Health of Older People Workstream Work Plan 2020-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. Equitable Access for Services for Kaumātua	Continue to develop support services for kaumātua in rural areas by (EOA): ▪ Completing first year of Kahukura Kaumātua programme and gathering feedback from participants (Q2). ▪ Preparing a report on first year of Kahukura Kaumātua project (Birdlings Flat) (Q2). ▪ Handover planning for Kahukura Kaumātua project in Birdlings Flat initiated (Q3).	Q2: Eight sessions completed. Q3: Report circulated to stakeholders.	▪ Equity ▪ People are supported to stay well ▪ Community resilience /capacity enhanced
	Kahukura Kaumātua project rolled out in the Hurunui (EOA): ▪ Initial hui held in Hurunui. ▪ Hurunui programme developed. ▪ Business plan written for Hurunui programme.	Q2: Hui held in Hurunui. Q3: Programme developed alongside local community. Q4: Business plan completed.	
	Kahukura Kaumātua Birdlings Flat project handover to local community (EOA).	Year 2021/22 Q3: First sessions of 2022 run by local kaiawhina.	▪ Equity ▪ People are supported to stay well ▪ Community resilience /capacity enhanced
	Hurunui programme delivered (EOA).	Year 2021/22 Q4: Introductory programme established according to findings from 20/21.	
	Training resource developed to enable other groups to undertake similar process of engagement with cultural communities (EOA).	Year 2021/22 Q3-Q4: Resource drafted and circulated.	▪ Equity
2. Improved actions to meet anticipated increase in people with Dementia	Produce report with recommendations for service interventions to address delayed dementia diagnoses including: ▪ Dementia Specialist Nurse ▪ Diagnosis funding package	Q2: Report produced.	▪ Earlier Diagnoses ▪ Management of disease (best practice)
	Work with primary care to implement recommendations.	Q4: Business case presented.	
	Continue to work with Community and Public Health to promote dementia specific health messaging.	Q1: Promotional strategy confirmed. Q4: Promotional documents published.	▪ Population interventions
	Continue to work with primary care to implement recommendations.		▪ Earlier Diagnoses ▪ Management of disease (best practice)
	Continue to promote Dementia awareness.		▪ Populations interventions
	Liaise with #wellconnectednz to compile community resources that	Q2: Meetings held. Q3: Document produced.	▪ Behavioural interventions

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3. Improved Social integration for Older People	promote social integration, with a focus on transport options and solutions to other barriers.	Q4: Document distributed through HCSS providers.	delivered ▪ Social environment supports health
	Investigate and report on the potential for a "Social Prescription" model for older people, with attention to people's cultural and linguistic needs.	Q4: Report presented.	
	Work to implement "Social Prescription" model for selected cohort.	Year 2021/22	▪ Behavioural interventions delivered ▪ Community capacity enhanced
4. Enhanced support for cares	Enable streamlined uptake of Carer Support by simplifying systems including (EOA): ▪ Modifying claims process. ▪ Aligning with Funded Family Care policies. ▪ Developing pathways for use of Individualised Funding options.	Q1: Baseline established of Carer Support utilized and service gaps identified. Q4: Growth in Carer Support utilization measured over time. Q4: Health Pathways revised.	▪ Behavioural interventions delivered ▪ Community capacity ▪ enhanced
	Develop up-to-date information package for Carers promoting the benefits of taking time out and detailing strategies to enable people to do so.	Q3: Package produced and approved. Q4: Education package distributed at time of referral.	
	Continue to monitor Carer Support uptake and continue to work to enable accessibility.	Year 2021/22: Increased utilisation of Carer Support.	
5. Quality Improvement in ARC	Work with Health Quality Safety Commission to support work on de-prescribing in Aged Residential Care (ARC).	Q1-Q4	
	Continue work to improve HealthOne access for ARC facilities.	Q1-Q4: Increase ARC facilities have access to HealthOne.	▪ Coordinated care
	▪ Work towards increased ARC engagement in Falls Prevention. ▪ Hold Falls Prevention education session in ARC forum. ▪ Bring together ARC working group to develop strategic direction for falls prevention in Residential Care.	Q2: Falls Prevention session held. Q3: Group meeting. Q4: Strategic plan developed.	▪ Behavioural interventions delivered ▪ Access to care improved
	▪ Cross-provider resource developed to support appropriate de-prescribing of antipsychotics. ▪ Implementation of Falls Prevention plan for ARC.	Year 2021/22	▪ People are supported to stay well ▪ Management of disease (best practice)
6. Provide support for older people identified as Pre-Frail	Identify cohort of pre-frail older people via case-mix group and CAPs.	Q1: Cohort identified.	▪ People are supported to stay well
	Develop system to allow referrals for this cohort to appropriate services including Falls prevention.	Q1: Appropriate services identified. Q3: Referral.	

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	Monitor uptake of referred services from this cohort and evaluate success of this approach; adjust appropriately.	Year 2021/22	▪ People are supported to stay well
Actions towards monitoring progress			
7. Wider access to health plans	Monitor the uptake of: ▪ Advance Care Plans ▪ Medical Care Guidance Plans ▪ Personalised Care Plan	Q1-Q4: Increased use of all plans.	▪ Access to care improved
8. Health literacy	Monitor use of HealthInfo.	Q1-Q4: Traffic on site reported quarterly.	▪ Social environment supports health
9. Pressure injuries project	Review data updates from Sue Wood and team.	Q1-Q4: Reports received.	▪ Management of disease (best practice)
10. Palliative care	Maintain links with South Island Alliance Palliative Care Workstream.	Q1-Q4: Quarterly reports from ARC Palliative Care NZ service received.	▪ Access to care improved ▪ death with dignity
11. CREST	Monitor CREST transition.	Q1-Q4: Report from CSSLA.	▪ Access to care improved
12. Falls and fractures	▪ Monitor transition of Falls & Fractures SLA. ▪ Consider appropriate data monitoring to support strategic developments in falls prevention.	Q1-Q4: Reports received.	▪ People are supported to stay well
Key metrics to indicate progress delivering work plan actions, impact on health outcomes and/or monitor performance			
Description of metric			Data Source
1. Admission to ARC by ethnicity (50+ Māori).			
2. Admissions to Hospital 65+ by ethnicity (50+ Māori).			
3. Length of Stay 65+ by ethnicity (50+ Māori).			
4. ED presentations 65+ by ethnicity (55+ Māori).			
5. Number of #NOF or # humerus referred to in-home FPP (75+) – (55+ Māori).			

The 2020-21/22 CCN Work Plan for all alliance groups can be viewed on the CCN website here.