Health of Older People Workstream Work Plan 2021-22

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	Kahukura Kaumātua project rolled out in the Hurunui (EOA): ▪ Initial hui held in Hurunui. ▪ Hurunui programme developed.	Q2: Hui held in Hurunui. Q3: Programme developed alongside local community.	▪ Equity ▪ People are supported to stay well ▪ Community resilience /capacity enhanced
	Business case developed for the sustainable development of this programme (EOA).	Q3: Business Plan completed.	
	Training resource developed to enable other groups to undertake similar processes of engagement with cultural communities (EOA).	Q3-4: 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 (EOA).	Q2: Report produced.	▪ Earlier diagnoses ▪ Management of disease (best practice)
	Continue to work with Community and Public Health to promote dementia specific health messaging.	Q2: Meetings held. Q3: Strategy developed.	
3. Improved social integration for older people	Investigate and report on the potential for a "Social Prescription" model for older people, with attention to people's cultural and linguistic needs (EOA).	Q4: Report presented.	▪ Behavioral interventions delivered ▪ Equity ▪ Social environment supports health
	Work to implement "Social Prescription" model for selected cohort.	Q1: Meetings held to agree strategy. Q2: Cohort identified. Q3: Pilot begun.	▪ Behavioural interventions delivered ▪ Community capacity enhanced
4. Improved social integration for older people	Enable streamlined uptake of Carer Support by simplifying systems including: ▪ Modifying claims process ▪ Aligning with Funded Family Care policies ▪ Developing pathways for use of Individualised Funding options	Q1: Baseline established of Carer Support utilised and service gaps identified. Q4: Growth in Carer Support utilisation measured over time. Q4: Health Pathways revised.	▪ Behavioral interventions delivered ▪ Community capacity enhanced
5. Enhanced support for carers	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.	▪ Behavioral interventions delivered ▪ Community capacity enhanced
	Enable streamlined uptake of carer Support by simplifying systems including: ▪ Modifying claims process.	Q1: Baseline uptake established. Q4: Qualitative survey of users. Q4: Increased uptake identified	▪ People are supported to stay well ▪ Community capacity enhanced

*EOA – Equity Outcome Action / *SLM – System Level Measures

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	▪ Aligning with Funded Family Care policies. ▪ Developing pathways for use of Individualised Funding options.		
6. Quality Improvement in ARC	▪ Work towards increased ARC engagement in Falls Prevention. ▪ Bring together ARC working group to develop strategic direction for falls prevention in Residential Care.	Q2: Falls prevention sessions held. Q3: Group meeting. Q4: Strategic plan developed.	▪ Behavioral interventions delivered ▪ Access to care improved
	Cross-provider resource developed to support appropriate de-prescribing of antipsychotics.	Q2: Strategy developed. Q3: Pilot implementation developed. Q4: Pilot begun.	▪ People are supported to stay well ▪ Management of disease (best practice)
Actions towards monitoring progress			
7. Wider Access to Health Plans	Monitor the uptake of: ▪ Advance Care Plans ▪ Medical Care Guidance Plans ▪ Personalised Care Plan	Q1-4: Increased use of all plans.	▪ Access to care improved
8. Health literacy	Monitor use of HealthInfo.	Q1-4: Traffic on site reported quarterly.	▪ Social environment supports health
9. Palliative care	Maintain links with South Island Alliance Palliative Care Workstream (SLM).	Q1-4: Quarterly reports from ARC Palliative Care NZ service received.	▪ Access to care improved ▪ Death with Dignity
10. CREST	Continue to monitor CREST transition.	Q1-4: Report from CSSLA.	▪ Access to care improved
11. Falls and fractures	Monitor CSSLA Falls Prevention actions and receive reports of developments and progress in this area.	Q1-4: 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	
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 current CCN Work Plan for all alliance groups can be viewed on the CCN website here.