health care services. We can all be proud of that.

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

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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).

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.

‘Ala Mo’ui – Pathways to Pacific Health and Wellbeing 2014–2018

‘Ala 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. ‘Ala 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.



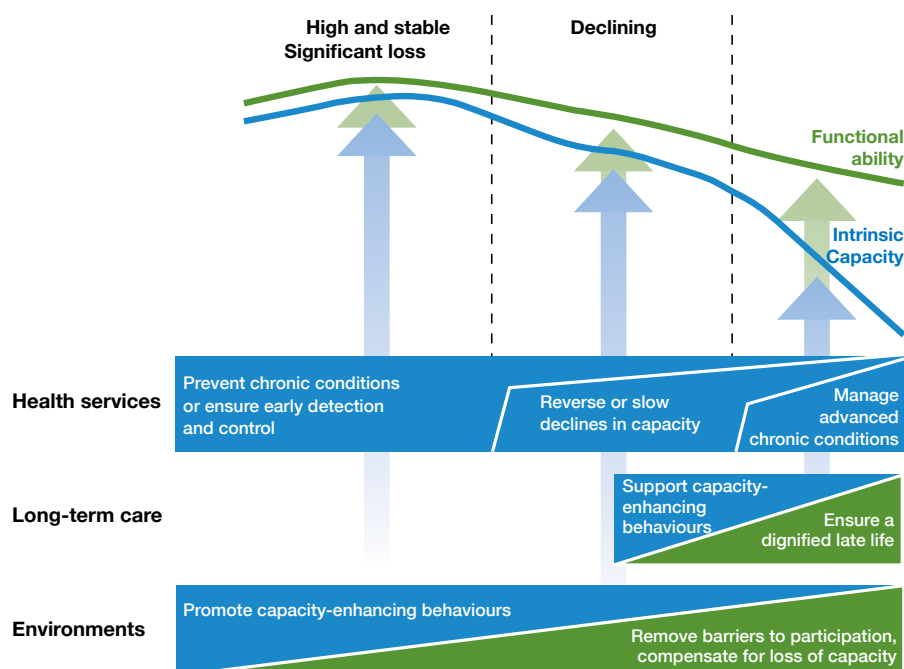
Also highly influential are our physical and mental capabilities; our access to resources and opportunities; our resilience including in the face of adversity; our relationships; our personal circumstances, including our occupation, level of wealth, educational attainment and gender; our potential for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



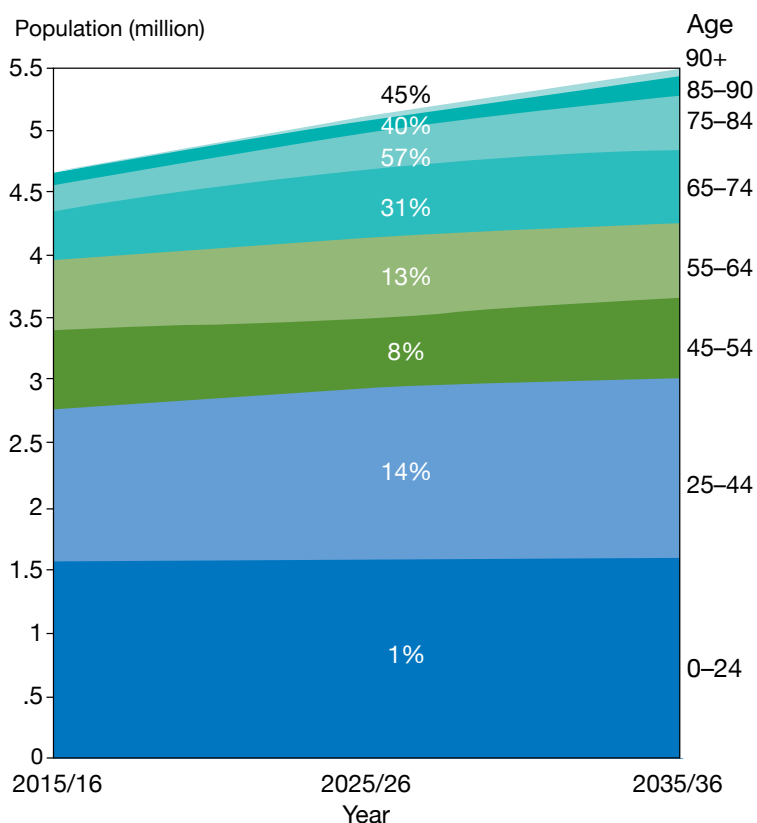
This older population, and our communities, will also become more ethnically diverse. The Māori population of people aged 65 and older is projected to increase by 79 percent in the 10 years to 2026. The older Pacific population is expected to increase by 63 percent, and older Asian population by 125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

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.

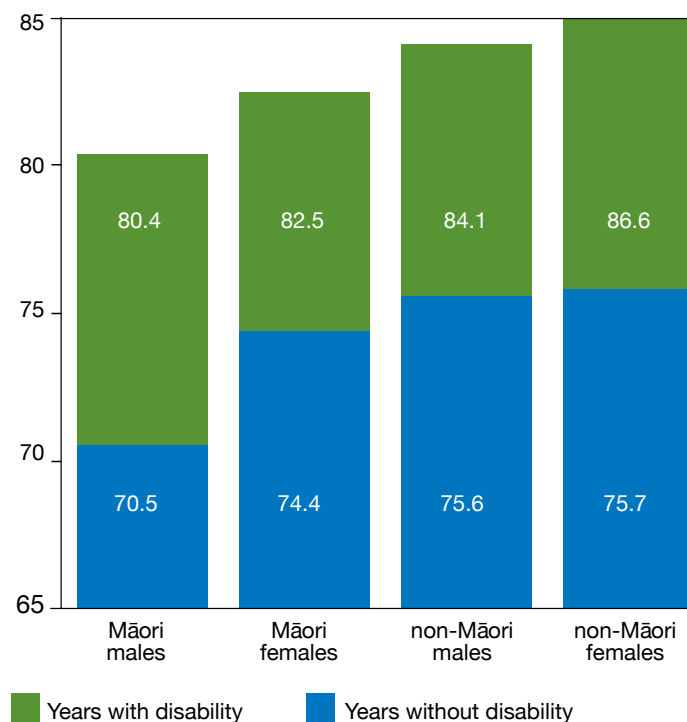
Figure 2: Population projections by age group with 10 year percent change



Source: Statistics New Zealand, 2016

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

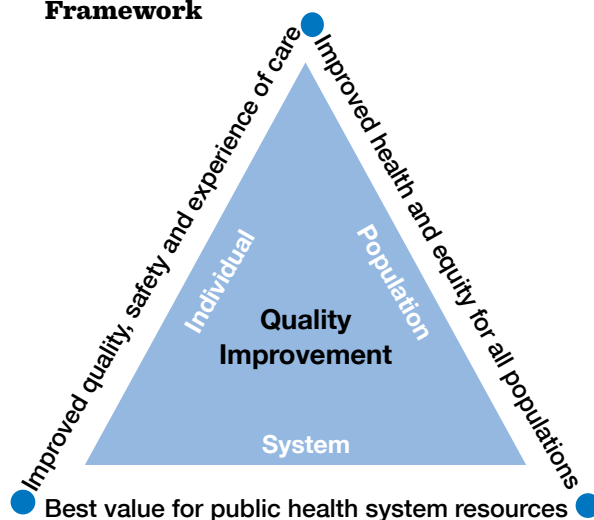
for a whole-of-system approach to achieving, balancing and measuring improved health and equity for all populations, best value for public health system resources and improved quality, safety and experience of care.

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.

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

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.



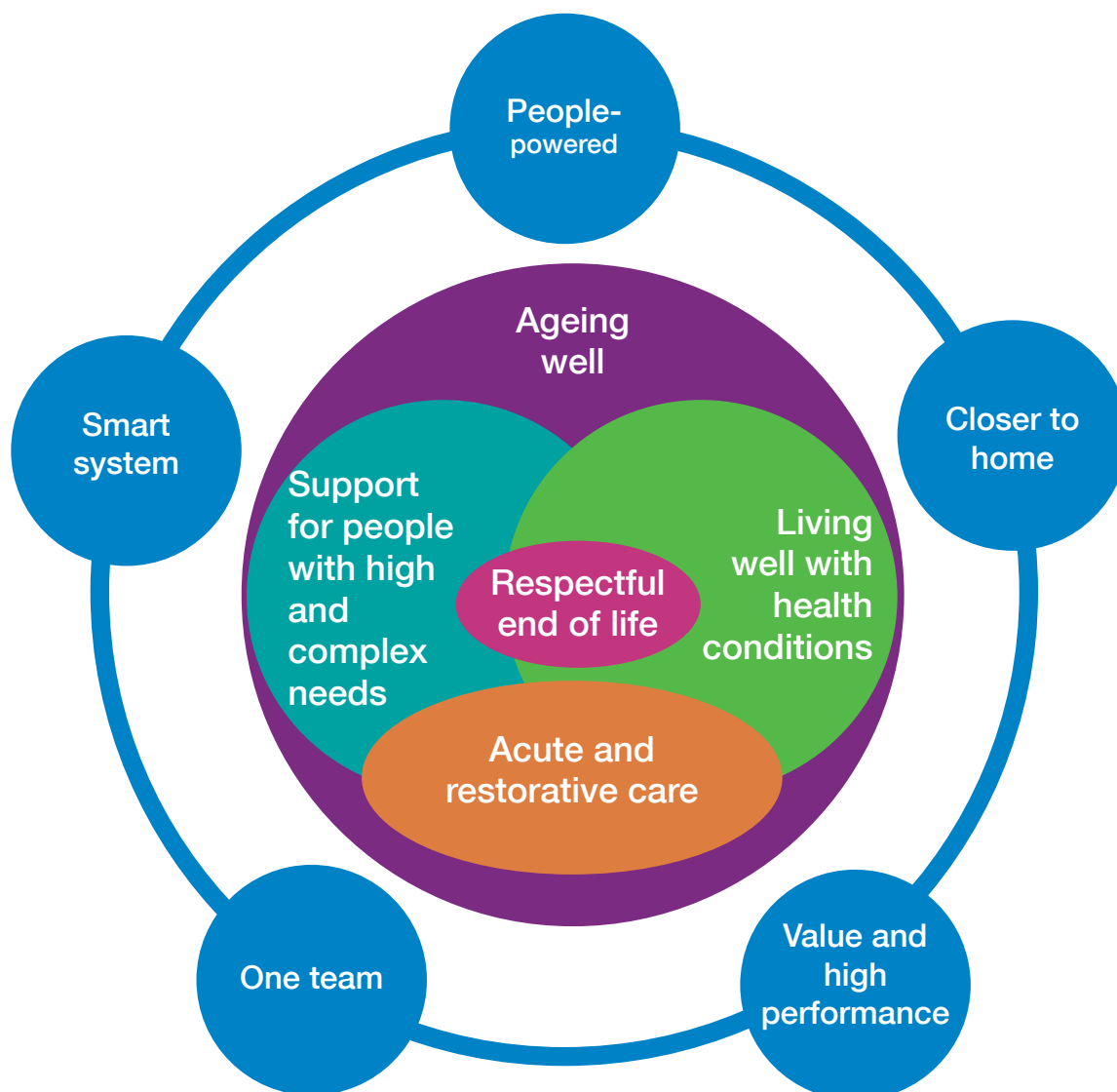
To achieve this vision, we need to ensure our policies, funding, planning and service delivery:

- 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 kaumātuaanga

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 health 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

Ngā tuāhuatanga 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 on-going 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.

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).

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

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 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 as 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 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.* 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.* 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.*	 Office for Seniors National, regional and local government agencies and NGOs, older people other community members

Actions	Lead Partners
<p>d. Develop, through a co-design process, a New Zealand-centric approach to age-friendly communities that:*</p> <ul style="list-style-type: none"> – draws from the WHO framework for age-friendly cities – builds on local experience – includes a networked infrastructure at national, regional and local levels. 	
2. Increase physical and mental resilience.	
<p>a. Increase the availability of strength and balance programmes in people's homes and community settings.*</p>	<p>● ● ACC Health Quality & Safety Commission New Zealand, Ministry of Health, DHBs</p>
<p>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.</p>	<p>● DHBs Government agencies</p>
<p>c. Review the Green Prescription programme, including the potential for other health professionals to prescribe and improve its utilisation by older people.</p>	<p>● Ministry of Health DHBs, primary health care</p>
<p>d. Increase understanding and explore partnerships in promoting mental health for older people at an individual, organisational and community level.</p>	<p>● Ministry of Health</p>
<p>e. Encourage services and providers to promote healthy eating, physical activity and healthy lifestyles.*</p>	<p>● ● DHBs health organisations, NGOs, New Zealand Nutritional Foundation</p>
<p>f. Encourage services and providers to promote the reduction of alcohol-related harm.*</p>	<p>Health Promotion Agency</p>

* Implemented in the first two years

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

Actions	Lead Partners
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, 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, Ministry of Justice
c. Update the <i>2007 Family Violence Intervention Guidelines: Elder Abuse and Neglect</i> , 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 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 Te Puni Kōkiri, Ministry of Health

Actions	Lead Partners
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 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 New Zealand Transport Agency
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 Primary health care
c. Improve the effectiveness of health literacy information distributed by health and social sector agencies.	● Ministry of Health Health Promotion Agency
d. Support older people's uptake of technologies for communication with health providers and their family and whānau.*	● DHBs 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 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 Office for Seniors, Ministry of Social Development, community organisations

* Implemented in the first two years

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

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 Key partners
5. Reduce inappropriate acute admissions and improve assessment processes.	DHBs
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.* b. Work with the health sector to streamline acute assessment tools and processes and spread best practice options.*	Primary health care providers, emergency response services, aged residential care providers, needs assessment service providers, home and community support providers

Actions	Lead Key partners
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:✱ <ul style="list-style-type: none"> – improve the patient journey and experience, including for those with delirium, dementia, and common frailty symptoms – improve the quality of care for those admitted for falls and fractures, including hip fractures – enhance early supported discharge planning – ensure patient experience and cultural responsiveness are reflected in quality measures. 	● ACC 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 Ministry of Health, Health Quality & Safety Commission New Zealand, DHBs
7. Support effective rehabilitation closer to home by working across the whole system.	
a. Work with the sector (including service users) to identify and promote best practice in:✱ <ul style="list-style-type: none"> – rehabilitation partnerships with primary health care, allied health, community nurses, pharmacists, aged care providers, home support providers, family and whānau – home-based and community-based models that support ongoing rehabilitation and restoration of older people – facilitating staff working in rehabilitation to collaborate across workforce groups and work to the top of their scope. 	● Ministry of Health DHBs, primary care providers, aged-residential care, home support providers, older people, and carers
✱ Implemented in the first two years ● People powered ● Closer to home ● Value and high performance ● One team ● Smart system	

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 Key partners
<p>8. Improve models of care for home and community support services.</p> <p>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:*</p> <ul style="list-style-type: none"> – involve service users and their family and whānau – review the role of needs assessment and service coordination – ensure needs assessment and care planning are culturally appropriate and meet the needs of Māori and other priority population groups. <p>b. Use interRAI assessment data to identify quality indicators and service development opportunities including with health providers.*</p>	<p>Ministry of Health DHBs, aged-care providers</p> <p>● ●</p> <p>●</p> <p>Ministry of Health DHBs, aged care providers</p>

Actions	Lead Key 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 DHBs, aged care providers
b. Ensure undergraduate and graduate curricula support an integrated model of care that: <ul style="list-style-type: none"> – enables all health professionals to work as one team – works in partnership with older people and their family (including cultural understanding of older Māori) – promotes healthy ageing and restoration – addresses risk factors for social isolation and mental health and problematic alcohol use. 	● ● ● Health Workforce New Zealand 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 <i>Kaiāwhina Action Plan</i> .*	● ● 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 <i>Workforce for the care of older people</i> and development of a whole of workforce action plan.*	● Ministry of Health 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 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

* Implemented in the first two years

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

Actions	Lead Key partners
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 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 <i>Pharmacy Action Plan 2016 to 2020</i> (Ministry of Health 2016), improve medicines management and encourage better liaison between pharmacists and other health professionals including through: <ul style="list-style-type: none"> – 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. 	DHBs
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 <i>Improving the Lives of People with Dementia</i> (Ministry of Health 2014).*	 DHBs
b. Work with health and social services and communities to become more dementia-friendly.*	 Ministry of Health Office for Seniors, DHBs, Alzheimers New Zealand, Dementia Cooperative and other dementia organisations

Actions	Lead Key partners
c. Reduce the instances of complications from diabetes, particularly for people in aged residential care in line with <i>Living Well with Diabetes: A plan for people at high risk of or living with diabetes 2015–2020</i> (Ministry of Health 2015a), by providing tools, resources and quality standards.*	DHBs 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 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 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 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 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 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

* Implemented in the first two years

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

Actions	Lead Key partners
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 Primary health care
c. Promote the use of assistive technologies to support home-care workers to achieve good outcomes.	● ● DHBs
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 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 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 DHBs, PHOs, oral health service providers, aged care providers
* Implemented in the first two years	
● People powered	● Closer to home
● Value and high performance	● One team
● Smart system	








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 Key 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 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 DHBs

* Implemented in the first two years

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

Actions	Lead Key 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 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: <ul style="list-style-type: none"> – are strongly person centred and take account of family and whānau carer needs – assist older people to meet their individual objectives – minimise the need for the most expensive health and support services – could include primary health care, pharmacy, ambulance, home and community support, aged residential care and acute care services. 	 DHBs 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 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 Government agencies, NGOs
d. Improve the coordination of health and social services to vulnerable older people within health and across the social sector.	 DHBs Government agencies

Actions	Lead Key partners
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 Specialist AOD and Mental Health Services, primary health care, Ministry of Health, NZ Aged Care Association, aged care providers
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 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 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 NZ Aged Care Association, Ministry of Health

* Implemented in the first two years

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Actions	Lead Key partners
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.	<div>●</div> Ministry of Health 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.	<div>● ●</div> DHBs 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.	<div>●</div> Primary health care 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.	<div>●</div> DHBs 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.	<div>● ● ●</div> Primary health care Pharmacists, Home Support providers, aged residential care providers, DHBs

Actions	Lead Key partners
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 Pharmacists, primary health care, home and community support providers, aged residential care providers
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 <i>Caring for Carers: New Zealand Carers' Strategy Action Plan for 2014–2018</i> , including for various types of respite care, guidance and information, and training.	Ministry of Social Development Ministry of Health, Ministry of Business, Innovation & Employment, ACC
* Implemented in the first two years	
● People powered	● Closer to home
● Value and high performance	● One team
● Smart system	

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 Key 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.	<div>●</div> Ministry of Health 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.	<div>●</div> Ministry of Health DHBs
c. Better utilise pharmacists, allied health and advanced nursing roles, and specialist palliative care nurses as members of integrated palliative care teams.	<div>●</div> Ministry of Health, 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.	<div>●</div> Ministry of Health, DHBs

Actions	Lead Key partners
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 DHBs
c. Support the implementation of <i>Te Ara Whakapiri: Principles and guidance for the last days of life</i> (Ministry of Health 2015b).*	Ministry of Health 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 Health, Quality & Safety Commission New Zealand

* Implemented in the first two years

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Implementation, measurement and review

Actions	Lead Key partners
25. Implement the Healthy Ageing Strategy.	Ministry of Health Wide range of partners
a. With health and social sector partners, complete a Healthy Ageing Strategy Implementation Plan within the first four months of the Strategy's release.*	● ● ●
26. Include older people in service design, development and review and other decision-making processes.	DHBs
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.	● ●
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.	●
c. Improve the knowledge of user's experience in home and community support and in aged residential care for service commissioning and monitoring outcomes.*	●
d. Include representatives of older people in DHB forums.*	●
e. As part of implementing the <i>Pharmacy Action Plan 2016 to 2020</i> (Ministry of Health 2016), co-design a service model with consumers to support the development and implementation of a minor ailments and referral service.*	●
27. Establish an outcomes and measurement framework, commissioning and review processes.	Ministry of Health
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.	●

Actions	Lead Key partners
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 DHBs, health providers, organisations representing older people
c. Regularly review the Healthy Ageing Strategy implementation progress and the prioritisation of actions.*	Ministry of Health DHBs
d. Publish indicators for each DHB on a regular basis.*	Ministry of Health 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 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 NGOs
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

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

References

Ministry of Health. 2013. *New Zealand Framework for Dementia Care*. Wellington: Ministry of Health.

Ministry of Health. 2014. *Improving the Lives of People with Dementia*. Wellington: Ministry of Health.

Ministry of Health. 2015a. *Living Well with Diabetes: A plan for people at high risk of or living with diabetes 2015–2020*. Wellington: Ministry of Health.

Ministry of Health. 2015b. *Te Ara Whakapiri: Principles and guidance for the last days of life*. Wellington: Ministry of Health.

Ministry of Health. 2016. *Pharmacy Action Plan 2016 to 2020*. Wellington: Ministry of Health.

Ministry of Social Development. 2014. *Caring for the Carers: New Zealand Carers' Strategy Action Plan for 2014 to 2018*. Wellington: Ministry of Social Development.

WHO. 2015. *World Report on Ageing and Health*. Geneva: World Health Organization. URL: http://apps.who.int/iris/bitstream/10665/186463/1/9789240694811_eng.pdf (accessed 26 October 2016).

	quarterly Project Reporting	Status				Measures	Measures 2017 - 2018	Recent Work Completed	Current Activity	Major activities planned next quarter	Target date and expected outcome/any risks or issues
Leadership		CCDHB	HVDHB	WDHB	3 DHB	2017 - 2018					
1.1	Encourage intersectoral leadership on disability issues across key government organisations including Community and Public Health Services to Partner Work with local communities				On track	Intersectoral leadership that has begun ensures that the commonalities and a shared social investment approach lead to improved access to health and social services and therefore improved health outcomes.	In 2017/18, active engagement with and from primary care, partnership arrangement in place with MoH and HDC, HSQC	Partnership with HDC agreed and in process Early meetings with MOH have occurred and funding of \$52,000 has been allocated to a process with PWC Meetings with Minister Wagner have produced national support	Negotiation with MOH PWC on funding for codesign of electronic passport	Implementation of codesign and rewrite health passport	June 2018 early testing produces direction for national process. Proposed cost of passport redesign and electronic implementation cost to be addressed December to February 2018 (MOH HSC SIP)
1.2	Practice positive partnerships to enhance collaboration and co-design				On track	People and their families are respected as experts in their own health care and proactively engaged at different levels in advising and co-design of new and existing health services and systems.	Consumer engagement, citizen engagement, coproduction on projects and design.	Sub regional group is developing annual work plan for calendar year 2018 Joint initiative with proposed CHC and mental health leadership group	Restructure of MH leadership group aligns with disability strategy and Integrated Mental Health Strategy CHC proposal to Board. On target for embedded engagement strategy in all local areas	Establish CHC and MH leadership group Planning begins for sub regional forum target September 18. Engagement with Maori and Pacific disability community leadership in early stages	community led proposal for community led local networks and sub regional structure to SIP MH December. Establishment and agreement three DHBs march 2018
1.3	Uphold the key principles of the Treaty of Waitangi				On track	Whāia Te Ao Mārama guiding principles embedded in all actions lead to improved engagement with Māori with Disabilities.	Whāia Te Ao Mārama guiding principles embedded in all actions lead to improved engagement with Māori with Disabilities.	Maori rep of SRDAG on Te Ao Marama strategy panel. Disability plan and monitoring established to embed and develop critical Maori lense consistently.	Early planning for Maori lead sub regional planning	Meeting with Maori facilitator and identified Maori with disabilities committed to engagement and development hui	Intersectoral forum: Building resilience and welleing through person/whanau community activated innovation. September 18
1.4	Utilize the skills and resource of the Disability Action Group and refresh the Champions network to ensure efficient action within the DHB	On track	On hold	On track		Disability action groups and associated champions provide easy navigation networks and support for people using services sub regionally	Disability action group to be established at Hutt and Wairarapa DHBs 17/18	Champion networks refreshed in all three DHBs. Website development to socialise now planned	Disability Action Group based on CCDHB model in development with Wairarapa DHB ELT to support champions and advisor resource.	DAG model and TOR agreed Wairarapa DHB ELT November 17 and first meeting March 18. Hutt model to be developed beginning March	Wairarapa DAG activated March 18. Policy development begins. Hutt Valley DHB development begins March 18
1.5	Ensure better accountability by creating a monitoring framework	Complete	On hold	On track		Accountability for improvement of practice is measurable and leads to initiatives reduced admissions to hospital, shorter stays where admission is necessary and by increased quality feedback from people using community and hospital services.	Monitoring framework developed and actively utilised. Dashboard of baseline structural measures is adapted for Hutt Valley DHB followed by Wairarapa DHB 18/19	Development of Outcomes framework is a key component of the strategic plan and launched June 2017. Academic and analyst input to review quality and implications of disability alerts	Draft framework being codesigned with team.	Monitoring framework in place. Completion of work plan for establishment of alert/icon at Wairarapa DHB. Establishment of webpas Wairarapa DHB. Target internal medicine CCDHB for analysis of longer average length of stay	March 18 Wairarapa icon in place. Dashboard development Hutt Valley begins by June. Analysis of CCDHB ALOS internal medicine quarter 4 (Annual Plan)
1.6	Lead a disability responsiveness education programme throughout the 3 DHBs				On track	Consumer led education targeted to for clinical and non-clinical staff contributes to greater understanding by staff leading to improved patient experience and a seamless patient journey.	Learning plan on track and implemented in each local DHB. Education of staff co led with education team and people with lived experience including whanau. (70%) to date.	KPIs for each local area educator in place	Consistent learning framework shared sub regional educational tools and sub regional consistency of aims and outcomes has been framed	Resource commissioned (disability led) to produce data on sub on optimal staff outcomes and learning models	Consistent framework for learning sub regionally with specific local variations with annual targets
Inclusion & support		CCDHB	HVDHB	WDHB	3 DHB						
2.1	Improve access to funding, information, services and support				Behind schedule	The guide to Under 65 NASCS (DSS) services means people will understand what they can access and where. This enables people and their families to be more in control of their support.	Guide will be completed within 17/18 annual plan timeframe	Guide has been edited Consultation process with MOH completed	Three DHB DSS NASCS checking details and completing approval process awaiting appointment	MOH approval sought	Guide completed and launched June 2018
2.2	Ensure IT platforms accommodate disability responsiveness tools				On track	Technology used across health and disability services enables health practitioners to understand the various components and inputs to the overall support of people and their families.	New health passport will be tested sub regionally and national roll out considered	Consultation and negotiation with MOH and HDC completed for first stage funding	Co design with Price Waterhouse MOH DHBs and HDC phase one and two completed 27 October	Proposition will be with all parties for prototype testing	Sub regional launch for testing application over three months 18/19

	quarterly Project Reporting	Status				Measures	Measures 2017 - 2018	Recent Work Completed	Current Activity	Major activities planned next quarter	Target date and expected outcome/any risks or issues
2.3	Improve transition for children and young people from child to adult services within the healthcare system	Not due to start	On track	Not due to start		The electronic pathway and tool kit co-designed with families enable them to access community health and disability services with general practice as allies.	An electronic version of the tool kit is launched in preparation for primary care demonstration Hutt Valley Three DHB	Appropriate skills to develop electronic version with demonstration site families identified	Contract to develop electronic version being negotiated and aligned to health passport development	Testing with families feedback on prototype of application	Prototype approved and testing with Primary care planned 18/19. Prototype agreed by February 2018
2.4	Ensure health professionals are flexible and cater to a persons specific needs				On track	Tools such as the disability alerts, the health passport and shared care planning enable staff to facilitate a seamless journey through health services, including funded health and disability services	Disability alerts quality framework and process is finalized. Three DHBs. Dashboard for CCDHB is agreed (CCDHB only)	Data entry process and framework simplified CCDHB and Hutt Valley and project plan refreshed	Patient pathways and clinical engagement plan developed for each local dnb. Preparation for clinical/patient collaboration on alerts Wairarapa DHB	Stocktake of clinical service use of alerts	Alerts pathway and 18/19 plan in place for incremental quality improvement
2.5	Encourage better use of technology				On track	IT tools give people options on ensuring critical information about individuals can be shared. An electronic version of the health passport enables disabled people who prefer to use their devices enables to share support information in real time.	see above 1.1, 2.2 and 2.3		Maurice Priestley beginning contract on website FAQ for people with access needs	Launch of website March 2018	
2.6	Improve accountability and integration across the planning and funding arms of the DHB				On track	A disability clause obligates providers to develop plans and improve access on a developmental basis each year. This improves access to general health and community services.	The new sub regional plan provides opportunities for refreshed approaches across all services to include disability	New clause circulated with launch of updated strategy	Examples and discussions held with providers as to what they can complete during 17/18	Reminders for reporting sent out and advice hotline in place	Summary report on implementation across NGOS and Primary care will provide baseline for future action
2.7	Ensure people are supported in decision making				On track	Staffs understand supported decision-making enabling people to better participate in decision-making about their health care.	Informed consent guidelines for staff, people with learning disabilities will be completed 17/18 (contribution to longer term skills development and supported decision making)	Negotiated resource to develop key annual plan deliverable	Consultation begins with community and staff champions	Draft kit completed for wider consultation	Kit will be released June 18 as per annual plan
2.8	Promote a whole of life approach to needs assessment and service coordination	On track				A whole of life approach across needs assessment services reduces fragmentation and enables more timely access to the appropriate support pathways irrespective of age group and condition.	Concept for a new model proposed to ELT CCDHB	Project plan and strategic whole of life leadership group established	Analytics work stream will report key population and impacts of current model of needs assessment	Concept will be developed in more detail based on analytics and ICT feedback	Model for procurement of simplified approach presented June 18
Access											
		CCDHB	HVDHB	WDHB	3 DHB						
3.1	Create an enabling environment where the person is at the centre				On track	Information available in plain language documents and in accessible formats across the 3 DHBs electronically and in hard copy puts the person in charge of their journey through the health system.	Identification of targets for 18/19 by each local DHB with its Disability Action Group	Negotiation of a Frequently asked questions website and suitable skills set identified (CCDHB first)	Review of unfinished work on navigation of services by internet	Complete Q and A website CCDHB	CCDHB model used to adapt for Wai and Hutt 18/19 plan

	quarterly Project Reporting	Status				Measures	Measures 2017 - 2018	Recent Work Completed	Current Activity	Major activities planned next quarter	Target date and expected outcome/any risks or issues
3.2	Community Resilience is promoted across the sub-region	On track	On track	Not due to start		Collaboration with councils, other government bodies and community members working across localities provides safety and better emergency preparedness as well improved connection with neighbours and other natural supports.	Vulnerable persons plan in place for all DHBs. A community circles concept for building community resilience is developed for consideration for commissioning	Good neighbours network (WCC) information shared sub regionally	Vulnerable persons plan drafted Training on community circles for staff and consumers being made available	Interagency collaboration and consultation. Review of contracts to ensure emergency preparedness is considered. Plan for commissioning community circles in at least one DHB	Draft plan is approved at CCDHB. Small demonstration site for community circles is considered aligned with whole of life nasc where there is a high percentage of isolated older people
3.3	Physical access remains a priority within the DHB	On track	On track	Not due to start		As buildings are developed, input from access experts ensures that future health care is fit for all groups irrespective of impairment.	17/18 design of new buildings has Barrier Free and consumer inputs at an early stage	Concept for children's hospital has detailed access and consumer engagement plan. Early engagement on Mental health Unit planned	Engagement plan is implemented	Service design is rigorously developed alongside communities most impacted	February 2018 phase one
3.4	Improve access to New Zealand Sign Language interpreters and quality of care for Deaf community			On track		Each year deaf people using general and mental health services have a safer journey through the health system, have improved health literacy and a large proportion of staff understand the cultural needs of deaf people.	Resources electronically available for improved navigation of health services by deaf people. Guidelines for working with people who are deaf and hearing impaired approved.	MSd funding obtained. NZSL project lead employed for sub regional programme. Research publication accepted by NZMJ	Co design of resources for staff and Deaf consumers being undertaken. Conference presentations on Deaf issues Auckland and Otago Nov 2017.	. Publication of research leads to wider national communications on deaf issues Intranet and internet resources launched. New funding to be sought via MSD and MOH	Phase one of implementation of full accessibility plan for NZSL users will be completed June 18. New funding identified for phase 2
Health											
		CCDHB	HVDHB	WDHB	3 DHB						
4.1	Direct a culture shift towards person/whanau-directed care Project plan for whole of life needs assessment Interim clinical governance established CCDHB and Hutt	On track	On track	Not due to start		Disabled people are able to access quality health care in community and hospital irrespective of multiple specialists and conditions.	Evidence: Processes for managing system & funder complexity impacting individuals facilitate collaboration & Improved	Project plan for whole of life assessment. Interim clinical governance established CCDHB & Hutt. Interim clinical governance established CCDHB and Hutt	Analytics work stream gathers data on people impacts on people across all funders. Thematic analysis on issues facing people with multiple inputs indicates need for consistent discharge processes in hospital services	Concept for whole of life pathways developed based on data gathering. Education on funding streams and discharge processes are co designed.	Concept for whole of life nasc is completed and procurement is planned
4.2	Support PHOs to improve access to services by education information from and by empowered consumers				On track	Alliance Leadership Teams and PHOs lead the way in improving disability responsiveness in general practice settings by integrating a professional and consumer disability lens in education.	Hutt Valley collaboration agreed on demonstration site. CCDHB and Wairarapa Compass Endorse and co produce E health passport and whole of life pathway. Education plan in place with clinical staff.	Strategy socialised with alliance teams and specific local deliverables agreed	Each PHO and local area engaged in planning first steps of each individual plan	Liaison and support from SIP on plan with each PHO and reporting for quarter 4	PHOs report specific actions and subsequent plan in 17/18 end of year report
4.3	Support any initiatives developed in the area of improving access to rehabilitation by providing advice and expertise available to the Directorate	On track	On track	Not due to start		Rehabilitation services improve with disability community input and good practice models are shared across health ACC and the Ministry of Health.	Collaboration SIP SPO and MOH with a new NGO alliance with philanthropic funding initially targeting post polio survivors is supported and first clinics based at NZAL centre 18/19	research into rehabilitation beds undertaken 2014 is revisited. SIP negotiation with ABI leads to identification of possible skill sharing	Meetings with Duncan Foundation and subregional allied health supportive of new initiative	Third meeting with Duncan Foundation lead and consultation with SRDAG and other interested bodies	A plan for first clinics and future potential for wider community hub approach to rehabilitation (wider sector) 18/19. Update June 18
4.4	Provide staff with engaging education and information to ensure better health outcomes for people within the hospital system				On track	Staff at pre-registration and post-registration are competent in disability literacy and adapt care to meet the needs of any person irrespective of impairments or health.	Disability literacy guide to be completed and made available electronically and in hard copy for targeted to front line administration staff	e learning launched at Hutt and CCDHB. E learning mandatory and launch date set Wairarapa	Wairarapa proposal to ELT for mandatory E learning all staff endorsed. New e learning model for Wairarapa DHB signed off linked with disability alert proposal.	Joint meeting with Educators from each area and disability strategy team agrees a sub regional disability literacy guide for each intranet locally	Disability literacy guide is socialised and well identified by critical front line staff in each local dhb